Hospital Readmission Payment Policy

Policy Statement

Neighborhood Health Plan of Rhode Island (NHPRI) shall conduct hospital readmission review to determine if the readmission was considered clinically related to the previous admission. Readmissions determined to be related to the previous admission will not be reimbursed.

Scope

This policy applies to all lines of business, Medicaid, Commercial, and INTEGRITY, and types of acute care admissions. In the instance of multiple readmissions, each admission will be reviewed against criteria relative to the immediate preceding admission.

This policy applies to in-network facilities for readmissions that have occurred within thirty (30) calendar days of a previous discharge within the same hospital. NHPRI shall conduct a medical records review to determine if the subsequent hospital admission is related to the previous hospital admission.

Reimbursement Requirements

By definition, a readmission generally means an acute care hospital admission within 30 days of discharge from the same or other acute care facility.

Note:
**Hospital Contracts supersede the language in this policy.*
**This policy does not supersede any current inpatient recommended or required preauthorization or notification rules.*

CRITERIA

Medical records shall be reviewed to determine if the readmission was clinically related to the previous admission based on one of the following criteria:

- A medical readmission for a continuation or recurrence for the previous admission or closely related condition (e.g., readmission for diabetes following an initial admission for diabetes).
- A medical complication related to an acute medical complication related to care during the previous admission, (e.g., patient discharged with urinary catheter readmitted for treatment of a urinary tract infection).
- An unplanned readmission for surgical procedure to address a continuation or a recurrence of a problem causing the previous admission (e.g., readmitted for appendectomy following a previous admission for abdominal pain and fever)

· An unplanned readmission for a surgical procedure to address a complication resulting from the previous admission (e.g., readmission for drainage of a post-operative wound abscess following an admission for a bowel resection)

Note: *Medical record review is to determine if the admission is related and not an assessment of medical necessity or appropriateness of the setting.*

Excluded from readmission review are:

· Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, or other similar repetitive treatments or scheduled elective surgery.
· Readmissions due to malignancies (limited to those who are in an active chemotherapy regimen), burns, or cystic fibrosis
· Readmissions due to organ or bone marrow transplants
· Obstetrical admissions
· Readmissions with a documented discharge status of left against medical advice
· Readmissions greater than 30 calendar days from the last discharge
· Readmissions when the previous admissions for transient ischemia attack (TIA) had all of the following:

1. ABCD score of 3 or greater
2. Brain, carotid and cardiac imaging was completed
3. Started on anti-platelets during the first admission
4. Had CVA within 30 days

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within 90 days of the date services are provided to members.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with National Claims Standards.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding

and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
01/06/2020	Policy Effective

References

1. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 12/10/10. Available at: http://www.cms.gov/manuals/downloads/clm104c03.pdf. Accessed September 29, 2011.

2. Centers for Medicare & Medicaid Services (CMS). Medicare Learning Network. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. 12/17/10. Available at: http://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf Accessed September 29, 2011.