Readmission Policy

Policy Number	2018F7001A	Annual Approval Date	11/11/2017	Approved By	Reimbursement Policy Oversight Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

***Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the facility or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies**.*

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication. CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities including, but not limited to, non-network authorized and percent of charge contract facilities.

Payment Policies for Medicare & Retirement, UnitedHealthcare Community Plan Medicare and Employer & Individual please use this link.
Medicare & Retirement and UnitedHealthcare Community Plan Medicare Policies are listed under Medicare Advantage Reimbursement Policies.
Employer & Individual are listed under Reimbursement Policies-Commercial.

Policy

Overview

Based on CMS findings in 2008: 18% of all hospital discharges result in a readmission within 30 days; and $15 billion in spending, $12 billion of which is spent on potentially preventable readmissions. Proper discharge planning and post discharge follow up care are the keys to these preventable readmissions.

Consistent with the Centers for Medicare and Medicaid Services (CMS), UnitedHealthcare Community Plan recognizes that the frequency of readmission to an acute care hospital shortly after discharge is an indicator for quality of care, and thus CMS has implemented a process for reviewing such readmissions.

UnitedHealthcare Community Plan will do likewise by reviewing all readmissions for our members to an acute care hospital within 30 days of discharge via one of three methods: Concurrent Review, Pre- adjudication Review, and/or Post payment/Adjustment Review. Applies to acute inpatient admissions only.

Reimbursement Guidelines

Review of the facility or state contract to determine if readmission review is applicable. At the request of UHC, the hospital must submit medical records pertaining to the readmission as well as the index/anchor admission to first identify whether the case is a preventable readmission. Initial review should determine whether the readmission was clinically related to the index/anchor admission. A readmission is considered to be clinically related to the initial admission if it belongs to one of five different categories: (10)

- A medical readmission for a continuation or recurrence of the reason for the initial admission or closely related condition. (e.g., readmission for diabetes following an initial admission for diabetes) (10)
- A medical readmission for an acute decompensation of a chronic problem that was not related to the initial admission but was plausibly related to care either during or immediately after the initial admission (e.g., a readmission for previously diagnosed diabetes in a patient whose initial admission was for an acute myocardial infarction (10)
- A medical readmission for an acute medical complication plausibly related to care during the initial admission (e.g., a patient with a hernia repair discharged with a urinary catheter readmitted for treatment of a urinary tract infection) (10)
- An unplanned readmission for surgical procedure to address a continuation or a recurrence of the problem causing the initial admission (e.g., a patient readmitted for an appendectomy following and initial admit for abdominal pain and fever) (10)
- An unplanned readmission for a surgical procedure to address a complication resulting from care during the initial admission (e.g., a readmission for drainage of a postoperative wound abscess following an initial admission for a bowel resection) (10)

Once the initial review has determined to be clinically related, further evaluation would determine whether the readmission was potentially preventable. The review shall focus on the following:

- Whether the patient meets inpatient or alternative setting criteria using the appropriate Milliman Care Guidelines.
- Whether discharge plans were followed according to generally accepted medical standards (Generally Accepted Standards of Medical Practice, 2011 Certificate of Coverage). These are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered.
- Documentation in the hospital record that an appointment was made within the first week or within an appropriate time frame after discharge from the initial admission (11)
- Whether appropriate telephone numbers have been given to the patient for calls to the hospital or primary care provider for related discharge questions. (11)
- Whether a health care advocate/provider did an in-home safety assessment and appropriate follow up as needed.
- Whether written discharge instructions were provided and explained to the patient/caregiver prior to discharge (Project Boost).
- Documentation that all required prescriptions were given to the patient and the patient was educated in the appropriate use of the medication. (9) (11)
- Whether documentation supports that durable medical equipment has been arranged for the patient and the patient has been appropriately educated on its use.
- Whether documentation supports that all salient financial and social needs of the patient have been addressed.

Readmission Definitions

Readmission is defined as (Check State contracts for the specific definition):

- 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.

Concurrent Review

The Utilization Management nurse, during the course of an inpatient concurrent review, examines the dates of a

member's prior admissions and discharges. Readmissions within the same or a different hospital facility that appear to be related to an initial prior admission, will be tied-in/combined into the previous admission. Tie-in timeframes can be regulatory and/or dictated by facility contract. The facility will be: (1) notified verbally of the tie-in; (2) sent a tie-in administrative denial determination letter; and (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 UnitedHealthcare Community 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:

- If submitted with medical records the claim will pend for Medical Claims Review (MCR); or
- 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.

Post payment/Adjustment Review
All Diagnostic Related Group (DRG) paid claims are extracted on a report and provided to the medical review team. The team compares their criteria to the DRG report. They verify whether or not the diagnoses are part of the excluded list and/or related to previous admissions. If it is determined that a claim may be related to a previous admission (thus could possibly be deemed a readmission), then medical records are requested from the facility for all related admissions. All claims and the related medical records, for all related admissions, are reviewed by a physician to make a final determination on whether or not the admission meets the criteria of a readmission. If it is determined to be a readmission, written notification is sent to facility and the appeals timeline begins. After all appeals timeframes are expired or appeals exhausted, claim is returned to Claims Cost Management for adjustment.

State Exceptions	
Arizona	Exempt from policy.
Delaware	Readmissions are subject to review when within 10 days.
Hawaii	Readmissions are subject to review when within the timeframe listed in the facility agreement.
Iowa	Readmissions are subject to review for specific contracted facilities when within 15 or 30 days.
Kansas	Exempt from policy.
Maryland	Exempt from policy.
Massachusetts	Exempt from policy.
Michigan	Readmissions are subject to review when within 15 days If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode.
Nebraska	Readmissions are subject to review when within 31 days. Retro-review for contracted providers.
New Jersey	Readmissions are subject to review for specific contracted facilities when within 72 hours, 15 days, or 30 days.
New Mexico	Readmissions are subject to review when within 15 days.
New York	Exempt from policy
Tennessee	Readmissions are subject to review for specific contracted facilities when within 30 days.

Texas	Readmissions are subject to review when within 24 hours.
Washington	Readmissions are subject to review within 14 days and handled post-pay only. The Clinical Claims review team has specific criteria and further exceptions.
Wisconsin	Readmissions are subject to review for specific contracted facilities when within 31 days

Definitions	
Readmission	A return hospitalization to an acute care hospital that follows a prior acute admission within a specified time period, which is clinically related to that prior admission.
MCR	Medical Claims Review – A department of nurses that utilize Benefits, Plans Specifics, Federal/CMS and State specific coverage mandates, and medical records review to determine coverage of services.

Questions and Answers	
1	**Q**: How does this policy vary from the CMS policy? **A:** Currently, CMS utilizes a 30 day window for its Readmission Policy. State regulations vary from a short of 10 days to a long of 31 days, with some being silent on the matter. UnitedHealthcare Community Plan is implementing this policy consistent with CMS, using a 30 day readmission timeframe across all markets where allowed by State regulation. In the markets that do not allow for 30 days, we will comply with that particular State's timeframe.
2	**Q:** Are there any circumstances where a patient is admitted within 30 days for the same or similar diagnoses that are NOT considered readmissions? **A:** Yes, there are several circumstances that fit this criteria including: • The initial discharge was patient initiated and was against medical advice (AMA). Such a situation must be documented in detail in the patient's medical record for BOTH admissions. • The second admission was a planned readmission due to a Staged Procedure. Again, this must be documented in detail in the patient's medical record for BOTH admissions. The second admission was a planned readmission for some other reason. This is up to the discretion of the Medical Director reviewing the case, and must be documented in detail in the patient's medical record for BOTH admissions. It is advised in such a situation that a PreDetermination be obtained prior to the second admission.

Resources

1. Mayo Clinic Proceedings; 2005: 80(8):991-994.
2. Arch Int Med; 2007: 167: 1305-1311
3. Ann Int Med; 2005; 143(2): 121-8
4. J Gen Internal Med; 2009; 24(9):1002-6
5. JAMA; 2007: 297: 831-41
6. Ann Intern Med.; 2009; 150:178-187.
7. J Gen Intern Med.; 2008; 8:1228-1233.
8. Identifying Potentially Preventable Readmission Using a Present on Admission Indicator, Health Care Finance Review Spring 2006
9. Society of Hospital Medicine, Care Transitions Implementation Guide; 2009: 12-14
10. Identifying Potentially Preventable Readmissions, Health Care Financing Review/Fall 2008, Volume 30, Number 1
11. Report on Medicare Compliance – Volume 17, Number 24, June 30, 2008

12. www.cms.gov (use search term “readmissions”)
13. Individual state Medicaid regulations, manuals
14.Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
15.National Uniform Claim Committee (NUCC)

History	
3/20/2018	Annual Policy Version Change State Exceptions section: Added Washington History Sections prior to 1/1/2016 removed
1/1/2017	Annual Version Change
2/29/2016	State Exceptions: Removed verbiage for WA
1/1/2016	Annual Version Change
11/14/2011	Policy implemented by UnitedHealthcare Community & State

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