Policy:	GG.1668
Title:	**Inpatient Interfacility Transfers**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	12/05/2024
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines the Interfacility Transfer of a Member who is an admitted inpatient from one acute care Facility to another acute care Facility and admitted as an inpatient.

This policy does not address transfers from the Emergency Department (ED) for Emergency Medical Treatment and Active Labor Act (EMTALA) according to Section 1867 of the Social Security Act (42 U.S. Code § 1395dd) or transfers to Facilities such as sub-acute, Long-Term Acute Care Hospitals (LTACH), Acute Rehabilitation Facilities (ARF), or Skilled Nursing Facilities (SNF).

II. POLICY

A. CalOptima Health shall provide coverage for Interfacility Transfers when one or more of the following Medical Necessity criteria has been met:

1. The Member requires a level of care (i.e., a neonatal care unit or level 1 trauma center) which is not available at the Originating Facility;

2. The Member requires the services of a specialist to evaluate, diagnose or treat the Member's condition when that specialist is not available at the Originating Facility;

3. The Member has received care at a specific prior institution for a condition not normally managed at the Originating Facility (i.e. organ transplant recipients). A transfer is needed to the prior institution to diagnose, manage, or treat a complication or other acute issue related to the prior admission; or

4. At the request of the treating Provider to meet specific medical condition unique to the Member after a peer-to-peer discussion.

B. Not Medically Necessary:

1. Interfacility Transfers are not considered Medically Necessary when:

a. Medical Necessity criteria has not been met as outlined in Section II.A. of this policy; or

b. The Interfacility Transfer is primarily for the convenience of the individual, the individual's family, the physician, or the Originating Facility.

2. Admission and subsequent care at the receiving facility is considered not Medically Necessary when:

    a. Medical Necessity criteria has not been met as outlined in Section II.A. of this policy; or

    b. The Interfacility Transfer is primarily for the convenience of the individual, the individual's family, the physician or the Originating Facility.

C. A Prior Authorization is required for Transfer Back to the Originating Facility when all the following criteria are met:

    1. Higher level of care needs met;

    2. Medically stable;

    3. Originating Facility will be able to safely continue ongoing care;

    4. The Member or Member's Authorized Representative consents to transfer back to the Originating Facility; and

    5. Copy of Take Back Agreement (TBA).

D. CalOptima Health requires the following for each Interfacility Transfer that has met Medical Necessity criteria as mentioned in Section II.A. of this policy. Each Facility performing the transfer is responsible for ensuring the following coordination-of-care standards listed below are performed:

    1. Member receives all necessary transitional care services with a documented Plan of Care;

    2. Implement a standardized discharge risk assessment;

    3. Obtain permission from Members or Authorized Representatives to share information;

    4. Medication reconciliation is conducted pre-and post-transition;

    5. All Prior Authorizations are timely processed;

    6. Hospitals educate its staff on services and supplies requiring Prior Authorization;

    7. Establish mutually agreed-upon policies and procedures for transitional care services;

    8. Prevent delayed transfers;

    9. Each Member is evaluated for all appropriate care settings; and

    10. Members with Substance Use Disorder (SUD) and mental health needs receive treatment upon discharge and/or referred to the appropriate resources.

E. Patient transfers will not be predicated on arbitrary, capricious, or unreasonable discrimination because of race, color, religion, national origin, age, sex, physical condition, disability, sexual orientation, gender identity or expression, genetic information, veteran status, economic or insurance status, or ability to pay.

III. PROCEDURE

A. CalOptima Health and its Health Networks that are responsible for Utilization Management (UM) of hospital services shall have a plan health professional or a contracting physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary Post-Stabilization Services, to coordinate the transfer of stabilized Members in an emergency department if necessary, and for general communication with emergency room personnel.

B. Prior Authorization Request:

1. Prior Authorization request for Medically Necessary and Post-Stabilization Services shall be submitted in accordance with policy GG.1508: Authorization and Processing of Referrals.

2. Prior Authorization request for Medically Necessary post-stabilization services will be processed in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

3. Notification of UM Decision:

a. CalOptima Health and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

b. For OneCare, CalOptima Health and its Health Networks shall ensure compliance with the notification requirements set forth in CalOptima Health Policy MA.6042: Integrated Organization Determinations.

C. For purposes of a Member transfer, it is the physician at the sending hospital that is primarily responsible for the determination of patient stability and clinical appropriateness for a transfer.

D. It is not considered an Interfacility Transfer when the following occur:

1. Movement of a stable patient from the originating Facility to another hospital for testing or outpatient procedure.

2. Member not been discharged from the originating Facility.

3. Will not remain overnight at receiving hospital.

4. Will return to the originating Facility after completion of testing or outpatient procedure.

E. Claims process for Interfacility Transfers:

1. Claims are processed in accordance with CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group.

2. If a Member is not discharged, sent to a second hospital for a procedure or testing, not discharged, and then returns to the originating hospital, the originating hospital is responsible for submitting claim, in accordance with CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group.

a. The second hospital should not submit claim in accordance with CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group and DHCS Medi-Cal Diagnosis related groups FAQ FY 2022-23.

F. CalOptima Health will engage Members transferring from one setting or level of care to another ensuring Members are support from discharge planning until they have been successfully connected to all needed services and supports in accordance with CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serva a CalOptima Health Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group
B. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS)
C. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
D. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
E. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Health Policy MA.6042: Integrated Organization Determinations
G. Centers for Medicare and Medicaid Services. Administration. Code of Federal Regulations. Chapter IV, Part 412.4; Prospective payment systems for inpatient hospital services. Discharges and transfers
H. Department of Health Care Services (DHCS) DRG/SFY/2022-23 Medi-Cal DRG FAQ
I. Department of Health Care Services (DHCS) Medi-Cal Billing Manual
J. Department of Health Care Services (DHCS): Administrative Days
K. 42 Code of Federal Regulations (CFR) CFR § 438.114
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services.
M. 42 United States Code (USC) § 1395dd

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2024	GG.1668	Inpatient Interfacility Transfers	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Acute Care Transfer	As defined by the Centers for Medicare & Medicaid Services (CMS), this occurs when a hospital patient is discharged and then readmitted to another hospital on the same day.
Authorized Representative	Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. OneCare: Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
Facility	Any premise that is: 1. Owned, leased, used or operated directly or indirectly by or for CalOptima Health for purposes related in the DHCS Medi-Cal Contract, or 2. Maintained by a Provider to provide services on behalf of CalOptima Health.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Interfacility Transfer	Transfer of a member who is an admitted inpatient from one acute care facility to another acute care facility as an inpatient.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima

Term	Definition
	Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A beneficiary enrolled in a CalOptima Health program.
Originating Facility	The acute care hospital where member is originally admitted as Inpatient and receiving services.
Plan of Care	An individual written plan of care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Post Stabilization Services	Covered services related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, to improve or resolved the condition.
Practitioner	A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services.
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual

Term	Definition
	that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Substance Use Disorder (SUD)	Those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.
Transfer Back	Transferring the member back to the originating hospital