moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM066
Policy Title:	DRG Payment With Patient Transfers		
Section:	Facility-Specific	Subsection:	Inpatient

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☐ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☐ All dates ☒ Specific date(s): 7/1/2019 and following ☒ Date of Service; For Facilities: ☒ Facility discharge or transfer ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network When Inpatient claims are paid on DRG methodology.

Originally Effective:	7/1/2019	Initially Published:	4/10/2019
Last Updated:	5/8/2024	Last Reviewed:	5/8/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		5/8/2024	

Purpose

The purpose of this transfer reimbursement policy is to:

- Define what constitutes an acute care transfer.
- If an applicable transfer occurs, define how to determine the correct allowable amount for the transferring hospital and the receiving hospital.
- Incentivize acute-care hospitals to complete a patient's episode of care if medically feasible for maximum reimbursement.

The transfer policy adjusts the payments proportionate to the shorter/partial length of stay, thus approximating the reduced costs of transfer cases.

Reimbursement Guidelines

A. Overall Policy Statement

Effective for discharge/transfer dates of service 7/1/2019 and following, when a hospital is paid on a DRG methodology and an inpatient is transferred to another inpatient hospital the transferring hospital is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the DRG allowable amount.

1. For Commercial and Medicare Advantage claims, the per diem rate is based on a calculation defined by The Centers for Medicare and Medicaid Services (CMS).
2. For Medicaid claims, the per diem rate is based on an Oregon Health Authority (OHA) calculation defined by OAR 410-125-0141.
3. The details are described below.

B. Discharge Versus Transfer

1. For discussing DRG payments and inpatient care, the following terms describe when a patient leaves the hospital.
    a. A "**discharge**" occurs when a Moda Health member:
        i. Has received complete acute care treatment and leaves an acute care hospital for home or a lower level of treatment.
            1) It is essential that the patient is not readmitted to any inpatient hospital for a related condition within 24 hours of discharge. A readmission within 24 hours of discharge changes the discharge to a transfer.
            2) Examples of a lower level of treatment include long term care, skilled nursing, or rehabilitation facility, a psychiatric hospital, or home health agency.
            3) Discharge status codes 01, 03, 04, 06, 21, etc.
        ii. Dies in the hospital. Discharge status 20 must be used.
    b. An "**acute transfer**" occurs when a Moda Health member is:
        i. Moved from one inpatient acute care hospital to another acute care hospital for related care. Patient discharge status code 02 must be used when a transfer is performed.
        ii. Admitted to the same or another acute care hospital within 24 hours after leaving the hospital against medical advice (patient discharge status code 07).
        iii. Discharged but is then readmitted within 24 hours to another acute care hospital (unless the readmission is unrelated to the initial discharge).
2. The above definitions are based upon and adapted from the CMS definitions of discharges and transfers, which are under the Inpatient [Hospital] Prospective Payment System (IPPS) and can be found in 42 Code of Federal Regulations (CFR) 412.4 (d).

C. Length of Stay (LOS)

1. Each MS-DRG is assigned a geometric mean length of stay (GMLOS).
    a. This information is published in the MS-DRG table (Table 5) of the CMS annual IPPS Final Rule.
    b. The geometric mean length of stay is used to calculate the correct DRG payment to the Transferring Hospital when a transfer occurs.

2. The actual length of stay (ActLOS) is calculated by subtracting day of admission from day of discharge. In summary, the discharge/transfer day is not counted for the actual length of stay, unless admitted and discharged/deceased on the same day. (MPAR[6])

   Example:
   Admit day = February 21, 2019
   Transfer day = February 24, 2019

Transfer	Minus	Admit	Equals	Actual Length of Stay (days)
24	**-**	**21**	**=**	**3**

D. Reimbursement Adjustments

1. Transferring Hospital.

   a. It is important to note that a hospital may discharge a patient, but later become a Transferring Hospital if and when the patient is readmitted to the same or another inpatient hospital within a specific period of time. See section B above.

   b. If the actual length of stay covered days are equal to or exceed the geometric mean length of stay for the DRG, then the standard DRG payment applies.

   c. If the actual length of stay covered days are less than the geometric mean length of stay for the DRG, then the Transferring Hospital is paid based upon a per diem rate.

      1) For Commercial and Medicare Advantage claims, the per diem rate methodology is as follows:

         i) The payment is determined by dividing the appropriate DRG rate by the geometric mean length of stay for the specific DRG under which the patient was treated.

         ii) The graduated payment is two times the per diem rate for the first day and the per diem amount for each subsequent day up to the full DRG payment. No payment is made for the day of discharge/transfer.

            Example:

            Four-day inpatient hospital stay and discharge on the fifth day, ActLOS 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.

            Date of admission $1,000 x 2 = $2,000

            Day two through four $1,000 x 3 days = $3,000

            Day five no payment = $0

            Total reimbursement for transfer = $5,000

         iii) If outlier criteria is met, the Transferring Hospital qualifies for a cost outlier payment. The outlier threshold calculation is the same for transfers as for non-transfer cases. The transfer DRG rate and the total billed charges are used to calculate both the outlier threshold and the outlier payment. No per diem payment is made for the day of transfer. The payment to the transferring hospital will not exceed the (non-transfer) DRG payment (with or without outliers) and will not exceed the billed charges.

Example:

ActLOS: 1 (Admit date hospital stay and transfer next day)

GMLOS: 2.9

DRG hospital-specific payment rate of $54,299.70

Total billed Charges: $82,234.17

Outlier threshold: 180%

Outlier payment: 70%

Graduated Payment Calculation

$54,299.70/2.9 = $18,724.03; $18,724.03/day is the transfer per-diem rate.

Date of admission $18,724.03 x 2 = $37,448.07

Day 2 (day of transfer) no payment = $0

Total Per Diem graduated payment: $37,448.07

Outlier Payment Calculation

$37,448.07 x 180% = $67,406.53

$82,234.17 - $67,406.53 = $14,827.64

$14,827.64 x 70% = $10,379.35

Total payment for transfer: $37,448.07 + $10,379.35 = $47,827.42

2) For Medicaid claims, the per diem rate methodology is as follows:

   i) The payment is determined by dividing the appropriate DRG rate by the geometric mean length of stay for the specific DRG under which the patient was treated.

   ii) A flat per diem rate applies for each day from admit through the day before discharge, up to the full DRG payment. No per diem payment is made for the day of discharge/transfer.

   iii) No outlier is added for the transferring hospital in the OHA transfer per diem methodology.

Example:

ActLOS: 1 (Admit date hospital stay and transfer next day)

GMLOS: 2.9

DRG hospital-specific payment rate of $24,670.25

Total billed Charges: $52,234.17

Per Diem Payment Calculation

$24,670.25/2.9 = $8,506.98; $8,506.98/day is the transfer per-diem rate.

Date of admission $8,506.98 x 1 = $8,506.98

Day 2 (day of transfer) no payment = $0

Total Per Diem payment: $8,506.98

2. Discharge Hospital.
    a. In the case of transfers, the receiving facility that ultimately discharges the transferred patient without a readmission within 24 hours is considered the Discharge Hospital.
    b. The final Discharging Hospital receives the applicable full DRG payment, regardless of the length of the patient's inpatient stay. The applicable DRG will be determined by Moda during adjudication and/or review. The outlier threshold and payment are calculated the same as any other discharge without a transfer.
3. Full MS-DRG payments are made to hospitals when the patient is discharged to their home (patient discharge status code 01) or another lower level of care and not readmitted to an acute-care hospital within 24 hours.
4. Full MS-DRG payments are made for properly billed MS-DRG 789. (CMS[12])

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
ActLOS	=	Actual Length of Stay
AHA	=	American Hospital Association
AMA	=	American Medical Association
ASO	=	Administrative Services Only
CAH	=	Critical Access Hospital
CCI	=	Correct Coding Initiative (see “NCCI”)
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
GMLOS	=	Geometric Mean Length Of Stay
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
ICD	=	International Classification of Diseases
ICD-10	=	International Classification of Diseases, Tenth Edition

Acronym or Abbreviation		Definition
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	=	International Classification of Diseases, Tenth Edition, Procedure Coding System
IPPS	=	Inpatient [Hospital] Prospective Payment System
LOS	=	Length of Stay
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
OHA	=	Oregon Health Authority
OON	=	Out-of-network
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill
UHDDS	=	Uniform Hospital Discharge Data Set

Definition of Terms

Term	Definition
Allowable Amount	The full fee amount allowed under the applicable fee schedule, whether in-network or out-of-network. The allowable amount includes both the carrier payment amount and the member-responsibility cost-sharing amount.
Discharge	A **"discharge"** occurs when a member: 1. Has received complete acute care treatment and leaves an acute care hospital for home or a lower level of treatment. 2. Leaves against medical advice and is not readmitted to an acute care hospital within 24 hours of discharge. 3. Dies in the hospital.
Discharge Hospital	The facility from which the member is discharged to a lower level of care and is not readmitted to any acute care hospital within 24 hours of discharge. (Or the facility at which the member dies, if applicable.)
Geometric Mean Length Of Stay (GMLOS)	A DRG's Geometric Mean Length of Stay refers to the length of stay that CMS has determined should be expected for that particular DRG. (Jaccard & Carroll[5]) The Geometric Mean is a more precise representation of the central value of an ensemble of points; it is not as sensitive to outliers as the Arithmetic Mean, or Average value. (Mastrangelo[4])
Length of stay (LOS)	A term used to describe the duration of a single episode of care at a facility (for example, at an Inpatient hospital).

Term	Definition
Outlier	Stop-loss
Per Diem Adverb: Per Diem Adjective: Per Diem	For each day (used in financial contexts).
Per Diem Noun: Per Diem	An allowance or payment made for each day.
Per Diem, Flat	A flat per diem is an allowance or payment made for each day, and the rate per day is exactly the same for each day.
Per Diem, Graduated	A graduated per diem is an allowance or payment made for each day, but the rate per day varies and is not exactly the same for each day. (The rate variation will be specified in applicable guidelines or documentation.)
Receiving Hospital	• The Receiving Hospital only becomes the Discharge Hospital if the member is discharged to home or a lower level of care and is not readmitted to any acute care hospital within 24 hours of discharge. • If the member is again transferred to another acute care hospital, the Receiving Hospital is also a Transfer Hospital. • If the member is discharged and then is readmitted within 24 hours of discharge, then the Receiving Hospital also becomes a Transfer Hospital, and is subject to Transfer Hospital rules. If the readmission is to a different acute-care hospital, this change in status for the Receiving Hospital may not become evident until the claim from the readmission hospital stay is received and processed. Depending upon the actual length of stay, the Receiving Hospital's discharge claim may then need to be reprocessed under transfer rules and adjusted.
Stop-loss	Outlier
Transfer, acute care	An **"acute care transfer"** occurs when a member: 1. Is transferred to another acute care hospital for related care. 2. Leaves against medical advice and is subsequently admitted to another acute care hospital within 24 hours of leaving. 3. Is discharged but then readmitted within 24 hours to another acute care hospital (unless the readmission is unrelated to the initial discharge).

Term	Definition
Transfer Hospital	The facility from which the member either: 1. Is transferred to another acute care hospital for related care. 2. Leaves against medical advice and is subsequently admitted to the same or another acute care hospital within 24 hours of leaving. 3. Is discharged to a lower level of care but is subsequently readmitted to the same or another acute care hospital within 24 hours of discharge.

Discharge status codes (key codes, list not all-inclusive):

Code	Code Description
01	Discharged to Home or Self-Care (Routine Discharge)
02	Discharged/Transferred to Another Short-Term General Hospital for Inpatient Care
03	Discharged/Transferred to SNF with Medicare Certification in Anticipation of Skilled Care
04	Discharged/Transferred to a Facility That Provides Custodial or Supportive Care
05	Discharged/Transferred to a Designated Cancer Center or Children's Hospital
06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in anticipation of covered skilled care
07	Left Against Medical Advice or Discontinued Care
20	Expired
30	Still a Patient
43	Discharged/Transferred to a Federal Health Care Facility
50	Discharged/transferred to Hospice (home)-or alternative setting that is the patient's home such as nursing facility, and will receive in-home hospice services
51	Discharged/transferred to Hospice medical facility- patient went to an IP facility that is qualified and the patient is to receive the general IP hospice level of care or hospice respite care. Used also if the patient is discharged from an IP acute care hospital to remain in hospital under hospice care
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to a long term care hospital
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharges/Transfers to a Critical Access Hospital
70	Discharged/Transferred to Another Type of Healthcare Institution Not Defined Elsewhere in this Code List
81 - 95	Discharged to [various places] with a Planned Acute Care Hospital Inpatient Readmission

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Day of Discharge or Death is not counted as a covered day, unless admitted and discharged/deceased on the same day." (MPAR[6])

"Deaths and transfers are reimbursed based on the assigned DRG and payment hierarchy logic. There are no special reimbursement arrangements applicable to deaths and transfers." (MPAR[7])

"An exception to the transfer policy applies to MS-DRG 789. The weighting factor for this MS-DRG assumes that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into this MS-DRG is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable." (CMS[12])

Cross References

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "Facility Guidelines, General Overview." Moda Health Reimbursement Policy Manual, RPM065.

References & Resources

1. CMS. "Clarification of Patient Discharge Status Codes and Hospital Transfer Policies." MLN Matters Number SE1411. Reissued November 17, 2015. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1411.pdf .

2. CMS. "Clarification of Medicare's Transfer Policy Under the Inpatient Prospective Payment System." MLN Matters Number SE0459. April 9, 2013. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0459.pdf .

3. CMS. "Transfers." *Medicare Claims Processing Manual*. Chapter 3 - Inpatient Hospital Billing, (Rev. 4166, 11-09-18), § 20.1.2.4. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf .

4. Mastrangelo, Kris. "Length of Stay (LOS) - What is the Best Calculation?" Harmony Healthcare Blog. December 10, 2014: March 19, 2019. http://www.harmony-healthcare.com/blog/what-is-the-best-calculation-for-los .

5. Jaccard, Laurie, RN and Carroll, Sharon, FCAS. "Using Data Analytics to Transform Care Management and Reduce Clinical Variation." *Early Edition of HFM Magazine*, May 2017, Page 2. Healthcare Financial Management Association. May 2017: March 19, 2019. http://www.clinical-intelligence.org/wp-content/uploads/2017/06/0517_HFM_Jaccard.pdf .

6. MPAR. "Inpatient Hospital Requirements - DRG and Per Diem concept." MedicarePaymentandReimbursement.com (MPAR). Last accessed Marcy 27, 2019. http://www.medicarepaymentandreimbursement.com/2016/11/inpatient-hospital-requirements-drg-and.html .

7. MPAR. “DRG.” MedicarePaymentandReimbursement.com (MPAR). Last accessed Marcy 27, 2019. http://www.medicarepaymentandreimbursement.com/2016/07/billing-guide-for-partial.html .

8. OHA. “Oregon Health Authority Hospital Services Administrative Rulebook.” January 1, 2020: August 26, 2020. https://www.oregon.gov/oha/HSD/OHP/Policies/125rb010120.pdf .

9. OHA. “DRG Rate Methodology.” OAR 410-125-0141. Last accessed August 26, 2020. https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-125-0141 .

10. CMS. “Acute Care Hospital Inpatient Prospective Payment System.” ICN MLN006815 March 2020. Last accessed April 12, 2021. Page 14 of 17. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf .

11. CMS. “Clarification of Medicare’s Transfer Policy Under the Inpatient Prospective Payment System.” MLN Matters Number SE1411. November 17, 2015. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1411.pdf .

12. CMS. “IPPS Transfers Between Hospitals.” *Medicare Claims Processing Manual*. Chapter 3 - Inpatient Hospital Billing, (Rev. 4166, 11-09-18), § 40.2.4. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf .

Background Information

MS-DRGs are a CMS payment methodology that provides a case-rate payment for the episode of care based on the DRG classification or grouping of care assigned. When a member is moved from one acute care hospital to another acute care hospital, a transfer has occurred. CMS has outlined rules and calculations for when and how DRG payment should be adjusted, including when transfers between facilities occur during the episode of care.

This CMS DRG payment methodology and the related rules are considered an industry-standard for many Commercial plans and carriers in developing their contracts and policies.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member’s medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member’s medical benefit plan, the member’s medical

benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
5/8/2024	Annual review/Formatting: Cross References: Hyperlinks updated. No content changes.
7/12/2023	Annual review. Section D.4 added. Coding Guidelines & Sources: 1 entry added. Minor formatting fixes (font size inconsistencies).
12/14/2022	Formatting/Update Scope, States: Idaho added. Cross References: Hyperlinks added.
6/8/2022	Annual/format Change to new header. Acronym table: Added 5 entries. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
4/10/2019	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
7/1/2019	Original Effective Date (with or without formal documentation). Policy based on CMS Transfer policy. (CMS[1, 2, 3, 10, 11, 12])