	Reimbursement Policy

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

Effective Date: **10/01/17**	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://providers.amerigroup.com/DC. *****

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 an enrollee's Amerigroup District of Columbia, Inc. benefit plan. The determination that a service, procedure, item, etc. is covered under an enrollee'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 enrollee's District 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 These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements.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 contract, federal and/or district guidelines regarding facility transfers payment. In the absence of such guidelines, we will use the following criteria: • Transferring facility receives the lesser of the DRG base payment and the calculated per diem rate based on the length of stay plus one day • Receiving facility receives full DRG payment

History	• Biennial review approved **09/30/19** • Initial policy approved **07/19/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • DC Department of Health Care Finance policies • Amerigroup contract with the DC Department of Health Care Finance
Definitions	• **General 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 HealthCare-Acquired Conditions
Related Materials	• None