moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM068
Policy Title:	Readmissions		
Section:	Facility-specific	Subsection:	Inpatient

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☐ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms) Does not apply to Critical Access Hospitals (CAHs) or claims with percent of charges reimbursement.
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Secondary network ☒ Out of Network

Originally Effective:	10/1/2012	Initially Published:	5/8/2019
Last Updated:	1/10/2024	Last Reviewed:	1/10/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		1/10/2024	

Reimbursement Guidelines

A. Overall Policy Statement

We follow CMS policy for hospital readmissions.

All hospital readmissions from and to the same hospital/facility for related or similar conditions are considered a continuation of initial treatment.

Inpatient hospitals will not be reimbursed for related readmissions billed as separate episodes of care, nor allowed to retain reimbursement for multiple claims in these circumstances.

B. Readmission Billing Requirements

1. Readmission is classified as subsequent acute care inpatient admission of the same patient between 1-30 days of discharge of the initial inpatient acute care admission.
    a. Services that are related are to be combined into a single claim for one episode of care.

b. If the initial admission claim has already been submitted, submit a corrected claim using TOB code 117 *Replacement of Prior Claim*.

c. Related services billed as two/multiple separate inpatient episodes of care and meet the criteria in section E below for being combined into one episode of care will be combined for processing.

2. Multiple readmissions are not eligible for separate reimbursement, when each inpatient hospital stay is paid per case or per admission (e.g., DRG methodology payment).

C. Review and Processing of Commercial Plan Claims

1. All hospital readmissions from and to the same hospital/facility are considered a continuation of initial treatment.

2. Readmission to the same hospital within 30-days of discharge is subject to clinical review to determine if the readmission claim is eligible for combining with the initial admission claim for processing.

   a. Readmissions occurring within 24-hours after discharge will be processed as a single claim.

   b. Readmissions occurring within 2 – 30 days will be subject to clinical reviews. If the clinical review indicates that the readmission is related (see section E.1 below), it will be considered a continuation of the initial admission for the purposes of reimbursement.

3. The two (or multiple) DRG hospital claims (identified using the assigned provider identifier) will be consolidated into one single claim, combining all necessary codes, billed charges and the length of stay.

   a. The maximum allowable for the consolidated claim will be recalculated using an industry standard DRG grouper and the DRG methodology so that reimbursement is for a single, per case reimbursement.

   b. The combined episode of care will be processed (or adjusted if necessary) under the claim for the initial inpatient acute-care hospital stay.

   c. The claims for the other related readmissions:

      i. If they have not yet been released for payment, these claims will be closed.

      ii. If they have already been processed, the claims will be adjusted. Refunds will be requested when applicable.

D. Review and Processing of Medicare Advantage and Medicaid Plan Claims

1. Our Medicare Advantage and Medicaid readmission policy aligns with CMS and includes readmission to the same hospital (using the assigned provider identifier) within 30 days of the initial admission.

2. Hospital stays are subject to clinical review to determine if the readmission is related to or similar to the initial admission.

   a. Readmissions occurring within 24 hours after discharge will be processed as a single claim.

   b. Readmissions occurring within 2-30 days will be subject to clinical reviews. If the clinical review indicates that the readmission is related (see section E.1 below), it may be considered a continuation of the initial admission for the purposes of reimbursement.

3. Combining related DRG claims.

   When we receive DRG claims for both an initial and subsequent hospital stay, we combine the subsequent hospital stay with the initial claim within our system.

   a. When this occurs, we will send you a notification reflecting these changes and additional payment, if applicable.

   b. The combined episode of care will be processed (or adjusted if necessary) under the claim for the initial inpatient acute-care hospital stay.

   c. The claims for the other related readmissions:

      i. If they have not yet been released for payment, these claims will be closed.

      ii. If they have already been processed, the claims will be adjusted. Refunds will be requested when applicable.

E. Applicable Readmission Situations (for all Lines of Business)

1. This policy applies to the following situations (including, but not limited to):
   a. Clinically related readmissions
   b. Planned readmissions or leave of absence
   c. Emergent readmissions
   d. Psychiatric readmissions
   e. Readmission for pre-delivery obstetrical care
2. This policy does not apply to:
   a. Transfer from one acute care hospital to another
   b. Patient discharged from the hospital against medical advice
   c. Planned readmissions for cancer chemotherapy, transfusion for chronic anemia or other similar repetitive treatments
   d. Readmission for unrelated condition
   e. Readmission for the medical treatment of rehabilitation care

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CAH	=	Critical Access Hospital
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
ER	=	Emergency Room (also known as/see also ED)

Acronym or Abbreviation		Definition
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
ICD	=	International Classification of Diseases
ICD-10	=	International Classification of Diseases, Tenth Edition
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	=	International Classification of Diseases, Tenth Edition, Procedure Coding System
LOB	=	Lines of Business
MCG	=	Milliman Care Guidelines
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
NUBC	=	National Uniform Billing Committee
NUCC	=	National Uniform Claim Committee
POA	=	Present on Admission
QRURs	=	Quality and Resource Use Reports
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
TOB	=	Type of Bill
UB	=	Uniform Bill
UHDDS	=	Uniform Hospital Discharge Data Set

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

Services rendered by other entities during a combined stay must be paid by the acute care PPS hospital. The acute care PPS hospital is responsible for the other entity's services per common Medicare practice.

NOTE: Medicare does not reimburse other entities for services performed during two inpatient acute care PPS stays that are combined onto a single claim. However, the other entity's services may be considered and billed as covered services, when appropriate, by the acute care PPS hospital." (CMS[1])

Cross References

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "Facility Guidelines, General Overview." Moda Health Reimbursement Policy Manual, RPM065.

C. "DRG Payment With Patient Transfers." Moda Health Reimbursement Policy Manual, RPM066.

References & Resources

1. CMS. "Repeat Admissions." *Centers for Medicare & Medicaid Services (CMS) Pub. 100-04 Claims Processing Manual.* Chapter 3 – Inpatient Hospital Billing, § 40.2.5.

2. CMS. "Readmission Review." *Centers for Medicare & Medicaid Services (CMS) Pub. 100-10 Quality Improvement Organization (QIO) Manual.* Chapter 4 – Case Review, § 4240.

3. CMS. "2015 Measure Information About The 30-Day All-Cause Hospital Readmission Measure, Calculated For The Value-Based Payment Modifier Program." https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf . Last updated March 2017; Last accessed April 23, 2019.

4. CMS. "Readmission Review." Quality Improvement Organization Manual, Pub. 100-10, Chapter 4 – Case Review, § 4240.

Background Information

Hospital unplanned readmissions are associated with high costs and lower patient outcomes. Some readmissions are unavoidable, but they may also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. In 2012 CMS initiated a policy of combining related readmissions into a single episode of care for DRG reimbursement. In 2014, CMS added a 30-day All-Cause Hospital Readmission Quality and Resource Use Reports (QRURs) measure. CMS applied this measure to the Value Modifier because reducing avoidable readmissions is a key component in the effort to promote more efficient, high-quality care. (CMS[3])

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
1/10/2024	Annual/Update: Cross References: Hyperlinks updated. Minor rephrasing; no content changes.
12/14/2022	Format/Update Scope, States: Idaho added. Cross References: Hyperlinks added.
6/8/2022	Format/Update Change to new header. Acronym Table: 7 entries added. 1 entry removed. Coding Guidelines: Key quote added from References & Resources entry # 1. Policy History section added. Entries prior to 2022 omitted (in archive storage).
5/8/2019	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
10/1/2012	Original Effective Date (with or without formal documentation). Policy based on CMS readmission policy. (CMS[1, 2, 3, 4])