Payment Guideline: DRG Readmission

Read First

IMPORTANT INFORMATION CONCERNING WELLFLEET PAYMENT GUIDELINES

This Payment Guideline serves as notice to health care providers of Wellfleet's payment practices. Health providers are advised to consult their own network provider agreement for determining specific payment policies.

Wellfleet may use reasonable discretion in applying these Payment Guidelines to health care services provided to its enrollees. This Payment Guideline does not address all the issues related to reimbursement for health care services. Other factors impacting reimbursement may supplement, modify or, in some cases, supersede this Payment Guideline. These factors may include, but are not limited to, legislative mandates, the type of provider arrangement and the terms of that agreement, and/or the member's benefit coverage document.

Wellfleet may modify this Payment Guideline at any time to comply with changes in national standards, changes in best practices, or other factors that may impact this payment Guideline. Should this Payment Guideline be revised, Wellfleet shall publish a new version of this Payment Guideline. Wellfleet encourages providers to keep current with any CPT or HCPCS updates as well as industry standards related to the services described in this Payment Guideline.

Providers are responsible for submission of accurate claims. Wellfleet reserves the right to request supporting documentation for claims submitted, including provider records.

Applicable Plans

- ☒ Student Health Insurance (for policies issued or renewing after May 2019)
  - ☒ Fully Insured
    - ☐ Excluding policies issued in the following states: N/A
    - ☐ Excluding ISO
  - ☒ Self-Funded
    - ☐ Excluding policies issued by the following schools: N/A
- ☐ Student Sports
  - ☐ Fully Insured; for policies issued by the following carriers:
    - ☐ AIG
    - ☐ Axis

☐ Commercial Casualty Insurance Company/Wellfleet Insurance

☐ Self-Funded

☐ Excluding policies issued by the following schools: N/A

☐ Fully Insured Student Accident; for policies issued by the following carriers:

☐ AIG

☐ Axis

☐ Commercial Casualty Insurance Company/Wellfleet Insurance

Purpose

To describe parameters for determining payment for claims that have been identified as DRG readmissions, as defined in the Scope, to (1) the same facility, or another facility that has the same tax identification number AND (2) is reimbursed by DRG methodology.

Scope

All inpatient claims identified as:

- Being reimbursed by DRG methodology AND
- Belonging to the same facility, or another facility that has the same tax identification number AND
- Having the 2nd admission date ≤ 7 days of the 1st discharge date

With the following exclusions:

- Readmissions (≥ 2 admissions) for chemotherapy or immunotherapy treatment, when treatment is provided during both admissions
  - Not including a 2nd admission for complications of chemotherapy or immunotherapy treatment, without the treatment being provided during the 2nd admission
- Admissions to a substance abuse unit or facility
- Admissions to an inpatient rehabilitation unit
- Staged procedures following commonly accepted practices
- Admissions for covered transplant services during the global case rate period for the transplant

---

Definitions

- DRG (Diagnosis Related Group): A inpatient payment methodology, developed by the Centers for Medicare and Medicaid Services (CMS), whereby the facility is paid a single lump sum for an entire episode of treatment based on the main diagnoses and/or procedures.

Guidelines

I. Claims being considered for combining DRG readmissions as described under "Scope" shall be reviewed by Clinical staff to determine:
   A. Level of care of both claims
      1. The 1st admission determination must be Acute Inpatient Level of Care but the 2nd admission may be either Inpatient or Observation Level of Care to qualify for combining DRG readmissions
   B. Reason for admission for both claims
      1. Reason for 2nd admission must be related to something that occurred/was addressed during 1st claim to qualify for combining DRG readmissions
      2. The assigned DRGs for the 2 claims do not have to be identical to qualify for combining DRG readmissions

II. Claims meeting both A & B above qualify for combining DRG readmissions
   A. The 2nd claim will be denied using Code #2886 "Combined DRG, care included under prior admission"
   B. The 1st claim needs to be reassessed for upcoding, or entire change of, the original DRG based on the additional clinical information from the 2nd claim, which is now covered by this DRG
      1. If upcoding or change of the DRG is appropriate, use Code # 2887 Combined DRG, initial DRG revised

III. Claims not meeting either A &/or B above do not qualify for combining DRG readmissions
   A. These claims should be reviewed and processed as separate admissions

Change History

Version	Effective Date	Next Review Date
1.0	7/1/2023	7/1/2024