PCHP Reimbursement Policy		
Topic: Hospital Transfers	Policy Number: PCHP.RI.006	Policy Section: Administration
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

PCHP allows payment for services provided by both the originating and receiving facilities when a member is admitted to one acute care facility and then transferred to another for the same episode of care, unless specified otherwise by provider, state, federal, or CMS contracts or requirements.

The hospital providing the highest/most significant level of care will receive full DRG payment from PCHP, while the other hospital will be reimbursed at a per diem rate.

Failure to use the appropriate discharge status code on the transferring claim to indicate the member's transfer from one acute care facility to another may result in incorrect payment or denial of the claim.

References:

This policy has been developed through consideration of the following:

CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative, National Uniform Billing Committee (NUBC)

Parkland
Community Health Plan

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025