buckeye health plan

PAYMENT POLICY

30-DAY READMISSION PAYMENT POLICY

POLICY NUMBER:	OH.PP.501	ORIGINAL EFFECTIVE DATE:	6/1/2016
PRODUCT TYPE(S):	ALL	REVISION EFFECTIVE DATE:	6/21/2016

IMPORTANT REMINDER

This policy is current at the time of publication. Centene Corporation retains the right to change or amend this policy at any time.

While this policy provides guidance regarding reimbursement, it is not intended to address every reimbursement situation. In instances that are not specifically addressed by this policy, or addressed by another policy or contract, Centene Corporation retains the right to use reasonable discretion in interpreting this policy and applying it (or not applying it) to the reimbursement of services provided to all or certain members. The provider is responsible for the accuracy of all claims.

This policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this policy or any information contained herein are strictly prohibited.

This policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2014, American Medical Association. All rights reserved. CPT® codes and CPT® descriptions are from current 2015 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

You agree to be bound by the terms and conditions expressed herein, in addition to the Site Use Agreement for Health Plans associated with Centene Corporation.

Policy Overview

As a part of the Affordable Care Act (ACA), Congress mandated that CMS reduce hospital readmissions through certain payment incentives. Section 3025 of the ACA added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

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The Ohio Department of Medicaid (ODM) references hospital readmissions in Ohio Administrative Code 5160-2-07.13(2).

The purpose of this policy is to promote more clinically effective, cost efficient and improved health care through appropriate and safe hospital discharge of patients.

Application

This policy applies to individual hospitals.

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

Initial Admission – an inpatient admission at an acute, general, or short-term hospital.. and for which the date of discharge for such admission is used to determine whether a subsequent admission at that same hospital or a occurs within 30 days.

Potentially Preventable Readmission (PPR) – A potentially preventable readmission is a readmission (re-hospitalization within a specified time interval) that is clinically related (as defined above) and may have been prevented had adequate care been provided during the initial hospital stay.

Readmission – an admission to a hospital occurring within 30 days of the date of discharge from the same hospital. 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. For the purpose of calculating the 30-day readmission window, neither the day of discharge nor the day of admission is counted.

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Policy Description

This policy is based, in part, on the methodology set forth in the Quality Improvement Organization Manual, CMS Publication 100-10, Chapter 4, Section 4240, for determining an inappropriate readmission.

> *Analyze the cases specifically to determine whether the patient was prematurely discharged from the first confinement, thus causing readmission. Perform an analysis of the stay at the first hospital to determine the cause(s) and extent of any problem(s) (e.g., incomplete or substandard treatment). Consider the information available to the attending physician who discharged the patient from the first confinement. Do not base a determination of a premature discharge on information that the physician or provider could not have known or events that could not have been anticipated at the time of discharge.*

A readmission will be considered to be inappropriate or preventable under the following circumstances:

- If the readmission was medically unnecessary;
- If the readmission resulted from a prior premature discharge from the same hospital;
- If the readmission resulted from a failure to have proper and adequate discharge planning;
- If the readmission resulted from a failure to have proper coordination between the inpatient and outpatient health care teams; and/or
- If the readmission was the result of circumvention of the contracted rate by the hospital

The following readmissions are excluded from 30-day readmission review:

- Transfers from out-of-network to in-network facilities;
- Transfers of patients to receive care not available at the first facility;
- Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy or staged surgical procedures;
- Readmissions associated with malignancies, burns, or cystic fibrosis;
- Admissions to Skilled Nursing Facilities, Long Term Acute Care facilities, and Inpatient Rehabilitation Facilities (SNF, LTAC, and IRF);
- Readmissions where the first admission had a discharge status of "left against medical advice";

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- Obstetrical readmissions;
- Readmissions ≥ 31 days from the data of discharge from the first admission.
- Readmissions for patients under 12 months old at time of service.

Upon request from Buckeye, a hospital must forward all medical records and supporting documentation of the initial admission and readmission to Buckeye. 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.

Post-Payment Review

Buckeye will endeavor to monitor claim submissions to minimize the need for post-payment adjustments; however, Buckeye may review payments retrospectively.

1. If a claim is determined to be related to a previous admission (and thus could possibly be determined to be an inappropriate, unnecessary, or preventable readmission), the hospital must forward medical records for all related admissions to Buckeye, upon its request. All clinical information from the admissions will be reviewed by a qualified clinician to determine if any readmission was inappropriate, unnecessary, or preventable based on the above guidelines.
2. If a readmission is determined to be inappropriate, unnecessary, or preventable, written notification of such determination will be sent to the hospital. Standard appeal timelines will apply.

3. After appeal timelines are expired or appeals have been exhausted, Buckeye will forward the claim to the Claims Management Team for adjustment to collapse admissions into a single payment.

Additional Information

Not applicable

Related Documents or Resources

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CMS Publication 100-10 (Quality Improvement Organization Manual), Chapter 4, Section 4240 (Readmission Review), available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/qio110c04.pdf

References

1. 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.
2. 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.
3. 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
4. Centers for Medicare and Medicaid Readmission Reduction Program information available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
5. Gerard F. Anderson and Earl P. Steinberg, "Hospital Readmissions in the Medicare Population," New England Journal of Medicine, 311:21 (Nov. 22, 1984), pp. 1349-1353
6. Ohio Administrative Code available at http://codes.ohio.gov/oac/

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REVISION HISTORY	