RB.018.A MEDICARE READMISSIONS

Original Implementation Date : 1/1/2014
Version [A] Date : 1/1/2021
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PRODUCT VARIATIONS

This policy only applies to Jefferson Health Plans **Medicare Advantage** product line.

Application of a Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may also vary based on individual provider contractual arrangements.

POLICY STATEMENT

Our Medicare Advantage does not separately reimburse for inpatient readmission claims to the same inpatient acute care hospital, or an inpatient acute care hospital within the same health system, within 30 days of discharge from the previous inpatient hospital stay for a condition related to the initial stay. (e.g., post-operative infection, sepsis, or complication diagnosis). Our Individual and Family Plan Medical Director will perform a medical review of the two admissions to determine if the readmission is for a related condition.

For reimbursement purposes we will treat both inpatient hospital admissions as a single clinical event. The claim with the higher payment will remain in place, and the claim for the other related admission will be retracted post payment. This will eliminate the payment of multiple case rates for a single clinical event.

Exclusions

The following readmission scenarios are excluded from the above listed payment limitations:

*(**Note**: Usual preauthorization and notification requirements apply to all exclusions.)*

a. Planned unrelated readmissions when the readmission occurs less than 31 calendar days from the date of the discharge from the same facility.[6] *(Please also see definition of Planned Readmission).*

Examples:

i. *Planned admission for lung volume reduction surgery after a motor vehicle accident admission for loss of consciousness.*

ii. *Planned total knee replacement admission after syncope admission.*

b. Staged inpatient procedure(s) after the initial surgical admission when a staged procedure is medically acceptable AND warranted.

c. Planned related readmissions for inpatient appropriate care when the frequency of the needed services is medically appropriate. *For example, chemotherapy administration that is most appropriate as an inpatient and occurs every 3 weeks according to acceptable oncologic protocol.* [6]

POLICY GUIDELINES

1. **Initial Review Process**

a. Our Medical Director will determine if the request is appropriate for the inpatient level of care using our Necessity policy, CMS inpatient guidelines and InterQual Acute Module, our policy, CMS to reflect the current standards of practice. If an alternative setting is more appropriate, the request will be denied as not medically necessary.

b. A medical condition resulting in readmission could have reasonably been prevented by the provision of appropriate care consistent with accepted medical standards either prior to the initial discharge or during the post-discharge follow up period.

c. Hospital care is now required as a result of care provided (or inappropriately not provided) during the original admission through a period immediately following discharge, such as but not limited to:

i. The same or closely related condition or procedure that existed prior to the initial discharge.

ii. An infection or other complication of care

iii. A condition or procedure indicative of a failed surgical intervention

iv. An acute decompensation of a coexisting chronic disease

d. An issue was caused by a premature discharge from the same facility.

e. A readmission occurred within 24 hours of discharge from the same facility.

f. A planned or unplanned readmission for services that should have been provided during the first admission.

g. Determine if the care rendered during the readmission is "clinically related" to the care rendered during the initial admission**:** The readmission is plausibly "clinically related" to the original admission if any of the following examples apply. These are only intended as examples:

i. **Ongoing or recurrent condition treated during initial admission:** Readmission is for continuation or recurrence of a condition treated during the initial admission.

ii. **Acute decompensation of chronic problem presents during prior admission:** Readmission is for acute decompensation of a chronic problem present on the prior admission but was not necessarily the focus of the initial admission. Treatment of an acute condition may have worsened this chronic problem.

iii. **Unplanned readmission for surgery:** Readmission is for an unplanned surgery related to a complication of care during the initial admission or the extent of the patient's condition was not fully evaluated or not fully treated.

iv. **Surgery for a problem from the first admission:** Readmission (planned or unplanned) for surgery to address a continuation or recurrence of a problem that was identified or should have been identified within the first admission where a staged procedure is either not medically appropriate or the delay was not warranted.

If the care in the readmission is plausibly "clinically related" to the first admission, the readmission will be APPROVED but considered RELATED to the prior admission. For payment purposes this means that the second admission will not be reimbursed.

2. **Appeal Process:** On Appeal, a Medical Director will

a. **Clinically Related Review:** Determine if the initial determination of being plausibly "clinically related" was accurate using the above defined process.

b. **Potentially Avoidable:** Determine if the readmission was potentially avoidable. The medical director should consider whether **ALL** of the following was done.

i. A discharge plan was created that was comprehensive and consistent with the current standard of care for the condition(s) and unique member circumstances. Potential language barriers were assessed and mitigated with use of an appropriate translator.

ii. The comprehensive discharge plan was clearly communicated to the member.

iii. A post hospitalization appointment was arranged for the Member within an acceptable timeframe for the Member's condition. The discharging facility assessed the Member's ability to attend the appointment and attempted to mitigate any issues such as but not limited to transportation, travel challenges (ability to travel alone or need for assistance etc.), and conflict with work or childcare.

iv. Medication reconciliation was done, prescriptions provided (or arranged) and communicated to the Member.

v. If needed, Durable Medical Equipment, (DME) was arranged to ensure prompt delivery.

vi. The need for home care was assessed and arranged where appropriate.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

CPT Code	Description
N/A	

HCPCS Code	Description
N/A	

ICD-10 Codes	Description

N/A	

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DESCRIPTION OF SERVICES

Some readmissions are unavoidable, but they may also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care.

Multiple factors affect readmission rates and other measures including: the complexity of the medical condition and associated therapies; effectiveness of inpatient treatment and care transitions; patient understanding of and adherence to treatment plans; patient health literacy and language barriers; and the availability and quality of post-acute and community-based services, particularly for patients with low income. Readmission measurement should reinforce national efforts to focus all stakeholders' attention and collaboration on this important issue.

We are responsible, as a Medicare Advantage Organization (MAO), to monitor the quality of the care our members receive. This includes potentially avoidable readmissions. CMS holds MAO's accountable for quality measures through the CMS Star Rating System. One of the more heavily weighted Star measures is preventable readmissions.

Determination of Medical Necessity for covered care and services; whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing:

The determination is based on medical information provided by the Member, the Member's family/caretaker, and the Primary Care Practitioner, as well as any other Providers, programs, and agencies that have evaluated the Member

Readmission: "Admissions to an acute, general, short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, short-term

hospital (See §1154(a)(13) and 42 CFR 476.71(a)(8)(ii)). Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred."[1a]

Premature discharge: "This occurs when a patient is discharged even though he/she should have remained in the hospital for further testing or treatment or was not medically stable at the time of discharge. A patient is not medically stable when, in [the reviewer's] judgment, the patient's condition is such that it is medically unsound to discharge or transfer the patient. Evidence such as elevated temperature, postoperative wound draining or bleeding, or abnormal laboratory studies on the day of discharge indicate that a patient may have been prematurely discharged from the hospital."1c.

Planned readmission: A planned readmission is "a non-acute admission for a scheduled procedure within 31 days of discharge from the Same Facility.

1. A few specific, limited types of care are always considered planned (obstetrical delivery, transplant surgery, maintenance chemotherapy/radiotherapy/immunotherapy, rehabilitation).

2. Admissions for acute illness or for complications of care are never planned."[6.]

Same Hospital/Facility: A hospital is considered the "Same Hospital" for purposes of determination of readmissions, when the hospital shares the same Tax ID Number (TIN).

DEFINITIONS

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed by us to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2024 Review.		
2022 Review. No changes. Reissue as written.	A	1/1/2021
2020 Review: Policy # changed from AD.001.C to RB.018. A. Additional language added for clarity purposes.	A	1/1/2021
2018 Review: Readmission calendar days changed from 15 days to 30 days. A defined Review Process was added. Changed payment condition from being unrelated to being unavoidable. AD.001.C	C	4/1/2018
Language added for clarity. AD.001.B	B	11/16/17
New policy: AD.001.A	A	1/1/2014

REFERENCES

1. **Quality Improvement Organization Manual, Chapter 4, Case Review**
    a) Section 4240 - Readmission Review
    b) Section 4250 – Transfer Review
    c) Section 4255 - Circumvention of Prospective Payment System (PPS) Electronically available at: Medicare (cms.gov)

2. **Social Security Act, Title 18**
   Electronically accessible at: http://www.ssa.gov/OP_Home/ssact/title18/1886.htm

3. **Social Security Act, Title 11**
   Electronically available at: http://www.ssa.gov/OP_Home/ssact/title11/1154.htm

4. **42 CFR 476.71 QIO Review Requirements**
   Electronically accessible at: https://www.law.cornell.edu/cfr/text/42/476.71

5. **State Operations Manual**
   Electronically accessible at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

6. **Pub 100-16, Medicare Managed Care Manual**, Chapter 4, Benefits and Beneficiary Protections, Section, Section 30.3 – Examples of Eligible Supplemental Benefits. Electronically accessible at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

7. **Pub 100-16, Medicare Managed Care Manual, Chapter 5, Quality Assessment, Section 20.1.2 - Quality Improvement Project (QIP)**
   Electronically accessible at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf