MEDICAL POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Non-Emergency Facility to Facility Transfers-GA MCD-MM-1447	11/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are developed from a review of the available evidence-based, clinical information based on and supported by clinical guidelines from medical specialties, peer-reviewed medical and scientific studies, nationally recognized utilization and technology assessment guidelines, and other medical management industry standards to aid in determining the medical necessity of a service. Medically necessary services are defined in the plan-specific Evidence of Coverage, Member Handbooks, Provider Manuals, Medical Policy Statements, and/or other plan policies and procedures.

Medical Policy Statements do not guarantee an authorization or payment of services. Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject

Non-Emergency Facility to Facility Transfers

B. Background

This policy addresses the necessity of transferring a patient to a second acute care facility (receiving facility) when the individual requires care not available at the original facility. The goal of any transfer is to maintain the optimal health of the patient. This is accomplished by transferring the patient to the nearest facility that provides the highest specialized care needed.

Inter-hospital patient transfer is an important aspect of patient care, most often to improve patient management. During such transfers, there must be continuity of medical care. Key elements include the decision to transfer and communication, pre-transfer stabilization and preparation, choosing the appropriate mode of transfer, personnel accompanying the patient, equipment and monitoring required during the transfer, and documentation and handover of the patient at the receiving facility.

Transfer, admission, and subsequent care to the receiving facility is not medically necessary when the needed care is available at the originating facility.

C. Definitions

- **Inter-Facility Transfer** – The transfer of patients between two healthcare facilities.
- **Intra-Facility Transfer** – The transfer of patients within the same facility.
- **Non-Emergency** – A situation for which immediate response is not needed for the provision of medical treatment.
- **Non-Participating (Out-of-Network) Facility** – Facility that is not contracted with CareSource.
- **Originating Facility** – The current facility to which an individual has been admitted for care and from which a transfer is planned.
- **Participating (In-Network) Facility** – Facility that is contracted with CareSource.
- **Receiving Facility** – The facility to which a transfer is planned.

D. Policy

I. The following non-emergency transfers require a medical necessity review:
   A. a non-emergency transfer from a participating inpatient facility to a participating inpatient facility that is not within the same healthcare system
   B. a non-emergency transfer from a non-participating facility to a participating facility
   C. a non-emergency transfer from a non-participating facility to a non-participating facility

II. For non-emergency transfers that require a medical necessity review, the receiving facility submits the medical necessity review request to CareSource.

III. Requests for transfers that require a medical necessity review require that the member be medically stable for transfer AND meet at least 1 of the following criteria:
   A. Member requires transfer to a level of care unavailable at the originating facility.

B. Member requires transfer for a medically necessary diagnostic or therapeutic service unavailable at the originating facility.
C. Member requires transfer for services of a specialist to evaluate, diagnose, or treat a condition when that specialist is not available at the originating facility.
D. Member requires transfer because care was received by the member 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.
E. Member requires transfer to improve the health and welfare of the member (ie, parental bonding).
F. 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.

III. The following non-emergency transfers do not require a medical necessity review:
A. inter-facility transfers within the same healthcare system
B. intra-facility transfers within the same facility

IV. 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 provider, 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	02/14/2024 01/15/2025 01/28/2026	Annual review. No changes. Updated references. Approved at Committee. Annual review. Updated references. Approved at Committee. Annual review. Replaced prior authorization with medical necessity review and physician with provider. Updated references. Approved at Committee.
Date Effective	11/01/2026	
Date Archived		

H. References
1. Appropriate interhospital patient transfer. American College of Emergency Physicians. January 2022. Accessed January 07, 2026. www.acep.org

2. Discharges and Transfers, 42 C.F.R. § 412.4 (2026).
3. Heaton JK. EMS Inter-Facility transport. StatPearls. StatPearls Publishing. Updated February 18, 2025. Accessed January 07, 2026. www.ncbi.nlm.nih.gov
4. 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
5. *Obstetric Care Consensus Number 9. Levels of Maternal Care.* American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine; 2023. Accessed January 07, 2026. www.acep.org

Independent medical review – 02/21/2023