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CENTRAL HEALTH MEDICARE PLAN

Policies and Procedures

Readmission Review			
POLICY #	**MED-095**	**CURRENT VERSION**	**2**
POLICY OWNER	**Maureen Murray**	**CURRENT VERSION EFFECTIVE DATE**	**January 26, 2023**
DEPARTMENT	**Clinical Services**	**ORIGINAL/INITIAL EFFECTIVE DATE**	**February 11, 2022**

DEFINITIONS

1. **Centers for Medicare and Medicaid Services (CMS) -** The Centers for Medicare and Medicaid Services oversees the federally funded insurance programs for seniors, persons with disabilities (Medicare) and low income (Medi-CAL) for citizens of the United States of America.

2. **Licensed clinical staff** – For this purpose of this policy, this includes Licensed vocational nurse (LVN), Licensed practical nurse (LPN), Registered nurse (RN), or physician (MD or DO)

3. **Readmission** - a readmission occurs when a member has a hospital stay, either observation or full admission, within a specified time period after being discharged from an earlier (initial) hospitalization.

PURPOSE

The purpose of this policy is to describe Brand New Day/Central Health Medicare Plan implementation of CMS guidance and requirements related to the review and payment of readmissions to acute care facilities.

SCOPE

This policy applies to same-facility readmissions for acute care facilities (in-network and out-of-network) receiving payments on a Medicare Severity Diagnosis Related Group (MS-DRG), so long as this policy is not superseded by contractual obligations or state requirements. This policy further applies to Brand New Day/Central Health Medicare Plan and all its affiliates.

POLICY

Brand New Day/Central Health Medicare Plan will review same-facility readmissions that occur at any acute care facility (in- network or out-of-network) to assess quality of care and determine if the readmissions were preventable.

Medicare Severity Diagnosis Related Group (MS-DRG) payments for unnecessary readmissions are subject to denial by CMS per section 1886(f) of the Social Security Act. Readmission review per CMS guidelines is discussed in the Medicare Quality Improvement Organization (QIO) Manual, Chapter 4, section 4240. While not a QIO, Brand New Day/Central Health Medicare Plan

and/or its affiliates is a CMS contractor, and this policy is consistent with CMS guidance for the purposes of ensuring quality of care for members and compliance with CMS's Inpatient Prospective Payment System (PPS).

Readmission review will occur either during concurrent review or after receipt of claims, and can be subdivided into the following categories:

- Same-day readmissions – member re-presents to an acute care or emergency facility within 24 hours of inpatient discharge and is subsequently readmitted.
- Planned readmission (leave of absence).
- Unplanned readmissions within 30 days of prior discharge from the same facility.

Same-day readmissions

Hospital stays for members who present for same-day readmission as defined above for a related condition will be combined with the preceding hospital stay. Determinations of related stays will be made either concurrently or upon receipt of claim.

Planned readmissions

Planned readmission, or leave of absence, will be considered a continuation of the prior hospitalization per the Medicare Claims Processing Manual[1], and will result in a single combined DRG payment. Leave of absence occurs when readmission is expected, but the patient does not require hospital level of care in the interim. Such situations may include when surgery is needed but could not be scheduled immediately or when diagnostic tests demonstrate need for further treatment, but treatments cannot begin immediately. This may be identified either during concurrent review or upon receipt of claim.

Unplanned readmissions within 30 days of discharge

Readmissions meeting the scope above will be reviewed for determination of whether the readmission was related to the preceding admission or whether the readmission was preventable.

Factors included in making such a determination include, but are not limited to:

- Inadequate discharge planning[2]
    - *Outpatient follow-up* – It is expected that communication with providers who are to perform follow-up care or treatment occurs in a timely fashion and that discharge planning takes into account follow-up availability.
    - *Rehabilitation planning* – Evaluation of a member's ability to perform adequate self-care and rehabilitation to address any deficits is an expected part of discharge planning.
    - Appropriate medication reconciliation

- Premature discharge
    - *Presence of symptoms prior to discharge* – Symptoms present prior to discharge that worsen or fail to resolve and result in a subsequent admission may be considered a premature discharge.

[1] Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Pub 100-04, Chapter 3 § 40.2.5 and 40.2.6
[2] See Medicare QIO manual, Chapter 4, Section 4240

- *Evaluation of treatment plan efficacy occurred prior to discharge* – failure to evaluate and establish efficacy of planned treatment regimen prior to discharge is considered a premature discharge.

- Chronic disease considerations – These include, but are not limited to, adequate treatment of acute exacerbation, medication reconciliation with respect to chronic disease management (resumption/planned resumption of chronic medications, appropriate adjustment to regimen after acute exacerbation), follow-up care, and appropriate patient education.
- Non-compliance – in general, member non-compliance will not result in denial of a readmission provided documentation supports that physician orders were appropriately communicated, the member or surrogate decision-maker is mentally competent and capable of making decisions, any financial or psychosocial barriers that may interfere with following medical advice have been addressed in good faith, and efforts were made to ensure safe discharge even for members who may leave against medical advice (AMA).

PROCEDURE

Utilization Management Concurrent Review

1) Readmissions within 30 days will be reviewed by the utilization management concurrent review team to identify which of the above categories a readmission falls under.
2) Licensed clinical staff on the concurrent review team will perform a clinical evaluation of whether:
    a. The readmission was related to the prior admission.
    b. The second admission constituted a planned readmission.
    c. The readmission was preventable.
    d. There was an indication the facility was attempting to circumvent the PPS system.
3) For same-day readmissions that are determined to be related and for planned readmissions, a Brand New Day/Central Health Medicare Plan physician will review and confirm that an adverse determination/denial is issued for the readmission, and that the precertification for the prior admission will be reopened and the current stay incorporated
4) For unplanned readmissions that are determined to be preventable or there was an attempt to circumvent the PPS system, a Brand New Day/Central Health Medicare Plan physician will review and confirm that a denial is issued for the readmission.

Claims

1) Claims received for readmissions that occurred within 30 days will be identified by the claims team.
2) Records from both the original admission and the subsequent readmission will be requested if not already available.
3) Licensed clinical staff will review the two admissions to determine which of the readmission categories the readmission falls under (same-day, planned, or unplanned) and whether:
    a) The readmission was related to the prior admission.
    b) The second admission constituted a planned readmission.
    c) The readmission was preventable.
    d) There was an indication the facility was attempting to circumvent the PPS system.

4) Claims Processing:
   a) Same day readmissions:
      i) If the readmission appears related, the readmission will be combined with the prior admission in accordance with the Medicare Claims Processing Manual[3].
      ii) If the readmission is unrelated to the prior admission, the admission must contain the applicable condition code and the code will be added if it is not present[4]
   b) Planned readmissions: Claims will be processed as a single combined DRG payment per the Medicare Claims Processing Manual.[5] If payment for the prior claim has already been processed and the combined DRG payment results in a reimbursement higher than the original reimbursement amount, a second payment will be processed for the difference.
   c) Unplanned readmissions: Claims readmissions that were determined to be preventable or in which there was an attempt to circumvent the PPS system will be denied.

REFERENCES/CITATIONS

1) Social Security Administration. *Payment to Hospitals for Inpatient Hospital Services* §1886. Retrieved Oct 21, 2021 from https://www.ssa.gov/OP_Home/ssact/title18/1886.htm.
2) Centers for Medicare & Medicaid Services. Medicare Quality Improvement Manual, Pub 100-10, Chapter 4 § 4240. *Readmission Review*. Rev 18.
3) Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Pub 100-04, Chapter 3 § 40.2.5 and 40.2.6. *Repeat Admissions* and *Leave of Absence*. Rev 10869.

EXHIBITS/ATTACHMENTS

None

POLICY HISTORY

Initial Approval Date: February 10, 2022
Version 2, Approval Date: January 26, 2023
Version 3, January 1, 2024

AUTHORIZATION

The following signatory certifies that this policy has been approved by the Policy Review Committee or has received other necessary approval pursuant to the policy CMP-013 Policy Development for implementation by the applicable department.

DocuSigned by:
Maureen Murray
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1/30/2023
Policy Owner

[3] Chapter 3 Section 40.2.5
[4] Condition Code B4 per section 40.2.5 if Chapter 3
[5] Chapter 3 Section 40.2.5 and 40.2.6