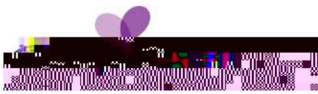
MEDICAL POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Non-Emergency Facility to Facility Transfers-MP-1448	05/01/2024
Policy Type	

and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services.



III. Requests for transfers that require a prior authorization must meet the following criteria:
   A. Member must be medically stable for transfer AND
      1. Member requires transfer to a level of care which is not available at the originating facility.
      2. Member requires transfer for a medically necessary diagnostic or therapeutic service which is not available at the originating facility.
      3. Member requires transfer for services of a specialist to evaluate, diagnose, or treat their condition when that specialist is not available at the originating facility.
      4. Member requires transfer because member has received care at a specific prior institution for a condition not normally managed at the originating facility and return to that prior institution is needed to diagnose, manage, or treat a complication or other acute issue.
      5. Member requires transfer to improve the health and welfare of the member (ie, parental bonding).
      6. Transfer to allow a parent who gave birth to remain with the neonate is considered medically necessary when the 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.

IV. The following non-emergency transfers do not require a prior authorization:
   A. Inter-facility transfers within the same healthcare system.
   B. Intra-facility transfers within the same facility.

V. Non-emergency (elective) transfers are not a covered service for the following:
   A. The criteria above have not been met.
   B. The transfer is for the convenience of the member, the member’s family, the physician, or the originating facility.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	03/15/2023	New policy. Approved at Committee.
Date Revised		

H. References

1. Appropriate interhospital patient transfer. American College of Emergency Physicians. January 2022. Accessed January, 22, 2024. www.acep.org
2. Discharges and Transfers, 42 C.F.R. § 412.4 (2022).
3. Heaton JK. EMS Inter-Facility Transport. *StatPearls*. StatPearls Publishing; 2022.
4. *Obstetric Care Consensus Number 9. Levels of Maternal Care.* American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM); 2019. Accessed January, 22, 2024. www.acep.org
5. Kulshrestha A, Singh J. Inter-hospital and intra-hospital patient transfer: recent concepts. *Indian J Anaesth*. 2016;60(7):451-457. doi:10.4103/0019-5049.186012

Independent medical review – 02/21/2023