Priority Health	BILLING POLICY No. 177

Facility to Facility Transfer

Date of origin: Jan 2026	Review dates: None yet recorded

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

A facility-to-facility, or interfacility transfer (IFT) moves a patient from one licensed healthcare facility to another such as a hospital, rehab center, or long-term care. -These transfers occur when the receiving facility can provide a level of care, specialized services, or diagnostic capabilities that are not available at the originating facility. It requires a -physician-to-physician referral, patient stabilization, transfer of medical records, and qualified transport with appropriate equipment, all in comp-liance with safety and regulatory standards.

Definitions

Reasons for Patient Transfers

1. **Access to Specialized Services:**
   Transfers may occur when the patient requires clinical services, procedures, or diagnostic capabilities (e.g., oncology, cardiac surgery, advanced imaging) that are not available at the originating facility.

2. **Alignment With Appropriate Level of Care:**
   Patients may be transferred to ensure placement in the most suitable care setting, including transitions to higher acuity facilities (such as tertiary or specialty centers) or to lower acuity environments (such as rehabilitation or skilled nursing facilities).

3. **Continuity and Coordination of Care:**
   Transfers within the same healthcare system may be initiated to support ongoing treatment needs, such as movement from an acute care hospital to a long-term acute care facility or another system-affiliated site best equipped to manage the next phase of care.

4. **Facility- or Eligibility Related Considerations:**
   Transfers may result from changes in insurance eligibility (e.g., termination from Medicaid), operational constraints, or documented patient/family preference for a facility determined to be more appropriate for the patient's care needs.

BILLING POLICY

- Billing policy No 126 Ambulance Services

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Patient Transfer Process

1. Physician-to-Physician Communication

The sending physician contacts the receiving physician to confirm that the receiving provider and facility can accept the patient.

2. Patient Stabilization and Preparation

The sending facility stabilizes the patient and prepares them for transport. All relevant clinical documentation must accompany the patient—either physically or through secure electronic transmission.

3. Information Exchange

Comprehensive patient information—including diagnosis, treatments received, current condition, and transport-related needs—must be shared between facilities to support safe and coordinated care.

4. Patient Transport

A qualified transport team, via air or ground as appropriate, transfers the patient in alignment with regulatory requirements, organizational protocols, and the patient's clinical needs.

5. Transition of Care

Upon arrival, the receiving facility assumes care of the patient following a complete verbal and written handoff from the transport team and sending facility.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Clear and detailed documentation is essential to support reported diagnoses and services, particularly when distinguishing conditions that have been resolved from those that still require treatment in the new facility.

Facilities must maintain documentation that supports all reported transfer codes, including:

- Physician orders
- Nursing and discharge notes
- Transfer forms or electronic transfer summaries
- Care coordination or case management documentation
- Transport records, if applicable

Requirements for Interfacility Transfers

Medical Necessity

Transfers must be clinically justified. A transfer is appropriate when the originating facility lacks the diagnostic, therapeutic, or specialty of resources required to meet the patient's medical needs.

Patient Rights and Consent

Patients or their legally authorized representatives must be informed of the reason for transfer and provide consent. They must also be informed of their right to refuse the transfer or request an appeal when applicable.

Post Acute Care Transfer

A post-acute care transfer occurs when a patient assigned to an MS-DRG is discharged or transferred to one of the following settings:

- Another hospital or a distinct part unit that is excluded from the IPPS
- A skilled nursing facility (SNF)
- Hospice care at home
- Home with a written plan of care for home health services, when those services are scheduled to begin within 3 days of hospital discharge

These services are paid using a graduated per diem rate when the patient's stay has been reimbursed with a MS-DRG payment with a post-acute transfer with an appropriate discharge status.

Physician to Physician Transfer Requirements

1. Receiving Physician Acceptance

Before the transfer occurs, a licensed physician at the receiving hospital must formally accept responsibility for the patient. The accepting physician's name must be clearly documented in the transfer orders.

2. Medical Necessity

Transfers must be clinically justified, and the documentation should clearly support the medical need—such as access to specialized services or a higher level of care. Transfers may not be initiated for nonclinical reasons, including financial concerns, patient age, insurance status, or any other nonmedical factors.

3. Patient Consent

The patient or their legal guardian must provide consent for the transfer, and this consent should be documented in writing whenever possible. In emergency situations where written consent cannot be obtained, the reason must be thoroughly documented in the medical record.

4. Required Documentation

The patient must be accompanied by complete, up-to-date medical records, including:

- A transfer summary describing the patient's current condition, accurately reflecting their status at the time of transfer.
- A formal handoff or verbal report communicated to the receiving care team.

5. Patient Stabilization

The sending facility is responsible for stabilizing the patient to the fullest extent possible. If full stabilization cannot be achieved, a physician must certify and document that the anticipated benefits of transfer outweigh the associated risks.

6. Appropriate Transportation

Transportation must include qualified personnel and equipment appropriate to the patient's clinical needs.

7. EMTALA Compliance

All transfers must comply with the Emergency Medical Treatment and Labor Act (EMTALA). Facilities may not refuse medically appropriate transfers of Medicare-eligible or emergency patients when they have the capacity and capability to provide the required treatment.

8. Institutional Protocols

Facilities should maintain written policies, procedures, and interfacility agreements—including trauma or specialty care agreements—to ensure safe, efficient, and compliant patient transfers.

Coding specifics

For facility-to-facility transfers, documentation must include all required elements that describe both the services rendered and the member's intended destination. Revenue codes identify the department or type of care provided, while the patient's discharge status code must indicate the location to which the member is being transferred.

In addition, for all facility-to-facility transfers, the Place of Service (POS) code must reflect the type of facility receiving the member, and the Point of Origin (POO) code must be reported to indicate the member's originating location.

Discharge Status Codes (Sending Facility)

The sending facility must accurately report one of the following codes when the patient is transferred:

- **01 –** Discharge to home or self-care
- **02 –** Patient transferred to another acute-care hospital.
- **03** – Patient transferred to a Skilled Nursing Facility (SNF).
- **06** – Patient transferred to another Home Health Agency (HHA).
- **09** – Patient transferred to a designated cancer hospital or children's hospital.
- **62** – Patient transferred to an Inpatient Rehabilitation Facility (IRF).

Coding Accuracy

- The discharge status code must reflect the *actual* physical location where the patient is sent.

 Incorrect discharge codes may result in claim denials, payment adjustments, or retroactive recoupment.

Condition code
A code of two digits that describes a condition that affects how the claim is processed and paid.

- 42 – Continued care plan is not related to the patient's inpatient admission condition or diagnosis
- 43 – Continued care not provided within the post discharge window

Documentation must demonstrate that the ongoing care is unrelated to the condition or diagnosis from the patient's inpatient admission, or that the services occurred outside the post-discharge time frame.

Point of Origin Codes (Receiving Facility – New Claim)

The receiving facility must report the appropriate point-of-origin code to reflect where the patient was transferred from:

- **Code 4** – Transfer from another hospital (not the same facility).
- **Code 5** – Transfer from a SNF, Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or Nursing Residence (NR).
- **Code 6** – Transfer from another type of health care facility.
- **Code D** – Transfer from one unit to another **within the same hospital**, resulting in a separate claim.

Coding Guidance

- The point-of-origin code must match structured documentation and any transfer records included with the admission packet.
- For Code D, the receiving unit must issue a distinct claim.

Revenue Codes (UB-04, Field Locator 42)

The following revenue codes apply to transfer-related services or facility type:

- **0022** – Indicates Skilled Nursing Facility Prospective Payment System (SNF PPS) services, including associated HIPPS rate codes.
- **0450** – Emergency Room services: blood transfusion.
- **0761** – Treatment room services: blood transfusion.
- **0110** – General routine care may include non-covered room and board services.

Revenue Code Integrity

- Revenue codes must align with clinical documentation, nursing notes, and the facility's charge of master.
- Inaccurate coding may lead to payment delays or audit findings.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

For **facility-to-facility- ambulance transfers**, HCPCS Level II **origin and destination modifiers** must be used to identify both the setting from which the patient is transported and the destination of the transport. These modifiers (e.g., **H – Hospital**, **N – Skilled Nursing Facility**, **D – Diagnostic or therapeutic site**) are appended to the ambulance HCPCS code to accurately represent the transport path.

Common Ambulance Facility Transfer Modifiers (HCPCS Origin/Destination Modifiers)
These two-character modifiers (e.g., HN, DH) describe the origin and destination of the ambulance trip.

- **H**: Hospital
- **D**: Diagnostic or therapeutic site (other than P or H)
- **N**: Skilled Nursing Facility (SNF)
- **G**: Hospital-based ESRD facility
- **J**: Freestanding ESRD facility
- **R**: Residence
- **S**: Scene of accident/acute event
- **I**: Site of transfer (e.g., helipad) between ambulance modes
- **Example**: HN (Hospital to SNF), DH (Diagnostic site to Hospital).

Additional Required Modifiers

- **QM:** Ambulance service provided under arrangement (contracted)
- **QN:** Ambulance service furnished directly by the provider
- **Modifier AI** is used to identify the admitting or attending physician who oversees the patient's care while in an inpatient or nursing facility setting
    - Appended to the initial inpatient hospital visit procedure code
    - Appended to the initial nursing facility procedure code

  This is an informational only modifier. The modifier will not make any changes in processing or amounts payable. Therefore, append any payment modifiers before the AI modifier.

Resources

- DRGs and outlier payments | Priority Health
- https://med.noridianmedicare.com/web/jea/topics/claim-submission/condition-codes#hospitalization-products-services
- MLN Matters SE21001
- Medicare Claims Processing Manual Chapter 3 – Inpatient Hospital Billing

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Jan 2026	New policy