Payment Policy: 30 Day Readmission FL Medicaid

Reference Number: FL.PP.501
Product Types: Medicaid
Effective Date: 05/12/2020
Last Review Date: 05/12/2020

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
A readmission occurs when a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital, or hospital within the same network, within 30 days for symptoms related to, or for evaluation and management of, the prior stay's medical condition. According to the Agency for Healthcare Research and Quality, nearly one in five of all hospital patients covered by Medicare are readmitted within 30 days, accounting for $15 billion a year in medical expense.

In accordance with CMS (Center for Medicare & Medicaid Services) guidance to Quality Improvement Organizations (QIOs), state Medicaid programs are instituting tailored readmission reduction efforts to address potentially preventable readmissions. Sunshine Health Plan may perform readmission review of admissions to an acute, general, short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, short-term hospital (See §1154(a)(13) and 42 CFR 476.71(a)(8)(ii)). Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred.

Sunshine may review hospital readmissions concurrently, on a pre-pay basis or on a post-pay basis, when a Sunshine member is readmitted to the same hospital, its affiliate, or within the same hospital system. Sunshine may deny payment if the second admission was related to the first admission, including (but not limited to) instances in which the second admission was preventable if the member was discharged prematurely, if the member was discharged to an inappropriate level of care, or if the readmission was a result of circumvention of the PPS.

As per the Medicare Claims Processing Manual Chapter 3 (40.2.5 - Repeat Admissions), when a patient is discharged/transferred from an acute care PPS hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Sunshine reserves the right to follow CMS guidance when a member is readmitted on the same day to ensure both admissions are on placed on the same claim.

Application
This policy applies to individual hospitals or hospitals within the same hospital system.

Policy Description
Pursuant to Medicaid guidelines, Sunshine has implemented a process of reviewing, adjudicating, and adjusting claims payments for inpatient admissions that are deemed to be a readmission.

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 and, as such, is subject to this policy.

Claims Edit Guideline

Procedure - Pre-Payment

- Sunshine reserves the right to evaluate readmissions prior to payment.
- Sunshine will identify which claims are most likely avoidable or preventable readmissions and deny the second payment. The identification is based on billed DRGs as well as the same or similar diagnoses found on the two related hospital claims.
- If the provider disagrees with Sunshine's determination, the provider has the right to appeal the determination. The provider must submit records for both admissions to Sunshine, or its contracted vendor, to determine if the second admission was preventable or related to the first admission.
- If a provider appeals and it is found the second admission was not related nor preventable, Sunshine will release payment for the second admission.
- If a provider appeals and Sunshine determines the second admission was preventable or related to the index hospitalization, the provider will be notified and the denial is upheld.

Recommended documentation to submit with a dispute/appeal:*

- Case Management Notes/Social Work Notes
- Consultations
- Diagnostic testing results (e.g., EKG, Echocardiogram, Laboratory Reports, X-Ray)
- Discharge Instructions
- Discharge Medication List
- Discharge Summary
- Therapy Notes
- ER Report
- History and Physical
- Itemized Bill
- MAR (Medication Administration Record)
- Nursing Notes
- Operative Report
- Pathology Report
- Physician Orders
- Physician Progress Notes
- Respiratory/Ventilation Sheets
- TAR (Treatment Administration Record)
- UB 92 or UB 04 form

**Documentation to exclude: Consent Forms; Dietary Notes; Duplicate Pages; Flow Sheets; and Holter Monitor Tracings*.

Coding and Billing

Covered Bill Types - 11x, Hospital Inpatient claim

Covered Place of Service - 21, Inpatient Hospital

DRGs - As appropriate

REV Codes - As appropriate

ICD-10 CM and PCS Codes - As appropriate

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws

Related Policies
Not Applicable

References

1. *Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing. Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf. Revision 10002 Issued 03/20/20. Accessed April 27, 2020.*
2. *HCUP National Readmissions Database Tracks Hospital Readmission Rates. Agency for Healthcare Research Web site. https://www.hcup-us.ahrq.gov/nrdoverview.jsp. Accessed April 27, 2020*
3. *Quality Improvement Organization Manual, Chapter 4: Case Review. Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/qio110c04.pdf Published July 11, 2003. Accessed April 27, 2020.*

Revision History	
05/12/2020	Initial policy draft
05/12/2020	Approval

Important Reminder
For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.