Commercial Reimbursement Policy

Subject: **Inpatient Readmissions - Facility**	
Policy Number: **C-17002**	Policy Section: **Facilities**
Last Approval Date: **04/28/2021**	Effective Date: **05/27/2020**

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem benefit plan. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and non-participating professionals and facilities as indicated.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim
- Recover and/or recoup claim payment

These policies may be superseded by provider or state contract language, or state, federal requirements or mandates. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan does not allow separate reimbursement for claims that have been identified as a readmission to the same facility or another facility that (i) operates under the same Facility Agreement, (ii) has the same tax identification number as Facility, or (iii) is under common ownership as Facility. The Health Plan uses the following standards:

- Readmission up to 30-days from discharge
- Same diagnosis or similar diagnoses

Reimbursement is only allowed for the original admission. The admissions should not be combined to qualify for outlier reimbursement.

The Health Plan will utilize clinical coding criteria and/or licensed clinical medical review, to determine if the subsequent admission is for:

- The same or closely related condition or procedure as the prior discharge
- An infection or other complication of care
- A condition or procedure indicative of a failed surgical intervention
- An acute decompensation of a coexisting chronic disease
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow up period
- An issue caused by a premature discharge from the original admission facility

The Health Plan reserves the right to reject or deny the claim or to recoup and/or recover monies previously paid on a claim that falls within the guidelines of this policy.

Exclusions:

- Admissions for the medical treatment of cancer, substance abuse or rehabilitation
- Planned admissions
- Transfers from one facility to another
- Member discharged from a facility against medical advice
- Admissions for covered transplant services during the global case rate period for the transplant

This policy applies to those facilities reimbursed for inpatient services by a DRG or Case Rate methodology.

Related Coding

Standard correct coding applies

Policy History

04/28/2021	Review approved: policy language updated; bullet removed (reason that is medically unnecessary); policy title updated
05/27/2020	Biennial review approved; policy language updated, and clinical exclusions removed
06/01/2019	New template policy: removed description section and added definition section
08/03/2018	Exclusion section updated to allow for readmissions criteria to be applied to psychiatric services. Exclusion section effective 1/1/2019
07/06/2017	Initial Enterprise Facility Reimbursement Committee approval and effective date

References and Research Materials

This policy has been developed through consideration of the following:

- Center for Medicare and Medicaid Services (CMS)
- The National Quality Forum (NQF)

Definitions

General Reimbursement Policy Definitions	
Readmission	• Admission to the same facility or another facility that (i) operates under the same Facility Agreement, (ii) has the same tax identification number as the Facility, or (iii) is under common ownership as the Facility within 30-days from discharge of the original admission, and • Such subsequent admission is for the same, similar, or related diagnosis or for a complication arising out of the first admission, and • Original admission is reimbursed using DRG or Case Rate methodology

Related Policies and Materials

None

Use of Reimbursement Policy:
State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.