HOSPITAL DIVISION

FINANCIAL

POLICIES and PROCEDURES MANUAL

TABLE OF CONTENTS

SECTION 2.0 – PATIENT ADMISSIONS, DISCHARGES AND TRANSFERS

POLICY

The services provided by this hospital are described in the hospital's Plan for the Provision of Patient Care. Such services and selection criteria must be applied equally to all persons seeking care in the hospital. Patient admissions are based upon documented consent, accurate billing and payment information and completed timely.

PURPOSE

To provide guidelines for obtaining proper admission documentation and timely admitting procedures to the hospital according to the hospital's established criteria.

SCOPE

This policy applies to all patient admissions.

2.1 Introduction

Admissions procedures are designed to collect referral registration data and assure pre-certification is obtained as needed prior to admissions. Prior authorization will be deemed necessary as the third party requires.

The procedures help ensure that a) the appropriate legal representative is identified, b) consent for the admission is obtained c) patient information is collected and formatted uniformly, d) pre-certification and verification of insurance and other payer information is obtained, e) accurate data is communicated throughout the organization, and f) an audit trail is provided for managers to maintain quality assurance. In conjunction with the Sales and Marketing Department, financial and operating controls ensure that patients meet admission requirements and that clinical information is captured prior to admission.

The essential elements in the admissions process include:

- Obtain referral status
- Confirm preadmission information
- Document admissions decision made by the CEO/Administrator/designee
- Identify the appropriate legal representative for the admission
- Communicate and explain the admissions process
- Provide a complete admissions documentation package to the patient and/or legal representative and obtain the necessary signatures
- Obtain and verify billing and payment information

2.2 Pre-Admission

The Clinical Liaison/designee shall confirm whether the patient is able to make his/her own decisions. Any patients who are competent may admit themselves. Any questions concerning competency and legal representation should be referred to the

CEO/Administrator/designee. If the patient has a legal representative, the Clinical Liaison/designee shall document the identity of the representative and ask for photo identification to confirm identity. If there is no available legal representative, defer the decision to admit until appropriate representation is obtained and inform CEO/Administrator/designee of all such deferrals.

The Referral Manager Pre-Admission Edit Routine allows the Admissions Clerk/designee to pre-register the patient and/or edit the pre-admission (Note: A thorough MPI search shall be performed to ensure a duplicate medical record number is not assigned). When pre-admitting a previously admitted patient, make sure the prior stay/episode has been properly discharged to prevent charting and/or billing errors.

Knect/Hospital Division/Training/Referral Manager

2.3 Admission Compliance Information

The services provided by this hospital are described in the hospital's Plan for the Provision of Patient Care. Such services and selection criteria must be applied equally to all persons seeking care in the hospital.

a) Upon approval by the CEO/Administrator/designee to accept a patient, the Admissions Clerk/designee shall begin the admissions process.

Knect/Hospital Division/Training/Referral Manager

b) Waiver of Deductible, Coinsurance and Out of Network Payment Penalties

- Medicare Patients
  In no circumstance may the Medicare co-pays or deductibles be waived. CFO/Controller shall get consult and approval from HD Legal Department
- Commercial Patients
  Kindred will comply with all State and Federal Laws regarding waiver of deductible, co-pay and out of network penalties.

  In general, deductible, insurance co-pays and out of network penalties may not be waived upon admission. There may be circumstances where waiving co-pay or deductibles may be acceptable. In those circumstances, the CFO/Controller shall get approval from both the District Chief Financial Officer (DCFO) and the Corporate Legal Department prior to waiving any co-pays or deductibles.

2.4 Admissions – General Information

Patient Classification

- Inpatient

An **inpatient** is a person who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient if formally admitted as a patient with the expectation of remaining at least overnight and occupying a bed, even though the patient may be discharged or transferred to another hospital and not actually use a hospital bed overnight.

- Outpatient

  An **outpatient's** classification is determined by the patient's physician. The patient will be admitted as an outpatient in Meditech and receive services (rather than supplies alone) from the hospital.

  If a patient with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital less than 24 hours, the patient is considered to be an outpatient for coverage purposes (regardless of the hour that the patient entered the hospital, whether the patient used a bed, or whether the patient remained in the hospital past midnight).

a) Types of hospital outpatient services:

- Services that are diagnostic in nature (e.g. laboratory and imaging)
- Outpatient surgery
- Occupational, physical, speech and respiratory therapies
- Wound care
- Other services which aid physicians in the treatment of patients.

b) Definitions of Meditech Outpatient Routine Designations

▪ Clinical (CLI)	Used for those patients receiving outpatient ancillary services such as laboratory tests, x-rays or blood tests.
▪ Recurring (RCR)	Outpatients basis receiving a series of treatments such as physical therapy, occupational therapy, speech therapy, chemotherapy, and wound care. Meditech Recurring Admission Training Guide
▪ Emergency (ER)	Patients treated in the emergency room.
▪ Surgical Day Care (SDC)	Patients admitted to the hospital for same-day surgery.
▪ Referred (REF)	Patients receiving outpatient services used for client billing (industrial accounts).
▪ Observation (Ino)	Observation patients are assigned a room and bed, but do not receive automatic room/bed charges (Note: this level shall not be assigned prior to assessment by case management).

2.5 Patient Admissions

The Admission Routines allow the Nursing Supervisor/designee to admit patients to the hospital through the Meditech Admissions function and to create ProTouch™ registrations. It is required that this function is performed by facility roles that are available 24 hours a day, 365 days a year.

Starting with the implementation of the Referral Manager Admissions Routine, the hospital will be required to process all inpatient LTACH admissions through this process.

Knect/Hospital Division/Training/Referral Manager

a) Account Number Assignment

The automated Master Patient Index (MPI) should be used to search for a prior stay/episode at the unit number prompt. If the referred patient has a previous stay/episode, the automated process in Referral Manager should be used to select the patient so that the same unit number (medical record number) may be assigned.
Referral Manager performs in the background an automatic search and the system determines if a new MRN needs to be assigned.

The Nursing Supervisor/designee shall verify data fields, and edit prior stay demographic information, when necessary.

Meditech assigns a visit-specific account number once all required fields are completed.

b) Completing Admission Forms

- Explain all benefits to the patient or responsible party upon admission
- Document this explanation on the documents scanned into the VPFF.
- Ensure that ***all*** fields are completed on admission documents and that the documents are signed by the patient/representative upon admission.
- Notify Controller/designee when signatures cannot be obtained and document reason.
- Ensure that Advance Directive information follow-up items are noted and tracked to completion.
- Attach the applicable admission forms to the patient's medical record and scan all documents into the Virtual Patient File Folder as indicated on the Admissions Document Checklist.

All patient admissions and registrations will be completed using the procedures outlined in Section 2.5 with the following exception:

Meditech Downtime Procedures-The Nursing Supervisor/designee shall perform admissions in the event of Meditech system downtime using the Virtual Patient File Folder downtime forms routine.

2.6 Admission Documents

The Meditech Admissions Package contains all required forms specific to a facility. Additional optional forms are also available and can be printed upon demand from the Virtual Patient File Folder.

Virtual Patient File Folder (VPFF)

The Virtual Patient File Folder (VPFF) allows users to access all Admission Documents, as well as other financial documents from a central location. All documents generated out of Meditech print with a bar code at the bottom of each page. In addition, all forms shall be printed from the VPFF.

For work instructions and access to the VPFF go to: Knect – Hospital Division – CBO Patient Financial Folder.

a) Required Inpatient Forms:

- Admission Agreement (includes Consent to Treat)
- Patient Rights and Responsibilities
- Alternative Dispute Resolution (ADR) Agreements - Alternative Dispute Resolution is a voluntary program that permits patients or their authorized representative to obtain faster resolution to any disputes (including quality of care or billing issues)

  Alternative Dispute Resolution Procedures

- Organ Donor Consent Forms (Utilize only if required by State law):
  - Anatomical Gift by a Living Donor
  - Anatomical Gift by Next of Kin or other Authorized Persons
- Advance Directives - Form should be utilized by the Social Service Manager/designee to ensure the patient has necessary information and assistance to establish an advance directive if desired. Follow-up action is required to obtain copies of Advance Directives identified on this form (See State specific guidelines).
- Your Right to Decide
- Statement of Ethical Policies
- Notice of Privacy Practices
- Designation of Individuals Authorized to Receive PHI
- Important Message from Medicare/Champus – (Medicare only - see note below)
- Medicare Secondary Payer Questionnaire – (All potential Medicare patients - see note below)
- Election Not to Use Lifetime Reserve Days and document on the Admission Checklist – (Medicare only - see note below)
  Request for Insurance Policy/Letter – (see section 2.8 below)
- Valuables Statement – (see section 2.10 below)

- Admission Document Checklist. (Hospitals may determine it sufficient to obtain the patient's signature on the checklist and the patient's initials on all forms listed on the checklist.)

b) Additional Resource Forms available within Meditech:

- Emergency Contacts
- Revocation of Election Not to Use Lifetime Reserve Days – (see note below)
- Anatomical Gift
- Cafeteria Ticket
- Authorization and Consent for Surgery (some state specific)
- Refusal for Medical Care (some state specific)
- Revocation of Alternative Dispute Resolution

c) Explanation of additional forms required for Medicare patients:

- Inpatients - An Important Message from Medicare/Champus - This form shall be given to the patient within 2 calendar days of admission and be signed by the patient/representative. A follow-up copy of the form signed at admission shall be given to the patient within 2 calendar days of discharge. This form requires the address of the state Quality Improvement Organization (QIO) be pre-printed. It is the responsibility of the DQM / Admissions Clerk to ensure that this information is accurate. Use http://cms.hhs.gov/QualityImprovementOrgs/ as a resource.

- All patients - Medicare Secondary Payer Questionnaire - Medicare regulations require the hospital to obtain information on possible Medicare secondary payer situations. Also see Section 6.2 "B" Medicare Part A – Specific Instructions. Medicare-completed accomplished by the Facility Based Admission Clerk/Designee.

- Inpatients - Election Not to Use Lifetime Reserve Days. The Facility Based Admissions Clerk/designee is required to notify patients who have already used, or will use, 90 days of benefits in a spell of illness that they can elect not to use reserve days for all, or part of, the stay. Lifetime Reserve Day use is generally in the beneficiary's best financial interest and thus the patient is "deemed" to have chosen to use these days unless they make an affirmative election to not use this benefit. If a patient elects not to use Lifetime Reserve Days, the Election Not to Use Lifetime Reserve Days Form shall be completed and maintained in the patient's financial folder.

  A Medicare beneficiary who is eligible for medical assistance (Medicaid) under a state plan shall be advised that such assistance will not be available if the beneficiary elects not to use Lifetime Reserve Days.

  Medicare Supplement plans may also require the beneficiary to use all Lifetime Reserve Days before the plan coverage begins.

- Inpatients - Revocation of Election Not to Use Lifetime Reserve Days – Use this form only when a Medicare beneficiary who previously elected not to use Lifetime Reserve Days desires to revoke that election.

d) Required Outpatient Forms

- Patient-specific face sheet
- Admission Agreement (includes Consent to Treat)
- Patient Rights and Responsibilities
- Alternative Dispute Resolution (ADR) Agreement - Alternative Dispute Resolution is a voluntary program that permits patients or their authorized representative to obtain faster resolution to any disputes (including quality of care or billing issues). See State specific guidelines.

  Alternative Dispute Resolution Procedures

- Advance Directives - Form should be utilized by the Social Service Manager/designee to ensure the patient has necessary information and assistance to establish an advance directive if desired. Follow-up action is required to obtain copies of Advance Directives identified on this form.

2.7 Admissions Documentation Audit

The CBO shall review three (3) inpatient and three (3) outpatient (where relevant) financial folders on a monthly basis to ensure admissions documentation is adequate. Evidence of this review shall be documented and retained.

2.8 Request for Insurance Policy

The patient and/or family members shall be requested to provide the hospital with a copy of the patient's insurance policy, whether a supplement to Medicare or any other insurance which the hospital is to bill. The hospital may prepare, in advance, a form letter (to be signed by the patient or authorized representative) requesting that a copy of the patient's insurance policy be mailed directly to the hospital from the insurance carrier for billing purposes.

Request for Copy of Insurance Policy Form (sample)

Insurance Company Request for Policy Letter (sample)

The Facility Based Admissions Clerk/designee shall document all attempts to obtain copies of the patient's insurance policy, insurance card, and other insurance information in the patient's Meditech notes. If the patient is unable to provide a copy of the primary or supplemental insurance policy, the request for policy letter (provided that it bears the signature of the patient or authorized representative) will permit the CBO/designee to obtain a copy directly from the insurance carrier. If the above information cannot be obtained, the CBO/designee shall notify the CFO/Controller.

The hospital is not required to obtain copies of insurance policies for Medicaid, established managed care contracts or outpatients.

2.9 Patient-Specific Contracts

If upon initial insurance verification of a prospective admission, an insurance company requests a discount from verified benefits, the Managed Care Representative / Designee shall be responsible for negotiating the patient-specific contract. Additionally, any subsequent "Letter of Agreement" shall be prepared and controlled by Managed Care / Designee.

A patient-specific "Letter of Agreement" may be created under the following situations involving a non-contracted insurance company requesting a discount from the payment methodology identified in the verification of benefits:

Example 1: Acute benefits are verified at 100% of all billed charges, but the insurer requests a discount.

Example 2: Acute benefits are verified at a percent of charges, but the insurer requests a per diem rate.

Example 3: After admission, the patient moves to different level of care (ICU to Med/Surg) and the insurer requests a different rate.

LOA – Medicare Advantage Template

LOA - Per Diems - Exclusions - Stop Loss Template

LOA - % of Charge Template

All patient-specific "Letters of Agreement" should contain language covering the following areas:

A. **Reimbursement:**

The CFO/Controller/Manager Care Representative shall negotiate the reimbursement terms. The preferred order is:

1) Percent of billed charges
2) Per diem plus exclusions and stop-loss provisions
3) All-inclusive per diems and stop-loss provisions

B. **Level of Care:**

The Admissions Coordinator/Clinical Liaison shall inform the CFO/Controller as to what level of care (e.g. ICU, Med/Surg or Acute Rehab, subacute, etc.) the patient will be admitted.

C. **Inclusions / Exclusions:**

List of specific hospital services to be provided and reimbursement for each excluded item. References to AWP (Avg. Wholesale Price) cost plus mark-ups should be avoided due to complexity in administering and billing.

D. **Stop-Loss Language:**

Protection from financial loss due to medically complex patient.

Example:

Switch from per diem to percent of billed charges for all billed charges exceeding a certain charge threshold.

E. **Prompt Payment:**

Expected number of days for an insurance company to pay a bill before payment of total billed charges required.

Suggested Guideline:

If payment under this arrangement is not made within 30 days after receipt of claim, the above- mentioned discounted rate shall be forfeited and full payment is required.

F. **Execution of Letter of Agreement:**

The Letter of Agreement shall be signed by the CFO/Controller/designee and forwarded to the insurer (via mail or fax) for execution. The fully executed Letter of Agreement shall be stored in Sonata.

G. The CBO shall input the patient specific contract in Meditech.

I. **Insurance Mnemonics:**

If a new insurance mnemonic is required for setup in Meditech, the Insurance Mnemonic Contract Request Form shall be completed and sent directly to the Regional Senior Director of Patient Accounting for approval. Pending approval, the Regional Senior Director of Patient Accounting will forward the request to the Managed Care Department for assignment of the managed care organization code (MCO) and to the email group 'IS-FSD Patient Accounting' for creation in Meditech. Please note that facility personnel will no longer need to call the help

desk to open a ticket. Once the insurance mnemonic is complete or if there is an issue with the form, the Meditech Group will notify facility personnel.

Insurance Mnemonic Contract Request

2.10 Medicaid Eligibility/Application Process

The Director of Case Management/designee shall facilitate the Medicaid application process, and the family is responsible for completing state-specific financial disclosure forms for medical assistance eligibility. The DC/designee shall utilize third party vendor support where available to assist with this process.

2.11 Patient Valuables

Patients should be discouraged from bringing valuables into the hospital. Valuables should be placed with family members upon admission. If no family members are present, valuables should be inventoried by at least two hospital employees on an inventory form (item by item) and placed in a secure location approved by the CFO/Controller. The original copy of the inventory form shall be signed by the persons performing the inventory and placed in the patient's medical chart, indicating items are being held at the patient's request. A copy of this form shall be given to the patient or responsible party, with another copy of the form accompanying the valuables.

All valuables must be returned upon the patient's request. The patient/representative shall sign the inventory form, indicating the valuables are received/returned. (Copy shall be maintained in the patient's records). State guidelines must be followed when returning valuables.

Patient Valuables Inventory Form (Sample)

2.12 Patient Discharge

A physician's order is required for all discharges (See Administrative Policies and Procedures manual for Kindred's discharge policies.).

The Nursing Department shall discharge all patients through ProTouch™.

The Facility Based Admissions Clerk/designee shall verify that discharges are occurring accurately in Meditech (e.g. review of Midnight Census Report, room-by-room visual check of patient's, etc.) The discharge disposition (terms upon which the patient leaves the hospital) is required before a DRG can be calculated.

Note: (Outside Services) In general, patients should not be discharged when sent to another facility for outside services (e.g. outpatient surgery, CT or MRI). Patients should be discharged only in the following circumstances:

a) The patient will be receiving a service from the outside provider that is normally performed on an inpatient basis.
b) The patient has complications while at the other facility and the physician decides to admit the patient in that facility. The patient should then be discharged at the time he/she left our hospital.
c) If the patient is kept in observation over 48 hours at the outside provider facility, the patient should be discharged to that facility. The patient should be discharged at the time he/she left our hospital.
d) Observation should be less than 23 hours. Therefore, all patients in observation between 23 to 48 hours should be assessed on a one-by-one basis.

NOTE: See section 6.5.E for hospice elections during an inpatient stay.

2.13 Midnight Census

The purpose of verifying the daily census is to ensure the accuracy of admissions, discharges, census, and location of patients. This process will identify patients not admitted or discharged from Meditech and any change in accommodation type (e.g., a patient was moved from ICU to Med-Surg) and not entered into Meditech.

The Midnight Census Form is completed and initialed by the House Supervisor each evening at Midnight and routed to the Medical Records Department.

Midnight Census Form

The Medical Records Director/designee completes a Medical Records Census report based on the Midnight Census Form information provided by the House Supervisor and forwards this and the Nursing Midnight Census Report to the Admission Director/designee.

Medical Records Census Report

The Admissions Clerk/designee runs the Meditech Census by Unit report and compares the information to these reports (Midnight Census Form, Medical Records Census Report, and Meditech Census) - any discrepancies are resolved and reconciled (review unit charts, nurses notes, etc.). The Midnight Census report, Medical Records Census report, and Meditech Census by Unit report are signed and dated by the Admissions Clerk/designee and forwarded to the business office.

The Admissions Clerk/designee compares these reports (The Midnight Census report, Medical Records Census report, and Meditech Census by Unit report) to the daily ADM batch to ensure room and board charges are accurate based on patient location prior to posting (ADM room and board charges agree to Meditech census). Admissions Clerk/designee initials and dates the package of reports and maintains in business office.

After the verification process is complete, the Facility Based Admissions Clerk/designee runs the Census by Unit report in Meditech each day and distributes to the following department managers, as needed or requested:

CFO/Controller, CCO, Social Services, Materials Mgmt., Rehabilitation, Environmental Services, Nursing Administration

Census by Unit – (Meditech→Admissions→ Reports →Inpatient → Census →Nursing Unit)

2.14 Transfer of DRG Payer Patients (between hospitals sharing Medicare provider number)

For hospitals that share a single Medicare provider number, the following policies and procedures shall be followed with regard to the transfer of DRG Payer patients between hospitals. These payers include but are not limited to Medicare, Medicare Managed DRG and TRICARE:

- A transfer log shall be maintained and reviewed by CFO/Controller/designee at the original and discharging hospitals to track admissions, days, length of stay, transfer date, discharges and DRG revenue per case. In addition, a transfer reconciliation shall be prepared each month to ensure all statistical information has been handled correctly.

  Transfer Log Transfer Reconciliation

- The transferring hospital shall notify CMR (Central Medical Records), via CMR tracker, of all discharges to a hospital with the same Medicare provider number. The receiving hospital shall admit the patient as an exception to the interrupted stay rule, using the original date of admission of the patient.
- Upon patient transfer and admission to the receiving hospital, notify 'IS-FSD Billing Support' to move all patient days and gross charges from the original (discharging) hospital to the receiving hospital in Meditech.
- Once all charges have been moved, cancel Admission in the discharging hospital
- Physician orders will not transfer within Protouch and must be re-entered into the new facility admission.
  - The final bill shall be submitted to the Medicare intermediary by the discharging hospital.
  - Gross charges and patient days will be included in the Business Warehouse data on the discharging hospital.
  - Remove 1 admission from the discharging hospital (via SKF entry to SAP) in the month of patient transfer (Meditech counting 2 admissions).
  - Remove 1 discharge from the original hospital (via SKF entry to SAP) in the month of patient transfer (Meditech counting 2 discharges).
  - Discharging hospital shall move applicable Medicare patient days to the original hospital via SKF entry to SAP (based upon transfer log information).
  - The following 3 new SKF accounts shall be used to record the manual adjustments required above:

    ADM46 Medicare Admissions Transfer Chronic

DIS47 Medicare Discharges Transfer Chronic
PDAY74 Medicare PD Transfer

- Discharging hospital shall compute net revenue per patient day (PPD) applicable to the patient's entire stay and apply the PPD rate to the length of stay at the original hospital (based upon transfer log – see above).
- Discharging hospital shall move revenue computed above to the original hospital via journal entry to SAP.
- Medicare Part B bill shall be completed manually by the discharging hospital, and Medicaid billing responsibility shall remain with the hospital which provided Medicaid services.