Facility REIMBURSEMENT POLICY

POLICY TITLE	**Avoidable Inpatient Readmission**
POLICY NUMBER	**FR-02.001**

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DESCRIPTION/BACKGROUND DEFINITIONS POLICY
EXCLUSIONS VARIATIONS-Yes REFERENCES

I. DESCRIPTION/BACKGROUND

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The intent of this policy is to enhance quality of care outcomes for our members and to hold the member and payor/employer financially harmless for avoidable and/or related Readmissions. Peer reviewed literature demonstrates Readmissions may be avoided if certain standards of care are delivered prior to, during, and after the patient's discharge.

This policy documents Capital Blue Cross' reimbursement methodology for Acute Inpatient Hospital Readmissions that occur within five (5) calendar days of discharge from the same Inpatient Acute Hospital as a previous admission.

II. DEFINITIONS

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Readmission – admission to a hospital after a previous hospital stay. For the purposes of this policy, it includes only Readmissions to the same Inpatient Acute Hospital (defined as one having the same National Provider Identifier) as the previous Inpatient Acute Hospital stay.

Inpatient Acute Hospital – setting where patients receive short-term medical treatment for illnesses, injury, or surgery. For purposes of this policy, it does not include distinct units within a hospital such as psychiatric/substance abuse, rehabilitation, or subacute.

Leave of Absence – for the purpose of this policy, this is a situation where a readmission is expected at the time of discharge and the patient does not require hospital level of care in the interim period.

III. POLICY

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Readmission to the same Inpatient Acute Hospital within five (5) days of discharge from the previous Inpatient Acute Hospital stay is not eligible for separate reimbursement.

If, within five (5) days of discharge from an Inpatient Acute Hospital stay, a member is readmitted, for any reason, to the same Inpatient Acute Hospital, all inpatient facility charges for the Readmission will be administratively denied. This denial will occur upon claims submission for Readmission claims with an admission date on or after January 1, 2018. This reimbursement policy does not preclude the requirements under Capital Blue Cross' Utilization Management program. The Inpatient Acute Hospital may not bill the member for the denied services and must return any member payments (e.g. co-payments) related to the denied services to the member. Each Readmission to the Inpatient Acute Hospital, whether paid or denied, will be evaluated against the five (5) day Readmission criteria if a subsequent Inpatient Acute Hospital stay occurs.

Upon receipt of notification that the Readmission is denied, the provider may submit an administrative appeal with all required documentation included, as set forth in the provider manual. The administrative appeal must include the following and substantiate that the Readmission was not related and/or avoidable or preventable:

- Appeal letter that outlines sufficient evidence demonstrating that no additional interventions could have prevented the readmission.
- Medical Records from both admissions (i.e. initial admission and readmission record) which may include:
    - Admission and discharge summaries (from the initial admission and Readmission)
    - Emergency room records (if applicable)
    - Physician's orders
    - Nurse's notes
    - Physician's daily progress notes
    - Laboratory and diagnostic testing/results

  - Case management notes (including member instructions, scheduled follow up appointments, etc.)
- Discharge planning documentation, if not included in medical record.
- Post-discharge follow-up
- Transitions of care.

If the administrative appeal letter and supporting documentation substantiates the Readmission could not be prevented or avoided, the Readmission denial will be overturned and the claim will be processed following all other guidelines, procedures, and benefit determinations. It is the Inpatient Acute Facility's responsibility to substantiate that the Readmission was not related and/or avoidable or preventable and that sufficient evidence supports this attestation. No more than one (1) administrative appeal will be granted for each denial. Failure to submit both admission records (i.e. initial admission and readmission) will result in an immediate uphold of the denial.

Note: A scheduled planned admission (e.g. scheduled chemotherapy, elective surgical admissions) will not be considered avoidable under this policy. The scheduled planned admission must be clearly identifiable in the patient medical record, and the discharge summary must document and support the planned readmission. Proof of the scheduled planned admission must be provided via a provider appeal.

IV. Leave of Absence

A patient may be placed on a Leave of Absence (LOA) when readmission is expected, and the patient does not require a hospital level of care during the interim period. Examples may include, but are not limited to:

- Situations where surgery could not be scheduled immediately
- Specific surgical team was not available
- Bilateral surgery was planned
- Further treatment is indicated following diagnostic tests but cannot begin immediately.

Placing a patient on LOA would not generate two (2) payments. Since LOA is not considered as two (2) separate admissions, the provider should only submit one (1) bill and only one (1) Diagnosis Related Group (DRG) payment would be made.

Note: The patient medical record should contain documentation that supports the leave of absence and a continued treatment plan should be clearly identifiable in the patient medical record. The patient discharge summary must document the planned readmission.

In addition to the criteria and conditions contained in this policy, the service, procedure or item must be deemed medically necessary, must be a covered member benefit and is subject to member cost sharing provisions.

V. EXCLUSIONS

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The following Readmissions will not be considered avoidable and/or in scope, thus, will not be denied under this policy:

- Reason for initial discharge is against medical advice (Discharge Status Code 07)
- Readmissions that occur more than 5 days after the initial inpatient discharge date
- Readmissions to facilities other than Inpatient Acute Hospitals
- Readmissions for patients 0 – 1 year of age.

VI. VARIATIONS

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This policy is applicable to all programs and products administered by Capital Blue Cross unless otherwise indicated below.

- Medicare Supplement Plans
- FEP
- BlueCard Home

VII. BILLING GUIDANCE

Capital Blue Cross will follow guidance set forth in the *Medicare Claims Processing Manual Chapter 3 Inpatient Hospital Billing Section 40.2.5 Repeat Admissions* for when a repeat admission is expected and the patient does not require a hospital level of care during the interim period. Institutional providers must not use the leave of absence billing procedure when the second admission is unexpected. In addition, Capital Blue Cross may request medical records from Providers and be subject to review for compliance with applicable billing practice and guidelines as set forth in the *Medicare Claims Processing Manual.* Providers should be aware the guidelines

in Section 40.2.5 further states that services rendered by other entities during a combined stay must be paid by the acute care hospital. Capital Blue Cross may request documentation of a hospital's leave of absence policy.

VIII. REFERENCES

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