Payment Policy | Hospital Readmission

EFFECTIVE DATE: 01|01|2015
POLICY LAST UPDATED: 10|20|2015

OVERVIEW

This an administrative policy that defines payment rules for hospitals that are reimbursed for inpatient services when the following scenarios occur:

- Inpatient transfers between a hospital and another acute care inpatient unit transfer to another facility for service while inpatient
- Outpatient services 3 days prior to inpatient admission provides a definition of an inpatient day

This policy is applicable to local in network facilities only

MEDICAL CRITERIA

None

PRIOR AUTHORIZATION

None

POLICY STATEMENT

The following payment guidelines are applicable to local in network facilities only that are reimbursed as a DRG/Case Rate. (Note: Individual hospital contract language supersedes policy.)

Payment guidelines for inpatient transfers between a hospital and another acute care inpatient unit when one of the hospitals

Transferring hospital:

When a patient is transferred and the length of stay is less than the geometric mean or average length of stay for the DRG (depending on the contracted grouper) to which the case is assigned, the transferring hospital is paid based on a graduated per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Receiving facility:

In the case of acute care transfers, the receiving facility that ultimately discharges the transferred patient receives a full DRG payment based on the new admitting diagnosis.

Patient leaves against medical advice:

If a patient leaves a hospital against medical advice and is subsequently admitted to a different hospital on the same day, the initial hospital is paid as a transferring hospital and be paid as a graduated per diem rate for each day of the stay, not to exceed the full DRG payment.

Transfer to another facility for service while inpatient

Any services performed by another hospital, facility, or other freestanding provider will not be reimbursed separately by Blue Cross & Blue Shield of Rhode Island (BCBSRI), unless those services, when rendered in the inpatient setting, are separately reimbursable (e.g., professional services). Reimbursements for all other services are the responsibility of the inpatient facility.

Outpatient services 3 days prior to an inpatient admission

Outpatient services provided by the admitting facility or an entity wholly-owned or operated by the admitting facility will be combined with the inpatient admission payment when rendered within three (3) days of the admission.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Subscriber Agreement or Evidence of Coverage for applicable inpatient coverage/benefits.

BACKGROUND

Inpatient transfers between a hospitals and another acute care inpatient unit

DRG/Case Rate hospitals

The purpose of this transfer payment rule is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG or case rate payment. The transfer rule adjusts the payments to approximate the reduced costs of the transfer cases.

BCBSRI defines a transfer as a member moving from one acute care hospital to another. In transfer situations, the transferring hospital is paid based on a per diem rate for each day of the stay, not to exceed the full DRG or case rate payment that would have been made if the patient had been discharged without being transferred.

DRG

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the appropriate geometric mean or average length of stay for the DRG, depending on the grouper the hospital is contracted with. Transfer cases are also eligible for outlier payments.[1]
Note: Case Rate methodology varies by hospital contracts.

Because this rule only impacts DRG or case rate facilities, the transferring hospital is the one potentially affected by reduced reimbursement. For example if the transferring hospital is not reimbursed based on DRGs or case rate and the receiving hospital is, there is no impact under this payment rule. For any reduction in reimbursement to occur the transferring hospital must be reimbursed on DRGs or case rates, and the receiving hospital must be another short-term acute care hospital. No reductions will be made if the patient is discharged to a long term care facility, rehabilitation, or psychiatric hospital, or to a skilled nursing facility or home health agency.

Transfer to another facility for service while inpatient

DRG/Case Rate or per-diem hospitals

There may be occasions where a member is admitted as an inpatient at a hospital and needs medical services that are not available at that hospital. In some of these instances, instead of discharging the member and transferring to another hospital, the member is simply transported to another Hospital or other freestanding provider to receive the needed services as an outpatient, and then returned to the Hospital where he or she was admitted. When this situation occurs it is necessary to clarify how the providers will be reimbursed.

Example: A member is inpatient at a inpatient rehabilitation facility and is transferred for radiation treatment to another facility. BCBSRI would reimburse the professional component to the radiation treatment provider and the rehabilitation facility would be responsible for reimbursing any additional services.

For coverage of ambulance services, please refer to the Ambulance: Ground Policy.

Outpatient Services three days prior to inpatient admission

DRG/Case Rate Hospitals

Outpatient services provided by the admitting facility or an entity wholly-owned or operated by the admitting facility will be combined with the inpatient admission under the following circumstances:

All outpatient diagnostic services, observation services, related therapeutic or related non-diagnostic service provided within three (3) days prior to the inpatient admission will be combined with the inpatient admission payment. Any services, items, and/or supplies that are integral to the performance of a diagnostic procedure will also be combined with the inpatient admission payment.

Example: A patient is admitted on a Wednesday; outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient payment.

Additionally, the following services are not considered inclusive in the inpatient admission payment:

- Services provided by a home health agency
- Skilled nursing facility services
- Hospice
- Maintenance renal dialysis
- Physician professional services
- Screening mammography

Definitions

Diagnostic Service:

An examination or procedure that is performed to obtain information to aid in the assessment of the medical condition or disease state. Services that are considered diagnostic include, but are not limited to, diagnostic radiology services, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, laboratory services such as hematology and chemistry.

Any services, items, and/or supplies that are integral to the performance of a diagnostic procedure also are combined with the inpatient admission. For example, pharmacy items and injections provided in conjunction with a diagnostic radiology procedure is subject to the three (3) day window and must be combined with the inpatient admission.

This also includes services in the emergency room if the patient is admitted with the same or related diagnosis as treated in the emergency room.

Non-diagnostic Services:

Services and supplies furnished as in integral, although incidental, part of a physician's professional service in the course of diagnosis or treatment of an illness or injury.

Wholly-owned or Operated:

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

Date of Admission/Discharge: Inpatient Day

- To be counted as an inpatient day, member must be inpatient at midnight on the day of admission; OR

- If admission and discharge or death occurs on the same day, this day will be considered the day of admission and count as one inpatient day.
- No daily service charge or fractional part thereof shall be billed by the Hospital to either BCBSRI or member for the day of discharge or death.

Ambulatory Surgery Admission:

- Reimbursed as part of the inpatient hospitalization for those members admitted as inpatient following ambulatory surgery

CODING

Not applicable

RELATED POLICIES

Hospital Readmission

PUBLISHED

Provider Update, December 2015
Provider Update, November 2014
Provider Update, March 2014
Provider Update, August 2013

REFERENCES

Centers for Medicare and Medicaid Services (CMS). February 6, 2004;Transmittal 87:Change Request 2934. http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R87CP.pdf

Centers for Medicare and Medicaid Services (CMS). Retrieved on 03/4/10 from: http://www.cms.hhs.gov/AcuteInpatientPPS/09_Postacute_Transfer_Policy.asp.

[1] Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing. Rev. 1895; 01-15-10:118-120 .http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf

[2]CMS. Quality Improvement Organization Manual Chapter 4 - Case Review (Rev. 2, 07-11-03): https://www.cms.gov/manuals/downloads/qio110c04.pdf

Department of Health and Human Services. Federal Register;63(243);12/18/1998:70138. Accessed 9/21/11: http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS