Payment Policy: 30 Day Readmission

Reference Number: LA.PP.501 **Implications**
Coding
Effective Date: **Revision Log**
Last Review Date:

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

Policy Overview

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.
The "30-day readmission" refers to a patient being readmitted to the hospital for the same or related condition within 30 days of their initial discharge.

Similarly, state Medicaid programs are instituting readmission reduction efforts based on CMS's initiative, but tailored to meet specific state Medicaid programs. Potentially preventable readmissions to hospitals have long been recognized as a measure of quality of care. 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.

Application

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

For a readmission that is determined to have been inappropriate or preventable according to the clinical review guidelines set forth below, LHCC will deny payment or reimbursement.

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

- **If the readmission was medically unnecessary;**
- **If the readmission resulted from a prior premature discharge from the same hospital or a related hospital;**
- **If the readmission resulted from a failure to have proper and adequate discharge planning;**
- **If the readmission resulted from a failure to have proper coordination between the inpatient and outpatient health care teams; and/or**
- **If the readmission was the result of circumvention of the contracted rate by the hospital or a related hospital.**

The following readmissions are excluded from 30-day readmission review:

- **Transfers from out-of-network to in-network facilities;**

- **Transfers of patients to receive care not available at the first facility;**
- **Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy or staged surgical procedures;**
- **Readmissions associated with malignancies, burns, or cystic fibrosis;**
- **Admissions to Skilled Nursing Facilities, Long Term Acute Care facilities, and Inpatient Rehabilitation Facilities (SNF, LTAC, and IRF);**
- **Readmissions where the first admission had a discharge status of "left against medical advice";**
- **Obstetrical readmissions;**
- **Readmissions ≥ 31 days from the data of discharge from the first admission.**
- **Age ≤1**
- **Critical Access Hospitals**

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 30-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 LHCC, 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. 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 an enrollee that qualify as a readmission within 30 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.

Post-Payment Review

LHCC will monitor claim submissions to minimize the need for post-payment adjustments; however, we 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. 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.

Utilization

Not Applicable

Documentation Requirements

Upon request a hospital or related hospital must forward all medical records and supporting documentation of the first and subsequent admission(s) to LHCC 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 30 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 30 days of the date of discharge from the same hospital or a related hospital for the same or related condition. 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: https://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. ***https://www.cms.gov/medicare/quality/value-based-programs/hospital-readmissions***

Coding Implications

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Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Convert corporate to local policy	12/2024		

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. 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. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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.

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