Inpatient Hospital Readmission

Policy Numbers:
UM19P0035A1
SC19P0072A1
EX19P0016A1

Effective Date: January 1, 2020
Last Update: May 28, 2021

PAYMENT POLICY HISTORY

DATE	SUMMARY OF CHANGE
May 28, 2021	The Inpatient Hospital Readmission policy is moved to an updated format. As a result, some information may have been reformatted. In addition, the following updates were made to the policy: • The process UCare will use for multiple hospital stays that bundle to the same DRG (MS- or APR-DRG; • Additional information was added to clarify the difference between same day/next day readmissions vs. readmissions occurring 3 – 30 days after another related hospital stay; • Clarification regarding readmissions that are exempt from readmission review; • Information about the process UCare will follow when retroactively reviewing inpatient hospital admissions; and • A link to the UCare Provider Manual and the UCare appeal process was added to the policy.
January 1, 2020	UCare published the Inpatient Hospital Readmission policy.

AUDIENCE

Indicates whether this policy will be published only internally of the policy will be published internally and externally.

Internal	√
External	√

APPLICABLE PRODUCTS

This policy applies to the products checked below:

UCARE PRODUCT	APPLIES TO
UCare MinnesotaCare	√
UCare Minnesota Senior Care Plus (MSC+)	√
UCare Prepaid Medical Assistance (PMAP)	√
UCare Connect	√
UCare Connect +Medicare (When MHCP is the primary payer)	√
UCare Minnesota Senior Health Options (MSHO) (When MHCP is the primary payer)	√
UCare Medicare Plans	√
UCare EssentiaCare	√
UCare Medicare M Health Fairview & North Memorial	√
UCare Individual & Family Plans	√
UCare Individual & Family Plans M Health Fairview	√

For UCare integrated (dual eligible) products that have a Medicare and State Public Programs component, the thirty (30) day readmission date span will be applied to the claim when the service is covered by Medicare. When the services are not covered by Medicare, the 15-day readmission date span will be used.

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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 UCare and provide services to a member enrolled in one of UCare's 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 UCare Hospital Readmission policy addresses inpatient hospital readmissions occurring:
  - on the same day or next day for an un-related medical condition;
  - within thirty (30) days of a previous inpatient stay for Medicare, UCare integrated (dual eligible) products when Medicare is the primary payor/benefit, and UCare Individual and Family products;
  - within fifteen (15) days of a previous inpatient stay for State Public Programs; and
- Applies to all facilities that are paid based on:
  - Medicare Severity Diagnosis Related Group (MS-DRGs); or
  - All Patient Refined Diagnosis Related Groups (APR-DRGs).

POLICY DEFINITIONS

TERM	NARRATIVE DESCRIPTION
Clinically Related	Means that the underlying reason for readmission is plausibly related to the care rendered during or immediately following 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 UCARE 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 all enrolled UCare members.

ELIGIBLE PROVIDERS OR FACILITIES

OUTLINED BELOW IS THE SPECIFIC CRITERIA A PROVIDER MUST MEET IN ORDER FOR THE SERVICE(S) IN THIS POLICY TO BE ELIGIBLE FOR PAYMENT. THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT

Provider

Not applicable.

Facility

This policy applies to participating and non-participating facilities.

Other and/or Additional Information

EXLUDED 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®) 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

Revenue Codes

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

CPT and/or HCPCS Code(s)

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

CONDITION CODE

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

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

PAYMENT INFORMATION

Same Day, Next Day Hospital Readmissions

Readmissions occurring on the same or one day following discharge from the hospital for the same or similar/related medical condition are considered one continuous hospital stay and should be not be billed separately.

When a patient is re-admitted on the same or next day for an unrelated medical condition, the B4 condition must be included on the claim. The B4 condition code is an attestation that that the two hospital admissions (initial and subsequent) are unrelated.

Post-Payment Review Process

UCare will be conducting post-payment review of inpatient hospital admissions. If an inpatient readmission took place on the same or next day and the B4 condition code is not present, UCare will treat the claim as incorrectly billed. UCare will notify providers that a corrected claim must be submitted. Within the time frame outlined in the communication the provider may:

- Submit a single claim that replaces the initial and subsequent hospital confinements; or
- Submit a replacement claim for the subsequent hospital readmission that includes the B4 condition code, attesting that the hospital stay is not related to the initial hospital confinement.

UCare reserves the right to recover monies previously paid on a claim that falls within the guidelines of a readmission for the same or related condition. If a provider does not submit a corrected claim within the timeframe specified in UCare's correspondence, payment for second claim (readmission) submitted to UCare will be recovered.

UCare reserves the right to review readmissions and request medical records to determine if claims were properly billed.

Inpatient Hospital Readmissions (Days Three (3) – Thirty (30) Days)

UCare Medicare, Individual and Family Plans, and State Public Programs Integrated (Dual Eligible) Products (When Medicare is the Primary Benefit/Covered Service)

For the UCare products listed above inpatient hospital readmission payment guidelines apply to hospital readmissions occurring three (3) through thirty (30) days from a previous inpatient hospital stay.

State Public Programs (SPP) Including Integrated (Dual Eligible Products) Products (When SPP is the Primary Benefit/Covered Service)

For the products listed above the inpatient hospital readmission apply to inpatient hospital readmissions occurring three (3) through fifteen (15) 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; and
  - Psychiatric disease;
  - Hospice;
  - Rehabilitation;
  - Neonatal or obstetrical care;
  - Ophthalmic emergencies; and

- Sickle Cell Crisis; and
- Transplants and transplant related admissions.

- Claims meeting the following criteria will also be excluded from inpatient hospital:
  - Certain readmissions;
    - Readmissions to a different facility; and
    - Patient transfers from one acute care hospital to another.

Post Payment Review Process

UCare will be conducting post-payment review of inpatient hospital admissions. When multiple hospital stays bundle to the same DRG, UCare will identify these stays as one hospital confinement. Medical records will not be requested, and providers will be notified to submit a corrected claim. In all other cases, when review of available information suggests that two or more hospital confinements may be related, UCare will request medical records from the provider.

When medical records are requested UCare communication will identify the confinements that require review and the timeline to submit medical records. When it is determined that the two confinements are clinically related UCare will contact the provider. Within the time frame outlined in the communication the provider may:

- Submit a single claim that replaces the initial and subsequent hospital confinements; or
- Appeal UCare's decision by submitting detailed medical information that refutes UCare's decision. Refer to the UCare Provider Manual, Section 9-1 Claims Reconsiderations for information about how to appeal a claim

If a provider does not provide documentation in the timeframe requested, UCare will send a second request to the provider. If the provider fails to respond to the request for documentation, UCare will treat the claim as incorrectly paid and begin the process of taking back payment for the second or additional hospital readmissions.

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 AUTHORIZATI0N, NOTIFICATION AND THRESHOLD INFORMATION

Prior Authorization and Notification Requirements

UCare does update its' 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

UCare payment policies are updated from time to time. The most current UCare payment policies can be found here.

SOURCE DOCUMENTS AND REGULATORY REFENCES

LISTED BELOW ARE LINKS TO CMS, MHCP, 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)

MHCP Provider Manual, Inpatient Hospital Authorizations

DISCLAIMER

"Payment Policies assist in administering payment for UCare benefits under UCare's health benefit Plans. Payment Policies are intended to serve only as a general reference resource regarding UCare's administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. When submitting claims, all providers must first identify member eligibility, federal and state legislation or regulatory guidance regarding claims submission, UCare 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, UCare 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 UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations."