Payment Policy | Transfers Between DRG Facilities

EFFECTIVE DATE: 12|07|2022
POLICY LAST UPDATED: 12|07|2022

OVERVIEW

This administrative policy defines payment rules for hospitals that are reimbursed for inpatient services when inpatient transfers occur between two Diagnosis-related group (DRG) facilities.

NOTE: The effective date of this policy relates to the date BCBSRI created documentation to reflect reimbursement processes that are established and does not indicate a change in the payment process.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

The following payment guidelines are applicable to local in network facilities only that are reimbursed as a DRG, excluding mental health, maternity, and rehabilitation. Transfer logic only applies to transfer status 02 and 05.

Payment guidelines for inpatient transfers between a hospital and another acute care inpatient unit when one of the hospitals is:

Transferring hospital:

When a patient is transferred to another acute care facility, the admitting facility is paid based on a per diem rate up to the full DRG payment. The per diem amount is calculated based on the average arithmetic length of stay (ALOS) days for the DRG to which the case is assigned, divided by the full DRG allowance. Payment calculations vary by contractual guidelines.

Receiving facility:

In the case of acute care transfers, the receiving facility that ultimately discharges the transferred patient receives a full DRG payment based on the calculated DRG.

Patient leaves against medical advice:

If a patient leaves a hospital against medical advice and is subsequently admitted to a different hospital on the same day, the initial hospital is paid as a transferring hospital and is paid as a graduated per diem rate for each day of the stay, not to exceed the full DRG payment.

Transfer to another facility for service while inpatient

Any services performed by another hospital, facility, or other freestanding provider will not be reimbursed separately by Blue Cross & Blue Shield of Rhode Island (BCBSRI), unless those services, when rendered in the inpatient setting, are separately reimbursable (e.g., professional services). Reimbursements for all other services are the responsibility of the inpatient facility.

Example: A member is inpatient at a facility and is transferred for radiation treatment to another facility. BCBSRI would reimburse the professional component to the radiation treatment provider and the facility would be responsible for reimbursing any additional services.

COVERAGE
Individual hospital contract language supersedes policy.

BACKGROUND
It is necessary to clarify how providers will be reimbursed in different transfer situations. For coverage of ambulance services, please refer to the policy entitled "Ambulance Services - Ground".

CODING
Not applicable

RELATED POLICIES
None

PUBLISHED
Provider Update, February 2023

REFERENCES
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2. Centers for Medicare and Medicaid Services (CMS) MLN Matters. Retrieved on 07/14/2022 from: https://www.cms.gov/files/document/se21001.p
3. Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing. Rev. 1895; 01-15-10:118-120 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
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5. Department of Health and Human Services. Federal Register;63(243);12/18/1998:70138. Accessed 9/21/11: http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf