Readmission Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for the 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. Blue Cross and Blue Shield of Texas (BCBSTX) 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 CMS 1500 forms and, when specified, to those 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 BCBSTX's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, BCBSTX may use reasonable discretion in interpreting and applying this policy to health care services provided in a case. Further, the policy does not address all issues related to reimbursement for health care services provided to BCBSTX enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include but are not limited to: federal and/or state regulatory requirements, the physician 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 the same way on the different electronic claims processing systems used by BCBSTX due to programming or other constraints; however, BCBSTX strives to minimize these variations.

BCBSTX 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 BCBSTX Medicaid products. This reimbursement policy applies to services reported using the CMS-1450 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities that are paid based on Diagnosis Related Grouping (DRG) payment methodology.

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Overview

Consistent with CMS, BCBSTX recognizes that the frequency of readmission to an acute care hospital shortly after discharge is an indicator for quality of care, and thus has implemented a process for reviewing such readmissions.

BCBSTX will review all readmissions to an acute care hospital within 30 days of discharge (or as otherwise stated by State law and/or provider contract) pursuant to this policy through the process outlined below.

Reimbursement Guidelines

BCBSTX reviews claims that fall into any one of the following three categories:

- Same-day readmission for a related condition
- Planned readmission
- Unplanned readmission less than 31 days after the prior discharge (or as otherwise stated by State law or contract and/or provider contract)

Same-Day Readmissions: Same or Related Condition

BCBSTX will review claims for same-day readmissions and request medical records to determine if the claim was properly billed. If a patient was readmitted during the same day for the same or a related condition, BCBSTX will deny both the initial and subsequent admissions for payment as separate DRGs. The facility must resubmit both admissions combined on a single claim to receive reimbursement.

Planned Readmission / Leave of Absence

When a patient is readmitted in less than 31 days to a facility as part of a planned readmission, the admissions are not considered two separate admissions. The medical records from the initial admission should indicate that additional work-up, treatment or surgical procedures are planned or expected for the same episode of illness, including bilateral procedures. When a readmission or procedure is expected (even if the date of readmission is different from that initially planned), the readmission will be treated as one claim and one episode of care combined DRG payment. Readmissions for surgical interventions that are expected or planned when conservative and/or non-operative therapy have failed also qualify for the combined DRG review. When the patient is ultimately discharged from the subsequent admission, the facility should submit one bill for covered days and days of leave. If a planned readmission or leave of absence is identified, BCBSTX may combine the initial and subsequent admissions into a single claim resulting in a combined DRG payment.

BCBSTX does not apply planned readmission guidelines to cancer chemotherapy, transfusions for chronic anemia, dialysis or similar repetitive treatments. However, surgery that is delayed while outpatient work-up is completed does fall under the leave of absence billing guidelines.

30-Day Readmission Review: Determination of Preventable Readmissions

BCBSTX reviews acute care hospital admissions occurring fewer than 31 days (or as otherwise stated by State law or contract and/or provider contract) following a prior discharge to the same facility. BCBSTX will review the initial claims and determine whether the subsequent admission meets the following criteria:

- The subsequent admission occurred fewer than 31 days (or as otherwise stated by State law and/or provider contract) after the initial discharge.
- The subsequent admission was for a diagnosis related to the initial admission.
- The subsequent admission was to the same facility.

If the criteria are met, BCBSTX will request medical records and supporting documentation relating to the initial admission, including the initial discharge and subsequent admission.

To determine whether a patient's readmission was preventable, multiple factors are taken into consideration, including, but not limited to premature discharge due to clinical instability, inadequate medication management and discharge planning. Please note that a readmission may be medically necessary, but nonetheless preventable and would still be subject to the clinical preventable readmission review.

- **Inadequate Outpatient Follow-Up or Treatment:** Discharge planning must take into account the availability and criticality of outpatient follow-up visits and treatment. Communication with practitioners who will provide follow-up care is expected.
- **Failure to Address Rehabilitation Needs:** Significant decline in function and inability to perform activities of daily living (ADL) is common following hospitalization of the elderly. Failure to properly address rehabilitation needs related to an inability to self-care is an avoidable cause of readmission.
- **Failed Discharge to Another Facility:** Failed transfers to a skilled nursing facility (SNF), long term care hospital (LTCH), acute inpatient rehabilitation (AIR) or a similar facility can be an indicator of premature discharge. Discharges with expected readmissions are treated as leaves of absence with combined DRG reimbursement. Errors made at the receiving facility unrelated to the orders it received upon transfer (e.g., falls, treatment delivery failure) will not result in a payment denial for the readmission.

Additional factors to be considered in deciding whether subsequent admission was preventable include:

- **Emerging Symptoms:** Symptoms that had onset or were present during a previous admission and subsequently worsened, leading to readmission, are a possible indicator of a premature discharge. Discharge prior to establishing the safety or efficacy of a new treatment regimen is also considered a premature discharge.
- **Chronic Disease:** Chronic diseases vary in severity, and entry into the terminal phase of an illness can be gradual. When reviewing readmissions related to chronic disease, readmission within a short period of time should be assessed for adequacy of follow-up care and outpatient management using accepted practice guidelines and treatment protocols.

- **Patient Non-Compliance:** Facilities will not be held accountable for patient noncompliance if all the following conditions are met:
    - There is adequate documentation that physician orders have been appropriately communicated to the patient.
    - There is adequate documentation that the patient/caretaker is mentally competent and capable of following the instructions and made an informed decision not to follow them.
    - There were no financial or other barriers to following instructions. The medical records should document reasonable efforts by the facility to address placement and access-to-treatment difficulties due to financial constraints or social issues, including consultation with social services, use of community resources and frank discussions of risks and alternatives.
    - The noncompliance is clearly documented in the medical record. For example, documentation for a discharge to the home when the discharge is felt to be unsafe should include signature by the patient/caregiver as leaving against medical advice (AMA). An unsafe discharge is not mitigated by a comment stating, “patient preference.”

If the readmission stay is determined to have been preventable, (regardless of whether the admission, at the time it occurred, was medically necessary), BCBSTX will deny payment for the readmission claim.

Definitions

Medical Records	Major documentation components of the medical record from both stays, particularly those relevant to the quality of care concern, including, but not limited to the following: • Fact sheet • Admission history and physical • Physicians’ orders • Emergency room records • Operative notes • Progress notes • Nursing notes • Diagnostic and laboratory testing • Discharge summaries • Discharge medication list • Intake and output flowsheets • Vital signs flow sheets • Physical/Occupational/Speech Therapy notes • Social work/discharge planning notes • Medication Adjudication Record (MAR)
Leave of Absence	A leave of absence for the purposes of this policy is a situation where readmission is expected, and the patient does not require a hospital level of care during the interim period.
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.

History	
02/11/2021	Policy implemented by Blue Cross and Blue Shield of Texas

Resources

1. Individual state Medicaid regulations, manuals and fee schedules
2. Quality Improvement Organization Manual; Chapter 4 Case Review
3. Social Security Act, §1886(d)
4. AHCCCS APR-DRG Payment System Design

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Centers for Medicare and Medicaid Services (CMS)

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