Policy and Procedure

Title: Readmission Policy	**Division: Medical Management** **Department: Utilization Management**
Approval Date: 3/30/18	**LOB: Medicaid, Medicare, FIDA, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP**
Effective Date: 3/30/18	**Policy Number: UM-MP226**
Review Date: 3/30/19	**Cross Reference Number:**
Retired Date:	**Page 1 of 6**

1. **POLICY DESCRIPTION:**
   The purpose of this policy is to support guidelines set forth by the Centers for Medicare and Medicaid Services (CMS) and New York State Medicaid for determining an inappropriate readmission. This policy is applicable to facilities reimbursed based on a contracted Diagnosis-Related Group (DRG) or case rate methodology. It defines Utilization Management review procedures and payment guidelines for readmissions to an acute general short-term hospital occurring within thirty (30) calendar days of the date of discharge from the same acute general short-term hospital for the same, similar, or related diagnosis. In the instance of multiple readmissions, each admission will be reviewed against criteria relative to the immediate preceding admission.

   MetroPlus Health Plan will conduct a medical records review to determine if a subsequent hospital admission is related to the previous hospital admission.

2. **RESPONSIBLE PARTIES:**
   Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. **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 occurs within 30 days.

   Readmission - The subsequent acute admission for the same patient within 30 days of discharge of the initial admission and at least one day between the discharge and new admission (to ensure transfers are not counted as readmissions). Readmissions can be both categorized as planned and emergency admissions.

4. **POLICY:**

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MetroPlus Health Plan will conduct hospital readmission review to determine if the readmission was considered clinically related to the previous admission. Readmissions determined to be related to the previous admission will not be reimbursed.
This policy applies to facilities for readmissions that have occurred within thirty (30) calendar days of a previous discharge within the same hospital.

Medical records shall be reviewed to determine if the readmission was clinically related to the previous admission based on one of the following criteria:

- A medical readmission for a continuation or recurrence for the previous admission or closely related condition (e.g., readmission for diabetes following an initial admission for diabetes)
- A medical complication related to an acute medical complication related to care during the previous admission, (e.g., patient discharged with urinary catheter readmitted for treatment of a urinary tract infection)
- An unplanned readmission for surgical procedure to address a continuation or a recurrence of a problem causing the previous admission (e.g., readmitted for appendectomy following a previous admission for abdominal pain and fever)
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the previous admission (e.g., readmission for drainage of a post-operative wound abscess following an admission for a bowel resection)

Note: Medical record review is to determine if the admission is related and not an assessment of medical necessity or appropriateness of the setting.

Concurrent Review
Upon receipt of an inpatient authorization request from a provider, Utilization Management (UM) nurse will review for both medical necessity and for identification of a potential readmission. The UM nurse examines the dates of a member's prior admissions and discharges. Readmissions within the same facility that appear to be related to an initial prior admission, will be tied-in/combined into the previous admission.

If an inpatient authorization is approvable after medical necessity review and is identified as a potential readmission, this will be noted on the authorization. MetroPlus Health Plan will notify the requesting provider of identification of a potential readmission, upon communication of the authorization status.

A clinical review of the medical records relating to the previous admission will determine whether the readmission was related. Once the readmission is determined to be clinically related, it will be further evaluated to determine whether it 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.

A request for medical records will be sent to the provider if they are not currently on file, or are missing needed information to aid staff in making a final determination.

Once the initial concurrent review has determined the admissions are clinically related, a final determination is made. The UM Nurse will complete an administrative denial of the readmission case and adjust the initial admission case to tie-in/combine the cases. Tie-in timeframes can be regulatory and/or dictated by facility contract. See table in Section 6 below for readmission days.
The facility will be:

1) Notified verbally of the tie-in/combination;
2) Sent a tie-in administrative denial determination letter;
3) The tie-in is documented on the hospital log and faxed to the facility.

Pre-adjudication Review
All inpatient facility claims submitted for a MetroPlus Health Plan member, which would qualify as a readmission within 30 days (or as otherwise stated by State and/or provider contract) of a discharge from an acute care hospital (the same OR different facility) will be subject for clinical review in one of two ways:

1) If submitted with medical records the claim will pend for Medical Claims Review; or
2) If not submitted with medical records, the claim will deny indicating that records are required. Submitted medical records must include all documentation from EACH related inpatient stay, even if at different, unrelated facilities.

5. LIMITATIONS/ EXCLUSIONS:

Excluded from readmission review are:

- Readmissions greater than 30 calendar days from the last discharge
- The original discharge was a patient initiated discharge and was against medical advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.
- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, or other similar repetitive treatments or scheduled elective surgery
- Readmissions due to malignancies (limited to those who are in an active chemotherapy regimen), burns, or cystic fibrosis
- Readmissions due to bone marrow transplants
- Obstetrical admissions

- Readmissions with a documented discharge status of left against medical advice
- Transfers from out of network to in-network facilities
- Transfers of patients to receive care not available at the first facility
- Skilled Nursing and Rehabilitation facilities (SNF and Rehab)
- Readmissions when the previous admissions for transient ischemia attack (TIA) had all of the following:
    - ABCD score of 3 or greater
    - Brain, carotid and cardiac imaging was completed
    - Started on anti-platelets during the first admission
    - Had CVA within 30 days

MetroPlus Health Plan reserves the right to perform concurrent or retrospective medical records reviews and retract payment according to the guidelines in this policy. Standard administrative provider appeal rights/process is applicable in cases in which MetroPlus Health Plan determines the readmission is related to the previous admission and the provider is in disagreement with the determination of non-payment of the readmission by MetroPlus Health Plan.

Below is the breakdown of the maximum amount of time for an admission to be potentially classified as a readmission.

Regulatory Body	Readmission Days	Source
Medicare	30	Section 3025 Section 1886(q)
New York State	31	10 NY ADC 86-1.37/NYCRR Title 10, Section 86-1.54

6. APPLICABLE PROCEDURE CODES:

7. APPLICABLE DIAGNOSIS CODES:

NA

8. REFERENCES:

- Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 12/10/10. Available at: http://www.cms.gov/manuals/downloads/clm104c03.pdf. Accessed September 29, 2011.

- Centers for Medicare & Medicaid Services (CMS). Medicare Learning Network. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. 12/17/10. Available at: http://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf. Accessed September 29, 2011.

- Centers for Medicare & Medicaid Services (CMS). Readmissions Reduction Program (HRRP) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

- CMS Publication 100-10 (Quality Improvement Organization Manual), (Readmission Review), available at: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html

- 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)

REVISION LOG:

REVISIONS	DATE
Creation date	2/16/18

Approved:	Date:	Approved:	Date:
Sosler Bruce, MD Clinical Medical Director		Talya Schwartz, MD Chief Medical Officer	

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Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.