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<p style="text-align: center;"><b>Manual</b></p>	<p style="text-align: center;"><b>Section</b></p>	<p style="text-align: center;"><b>Policy Number</b></p>
<p style="text-align: center;">Nursing</p>	<p style="text-align: center;">Nursing</p>	<p style="text-align: center;"><b>N. 001</b></p>
	<p style="text-align: center;"><b>Effective Date: 03/2003</b></p>	<p style="text-align: center;"><b>Supersedes or Revised  Date: 5/2012</b></p>

**PURPOSE**

To provide a structure by which defined standards of nursing care can be systematically organized, monitored and evaluated, consistent with the mission and the vision of Kindred Healthcare.

- i. Nursing care is those functions, including basic healthcare, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof, which require a substantial amount of scientific knowledge or technical skill and includes all of the following: Direct and indirect patient care services to ensure the safety, comfort, personal hygiene, and protection of patients, and the performance of disease prevention and restorative measures.
- ii. Direct and indirect patient care services, including but not limited to, the administration of medications and therapeutic agents necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by the state codes.
- iii. The performance of skin tests, immunization, and the withdrawal of human blood from veins and arteries.
- iv. Observation for signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and implementation, based on observed abnormalities of appropriate reporting or referral of standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

Written standards of nursing care are used within the hospital to monitor and evaluate the quality and appropriateness of nursing care. See the Nursing Standards of Care Policy.

**SCOPE OF SERVICES**

**Admission Criteria**

Admission Criteria are to be used as guidelines; they are not intended to be all inclusive or exclusive. The guidelines will assist staff in decision making and directing questions for the team to best place our patients.

**Medical Admissions**

Kindred Hospital accepts adult and geriatric patients with various medical conditions and physical disabilities. We recognize that care may take place over many months due to the

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medical complexity of our patients. A review is done prior to admission to assure the persons care needs can be met with projected staff levels.

1. We accept patients within, but not limited to, the following classifications:
  - a. Pulmonary Cases:
    - i. Presently ventilator-dependent but are weanable.
    - ii. Totally ventilator-dependent and are not weanable.
    - iii. Require assisted or partial ventilator support.
    - iv. Have tracheostomy and require supplemental oxygen and bronchial hygiene.
  - b. Cardio-Pulmonary Disorders:
    - i. Obstructive Diseases.
    - ii. Restrictive Diseases.
    - iii. Adult Respiratory Distress Syndrome.
    - iv. Broncho-Pulmonary Dysplasia.
    - v. Congestive Heart Failure.
    - vi. Post Myocardial Infarction.
    - vii. Respiratory Insufficiency.
    - viii. Central Hypoventilation.
    - ix. Respiratory Failure.
  - c. Central Nervous System Disorders:
    - i. Motor Neuron Diseases.
    - ii. Neuromuscular Diseases (*e.g.* Multiple Sclerosis).
    - iii. Post-polio Status.
    - iv. Developmental Anomalies.
    - v. Phrenic Nerve Dysfunction.
    - vi. Amyotrophic Lateral Sclerosis (ALS)
  - d. Neurological & Orthopedic Disorders:
    - i. Head Injury.
    - ii. Brain Stem Trauma.
    - iii. Spinal Cord Trauma.
    - iv. Cerebral Vascular Accident.
    - v. Central Nervous System Insult.
    - vi. Chemical Brain Injuries.
    - vii. Post-Op orthopedic patients and/or casted patients.
    - viii. Neoplastic Compromise.
  - e. Wound Care
  - f. Bariatric Patients (Patients greater than 300 lbs or BMI 40% or greater.) with medically complex needs
    - i. Weight limit 417lbs
    - ii. Guideline to keep total number of bariatric patients to 4 or less, more than 4 would require administrative approval and review of equipment/resources needed to provide care.

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2. The attending physician/nurse practitioner is expected to see new admissions within specified time periods, as follows:
  - Patients transferred from another physician; within 6 hours of admission
  - Patients transferred from another facility but maintaining the same physician: the day of transfer at either facility.

### **ICU Admission Guidelines**

1. Patients with any of the following conditions meet admission criteria for the ICU:
  - a. Hemodynamic instability, close monitoring, and/or intravenous vasoactive drugs requiring titration.
  - b. Cardiac dysrhythmias requiring titration of intravenous anti-dysrhythmic medications.
  - c. Respiratory status instability e.g. patients with ETT, frequent changes in respiratory management, unstable pulmonary embolism, unstable congestive heart failure.
  - d. Deterioration or potential for acute deterioration in neurological status, e.g. uncontrolled seizures, acute CVA.
  - e. Rapidly changing electrolytes and/or blood and fluid volumes e.g. active gastrointestinal monitoring, unstable diabetes.
  - f. Invasive hemodynamic monitoring.
  - g. Requirement for more intense nursing, respiratory care, or supervision.
3. The attending physician is expected to see new admissions to the ICU within specified time periods, as follows:
  - Patients transferred from another physician; within 4 hours of admission
  - Inpatients with acute changes requiring admission: within 2 hours. (The House physician or ARNP may provide this assessment, in conjunction with phone contact to the attending physician.) That physician then needs to record their assessment in the medical record.

### **Discharge/Transfer Criteria**

#### **ICU Discharge/Transfer to Medical Status**

The criteria are a guideline for discharge from the ICU. Patients who meet some, but not all criteria, depending on the particular circumstances, may be transfer candidates. The medical provider will assess the patient and determine intensity of service needed. Patients may be transferred within the facility from ICU to the medical unit depending on the criteria listed above for admission to medical unit and as follows:

- Blood Pressure stable, no longer requiring checks more often than every two hours.
- Absence of shock
- Absence of severe hypertension
- Not requiring intravenous vasopressors/vasodilator drips
- Intra-arterial monitoring or pulmonary artery monitoring discontinued
- Temperature WNL

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- Absence of life-threatening dysrhythmias
- Absence of frequent changes in respiratory management
- Does not require suctioning more than every two hours
- Stable level of consciousness appropriate to existing diagnosis
- Does not require neurological checks more than every two hours
- Stable electrolyte values
- Does not require measurement of I & O more than every two hours
- Absence of active GI bleeding

**Special Note:** The Medical Director of the Intensive Care Unit (or designee) will retain final decision making responsibility for all patient admissions, transfers, and/or discharges when the prioritization of beds must be made.

#### **Transfers/Discharges to Short Term Acute Care Hospitals**

Patients may be transferred to a short term acute care hospital if they require services not provided at Kindred including but not limited to diagnostic services, surgical services, procedural services such as MRI, cardiac critical care, etc. Patients may be transferred to a higher level of care if they become more hemodynamically unstable and as deemed necessary by the medical and nursing staff.

#### **Transfers/Discharges to Lower Level of Care or Home**

Patients will be transferred to another facility or discharged depending on their health status. The team will decide based on medical criteria, using Qualis guidelines, when a patient is ready for a lower level of care.

#### **Requirements For Staff: (See Education Plan for New Employee Orientation Requirements in addition to the below clinical competencies for nursing and the Scope of Service Plan for Nursing)**

1. Supervisors will be clinically competent for hiring if they:
  - a. Current state licensure as an RN.
  - b. Current BCLS.
  - c. Current ACLS.
  - d. Minimum of 2 years as an RN in med/surg and/or ICU experience or equivalent.
  - e. Prefer a minimum of 1-2 years of supervisory experience.
  - f. Will demonstrate successful completion of new employee orientation which includes 80% or better scoring on exams on medication, IV therapy, and Basic EKG / Dysrhythmias recognition.
  - g. Within 90 day probationary period will complete a minimum of 80% of unit based skills/competency orientation checklist.
  - h. Complete annual requirements as outlined within the education plan and any mandatory unit specific competencies identified through survey or high risk/problem prone or new procedures.
2. The basic requirements for RN staff include:

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- a. Current state licensure as an RN.
- b. Current BCLS.
- c. Minimum of 2 years RN experience in Medical-Surgical and/or ICU or equivalent preferred.
- d. Current ACLS preferred.
- e. For RN's working in the ICU, ACLS is required along with documentation of an ICU course and/or documentation and verification of at least 1 year recent ICU experience.
- f. Will demonstrate successful completion of new employee orientation which includes 80% or better scoring on exams on medication, IV therapy, and within one year of hire an 80% score or greater on the exam for Basic EKG / Dysrhythmia recognition.
- g. Within 90 day probationary period will complete a minimum of 80% of unit based skills/competency orientation checklist.
- h. Complete annual requirements as outlined within the education plan and any mandatory unit specific competencies identified through survey or high risk/problem prone or new procedures.

3. The basic requirements for LPNs include:

- a. Current state license as LPN.
- b. Current BCLS.
- c. Minimum of 2 years clinical experience in Medical-Surgical or equivalent preferred.
- d. ACLS preferred and must be completed within first year of employment.
- e. For LPNs working in the ICU, ACLS is required along with documentation of an ICU course and/or EKG interpretation course. If no course taken, documentation and verification of at least (1) year ICU experience.
- f. Will demonstrate successful completion of new employee orientation which includes 80% or better scoring on exams on medication and IV therapy.
- g. Within 90 day probationary period will complete a minimum of 80% of unit based skills/competency orientation checklist.
- h. Complete annual requirements as outlined within the education plan and any mandatory unit specific competencies identified through survey or high risk/problem prone or new procedures.

4. The basic requirements for Nursing Assistants include:

- a. Certification as a Nursing Assistant by the state.
- b. Certification by the state within 90 days of employment for specific circumstances including nursing students, aides with certification from another state, or experienced aide enrolled in certification program.
- c. Current BCLS.
- d. One year of clinical experience as a nursing assistant in an acute care hospital setting or equivalent is preferred.
- e. Will demonstrate successful completion of new employee orientation.
- f. Within 90 day probationary period will complete a minimum of 80% of unit based skills/competency orientation checklist.

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g. Complete annual requirements as outlined within the education plan and any mandatory unit specific competencies identified through survey or high risk/problem prone or new procedures.

5. The basic requirements for the Wound Care Coordinator include:

- a. Current licensure as either an RN or LPN in Washington.
- b. Wound Care certification within first year of hire.
- c. Minimum 1 year experience as wound care nurse.
- d. Current BCLS.
- e. One year of clinical experience in surgical unit preferred.
- f. Will demonstrate successful completion of new employee orientation.
- h. Within 90 day probationary period will complete a minimum of 80% of unit based skills/competency orientation checklist.
- i. Complete annual requirements as outlined within the education plan and any mandatory unit specific competencies identified through survey or high risk/problem prone or new procedures.

6. The basic requirements for Unit Clerk/Telemetry Technician include:

- a. One year of experience as a unit clerk or equivalent experience.
- b. Current BCLS.
- c. Have successfully completed the Basic EKG/Dysrhythmia exam with 80% or better score.
- d. Will demonstrate successful completion of new employee orientation.
- e. Within 90 day probationary period will complete a minimum of 80% of unit based skills/competency orientation checklist.
- f. Complete annual requirements as outlined within the education plan and any mandatory unit specific competencies identified through survey or high risk/problem prone or new procedures.

## **RETENTION AND RECRUITMENT**

1. We recognize, value, and reward qualified staff. Budgetary allocation and other resources are dedicated to support hiring and retention of staff as well as improvement and innovation in nursing practice per the hospital mission statement.
2. Tuition reimbursement is a benefit available to any regular qualified staff member for educational improvements which relate to their professional endeavors. BCLS and ACLS classes are offered, as needed, at reduced or fully reimbursed rates.
3. Continuing education classes that relate to the patient population and have been identified as important aspects of care are offered, as well as in-service training on new equipment and changing technology. Feedback from staff is requested to identify their perceived/real educational needs. See the Education Plan.
4. Employees are reimbursed for their attendance at educational in-service sessions as well as staff meetings.

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5. Funds have been allocated for and used in local advertising to fill staff vacancies.
6. All staff members are encouraged to actively participate in their professional organizations.

### **PATIENT SAFETY**

The patients' plan of care will reflect their individual safety needs.

Emergency equipment will be checked every 24 hours for completeness and actions taken to ensure completeness as needed.

#### **Patient Identification**

The patient will be identified using two identifiers prior to medication administration or other procedures. See policy on patient identification.

#### **Electrical Safety**

Preventative maintenance for electrical patient equipment is completed on a regular basis by the Biomedical Services. See Environment of Care Policies for details.

All employees are responsible to immediately report defective equipment and remove it from use following the defective equipment procedure under the Environment of Care Policies.

Compliance with electrical safety procedures will be maintained at all times.

#### **Clinical Alarms**

The following equipment has clinical alarms:

- IV pumps and PCA pumps – Audible alarms from the patient room and in the hallway up to 3-4 rooms distant. Non-urgent alarms and will be responded to as soon as feasible.
- Feeding pumps – Audible alarms from the patient room and in the hallway up to 3-4 rooms distant. Non-urgent alarms and will be responded to as soon as feasible.
- Telemetry monitors – Telemetry is viewed from the nursing station and in room 218. Clinical alarms are responded to immediately as they are audible from these areas and someone is accountable for monitoring telemetry at all times.
- Pulse oximetry – Audible alarm from patient room and in the hallway up to 5-6 rooms distant. Respiratory therapy will respond to pulse oximetry alarms as soon as feasible. Non-urgent alarms, if patient condition becomes urgent, either the ventilator alarms or telemetry will sound for immediate response.
- Bed alarms – Patients at risk for falls may be placed on bed alarms, audible alarm from patient room and in hallway up to 5-6 rooms distant. Staff would respond to bed alarms rapidly to minimize risk of falls.
- Ventilator – Audible alarm is tied into our overhead alarm system and can be heard throughout the unit. Response time varies depending on urgency of the type of ventilator alarm.

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### **Infection Control**

We maintain consistency with guidelines from OSHA, JCAHO, CDC and internal infection control policies. Standard precautions and CDC hand hygiene guidelines are followed when administering all levels of patient care.

### **ANNUAL BUDGET DEVELOPMENT PROCESS**

The Department of Nursing annual budget, operational and capital, is developed and incorporated into the hospital budget. The primary responsibility for this process belongs to the Chief Clinical Officer in conjunction with the senior leadership team and review from the Governing Board and Kindred Healthcare Corporate Office.

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## **POLICY**

Appropriate clinical and financial information shall be obtained on all referrals.

## **PURPOSE**

To ensure consistent pre-admission clinical evaluation is completed and medical necessity for LTAC level of care is evidenced and documented prior to admissions.

## **SCOPE**

This policy applies to all patient referrals.

### **1.1 Introduction**

Patient referrals and admissions are controlled at the local level by the hospital Sales and Marketing and Admissions Departments. Hospitals may elect to establish an Admissions Review Committee to jointly review the admission information of referred patients.

If hospitals utilize an Admission Review Committee, the committee may be comprised of the following positions: CEO/Administrator, CFO/Controller, Case Manager, Director of Nursing and Director of Sales and Marketing/Designee. This committee will meet at regularly scheduled times to review referred patients (times will vary according to admission issues).

### **1.2 Patient Referral Documentation**

Patient referrals from short-term acute care facilities, skilled nursing facilities and direct admits from home and/or physician offices are to be received directly by the hospital Clinical Liaison/Admissions Coordinator.

It is the practice of Kindred Healthcare, Inc. to safeguard Protected Health Information (PHI) that is gathered, used and disclosed in advance of a patient's admission to the hospital to determine whether a prospective patient will be admitted. (See HD Information Management – Pre-admission Patient Health Information Policy HIM 3.033).

All patient financial and clinical information gathered during pre-admission shall be retained in a patient file that is kept in a secure area. Referral information for patients not admitted shall be retained for one year.

**1.2 Patient Referral Documentation (contd.)**

For referrals received by the hospital Clinical Liaison/Admissions Coordinator, the Pre-Admission Clinical Evaluation (PACE form shall be completed, detailed procedures are as follows:

1. All referred patients are screened prior to admission using the PACE forms. For direct admitted patients (see Case Management Direct Admission H-ML 10-012 in the Clinical Policies & Procedures).

**PACE Form**

NOTE: Order this form via IntelliOrder under the corporate vendor Standard Register. This form should be ordered, not photo copied. This and other forms may be viewed from the SMARTworks application. The form is in the Corporate Catalog.

2. All non-Physician Reviewer(s) who are determining Level One Medical Appropriateness will be trained in the use of the Kindred LTAC Appropriateness Guidelines.
3. All data fields of the PACE form must be completed. The asterisk fields are required for APACHE score.
4. If the patient meets the LTAC Appropriateness Guidelines this shall be documented on the PACE form in the Clinical Appropriateness section.
5. Failure of a case to meet the LTAC Appropriateness Guidelines does not equate to a medical necessity or admission denial. It results only in the referral moving to the next level of Appropriateness of admission.
6. If through further review, it cannot be determined that the patient meets the Kindred LTAC Appropriateness Guidelines, then the PACE form shall be reviewed with the referring Physician for further consideration of medical necessity. If through review with the referring Physician determines that the patient meets the Kindred LTAC Appropriateness Guidelines, this shall be clearly documented on the PACE form in the Medical Appropriateness section. The Admissions Process shall then be continued as outlined in the Hospital Financial Policy & Procedures section 2.0.
7. If the review with the referring Physician cannot determine that the patient meets the Kindred LTAC Appropriateness Guidelines, then the PACE form is referred to the Kindred Admitting/Attending Physician or Physician Advisor for further consideration. The Physician Advisor is a physician designated by the hospital to further review the case. The Kindred Admitting/Attending Physician is the physician who will be admitting the patient to the hospital.

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1.2 Patient Referral Documentation (contd.)

8. If through further review, it is determined that the patient meets Kindred LTAC Appropriate Guidelines, this shall be clearly documented on the PACE form in the Medical Appropriateness section.
9. If it cannot be determined the patient meets the Kindred LTAC Appropriateness Guidelines, but the Kindred Admitting/Attending Physician or Physician Advisor still believes the patient has special circumstances and should be admitted to a Kindred Hospital, they shall document the special circumstances regarding the case that causes the need for admission consideration on the PACE form in the Medical Appropriateness section.
10. Completed PACE forms for all admitted patients shall be routed to the Admissions Office/Clerk/designee and scanned into the Referral Tab in the Virtual Patient File Folder (See HD FP&P Section 2.5 and 2.6).
11. BOM/designee shall review PACE forms and complete the verification of insurance benefits to determine patient financial feasibility (See HD FP&P Section 1.4).
12. If the PACE form is more than 48 hours old, a PACE re-evaluation form shall be completed and reviewed by Clinical Liaisons for continued admission appropriateness. The updated PACE re-evaluation document shall be routed to Admissions and scanned into the Referral Tab in the Virtual Patient File Folder.
13. Hospital Administration shall review all applicable clinical and financial information to determine if patient meets criteria.

**Note:** Hospital CEO/Administrator/designee shall make final decision on approval or denial of all admissions.
14. Upon approval of admission, the Admission's office shall arrange patient transfer with the referring facility, and ensure appropriate bed assignment is made and communicated to appropriate business office and clinical personnel. The Clinical Liaison/Admissions Coordinator/designee shall change the referral status in Meditech from "Pending" to "Approved".



**1.2 Patient Referral Documentation (contd.)**

15. Upon denial of admission, route the PACE form to a denied referrals file for possible future reference. The Clinical Liaison/Admissions Coordinator/designee shall change the referral status in Meditech from "Pending" to "Denied". Completed PACE forms for non-admitted patients shall be maintained on record and stored in the Admission Department and the Virtual Patient File Folder for 1 year from date of initial assessment. After 1 year, PACE forms shall be shredded and removed from the Virtual Patient File Folder.
16. The Admissions Office shall instruct patient family members or guardian /guarantor to contact the hospital Admissions Clerk/designee at time of admission to complete the admissions process.
17. The Admissions Clerk/Business Office shall collect from patient's family member / guardian a copy of all insurance identification cards and request a copy of all non-Medicare insurance policies before or upon admission of the patient. If the above information cannot be obtained, the Admissions Clerk/Business Office shall document all attempts to obtain the information in the patient's financial folder.

Note: If a Referral Center is used to collect referral information, this data will be routed to the appropriate hospital personnel to follow the same steps listed above.



1.3 Referral Status

The Meditech Referral Routine shall be completed by the Admissions Clerk/designee for each patient for whom a referral has been obtained.

Link to Meditech Referral Routine in the Meditech Admissions Manual

Referral status fields shall be completed and updated by the Admissions Clerk when the referral status changes. Referral status options are as follows:

<u>Mnemonic</u>	<u>Name</u>
ADM	Admitted
APP	Approved
DEN	Denied (Hit F9 to select choice of denial reasons)
EVAL	Duplicate Account
EXP	Expired
LOST	Lost to Another Fac
OTH	Other
PEN	Pending
REF	Refused

Based upon daily meetings with the Sales and Marketing Department, the CEO/Administrator/CFO/Controller/designee shall notify the BOM of pre-registrations or registrations in Meditech that require cancellation to prevent incorrect charges from being applied to these patient account numbers.

1.4 Insurance Verification/Pre-Certification

The BOM/designee shall perform the following patient financial assessment procedures *prior* to admission:

1. Obtain the PACE Form from the Clinical Liaison or Admissions Coordinator, see FP&P Section 1.2.
2. Provide a completed copy of the Insurance Verification Form (link and instructions provided below) to the CFO/Controller/designee and Admissions Department. The CFO/Controller/designee shall review, initial and date the Insurance Verification Form. The Insurance Verification Form shall be scanned into the Virtual Patient File Folder and original / hard copy placed in the patient's file folder. In addition, the insurance verification terms shall be included in the Meditech collection notes by the BOM/designee.

Link to Primary Insurance Verification Form (sample)

Workers Compensation Insurance Verification Form (sample)

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#### 1.4 Insurance Verification/Pre-Certification (Contd.)

- 3). Access the Medicare Common Working File (CWF) to determine the eligibility of Medicare and Medicare Advantage / Medicare Replacement plans for each referral. The CWF will reflect information regarding the patient's current spell of illness based upon the days actually billed at the time of review.

The Admissions Coordinator/designee shall provide information to assist the BOM/designee in estimating the Medicare exhaust date for the current spell of illness. The BOM/designee must consider current spell of illness days not billed by the referring and/or other facilities. The CWF should be printed by the BOM/designee and the exhaust date noted on the CWF and the Insurance Verification Form.

- 4). Determine if pre-certification is required on primary and/or secondary insurance (as required by the Insurance Verification Form).

**Note:** If pre-certification is required and the patient is approved for admission, a pre-certification number must be obtained prior to admission by the Admissions Coordinator/designee. The insurance carrier may require re-certification for each interim billing period (or other periods of time), and the Case Management Department shall ensure that subsequent re-certification procedures are followed as required, and appropriate information is forwarded to the Business Office/CBO. The BOM/designee shall ensure the information is documented in Meditech collection notes.

#### [Link to Re-certification Process](#)

3. Verification of benefits and rate negotiations with the insurance payor shall be recorded (once the recorded party as been advised of the recording and consented) via tape recorder or other medium. The verification can be performed on-line through third party software or insurance company web site, and a printout of the verification shall be retained.

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## **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**

Kindred's admission procedures are designed to collect admission and registration data for all patients treated by the hospital.

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 payor 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 Meditech 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). This Routine will create a ProTouch registration and allow immediate medical record documentation. When pre-admitting a previously admitted patient, make sure the prior stay/episode has been properly discharged to prevent charting and/or billing errors.

[Link to Pre-Admission Edit Routine in the Meditech Admissions Manual](#)



**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.

[Link to Meditech Referral Routine in the Meditech Admissions Manual](#)

- 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.**

▪ 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 Regional Vice-President of Finance (RVPF) and the Corporate Legal Department prior to waiving any co-pays or deductibles.

- c) Payment of Insurance Premiums and COBRA by Kindred

▪ Medicare Patients

**In no circumstance shall the Medicare Part B premiums be paid.**

▪ Commercial Patients

Kindred will comply with all State and Federal Laws regarding payment of insurance premiums and COBRA payments for patients or potential patients of Kindred hospitals.

In general, insurance and COBRA premiums shall not be paid for the benefit of a patient or potential patient. In circumstances where a premium payment is considered, the CFO/Controller shall obtain approval from both the RVPF and Corporate Legal Department prior to making any payments or promises to pay.

If premium payments are made by the hospital, the patient/family must sign a promissory note that they will repay the hospital, and the hospital shall follow normal collection procedures to collect the note balance.



## **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.

**2.4 Admission – General Information (Contd.)**

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, and chemotherapy.
- 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 Admissions Clerk/designee to admit patients to the hospital through the Meditech Admissions function and to create ProTouch™ registrations.

[Link to Admissions routine in the Meditech Admissions Manual](#)

a) Apache Scoring

Admissions with a Meditech admission source of '4' (Transfer from Hospital) require an Apache score. The clinical pre-assessment information shall be entered into Meditech, generating an Apache III score. The Apache score is a predictor of acuity and LOS (Length of Stay) for critical care patients. For all other admissions, an Apache score *shall not* be obtained.

[Link to Apache Score Routine in the Meditech Admissions Manual](#)

If the system does not return an Apache Score when requested, verify the following fields are complete: date of birth, temperature, GCS (Glasgow Coma Score) medications, SBP (Systolic Blood Pressure), DBP (Diastolic Blood Pressure), heart rate, ventilator status, respiratory rate, and referral date. Eyes, motor, and verbal fields are required if the GCS Meds field is marked "Yes." Complete the admission and re-calculate the Apache Score through the Meditech Inpatient Admissions Edit or Pre-Admit Routine



**2.5 Patient Admissions (Contd.)**

**b) Account Number Assignment**

Account numbers (unit number, medical record number) are not assigned for new patients when completing Apache Scoring. Instead, the automated Master Patient Index (MPI) in Meditech 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 Meditech should be used to select the patient so that the same unit number (medical record number) may be assigned.

If a patient is selected from within the MPI, the patient's previous demographic information will be pulled into the referral fields, reducing time for entering the referral. The Admissions Clerk/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.

**c) Completing Admission Forms**

- Explain all benefits to the patient or responsible party upon admission
- Document this explanation in the patient's financial folder
- Ensure that *all* fields are completed on admission documents and that the documents are signed by the patient/representative upon admission.
- Notify BOM 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 exceptions.

**a) After Hours Admission**

When Admissions Clerk/designee is not available, the Nursing Supervisor/designee shall register the patient in Meditech through the After Hours Admission Routine to create the ProTouch registration and allow for immediate medical record documentation.

[Link to After Hours Admission Edit Routine in the Meditech Admissions Manual](#)

**b) Meditech Downtime Procedures**

The Admissions Clerk/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 (VFFF)**

The Virtual Patient File Folder (VFFF) 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. All admission documents, including the PACE, Insurance Verification, and Insurance Card must be scanned into the folder. In addition, all forms are to be printed from the VFFF with the exception of the Admission Face Sheet, which can still be printed from Meditech.

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

#### **a) Required Inpatient Forms:**

- Admission Face Sheet
- 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)

#### **Link to 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)



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**2.6 Admission Documents (Contd.)**

- 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.)
  - Pre-Admission Clinical Evaluation (PACE) Form
- 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 CFO/Controller 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 payor situations. Also see Section 6.2 "B" Medicare Part A – Specific Instructions.

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## 2.6 Admission Documents (Contd.)

- Inpatients - Election Not to Use Lifetime Reserve Days. The BOM/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.

[Link to 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 BOM 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. [Link to Request for Copy of Insurance Policy Form \(sample\)](#)

[Link to Insurance Company Request for Policy Letter \(sample\)](#)

The BOM/designee shall document all attempts to obtain copies of the patient's insurance policy, insurance card, and other insurance information in the patient's financial folder or 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 BOM to obtain a copy directly from the insurance carrier. If the above information cannot be obtained, the BOM 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 CFO/Controller shall be responsible for negotiating the patient-specific contract. Additionally, any subsequent "Letter of Agreement" shall be prepared and controlled by the CFO/Controller.

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.

[Link to Letter of Agreement \(sample\)](#)

**2.9 Patient-Specific Contracts (contd.)**

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

**A. Reimbursement:**

The CFO/Controller 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 the patient’s financial folder.

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## 2.9 Patient-Specific Contracts (contd.)

### G. Insurance Mnemonics:

Anytime a facility needs to request a new insurance mnemonic to be setup in Meditech, they are to complete the attached request form and send it directly to the Meditech Group via fax or email. 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.

### 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.

[Link to 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 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.

### **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.

#### [Link to 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.

#### [Link to Medical Records Census Report](#)

The Admissions Director/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 Director/designee and forwarded to the business office.

The BOM/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). BOM/designee initials and dates the package of reports and maintains in business office.

After the verification process is complete, the BOM/designee runs the Census by Unit report in Meditech each day and distributes to the following department managers:

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

Census by Unit – (Meditech  Admissions  Reports/Statistics  Inpatient Reports  Census  Nursing Unit)



**2.14 Transfer of Medicare 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 Medicare patients between hospitals:

- A transfer log shall be maintained and reviewed by CFO/Controller 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.

[Link to Transfer Log](#)

[Link to 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.
- Upon final patient discharge, move all patient days and gross charges from the original hospital to the discharging hospital in Meditech:
  - 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.



### **2.15 Clinical Liaison Bonus Plan**

The Clinical Liaison Bonus Plan is formulated by the Corporate VP of Sales and Marketing. The approved Plan is available through the Regional Senior Director Sales & Marketing (RSDM) for the HD Region. An automated system created for the monthly calculation of the incentive payouts is located on Knect under the following path:

Knect>Business Warehouse Reports>Hospital Clinical Liaison Incentives

The hospital Director of Marketing (DOM) shall input the admissions goals for each Clinical Liaison into the Clinical Liaison Incentive Program before the last day of the previous month (e.g. May goal entered before April 30<sup>th</sup>). The system is closed on the first day of each month, and additions to previous month data will not be accepted after this date.

Upon closing a month, the DOM shall run the Clinical Liaison Incentive program on Knect, verify all data prior to the 15<sup>th</sup> day of the month, (e.g. May close – data reviewed by June 15<sup>th</sup>), save the file to Excel, and forward the file via email to the Regional Senior Director of Marketing (RSDM) for review and approval. Once approved, the bonus file is sent by the RSDM via email to the hospital CFO/Controller (with copy to DOM) for review, processing and payment. Payment shall be made before the end of the month. Any exceptions to the plan are to be approved by the RSDM and documented on the report before final payment is approved and processed.

Each month, the CFO/Controller shall make an estimate for the anticipated Clinical Liaison bonus payout and expense to a/c#71684 Clinical Liaison Bonus and accrue to a/c#22111 Clinical Liaison Bonus Payable.