Reimbursement Policy

Transfers Between Hospitals

REIMBURSEMENT POLICY NUMBER: 75

Effective Date: 6/1/2026

Last Review Date: 5/2026

Next Annual Review: 5/2027

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

☐ Professional Claims

☐ DMEPOS Suppliers

☐ All health care services billed on CMS 1500 forms

☐ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☒ Facilities

Plan Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

☐ All health care services billed on UB04 forms (CMS 1450)

Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

☒ DRG

☒ Modified DRG

☐ Percentage of billed charges/per diem

POLICY STATEMENT

Note: The following policy statement does **not** apply to national networks or rented networks (e.g., Premera/BlueCard).

I. The transfer rule (criterion II.) **applies** when a member in an acute care inpatient hospital (with any MS-DRG) is:

A. Transferred to another acute care inpatient hospital or unit for related care (discharge status code 02 or 82); **or**
B. Admitted to another acute care inpatient hospital on the **same date** after leaving their designated hospital against medical advice (discharge status code 07); **or**
C. Discharged but then readmitted on the **same date** to another acute care inpatient hospital (unless the readmission is unrelated to the initial discharge*).

See Policy Guidelines for discharge versus transfer rules.

II. The Plan allows reimbursement for services rendered by both the transferring and the final discharging facility when criterion I. above is met. The following reimbursement methodology applies:

A. **For commercial and Medicare members**: Transferring facility reimbursement is based upon a graduate per diem rate** (see Policy Guidelines) *if there is no specific transfer language in the contract.*
B. **For OHP members**: Transferring facility reimbursement is based on the number of inpatient days spent at the transferring hospital multiplied by the per diem inter-hospital transfer payment rate (see Policy Guidelines).
C. **For all lines of business:** Payment is made to the final discharging hospital at the full DRG payment rate.

*Where a transfer case results in treatment in the second hospital under a MS-DRG different than the MS-DRG in the transferring hospital, payment to each is based upon the MS-DRG under which the patient was treated.

**An exception to the transfer policy applies to MS-DRG 789. The weighting factor for this MS-DRG assumes that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into this MS-DRG is

paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

POLICY GUIDELINES

Table 1.

Discharge versus Transfer versus Readmission[1-3]		
Discharge	Transfer	Readmission
• Member has received complete acute care treatment and leaves an acute care hospital for home or a lower level of treatment (e.g., long term care, skilled nursing, etc); **or** • Member dies in the hospital. ***Note:*** **if a member is discharged but then readmitted on the same date to another acute care hospital for the same condition, the discharge is considered a transfer and transfer rules apply.**	• Transferred to another inpatient hospital for related care (discharge status code 02 or 82); **or** • Admitted to another inpatient hospital on the **same date** after leaving their designated facility against medical advice (discharge status code 07); **or** • Discharged but then readmitted on the **same date** to another inpatient hospital (unless the readmission is unrelated to the initial discharge).	Admitted to the same inpatient hospital less than 31 calendar days from the date of the initial discharge for a related condition or complication arising from the initial admission.

GRADUATED PER DIEM RATE (COMMERCIAL AND MEDICARE)[2]

For **commercial and Medicare Advantage** claims, transferring hospital reimbursement (i.e., the graduated per diem rate) is determined by dividing the appropriate DRG allowable by the geometric mean length of stay (GMLOS) for the specific DRG into which the case falls.

The graduated per diem rate is two times the per diem rate for the first day of the stay and the per diem rate for every following day **up to the full DRG amount**. No payment is made for the day of discharge/transfer.

INTER-HOSPITAL TRANSFER PAYMENT RATE (OHP)[4]

For **Oregon Health Plan (OHP)** members, transferring hospital reimbursement is determined by the number of inpatient days spent at the transferring hospital multiplied by the per diem inter-hospital transfer payment rate.

The per diem inter-hospital transfer payment rate is equal to the DRG payment divided by the geometric mean length of stay for the DRG under which the member was treated. Payment to the transferring hospital will not exceed the DRG payment.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 4/13/2026, the following Centers for Medicare & Medicaid (CMS) references were identified which address hospital transfers:

- 42 CFR § 412.4
- Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §20.1.2.4 Transfers
- Medicare MLN Matters Article – 2/22/2021. Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services & Other Information on Patient Discharge Status Codes

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding hospital transfers.

As of 4/13/2026, the following Oregon Health Authority (OHA) references were identified:

- Oregon Administrative Rules (OAR) 410-125-0165 - Transfers and Reimbursement

CROSS REFERENCES

- Inpatient Readmissions, UM55

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. 42 CFR § 412.4 - discharges and transfers. Legal Information Institute. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-A/section-412.4. Accessed 4/13/2026.
2. Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3 - Inpatient Hospital Billing, Section 20.1.2.4 Transfers. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf. Accessed 4/13/2026.
3. Medicare MLN Matters. Review of hospital compliance with Medicare's transfer policy with the Resumption of Home Health Services & Other Information on Patient Discharge Status Codes. Published 2/22/2021. https://www.cms.gov/files/document/se21001.pdf. Accessed 4/13/2026.
4. OAR 410-125-0165 - Transfers and Reimbursement - Oregon Administrative Rules. https://oregon.public.law/rules/oar_410-125-0165. Accessed 4/13/2026.

POLICY REVISION HISTORY

Date	Revision Summary
7/2022	Annual review (Policy updated to new format 2/2023)
7/2023	Annual review; no changes
7/2024	Annual review; no changes
8/2025	Annual review; no changes
5/2026	Interim update; update graduated per diem rate language
6/2026	Annual review; no changes to policy statement; add CMS section; update references