	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/TX.*****

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 STAR+PLUS MMP (Medicare-Medicaid Plan) benefits. 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 STAR+PLUS MMP may:

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

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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

Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP 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 STAR+PLUS MMP 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** • Initial policy approved **04/03/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS policies • Texas Health and Human Services Commission (HHSC) • Amerigroup STAR+PLUS MMP contract with HHSC
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Diagnoses used in Diagnosis-Related Group Computation • Documentation Standards for Episodes of Care • Inpatient Readmissions • Other Provider Preventable Conditions • Present on Admission Indicator for HealthCare-Acquired Conditions
Related Materials	• None