Reimbursement Policy:

Hospital Readmission Policy

(Commercial, Medicare and Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20220022	8/30/2022	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

This policy is applicable to all acute care facilities. It defines the payment guidelines for readmissions to an acute general short-term hospital occurring within thirty (30) calendar days of the date of discharge from the same acute general short-term hospital or hospitals within the same hospital system for the same, similar, or related diagnosis. In the instance of multiple readmissions, each admission will be reviewed against criteria relative to the immediate preceding admission.

Policy Statement:

The Plan reviews all readmissions to the same facility or hospital network on a concurrent basis. It is the responsibility of the discharging facility to perform discharge planning and assure that the member is appropriate for discharge.

Any readmission to the same acute general short-term hospital or hospitals within the same hospital system for the same, similar, or related diagnosis within 30 calendar days of a member's discharge is subject to a clinical review. Medical records will be reviewed to determine if the readmission is related to the preceding admission.

Readmission is defined as an unexpected admission to the same acute care facility or an acute care facility that is part of the same hospital network within 30 calendar days of the previous hospital discharge date. This is concordant with the Centers for Medicare and Medicaid Services (CMS) definition of readmission as, "an admission to an acute care hospital within 30 days of discharge from the same or another acute care hospital."

CMS uses an "all-cause" definition, meaning that the cause of the readmission does not need to be related to the cause of the initial hospitalization. This policy takes the CMS definition into consideration along with market specific considerations.

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The time frame was set at 30 days because readmissions during this time can be influenced by the quality of care received at the hospital and how well discharges were coordinated.

Medical record review will be performed for all admissions that fall within 30 days of an inpatient discharge to determine if the readmission is related to the preceding admission.

This policy applies to all EmblemHealth/ConnectiCare lines of business, including Medicare, Medicaid and Commercial.

This policy applies to the following situations (including, but not limited to): a.) Clinically related readmissions; b.) Planned readmissions or leave of absence; c.) Emergent readmissions; d.) Psychiatric readmissions; and e.) Readmission for pre-delivery obstetrical care.

Reimbursement Guidelines:

Readmission Billing Requirements

Multiple readmissions are not eligible for separate reimbursement, when each inpatient hospital stay is paid per case or per admission (e.g., DRG methodology payment).

a) Related services must be combined into a single claim for one episode of care.

b) If the initial admission claim has already been submitted, submit a corrected claim using TOB code 117 *Replacement of Prior Claim* (for more information regarding corrected claims, please see EmblemHealth/ConnectiCare Corrected Claim Submission Reimbursement Policy).

c) Related services billed as two/multiple separate inpatient episodes of care and meet the criteria as outlined in this policy for being combined into one episode of care may be combined for processing or returned for corrected submission.

Review and Processing of Commercial Plan Claims

All hospital readmissions from and to the same hospital/facility are considered a continuation of initial treatment.

Readmission to the same hospital within 30-days of discharge will be clinically reviewed to determine if the readmission claim is eligible for combining with the initial admission claim for processing.

The two (or multiple) DRG hospital claims (determined by the assigned provider identifier) will be combined into one single claim; all necessary codes, billed charges and the length of stay will be consolidated.

a) The maximum allowable for the combined claim will be reprocessed using an industry standard DRG grouper and the DRG methodology. Reimbursement will be recalculated as a single, per case reimbursement.

b) The combined episode of care will be processed (or adjusted if necessary) under the claim for the initial inpatient acute-care hospital stay.

c) The claims for the other related readmissions:

   i. If they have not yet been adjudicated for payment, these claims will be closed.

   ii. If they have already been adjudicated, the claims will be reprocessed. Refunds will be requested when applicable.

Review and Processing of Medicare Advantage and Medicaid Plan Claims

Emblemhealth/ConnectiCare Medicare Advantage and Medicaid readmission policy aligns with CMS and includes readmission to the same hospital/same hospital system (using the assigned provider identifier) within 30 days of the initial admission.

Hospital stays are subject to clinical review to determine if the readmission is related to or similar to the initial admission.

When a DRG claim is received for both an initial and subsequent hospital stay, the subsequent hospital stay will be denied, and a corrected claim will need to be submitted.

Exclusions:

Admissions are excluded from the readmission measure if they meet one of the following:

- The patient was discharged against medical advice (AMA)
- A planned readmission as part of a treatment plan for a diagnosis of cancer
- A planned readmission as part of a treatment plan for transplant services
- An elective admission of a staged procedure that follows commonly accepted practices
- An obstetrical admission related to delayed delivery
- *An admission to an out-of-network facility
- Transfer of patients to receive care not available at the first facility
- An admission to a psychiatric/substance abuse unit or facility
- An admission to a Long-Term Acute Care Hospital (LTACH)
- **An Unavoidable complication (Non-Preventable Readmission)

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**Out of Network/Non-Participating Facilities:* For these facilities, all admissions are reviewed following the Concurrent Review process and reviewed for medical necessity. If a participating facility/network has contractual language outlining readmission reviews, the facility/network contract language will be followed.

***Unavoidable complication:* Determination of Non-Preventable Readmissions To determine whether a patient's readmission was preventable or not, multiple factors are taken into consideration, including, but not limited to, premature discharge due to clinical instability, inadequate medication management, inadequate discharge planning, and patient non-compliance to discharge instructions. Please note that a readmission may be medically necessary, but nonetheless preventable and would still be subject to the clinical preventable readmission review.

Elements of Discharge Planning:

Discharge planning must take into account the availability and criticality of outpatient follow-up visits and treatment. Communication with practitioners who will provide follow-up care is expected.

- An example is failure to address rehabilitation needs: Significant decline in function and inability to perform Activities of Daily Living (ADL) is common following hospitalization of the elderly. Failure to properly address rehabilitation needs related to an inability to self-care is an avoidable cause of Readmission

Additional factors to be considered in making a decision about whether subsequent admission was preventable: This may include

- Emerging Symptoms: Symptoms that had onset or were present during a previous admission and subsequently worsened, leading to Readmission, are a possible indicator of a premature discharge. Discharge prior to establishing the safety or efficacy of a new treatment regimen is also considered a premature discharge
- Chronic Disease: Chronic diseases vary in severity, and entry into the terminal phase of an illness can be gradual. When reviewing Readmissions related to chronic disease, Readmission within a short period of time should be assessed for adequacy of follow- up care and outpatient management using accepted practice guidelines and treatment protocols

Patient Non-Compliance: Facilities will not be held accountable for patient noncompliance if all the following conditions are met:

- There is adequate documentation that physician orders have been appropriately communicated to the patient
- There is adequate documentation that the patient/caretaker is mentally competent and capable of following the instructions and made an informed decision not to follow them
- There were no financial or other barriers to following instructions. The Medical Records should document reasonable efforts by the facility to address placement and access-to-treatment difficulties due to financial constraints or social issues, including consultation with social services, use of community resources, and frank discussions of risks and alternatives

- The noncompliance is clearly documented in the medical record. *For example, documentation for a discharge to the home when the discharge is felt to be unsafe should include signature by the patient/caregiver as leaving Against Medical Advice (AMA).*

Preauthorization:

This policy does not supersede any inpatient recommended or required preauthorization or notification rules that are currently in place.

Coverage:

Benefits may vary between groups/contracts. Please refer to the appropriate Membership Agreement or Evidence of Coverage for applicable inpatient coverage/benefits.

References:

1. CMS. "Repeat Admissions." Centers for Medicare & Medicaid Services (CMS) Pub. 100-04 Claims Processing Manual. Chapter 3 – Inpatient Hospital Billing, § 40.2.5.
2. CMS. "Readmission Review." Centers for Medicare & Medicaid Services (CMS) Pub. 100-10 Quality Improvement Organization (QIO) Manual. Chapter 4 – Case Review, § 4240.
3. CMS. "2015 Measure Information About The 30-Day All-Cause Hospital Readmission Measure, Calculated For The Value-Based Payment Modifier Program." https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf . Last updated March 2017; Last accessed April 23, 2019.
4. CMS. "Readmission Review." Quality Improvement Organization Manual, Pub. 100-10, Chapter 4 – Case Review, § 4240.

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	11/2024	• Updated with clarification of billing instructions.
EmblemHealth ConnectiCare	8/2024	• Annual Policy Review – no changes to existing criteria.
EmblemHealth ConnectiCare	2/01/2024	• Policy language updated to clarify medical record review. No changes to existing policy criteria

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EmblemHealth ConnectiCare	3/2022	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number • Clarified Obstetric Admissions exception • Added exception of unavoidable complication
ConnectiCare	3/2022	• Updated to include all acute care hospital payment methodologies • Removed skilled nursing and rehabilitation facilities from exceptions • Readmissions for cystic fibrosis and burns removed from exceptions • Long Term Acute Care Hospitals (LTACH) added to exceptions