PolicyStat ID 13328890

Last Approved	3/17/2023	Lines Of Business	All Lines of Business
Effective	5/12/2023	Area	Payment Policy
Next Review	4/30/2024		

Hospital Readmission Occurring Within 30 Days of an Index Admission

Applicable Lines of Business:

✓ Commercial - Health Maintenance Organization (HMO), Preferred Provider Option (PPO) and Point of Service (POS)
✓ Medicare Advantage - SecureCare HMO (includes the Dual Eligible Special Needs Plan [DSNP]) and SecureChoice PPO
✓ Mountain Health Trust (MHT) including WV Medicaid (Temporary Assistance for Needy Families [TANF], Expansion [WV Health Bridge] and Supplemental Security Income [SSI] populations) and West Virginia Children's Health Insurance Program (WVCHIP)
✓ Self-Funded/Administrative Services Only (ASO)
✓ West Virginia Public Insurance Agency (WV PEIA)

Applicable Claim Type:

Dental
✓ Facility
Pharmacy
Professional

Definitions:

Term	Definition
Centers for Medicare and Medicaid Services (CMS)	A federal agency that provides health coverage to more than 100 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program (CHIP) provides low-cost health coverage to children in families that earn too much money

	to qualify for Medicaid.
Clinically related	An underlying reason for a subsequent admission that is plausibly related to the care rendered during or immediately following a prior hospital admission. A clinically related readmission may have resulted from the process of care and treatment during the index admission (e.g. readmission for surgical wound infection) or from lack of, or improper, post admission care coordination (e.g. failure to transmit orders to home infusion provider for antibiotics necessitating readmission) rather than from unrelated events that occurred after the index admission (e.g. broken leg due to trauma following a medical admission) within a specified readmission time interval.
Diagnosis-related group (DRG)	A patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives. In general, a DRG payment covers all charges associated with an inpatient stay from the time of admission to discharge.
Hospital Readmission Reduction Program (HRRP)	HRRP is a Medicare value-based purchasing program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions.
Index admission	An inpatient admission to an acute, general, or short term hospital with a principal diagnosis of a specified condition that is used to determine whether a subsequent admission at that same hospital has occurred within 30 days.
Readmission	An admission to a hospital occurring within 30 days of the date of discharge from the same hospital.
Remittance Advice Details (RAD)	Unique free-form messages that more accurately describe claim submittal errors and denial reasons.

Policy Purpose:

The purpose of this policy is to address general coverage guidelines related to hospital readmissions occurring within 30 days of an index admission as defined by the Centers for Medicare and Medicaid Services (CMS).

Policy Description:

This policy is applicable to members of The Health Plan's (THP) Commercial, Medicare Advantage, Mountain Health Trust (MHT), Self-Funded/ASO and WV PEIA lines of business that utilize participating network hospitals.

Readmissions to an acute, general, or short-term hospital occurring within thirty (30) calendar days of the date of discharge from the same acute, general, or short-term hospital for the same, similar or clinically related diagnosis(es) will not be separately reimbursed.

THP's Clinical Services Department conducts hospital readmission review to determine if a readmission is considered clinically related to the index admission.

For the purpose of calculating the 30 day readmission window the day of discharge is not counted.

Intervening admissions to non-acute care facilities (e.g., a skilled nursing facility) are not considered readmissions and do not affect the designation of an admission as a readmission.

Commercial, Medicare Advantage, Mountain Health Trust, Self-Funded/ASO and WV PEIA Reimbursement Guidelines

All clinically related/potentially preventable readmissions occurring within a thirty (30) day period will be subject to review.

A readmission is inappropriate or preventable under the following circumstances:

- If the readmission was medically unnecessary;
- If the readmission resulted from a prior premature discharge from the same hospital;
- If the readmission resulted from a failure to have proper and adequate discharge planning;
- If the readmission resulted from a failure to have proper coordination between the inpatient and outpatient health care teams; and/or If the readmission was the result of circumvention of the contracted rate by the hospital.

The following readmissions are excluded from the 30-day readmission review:

- Transfers from out-of-network to in-network facilities;
- Transfers of patient for care not available at the first facility;
- Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy or staged surgical procedures;
- Readmissions associated chronic diseases (e.g. malignancies, burns, or cystic fibrosis);
- Readmissions for primary psychiatric disease. Thirty (30) day readmission reviews are **NOT** applied to behavioral health inpatient admissions;
- Relapses for Substance Use Disorder (SUD) causing readmission;
- Admissions to Skilled Nursing Facilities (SNF), Long-Term Acute Care (LTAC) facilities, and Inpatient Rehabilitation Facilities (IRF);
- Readmission where the first admission had a discharge status of "left against medical advice;"
- Readmissions > 31 days from the date of discharge from the first admission;
- Readmissions for patients under 12 months old at the time of service;

- Obstetrical readmissions;
- Readmissions related to non-compliance as long as discharge orders were appropriately communicated, there is documentation that the patient is competent, financial or other barriers were addressed by the institution, and the non-compliance was clearly documented in the patient record.

Billing Information and Guidelines:

Clinically related admits only apply to hospitals contracted as diagnosis-related groups (DRG).

Upon request from THP, a hospital must forward all medical records and supporting documentation of the index admission and readmission to THP.

The initial review of the medical records will determine whether the readmission was clinically related to the index admission.

Once the readmission is determined to be clinically related, the readmission will be further evaluated to determine whether the readmission was inappropriate and/or potentially preventable.

The review will evaluate the index admission's appropriateness of discharge, as well as the quality of the discharge plan.

If THP determines that a hospital claim is clinically related and potentially preventable to the index admission, the claim for the readmission will deny with remittance advice details (RAD).

The hospital is required to combine the index admission and readmission on one claim to receive payment for the collective stays.

Providers are advised to follow the billing guidelines below:

- Hospital readmissions within 30 days for the same or similar diagnosis/DRG should be billed and paid as one claim;
- The hospital should combine both inpatient admissions on one claim and bill a corrected claim;
- Combine the appropriate number of observation and inpatient days for the index admission and the readmission;
- To resubmit a UB04 paper hospital claim:
    - Use bill type 117 in Box 4;
    - Place the index admission date in Box 12;
    - In Box 42 on the claim form, enter 180 (or the appropriate Leave of Absence code);
    - Enter the appropriate service units (Box 46) to account for the days between the admission and the readmission when the member was not receiving services;
    - Place $0.00 in Box 47 "Total Charges."
- To resubmit a hospital claim electronically:
    - Indicate the original claim number in Loop 2300, Segment REF02;
    - Indicate 6 (corrected claim) for the Claim Frequency Code in Loop 2300, Segment

CLM05-3.

Once the corrected claim is received by THP the index admission payment will be reversed, and the corrected claim will be reviewed and processed.

Additional billing information may be found in THP's Provider Manual located at healthplan.org "For Providers," "Resources."

References and Research Materials:

A. Hospital Readmissions Reduction Program (HRRP). Centers for Medicare and Medicaid Services. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program . Lasted updated August 8, 2022. Accessed February 13, 2023.

B. Centers for Medicare and Medicaid Services (CMS). Inpatient Hospital Billing. "Repeat Admissions." Medicare Claims Processing Manual, Chapter 3, Section 40.2.5, page 114. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf . Accessed February 13, 2023.

Policy History:

Date	Summary of Changes
4/14/2022	Annual review: Changed "Readmissions associated with malignancies, burns, or cystic fibrosis" to "Readmissions associated with chronic diseases", changed the list of diagnoses to examples. Removed requirement that readmissions associate with malignancies must be while patient is on a chemotherapeutic regimen. Added criteria for non-compliant patients.
2/22/2023	Annual Review: Reviewed criteria and links. Updated references.

Disclaimer:

This policy is intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry standard claims editing logic, benefit design and other factors are considered in developing payment policies. This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating

providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

All Revision Dates

3/17/2023, 5/18/2022, 4/6/2021

Attachments

CMS Hospital Readmissions Reduction Program.pdf

Medicare Claims Processing Manual Ch. 3.pdf