	Category: Pricing Methodology	
Subject: Readmissions	Page 1 of 6	Policy #: FIN.004
Title: Thirty (30) Day Readmission Payment Policy - Inpatient	Approval Date: 6/4/2021	Effective Date: 7/1/2021

PURPOSE

The purpose of this policy is to provide an explanation of the CountyCare Health Plan (CountyCare) process for reviewing inpatient readmissions and processing reimbursement of potentially preventable readmissions (PPR). Under this policy, reimbursement may be denied or reduced for services rendered during a potentially preventable readmission. Providers may dispute a determination of PPR through CountyCare's claims review process.

AFFECTED AREAS

Medicaid Operations, Provider Contracting, Provider Data Management & Network, Claims, Clinical Services, and Utilization Management.

IMPACTED POPULATIONS

☒ **MEDICAID – ACA/FHP/ICP** ☒ **MEDICAID – LTSS** ☒ **MEDICAID – MLTSS**

DEFINITIONS

Clinically Related – An underlying reason for a subsequent admission is plausibly related to the care rendered during or immediately following a prior hospital or hospital system admission. Clinically related readmission may have resulted from the process of care and treatment during the prior admission or from a lack of post-admission follow-up rather than from unrelated events that occurred after the prior admission within a specified readmission time interval.

Provider Dispute – Any provider issue or escalated complaint through the CountyCare Dispute System or HFS Provider Complaint Portal.

Initial (Anchor) Claim or Initial (Anchor) Admission – The first inpatient admission and the related claim for services at an acute, general, or short-term hospital or hospital system and for which the date of discharge for such admission is used to determine whether a subsequent admission at that same hospital or hospital system occurs within (30) days.

Potentially Preventable Readmission (PPR) – A readmission within a specified time interval that is plausibly related to the care rendered during prior hospital or hospital system admission or resulted from inadequate discharge planning and may have been prevented had adequate care or discharge planning been provided during the initial hospital or hospital system stay.
Note: The PPR Chain may have one or more readmissions that are clinically related to the Initial Admission. The first readmission is within 30 days after the Initial Admission, but the 30-day timeframe begins again at the discharge of either the Initial Admission or the most recent readmission clinically related to the Initial Admission.

Readmission – An inpatient admission that occurred within 30-days after the initial discharge from the same hospital or hospital system that is clinically related to the initial admission.

Note: 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.

POLICY

Section 3025 of the ACA added section 1886(q) to the Social Security Act established 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.[1] The Illinois Department of Healthcare and Family Services (HFS) has similarly instituted readmission reduction efforts to align with CMS' initiative.

This policy includes payment provision guidance for the reimbursement of Potentially Preventable Readmissions. The Health Plan retains the right to use discretion in interpreting this policy and applying or not applying it to the reimbursement of services provided.

CountyCare may review claims for hospital or hospital system readmissions according to predefined criteria as set forth in this policy. Under this policy, reimbursement may be denied or reduced for services rendered during a potentially preventable readmission. CountyCare reserves the right to recoup or recover monies previously paid on a claim for services rendered during a readmission that is later determined to have been potentially preventable. Providers have the right to request a review of any claim decision after adjudication or service authorization contesting denial, reduction, suspension, or termination of a previously authorized service made by CountyCare.

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Please note, this policy does not guarantee reimbursement. Providers must comply with other state and federal requirements to receive payment for services, including the Code of Federal Regulations (CFR), state statutes, regulations, and billing instructions.

PROCEDURE

Indications and Limitations of Coverage

The readmission must be supported in the medical records for the initial admission and the readmission.

This policy covers the Medicaid line of business only with CountyCare. Eligible services will be subject to the subscriber benefits, HFS fee schedule amount, and any coding edits.

- Readmission for an inpatient stay within (30) days of the initial stay for the same, similar, or related diagnosis may be denied or claim payment reduced based on this policy.
- Any readmission to the same hospital or hospital system within (30) days of initial discharge is subject to a medical record review on a pre-adjudication or post-payment basis.
- The readmission must be supported in the medical records for the initial admission and the readmission.

The following applies to all claim submissions:

All coding and reimbursement are subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all health services is subject to current CountyCare medical policies criteria, policies found in provider policy sections, reimbursement policies, and all other provisions of the Provider Service Agreement (Agreement).

If any new codes are developed during Provider's Agreement, such new codes will be reimbursed according to the standard or applicable HFS fee schedule with the Provider's current Agreement. All payment for codes based on Relative Value Units (RVU) will include a site of service differential and calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

[1] Subpart I of 42 CFR part 412 (§412.150 through §412.154

READMISSIONS REVIEW CRITERIA

POTENTIALLY PREVENTABLE READMISSIONS

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

- The readmission is for a condition or procedure related to the care or lack of care provided during the prior discharge or the period immediately following the prior discharge, consistent with accepted standards.
- The readmission resulted from a previous premature discharge from the same hospital, related hospital, or hospital system as determined through medical record reviews. Reference Q.002 Quality of Care Investigations for more information.
- The readmission resulted from inadequate discharge planning as determined through medical record reviews.
- The readmission resulted from circumvention of the contracted rate by the hospital, related hospital, and hospital system.

READMISSIONS EXCLUDED FROM REVIEW

The following readmissions are excluded from (30) day readmission review:[2]

- Readmissions to the same hospital or hospital system on the same date of last discharge for the same primary diagnosis (continuous stay).
- Transfers from out-of-network to in-network hospitals or hospital systems.
- Transfers of members to receive care not available at the first hospital or hospital system.
- Non-Acute Events (admissions to Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Long-Term Acute Care Facilities.
- Planned readmissions for repetitive or staged treatments, such as cancer chemotherapy or staged surgical procedures.
- Readmissions associated with major or metastatic malignancy, multiple traumas, burns, cystic fibrosis, sickle cell anemia, multiple traumas, transplants, or applicable HIV Diagnostic Related Groupings (DRG).
- Readmissions for children defined as less than the age of 19 who have a primary diagnosis at discharge for Behavioral Health[3].
    - Note: Admissions for detoxification services within (60) days of a prior detox admission are not a covered benefit under Illinois Medicaid. Traditional Medicaid and the MCOs cannot make payment for (60) day detox readmissions per Public Act (PA) 097-0689, referred to as the Save Medicaid Access and Resources Together (SMART) Act.
- Neonatal and Obstetrical readmissions.
- Readmissions where the first admission had a patient discharge status of "left against medical advice" or noncompliance.
- Readmissions ≥ (31) days from the date of discharge from the first admission.
- Readmissions where there is documented evidence that the MCO failed to carry out its shared responsibilities, including:
    - Approval of in-network post-acute providers of medical-necessary Medicaid covered services.
    - Approval of out-of-network post-acute providers of medically necessary Medicaid covered services when in-network options are exhausted.
    - Upon request of the hospital or hospital system, provide daily engagement with a Health Plan Utilization Management (UM) or Care Management (CM) Coordinator to assist the hospital or hospital system with challenging discharge planning.

[2] 89 Ill. Adm. 152.300(d)(2)
[3] 89 Ill. Adm. 152.300(d)(2)(D)

CLAIMS REVIEW PROCESS

CountyCare will review a claim at the time of receipt to determine if it meets the potentially preventable readmission criteria outlined in this policy. In the case where a claim meets the criteria for preventable readmission, the claim will be denied, and the Provider will receive an explanation of payment stating that the claim was identified to be readmission. The Provider may follow the claim reconsideration process to provide the additional supporting clinical documentation inclusive of the treatment and discharge plan. Claim dispute timeliness will apply.

The initial admission and subsequent readmissions will be adjudicated with the following considerations:

- The initial admission and readmission will be considered as a single admission.
- All days for the initial admission and readmission must be pre-authorized.
    - All authorized days for the initial admission and readmission will be combined to determine the approved length of stay.
    - All days in-between admissions will not be considered for reimbursement.
- In cases where the authorized days from the readmission causes the combined admission to exceed the average length of stay determined for the assigned DRG, high-trim days will not be reimbursed in addition to the assigned DRG reimbursement.
- All services for initial admission and readmission will be considered as a single claim for both inpatient stays.
- Multiple readmissions will not be separately reimbursed when each stay is reimbursed per case/per admission.
- If initial admission has been reimbursed, claims will be combined to determine reimbursement.

Readmissions that occur within (24) hours of the previous discharge of an eligible recipient with the same or related diagnosis-related group (DRG) will be considered part of the prior admission and not paid separately when the admissions are to the same hospital or hospital system. When the second admission is to a different hospital or hospital system, the claims may be reviewed to determine if the initial claim should be considered as a transfer.

A claim review of services rendered during a potentially preventable readmission may occur pre-adjudication or post-payment and may include, but is not limited to, the following:

- Provider contract assessment (in-network).
- Diagnosis-related to initial admission.
- PPR
- Prior admissions and discharge dates of service.
- Medical records submitted with the claim (claim adjudication is dependent on the outcome of a medical record review).
- A medical record will be requested if not accompanied by the claim submission.

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

- CPT/HCPCS Modifier: As Appropriate
- ICD-Diagnosis: As Appropriate
- ICD-Procedure: As Appropriate
- HCPCS: As Appropriate
- Revenue Codes: As Appropriate
- Deleted Codes: As Appropriate

PROVIDER DISPUTE PROCESS

Providers have the right to request a review of any claim decision after adjudication or service authorization contesting denial, reduction, suspension, or termination of a previously authorized service made by CountyCare. All claim disputes must be received within (60) calendar days from the date of the Explanation of Payment (EOP) or Remittance Notice as outlined in NM.004. Provider claim disputes related to services rendered during a potentially preventable readmission will be processed as follows:

1. Third Party Administrator Evolent Health LLC – Marketing Operations and CountyCare Health Plan – Operations will triage provider claim disputes as outlined in NM.004.
    a. Requests for review of claims denied or reduced for services rendered during a potentially preventable readmission will be routed to Claims and Utilization Management.
2. The dispute is assigned to an Appeals Nurse in Utilization Management. The Appeals Nurse will compile all clinical information and related guidelines and submit the information to Evolent. Note that providers may submit additional clinical information. Evolent will assign an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision. relevant to the dispute.
3. CountyCare will provide a substantive response intended to resolve the dispute within (30) business days after receipt of the dispute request from the Provider as outlined in NM.004.

CROSS REFERENCES

NM.004 Provider Complaint Resolution Process
Q.002 Quality of Care Investigations

RELATED REFERENCES

CP.003 Provider Preventable Conditions

REGULATORY REFERENCES

American Medical Association. *2021 Current Procedural Terminology*. American Medical Association: 2021.

Centers for Medicare and Medicaid Services. *Readmissions Reduction Program (HRRP)*. Baltimore (MD): CMS; [last updated 2016 Apr 18; cited 2017 Feb 24]. Available from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.

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 from: http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf.

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.

Illinois Department of Healthcare and Family Services. *Potentially Preventable Readmissions Policy*. 2014. Available from: https://www.illinois.gov/hfs/SiteCollectionDocuments/PPR_Overview.pdf.

Illinois General Assembly. *Administrative Code – Title 89: Section 152.300: Adjustment for Potentially Preventable Readmissions*. 2019. Available from: https://www.ilga.gov/commission/jcar/admincode/089/089001520003000r.html.

Illinois Senate Bill 2840. *Public (SMART) Act 097-0689*. 2012. Available from: https://www.ilga.gov/legislation/publicacts/97/097-0689.htm.

Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3025,124 Stat. 119, 408 (2010) *amended by* § 10309, 124 Stat. 119, 942 (2010) (codified as amended at 42 U.S.C. § 1395ww(q) (2010)).

POLICY SCHEDULE UPDATE	At least every two (2) years or more often as needed.	
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POLICY HISTORY

REVISION LOG	**DATE WRITTEN**	**APPROVED**	**EFFECTIVE**
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