Reimbursement Policy:

Facility Transfer - (Medicare/Medicaid)

POLICY NUMBER	REVIEW DATE:	APPROVED BY
RPC20260027	February 2026	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpage on emblemhealth.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

This policy defines the payment guidelines for transfers from one inpatient acute care hospital to another acute care hospital for related care and/or emergency room transfers between outpatient facilities.

This policy is applicable to all acute care facilities and applies to EmblemHealth Medicare *(including Commercial contracts that follow Medicare payment methodology)* and Medicaid *(including EmblemHealth Essential Plans*) contracts only.

Policy Statement:

This policy defines how EmblemHealth determines reimbursement for the transferring hospital and the receiving (discharging) hospital and emergency room transfers between outpatient facilities.

EmblemHealth aligns with CMS and transfers from a facility capable of providing the necessary care or solely based on patient or family preference (i.e. patient and/or the patient's family prefer a specific hospital or physician) *will not be considered*. EmblemHealth will consider non-emergent acute to acute facility transfers for medical necessity only.

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Emergency Room Transfer Between Outpatient Facilities:

EmblemHealth allows reimbursement for one emergency room visit when a patient is transferred between outpatient facilities without being admitted.

Consistent with CMS, EmblemHealth considers these transfers to be a single episode of care, and the transferring facility *will not be eligible for separate reimbursement.* Reimbursement will be considered for the final discharging facility only.

Inpatient Discharge vs. Transfer:

DRG Payments and Inpatient Care: The following terms describe when a patient leaves the hospital

- 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.
     a. Examples of a lower level of treatment include long term care, skilled nursing, rehabilitation facility, a psychiatric hospital, or home health agency.
  2. Dies in the hospital; discharge status 20 must be used.

Readmission to any inpatient hospital for a related condition within 24 hours of discharge changes *the discharge to a transfer*.

- An **"acute transfer"** occurs when a member:
  1. 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.
  2. Admitted to the same or another acute care hospital within 24 hours after leaving the hospital against medical advice (patient discharge status code 07).
  3. Discharged but is then readmitted within 24 hours to another acute care hospital *(unless the readmission is unrelated to the initial discharge).*

- **"Same day transfer" (transfers occurring within 24 hours)**:
  1. Append claim with condition code 40 (Same day transfer)
  2. Append claim with an appropriate patient status code

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Length of Stay:

- Each MS-DRG is assigned a geometric mean length of stay (GMLOS). This information is published in the MS-DRG table (Table 5) of the CMS annual IPPS Final Rule.
- The geometric mean length of stay is used to calculate the correct DRG payment to the Transferring Hospital when a transfer occurs.
- The actual length of stay (ActLOS) is calculated by subtracting day of admission from day of discharge. The discharge/transfer day is not counted for the actual length of stay, unless admitted and discharged/deceased on the same day.

  EXAMPLE:

  Admit day = March 21, 2025

  Transfer day = March 24, 2025

Transfer	Minus	Admit	Equals	Actual Length of Stay (Days) (ALOS)
24	-	21	=	3

Reimbursement Adjustments - Medicare:

Note: 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 Above - Inpatient Discharge vs. Transfer

Applicable to EmblemHealth Medicare (including Commercial contracts that follow Medicare payment methodology).

EmblemHealth follows prevailing CMS DRG reimbursement methodologies for both the Transferring Hospital and the Discharge Hospital.

- ***No payment is made for the day of discharge/transfer***
- ***No payment is made for same day transfer (transfers occurring within 24 hours) and/or the day of discharge/transfer.***

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Reimbursement Adjustments – Medicaid:

Note: 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 Above - Inpatient Discharge vs. Transfer

Applicable to EmblemHealth Medicaid (including EmblemHealth Essential Plans).

- EmblemHealth follows prevailing NY State Medicaid reimbursement methodologies for both the Transferring Hospital and the Discharge Hospital.
- ***No payment is made for the day of discharge/transfer***
- ***No payment is made for same day transfer (transfers occurring within 24 hours) and/or the day of discharge/transfer.***

Definitions:

Term	Definition
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)	Geometric Mean Length of Stay refers to the length of stay that CMS has determined should be expected for particular DRG. 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 Average Length of Stay
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).

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Term	Definition
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.
Transfer, acute care	An "acute care transfer" occurs when a member: • Is transferred to another acute care hospital for related care. • Leaves against medical advice and is subsequently admitted to another acute care hospital within 24 hours of leaving. • Is discharged but then readmitted within 24 hours to another acute care hospital (unless the readmission is unrelated to the initial discharge).
Transfer Hospital	The facility from which the member either: • Is transferred to another acute care hospital for related care. • Leaves against medical advice and is subsequently admitted to the same or another acute care hospital within 24 hours of leaving. • 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:

Status	Description
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification

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Status	Description
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
21	Discharged/transferred to court/law enforcement
30	Still patient
43	Discharged/transferred to a federal health care facility
50	Hospice - home
51	Hospice - medical facility (certified) providing hospice level of care
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
81-95	Discharged to [various places] with a Planned Acute Care Hospital Inpatient Readmission

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References:

CMS Annual IPPS Final Rule published by CMS https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps

CMS Medicare Claims Processing Manual, Chapter 3, Section 40.2.4, https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912

CMS. "Transfers." Medicare Claims Processing Manual. Chapter 3 - Inpatient Hospital Billing, Section 20.1.2.4. https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912

New York State Department of Health (DOH) APR-DRG Weights and ALOS for Acute Services https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/weights/

Revision History

Company	DATE	REVISION
EmblemHealth	2/2026	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number