If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of IL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. Blue Cross and Blue Shield of IL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Transfer Diagnosis Related Group (tDRG)

Policy Number: CPCPILtDRG

Version 1.0

Clinical Payment and Coding Policy Committee Approval Date: February 7, 2025

Plan Effective Date: February 7, 2025

Description:

The purpose of this policy is to provide information on Transfer Diagnosis-Related Group ("DRG") ("tDRG") and when it is applicable. Transfer DRG is based on Medicare Severity (MS) DRG ("MS-DRG"). The tDRG and payment methodology discussed in this policy may not be limited to covered services. References to services herein are not a guarantee or representation of coverage or payment. Providers are urged to refer to applicable state and federal statutes, regulations, laws, and

mandates for eligible coverage and to the member's benefits for home health care services.

Health care providers are expected to exercise independent judgment in providing care to members. This policy is not intended to impact care decisions or medical practice.

This policy applies to claims from transferring hospitals that are reimbursed on a DRG case rate basis.

Reimbursement Information:

The plan reserves the right to request supporting documentation to determine eligible reimbursement. Failure to adhere to coding and billing policies, as well as, reporting correct Patient Discharge Status Codes-PDSC, and condition codes may impact claims processing and reimbursement.

If a member's hospital stay is shorter than the average length of stay and the member is transferred to another facility or home, the DRG claim submitted by the [transferring hospital] will be prorated to match the length of the stay. These transfer rules apply to:

- All inpatient DRG claims for acute care transfers from a hospital to another acute care setting (when the transfer is made to a post-acute setting) with eligible DRG codes

- When a member is moved from an acute care, hospital including:
    - Transfers to another acute care hospital or unit for related care, (PDSC 02 or 82)
    - Transfers from acute care hospital to a post-acute setting
        - Transfer to an inpatient rehabilitation facility or unit (PDSC 62 or 90)
        - Transfer to long term acute care facility (PDSC 63 or 91)
        - Transfer to a psychiatric care facility (PDSC 65 or 93)
        - Transfer to a children's hospital, cancer hospital (PDSC 05 or 85)
        - Transfer to a skilled nursing facility (PDSC 03 or 83)
        - Transfer to Hospice care (PDSC 50 or 51)
        - Transfer to Critical Access (PDSC 66 or 94)
        - Transfer to home under a written plan of care for the provision of home health services from a home health agency (PDSC 06 or 86) except when Condition Code 42 or 43 is on the transferring hospital's claim

Reimbursement is based upon a graduated per diem rate (i.e., the prospective payment rate divided by the geometric mean length of stay for the specific MS-DRG into which the case falls; hospitals receive twice the per diem rate for the first day of the stay and the per diem rate for every following day up to the full MS-DRG amount).

References:

Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 3-Inpatient Hospital Billing. Accessed November 8, 2024.

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf

CFR-2011-title42-vol2-part412. Accessed November 8, 2024.

https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-part412.pdf

Policy Update History:

09/26/2023	New policy
02/07/2025	Annual Review; Minor grammatical changes.