



<u>Payment Policy:</u> Readmission Within 30 Days		
<u>Original Date Approved:</u> 12/18/2018	<u>Effective Date</u> 3/3/2019	<u>Date Revised:</u> 8/27/2019
<u>Scope:</u> Commonwealth Care Alliance (CCA) Product Lines:		
<input checked="" type="checkbox"/> <u>Senior Care Options</u> <input checked="" type="checkbox"/> <u>One Care</u>		

PAYMENT POLICY SUMMARY:

Following the precedent established by the Centers for Medicare and Medicaid Services (CMS), CCA recognizes that the frequency of readmissions to an acute care hospital shortly after discharge is an index for quality of care, and thus, CCA has implemented a process for reviewing such readmissions.

Payment for a readmission to the same hospital or hospital system within 30 days may be denied or recouped if this admission was deemed preventable, medically unnecessary, or due to a premature discharge of the prior admission.

REFERRAL/NOTIFICATION/PRIOR AUTHORIZATION REQUIREMENTS:

Prior Authorization is required for all inpatient admissions. Please refer to the Provider Manual for additional information [Section 4: Covered Services & Prior Authorization Requirements](#)

PROVIDER REIMBURSEMENT GUIDELINES:

Admissions to an acute hospital occurring within 30 days of the date of discharge from the same acute hospital or hospital system for the same, similar, or related diagnosis will be subject to readmission review.

CCA and its affiliates will conduct readmission reviews to determine if the admission could have been prevented by one or more of the following:

- Optimal provision of care during the initial admission
- Optimal discharge planning
- Optimal post-discharge follow up
- Improved coordination between inpatient and outpatient health care teams

Exclusions from readmission include but are not limited to:

- 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 treatments such as cancer chemotherapy, transfusions for chronic anemia, or similar repetitive treatments or for scheduled elective surgery.
- Admissions to Skilled Nursing Facilities and Rehabilitation Facilities
- Admissions associated with malignancies, burns, and Cystic Fibrosis
- Admissions with a discharge status of left against medical advice
- Obstetrical Readmissions
- Readmissions > 30 days from the initial admission

CCA reserves the right to deny separate payment and/or recoup monies previously paid on a claim that falls within the above guidelines of a readmission for the same, similar, or related condition deemed preventable.

CCA will inform the provider of the denial reason in writing and include the appropriate code for reference. In-Network hospitals may submit an appeal of CCA's decision within 90 days of the written denial notice, unless otherwise specified in a provider contract. Out-of-Network providers may submit an appeal within 60 days.

CCA will have the case clinically reviewed, considering the available medical information, the rationale for CCA's initial denial decision, the information provided by the hospital in the letter of appeal, and any other information provided during the appeal that was not available at the time of the initial review.

When a denial is received for a Readmission within 30 days of a previous admission, please submit **ALL** pertinent documentation relative to both the initial admission and the readmission, for clinical review. If all pertinent documentation is not received, the claim will be denied.

Address to send claims, clinical documentation, and/or supporting invoices:

Commonwealth Care Alliance
PO Box 22280
Portsmouth, NH 03802-2280

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

CCA reserves the right to request preauthorization to complete a retrospective review of services provided. In some instances, medical records may be requested for determination of medical necessity. When medical records or clinical information is requested, all supporting documentation to support medically necessary services should be included for clinical review. If the requested records or clinical information is not received by CCA within 30 days of the request, claims under review will be denied.

CCA reimbursement policies are developed based upon nationally and locally accepted industry standards and coding principles. These policies may be superseded by mandates in provider state, federal, or CMS contracts and requirements. System logic or set up may prevent the loading policies into claims platforms in the same manner as described; however, CCA strives to minimize these discrepancies.

CCA reserves the right to review and revise our policies when necessary. When there is an update, we will publish the most current policy to this site.

REFERENCES:

This policy has been developed through consideration of the following:

Centers for Medicare and Medicaid Services, CMS Manual System, and other CMS publications and services.
(www.cms.gov)

POLICY TIMELINE DETAILS

1. December 2018 Approved
2. Effective date 3/3/2019
3. Annual review and format revision 8/15/2019
4. Pertinent documentation needed 8/27/2019