Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Diagnosis-Related Group (DRG) Inpatient Facility Transfers		
Effective Date: **01/01/15**	Committee Approval Obtained: **09/30/19**	Section: **Administration**

*****The most current version of the 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://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicare. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Amerigroup Medicare Advantage 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage 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	In compliance with federal guidelines regarding facility transfers payment, Amerigroup Medicare Advantage 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. Amerigroup Medicare Advantage uses 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 and effective **11/09/15**: Policy template updated • Initial policy approval and effective date **01/01/15**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Diagnoses used in DRG Computation • Documentation Standards for Episodes of Care • Other Provider Preventable Conditions • Present on Admission Facility Acquired Conditions • Inpatient Readmissions
Related Materials	• None