Readmissions

PURPOSE
This policy provides support and guidance for the process by which the health plan identifies and evaluates coverage for potential preventable, unplanned readmissions.

POLICY
As part of the Affordable Care Act (ACA), Congress mandated that CMS reduce unplanned hospital readmissions through certain payment incentives. Section 3025 of the ACA added section 1886(q) to the Social Security Act, establishing the Hospital Readmission Reduction Program (HRRP), which requires CMS to reduce payments to Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions, effective for discharges beginning on October 2, 2012. Preventable readmissions put members/enrollees at risk for iatrogenic (related to illness caused by medical treatment or care) and other unnecessary complications.

Clinically Related Admissions

A readmission is considered clinically related to the initial (index) admission if at least one (1) of the following is true. Member/enrollee is:

- Discharged before all medical treatment is completed, including a readmission related to the initial admission or closely related condition
- Discharged without discharge criteria being met, including the clinical level of care criteria
- Discharged having met discharge criteria, but non-clinical factors/barriers were not addressed prior to discharge (e.g., member is discharged to “home,” but is homeless)
- Discharged after inpatient stay and readmitted due to a continuation or recurrence of the problem causing the initial admission, or to manage a complication resulting from the care (or lack thereof) during the initial admission
- Discharged with a documented plan to readmit for additional services that could have been conducted during the initial admission. (Physician or member requested)
- Discharged to allow resolution of a medical problem that, unless resolved, would be a contraindication to the medically necessary care that will be provided during the second admission (e.g., discharge to await normalization of clotting times prior to a surgical intervention)
- Readmitted for an acute exacerbation of a chronic problem that was not related to the initial admission but was most probably related to care (or lack thereof) during or immediately after the initial admission
- Readmitted for a direct surgical complication
- Readmitted, but the readmission could have been potentially preventable by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period

- ***Exclusions*** :
- Readmission unrelated to the initial symptoms/conditions
- Readmission due to an unavoidable complication
- Readmission due to unavoidable member non-compliance with the discharge plan
- Maternity related stays
- Approved transfers such as transfers from out of network to in-network facilities and transfers of patients (members/enrollees) to receive care not available at the first facility
- Readmission outside the State-defined time from the initial admission
- Admissions and readmissions to hospital facilities with contract language prohibiting the readmission review process
- Observation stays as defined by the health plan
- Critical Access Hospitals
- Readmissions for unrelated symptoms or services (e.g., acute trauma) ---defined as a readmission classified with a unique Major Diagnostic Category (MDC) when compared to the initial admission.
- Denied initial admission.
- The discharge was a patient-initiated discharge and was Against Medical Advice (AMA) and the circumstances of the discharge and readmission are documented in the patient's medical record
- The admission was for the purpose of securing treatment for a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions, certain HIV APR DRGs (listed in the version of the 3M definitions manual applicable to the State fiscal year in question), alcohol or drug detoxification, nonacute events (rehabilitation admissions), or, for hospitals defined in 89 Ill. Adm. Code 148.25(d)(4), admissions with an APR-DRG code other than 740 through 760 The admission was for the purpose of securing treatment for sickle cell anemia
- Non-events are admissions to a nonacute care facility, such as a nursing home, or an admission to an acute care hospital for non-acute care or transfers from one acute hospital to another. Non-events are ignored and are not considered to be readmissions
- Inadequate care coordination and/or poor discharge planning • Readmissions for behavioral health related primary diagnosis at discharge

Once the potential readmission is determined to be clinically related to the initial admission, further evaluation is performed to determine whether the readmission was potentially preventable.:

- Whether the member/enrollee meets inpatient or alternative setting criteria (as determined using the appropriate guidelines in combination with clinical judgment).
- Whether discharge plans were followed according to generally accepted medical standards.
- 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.
- Whether a health care advocate/provider performed an in-home safety assessment and appropriate follow up, as needed.
- Whether written discharge instructions were provided and explained to the member/enrollee/caregiver prior to discharge.

- Documentation that all required prescriptions were given to the member/enrollee and the member/enrollee was educated in the appropriate use of the medication.
- Whether documentation supports that durable medical equipment had been arranged for and the member/enrollee had been appropriately educated on its use.
- Whether documentation supports that all important financial and social needs of the member/enrollee have been addressed.

Notice of Action Requirements

The health plan provides the facility with written notification (i.e., NOA) of any decision to deny payment, in whole or part, for a service.

DEFINITIONS:

1. **Diagnosis Related Group (DRG):** A diagnosis-related group (DRG) is a classification used to determine prospective payment rates for reimbursement of hospital care based on a patient's diagnosis. Medicare initiated this inpatient hospital prospective payment system (IPPS) for hospital services based on a predetermined rate for discharge based on a weighted DRG. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs. Patient cases are assigned to a DRG based on:
   - Principal diagnosis
   - Up to eight (8) additional (secondary) diagnoses
   - Up to six (6) procedures performed during the stay
   - Age
   - Sex
   - Discharge status of the patient
   - Diagnosis and procedure information is reported by hospitals using the International Classification of Diseases, 10th Revision -Clinical Modifications (ICD 10- CM) codes.
2. **Hospital Readmission (Medicaid):** A readmission is a hospital admission which occurs within a specifically defined readmission interval (usually 30 days) from the date of discharge from a prior (index) admission and is clinically related to the index admission.
3. **Index Admission:** The initial hospital admission from which readmission is measured.
4. **Hospital System/Related Hospital:** 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 subsequent 30 day interval 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 and, as such, subject to this policy.
5. **Potentially Preventable Readmission:** An unplanned readmission with a reasonable expectation that it could have been avoided and/or is evidenced to have resulted from one (1) or more of the following:
   - Premature discharge from the index admission at the same hospital or related hospital
   - Failure to perform adequate discharge planning
   - Failure to perform adequate post-discharge follow-up
   - Lack of coordination between inpatient and outpatient health care teams
   - The readmission was not medically necessary

- The readmission was the result of circumvention of the contracted rate by the hospital or a related hospital.

6. **Unavoidable Member/Enrollee Noncompliance:** Non-compliance by a member/enrollee that could not have directly or indirectly been managed by the provider. Facility documentation should include detailed discharge instructions from the index admission, as well as detailed evidence of member/enrollee non-compliance in readmission records and member/enrollee/caregiver disregard of clearly communicated post discharge instructions. Documentation may include evidence of appropriately prescribed medication, appropriate discharge planning facilitated post discharge follow-up, as well as provision of relevant information regarding the hospitalization to the physician responsible for outpatient follow up care.

Review/Revision History	
Effective	08/01/2021
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