Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

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

Effective Date: **02/01/15**	Committee Approval Obtained: **06/05/17**	Section: **Facilities**

*****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 > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

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 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, Amerigroup may:

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

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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

Amerigroup 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	Amerigroup 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, Amerigroup will use the following criteria: • Transferring facility will receive 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 will receive full DRG payment.
Exemptions	• Amerigroup Community Care in Georgia, in compliance with Georgia Department of Community Heath, uses the following reimbursement method: o If the same DRG, the transfer-from facility will get the rate calculated by the Cost-to-Charge Ratio (CCR). The transfer-to facility will receive full DRG payment. o If different DRGs, each facility will receive full DRG payment. • Amerigroup Kansas, Inc. reimburses the transferring hospital a DRG daily rate for each covered day of stay no greater than the standard DRG amount and the discharging hospital the standard DRG amount. • Amerigroup Texas, Inc. and Amerigroup Insurance Company, in accordance with the Texas Medicaid Provider Procedures Manual (TMPPM), reimburse the hospital furnishing the most significant amount of care the full DRG payment and the other hospital a per diem rate.
History	• Biennial review approved 06/05/17: o Effective 01/01/18: GA exemption updated; NJ exemption removed • Biennial review approved 11/09/15: Policy title updated; Policy template updated; Texas exemption added; Kansas exemption added; Related policies updated • Initial review approved 12/16/13 and effective 02/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts
Definitions	• **Reimbursement Policy Definitions**
Related Policies	• Diagnoses Used in DRG Computation • Documentation Standards for Episodes of Care • Inpatient Readmissions • Other Provider Preventable Conditions (OPPC) • Present on Admission Indicator for Health Care-Acquired Conditions

Related Materials	• None