Readmission Within 30 Days

Policy

Mass General Brigham Health Plan follows Centers for Medicare and Medicaid Services (CMS) guidelines for Readmission within 30 calendar days of discharge from the initial admission.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan's Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to the General Coding and Billing guidelines for more information

All claims are subject to audit and review. The Provider must furnish medical records upon MGBHP's request.

Mass General Brigham Health Plan reimbursement is based on the line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type:

The entire policy applies to members enrolled in the following lines of business:

- *Mass General Brigham ACO*
- *Commercial and Qualified Health Plans*
- *Senior Care Options (SCO)*
- *One Care*
- *Medicare Advantage*

Payment for a readmission to the same acute facility within 30 calendar days may be denied if the admission was deemed preventable, medically unnecessary or was due to premature discharge of the prior admission.

1. General
   Payment for a readmission to the same acute facility within 30 calendar days may be denied if the admission was deemed preventable, medically unnecessary or was due to a premature discharge of the prior admission. Please note that day of discharge from the initial hospital stay is not counted when determining the number of days between admissions.

2. Criteria for Preventable/Inappropriate Readmissions
   Mass General Brigham Health Plan may conduct a medical review to determine if the subsequent hospital admission/readmission is related to the most recent previous hospital admission. Readmissions which are deemed preventable or considered inappropriate pursuant to the following criteria may be denied:
   - The readmission was medically unnecessary
   - The readmission resulted from a premature discharge or is related to the previous admission, or that the readmission was for services that should have been rendered during the previous admission.
   - The readmission resulted from a failure to have proper and adequate discharge planning.
   - The readmission resulted from a failure to have proper coordination between the inpatient and outpatient health care teams;
   - The readmission was the result of circumvention of the contracted rate by the facility or a related facility.

- A medical readmission for a continuation or recurrence for the previous admission or closely related condition
- A medical complication related to an acute medical complication related to care during the previous admission.
- An unplanned readmission for surgical procedure to address a continuation or recurrence of a problem causing the previous admission.
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the previous admission.
- An unplanned readmission related to a suspected complication that was not treated prior to discharge.
- Complications related to Serious Reportable Events (SREs).

In the event that a readmission falls under one of the criteria listed above, the hospital may not bill a member for the readmission.

MGBHP will not reimburse for services submitted under Observation services when an inpatient level of care is warranted and would have resulted in a readmission.

3. Exclusions

MGBHP may consider as excluded from the criteria in section 2 above, readmissions related to certain conditions or situations, including, but not limited to:

- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, for similar repetitive treatments, or for elective surgery.
- Admissions associated with malignancies (limited to those who are in an active chemotherapy regimen-both infusion and oral), burns, or cystic fibrosis.
- Transplant services, including organ, tissue, bone marrow transplantation from a live or cadaveric donor.
- Admissions with a documented discharge status of “left against medical advice.”
- Obstetrical readmissions.
- Behavioral health readmissions.
- Substance use readmissions.
- In-network facilities that are not reimbursed based on contracted DRG or case rate methodology (e.g., per diem)

Related Mass General Brigham Health Plan Payment Guidelines

General Coding and Billing
Inpatient Hospital Admissions
Modifiers
Mass General Brigham Health Plan referral and Authorization User Guides
Not Payable Per MassHealth Code Set
Observation Services
Serious Reportable Events

References

CMS-Hospital-Acquired Condition Reduction Program

CMS-Hosp. Readmission Reduction

CMS-Medicare Claims Processing Manuals, Chapter 3: Inpatient Hospital Billing

Publication History

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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification, and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.