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I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Facility”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to ensure compliance with Medicare operational requirements unique to units that the Centers for Medicare and Medicaid Services (CMS) has designated as exempt from reimbursement under the Medicare inpatient prospective payment system (IPPS) applicable to acute care hospitals (Acute Care IPPS).


III. DEFINITIONS:

- A. **“Exempt Unit”** means a Facility unit that is recognized by CMS as meeting the criteria for exemption under the Acute Care IPPS.
- B. **“Exempt Psychiatric Unit”** means an Inpatient Psychiatric Facility (IPF) that is recognized by CMS as meeting the criteria for exemption under the Acute Care IPPS.
- C. **“Exempt Rehabilitation Unit”** means an Inpatient Rehabilitation Facility (IRF) that is recognized by CMS as meeting the criteria for exemption under the Acute Care IPPS.

IV. POLICY:

Tenet Facilities that have Exempt Units must, at all times, comply with the general requirements applicable to operation of such Exempt Units, including:

- Accurate and proper billing for services provided in Exempt Units;
- Accurate identification of admissions, discharges and transfers to and from Exempt Units;
- Proper utilization of beds and rooms in Exempt Units; and
- Permissible expansion/contraction of Exempt Units size and/or bed capacity.

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V. PROCEDURE:

A. Facility Implementation

1. Designation As An Exempt Unit

Acute hospitals or hospital units may be excluded from Acute Care IPPS and qualify as an Exempt Unit in accordance with the following:

- a. **Psychiatric Units:** Psychiatric units are exempt from Acute Care IPPS once CMS certifies that they satisfy the regulatory criteria.
- b. **Physical Rehabilitation Units:** Inpatient rehabilitation units are exempt from Acute Care IPPS once CMS certifies that they meet the regulatory criteria.


2. Payment for Services in an Exempt Unit

- a. **Psychiatric Units:** Medicare reimburses a hospital for the reasonable cost of medically necessary covered services furnished in an Exempt Psychiatric Unit through a distinct prospective payment system exclusive to the psychiatric context.
- b. **Physical Rehabilitation:** Medicare reimburses a hospital for the cost of medically necessary covered services furnished in an Exempt Rehabilitation Unit through a distinct prospective payment system exclusive to the rehabilitation context.

3. General Requirements

- a. Exempt Units must be operated in accord with all applicable state licensure laws.¹
- b. Exempt Units must be operated in compliance with all applicable federal requirements.
- c. Exempt Units must maintain distinct written utilization review standards applicable to the type of care offered on the Unit.
- d. Beds located within an Exempt Unit must be maintained physically separate from (i.e., may not be commingled with) the other beds in

¹This policy does not address state licensure law issues.

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the acute-care hospital.²

- e. Exempt Units must have medical records, which are separate from those of the hospital within which the Unit is located.
- f. A hospital may have no more than one Exempt Psychiatric Unit and one Exempt Rehabilitation Unit.

4. Admission Criteria


Exempt Units must maintain appropriate written admission criteria that are distinct from those of the hospital. Procedures must be in place to ensure patients admitted for care in the Exempt Unit meet the admission criteria and the criteria must be applied uniformly to Medicare and non-Medicare patients.

5. Transfer Requirements

a. Transfers within the same Facility


- (1) When a physician orders the transfer of **any** patient from the acute-care area of the Facility to an Exempt Unit within the same Facility:
 - (a) The patient disposition will reflect a discharge or, a transfer if the DRG is on the CMS list requiring a discharge be reported as a transfer (*i.e.*, a specified DRG), and the Facility will submit a claim to Medicare under the Facility’s Medicare acute-care provider number for the services rendered in the acute care setting.
 - (b) For the specified DRGs, the patient disposition is considered by Medicare to be a **qualified discharge** and is treated as a transfer for Medicare payment purposes and the status code will reflect a transfer to an Exempt Unit. (See Regulatory Compliance Policy COMP-RCC 4.01 Hospital Discharge/ Transfer Policy for Medicare Patients for more

²CMS approves Exempt Units on a bed-specific basis. The exemption letter that a hospital receives upon receiving approval for an Exempt Unit identifies the specific beds to which the exemption applies.

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information).

- (c) A new admission will be recorded and a new patient record will be created to reflect the admission of the patient to the Exempt Unit.
 - (d) The Facility will maintain written policies to ensure that when a patient within the hospital is discharge or transferred to an Exempt Unit, all necessary clinical information is concurrently transferred to the Exempt Unit.
- (2) If a patient in an Exempt Unit requires inpatient acute-care treatment:
- (a) The Facility will record a transfer (as opposed to a discharge) from the Exempt Unit and submit a claim to Medicare under the Facility's Exempt Unit provider number for the services rendered in the Exempt Unit.
 - (b) The patient disposition will designate a transfer to an acute-care setting.
 - (c) If acute-care treatment is to be furnished within the same Facility, a new admission and patient record will be initiated to reflect the admission of the patient to the acute-care area of the Facility.
 - (d) The Facility will maintain written policies to ensure that when a patient within the Facility is transferred from an Exempt Unit into an acute-care unit, all necessary clinical information is concurrently transferred to the acute-care unit.
- b. Overflow
- (1) An Exempt Unit patient should not be assigned to a bed that is part of the Acute Care IPSS Facility. However, if the Exempt Unit is full and the patient meets INTERQUAL criteria for inpatient admission, the patient may be admitted to the Acute Care IPSS Facility and the services provided

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must be billed under the Facility's acute hospital provider number.

- (2) An acute care patient should not be assigned to a bed in an Exempt Unit due to the requirement the Exempt Unit must have beds physically separate from acute care beds. In addition, state licensure laws may also prohibit such acts.
- (3) Because CMS has developed different reimbursement methodologies for Exempt Units, overflow situations, if not properly managed, coded, and billed, can result in inappropriate Medicare reimbursement.
- (4) If a Facility's Exempt Unit is full (*i.e.*, all designated beds are occupied) the following rules apply:
 - (a) Transfers within the same Facility
 - (i) A discharge from the acute-care area of the Facility shall not be recorded until and unless the patient is admitted to a bed in the Exempt Unit.
 - (ii) The Facility will not, for billing and/or reimbursement purposes, temporarily increase the size of the Exempt Unit to accommodate overflow situations.
 - (b) Transfers from another acute-care hospital
 - (i) A Facility will not accept transfers from another hospital unless it is medically necessary, and the patient's needs can be met at the receiving Facility.
 - (ii) A Facility will not accept a transfer for care to be furnished in an Exempt Unit unless the Exempt Unit has the capacity to provide the care (*i.e.*, a vacant bed) immediately upon arrival of the patient.
 - (iii) A Facility will not accept a transfer of a

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patient requiring care in the Exempt Unit and admit the patient to the acute-care area of the Facility in the expectation that a bed will be available in the Exempt Unit. See Prohibited Actions below.


(v) If the patient’s medical needs can be **immediately** met in the acute-care setting and the patient meets INTERQUAL criteria for inpatient admission, the patient may be admitted as an acute-care patient and treated in a bed in an acute-care unit. The case will be billed under the Facility’s acute hospital provider number and the Facility will be reimbursed according to the Acute Care IPPS.

(c) If the patient is subsequently discharged or transferred to the Exempt Unit when a bed becomes available, the Facility will bill and be reimbursed in accordance with Subsection IV.A.5.a.(1) above.

6. Charting, Coding and Billing

A Facility with an Exempt Unit will:

- a. Ensure that transfers to and from the Exempt Unit within the Facility are properly reflected in the patient’s record in accordance with this policy;
- b. Ensure that clinical documentation is supportive of the need for admission or transfer;
- c. Establish systems to identify admissions and transfers to and from Exempt Units for the purpose of ensuring that such admissions and discharges are properly coded and properly reflected in the Facility’s billing and financial records; and
- d. Ensure that claims submitted to Medicare under the provider number of the Exempt Unit include only the charges for and days of care furnished while the patient was in a bed in the Exempt Unit.

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7. Cost Reporting

- a. The costs associated with each Exempt Unit are to be reported to Medicare through the consolidated cost report filed by the Facility in which the Exempt Unit is located.
- b. The Facility must treat each Exempt Unit as a distinct cost center for purposes of cost finding and cost apportionment.
- c. The direct costs associated with inpatient care services provided in each Exempt Unit must be separately identified on the cost report (*i.e.*, reported separately from the costs incurred in the other areas of the Facility in which the Exempt Unit is located).
- d. Administrative, overhead, and other costs must be appropriately allocated to each Exempt Unit on the cost report, and the Facility must maintain adequate statistical data to support the allocation.


8. Changes in Classification

- a. A Facility unit may be reclassified from a non-Exempt Unit to an Exempt Unit only at the start of a cost reporting period. No such reclassification may occur during the course of the cost reporting period.
- b. A Facility unit may be reclassified from an Exempt Unit to a Non-Exempt Unit at any time during a cost reporting period so long as the Facility:
 - (1) notifies its Medicare Administrative Contractor (MAC) and CMS Regional Office at least 30 days before the date of the change; and
 - (2) maintains the information needed to accurately determine the costs attributable to the Exempt Unit.

Once the Exempt Unit is reclassified into a Non-Exempt Unit, it must remain a Non-Exempt Unit for the remainder of the cost reporting period.

9. Changes in Size or Bed-Capacity

- a. Except in the special cases noted in Section (b) below, changes in

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the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS Regional in writing of the planned change at least 30 days before the date of the change. The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period.

- b. Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes

10. Protocols for Changing the Status, Designated Beds and/or Size of an Exempt Unit

If a change in status or the size or bed capacity (increase or decrease) is planned in an Exempt Unit:

- a. The Facility must advise its Regional Counsel, Regional Senior Vice President and Facility Hospital Compliance Officer, as well as Tenet Government Programs *at least* 120 days prior to the planned implementation date (see Administrative Policy AD 1.16 Facility Operational Changes). This notice must be in writing and specify the:
 - (1) Exact change to bed/room designations currently within the Exempt Unit;
 - (2) Exact change to bed/room designations currently within the acute-care portion of the Facility; and
 - (3) Specify the size (in total square feet) and bed capacity in the Exempt Unit before and after planned changes are made.

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- b. Regional Counsel will prepare and submit all appropriate correspondence regarding the planned change to the state agencies responsible for licensure, survey, and inspection.
- d. Government Programs will prepare and submit all appropriate correspondence regarding the planned change to the MAC and CMS.

11. Prohibited Actions include the following:

- a. Submitting a claim to Medicare under the Facility's Exempt Unit provider number for services that were not furnished in the Exempt Unit.
- b. Admitting a patient to the acute-care area of the Facility even though the medical record shows that the patient required care in the Exempt Unit.
- c. Transferring a patient who requires only the level of care being provided in the Exempt Unit to the acute-care area of the same Facility or to a hospital-based skilled nursing unit or swing bed.

B. Responsible Person


Each Exempt Unit Director is responsible for assuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Facility, and that instances of noncompliance with this policy are reported to the designated Compliance Officer.

C. Auditing and Monitoring

Audit Services will monitor adherence to this policy

D. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

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VI. REFERENCES:

- Prospective Payment Systems for Inpatient Hospital Services, Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs, 42 CFR §§412.20 – 412.30
- Quality Improvement Organization Manual (QIO) §4255 Circumvention of Prospective Payment System (PPS)
- Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units, 42 CFR §412.600 - §412.632
- Publication 100-04 Medicare Claims Processing Manual, Chapter 3, section 140
- Publication 100-02 Medicare Benefits Manual, Chapter 2, section 10 through 80
- CMS Transmittal 59, “Inpatient Psychiatric Facility Prospective Payment System (IPF PPS),” dated 11/09/06
- CMS Transmittal 938, “Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS),” dated 05/05/06