Payment Policy: Readmissions Within 30 Days		
Original Date Approved: 12/18/2018	**Effective Date** 07/01/2021	**Date Revised:** 05/25/2021
Scope: Commonwealth Care Alliance (CCA) Product Lines: ☒ Senior Care Options ☒ One Care		

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance © (CCA) performs readmission reviews when admissions to an acute care hospital occur less than 31 calendar days from the date the member was discharged from the same acute care hospital. The date of admission and the date of discharge are not counted within that timeframe.

PROVIDER REIMBURSEMENT REQUIREMENTS:

CCA and/or its affiliates will conduct readmission reviews to determine if the admission could have been prevented according to one or more of the following conditions, in accordance with Medicare's Quality Improvement Organization manual 100-10 Chapter 4 sections 4240 Case Review and 4255 Circumvention of Prospective Payment System (PPS):

- If the readmission was medically unnecessary
- If the readmission resulted from a premature discharge from the same hospital or;
- If the readmission was the result of circumvention of PPS by the same hospital

Exclusions from readmission reviews 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, for similar repetitive treatments, or for 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
- Behavioral Health readmissions
- Substance Abuse readmissions
- Readmissions more than 30 days from the initial admission

If Exclusion Criteria Is Not Met

When a claim is flagged as a potentially preventable readmission (PPR), CCA and/or its affiliates will send an Intent to Audit Letter including a request for medical records. Medical records must be accompanied by the appropriately detailed cover letter citing the portion of the medical record that addresses the rationale for the readmission.

Provider will have no more than 60 days from the date of original Intent to Audit Letter to respond with the requested records. The provider is expected to supply all documentation related to the initial admission and subsequent admission(s) within the requested time frame. If medical records are not received in the requested time frame, payment for the subsequent admission claim(s) may be reversed.

Review of Records

Once received, CCA and/or its affiliates will review the medical records and appropriate summary documents for the admission(s) in question. A Nurse Auditor will conduct the initial review of these records. If it is determined that the readmission(s) was unrelated or unavoidable, the audit will be closed, and a no-finding letter will be issued. If the readmission appears to have been related or potentially preventable based on the records submitted, the findings will be reviewed and validated by a second Nurse Auditor. These results will be shared with the Medical Director and a final decision on the readmission(s) will be rendered. If the readmission is determined to have been preventable, payment for the readmission will be subject to reversal. A Finding Notice detailing the rationale behind the finding will be sent to the provider for review and potential appeal.

Appealing Readmission Determinations

If a finding is identified, providers are entitled to request an appeal. Appeals must be submitted within 60 days of the date on the Finding Notice. Appeals must be sent directly to CCA or its affiliates as instructed on the Finding Notice. The request to appeal must include evidence to support that services provided are covered and were properly coded and correctly billed.

The following data elements must be included in the appeal:

- Member Name and Date of Birth
- Dates of Service
- Claim number(s)
- Date of the Finding Notice
- A summary and relevant evidence for reconsideration

Non-contracted providers must also include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal per the CCA Provider Manual. This form must be accompanied by the claim appeal. The Waiver of Liability form is not required for contracted providers.

If an appeal is not received within 60 days from the date of the finding letter, recoupment may occur.

REFERRAL/NOTIFICATION/PRIOR AUTHORIZATION REQUIREMENTS:

Prior Authorization is required for all inpatient admissions. Please refer to Section 4 of the Provider Manual for more information.

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.

REFERENCES:

1. Medicare Quality Improvement Organization Manual Chapter 100-10 Chapter 4

POLICY TIMELINE DETAILS

1. Original approval 12/18/2018
2. Effective date 3/3/2019
3. Annual review and format revision 8/15/2019
4. Addition of pertinent documentation needed 8/27/2019
5. Policy suspended 1/1/2021
6. Policy revised with updated process and guidance 5/25/21