All-cause Readmission Payment Policy Review for Circumvention of Prospective Payment System

Medical Policy

Utilization Management

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I. PURPOSE:

This policy provides guidance regarding identification and reimbursement of a readmission and is not intended to address every situation. This policy is applicable to facilities that bill under diagnosis-related groups (DRG). In instances that are not addressed by this policy, or by another policy or contract, MyAdvocate Medicare Advantage retains the right to use discretion in interpreting this policy and applying it (or not applying it) to the reimbursement of services provided. The provider is responsible for submitting complete, accurate, and timely claims for payment consideration.

II. 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 post-surgical wound infection) or from lack of post admission follow-up (e.g., lack of follow-up arrangements with a primary care provider) rather than from unrelated events that occurred after the prior admission (e.g., broken pelvis due to trauma) within a specified readmission time interval.

Initial admission – An inpatient admission at a hospital, which the date of discharge for the admission is used to determine whether a subsequent admission at that same facility would be covered.

Readmission – An admission to a hospital occurring within 30 days of the date of discharge with the same or related condition from the same facility, or another facility that:

- Operates under the same Facility Agreement; or
- Has the same tax identification number as facility; or is
- Under common ownership as facility.

The MyAdvocate Medicare Advantage readmission payment policy will not be more restrictive than Federal regulations.

III. MEDICARE ADVANTAGE PLANS:

MyAdvocate Medicare Advantage follows Medicare guidelines.

Medicare reviews unplanned readmissions. The exclusions for this measure include patients:

- Admitted to Prospective Payment System-exempt cancer hospitals
- Without at least 30 days post-discharge enrollment in Medicare FFS – would not apply for Medicare Advantage
- Discharged against medical advice
- Admitted for primary psychiatric diagnoses
- Admitted for rehabilitation
- Admitted for medical treatment of cancer

Quality Improvement Organization Manual Chapter 4 (Section 4255)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf

CMS 2015 Measure Information about the 30-Day All-Cause Hospital Readmission Measure, Calculated for the Value-Based Payment Modifier Program
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf

IV. COMMENTS:

A denied authorization for the readmission will result in claim denials for the facility. These amounts cannot be billed to the member.

V. REFERENCES:

Hospital Readmissions Reduction Program (HRRP) | CMS