BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Inpatient Hospital Readmission

Active

Policy Number: Facility – 003
Policy Title: Inpatient Hospital Readmission
Section: Facility
Effective Date: 12/01/23

Description

This policy addresses inpatient readmissions within 30 calendar days of discharge from the same acute care hospital.

Definitions

Clinically related: A readmission is considered to be clinically related when the underlying reason for admission is plausibly related to the care rendered during or immediately following a prior hospital admission.

Preventable readmission: A readmission is deemed preventable if it is reasonably likely that inpatient hospital admission could have been prevented if the patient had received care consistent with accepted standards during the prior hospitalization and the post-discharge follow-up period. Examples of preventability could include, but are not limited to, acquired complications, lack of stability or return to baseline at discharge, failure to complete medication reconciliation, or patient/caregiver education in self-care, and lack of timely follow-up care.

Intervening admissions to non-acute care facilities (e.g., a skilled nursing facility) do not impact the designation of an admission as a readmission.

Policy Statement

Blue Cross and Blue Shield of Minnesota (Blue Cross) will review the following types of readmissions to determine eligibility for reimbursement:

- Readmission on the same calendar day as discharge
- Planned readmission/leave of absence
- Unplanned readmission within 30 calendar days post-discharge

Readmission on the Same Calendar Day

Readmission to the same hospital on the same calendar day as discharge for the same or a clinically related condition, is considered to be a continuation of treatment. In this situation, Blue Cross requires the initial and readmission stays to be combined on a single claim. Separately submitted claims will be denied.

If the reason for readmission to the same hospital is in no way related to the initial hospitalization, separate claims for the initial and readmission stays should be submitted.

Condition code B4 (Admission Unrelated to Discharge on the Same Day) must be included on the readmission claim for reimbursement to be considered.

Planned Readmission
There may be situations where readmission is expected and the patient does not require a hospital level of care during the interim period (for example, surgery cannot be scheduled immediately, a specific surgical team is not available, bilateral surgery is planned, or further treatment is indicated following diagnostic tests but cannot begin immediately).
For a planned readmission/leave of absence (LOA) within 30 days, a combined claim containing the initial and subsequent stay must be submitted. The LOA days should be reported with revenue code 018X and zero charges, occurrence span code 74 (Noncovered Level of Care/Leave of Absence Dates) and the dates the leave began and ended.

Readmission on Post-Discharge Calendar Days 1-30
Readmissions on post-discharge calendar days 1-30 will be reviewed to determine if the readmission was 1) clinically related to the initial admission and (2) preventable. Readmissions that are clinically related to the initial admission and that are determined to have been preventable will be denied.

Exclusions/Exemptions
The following types of care are exempt from readmission review:

- Neonatal care
- Obstetrical care
- Ophthalmologic emergency
- Sickle cell crisis
- Cancer or immunotherapy treatment
- Transplant and transplant-related care
- Hospice care
- The treatment of a mental health disorder as the primary reason for the admission
- Discharged from the hospital against medical advice
- Rehabilitation
- A principal or secondary diagnosis of COVID-19

Documentation Submission

The need for the readmission must be supported in the medical records for the initial admission and the readmission.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider

Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A
ICD-10 Diagnosis:	N/A
ICD-10 Procedure:	N/A
CPT/HCPCS:	N/A
Condition Code	B4
Occurrence Span Code	74
Revenue Codes:	018X

Resources

Medicare Claims Processing Manual, Chapter 3, Section 40.2.5, 40.2.6
Medicare Quality Improvement Organization (QIO) Manual, Chapter 4, Section 4240, 4255
National Uniform Billing Committee UB-04 Data Specifications Manual

Policy History

03/21/2018	Initial Committee Approval
12/19/2018	Annual Policy Review
01/08/2019	Annual Policy Review
01/04/2021	Annual Policy Review
11/22/2022	Revised
11/28/2023	Revised