Reimbursement Policy for Readmission

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any conflicts between this policy and the provider contract language, the provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Policy Overview

A readmission is generally defined as a second admission to a hospital within a set, pre-determined time frame of a discharge from the same or affiliated hospital.

Molina Healthcare reviews claims that fall into any one of the following four categories:

- Repeat Readmission
- Combined Payment Methodology Readmission
- Potentially Preventable Readmission
- Planned Readmission

Molina Healthcare considers repeat, not separately reimbursable, and planned readmissions to be a continuation of one episode of care for which a single DRG payment is made. Potentially preventable readmissions are considered paid in full for both the first (anchor) and second (readmission) hospital admissions by the single payment made for the first (anchor) admission.

Repeat Readmissions

Repeat readmissions occur when a patient is discharged and readmitted to the same or affiliated hospital, within a set, pre-determined time frame as directed by State/Federal regulations, usually 24 hours. If a repeat readmission occurs, Molina Healthcare will deny the subsequent (repeat) admission claim for a separate DRG (Diagnosis Related Group) payment. The facility must resubmit a single combined, corrected claim with the following: a combined length of stay; combined billed charges of both admissions; *the appropriate DRG that was billed for the circumstances of the first admission.*

Not Separately Reimbursable Readmissions

Not separately reimbursable readmissions occur when a patient is discharged and readmitted to the same or affiliated hospital within a set, pre-determined time frame as directed by State/Federal regulations (see State Specific Readmission grid below) with a same/similar/related condition to the initial/anchor admission. When a not separately reimbursable readmission occurs, Molina Healthcare will deny the subsequent (not separately reimbursable) admission claim for a separate DRG (Diagnosis Related Group) payment. The facility must resubmit a single combined, corrected claim with the following: a combined length of stay; combined billed charges of both admissions; *the appropriate DRG that was billed for the circumstances of the first admission.*

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Potentially Preventable Readmissions

Potentially preventable readmissions occur when a patient is discharged and readmitted to the same or affiliated hospital within a set, pre-determined time frame as directed by State/Federal regulations (see State Specific Readmission grid below) with a same/similar/related condition to the initial/anchor admission due to one or more of the following circumstances: premature or inadequate discharge from the initial admission; issues with transition or coordination of care from the initial admission; an acute medical complication that is plausibly related to care that occurred during the initial admission; inappropriate transfer to a lower level of care (i.e. skilled nursing facility, long term acute care hospital, acute inpatient rehabilitation, inpatient substance abuse treatment, home health, etc. When a potentially preventable readmission occurs, Molina Healthcare will deny the subsequent (potentially preventable) admission claim for a separate DRG (Diagnosis Related Group) payment as the payment made for the first (anchor) admission is considered payment in full.

Please note that a readmission may be medically necessary, but nonetheless preventable and would still be subject to the clinical preventable readmission review.

Planned and/or Leave of Absence Readmissions

Planned and/or Leave of Absence (LOA) readmissions occur when a patient is discharged and readmitted to the same or affiliated hospital within a set, pre-determined time frame as directed by State/Federal regulations (see State Specific Readmission grid below) for a planned non-acute readmission for a scheduled procedure. When a planned and/or LOA readmission occurs, Molina Healthcare will deny the subsequent readmission claim for a separate DRG (Diagnosis Related Group) payment. The facility must resubmit a single combined, corrected claim with the following: correct revenue, value, and occurrence span codes required for billing an LOA claim; a combined length of stay (including zero charge days of leave when applicable); and combined billed charges of both admissions.

The following are common occurrences that are a planned and/or LOA readmission:

- Surgery was unable to be scheduled immediately for any reason (i.e., surgical team is unavailable, pre-operative testing and/or clearance is pending, etc.)
- Planned bilateral or staged procedures.
- Surgical interventions that are expected or planned, should conservative and/or non-operative therapy fail.

The following are not circumstances are not considered to be a planned and/or LOA readmission:

- Obstetric delivery
- Transplant surgery
- Chemotherapy, transfusions, dialysis, or similar repetitive treatments.

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State/Plan	Applicable Readmission Time span (based on State Law)	Repeat Admissions (within 24 hours unless otherwise noted)	Potentially Preventable Readmissions	Combined Payment Methodology Readmission
Marketplace				
ALL	30 Days	Yes	Yes	Yes
Medicare				
ALL	30 Days	Yes	Yes	Yes
Medicaid				
Arizona	3 Days- Same Facility Only	Yes	Yes	No
California	30 Days	Yes	Yes	No
Florida	30 Days	Yes	Yes	No
Idaho	30 Days	Yes	Yes	Yes
Illinois	30 Days	Yes	Yes	Yes
Kentucky	14 Days	Yes	Yes	Yes
Massachusetts	30 Days	Yes	Yes	Yes
Michigan	15 Days	Yes	Yes	Yes
Mississippi	15 Days	Yes	Yes	Yes
Nevada	30 Days	Yes	Yes	Yes
New Mexico	15 Days	Yes	Yes	Yes
New York	30 Days	Yes	Yes	No
Ohio	30 Days	Yes	Yes	No
South Carolina	30 Days	Yes	Yes	Yes
Texas	Combined Payment Methodology Readmission – 30 Days	Yes	Yes	Yes

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	Potentially Preventable Readmissions - 15 Days			
Utah	30 Days	Yes	Yes	Yes
Virginia	Repeat Admissions - 0-5 Days Combined Payment Methodology Readmission - 6 - 30 Days Potentially Preventable Readmissions - 30 Days	Yes	Yes	Yes
Washington	14 Days	Yes	Yes	No
Wisconsin	30 Days	Yes	Yes	No

Virginia State Exclusions
Exclusions for the 6–30-day readmissions (claims that meet one of the exclusions are paid in full)

1) Excluding Planned Readmissions:
   a) Exclude readmissions when the first admission had one of the following discharge status codes:
      i) 81 = Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission
      ii) 82 = Discharge/Transfer to a Short-Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission
      iii) 83 = Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission
      iv) 84 = Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
      v) 85 = Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission
      vi) 86 = Discharged/Transferred to Home Under Care of Organized Home Health Service in Anticipation of Covered Skilled Care with a Planned Acute Care Hospital Inpatient Readmission
      vii) 87 = Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
      viii) 88 = Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
      ix) 89 = Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
      x) 90 = Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
      xi) Discharged/Transferred to a Medicare Certified Long Term Care Hospital with a Planned Acute Care Hospital Inpatient Readmission
      xii) 92 = Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission
      xiii) 93 = Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission

xiv) 94 = Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission

xv) 95 = Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in this Code List with a Planned Acute Care Hospital Inpatient Readmission

2) Excluding Patient Originally Discharged Against Medical Advice:
   a) Exclude readmissions when the discharge status code on the first admission is:
      i) 07 = Left Against Medical Advice
3) Excluding Obstetrical Readmissions:
   a) Exclude readmissions if the principal diagnosis code on the readmission is related to:
      i) Ectopic and Molar Pregnancy (630 – 633.91)
      ii) Other Pregnancy with Abortion Outcome (634- 6399)
      iii) Complications Mainly Related to Pregnancy (649-6498)
      iv) Normal Delivery and Other Indications for Care in Pregnancy, Labor and Delivery, Complications Occurring Mainly during Labor, and Delivery (660-6699)
      v) Complications of the Puerperium (670-677)
      vi) Other Maternal and Fetal Complications (678-6791)
4) Excluding Readmissions to Critical Access Hospitals:
   a) Exclude readmissions if the provider is a Critical Access Hospital. Molina Healthcare has provided the current list of Critical Access Hospitals and their Medicaid provider number and NPI in Molina Healthcare's provider enrollment file.

Provider Number	***Provider Name***	***NPI***
4900855	Carilion Giles Community	1033102942
4900472	Page Memorial Hospital, Inc.	1326040684
4901231	Rappahannock Gen Hosp	1922004530
4900065	Shenandoah Mem Hosp	1033166442
4900316	Stonewall Jackson Hosp	1518950484
10038146	Dickenson Community Hospital	1285685727
4900995	Bath County Comm Hosp	1417989278

Documentation History

Type	Date	Action
Published Date	07/01/2023	New Policy
Revised Date		

References

Agency	Reference Link
CMS	Guide to Reducing Disparities in Readmissions
CMS	Hospital Readmissions Reduction Program (HRRP)
AZ	AHCCCS Medical Policy Manual (AMPM)
AZ	AHCCCS APR-DRG Payment System Design Payment Policies Chapter 11 Page 19
CA	Inpatient Services Manual
FL	Medicaid Policy (myflorida.com)
ID	Idaho Medicaid Provider Handbook Page 115
IL	Illinois Medicaid Provider handbook
KY	907 KAR 10:830. Acute care inpatient hospital reimbursement.
MA	Comprehensive Quality Strategy
MA	Senior Whole Health by Molina Healthcare Provider Manual
MS	Mississippi QIPP Readmissions Methodology Supplement
NY	Title: Section 86-1.37 - Readmissions
OH	Hospital Inpatient Readmission Policy
SC	South Carolina Hospital Services Provider Manual
TX	Texas Medicaid Provider Handbook
UT	Utah Health, Health Care Financing, Coverage and Reimbursement Policy
UT	Utah Medicaid Provider Manual
VA	Billing Instructions (Hospital) | MES (virginia.gov)
WA	Washington Hospital Association Readmissions
W	Payment limits—Provider preventable fourteen-day readmissions
WA	Hospital reimbursement
WI	Wisconsin Department of Health Services (DHS)

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Supplemental Information

Definitions

Term	Definition
CMS	Center for Medicare and Medicaid
IP	Inpatient
Same or affiliated hospital	If a hospital is part of a hospital system operating under the same hospital agreement, and/or if the hospital shares the same tax identification number with one or more other hospitals, then a readmission during the same readmissions look-back period to another hospital within the same hospital system, or to another hospital operating under the same tax identification number as the first hospital, will be treated as a readmission to the same hospital and, as such, is subject to this policy.

State Exceptions

State	Exception
NV	**Nevada Is Excluded From this Policy**