PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE: 10/1/2018**
POLICY DESCRIPTION:	Readmission within 5 Days	
EFFECTIVE DATE:	10/1/2018	
PAGE:	1 of 2	**REPLACES POLICY DATED: 10/1/2015,7/30/2014, 1/1/2014, 9/1/2009, 9/22/2008, 10/1/2007**
REFERENCE NUMBER:	H - 7	**RETIRED DATE:**

SCOPE: Claims, Coding, Customer Service, Medical Management, Finance, Network Management

PURPOSE: To provide guidelines for reimbursement for Readmissions to the same Hospital within 5 days.

COVERAGE: Coverage is subject to the terms of an enrollee's benefit plan. To the extent there is any inconsistency between this policy and the terms of an enrollee's benefit plan, the terms of the enrollee's benefit plan documents will always control. Enrollees in PreferredOne Community Health Plan (PCHP) and some non-ERISA group health plans that PreferredOne Administrative Services, Inc, (PAS) administers are eligible to receive all benefits mandate by the state of Minnesota. Please call customer service telephone number on the back of the enrollee's insurance card with coverage inquiries.

PROCEDURE:

1. If more than one admission occurs for a given Enrollee with a related diagnosis or same Major Diagnostic Category (MDC) as determined by PreferredOne within a 5 day period, Hospital shall be financially responsible for facility charges for Services rendered to the Enrollee for the readmission.

2. At PreferredOne's discretion, both admissions may be considered as one continuous stay when the second admission is less than 24 hours.

3. If the readmission is a different MDC, but is related to the initial admission as a result of post-op infection (MS DRG 856 – 863), Hospital shall be financially responsible for facility charges for Services rendered to the Enrollee for the readmission.

4. The following DRGs are excluded from this policy:

MS-DRGs: 765 - 768, 774 - 775, 789 – 795, 783 – 788, 796 – 798, 805 – 807, 945, 946 (Note for date of service after 1/1/2008); effective 10/1/2015: 98x when diagnosis or procedure code indicates a delivery, and DRGs with revenue codes 128 and 118.

5. The following list does not apply:

   - A transfer from acute facility to rehab or long term care facilities/swing beds or a transfer from a rehab or longer term care facilities/swing beds to an acute facility (including but not limited to discharge status of 03, 06, 61, 62, 63)

- A transfer from acute facility to Substance Abuse/Mental Health or a transfer from a Substance Abuse/Mental health to an acute facility (including but not limited discharge status of 04, 65)

6. Also excluded from this policy are planned readmissions to acute care hospitals. The appropriate discharge status code should be used indicating the planned readmission. Valid planned readmission discharge status codes include 81 – 95. An example of a planned readmission is the scenario for a specific chemotherapy treatment plan that requires several hospital admissions over a period of time.

7. Please note that planned readmissions are ***different*** than a Leave of Absence (LOA). Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. In order to bill for LOA, submit one bill for covered days and days of leave when the patient is ultimately discharged. Report the leave days as non-covered, and report the beginning and ending dates of the leave with Occurrence Span Code 74. To account for the LOA Non-covered days in the billed accommodation days/units, show non-covered days/units under Revenue Code 018X (Leave of Absence) with zero charges. Hospitals may not use the LOA billing when the second admission is unexpected. Examples include, but are not limited to:
    - Situations where surgery could not be scheduled immediately
    - Specific surgical team was not available
    - When further treatment is indicated following diagnostic tests but cannot begin immediately.

DEFINITIONS:

REFERENCES: Contract Definition of Enrollee