MEDICAL MUTUAL®

Mutual News Bulletin

October 2019

Hospital Readmissions Reimbursement Policy

Medical Mutual recently evaluated how we review hospital readmissions. As a result of this evaluation, we are updating the following sections of our Provider Manual.

- Repeat Admissions/Leave of Absence Sub-section of Section 9 – Institutional Reimbursement Overview
- Billing for Hospital Readmissions Sub-section of the Additional Medicare Advantage Guidelines Sub-section of Section 12 – Medicare Advantage Plans and Guidelines.

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Contact Us

Visit **MedMutual.com/Provider** to log in to the Provider Portal.

If you have questions, please contact your provider contracting representative:

Central/Southeast Ohio (Columbus Office)
1-800-235-4026

Northeast Ohio (Cleveland Office)
1-800-625-2583

Northwest Ohio (Toledo Office)
1-888-258-3482

Southeast Ohio/Kentucky (Cincinnati/Dayton Office)
1-800-589-2583

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These updated sections will be effective Nov. 1, 2019. The revised Provider Manual with these updates can be found at MedMutual.com/Provider under Tools & Resources.

In addition, effective Nov. 1, 2019, Medical Mutual is implementing a Reimbursement Policy, Hospital Readmissions (Policy Number RP-201902). To view this policy, please visit MedMutual.com/Provider and select Tools & Resources then Payment Policies.

A summary of the Hospital Readmissions Reimbursement Policy, and the affected sections of the Medical Mutual Provider Manual, follows.

- Readmission review will continue to apply to all Commercial/Marketplace and Medicare Advantage products.
- Second admissions to the same acute care hospital or health system may be denied if the admission:
  - Occurs within 30 days after discharge from the prior admission.
  - Is clinically related to the prior admission and if the readmission could have been avoided or prevented according to the criteria set forth in Reimbursement Policy, Hospital Readmissions (Policy Number RP-201902).
- Certain medical conditions and other situations will be excluded from Medical Mutual's readmission review, as outlined in Reimbursement Policy, Hospital Readmissions (Policy Number RP-201902).
- Medical Mutual will apply readmission review to acute care hospitals and hospital systems reimbursed using DRG or Case Rate methodology.
- Leave of Absence (LOA) billing guidelines have been updated.
- Hospitals will continue to be required to submit medical records pertaining to the initial admission and readmission, which include documentation of discharge planning, clinical status at discharge, and discharge instructions.

Expansion of Strategic National Implementation Process (SNIP) Validation Rules and Implementation of Council for Affordable Quality Healthcare (CAQH) CORE Validation

Medical Mutual is expanding its front-end validation edits for all HIPAA-mandated transactions. We are also implementing validation edits as defined under CAHQ CORE Operating Rules. Starting in Q4 2019, you will receive warnings on the summary and detail report and response files when a claim or other electronic request fails validation. These will be warnings that are meant to prompt you to take action to address and correct the request(s).

Then, effective Nov. 1, 2019, Medical Mutual may reject claims and encounter data records that do not comply with HIPAA Implementation Guides. Information on the requirements can be found at https://www.cms.gov.

In the past, provider claims and data submissions to Medical Mutual have not been rejected for many of the HIPAA edits.

Many other insurance payers have already implemented these edits. Because of this, you may not notice any differences in your day-to-day procedures. If you or your clearinghouse have not implemented these edits, you could see a change with what Medical Mutual is accepting and processing.

How does this affect you?

- Claims and other electronic data transactions must have the correct format, including data content where required, to submit successfully into Medical Mutual's systems. If the correct format is not used, the claim or other transaction may be rejected.
- The rejection could happen at your clearinghouse or billing service.
- A rejection means that your claims or other data transactions will not make it to us for processing, which will delay payment or response to your request for information.
- Your rejected claim or other transaction will require correction and resubmission.

What you can do now

- Contact your clearinghouse or billing service and ask if they are using SNIP Level 6 edits and CMS SNIP Level 7 edits. Please ask specifically about dollar amount character limit 99,999,999.99 without commas. If they are not, ask them to implement these edits as soon as possible.
- Routinely review your electronic response reports to determine if additional action is needed to prevent delays.
- If you receive a warning or rejection, the code and description will tell you where the error occurred, why it failed validation, and what action needs to be taken to correct and resubmit.

Questions?

Please contact Medical Mutual's Customer Care Department at 1-800-362-1279 or EDISupport@MedMutual.com.

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Inside This Issue

This material is considered part of the ProviderManual for Medical Mutual of Ohio® and its subsidiaries. Mutual News and Mutual News Bulletin are published for network providers serving Medical Mutual. To contact us or for more information, visit Provider.MedMutual.com.