

Subject: Inpatient Interfacility Transfers**Guideline #:** CG-ANC-07**Status:** Revised**Publish Date:** 01/03/2024**Last Review Date:** 11/09/2023

Description

This document addresses the clinical features of a hospitalized individual who may require services unavailable at an initial acute care facility (originating facility) necessitating a transfer to a second acute care facility (receiving facility) and receiving subsequent care at the receiving facility.

This document does not address:

- the transport between emergency rooms of individuals requiring critical care; or
- the transfer of individuals to other types of facilities, such as sub-acute, long-term or rehabilitative facilities; or
- the medical necessity of a specific diagnostic or therapeutic procedure, a specific mode of interfacility transportation, or the inpatient level of care.

Note: Please see the following related documents for additional information:

- [CG-ANC-04 Ambulance Services: Air and Water](#)
- [CG-ANC-05 Ambulance Services: Ground: Emergent](#)
- [CG-ANC-06 Ambulance Services: Ground: Non-Emergent](#)
- [CG-MED-26 Neonatal Levels of Care](#)

Clinical Indications

Medically Necessary:

Interfacility transfers are considered **medically necessary** when **one or more** of the following criteria are met:

- The individual requires a *medically necessary* diagnostic or therapeutic service (for example, organ transplantation) which is not available at the originating facility; **or**
- The individual requires a level of care (for example, neonatal care unit or level 1 trauma center) which is not available at the originating facility; **or**
- The individual requires the services of a specialist to evaluate, diagnose or treat their condition when that specialist is not available in a timely manner at the originating facility (Note: Timeliness of care is a case/individual specific attribute. It may be appropriate for a medically stable individual to await availability of a specialist for several days while a medically unstable individual may require care sooner); **or**
- The individual has received care at a prior institution for a condition not normally managed at the originating facility (for example, organ transplant recipient) and return to that prior institution is needed to diagnose, manage, or treat a complication or other acute issue.

Interfacility transfer to allow the parent who gave birth to remain with neonate is considered **medically necessary** when neonate transfer meets the medically necessary criteria listed above and the parent who gave birth requires continued hospitalization due to birth complications or other medically necessary conditions.

Not Medically Necessary:

Interfacility transfers between an originating facility and a receiving facility are considered **not medically necessary** when:

- The criteria above have not been met; **or**
- The transfer is primarily for the convenience of the individual, the individual's family, the physician or the originating facility.

Admission and subsequent care at the receiving facility is considered **not medically necessary** when:

- The criteria above have not been met; **or**
- The transfer is primarily for the convenience of the individual, the individual's family, the physician or the originating facility.

Coding

Coding edits for medical necessity review are not implemented for this guideline. Where a more specific policy or guideline exists, that document will take precedence and may include specific coding edits and/or instructions. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Discussion/General Information

The Centers for Medicare & Medicaid Services (CMS) defines an acute care transfer as the discharge of an inpatient individual from one hospital and re-admittance of that individual to another hospital, when the readmission is related to the initial discharge. Each year, approximately 1.6 million individuals go through an interfacility transfer, which is approximately 3.5% of all inpatient admissions (Altieri, 2021; Usher, 2018). As regionalization of specialty care, such as pediatric care, has risen, fewer hospitals are able to provide inpatient care to children. This has led to an increase in interfacility transfers (White, 2020).

The interfacility transfer of individuals in the acute care setting comes with inherent risks and time delays (Kulshrestha, 2016; Singh, 2009; White, 2020). For example, Singh (2009) noted the following:

the available data suggest land ambulance accidents are a cause of healthcare worker and patient mortality and

occur with sufficient frequency that emergency medical personnel have a similar occupational risk of death as firefighters and police.

In a 2019 nationwide profile of hospitalized individuals, Hernandez-Boussard and associates utilized the data from two national databases to analyze the outcomes of adults who had been transferred (n=1,397,712). Transfer cases were identified and defined when the source of admission was from a different acute care hospital than the discharging hospital. The primary care outcomes evaluated were transfer status, risk-adjusted inpatient mortality, and quality of care received (development of an adverse event while in a hospital). Compared to non-transfer cases (n=31,692,211), transfer cases were associated with significantly higher risk-adjusted inpatient mortality (4.6 versus 2.1) and significantly higher in-hospital adverse events. Transfer cases also were associated with significantly longer lengths of stay and fewer routine disposition discharges.

Singh (2009) notes, "Critically ill patients may be at risk of clinical deterioration due to the stresses of transport, due to progression of their underlying disease or due to adverse events related to clinical care occurring before or during transport." When the individual requires services which are not available at the originating facility, the benefits of an interfacility transfer outweigh the inherent risks of such a transfer. However, the literature does not support that better clinical individual outcomes are achieved for those who are transferred for convenience.

de Nieuport and associates (2017) studied the effects of ambulance transfer of 91 premature infants from an intensive setting to a lower care setting. An analysis of the physiological and respiratory support data from the day prior to transport and 7 days following transport showed an increased number of bradycardias and need for respiratory support. Longer transfer times were associated with lower body temperatures, resulting in higher metabolic demands and possible earlier exhaustion of the infant. The authors noted that it is unknown whether transfers are associated with longer hospitalizations.

Kulshrestha and colleague (2016) noted that when an individual is transported, a number of adverse physiological alterations can take place. These alterations can include changes in levels of noise, vibration, temperature, humidity, acceleration and altitude. The goal of any transfer should be to maintain the optimal health of the individual, which is accomplished by transferring to the nearest facility which provides the highest specialized care needed.

Approximately 65,000 infants in the United States were transferred from the birth hospital to a tertiary care center in 2014 (Schwartz, 2018). The 2017 Society of Critical Care Medicine (SCCM) guidelines for family centered care in the neonatal, pediatric and adult ICU focus on the importance of family presence and support in the critical care setting. Schwartz (2018) notes:

Although admission to a tertiary NICU may enhance the survival and long-term prospects of the newborn, the separation of mother and neonate may have psychological consequences impacting long-term well-being.

Open flexible access as well as allowing the opportunity to assist in the care of a neonate is associated with improved parental confidence and psychological health during and following an ICU stay (Davidson, 2017).

Mueller and associates (2019) assessed the association between inter-hospital transfers (IHT) and clinical outcomes in a retrospective cohort analysis comparing the hospitalization claims of individuals who were transferred (n=53,420) against the claims of those who were not transferred (n=53,420). The cohort included 15 disease categories and individuals were matched within each diagnosis on their propensity score. The primary outcome was the 30-day mortality from the date of first admission. The results were mixed. The odds of 30-day mortality were significantly lower in the transferred group in those with acute myocardial infarction or sepsis, but was higher in those with esophageal/gastrointestinal disease, as well as congestive heart failure, pneumonia, renal failure, chronic obstructive pulmonary disease, hip fracture/dislocation, urinary tract infection and metabolic disorder. There was no significant difference between the groups for the remainder of the disease categories. The authors noted:

IHT exposes patients to known risks of discontinuity of care, such as errors in communication and gaps in information transfer. Moreover, patients undergoing IHT may be even more vulnerable to these risks than patients undergoing other care transitions, given the severity of illness in this patient population, and the absence of other factors to fill in gaps in communication, such as common electronic health records.

The transfer of an inpatient individual to a receiving acute facility with additional appropriate services is appropriate when the individual requires care not available at this original facility. However, the evidence does not support that transfer back to the original facility is more clinically appropriate than remaining at the receiving facility when the receiving facility provides all services and care which an individual requires.

Circumstances in which an individual's care needs cannot be met in their current facility will meet the medical necessity criteria in this guideline. Admission and subsequent care in the receiving facility is not medically necessary when the needed care is available in the originating facility.

Definitions

Originating facility: The facility at which an individual has been admitted for care and from which transfer is proposed.

Receiving facility: The facility to which transfer is proposed.

References

Peer Reviewed Publications:

1. Altieri Dunn SC, Bellon JE, Bilderback A, 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; 16(2):e0246669.
2. de Nieuport SMPD, van Beek R, Kornelisse RF, Tramper-Stranders G. Interhospital transfer of premature neonates from intensive to lower care settings: impact on the clinical condition. *Arch Dis Child Fetal Neonatal Ed*. 2017; 102(6):F560-F561.
3. Hernandez-Boussard T, Davies S, McDonald K, Wang NE. Interhospital facility transfers in the United States: a nationwide outcomes study. *J Patient Saf*. 2017; 13(4):187-191.
4. Kulshrestha A, Singh J. Inter-hospital and intra-hospital patient transfer: Recent concepts. *Indian J Anaesth*. 2016; 60(7):451-457.
5. Mueller S, Zheng J, Orav EJ, Schnipper JL. Inter-hospital transfer and patient outcomes: a retrospective cohort study. *BMJ Qual Saf*. 2019; 28(11):e1.
6. Ray JG, Urquia ML, Berger H, et al. Maternal and neonatal separation and mortality associated with concurrent admissions to intensive care units. *CMAJ*. 2012; 184(18):E956-E962.
7. Rosenthal JL, Romano PS, Kokroko J, et al. Receiving providers' perceptions on information transmission during interfacility transfers to general pediatric floors. *Hosp Pediatr*. 2017; 7(6):335-343.
8. Schwartz S, Raines DA. When a baby is sent away: evidence to support best practice after neonatal transport. *Neonatal Netw*.

2018; 37(3):178-181.

9. Singh JM, MacDonald RD. Pro/con debate: do the benefits of regionalized critical care delivery outweigh the risks of interfacility patient transport? Crit Care. 2009; 13(4):219.
10. Usher M, Sahni N, Herrigel D, et al. Diagnostic discordance, health information exchange, and inter-hospital transfer outcomes: a population study. J Gen Intern Med. 2018; 33(9):1447-1453.
11. White MJ, Sutton AG, Ritter V, et al. Interfacility transfers among patients with complex chronic conditions. Hosp Pediatr. 2020; 10(2):114-122.

Government Agency, Medical Society, and Other Authoritative Publications:

1. ACOG Obstetric Care Consensus No. 9: Levels of Maternal Care: Correction. Obstet Gynecol. 2023; 141(4):864.
2. American College of Emergency Physicians. Appropriate interhospital patient transfer. Approved January 2022. Available at: <https://www.acep.org/globalassets/new-pdfs/policy-statements/appropriate-interfacility-patient-transfer.pdf>. Accessed on September 11, 2023.
3. 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. Available at: <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec412-4.pdf>. Accessed on September 11, 2023.
4. Davidson JE, Aslakson RA, Long AC, et al. Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult ICU. Crit Care Med. 2017; 45(1):103-128.
5. Levels of Maternal Care: Obstetric Care Consensus No. 9. Obstet Gynecol. 2019; 134(2):e41-e55.

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Interfacility Transfer
Originating Facility
Receiving Acute Care Facility
Transferring Acute Care Facility

The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

History

Status	Date	Action
Revised	11/09/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Revised to change "more quickly" to "sooner", to remove the term specific from the term "specific prior institution" and to add "the" the term "parent who gave birth. Updated Discussion and References section.
Revised	11/10/2022	MPTAC review. Replaced gender specific terms within clinical indications with alternative non-specific terms without a change in intent. Updated Discussion and References sections.
Revised	11/11/2021	MPTAC review. Added term "considered" in not medically necessary statement to be consistent with rest of clinical criteria statements. Updated Discussion and References sections.
Reviewed	11/05/2020	MPTAC review. Updated Discussion and References sections.
Reviewed	11/07/2019	MPTAC review. Updated References section.
Revised	08/22/2019	MPTAC review. Added not medically necessary statements regarding admission and subsequent care at the receiving facility. Added Definitions section. Updated Description, Discussion and References sections.
Revised	03/21/2019	MPTAC review. Added medically necessary statement regarding mother/neonate transfer. Updated Discussion and References sections.
New	01/24/2019	MPTAC review. Initial document development.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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