MEDICAL POLICY

Excellus
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Medical Policy Title	**Interfacility Transfer of a Registered Inpatient**
Policy Number	**11.01.18**
Current Effective Date	March 20, 2025
Next Review Date	March 2026

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

Please note: This medical policy does not address the coverage of transportation of a registered inpatient but rather addresses the transferred admission of the patient from one acute care facility to another acute care facility.

I. Interfacility transfer of a registered inpatient from one acute care facility to another acute care facility, to obtain necessary, specialized diagnostic and/or therapeutic services is considered **medically appropriate** and, therefore, both hospital stays are **eligible for coverage** when **BOTH** criteria are met:

   A. The necessary diagnostic and/or therapeutic services are not available in the facility in which the patient is registered;

   B. The provider of the necessary service(s) is the participating facility nearest to the facility in which the patient is currently admitted that has the required capabilities for providing the necessary services.

II. Interfacility transfers for any other reasons are considered **not medically necessary** and, therefore, admission to the receiving facility is not eligible for coverage.

Newborn Transfer Criteria

III. If a newborn is transferred to a second facility for a higher level of care, then the transfer of the mother will be considered **medically necessary** unless the mother's medical status is such that her medical discharge is anticipated within 24 hours.

IV. If a newborn has been transferred to a second facility for medically necessary tertiary care that the birth facility is unable to provide, then the interfacility transfer of the newborn to return to the birth hospital will be **eligible for coverage** when:

   A. The newborn has completed tertiary care according to the InterQual® Level of Care Criteria Acute Pediatric for Level III or Level IV NICU care; and the criteria of 1 **AND** 2 **OR** 3 are met:

      1. The birth hospital is greater than 50 miles/one (1) hour driving time from the tertiary care facility;

         AND

      2. It is anticipated the newborn will remain in the receiving facility for at least three (3) days for convalescent care;

OR

3. Bed space is needed in the tertiary care facility, and the newborn can be safely cared for in the receiving acute hospital.

Note: Please contact your local Customer (Member/Provider) Service Department to determine specific regional interfacility newborn transfer requirements.

RELATED POLICIES

Corporate Medical Policy

10.01.07 Land/Ground Ambulance

11.01.06 Air Ambulance

POLICY GUIDELINE(S)

I. Coverage is not available for elective or convenience interfacility transfers (e.g., transferring a patient back to the originating facility when not medically necessary).

II. The receiving facility in an interfacility transfer should be the nearest participating facility that can provide the necessary care, unless there are extenuating circumstances. In the case of inability, lack of capacity, or refusal of the nearest participating facility to accept the patient, the patient should then be transferred to the next nearest participating facility that can provide the necessary care. Review by a Health Plan Medical Director is required in these circumstances.

III. Prior authorization for interfacility transfer is contract-dependent, and, where a member's subscriber contract so requires, authorization must be obtained prior to transfer of the patient. Some members' subscriber contracts exclude coverage for the transfer of a member between health care facilities.

Accepting the transfer of a registered inpatient from another facility through the emergency room, when the patient is not in need of emergent services, does not negate the requirement for prior authorization of the transfer if the member contract requires prior authorization for inpatient admissions.

IV. The transfer of a registered inpatient to another facility for a diagnostic procedure that is designated by the Health Plan as an outpatient procedure, is not considered an interfacility transfer if it does not meet the InterQual® Acute Inpatient Level of Care Criteria.

V. Hospital contracts with some health care systems provide for only one diagnostic related group (DRG) payment, irrespective of the number of facilities in which the patient becomes registered. Intra-system transfers with one DRG payment do not require prior authorization.

VI. A medically necessary determination for the interfacility transfer service of a registered inpatient to another facility does not automatically translate to an approval for transportation. A clinical review of the mode of ambulance transport service (air or land/ground) to the specified facility should also be performed in accordance with the applicable Corporate Medical Policy (#10.01.07 Land/Ground Ambulance or #11.01.06 Air Ambulance).

DESCRIPTION

Interfacility, or interhospital, transfer of a registered inpatient involves the transfer of a registered hospital inpatient to another acute care facility, to obtain medically necessary, specialized diagnostic or therapeutic services.

In order for an interfacility transfer to occur, the transferring physician should ensure that all required documentation relating to the transfer of patients is completed.

SUPPORTIVE LITERATURE

Not Applicable

PROFESSIONAL GUIDELINE(S)

Not Applicable

REGULATORY STATUS

Not Applicable

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
No specific code(s)	

HCPCS Codes

Code	Description
No specific code(s)	

ICD10 Codes

Code	Description
Numerous codes	

REFERENCES

Altieri Dunn SC, et al. SafeNET: Initial development and validation of a real-time tool for predicting mortality risk at the time of hospital transfer to a higher level of care. PLoS One. 2021 Feb 8; 16(2):e0246669.

Mueller S, et al. Inter-hospital transfer and patient outcomes: a retrospective cohort study. BMJ Qual Saf. 2019 Nov;28(11):e1.

Tanenbaum J, et al. Quantifying health insurance eligibility impact on interhospital transfers of injured patients: Evidence from the affordable care act's dependent coverage provision. Surgery 2025;178:108921.

White MJ, et al. Interfacility transfers among patients with complex chronic conditions. Hosp Pediatr. 2020 Feb;10(2):114-122.

SEARCH TERMS

Interfacility Transfer, Interhospital Transfer, Inpatient Transfer

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Based on our review, Interfacility Transfers of Registered Inpatients are not addressed in National or Regional Medicare coverage determinations or policies.

However, a payment formula is located in the National Archives and Records Administration. Code of Federal Regulations. (Chapter IV, Part 412.4./Prospective payment systems for inpatient hospital services. Discharges and transfers.) Available at: eCFR : 42 CFR Part 412 -- Prospective Payment Systems for Inpatient Hospital Services [accessed 2025 Jan 27]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.

- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
08/31/06, 02/22/07, 02/28/08, 02/26/09, 06/25/09, 06/24/10, 06/24/11, 10/25/12, 10/24/13, 10/23/14, 10/28/15, 10/27/16, 10/26/17, 04/26/18, 04/25/19, 04/23/20, 04/22/21, 06/24/21, 04/21/22, 04/20/23, 04/18/24, 03/20/25	
Date	**Summary of Changes**
03/20/25	• Annual review, policy intent unchanged
01/01/25	• Summary of changes tracking implemented.
08/25/05	• Original effective date