Payment Policy: 15 Day Readmission

Reference Number: KS.PP.501
Product Types: ALL
Effective Date: 01/01/2018 Coding Implications
Last Review Date: 01/24/2018 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
As a part of the Affordable Care Act (ACA), Congress mandated that CMS reduce hospital readmissions through certain payment incentives. Section 3025 of the ACA added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

The Kansas Medical Assistance Program established an inpatient readmission reduction program aimed at reducing the number of potentially preventable readmissions to hospitals. Potentially preventable readmissions to hospitals have long been recognized as a measure of quality of care.[1] Many Medicaid programs and other payers have policies under which they may deny payment for specific readmissions that result from sub-standard care that was provided in the initial admission. Examples include repeat admissions for asthma or admissions for post-operative bleeding. In principle, denial of payment for these specific cases motivates the hospital to bring its care up to standard.

The purpose of this policy is to promote more clinically effective, cost efficient and improved health care through appropriate and safe hospital discharge of patients.

Application
This policy applies to individual hospitals or hospitals within the same hospital system.

Policy Description
This policy is based, in part, on the methodology set forth in the Quality Improvement Organization Manual, CMS Publication 100-10, Chapter 4, Section 4240, for determining an inappropriate readmission.

> *Analyze the cases specifically to determine whether the patient was prematurely discharged from the first confinement, thus causing readmission. Perform an analysis of the stay at the first hospital to determine the cause(s) and extent of any problem(s) (e.g., incomplete or substandard treatment). Consider the information available to the attending physician who discharged the patient from the first confinement. Do not base a determination of a premature discharge on information that the physician or provider could not have known or events that could not have been anticipated at the time of discharge.*

For a readmission that is determined to have been inappropriate or preventable according to the clinical review guidelines set forth below, The Health Plan will deny payment or reimbursement. Medical records shall be reviewed to determine if the readmission was the result of an inappropriate discharge from the initial admission based on one of the following criteria:

A readmission will be considered to be inappropriate or preventable under the following circumstances:

- A medical readmission for a continuation or reoccurrence for the initial admission or closely related condition (e.g. readmission for diabetes following initial admission for diabetes);
- A medical complication related to an acute medical complication related to a care during the initial admission (e.g. patient discharged with urinary catheter readmitted for treatment of a urinary tract infection);
- An unplanned readmission for a surgical procedure to address a continuation or a recurrence of a problem causing the initial readmission (e.g. readmitted for appendectomy following a primary admission for abdominal pain and fever);
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the primary admission (e.g. readmission for drainage of a post-operative wound abscess following an initial admission for a bowel obstruction);
- The unplanned readmission is the result of a need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards prior to discharge or during the post-discharge follow up period;
- An issue caused by a premature discharge from the same facility;
- Readmission was medically unnecessary;

The following readmissions are excluded from readmission review:

- Readmission that are planned (such as repetitive treatments, i.e. cancer chemotherapy, transfusions for chronic anemia or other similar repetitive treatments);
- Readmission associated with malignancies, burns, cystic fibrosis and anemia;
- Readmission due to bone marrow transplants;
- Obstetrical readmissions;
- Readmissions that stems from an initial stay discharge status of “left against medical advice”;
- Admission to Skilled Nursing Facility (SNF), Long Term Acute Care facilities (LTAC), and Inpatient Rehabilitation Facilities (IRF);
- Admission for treatment when the primary diagnosis is psychiatric;
- Transfer of patient to receive care not available at the first facility;
- Readmissions ≥ 16 days from the data of discharge from the first admission.

If a hospital is part of a hospital system operating under the same hospital agreement, and/or if the hospital shares the same tax identification number with one or more other hospitals, then a readmission during the same 15-day period to another hospital within the same hospital system, or to another hospital operating under the same tax identification number as the first hospital, will be treated as a readmission to the same hospital and, as such, is subject to this policy.

Upon request from The Health Plan, a hospital must forward (and, if applicable, arrange for a related hospital to forward) all medical records and supporting documentation of the initial admission and readmission to The Health Plan. The initial review of the medical records will determine whether the readmission was clinically related to the initial admission. Once the readmission is determined to be clinically related, the readmission will be further evaluated to determine whether the readmission was inappropriate and/or potentially preventable. The review will evaluate the initial admission's appropriateness of discharge, as well as the quality of the discharge plan.

Reimbursement

Pre-Payment Review

A pre-payment review will be conducted in accordance with the provisions set forth below:

1. All hospital claims submitted for a plan member that qualify as a readmission within 15 days of a discharge from the same hospital or a related hospital are subject to clinical review.
    a. Medical records for both the original and subsequent admission(s) will be requested for a claim selected for clinical review. If medical records for both the original and subsequent admission are not received, the second claim will be denied.
    b. If both records are not received and a denial is issued, the hospital must submit an adjustment request or appeal request and submit the medical records for the first and subsequent admissions for further payment consideration and to initiate clinical review. Submission of medical records for only one admission will result in a denial of the adjustment or appeal request.
2. Clinical information for the admissions will be reviewed by a qualified clinician to determine if the readmission was inappropriate or preventable based on the above guidelines.
3. If a readmission is determined to be inappropriate, unnecessary, or preventable, written notification of the determination will be sent to the hospital and/or related hospital and payment for the readmission will be denied.
4. When a Medicaid beneficiary is discharged prematurely and subsequently readmitted within 15 days, only the DRG payment for the first stay will be made if the discharging and readmitting hospital are the same. If the discharging and readmitting hospitals are not the same, only the readmitting hospital will be reimbursed

Post-Payment Review

The Health Plan will endeavor to monitor claim submissions to minimize the need for post-payment adjustments; however, The Health Plan may review payments retrospectively, if a prepayment review was not conducted.

1. If a claim is determined to be related to a previous admission (and thus could possibly be determined to be an inappropriate, unnecessary, or preventable readmission), the hospital must forward (and, if applicable, arrange for a related hospital to forward) medical records for all related admissions to The Health Plan, upon its request. All clinical information from the admissions will be reviewed by a qualified clinician to determine if any readmission was inappropriate, unnecessary, or preventable based on the above guidelines.
2. If a readmission is determined to be inappropriate, unnecessary, or preventable, written notification of such determination will be sent to the hospital or related hospital, along with a request to the hospital to refund the applicable payment(s) for the readmission.
3. When a Medicaid beneficiary is discharged prematurely and subsequently readmitted within 15 days, only the DRG payment for the first stay will be made if the discharging and readmitting hospital are the same. If the discharging and readmitting hospitals are not the same, only there admitting hospital will be reimbursed.
4. If a hospital or related hospital fails to refund the applicable payment(s), The Health Plan may recover the applicable payment for the readmission by offset against future payments, unless expressly prohibited by law from doing so, or as stipulated in the hospital's contract.
5. The hospital may follow the established processes of a Provider Reconsideration, Appeal and State Fair Hearing if they would like to have the readmission determination reviewed subsequently.

Utilization
Not Applicable

Documentation Requirements
Upon request from The Health Plan, a hospital or related hospital must forward all medical records and supporting documentation of the first and subsequent admission(s) to the health plan for review.

Definitions
Clinically Related – an underlying reason for a subsequent admission that is plausibly related to the care rendered during or immediately following a prior hospital admission. A clinically related readmission may have resulted from the process of care and treatment during the prior admission (e.g., readmission for a surgical wound infection) or from a lack of post admission follow-up (lack of follow-up arrangements with a primary care physician) rather than from unrelated events that occurred after the prior admission (broken leg due to trauma) within a specified readmission time interval.

Initial Admission – an inpatient admission at an acute, general, or short-term hospital, or another hospital in the same hospital system (referred to as a "related hospital") and for which the date of discharge for such admission is used to determine whether a subsequent admission at that same hospital or a related hospital occurs within 15 days.

Potentially Preventable Readmission (PPR) – A potentially preventable readmission is a readmission (re-hospitalization within a specified time interval) that is clinically related (as defined above) and may have been prevented had adequate care been provided during the initial hospital stay.

Readmission – an admission to a hospital occurring within 15 days of the date of discharge from the same hospital or a related hospital. Intervening admissions to non-acute care facilities (e.g., a skilled nursing facility) are not considered readmissions and do not affect the designation of an admission as a readmission. For the purpose of calculating the 30-day readmission window, neither the day of discharge nor the day of admission is counted.

Related Policies
Not Applicable

Related Documents or Resources

CMS Publication 100-10 (Quality Improvement Organization Manual), Chapter 4, Section 4240 (Readmission Review), available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/qio110c04.pdf

References

1. *Patient Protection and Affordable Care Act Pub. L. No, 111-148 § 3025(a), 124 Stat. 119, 408 (2010). The Affordable Care Act, Section 3025, § 1886(q), requires the Secretary to establish a Hospital Readmissions Reduction program, under which payments to applicable hospitals are reduced in order to account for certain excess readmissions, effective for discharges beginning on October 1, 2012. This section also requires the Secretary to establish a Value-Based Purchasing (VBP) Program for inpatient hospitals (Hospital VBP Program), which requires CMS to make value-based incentive payments to hospitals that meet performance standards for applicable performance periods, effective for discharges beginning on October 1, 2012.*
2. *42 CFR 412.150 through 412.154 include the rules for determining the payment adjustment under the Hospital Readmission Reductions Program for applicable hospitals to account for excess readmissions in the hospital.*
3. *Federal Register, Vol. 79, No. 163, August 22, 2014, pages 50024 – 50048. This FY 2015 IPPS Final Rule outlines changes in policies to implement the Hospital Readmissions Reduction Program through FY 2017. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf*

4. *Centers for Medicare and Medicaid Readmission Reduction Program information available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html*
5. *Gerard F. Anderson and Earl P. Steinberg, "Hospital Readmissions in the Medicare Population," New England Journal of Medicine, 311:21 (Nov. 22, 1984), pp. 1349-1353*
6. *Current Procedural Terminology (CPT®)*, 2015
7. *HCPCS Level II*, 2015
8. *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM), 2015
9. *ICD-10-CM Official Draft Code Set*, 2015
10. Kansas Medical Assistance Program, Fee-for-Service Provider Manual, Hospital Services, Section 8410, p. 8-46 through 8-47, 2018

Revision History	
07/01/2015	Initial posting of policy.
6/8/2016	Revision of policy to clarify hospitals that it pertains as well as which are considered "Related Hospitals", appeal information, and clarify the criteria for cases are reviewed
01/03/3107	Converted to new corporate template and removed all branding.
04/18/2017	Converted to corporate template and annual review conducted.
08/23/2017	Revised policy to reflect 15 days instead of 30 days per request from KS (via Payment Integrity)
01/23/2018	Revised policy to reflect KMAP manual revisions for 1/2018

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.