PREMERA BLUE CROSS
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Payment Policy

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Title	**Inpatient Acute Transfers from DRG Hospitals**		
Number	**CP.PP.407.v1.3**		
Last Approval Date	**10/03/24**	**Original Effective Date**	**07/05/18**
Replaces			
Cross Reference			

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how the Plan will reimburse services on an Inpatient claim, when a patient is transferred from one acute care hospital (transferring facility) to another acute care hospital (receiving facility) that are submitted on a UB-04/CMS-1450 paper claim form or an 837I electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Definitions	**Transfer** – moving a patient from one acute care hospital to another. **Transferring facility** – the acute care facility that initially admitted the patient but for some reason must transfer that patient to another acute care facility for additional services **Receiving facility** – the acute care facility that receives a patient from a transferring acute care facility and ultimately discharges the transferred patient **Geometric Mean Length of Stay (GMLOS)** – the national mean length of stay for each diagnosis related group (DRG) as determined and published by CMS. **Average Length of Stay (ALOS) -** the average number of days a patient spends in the hospital before and after a particular procedure **Diagnosis Related Group (DRG)** – a statistical system of classifying any inpatient hospital stay into groups for the purposes of payment. This classification system divides diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for reimbursement by a fixed fee regardless of the actual costs incurred
Policy	This policy applies to those **transferring acute care facilities/hospitals** contractually reimbursed for cases paid by a DRG payment methodology. Any acute care hospital (transferring facility) that transfers a patient to another acute care DRG reimbursed facility (receiving facility) will be reimbursed with a calculated per diem rate and not a full DRG calculated rate. When an inpatient is transferred to another acute care hospital for additional or continued care that is not available in the initial hospital, and the transferring acute care hospital is contractually reimbursed on a DRG payment methodology, the Plan will

	reimburse the transferring acute care facility a graduated per diem rate for the DRG case rate for the services rendered. This per diem rate will not exceed the full DRG rate for the patient's stay in the transferring acute care hospital. If there are multiple transfers of the patient between multiple acute care hospitals all reimbursed on a DRG payment methodology, the final acute care hospital that discharges the patient to home will be reimbursed the full DRG case rate and all the transferring acute care hospitals will be reimbursed a graduated per diem of the DRG case rate for the services rendered. The per diem rate paid to any transferring DRG acute care facility will be determined by dividing the full DRG rate by the appropriate Geometric Mean Length of Stay (GMLOS) for the DRG, depending upon the version of the DRG. Each DRG is associated with a GMLOS. For acute care hospitals paid on a DRG reimbursement that keep a patient for fewer days than the GMLOS before transferring them to another acute care hospital, a reduced payment will be made, calculated as the normal DRG case rate divided by the GMLOS, multiplied by the actual days. For example: • An acute care hospital on a DRG contract admits a patient for two (2) days, and then transfers them to another acute care hospital • The DRG associated with the admit is 193 (Geometric Mean LOS is 5.7) • Case Rate = $20,790 • Per Diem = Case Rate / GMLOS: $20,790 / 5.7 = $3,647.37 • Payment to Transferring Hospital = Actual length of stay * Per Diem: 2 * $3,647.37 = $7,294.74 Payment to the transferring acute care facility cannot exceed what would have been allowed under a full DRG case rate for the stay. Stop loss cases will be handled by the provider's contract terms. The acute care hospital that performs the final patient discharge will be reimbursed with the full DRG case rate.
Codes and Coding Guidelines	The correct ***Discharge Status*** codes entered on the transferring facility claim (Field 17-Patient Discharge Status) which will identify a patient as being transferred to another facility include: • 02 – Discharged/transferred to other short term general hospital for inpatient care • 05 – Discharged/transferred to another type of institution for inpatient care • 43 – Discharged/transferred to a federal hospital • 66 – Discharged/transferred to a Critical Access Hospital (CAH) • 69 – Discharged/transferred to a designated disaster alternative care site • 70 – Discharged/transferred to another type of health care institution not defined elsewhere in code list • 82 – Discharged/transferred to a short-term general hospital for inpatient care with planned acute care hospital inpatient readmission • 85 – Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission

	• 88 – Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission • 94 – Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission • 95 – Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission The correct ***Admission Status*** code entered on the receiving facility claim (Field 15 – Point of Origin for Admission) which will identify a patient as a transfer admission from another facility include: • 4 – Transfer from a Hospital (Different facility) • 6 – Transfer from another Healthcare Facility
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	This policy is not applicable when either the transferring or receiving facility is one of the following: • Long term care center • Psychiatric hospital • Skilled nursing facility • Inpatient rehabilitation facility or unit • Home health agency This policy does not apply to transferring facilities that are **NOT** reimbursed on a DRG reimbursement methodology.
Laws, Regulations & Standards	
References and Resources	

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department	
Annual Review Dates	10/03/24; 01/16/24; 02/08/23; 03/04/22; 03/23/21; 04/01/20; 05/03/19; 05/28/18; 02/27/18	
Version History	02/27/18	Initial creation of policy
	05/28/18	Added reference to stop loss cases
	05/03/19	Clarified that both the transferring facility/hospital and the receiving facility/hospital are acute care facilities/hospitals

	04/01/20	Annual review; no changes
	03/23/21	Clarified in the Purpose statement that the policy applies to facility services billed on a UB-04/CMS-1450 paper claim form or 837I electronic claim form
	03/04/22	Annual review; no changes
	02/08/23	Annual review; no changes
	01/16/24	Annual review; no changes
	10/03/24	Annual review; no changes

Approval	Payment Integrity Oversight Committee
Print Name	Jennifer Sanders, Vice President Provider Network Management
Signature	*Electronic signature on file*
Date	*10/03/24*