

# Reimbursement Policy

## Transfers Between Hospitals

REIMBURSEMENT POLICY NUMBER: 75

<b>Effective Date:</b> 7/1/2023	SCOPE AND APPLICATION .....	1
<b>Last Review Date:</b> 6/2023	POLICY STATEMENT.....	2
<b>Next Annual Review:</b> 6/2024	POLICY GUIDELINES.....	3
	CROSS REFERENCES.....	3
	REFERENCES .....	4
	POLICY REVISION HISTORY .....	4

**INSTRUCTIONS FOR USE:** Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. 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. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

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

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

- DRG

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”).

Modified DRG

Percentage of billed charges/per diem (applies only to unplanned readmissions)

## 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<sup>\*</sup>).

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<sup>\*\*</sup> (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.

<sup>\*</sup>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.

<sup>\*\*</sup>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 <sup>1-3</sup>		
Discharge	Transfer	Readmission
<ul style="list-style-type: none"> <li>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); <b>or</b></li> <li>Member dies in the hospital.</li> </ul> <p><b>Note: if a member is discharged but then readmitted on the same date to <u>another</u> acute care hospital for the same condition, the discharge is considered a transfer and transfer rules apply.</b></p>	<ul style="list-style-type: none"> <li>Transferred to <u>another</u> inpatient hospital for related care (discharge status code 02 or 82); <b>or</b></li> <li>Admitted to <u>another</u> inpatient hospital on the <b>same date</b> after leaving their designated facility against medical advice (discharge status code 07); <b>or</b></li> <li>Discharged but then readmitted on the <b>same date</b> to <u>another</u> inpatient hospital (unless the readmission is unrelated to the initial discharge).</li> </ul>	Admitted to the <u>same</u> 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)<sup>2</sup>

For **commercial and Medicare Advantage** claims, transferring hospital reimbursement (i.e., the graduated per diem rate) is determined by dividing the appropriate DRG rate 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)<sup>4</sup>

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.

## 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.law.cornell.edu/cfr/text/42/412.4>. Accessed May 16, 2023.
2. Medicare Claims Processing Manual; Chapter 3 - Inpatient Hospital Billing.  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf>. Accessed May 16, 2023. Section 20.1.2.4 Transfers
3. Review of hospital compliance with Medicare's transfer policy.  
<https://www.cms.gov/files/document/se21001.pdf>. Accessed May 16, 2023.
4. OAR 410-125-0165 - Transfers and Reimbursement - Oregon Administrative Rules.  
[https://oregon.public.law/rules/oar\\_410-125-0165](https://oregon.public.law/rules/oar_410-125-0165). Accessed May 16, 2023.

## POLICY REVISION HISTORY

Date	Revision Summary
7/2022	Annual review (Policy updated to new format 2/2023)
7/2023	Annual review; no changes