Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Hospital Readmissions

Policy Number: RM030
Last Review: 11/01/2024

GUIDELINES:

- **This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.**
- **Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.**
- **This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.**

SCOPE:

_ Professional
X Facility

DESCRIPTION:

Hospital readmissions are considered an episode in which a patient has been discharged from an inpatient stay and then has a subsequent hospital stay within a specified time frame at or within the same acute care hospital or hospital system.

The purpose of this policy is to promote safe hospital discharges with improve transitional care, ultimately improving patient outcomes. There are readmissions that cannot and should not be prevented. However, studies demonstrate that hospitals engaging in various activities such as clarifying patient discharge instructions, coordinating with providers, and reducing medical complications during patients' initial hospital stays, do lower the rate of readmissions. Preventable readmission (PR) is an inpatient admission that follows a prior discharge from a physical/behavioral health hospitalization within 30 days that is deemed clinically related and clinically preventable to the initial 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, medication reconciliation and/or prescriptions related to treatment regimen provided at discharge) or from a lack of post admission follow-up (e.g., lack of follow-up arrangements with a primary care physician, transportation to the pharmacy or medication home delivery not scheduled) rather than from unrelated events that occurred after the prior admission (e.g., broken leg due to trauma) within a specified readmission time interval.

This policy addresses physical and behavioral health readmissions to an acute, general, short-term and Institute for Mental Disease (IMD) hospitalizations occurring within 30 days of the date of discharge from the same acute, general, short-term and IMD hospital for the same, similar, or related diagnosis.

Readmission reviews are conducted to determine if claims for the initial inpatient stay, and subsequent readmissions were clinically related and if the readmission had a reasonable expectation that it could have been avoided or prevented. Readmission reviews will be incorporated into the payment processes to ensure the best possible quality of care outcomes for members. A readmission occurring within thirty (30) days of discharge from the initial inpatient stay will be subject to review.

Readmission to the same hospital or hospital system for the same, similar, or related condition, is considered a continuation of initial treatment. Payment for a subsequent readmission to the same acute care hospital or hospital system where the initial inpatient stay occurred may be denied if the readmission is determined to be

clinically related, avoidable, or preventable, to the initial inpatient stay.

Discharge expectations include the following: for a reasonable expectation avoiding a readmission, but not limited to;

- All medical treatment has been rendered.
- Medication route/frequency and purpose is clearly communicated for all discharge medications
- Completing adequate discharge planning in accordance with accepted standards for acute care discharge planning. Discharge to another facility: Transfers to a Skilled Nursing Facility (SNF), Long Term Acute Care (LTAC), Acute Inpatient Physical Rehabilitation (IPR), or a similar facility.
- Outpatient follow-up appointments or treatments scheduled.
    - Discharge planning must consider the availability and criticality of outpatient follow-up visits and treatment.
    - Communication and/or scheduled appointments with practitioners who will provide follow-up care is expected.
    - Behavioral Health outpatient follow up appointments scheduled within 7 calendar days of discharge.
    - Medical outpatients follow up appointments scheduled within 7-14 calendar days of discharge.
    - If unable to schedule within time frame listed, document variance in the medical record.
- Discharge to an appropriate destination (e.g., home instead of a SNF, etc.).
- Addressing rehabilitation needs: Significant decline in function and inability to perform Activities of Daily Living (ADL) is common following hospitalization of the elderly. Failure to properly address rehabilitation needs related to an inability to self-care is an avoidable cause of readmission.
- Addressing social determinant of health care needs that may affect safe discharge (i.e., coordination of transportation to and from appointments/pharmacy for medication).

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

This policy applies to acute care hospitals and hospital systems contracted under DRG or Case Rate methodology. When the readmission occurs at a different acute care hospital within the same hospital system, this policy will apply when the initial admission was at an acute care hospital contracted under DRG or Case Rate methodology.

~~**Effective 01/01/2025 Observation Stays will be included in the Readmission Reviews**~~ **This review criteria has been removed**.

To align with CMS and industry guidelines, readmissions within thirty (30 days) to the same facility will be clinically reviewed by a Paramount Medical/Clinical Director. 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 Paramount, hospitals are required to forward (and, if applicable, arrange for a related hospital to forward) all medical records and supporting documentation of the initial inpatient admission and the subsequent 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 and the quality of the discharge plan.
- If the readmission is determined at the time of documentation review to be for the same, similar, or related diagnosis and/or a preventable readmission due to complications and/or other circumstances arising because of an early discharge and/or other treatment errors, the inpatient hospital stays will be denied.
- Same day readmissions for a related condition will deny as two separate payments. A single claim for both admissions must be submitted to receive reimbursement for same-day readmission. For a same day readmission to qualify for separate reimbursement, the medical record must support that conditions are

clinically unrelated.

Criteria and exclusions listed below

There is a formal appeal process for submission of additional clinical documentation to reconsider the determination. Applicable timely filing limits apply.

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Payment for the subsequent readmission to the same acute care hospital or hospital system where the initial inpatient admission occurred may be denied if the readmission is determined to be clinically related to the initial inpatient admission, and avoidable or preventable.

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. Clinical criteria and/or licensed clinical medical review will be utilized to determine if the subsequent admission claims readmission will be denied for payment, when all the following criteria are met:

- The readmission was clinically related to the initial admission if at least one of the following is met:
    - A medical readmission for a continuing or recurring reason for the initial admission or closely related condition.
    - A medical readmission for an acute decompensation of a chronic problem that was not related to the initial admission but was reasonably related to care either during or immediately after the initial admission.
    - A medical readmission for an acute medical complication credibly related to care during the initial admission.
    - An unplanned readmission for surgical procedure to address a continuation or a recurrence of the problem causing the initial admission.
    - An unplanned readmission for a surgical procedure to address a complication resulting from care during the initial admission.

- The readmission was potentially avoidable or preventable as identified by at least one of the following:
    - Premature discharge of patient that results in subsequent readmission of patient to a hospital due to one of the following reasons:
        - Patient is discharged even though he/she should have remained in the hospital for further testing or treatment.
            - Emerging symptoms: Symptoms that had onset or were present during a previous admission and subsequently worsened leading to readmission are a possible indicator of a premature discharge.
            - Discharge prior to establishing the safety or efficacy of a new treatment regimen is also considered a premature discharge.
        - Patient's condition was not medically stable at the time of discharge and therefore it is medically unsound to discharge or transfer the patient.
            - Clinical instability at the time of discharge or failure to address signs and symptoms during an admission also provides evidence of premature discharge and a preventable readmission.
        - There was inadequate discharge planning in place for a reasonable expectation that a readmission could be avoided as identified by at least one of the following:
            - Discharge prior to completing adequate discharge planning in accordance with accepted standards for acute care discharge planning.
            - Failed discharge to another facility: Failed transfers to a Skilled Nursing Facility (SNF), Long Term Acute Care (LTAC), Acute Inpatient Physical Rehabilitation

(IPR), or a similar facility can be an indicator of premature discharge. Discharges with expected readmissions are treated as leave of absences. Errors made at the receiving facility unrelated to the orders it received upon transfer (falls, treatment delivery failure) will not result in a denial of payment for the readmission. O

- Inadequate outpatient follow-up or treatment: Discharge planning must consider the availability and criticality of outpatient follow-up visits and treatment. Communication with practitioners who will provide follow-up care is expected.
- Discharge to an inappropriate destination (e.g., home instead of a SNF). o Failure to address rehabilitation needs: Significant decline in function and inability to perform Activities of Daily Living (ADL) is common following hospitalization of the elderly.
- Failure to properly address rehabilitation needs related to an inability to self-care is an avoidable cause of readmission.

- Readmission of patient to a hospital for care that could have been provided during the initial admission as identified by:
    - Patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the initial admission.
        - NOTE: This does not include circumstances in which it is not medically appropriate to provide the care during the initial admission.

- Additional factors considered regarding whether a subsequent admission was preventable include:
    - Chronic disease: Chronic diseases vary in severity, and entry into the terminal phase of an illness can be gradual.
        - Adequate follow-up care and outpatient management according to accepted practice guidelines and treatment protocol is not present.
        - Interruption and failure to resume a chronic medication or other medication errors are present.
    - Hospice: Decisions to enter hospice are made by patients and their families. Physicians are encouraged to counsel terminally ill patients regarding treatment options, including hospice.
        - Until a patient enters hospice, is documented as Do Not Resuscitate (DNR), or refuses further treatment, treatment is expected to follow established guidelines.

- Hospitals and health systems will not be held accountable for patient noncompliance if all the following
- conditions are met:
    - There is adequate documentation that physician orders have been appropriately and adequately communicated to the patient or their designated caregiver.
    - There is adequate documentation that the patient or designated caregiver is mentally competent and capable of following the instructions and made an informed decision not to follow them.
    - There were no financial or other barriers to following instructions.
        - NOTE: The medical records should document reasonable efforts by the facility to address placement and access-to-treatment difficulties due to financial constraints or social issues, including consultation with social services, use of community resources, and frank discussions of risks and alternatives.
    - The noncompliance is clearly documented in the medical record of the readmission. For example, documentation for a discharge to the home when the discharge is felt to be unsafe should include signature by the patient/caregiver as leaving Against Medical Advice (AMA).
        - NOTE: An unsafe discharge is not mitigated by a comment stating, ‘patient preference.’

Paramount considers a readmission to the same hospital or hospital system for the same, similar, or related condition on the same date of service to be a continuation of initial treatment.

Paramount will deny two separate payments for same date readmission for a related condition. A single claim for both admissions must be submitted to receive reimbursement for same-day readmission. For a same-day

readmission to qualify for separate reimbursement, the medical record must support that the conditions are clinically unrelated. Paramount defines same day as services rendered within a 24-hour period (from time of discharge to time of readmission) for participating providers.

For calculating the 30- day readmission window, neither the day of discharge nor the day of admission is counted.

Excluded from Readmission policy payment rules

The following exclusions are provided as a guide for payment determination; final decision at discretion of qualified clinical staff through medical review process.

- Readmissions for unrelated condition
- Transfer from one inpatient hospital to another
- Not applicable to planned readmissions
    - If the readmission is part of planned repetitive treatments or staged treatments, such as chemotherapy or staged surgical procedures
    - Note: If a hospital transfer is back to the hospital that did the initial treatment/surgery, it is not excluded
- Not applicable to conditions related to cancer, transplants, medical rehabilitation care, HIV infection, Neonatal/Newborn, Obstetrical care/deliveries, Behavioral Health cases, and poisoning
- Not applicable to readmissions to a different facility
- Not applicable to critical access facilities (CAH) and prospective payment system (PPS)
- Patient non-compliance or discharged against medical advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record
    - Documentation that physician orders were communicated to the patient or caregiver
    - Documentation that the patient or caregiver is medically competent, capable of following instructions, and made an informed decision not to follow them
    - No financial or other barriers to following instructions
    - Non-compliance clearly documented in the medical record for readmission
- Transfers from out-of-network to in-network facilities
- Transfers of patients to receive care not available at the first facility or unit
- Readmission ≥ 31 days from the date of discharge from the first admission

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."

Examples of a planned readmission/leave of absence, include, but are not limited to:

- Situations where surgery could not be scheduled immediately; or
- A specific surgical team was not available; or
- Bilateral surgery was planned; or
- Further treatment is indicated following diagnostic tests but cannot begin immediately; or
- Readmission for surgical intervention is planned if non-operative therapy fails.

A hospital may place a patient 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. Placing a patient on a LOA will not result in two separate payments.

- A single claim for inpatient stays including LOA is submitted once the patient is discharged following return from LOA; fails to return from LOA for 60 days (including the day the LOA began); or is readmitted to another institution.
- Medical record documentation will be required to support the rationale for expected readmission and why the member does not require a hospital level of care during the interim period.

- Claims for inpatient stays (including LOA) must:
  - have only one corresponding authorization record from Paramount;
  - include only approved dates of service;
  - omit non-covered charges for LOA days (i.e., holding a bed); and
  - include leave of absence dates with occurrence span code 74 to report the dates the leave began and ended
- Paramount and the Covered Person may not be billed for LOA days.

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.

When appealing a readmission claim denial hospitals are required to submit all supporting documentation for review related to both the initial admission and the subsequent readmission. This includes, but is not limited to, history and physical, progress notes, discharge summary, and all necessary information that supports that the subsequent readmission was not clinically related to the initial admission and not avoidable or preventable.

Prior authorization of the initial or subsequent inpatient stay is not a guarantee of payment and are subject to administrative review as well as review for medical necessity.

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 08/01/2024

Date	Explanation & Changes
08/01/2024	• Reimbursement/Billing policy created
10/01/2024	• Effective 01/01/2025 Observation Stays will be included in the Readmission process reviews • Review criteria clarified
11/01/2024	• Removed the 01/01/2025 Observation Stay criteria. Observation Stays will not be included in the Readmission process reviews. • The following has been removed/voided: ~~**Effective 01/01/2025 Observation Stays will be included in the Readmission Reviews**~~

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to
https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

NCDs https://www.cms.gov/medicare-coverage-database/searchresults.aspx?keyword=&keywordType=starts&areaId=s29&docType=NCD&contractOption=all

LCDs https://www.cms.gov/medicare-coverage-database/searchresults.aspx?keyword=&keywordType=starts&areaId=s29&docType=F,P&contractOption=all

National Quality Forum (NQF). (April 2010). Safe Practices for Better Healthcare - 2010 Update. Available at: https://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%93_2010_Update.aspx

National Transitions of Care Coalition. (September 2010). Improving Transitions of Care: Findings and Considerations of the "Vision of the National Transitions of Care Coalition". Available at: http://www.ntocc.org/portals/0/pdf/resources/ntoccissuebriefs.pdf.

National Committee for Quality Assurance (NCQA). HEDIS Measures and Technical Resources. HEDIS MY 2024 Measure Descriptions (Updated December 4, 2023). Available at https://www.ncqa.org/wpcontent/uploads/HEDIS-MY-2024-Measure-Description.pdf.

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., Lansdale, PA: Author. Health Technology Assessments. https://www.hayesinc.com/

Industry Standard Review

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.

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.

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