Hospital Readmission Payment Policy

Policy Statement

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

Scope

This policy applies to:

☒**Medicaid**
☒**INTEGRITY**
☒**Commercial**

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 readmission definition relative to the last covered admission.

This policy applies to contracted and non-contracted facilities for unplanned readmissions that have occurred within 30 calendar days of a previous discharge within the same hospital or system of care. NHPRI shall conduct a medical records review to determine if the subsequent hospital admission is related to the previous hospital admission.

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

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.

Members are not liable for claims denied as a readmission.

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 from the previous admission for the same/similar condition or related condition (e.g., readmission for diabetes following an initial admission for diabetes).
- A 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 contractually determined timely filing guidelines.

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.

Reevaluation of Initial Payment Decision

Any facility may request a reevaluation of the payment decision within 60 days of the receipt of remittance advice. The facility must submit a completed Readmission Reevaluation Request Form with an explanation of why the original determination should be re-evaluated. Please include any pertinent information. Requests should be sent to HRreevaluations@nhpri.org . A decision will be made within 60 days from receipt of all information.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

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
10/01/2022	Policy Review Date. Format changes only. No content changes.
01/01/2021	Policy Effective
12/29/2020	Policy Review Date

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]. Available at: http://www.cms.gov/manuals/downloads/clm104c03.pdf.