	Reimbursement Policy

Subject: Diagnosis-Related Group (DRG) Inpatient Facility Transfers

Effective Date: **02/01/15**	Committee Approval Obtained: **09/30/19**	Section: **Facilities**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://mediproviders.anthem.com/ky/pages/reimbursementpolicies.aspx**.*****

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Medicaid (Anthem) if the service is covered by a member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Anthem allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for same episode of care in compliance with provider contracts, federal and/or state guidelines regarding facility transfers payment. In the absence of such guidelines, Anthem will use the following criteria:

	• Transferring facility receives a calculated per diem rate based on length of stay not to exceed the amount that would have been paid if the patient had been discharged to another setting • Receiving facility receives full DRG payment
History	• Biennial review approved **09/30/19** • Biennial review approved **06/05/17**: Policy template updated • Biennial review approved **11/09/15**: Policy language updated; Policy template updated • Initial policy approved **01/01/14** and effective **02/01/15**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contract
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Diagnoses used in DRG Computation • Documentation Standards for Episodes of Care • Other Provider Preventable Conditions (OPPC) • Present on Admission Facility-Acquired Conditions • Inpatient Readmissions
Related Materials	• None