Readmissions

Reimbursement Policy ID: RPC.0003.5400

Recent review date: 08/2024

Next review date: 05/2025

AmeriHealth Caritas District of Columbia reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas District of Columbia may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

AmeriHealth Caritas District of Columbia will align with the Department of Health Care Finance guidelines to evaluate hospital readmissions within 30 days.

Exceptions

Never events are not reimbursable. See Health Care-Acquired Conditions policy RPC.0044.5400

Reimbursement Guidelines

Readmission reviews
AmeriHealth Caritas District of Columbia will evaluate inpatient claims with admission dates that are within 30 days following a discharge from the same or similar hospital to determine whether the subsequent admission was related to the initial admission.

Hospital readmissions within 30 days of discharge from a facility, that are due to complications, preventable clinically related conditions, or other circumstances that are related to the earlier admission will be subject to recoupment.

Preventable clinically related admissions

Readmissions that are preventable and clinically related to the first admission include but not limited to:

- If the readmission is due to inadequate coordination of care between facility, providers, and caregivers.
- If the readmission was the result of an acute complication related to care from the initial admission
- If the readmission is due to premature, inadequate, or incomplete discharge planning.
- Same diagnosis or diagnoses that fall into the same grouping.
- The same or closely related procedure as the prior discharge.

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

- The original discharge was initiated by the patient and was against medical advice (AMA) and the circumstances of that discharge are documented in the patients' medical record, including the discharge status
- Any planned or staged readmission including staged surgical procedures or treatments, including chemotherapy
- Transfers from an out-of-network facility to an in-network facility
- Transfers of patients to receive care that is not available at the first facility
- Obstetrical readmissions
- Readmissions that occur greater than 30 days from the discharge date of the initial admission
- Readmission for members under 12 months old at the time of readmission
- Readmissions when a patient has any condition related to cancer, transplants, HIV infection, and major trauma.

AmeriHealth Caritas District of Columbia will request medical records for both admissions for review to determine if the initial and subsequent admissions are related. While a readmission may be medically necessary, it may still be preventable and subject to review. Medical records should at a minimum include:

- Admission history and physical
- Physicians' orders
- Progress notes
- Emergency room records
- Operative records
- Testing (laboratory and diagnostic)
- Discharge summary/summaries
- Discharge medications
- Medication adjudication records

Post-payment review:

- AmeriHealth Caritas District of Columbia or it's designee will review retrospectively, post-payment, through a medical record review to determine if the readmission is related to the previous admission.
    - Pertinent medical records for both admissions must be included upon request to determine if the admission(s) is appropriate or is considered a readmission.
    - If the readmission is within 30 days, AmeriHealth Caritas District of Columbia will determine, through a clinical review, if the readmission was related to the first admission.

- If it is determined that the readmission within 30 days is unrelated to the earlier admission, the claims will be treated as two separate admissions.
- If it is determined that the readmission within 30 days is related to the first, then the two inpatient stays will be combined into one claim and any overpayment will be recouped.
    - The hospital will be instructed to submit a new claim with both inpatient stays and will be reimbursed as one DRG payment. Any payment made for the separate admissions will be recouped.
- Failure of the acute care facility or inpatient hospital to provide complete medical records will result in an automatic recoupment of the claim.

Appeals process

- All acute care facilities and inpatient hospitals have the right to appeal any readmission denial and request a peer-to-peer review or formal appeal.

Definitions

Readmission

Readmissions happening within 30 days of discharge from the initial admission. Includes patients who are readmitted to the same hospital, or another applicable acute care hospital for any reason.

Health care-acquired conditions (HCACs)

HCACs are conditions that occur in an inpatient setting and that are high cost or high volume or both, may result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and could reasonably have been prevented through the application of evidence-based guidelines.

Never event

Never events are serious and costly errors in the provision of health care services that should never happen. Never events which include surgeries performed on the wrong body part or transfusion of mismatched blood—cause serious injury or death to beneficiaries, and result in increased costs to the Medicare/Medicaid programs to treat the consequences of the error.

Provider preventable conditions (PPC)

PPCs are conditions that meet the definition of a Health Care-Acquired Condition (HCAC), a Never Event, or an Other Provider-Preventable Condition. Health Care-Acquired Conditions (HCACs), occur in inpatient hospital settings, and Other Provider-Preventable Conditions (OPPCs) may occur in either an inpatient or outpatient health care setting.

Edit Sources

I. State Medicaid manuals, fee schedules and guidelines.
II. https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/32957
III. https://www.federalregister.gov/documents/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-theCenters for Medicare and Medicaid Services (CMS).
IV. https://www.amerihealthcaritasdc.com/pdf/provider/manual.pdf

Attachments

N/A

Associated Policies

RPC.0044.5400 Healthcare Acquired Conditions

Policy History

08/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas District of Columbia from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section