REIMBURSEMENT POLICY	Inpatient Hospital Readmissions
Effective Date: 8/1/2022	UM54
 8/1/2022	Committee Approved Date: 3/2022; 7/2022
Medical Officer Date	

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

The following reimbursement policy applies to Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

- DRG
- modified DRG
- percent of billed charges/per diem (applies only to unplanned readmissions)

APPLIES TO:

All lines of business except Medicaid/OHP

POLICY STATEMENT

This policy does not apply to the following:

- Readmissions for a condition unrelated to the initial admission.
- Planned repetitive inpatient treatment, such as: cancer chemotherapy, transfusions for chronic anemia, or dialysis.
- Transfer from one inpatient hospital to another.
- LTAC, SNF, or inpatient rehabilitation stays.
- Patient non-compliance (see criterion IV. below) or patient discharge against medical advice (AMA).

I. Inpatient readmission and planned inpatient readmissions are reviewed when **all** of the following (A.-C.) criteria are met:

A. The second inpatient admission occurs less than 31 calendar days***** from the date of the initial inpatient discharge (neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred); **and**
B. Both inpatient admissions occurred at the *same,* acute, general, short-term hospital or *another* acute, general, short-term hospital that has the same Tax ID number, is under common ownership as the initial facility, and operates under the

same facility contract; **and**

C. The readmission is for the same or closely related condition treated during the initial admission or for a complication arising from the initial admission.

*****Readmissions beyond 31 calendar days may still be subject to review.

When criterion I. above is met, the following criteria addressing unplanned (III.) or planned (IV.) readmission should be utilized for review, as applicable.

Unplanned Inpatient Readmission

II. The second inpatient admission is **not reimbursable** when the readmission is related to **any** of the following (A.-D.):

A. The readmission was not medically necessary; **or**
B. A procedural infection or complication related to the initial inpatient admission; **or**
C. Indications of a failed procedural intervention; **or**
D. Premature discharge from the initial admission or a readmission that could have been reasonably prevented. To determine whether a readmission was preventable or due to a premature discharge, all of the following will be considered:

1. Inadequate discharge planning, outpatient follow-up care, and/or treatment (e.g., failure to restart medications at discharge that were present upon admission)
2. Failure to address rehabilitation needs
3. Failed discharge to another facility (e.g., Skilled Nursing Facility [SNF])
4. Emerging symptoms including, but not limited to, coexisting chronic disease(s) that were present during the initial admission and subsequently worsened
5. Discharge prior to establishing the efficacy of a new treatment regimen established during the initial inpatient admission.

III. When criterion II. above is not met, the two admissions are paid separately.

Planned Inpatient Readmission/Leave of Absence

IV. When **at least one** of the following (A. or B.) criteria is met related to a planned inpatient readmission, the initial and subsequent admissions will be combined into a single DRG payment, if applicable.

A. The medical records from the initial inpatient admission indicate that readmission is expected for the same episode of illness and the member does not require a hospital level of care during the interim readmission period. This includes, but is not limited to:
   1. Situations where surgery could not be scheduled immediately; **or**
   2. A specific surgical team was not available; **or**

3. Bilateral surgery was planned; **or**
4. Further treatment is indicated following diagnostic tests but cannot begin immediately; **or**

B. The medical records from the initial inpatient admission indicates readmission for surgical intervention is planned if non-operative therapy fails.

Notes:

- Criterion III. above applies even if the date of readmission is different from the date that was initially planned.
- Criterion III. does not apply to facilities reimbursed at a percent of billed charges or per diem payment methodology
- The final combined payment will be based on the DRG with the highest relative weight.

V. When criterion IV. above is not met, the two admissions are paid separately.

Patient Non-Compliance

VI. Inpatient readmission review is not applicable in instances of patient non-compliance when **all** of the following (A.-D.) criteria are clearly documented in the medical record:

A. Discharge instructions were adequately reviewed and discussed with the patient and/or patient representative; **and**
B. The patient and/or patient representative was competent and capable of following the discharge instructions; **and**
C. The patient and/or patient representative made an informed decision not to follow the discharge instructions; **and**
D. There were no barriers to complying with the discharge instructions or if there are barriers, the medical records document efforts by the facility to alleviate these barriers (e.g., social services, community resources, etc).

BILLING & CODING GUIDELINES

If the combined DRG exceeds the total amount of the two separate inpatient stays, then they will not be combined.

Planned Readmissions

When the patient is ultimately discharged from the subsequent admission, the facility should submit one bill for covered days and days of leave. Facilities must follow correct billing and coding rules and indicate inpatient stay days versus leave of absence days. If a planned readmission is identified, the initial and subsequent admissions will be combined into a single DRG payment.

DEFINITIONS

Unplanned Readmission

The following definition was obtained from the Centers for Medicare & Medicaid (CMS) Quality Improvement Organization Manual, Chapter 4—Case Review, §4240 – Readmission Review:

> "Readmission review involves 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. Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred."[1]

Planned Readmission/Leave of Absence

The following definition was obtained from the Centers for Medicare & Medicaid (CMS) Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.5—Repeat Admissions:

> "A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence. Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period."[2]

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

As of 2/1/2022, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses inpatient hospital readmissions:

- Quality Improvement Organization Manual, Chapter 4—Case Review, §4240 – Readmission Review[1]
- Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.5—Repeat Admissions[2]
- Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.6—Leave of Absence[3]

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding inpatient hospital readmissions.

INSTRUCTIONS FOR USE

Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do no not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). Quality Improvement Organization Manual, Chapter 4—Case Review, §4240 – Readmission Review. 2014; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf. Accessed 5/19/2021.
2. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.5—Repeat Admissions. 2021; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf. Accessed 5/19/2021.
3. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.6—Leave of Absence. 2021; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf. Accessed 5/19/2021.
4. Social Security Administration (SSA). Payment to Hospitals for Inpatient Hospital Services, Title 18, § 1886. https://www.ssa.gov/OP_Home/ssact/title18/1886.htm. Accessed 5/19/2021.
5. Centers for Medicare & Medicaid Services (CMS). Hospital Readmission Reduction Program (HRRP). 2020; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program. Accessed 5/19/2021.
6. UpToDate. Hospital Discharge and Readmission. 2021; https://www.uptodate.com/contents/hospital-discharge-and-readmission. Accessed 5/19/2021.