Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

June 2019

Inpatient readmission policy and billing guidance

Anthem Blue Cross and Blue Shield (Anthem) has **not** adopted the three-day readmission criteria identified in the Indiana Health Coverage Programs (IHCP) *Inpatient Hospital Services* Provider Reference Module. The readmission window is specified in the provider's contract documents and may vary by provider.

As a reminder, the Anthem reimbursement policy for inpatient readmissions does not allow additional diagnosis-related group (DRG) payment(s) for a second or subsequent inpatient admission for the same or similar condition. This is specific to prior inpatient admissions that were reimbursed on a DRG basis within the readmission window specified in the provider's contract.

When a member is readmitted for the same or similar condition within the readmission window identified in the provider's contract, all services from the original admission and subsequent readmission(s) must be submitted as a single admission. Only one DRG is reimbursed for all admissions.

When a member is admitted for a new, unrelated condition or an exclusion condition within the readmission window, the readmission policy does not apply and each admission is reimbursed as a separate DRG.

What constitutes a same or similar condition?

Anthem will use clinical coding criteria or, when appropriate, a licensed clinical medical review to determine if the subsequent admission is for:

- The same or closely related condition or procedure as the prior discharge.
- An infection or other complication of care.
- A condition or procedure indicative of a failed surgical intervention.
- An acute decompensation of a coexisting chronic disease.
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the postdischarge follow-up period.

Exclusions include:

- Admissions for chemotherapy or immunotherapy treatment.
- Admissions to a substance-abuse unit or facility.
- Admissions to an inpatient rehabilitation unit.
- Elective admissions or staged procedures following commonly accepted practices.
- Readmission after a patient is discharged from the hospital against medical advice.
- Admissions for covered transplant services during the global case rate period for the transplant.

What is the correct method to bill for a readmission?

Anthem does not allow separate reimbursement for claims that have been identified as a readmission to the same facility or two different facilities if both facilities:

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.
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- Operate under the same facility agreement.
- Have the same tax identification number.
- Are under common ownership.

To correctly bill for readmission, providers must account for the following:

- If the claim for the initial admission has already been processed whether paid or denied, the provider must submit a corrected claim with all related admission/readmission days.
- If the claim for the initial admission has not already been processed, the provider must combine all stays and submit a single claim.
- Providers must account for all days from the initial admission through the final discharge. Providers should use Revenue Code 180 (*Leave of Absence – General*) to report the days in between each stay.

Claim denial reasons

Please take note of the following denial reasons and why these denial codes may be applied:

- **FB6 — previous DRG grouper paid in full**: A claim identified as a readmission will be denied with this reason code, regardless of whether it is the first, second or subsequent claim received.
- **Y88 — billing error**: This denial will appear if the claim does not account for all days from the initial date of admission through the final discharge.
- **F00 — charges processed under original submission**: When the provider submits a corrected claim, the original claim will be adjusted to include all days and F00 will appear on the replacement claim.
- **JM1 — provider submitted corrected info**: There may be situations in which the claims processor must split a claim line to match the authorized units. When this occurs, JM1 will be applied.

Overpayments

Anthem continuously reviews the claims processing system for incorrectly paid inpatient readmission claims.

If you have any questions regarding this communication, please call Provider Services:

- Hoosier Healthwise — **1-866-408-6132**
- Healthy Indiana Plan — **1-844-533-1995**
- Hoosier Care Connect — **1-844-284-1798**