Medical Policy: Hospital Readmission (Commercial & Medicare)

POLICY NUMBER	ANNUAL APPROVAL DATE	APPROVED BY
M20180002	10/01/2018	MPC (Medical Policy Committee)

Overview

This administrative policy is applicable to facilities reimbursed based on a contracted Diagnosis-Related Group (DRG) or case rate methodology. 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 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.

This policy applies to in-network facilities for readmissions that have occurred within thirty (30) calendar days of a previous discharge within the same hospital or hospital system. This policy applies only to admissions which are reimbursed using DRG or case rate methodology. ConnectiCare shall conduct a medical records review to determine if the subsequent hospital admission is related to the previous hospital admission.

Preauthorization

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

Policy Statement

ConnectiCare shall conduct hospital readmission review to determine if the readmission was considered clinically related to the previous admission. Readmissions determined to be related to the previous admission will not be reimbursed.

Excluded from readmission review are:

- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, or other similar repetitive treatments or scheduled elective surgery
- Planned readmissions due to malignancies (limited to those who are in an active chemotherapy regimen), burns, or cystic fibrosis
- Planned readmissions due to bone marrow transplants
- Obstetrical admissions
- Readmissions with a documented discharge status of left against medical advice
- Readmissions greater than 30 calendar days from the last discharge
- Out-of-network facilities
- Transfer of patients to receive care not available at the first facility.
- Readmissions from skilled nursing and rehabilitation facilities
- Admission to a psychiatric / substance abuse unit or facility
- In-network facilities that are not reimbursed based on a contracted DRG or case rate methodology (e.g. per diem)

ConnectiCare reserves the right to perform retrospective medical records reviews and retract payment according to the guidelines in this policy. Standard administrative provider appeal rights/process is applicable in cases in which ConnectiCare determines the readmission is related to the previous admission and the provider is in disagreement with the determination of non-payment of the readmission by ConnectiCare.

Criteria

Medical records shall be reviewed to determine if the readmission was clinically related (same, similar, related diagnosis or avoidable complication) to the previous admission based on one of the following criteria:

- A medical readmission for a continuation or recurrence for the previous admission or closely related condition (e.g., readmission for diabetes following an initial admission for diabetes)
- A medical complication related to an acute medical complication related to care during the previous admission, (e.g., patient discharged with urinary catheter readmitted for treatment of a urinary tract infection)
- An unplanned readmission for surgical procedure to address a continuation or a recurrence of a problem causing the previous admission (e.g., readmitted for appendectomy following a previous admission for abdominal pain and fever)
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the previous admission (e.g., readmission for drainage of a post-operative wound abscess following an admission for a bowel resection)
- An unplanned readmission related to a suspected complication that was not treated prior to discharge. (e.g., cultures were done for suspected urinary tract infection but results not checked prior to discharge, member readmitted with urinary tract infection)

Note: Medical record review is to determine if the admission is related and not an assessment of medical necessity or appropriateness of the setting.

This policy will not supersede any individual facility contract provisions or state or federal guidelines.

Coverage

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

Coding

Not applicable

Effective Date

10/01/2018

References

1. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 12/10/10. Available at: http://www.cms.gov/manuals/downloads/clm104c03.pdf. Accessed September 29, 2011.

2. Centers for Medicare & Medicaid Services (CMS). Medicare Learning Network. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. 12/17/10. Available at: http://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf. Accessed September 29, 2011.

Revision history

DATE	REVISION
7/2018	• Reformatted and reorganized policy, transferred content to new template with new Medical Policy Number • Required review of readmission changed to 30 calendar days • Review expanded to include same system hospitals
7/2017	• Required review of readmission changed to 14 calendar days
3/2012	• Original policy. Review of readmission required for 7 calendar days or less