Clinical Policy: Readmission Review

Reference Number: MI.CP.MP.505
Last Review Date: 6/24

Coding Implications
Revision Log

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

Description

The Meridian Preventable Readmission Review Program is a component of the Centers for Medicare & Medicaid Services (CMS) and State Medicaid guidelines. A readmission is defined as a subsequent inpatient readmission within 15 days after discharge, or as specified by state regulations or provider contracts, that is clinically related to the initial admission and is determined to be a Potential Preventable Readmission.

Policy/Criteria

I. It is the policy of Meridian Health that Meridian will adhere to the following guidelines for readmissions:
   A. **Clinically Related Admissions:** A readmission is considered to be clinically related to the initial admission if it is identified to be applicable to **at least one** of the following categories:
      i. Member is discharged before all medical treatment is completed. This includes a readmission related to the initial admission or closely related condition.
      ii. Member is readmitted for an acute exacerbation of a chronic problem that was not related to the initial admission but was most probably related to care during or immediately after the initial admission.
      iii. Member is discharged without discharge criteria being met, including the clinical level of care criteria
      iv. Member is discharged meeting discharge criteria but non-clinical factors/barriers were not addressed prior to discharge (e.g., member is discharged home, but is homeless). Discharge planning beyond the typical is needed due to barriers.
      v. Member is discharged after surgery and readmitted due to a continuation or recurrence of the problem causing the initial admission, or to manage a complication resulting from the care during the initial admission.
      vi. Member is readmitted for a direct surgical complication and the standards of care for evaluation of the known complication is not documented in the medical record and/or addressed in the patient's discharge plan.
      vii. Member discharged with a planned documented plan to readmit for additional services that could have been conducted during the initial admission. (Physician/Provider or member requested).
      viii. Member is discharged to allow resolution of a medical problem that, unless resolved, is 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).

ix. The readmission is potentially preventable by the provision of appropriate care consistent with accepted standards, based on software, in the prior discharge or during the post-discharge follow up period.

B. **Patient Non-Compliance:** Facilities will not be held accountable for patient noncompliance if **all** of the following conditions are met:
   i. The member fails to follow the discharge plan of the first admission.
   ii. There is adequate documentation that physician/provider orders have been appropriately and adequately communicated to the patient or their designated caregiver.
   iii. There is adequate documentation that the patient or designated caregiver is mentally competent and capable of following the instructions and made an informed decision not to follow them.
   iv. There were no financial or other barriers to following instructions. (Note: 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.)
   v. The noncompliance is clearly documented in the medical record of the readmission. 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). The documentation must further demonstrate the facility's attempt to educate member regarding possible complications due to non-compliance with care plan and likelihood of readmission.

C. **Readmission Review:** Pursuant to Medicare and Medicaid guidelines, Meridian has implemented a process of reviewing, adjudicating, and adjusting claims payments for inpatient admissions that are deemed to be readmissions.

D. **Procedure Prospective Readmission Review:**
   i. Meridian reserves the right to evaluate subsequent admissions as outlined above prior to payment.
   ii. Meridian will identify which admission are most likely avoidable or preventable readmissions and deny the second admission The identification is based on billed DRGs, as well as the same or similar diagnoses found on the two related hospital claims.
   iii. If the provider disagrees with Meridian's determination, the provider has the right to dispute or appeal the determination. The provider must submit records for both admissions to Meridian, or its contracted vendor, to determine if the second admission was preventable or related to the first admission.
   iv. If a provider disputes the denial and it is found the second admission was neither related nor preventable, Meridian will release payment for the second admission.

v. If a provider disputes the denial and Meridian determines the second admission was preventable or related to the index hospitalization, the provider will be notified, and the denial will be upheld.

E. **Procedure Retrospective Readmission Review:**
   i. Meridian reserves the right to look back within the maximum allowed recovery period per state or federal guidelines, or as otherwise specified in the provider's contract, to identify any claims that may be readmissions.
   ii. Meridian will identify which claims that are most likely avoidable or preventable readmissions and request a refund. The identification is based on billed DRGs, as well as the same or similar diagnoses found the two related hospital claims.
   iii. If the provider disagrees with Meridian's determination, the provider has the right to appeal/dispute the determination. The provider must submit medical records for both admissions to Meridian or its contracted vendor. Meridian will evaluate the records to determine if the second admission was preventable or related to the first admission.
   iv. If it is determined that the second record is not a related readmission, the provider will be notified, and the refund request will be canceled.
   v. If Meridian determines that the second admission was preventable or related to the index hospitalization, the provider will be notified and subject to the refund request.

F. **Recommended Documentation to Submit with a Dispute/Appeal:**

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

G. **Documentation to Exclude with a Dispute/Appeal Submission:**
   i. Consent Forms
   ii. Dietary Notes
   iii. Duplicate Pages
   iv. Flow Sheets
   v. Holter Monitor Tracings

H. **Definitions:**

i. **Pre-Adjudication Review:** All inpatient facility claims submitted for a 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:

1. If submitted with medical records the claim will pend for Medical Claims Review (MCR); ***or***
2. 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

ii. **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 for adjustment. As part of the post-service/pre-payment readmission review process, we will request and review medical records and supporting documentation relating to the initial admission, including discharge plans, and the subsequent admission. We may deny payment to the facility for the subsequent admission if it meets certain criteria and is determined to have been preventable based on those criteria.

1. MHP reserves the right to look back within the maximum allowed recovery time frame per state guidelines or per specific provider contract to identify any claims that may be readmissions.
2. MHP will identify claims that are most likely readmissions for denial or request a refund. If it is determined to be a readmission, written notification is sent to the facility and the appeals timeline begins.
3. If the provider disagrees with MHP's determination, the provider has the right to appeal the determination. The provider must submit medical records for both admissions and a Meridian Health Plan Medical Director will evaluate the records to determine if the second admission is a readmission of the first admission.

I. **Absolute Contraindications/Exclusions:**
   i. The second admission was a planned readmission due to a Staged Procedure. This must be documented in detail in the patient's medical record for BOTH admissions.
   ii. The admission was for the purpose of securing treatment for a major or metastatic malignancy, multiple traumas, burns, neonatal, transplant, and obstetrical admissions, alcohol or drug detoxification
   iii. Skilled Nursing and Rehabilitation facilities (SNF and Rehab)

J. Classifications:
   i. MDHHS classifies related admissions within 15 days as potentially recoverable. MDHHS utilizes the following categories to classify 15-day readmission determinations. For any financial recovery or appeal determinations based on readmissions within 15 days of an initial admission, notice to the provider must cite the Michigan Provider Manual, Hospital Reimbursement Appendix, Special Circumstances Under DRG Reimbursement section as the applicable policy, and must include at a minimum the following information: Patient name, Patient ID, first admission dates of service, combined status reason (one of C1-C6, below), and admission date of second admission. **Please refer to the chart below.**

MICHIGAN 15 Day Readmissions				
Bill as Separate				
Category	**Description**	**Billing**	**Appeal Rights**	**Comments**
S1	Member is readmitted within 15 days for unrelated conditions.	Separate	NA	The documentation should indicate that the readmission does not meet any of the criteria for a combined admission. *Example: Admission 1 for gall bladder removal. Admission 2 for multiple injuries due to home accident*

S2	Member meets discharge criteria and has an appropriate discharge plan but requires readmission due to a new occurrence of same condition or due to a direct or related complication from surgery. All standards of care were met. Patient was stable at discharge. Health plan participated in discharge plan of first admission (preferred).	Separate	NA	Documentation must include a discharge plan that is appropriate and reasonable. Discharge plans should include the member's ability to follow the treatment plan after discharge Lack of health plan participation in discharge plan may create delay in determination for separate billing status *Example: Admission 1 for sickle cell with pain crisis, appropriate discharge plan, and meets criteria. Admission 2 for sickle cell with pain crisis.*
S3	Member fails to follow the discharge plan of the first admission (non-compliant).	Separate	NA	Documentation for the second admission must include that member reported non-compliance of first admission's discharge plan. *Example: Member did not get prescriptions filled.*

S4	Member leaves against medical advice and requires subsequent readmission.	Separate	NA	The documentation should show that the member signed out against medical advice. The documentation must further demonstrate the hospital's attempt to educate member regarding possible complications due to non-compliance with care plan and likelihood of readmission.
Bill as Combined				
Category	**Description**	**Billing**	**Appeal Rights**	**Comments**
C1	Member is discharged before all medical treatment is rendered. Care during the second admission should have occurred during the first admission.	Combine admissions as continuation of care	Yes; if documentation supports that the patient's condition was recognized and it was appropriately determined the treated condition did not require follow-up, or that appropriate outpatient follow-up arrangements are documented.	*Example: Member is treated for pneumonia, responds, and meets discharge criteria. However, a fecal occult blood test is positive -- Hgb 10.9 grams. The hospital record does not support that this was recognized, and appropriately determined not to require investigation during the first admission. No follow-up of the fecal occult blood test is documented. The member is readmitted five days later with*

				gastrointestinal bleeding. Combine the admissions as continuation of care. Example: Member is treated for pneumonia, responds, and meets discharge criteria. However, other lab tests performed during the initial admission are abnormal. The member is readmitted for a condition related to abnormal lab tests. No follow-up on the abnormal lab test is documented in the patient record for the first admission. Example: Member is treated for dehydration secondary to persistent emesis and responds. Member is discharged on a medication for outpatient use different than that used during inpatient care. Member is readmitted because the outpatient prescribed medication did not work
C2	Member is discharged without discharge criteria being met, including the	Combine admissions as premature discharge	Yes; if hospital is able to provide documentation indicating the member was	Clinical review supports that the member was prematurely discharged.

	clinical and level of care criteria.		stable at discharge.	
C3	Member is discharged from the hospital after surgery, but is readmitted within 15 days. The standards of care for evaluating the patient for known complications are not documented in the record. The readmission is due to a direct or related complication from the surgery.	Combine admissions as continuation of care.	Yes	The monitoring, evaluation and treatment of the member for known sequela or common complications following surgery is not documented in the record and/or is not addressed in the patient's discharge plan. *Example: An open appendectomy is performed, and the member is discharged on the second post-operative day without evaluation for known complications during the hospital stay or arranged as part of the discharge plan. The member returns in three to five days with a wound infection requiring hospitalization and further treatment for a condition that should have been checked during the first admission or through follow-up arranged by the hospital. The*

				admissions are combined as the DRG for an appendectomy.
C4	Member discharged from the hospital with a documented plan to readmit within 15 days for additional services. (doctor requested, member requested)	Combined as planned readmission	Yes	The care rendered during the subsequent admission was anticipated. *Examples: A discharge from hospital for physician/provider convenience (surgeon away/operating room booked), member convenience, member needs to return home or requests time to make a major health care decision.*
C5	Member is discharged to allow resolution of a medical problem that, unless resolved, is a contraindication to the medically necessary care that	Combined as planned readmission	Yes; if the hospital clearly documented the medical necessity for the interruption of care based on issues such as the specific co-	*Example: Discharge to await normalization of clotting times prior to a surgical intervention.*

	will be provided during the second admission.		morbidity and the stabilization of the member.	
C6	Member is discharged meeting discharge criteria, but non-clinical factors have not been addressed, and member has had previous 15-day admits. Member has issues or barriers that require discharge plans beyond the typical.	Combined as inadequate discharge plan	Yes; if hospital is able to document discharge plan addressed, and non-clinical contribution to re-admission were addressed.	*Example: Sickle cell with pneumonia and evidence of pneumonia on prior admission. No evidence that non-clinical factors that contribute to member's ability to comply with treatment plan were addressed (i.e., member is discharged home, but is homeless).*

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
N/A	

HCPCS ®* Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		
Annual Review	6/2020 7/2022	6/2020 7/2022
Annual Review • Updated reference material MDHHS date on dates from July 1, 2022, to January 1, 2023	1/20/2023	03/31/2023
Annual Review – references updated	5/11/2023	06/23
Annual Review • Updated 30 days to 15 days	6/24	6/24

References

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians/providers practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical 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 clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical 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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician/medical provider in connection with diagnosis and treatment decisions.

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

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees 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/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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