How Hospital-to-Hospital Transfer Policies Impact Billing and Coding

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To transfer or not to transfer – that is the question.

Transfers between hospitals are common

- As many as 1 in 20 critically ill patients admitted to an intensive care unit (ICU) will be transferred to a different ICU

- 90% of all patients transferred are non-emergent

The medical decision to **transfer** a patient to another acute-care facility is not an easy one.

Why Transfer a Patient

- Patient or family might want a second opinion
- The current hospital cannot address the needs of the patient
- The receiving hospital has more advanced care
- Other Clinical Reasons
- Non Clinical Reasons
  - Insurance coverage
  - Veterans

Federal Medicare regulations and each hospital's own hospital-to-hospital transfer policies shape the process and requirements for transferring patients to other acute-care facilities or alternative care sites.

EMTALA

- The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires anyone coming to an emergency department to be stabilized and treated
- Regardless of their insurance status or ability to pay
- Since its enactment in 1986 has remained an unfunded mandate

EMTALA

- All Medicare-participating hospitals must comply with the rules of EMTALA
- It governs how patients can be transferred from one hospital to another
- It only governs unstable patients; this does not apply to stable patients

Hospital Specific Policies

- Hospitals have their own transfer policies
- Most are geared to covering the requirements of EMTALA
- Requirements
  - Appropriate MSE completed
  - Stabilizing Treatment
  - Specifics for Non stabilized patients wanting or needing a transfer
  - Communication with legal representative and physican

Case Management

- Transitional planning is the process case managers employ to ensure the interdisciplinary team provides appropriate care in the most appropriate setting
- Transitional planning also includes planning and brokering of necessary services
- Case managers are the link that provides consistency for our patients during these periods of transition.
- Help to guide and track patients over time through a comprehensive array of healthcare services spanning the care

The Decision To Transfer

- The quality and safety of patient transportation, whether it be for non-emergent or critically ill patients, should "revolve around getting the right patient to the right place at the right time by the right people with the right transport receiving the right care throughout.

While **medical necessity** is always at the heart of this decision, the impact to hospital and physician reimbursement are also contributing factors.

Once the medical decision to move a patient is made and the transfer is in motion, hospitals must then ensure the claim being billed reflects the transfer. This includes codes for both

facility and physician services.

If either of these claims are billed incorrectly, there is risk of claim rejection and non-compliant billing.

Patient Discharge
Status Codes

The **patient discharge status code** identifies where the patient is going at the end of care or at the end of a billing cycle, whether it be an **inpatient** or **outpatient** encounter.

Outpatient = 01
Inpatient = 02

The code selected should most accurately reflect the care being provided post-discharge to the best of the provider's knowledge.

Many providers use an 02, whether the patient is transferring for outpatient follow up or an inpatient admission. This represents an incorrect use of the 02 code and causes an unnecessary reduction in hospital reimbursement.

This is because a discharge status code of 02 ***combined*** with a DRG that is impacted by the Medicare transfer policy results in the hospital receiving a reduced per diem rate versus the full DRG.

Occasionally, it is unclear whether a patient transfer will result in an admission.

When to use 02

An elderly patient who is transferred for a cardiac catheter procedure.

- This procedure is often completed on an outpatient basis, but the age and overall health of the patient may necessitate an inpatient stay.
- In this scenario, the hospital must code the highest level of care known at the time which is an 02 since an inpatient admission is highly anticipated.

When to use 01

A patient is discharged to receive outpatient oncology services at an acute facility specializing in oncology.

- This patient is going for outpatient services and thus the claim should be coded an 01.
- The discharge status code of 01, is not impacted by the transfer policy and the hospital is entitled to the full DRG.

Even when the Medicare inpatient transfer policy and the provider's own hospital-to-hospital transfer policy are well understood, there is still room for ~~eroor~~ error due to unknown post-discharge status.

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When unknown discharge status can cause errors…….

Example 1

A patient is transferred to a hospital for a cardiac catheter. The claim is coded an 02 and the patient does not get admitted. The hospital is going to receive the per diem payment in error. The discharge status should be an 01 and the hospital should receive the full DRG.

Example 2

Conversely, the patient is discharged to home (01) and ends up back in the hospital that day. This claim will be rejected until the discharge status is changed to an 02, even though the discharging physicians had no anticipation of the admission. This is a common error occurring in billing.

Physician Billing

Physicians may bill *either* one discharge code or one initial hospital care code on one day. At the receiving hospital or unit, the physician must not bill another hospital care code, but may combine the two visits as a subsequent care code to increase the complexity.

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There are specific requirements that would allow a physician to bill a discharge and an initial hospital code.

1. The transfer can’t occur the same day.
2. The hospital record must not be “merged”, meaning it is two separate facilities.

This rule applies to physician groups as well.

Two physicians in the same practice are held to the same limitations.

In Summary

- Patient Transfers should always have patient care at the center of the decision
- Make sure you understand federal and your hospital policies
- Understand the billing requirements and the impact on reimbursement
- Consider an internal process or vendor to confirm correct discharge codes

Thank you

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