Inpatient Hospital Readmission

Policy Number: AS23P0002A1

Effective Date: January 1, 2023
Last Update: April 19, 2024

Payment Policy History

DATE	SUMMARY OF CHANGE
April 19, 2024	Annual review complete. No technical changes made.
January 1, 2024	Removed reference to Aspirus Health Plan Elite RX product, which was termed 12/31/2023.
November 7, 2023	Aspirus Health Plan published the Inpatient Hospital Readmission policy.

Applicable Product(s)

This policy applies to:

- Aspirus Health Plan Essential Rx
- Aspirus Health Plan Elite

Table of Contents

Payment Policy History 1
Applicable Product(s) 1
Payment Policy Instructions 5
Payment Policy Overview 5
Policy Definitions 5
Enrollee Eligibility Criteria 6
Eligible Providers or Facilities 6
Provider 6
Facility 6
Other and/or Additional Information 6
Excluded Provider Types 6
Modifiers, CPT, HCPCS and Revenue Codes 6
General Information 7
Modifiers 7
CPT and/or HCPCS Code(s) 7
Revenue Codes 7
Condition Code 7
Payment Information 8
General Information 8
Inpatient Hospital Readmission Exclusions 8
Post Payment Review Process 8
Billing Requirements and Directions 9
Prior Authorization, Notification and Threshold Information 9
Prior Authorization and Notification Requirements 9

Related Payment Policy Information 9
Source Documents and Regulatory References 9
Disclaimer 10

This page was intentionally left blank

Payment Policy Instructions

A payment policy assists in determining provider reimbursement for specific covered services. To receive payment, the provider must be in a contractual relationship with Aspirus Health Plan and provide services to a member enrolled in one of Aspirus Health Plan products. This payment policy is intended to provide a foundation for system configuration, work instructions, call scripts, and provider communications. A payment policy describes the rules for payment, which include applicable fee schedules, additional payment rules by regulatory bodies, and contractual terms. This policy is a general guideline and may be superseded by specific provider contract language.

Payment Policy Overview

- The Aspirus Health Plan Medicare Advantage Hospital Readmission policy addresses inpatient hospital readmissions occurring within thirty (30) days of a previous inpatient stay.
- Applies to facilities that are paid based on Medicare Severity Diagnosis Related Group (MS-DRGs)

Policy Definitions

TERM	NARRATIVE DESCRIPTION
Clinically Related	Means that the underlying reason for readmission is the same, similar, or related condition to those occurring during a prior hospital admission.
Readmission	For purposes of this Policy readmission means an inpatient admission to the same facility or hospital that follows a previous hospital stay.

Enrollee Eligibility Criteria

This section of the policy provides information that is specific to the Aspirus Health Plan member, including information about the criteria the member must meet in order for the service(s) in the policy to be eligible for payment.

The Inpatient Hospital Readmission policy applies to enrolled Aspirus Health Plan Medicare Advantage plan members.

Eligible Providers or Facilities

Outlined below are the specific criteria a provider must meet in order for the service(s) in this policy to be eligible for payment.

Provider

Not applicable.

Facility

This policy applies to participating and non-participating facilities.

Other and/or Additional Information

Not applicable.

Excluded Provider Types

Outlined below is information regarding providers who are not eligible to furnish the service(s) listed in this policy.

Not applicable.

Modifiers, CPT, HCPCS and Revenue Codes

General Information

The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and Revenue codes listed in this policy are for reference purposes only. Including information in this policy does not imply that the service described by a code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee of claim payment.

Modifiers

Not applicable.

CPT and/or HCPCS Code(s)

This policy applies to facility claims. CPT/HCPC codes should be appended to revenue codes, as appropriate.

Revenue Codes

This policy applies to facility claims. The provider should use revenue codes that best represent the services provided to the patient.

Condition Code

CONDITION CODE	NARRATIVE DESCRIPTION
B4	Admission unrelated to discharge on same day

The B4 condition code should be used when submitting claims for an unrelated hospital readmission that occurs on the same day or next day following a previous inpatient stay.

Payment Information

General Information

For the Aspirus Health Plan products listed above inpatient hospital readmission payment guidelines apply to hospital readmissions occurring one (1) through thirty (30) days from a previous inpatient hospital stay.

Inpatient Hospital Readmission Exclusions

Outlined below are the medical conditions or circumstances that are excluded from readmission review.

- Admissions related to the medical treatment of:
  - Cancer;
  - Psychiatric disease;
  - Hospice;
  - Rehabilitation;
  - Neonatal or obstetrical care;
  - Ophthalmic emergencies;
  - Sickle cell crisis;
  - Mental health disorder; and
  - Transplants and transplant related admissions.
- Claims meeting the following criteria will also be excluded from inpatient hospital:
  - Readmissions to a different facility;
  - Planned readmissions;
  - Patient transfers from one acute care hospital to another;
  - Discharges from the hospital against medical advice

Post Payment Review Process

Aspirus Health Plan or its contracted third party vendor will be conducting post-payment reviews of applicable inpatient hospital admissions to assess whether the multiple hospital stays should bundle into one hospital confinement.

Aspirus Health Plan or its vendor reserves the right to review readmissions and request medical records from the provider to determine if the readmission billed claim was appropriate. If it is determined that the readmission was clinically related to a prior admission within the applicable timeframe, Aspirus Health Plan or its vendor will notify the provider of its findings, the reasoning behind the determination, and the timeline to submit medical records.

If the provider fails to respond to the request for medical records within the allotted timeframe or the third party vendor deems the claim(s) should be billed as one hospital confinement, Aspirus Health Plan reserves the right to recover monies previously paid on the related readmission claim(s).

Billing Requirements and Directions

This policy applies to inpatient hospital claims submitted using the 837-I format, or the electronic equivalent. Standard billing guidelines for hospital claims should be followed when submitting claims.

Prior Authorization, Notification and Threshold Information

Prior Authorization and Notification Requirements

Aspirus Health Plan does update authorization, notification, and threshold requirements from time-to- time. The most current prior authorization requirements can be found here.

Related Payment Policy Information

Outlined below are other policies that may relate to this policy and/or may have an impact on this policy.

POLICY NUMBER	POLICY TITLE

Aspirus Health Plan payment policies are updated from time to time. The most current Aspirus Health Plan payment policies can be found here.

Source Documents and Regulatory References

Listed below are links to CMS and statutory and regulatory references used to create this policy.

Medicare Quality Improvement Organization Manual, Chapter 4 - Case Review, Section 4240, 4255 (PDF)

Medicare Claims Processing Manual, Chapter 3 – Inpatient Hospital Billing, Section 40.2.5 (Readmissions)

Social Security Act, §1886(d)

Disclaimer

"Payment Policies assist in administering payment for Aspirus Health Plan benefits under Aspirus Health Plan benefit Plans. Payment Policies are intended to serve only as a general reference resource regarding Aspirus Health Plan administration of health benefits and are not intended to address all issues related to payment for health care services provided to Aspirus Health Plan members. When submitting claims, all providers must first identify member eligibility, federal and state legislation or regulatory guidance regarding claims submission, Aspirus Health Plan provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, Aspirus Health Plan also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT® or other sources in Aspirus Health Plan Payment Policies are for definitional purposes only and do not imply any right to payment. Other Aspirus Health Plan Policies and Coverage Determination Guidelines may also apply. Aspirus Health Plan reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other thanas described by Aspirus Health Plan Payment Policies when necessitated by operational considerations."