

Corporate Medical Policy

Inpatient Interfacility Transfers

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Description of Procedure or Service

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.

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

This document does not address the transportation between emergency rooms of individuals requiring critical care; or the transportation of individuals to other types of facilities, such as sub-acute, long-term, rehabilitative facilities. This document does not address medical necessity of a specific diagnostic or therapeutic procedure, a specific mode of interfacility transportation, or the inpatient level of care.

Related Policy:

Ambulance and Medical Transport Services

*****Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

Policy

BCBSNC will provide coverage for Inpatient Interfacility Transfers when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this medical policy.

When Inpatient Interfacility Transfer is covered

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

- 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 his or her 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 more quickly); or

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- The individual has received care at a specific 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.

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.

If a newborn has been transferred to a second facility for medically necessary tertiary care that the birth facility is unable to provide, 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; **and** either:
 1. The birth hospital is greater than 50 miles/one 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 days for convalescent care.

OR

3. If a state of emergency has been issued by the governor and bed space is needed in the tertiary care facility, and the newborn can be safely cared for in the receiving acute hospital.

Note: 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.

When Inpatient Interfacility Transfer is not covered

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.

Policy Guidelines

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

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 members 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.

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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 (Ambulance and Medical Transport Services).

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 are involved in an interfacility transfer, which is approximately 3.5% of all inpatient admissions (Altieri, 2021; Usher, 2018).

The interfacility transfer of individuals in the acute care setting comes with inherent risks and time delays (Kulshrestha, 2016; Singh, 2009). 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. In addition, transfer cases 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. Physiological and respiratory support data from the day prior to transport and 7 days following transport were analyzed. An increased number of bradycardias and need for respiratory support was reported. In addition, 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 authors noted that 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)

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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 outcomes were 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 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.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: See procedure code for the specific procedure or service.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

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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.

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American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM). Obstetric Care Consensus Number 9. Levels of Maternal Care. August 2019. Available at: <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care>

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>

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.

Medical Director review 12/2022

Specialty Matched Consultant Advisory Panel review 2/2023

Medical Director Review 2/2023

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Specialty Matched Consultant Advisory Panel review 2/2024

Medical Director Review 2/2024

Policy Implementation/Update Information

- 12/30/22 New policy developed. BCBSNC will provide coverage for Inpatient Interfacility Transfers when it is determined to be medically necessary because the medical criteria and guidelines are met. Medical Director Review 12/2022. **Notification given 12/30/2022 for effective date 3/7/2023.** (tt)
- 3/21/23 References updated. No change to policy statement. Specialty Matched Consultant Advisory Panel review 2/2023. Medical Director review 2/2023. (tt)
- 9/12/23 Updated description for clarity. Moved the following statement from Policy Guidelines to When Covered section for clarity, “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.” Medical Director review 8/2023. No change to policy statement. (tt)
- 3/6/24 References updated. No change to policy statement. Specialty Matched Consultant Advisory Panel review 2/2024. Medical Director review 2/2024. (tt)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.