FIDELIS CARE®

Payment Policy: 14 Day Readmission (Medicaid)

Reference Number: FC.PP.003
Product Types: MEDICAID
Last Review Date: 11/1/2022

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

Policy Overview[1]

As a part of the Affordable Care Act (ACA), Congress mandated that Centers for Medicare and Medicaid Services (CMS) reduce hospital Readmissions through certain payment incentives.
Section 3025 of the ACA added section 1886(q) to the Social Security Act establishing 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. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

Similarly, state Medicaid programs are instituting Readmission reduction efforts based on CMS's initiative, but tailored to meet specific state Medicaid programs. Potentially preventable Readmissions (PPRs) to hospitals have long been recognized as a measure of quality of care. Many Medicaid programs and other payers have policies under which they may deny payment for specific Readmissions that result from sub-standard care that was provided in the initial admission.
Examples include repeat admissions for asthma or admissions for post-operative bleeding. In principle, a denial or reduction of payment for these specific cases motivates the hospital to bringits care up to standard.

The purpose of this policy is to determine whether Readmissions within 14 days are due to thesame, similar, or related diagnosis.

Application

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

Policy Description[2]

The policy is based, in part, on the methodology set forth in the Quality Improvement Organization Manual, CMS Publication 100-10, Chapter 4, Section 4240, for determining an inappropriate Readmission:

> *Obtain the appropriate medical records for the initial admission and readmission. Perform case review on both stays. Analyze the cases specifically to determinewhether the patient was prematurely discharged from the first confinement, thuscausing readmission. Perform an analysis of the stay at the first hospital to determinethe cause(s) and extent of any problem(s) (e.g., incomplete or substandard treatment). Consider the information available to the attending physician who discharged the patient from the first confinement. Do not base a*

[1] Please note that the current policy list on the provider portal is not exhaustive. Fidelis Care may from time to time employ a vendor that appliespolicies to specific services; in such circumstances, the vendor's guidelines may also be used to determine whether a service has been correctlycoded. Other policies or contract terms may further determine whether a technology, procedure or treatment is payable by Fidelis Care.
[2] Please note that the corresponding policy is regarding correct coding and not medical necessity.

> *determination of a premature discharge on information that the physician or provider could not have known or events that could not have been anticipated at the time of discharge.*

New York's Readmission Regulation sets forth the following criteria for defining hospitals that have an excessive number of Readmissions:[3]

> Readmission is a return hospitalization following a prior discharge that meets all of the following criteria:
>
> - Readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.
> - Readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge and including, but not limited to:
>   - Same or closely related condition or procedure as the prior discharge.
>   - Infection or other complication of care.
>   - Condition or procedure indicative of a failed surgical intervention.
>   - Acute decompensation of a coexisting chronic disease.
> - Readmission is back to the same or to any other hospital.
>
> Readmissions, for the purposes of determining PPRs, exclude the following circumstances:
>
> - Original discharge was a patient-initiated discharge and was against medical advice (AMA) and the circumstances of such discharge and Readmission are documented in thepatient's medical record.
> - Original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions.
> - Readmission was a planned Readmission or one that occurred on or after 15 days following an initial admission.

Based on CMS and New York State guidelines, if a Readmission is determined to have been inappropriate or preventable according to the review guidelines set forth below, Fidelis Care will treat both admissions as a combined DRG and adjust the reimbursement accordingly.

A Readmission will therefore be considered to be preventable under the following circumstances:

- If the Readmission resulted from a prior premature discharge from the same hospital or a related hospital;
- If the Readmission resulted from a failure to have proper and adequate discharge planning; If the Readmission resulted from a failure to have proper coordination between the inpatient and outpatient health care teams;
- If the Readmission was the result of a complication of care resulting from the prior hospitalization;
- If the Readmission follows a prior discharge that is related to the prior hospital admission.

The following Readmissions are excluded from 14-day Readmission review:

- Transfers from out-of-network to in-network facilities;
- Transfers of patients to receive care not available at the first facility;
- Readmissions that are planned for repetitive or staged treatments, such as cancerchemotherapy or staged surgical procedures;

[3] New York Codes, Rules, and Regulation, Title 10, Volume A-2, Section 86-1.37 – Readmissions

- Readmissions associated with malignancies, multiple trauma, or burns;
- Admissions to Skilled Nursing Facilities, Long Term Acute Care facilities, and Inpatient Rehabilitation Facilities (SNF, LTAC, and IRF);
- Readmissions where the first admission had a discharge status of "left against medicaladvice";
- Neonatal and Obstetrical Readmissions;
- Transplant and transplant-related admissions.

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 14-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, willbe treated as a Readmission to the same hospital and, as such, is subject to this policy.

Upon request from Fidelis Care, a hospital must forward (and, if applicable, arrange for a related hospital to forward) all medical records and supporting documentation of the initial admission and Readmission to Fidelis Care. The initial review of the medical records will determine whether the Readmission was the same or similarly related to the initial diagnosis. Once the Readmission is determined to be related, the Readmission will be further evaluated to determine whether the Readmission was potentially preventable. The review will evaluate the initial discharge, as well asthe discharge plan.

Reimbursement[4]

- All hospital claims submitted for a plan member that qualify as a Readmission within14 days of a discharge from the same hospital or a related hospital are subject to review.
    - Medical records for both the original and subsequent admission(s) will be requested for a claim that has been selected for review, wherever applicable. Ifmedical records for both the original and subsequent admission are not received, the second claim will be denied.
    - If both records are not received and a denial is issued, the hospital must submitan adjustment request or appeal request and submit the medical records for the first and subsequent admissions for further payment consideration and toinitiate the review. Submission of medical records for only one admission willresult in a denial of the adjustment or appeal request.
- Clinical information for the admissions will be reviewed by a qualified clinician to determine if the Readmission was based on the above guidelines.
- If a Readmission is determined to be the same or similarly related, written notification of the determination will be sent to the hospital and/or related hospital and payment for the Readmission will be adjusted accordingly.

Please note that the policy is regarding correct coding and not medical necessity.

[4] Please be advised that authorization does not guarantee reimbursement and to receive reimbursement, providers should submit a claim forservices rendered (member eligibility should be re-confirmed at the time the service is rendered).

Utilization
Not Applicable

Definitions
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 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 offollow-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, or another hospital in the same hospital system (referred to as a "related hospital") and for which the date of discharge for such admission is used to determine whether a subsequent admission at that same hospital or a related hospital occurs within 14 days.

Observed Rate of Readmission – The number of admissions in each hospital that were actually followed by at least one Potentially Preventable Readmission (PPR) divided by the total numberof admissions.

Potentially Preventable Readmission (PPR) – a Readmission to a hospital that follows a priordischarge from a hospital within 14 days, and that is related to the prior hospital admission.

Readmission – an admission to a hospital occurring within 14 days of the date of discharge from the same hospital or a related hospital. Intervening admissions to non-acute care facilities (e.g., askilled nursing facility) are not considered Readmissions and do not affect the designation of an admission as a Readmission. For the purpose of calculating the 14-day Readmission window, neither the day of discharge nor the day of admission is counted.

Related Documents or Resources
1. CMS Publication 100-10 (Quality Improvement Organization Manual), Chapter 4, Section 4240 (Readmission Review). Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/qio110c04.pdf Accessed November 2022.

2. New York Codes, Rules, and Regulation, Title 10, Volume A-2, Section 86-1.37 – Readmissions. Available at: https://regs.health.ny.gov/content/section-86-137-readmissions. Accessed November 2022.

References
1. Patient Protection and Affordable Care Act Pub. L. No, 111-148 § 3025(a), 124 Stat.119, 408 (2010).
2. 42 CFR 412.150 through 412.154
3. Federal Register, Vol. 79, No. 163, August 22, 2014, pages 50024 – 50048. Availableat: http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf

4. Centers for Medicare and Medicaid Readmission Reduction Program information available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
5. Gerard F. Anderson and Earl P. Steinberg, "Hospital Readmissions in the Medicare Population," New England Journal of Medicine, 311:21 (Nov. 22, 1984), pp. 1349-1353.

Revision History	
8/1/2021	Conducted annual review, clarified footnotes, updated references and related documents, changed CPT® to version 2021.
11/1/2022	Conducted annual review, removed version number, updated references.

Important Reminder

For the purposes of this payment policy, Fidelis Care is a health plan that has adopted thispayment 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 administeringbenefits. 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.

Fidelis Care may make modifications to this payment policy, at its discretion, by publishing revisions to the policy on the Provider Portal. This payment policy is accurate and current as of the date of its publication. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the published payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Fidelis Care 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 isnot 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 responsiblefor 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 Fidelis Care has no control or right of control. Providers are notagents or employees of Fidelis Care.

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 tomembers 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 paymentpolicy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer tothe CMS website at http://www.cms.gov for additional information.

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