	Reimbursement Policy

Subject: Inpatient Readmissions

Effective Date:	Committee Approval Obtained:	Section:
06/01/18	**06/01/18**	**Facilities**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://mediproviders.anthem.com/nv**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem). The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Anthem allows separate reimbursement for claims that have been identified as a readmission to the same hospital for any condition unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Any readmission following a discharge is treated as a new admission, even if the readmission occurs within 24 hours of the discharge. This policy only affects those facilities reimbursed for inpatient services by the diagnosis related group (DRG) methodology.

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History	• Biennial review approved and effective **06/01/18**: Separate reimbursement for readmission language added; same-day readmission restriction language removed • Review approved **04/03/17**: Policy template updated • Biennial review approved **08/01/16** and effective **04/01/17**: Different hospital language added • Biennial review approved **04/27/15**: "Provider" added to absence of mandates language • Initial approval **03/25/13** and effective date **10/01/13**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Diagnoses Used in DRG Computation • Documentation Standards for Episodes of Care • Other Provider Preventable Conditions • Present on Admission Indicator for Health Care-Acquired Conditions
Related Materials	• None