If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any Plan document, as defined below, under which a member is entitled to Covered Services, the Plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or Plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Each Health Care Service Corporation (HCSC) Blue Cross and Blue Shield Plan ("Plan(s)") may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. The Plans have full and final discretionary authority for their interpretation and application to the extent provided under any applicable Plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Inpatient Readmissions

Policy Number: CPCP027
Version 2
Clinical Payment and Coding Policy Committee Approval Date: 02-05-2020
Effective Date: 04-01-2020

Description

The purpose of this policy is to provide an explanation of the Plan's process for reviewing inpatient reimbursement of stays that later result in a readmission. Under this policy, additional reimbursement *may* be denied or reduced for an inpatient readmission if the services rendered are considered a continuation of the initial treatment. While some readmissions are preventable it is understood that other readmissions are planned or are not preventable.

The Plan will review claims for hospital readmissions occurring within thirty (30) days, or the number of days specified in the providers contract, if different, of the initial discharge for the same, similar, or related diagnosis. This policy applies to all hospitals and facilities, including those within the same health system which practice under the same tax identification number (TIN) or subject to the same provider contract. **SEE BELOW FOR NM CENTENNIAL CARE SPECIFIC LANGUAGE for readmission within 24 hours and 15 days of discharge.**

MCG Transitions of Care Guidelines are used as the policy resource for discharge planning and follow-up care. Providers who do not have access to the MCG website may request the MCG Transitions of Care Guidelines by contacting the Plan and requesting the criteria for Discharge Planning and Post-Acute Care Follow-up. The plan will coordinate necessary services with the hospital discharge planning staff and the admitting physician.

Background:

CMS defines a hospital readmission as a return hospitalization to an acute care hospital that follows a prior acute care admission within thirty (30) days of discharge from the same or another acute care hospital under the same agreement for a clinically related admission. CMS implemented a review process for readmissions due to high volumes shortly after discharge.

The goal of the Inpatient Readmissions review process, similar to that of CMS, is to establish quality of care and outcomes by conducting medically appropriate discharge planning and follow up care to avoid Potentially Preventable Readmissions (PPR).

A large percentage of readmissions are preventable and are most often due to a premature hospital discharge and/or a lack of patient education pertaining to discharge and recovery. Examples of PPR may include, but are not limited to, the following:

- Heart failure accounts
- Infection or complication from care provided from the initial admission
- Same procedure or treatment from the initial admission
- Procedure needed for an unsuccessful surgical intervention from the initial admission

Readmissions for unrelated occurrences after the initial discharge are not classified as a PPR and are excluded from the review process.

Readmission Review - A readmission for an inpatient stay within 30 days of the initial stay for the same, similar, or related diagnosis may be denied or claim payment reduced based on this policy.

Medical Record Review Criteria

Any readmission to the same hospital within thirty (30) days of initial discharge is subject to a medical record review on a pre-adjudication or post-payment basis. The review criteria include, but is not limited to, the following:

- Readmissions related to the first admission
- Preventable readmissions
- Premature hospital discharge from the same facility or a facility within the same health system or under the same provider contract
- Unplanned surgery resulting in a continuation of the initial admission
- Condition or procedure attributed to readmission due to a failed surgical procedure or interventional service
- Infection due to the initial admission

- Medical necessity
- Exacerbation of symptoms of a chronic illness

Exclusions

The following are excluded from the review process:

- Psychiatric/Substance abuse admissions
- Transplant services admissions
- Readmission due to discharges against medical advice (may require medical record review for determination)
- Multiple trauma
- Burns
- Some chronic conditions that may require follow-up care
- Neonatal and obstetrical admissions
- Elective admissions or staged procedures following commonly accepted practices
- Transfer from an out of network to an in-network facility
- Transfer due to level of care unavailable at the first facility
- Planned readmissions

Claim Review Process

Any readmission to the same hospital or facility within the same health system practicing under the same contract or TIN within thirty (30) days of initial discharge is subject to a claim review. A claim review may occur pre-adjudication or post payment and may include, but is not limited to, the following:

- Provider contract assessment (In-network)
- Diagnosis related to initial admission
- PPR
- Prior admissions and discharge dates of service
- Medical records submitted with claim (claim adjudication is dependent on the outcome of a medical record review)
- Medical record will be requested if not accompanied with the claim submission

Claim Adjudication

The initial admission and subsequent readmissions will be adjudicated with the following considerations:

- The initial admission and readmission will be considered as a single admission
- All days for the initial admission and readmission must be pre-authorized
  - All authorized days for the initial admission and readmission will be combined to determine the approved length of stay
  - All days in-between admissions will not be considered for reimbursement
- If the authorized days from the readmission causes the combined admission to exceed the average length of stay determined for the assigned DRG, high-trim days will not be reimbursed in addition to the assigned DRG reimbursement

- All services for initial admission and readmission will be considered as a single claim for both inpatient stays
- Multiple readmissions will not be separately reimbursed when each stay is reimbursed per case/per admission
- If initial admission has been reimbursed, claims will be combined to determine reimbursement

New Mexico Centennial NMAC Regulation 8.311.3

Payment for readmissions: (a**) Readmissions that occur within 24 hours** of the previous discharge of an eligible recipient with the same or related diagnosis related group (DRG) will be considered part of the prior admission and not paid separately when the admissions are to the same hospital. When the second admission is to a different hospital, the claims may be reviewed to determine if the initial claim should be considered as a transfer. (b) **Readmissions occurring within 15 calendar** days of prior acute care admission for a related condition may be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the department.

References:

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Policy Update History: CPCP0027

HCSC Approval Date	Description	BCBSNM Approval Date	BCBSNM Effective Date	BCBSNM End Date
02/05/2020	New policy	02/11/2020	04/01/2020	