Inpatient Transfer Between Hospitals

Policy
Harvard Pilgrim reimburses services rendered by both the sending hospital and the receiving hospital when a patient is admitted to one acute care hospital and subsequently transferred to another acute care hospital.

Prerequisite(s)
Applicable Harvard Pilgrim referral, notification and prior authorization policies and procedures apply. Refer to Referral, Notification and Authorization for more information.

HMO/POS/PPO
• Notification is required for inpatient admissions, excluding obstetrical admissions; each facility must notify Harvard Pilgrim of the transfer. (Refer to Emergent/Urgent Admission Notification and Elective Admission Notification for specific requirements.)
• Prior authorization is required for some surgical procedures. (For a list of surgical procedures that require prior authorization, refer to the Prior Authorization Policy.)

Harvard Pilgrim Reimburses

Hospitals with DRG Rates
Payment to the acute care hospital that transferred the patient will be reimbursed based on a calculated per diem rate.

New York All Payor DRG (AP-DRG) Grouper
For hospitals contracted with the New York All Payor DRG Grouper, the calculated per diem is determined by dividing the arithmetic mean length of stay (AMLOS), downstate version, into the specific DRG rate of the case.

CMS Grouper (MS DRG)
For hospitals contracted with the CMS Grouper, the calculated per diem is determined by dividing the geometric mean length of stay (GMLOS) into the specific DRG rate of the case.

All Patient Refined DRG (APR-DRG) Grouper
For hospitals contracted with the All Patient Refined DRG Grouper, the calculated per diem is determined by dividing the average length of stay (ALOS) into the specified DRG rate of the case.

Transfer Reimbursement
The calculation for reimbursement is two times the calculated per diem for the first day of admission and the calculated per diem for all subsequent days; excluding the day of discharge; if this sum of the calculated per diem rate is greater than or equal to the hospital-specific DRG rate, then the hospital-specific DRG rate is the reimbursement rate.

Example:
Four-day inpatient hospital stay and discharge on the fifth day, ALOS or GMLOS of 10 and DRG hospital-specific payment rate of $10,000; $10,000/10 = $1,000; $1,000/day is the transfer per-diem rate.

<table>
<thead>
<tr>
<th>Date of admission</th>
<th>$1,000 x 2</th>
<th>$2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day two through four</td>
<td>$1,000 x 3 days</td>
<td>$3,000</td>
</tr>
<tr>
<td>Day five</td>
<td>no payment</td>
<td>$0</td>
</tr>
<tr>
<td>Total reimbursement for transfer</td>
<td></td>
<td>$5,000</td>
</tr>
</tbody>
</table>

Payment cannot exceed what would have been allowed under DRG payment. If the transferring hospital's discharge is less than one full day, two times the per diem is full payment. Hospitals that treat and release patients from the emergency room (i.e., no inpatient admission) do not receive a per diem and are paid for the emergency room services only. AP-DRG, CMS DRG, and APR DRG Groupers all have particular DRG(S) that are by definition transfers and always pay the full DRG and are not subject to the calculation noted above.

The receiving hospital is reimbursed for the full DRG amount when the patient is discharged. If the receiving hospital transfers the patient back to the original hospital or another acute care hospital, the calculation outlined above would apply. The final discharging hospital will receive the full DRG amount.

Hospitals Excluded from DRG
Payment to hospitals excluded from DRG reimbursements are paid at the Harvard Pilgrim–contracted rate.
Non-Emergent Transports
Medically necessary, authorized non-emergent ambulance transport services are reimbursed when arranged and provided by a contracted provider.

Member Cost-Sharing
Services subject to applicable member out-of-pocket cost (e.g., co-payment, coinsurance, deductible).

Provider Billing Guidelines and Documentation
• To submit a claim, use either a paper UB-04 or electronic 837I, version 5010 and appropriate billing code(s).
• Identify the claim as a Transfer to Another Facility with the discharge status code of 02 or 05 in Form Locator 17 of paper UB04 or loop 2300, segment CL1, data element CL103, or electronic 837I, version 5010.

Related Policies
• Ambulance Transport Payment Policy
• Prior Authorization Policy
• Claims Submission Guidelines
• Elective Admission Notification
• Inpatient Acute Medical Admissions Payment Policy
• Emergent Department/Urgent Admission Notification
• Medical Transportation Medical Review Criteria
• Hospice Payment Policy
• Notification Policy
• Skilled Nursing Facility (SNF) Payment Policy

Publication History
09/01/00 original documentation
05/01/01 authorization requirement changed to notification
07/01/02 added types of transfer excluded from calculated per diem
10/01/03 annual review; DRG reimbursement clarified; AP DRG Grouper added
07/31/07 annual review; clarified receiving hospital reimbursement calculation
07/31/08 annual review, added related policies and ambulance transport information
07/15/09 annual review; no changes
05/15/10 annual review; minor edits for clarity
04/15/11 annual review; no changes
01/01/12 removed First Seniority Freedom information from header
06/15/12 annual review; no changes
07/15/13 annual review; no changes
06/15/14 added Connecticut Open Access HMO referral information to Prerequisites
07/15/14 annual review; added All Patient Refined DRG Grouper
07/15/15 annual review; updated billing guidelines
07/15/16 annual review; no changes
07/15/17 annual review; administrative edits, added Medical Transportation Prior Authorization to Related Policies
08/01/18 annual review; administrative edits

This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.