Applicable To:

- ☑ Medicaid – Florida, Georgia, Hawaii, Illinois, Missouri, Nebraska, New Jersey, New York, South Carolina
- ☑ Medicare – All Markets

NOTE: Kentucky specific guideline available on Wellcare.com

Claims and Payment Policy: Inpatient Readmission

Policy Number: CPP-123

Original Effective Date: 3/1/2018
Revised Effective Date(s): 3/7/2019

BACKGROUND

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), Wellcare Health Plans (Wellcare) may perform a readmission review. These reviews involve 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.

Wellcare may review hospital readmissions concurrently, on a pre-pay basis, or on a post-pay basis, when a Wellcare member is readmitted to the same hospital, its affiliate, or within the same hospital system. Wellcare 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. Wellcare reserves the right to follow CMS guidance when a member is readmitted on the same day to ensure both admissions on placed on the same claim.

POSITION STATEMENT

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

Readmissions days vary by State and CMS. The breakdown below includes the maximum amount of time for an admission to be potentially classified as a readmission. When the State is silent, Wellcare will use the CMS definition.

State	Readmission Days	Source
Medicare		
Medicare	30	Section 3025 Section 1886(q)
Medicaid		
Florida	30	CMS Definition
Georgia	3	Georgia Medicaid Hospital Handbook, § 904
Illinois	30	89 Ill. Admin. Code 152.300
Nebraska	31	Nebraska Dept. of Health (10-010 Payment for Hospital Services)
New Jersey	7	NJ ADC 10:52-14.16
New York	14	10 NY ADC 86-1.37
South Carolina	30	CMS Definition

Procedure – Concurrent Review

- Wellcare reserves the right to evaluate readmissions concurrently during the second admission.
- Upon authorization request from a hospital, if it is determined that the member was discharged from the same hospital or hospital system **within the past 30 days**, Wellcare's clinical team will compare the current admission to the index admission.
- If it is determined that the two admissions are related, or the current admission could have been avoided, Wellcare will deny the inpatient authorization request from the hospital.
- Providers will be given normal and customary appeal rights.

Procedure – Pre-Payment

- Wellcare reserves the right to evaluate readmissions prior to payment.
- Wellcare 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 Wellcare's determination, the provider has the right to dispute or appeal the determination. The provider must submit records for both admissions to Wellcare, or its contracted vendor, to determine if the second admission was preventable or related to the first admission.
- If a provider disputes and it is found the second admission was not related nor preventable, Wellcare will release payment for the second admission.

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

Procedure – Post-Payment

- Wellcare reserves the right to look back within the maximum allowed recovery period per state or federal guidelines or per specific provider contract, to identify any claims that may be readmissions.
- Wellcare will identify which claims that are most likely avoidable or preventable readmissions for denial 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.
- If the provider disagrees with Wellcare's determination, the provider has the right to appeal/dispute the determination. The provider must submit medical records for both admissions to Wellcare or its contracted vendor. Wellcare will evaluate the records to determine if the second admission was preventable or related to the first admission.
- If it is determined that the second record is not a related readmission, the provider will be notified and no additional actions will occur.
- If Wellcare determines that the second admission was preventable or related to the index hospitalization, the provider will be notified that the denial or requested refund will be upheld.

Procedure – Disputes / Appeals

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

CODING & BILLING

NOTE: For Kentucky Medicare, reference the CPP specific to the Kentucky market on Wellcare.com

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.

DEFINITIONS

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.
Prospective Payment System (PPS)	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).

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. Published August 18, 2017. Accessed February 27, 2018.
2. New AHRQ Database Tracks Hospital Readmission Rates. Agency for Healthcare Research Web site. New AHRQ Database Tracks Hospital Readmission Rates | Health IT Answers.Published November 20, 2015. Accessed February 27, 2019.
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 February 27, 2019.

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.

The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.Wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
10/30/2019	• Approved by RGC