Priority Health	BILLING POLICY No. 029
READMISSIONS REIMBURSEMENT	
Date of origin: Mar. 2024	**Review dates: 2/2025**

Overview

Priority Health follows nationally accepted industry standards and coding principles in accordance with state and federal regulations and provider contract language. Unless otherwise stated in the facility contract, our policy is to review readmissions up to 30 days from discharge and consider them a part of the original admission. This policy applies to all products, in- or out-of-network. The goal of this policy is to support quality of care and outcomes to avoid preventable readmissions. Priority Health reserves the right to request supporting documentation to validate services billed with care and to guarantee accurate claims processing and reimbursement.

An inpatient readmission is defined as an admission to a hospital within a specific number of days (see table below) of a discharge from the same or different hospital for same or related conditions. Priority Health doesn't allow separate reimbursements for claims identified as readmissions for the same or related conditions regardless of whether they are the same or different hospital.

The following type of readmissions will be reviewed to establish eligibility for reimbursement:

- Same Facility Readmissions
- Different Facility Readmissions
- Planned readmission/leave of absence

Priority Health defines "same facility" as those within the same hospital system.

Readmission days vary state by state and CMS. Priority Health will apply the appropriate days as required. If the state is silent, Priority Health will use the CMS definition and guidelines.
Michigan Medicaid defines readmissions as within 15-days for a related condition, whether to the same or a different hospital, are considered a part of a single episode for payment purposes. The 15-day hospital readmission policy is in Section 2.3.A.6 of Special Circumstances of the Hospital Reimbursement Appendix in the Medicaid Provider Manual
CMS defines readmissions as within 30-days of discharge.

Line of business	Guidelines	Appeals rights
All	Same Day	Yes
Medicaid	15 Days	Yes
Medicare	30 Days	Yes
Commercial	30 Days	Yes

Same facility readmissions

Same or related conditions

An inpatient readmission is defined as an admission to a hospital within a specific number of days (see table above) of a discharge from the same or different hospital for same or related conditions. Priority Health doesn't allow separate reimbursements for claims identified as readmissions for the same or related conditions regardless of whether they are the same or different hospital.

Priority Health readmission guidelines follow a combination of CMS and Michigan Medicaid billing requirements when a patient is readmitted to a facility on the same day as a prior discharge for same or

related conditions. This is also referred to as the “Same Day Rule” according to The Medicare Claims Processing Manual, Pub, No. 100-04 (the Manual), chapter 3, section 40.2.5.

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim…

Priority Health defines same day readmissions to the same facility for related or same condition as a continuation of care. In alignment with CMS and Michigan Medicaid, both admissions must be combined on a single claim for reimbursement. Failure to combine claims may result in claim adjustment and/or denials.

Unrelated Conditions
Priority Health will determine if readmissions qualify for separate payments by reviewing medical records to determine if the admissions are clinically unrelated.

Priority Health follows CMS billing requirements as listed in Chapter 3, Section 40.2.5 of the Medicare Claims Processing Manual. When a patient is readmitted on the same day for unrelated conditions, the subsequent admission should be billed with condition code B4 and two claims should be submitted.

When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stays medical condition, hospitals shall place condition code (CC) B4 on the claim that contains an admission date equal to the prior admissions discharge date.

Different facility readmissions

Same or related conditions
An inpatient readmission is defined as an admission to a hospital within 30 days of a discharge from the same or different hospital for same or related conditions. Priority Health doesn’t allow separate reimbursements for claims identified as readmissions for the same or related conditions regardless of whether they’re from the same or different hospital.

Unrelated conditions
Priority Health will determine if readmissions qualify for separate payments by reviewing medical records to determine if the admissions are clinically unrelated.

Financial recovery
In alignment with industry guidelines, if the readmission is to a different hospital, full payment is made to the second hospital. The first hospital’s payment is reduced by the amount paid to the second hospital. The first hospital’s payment is never less than zero for the episode. (See the Scenarios section of this policy.)

Planned readmission/leave of absence

In situations where a readmission is planned or expected within 30 days in the same or different facility, a combined claim containing both the initial and subsequent readmission should be submitted. Examples of these situations include delays in surgical services, further testing or treatment is needed but time delay is required, surgical team not available, staged or related services in a post-op period, or leave of absence. This planned or expected reason should be documented in the medical record.

- Bill leave of absence (LOA) days with the following information:
- Revenue code 018X and zero charges
- Occurrence span code 74 (Noncovered Level of Care/Leave of Absence Dates)
- Date span covering the LOA beginning and end

Billing requirements

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

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

This policy is based, in part, on the methodology set forth in the Quality Improvement Organization Manual, CMS Publication 100-10, Chapter 4, Section 4240 for determining inappropriate readmission.

As stated in the CMS QIO Manual, Priority Health maintains that both admissions aren't limited to the same hospital or to the same hospital system. Priority Health follows the Readmission Review as outlined in section 4240:

Readmission review involves admissions to an acute, general, short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, short-term hospital (see §1154(a)(13) and 42 CFR 476.71(a)(8)(ii)). Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred.

Medical review procedures obtain the appropriate medical records for the initial admission and readmission. Perform case review on both stays. Analyze the cases specifically to determine whether the patient was prematurely discharged from the first confinement, thus causing readmission. Perform an analysis of the stay at the first hospital to determine the cause(s) and extent of any problem(s) (e.g., incomplete or substandard treatment). Consider the information available to the attending physician who discharged the patient from the first confinement. Do not base a determination of a premature discharge on information that the physician or provider could not have known or events that could not have been anticipated at the time of discharge.

Review both the initial admission and the readmission at the same time unless one of them has previously been reviewed.

Documentation requirements

Documentation must support medical necessity for hospital admission and readmission. Hospitals must submit relevant medical records associated with the inpatient hospitalization authorization request to determine if the readmission is related to the previous hospital admission (15 days for Medicaid, 30 days for all other plans). This would include all supporting documentation such as admission history and physical, physician orders, progress notes, emergency records (when applicable) and a discharge summary from the previous admission. Failure to submit supporting documentation may result in readmission denial.

Reminder: Each provider and facility is responsible for accurately documenting services and treatments along with selecting codes to the highest level of specificity. Priority Health may perform post pay reviews to validate the accuracy of coding along with assessment to determine if a readmission is related to a previous inpatient admission.

Exclusions

This policy doesn't apply to the following admissions:

- Admissions for chemotherapy or immunotherapy treatment
- Admissions to a substance abuse unit or facility
- The treatment of a mental health disorder as the primary reason for the admission
- Hospice care
- Neonatal care
- Obstetrical care
- Admissions to an inpatient rehabilitation unit

- Readmission after a patient is discharged from the hospital against medical advice
- Admissions for covered transplant services during the global case rate period for the transplant
- Ophthalmologic emergency
- Sickle cell crisis
- Transplant and transplant-related care

Scenarios

The scenarios outlined below reflect post-payment audit findings when related conditions are confirmed at the same or different facility.

In scenarios where the 1st claim reimbursement is greater than the 2nd claim reimbursement, we would issue full payment to the 2nd claim and recoup any difference between the amounts from the first claim.

Example 1		
Admission Date	**Description**	**Amount**
6/1/2022	Hospital #1 calculated payment (operating and capital)	$7,500
6/10/2022	Hospital #2 calculated payment for same case/episode (operating and capital)	$5,000
	Adjustment to Hospital #1 payment by amount of Hospital #2 payment, but not less than zero	$(5,000)
	Total payment for single case/episode	**$7,500**
	Hospital #1 net payment for episode	*$2,500*
	Hospital #2 net payment for episode	*$5,000*

In scenarios where the 2nd reimbursement is greater than the first reimbursement, the first reimbursement will be recouped and full payment will be issued to the 2nd claim.

Example 2		
Admission Date	**Description**	**Amount**
6/1/2022	Hospital #1 calculated payment (operating and capital)	$7,500
6/10/2022	Hospital #2 calculated payment for same case/episode (operating and capital)	$8,500
	Adjustment to Hospital #1 payment by amount of Hospital #2 payment, but not less than zero	$(7,500)
	Total payment for single case/episode	**$8,500**
	Hospital #1 net payment for episode	*$0*
	Hospital #2 net payment for episode	*$8,500*

Supporting documentation

- CMS Claims Processing Manual, Chapter 3, 40.2
- MI DHHS Medicaid Inpatient Hospital Providers
- US DHHS Affordable Care Act (ACA) Section 3025
- CMS Quality Improvement Organization Manual, Chapter 4 – Case Review, 4240 – Readmission Review – (Rev. 2, 07-11-03)

Revisions

Priority Health reserves the right to alter, amend, modify, or eliminate this procedure at any time without prior written notice.

Requesting readmission reimbursement

The facility may appeal a readmission denial based on readmission guidelines and/or contract. Log into your **prism** account to submit an appeal with medical documentation.

- All readmissions are reviewed against Priority Health readmission guidelines.
- Determinations for approval or denial are made based on readmission guidelines and/or a Medical Director decision.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

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

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 13, 2025	Added "Disclaimer" section