IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201928 MAY 28, 2019

IHCP to revise reimbursement policy regarding inpatient transfers

The Indiana Health Coverage Programs (IHCP) is revising the reimbursement policy of the inpatient transferring and transferee (receiving) policy to reimburse both hospitals at a diagnosis-related group (DRG) daily rate.

For dates of service (DOS) on or after July 1, 2019, the receiving hospital and the transferring hospital will **both** be reimbursed by a daily DRG rate.

Receiving hospital billing instructions

Receiving hospitals are instructed to use **admission source code 4** when submitting an institutional claim:

- Admission Source Code field on the IHCP Provider Health Care Portal (Portal) institutional claim
- Field 15 on the *UB-04* claim form
- Loop 2300 CL102 on the 837I electronic transaction

The admission source code is only required for the receiving hospital; however, if an invalid source code is submitted, providers will receive a claim denial with the following:

- Remark Code MA42 – *Admission Source Code is invalid*
- Explanation of benefits (EOB) 0029 – *Admission Source Code is invalid*

Transferring hospital identification

It remains important for providers to indicate the appropriate patient status discharge code to identify the transferring hospital on the institutional claim. To ensure accurate reimbursement, the appropriate patient status discharge code must be placed in the patient status field of the institutional claim:

- Patient Status field on the Portal Institutional claim
- Field 17 of the *UB-04* claim form
- Loop 2300 CL102 on the 837I electronic transaction

Policy reminders

Providers are not to bill separately for two DRG-reimbursed inpatient stays when a member is transferred from one unit of the hospital to another unit within the same inpatient facility. Inpatient transfer claims from one inpatient unit of the hospital to another inpatient unit should be billed on one claim (paper or electronic claim submission), as they are considered part of the same episode of care. Transfer claims continue to be subject to retrospective review to ensure appropriate billing and payment.

Claims for patients that are transferred within 24 hours of admission are to be billed as outpatient claims. However, certain DRGs include neonate transfer cases only and are no longer exempt from the transfer reimbursement policies; these cases will be reimbursed by the daily DRG rate. For DOS prior to July 1, 2019, All-Patient Refined Diagnosis-Related Group (APR-DRG) 581 and APR-DRG 580 were exempt from the transfer policy and were paid the full DRG rate. For DOS on or after July 1, 2019, these DRGs will no longer be exempt and will be reimbursed at the daily DRG rate.

All other transfer policies remain.

QUESTIONS?

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