



UnitedHealthcare Medicare Advantage Plans Readmission Review General Clinical Guidelines for Payment Review

Introduction

This readmission program will apply to all UnitedHealthcare Medicare Advantage products carrying the SecureHorizons®, AARP® MedicareComplete® from SecureHorizons, and Evercare® name.

UnitedHealthcare Medicare Advantage Plans recognizes the negative impact on quality that hospital readmissions are associated with. The Agency for Healthcare Research and Quality has also stated “rehospitalization may be the most powerful single example of the cost of fragmented, provider-centered care”. It is with this in mind in order to improve quality our readmission review program is in place. This Readmission Review program applies to facilities reimbursed based on Centers for Medicare & Medicaid Services (CMS’) Medicare Severity Diagnosis Related Group (MS-DRG) payment methodology. The review is based on Medicare guidelines for the inpatient prospective payment system and applies both to participating and nonparticipating hospitals. If a readmission undergoes clinical review because of the potential quality issue the claim may be denied. Please note if the claim is denied, it will be “provider liability” as providers are not permitted to balance bill the member for the denied claim.

There are two general components to this review:

- A. Billing guidelines were not followed
- B. The readmission was avoidable or preventable

For more details on what UnitedHealthcare is reviewing for the 30-Day Readmission Review Program, please reference the UnitedHealthcare Medicare Solutions 30-Day Readmission Review Program for Medicare Advantage Plans Frequently Asked Questions document found at www.UnitedHealthcareOnline.com. > Tools & Resources > Products & Services > Medicare or www.oxhp.com > Facilities > Tools & Resources > Oxford Programs or finally at www.Pacificare.com > Provider > Library > Product Information > Secure Horizons Medicare Advantage.

A. Billing guidelines were not followed

Chapter 3 of the Medicare Claims Processing Manual includes inpatient hospital billing guidelines. These are administrative in nature and govern payment for MS-DRG facilities. (Note that cases denied following review for avoidable or preventable readmission remain subject to the billing guidelines if that denial is overturned.)

Same day readmissions

These are described in the Medicare manual as Readmissions within same day. “Same day” is defined as midnight to midnight of a single day. According to the Medicare Claims Processing Manual - Chapter 3 - 40.2.5 - Repeat Admissions:

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 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...

Same day readmissions for unrelated symptoms are not subject to this rule. The Medicare Claims Processing Manual guidelines state:

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 unrelated to, and/or not for evaluation and management of, the prior stay’s medical condition, hospitals shall place condition code (CC) B4 on the claim that contains an admission date equal to the prior admissions discharge date. Upon the request of a Part A / Part B Medicare Administrative Contractors A/B MACs or the Fiscal Intermediate’s (FI)’s, hospitals must submit medical records pertaining to the readmission.

If it is determined that a patient was readmitted during the “same day” for a same or similar condition, both the initial and subsequent admissions will be denied for payment as a separate DRG. The facility must submit both admissions combined on a single claim to receive reimbursement. In order for a same day readmission to qualify for separate reimbursement, the medical record must support that the conditions are clinically unrelated.

Combined DRG’s (Leave of Absence)

These are described in the Medicare manual under leave of absence. According to the Medicare Claims Processing Manual - Chapter 3 - 40.2.5 - Repeat Admissions:

A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence. Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. Institutional providers may not use the leave of absence billing procedure when the second admission is unexpected.

The discharge summary from the previous admission will indicate that additional workup, treatment, or surgical procedures are planned for the same episode of illness. Note that we do not apply this rule to cancer chemotherapy, transfusions for chronic anemia, or similar repetitive treatments. However, surgery that is delayed while outpatient workup is completed does fall under this rule.

According to the Medicare Claims Processing Manual - Chapter 3 - 40.2.6 – Leave of absence:

Providers submit one bill for covered days and days of leave when the patient is ultimately discharged.

The provider bills for covered days with days of leave included in FL 8, Noncovered Days. Noncovered charges for leave of absence days (holding a bed) may be omitted from the bill or may be shown under revenue code 018x. Providers will be instructed by their FI on which billing method to use. Occurrence span code 74 is used to report the dates the leave began and ended. Although the Medicare program may not be billed for days of leave, the provider is not permitted to charge a beneficiary for them.

When a readmission is expected, but the date of readmission is different from that initially planned, the readmission should still be treated as a leave of absence and the DRG's combined. The fact that the patient had to return early due to failed outpatient management does not change the fact that this was an expected readmission.

B. Avoidable or Preventable Readmissions

In recognizing and supporting preventable readmission as a quality issue, UnitedHealthcare follows Center for Medicare & Medicaid Services (CMS) guidance in reviewing claims for avoidable or preventable readmissions. Under original Medicare, CMS engages the Quality Improvement Organizations (QIO) to review 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. In Medicare Quality Improvement Organization Manual Ch.4, 4240, CMS instructs QIOs to:

... analyze the cases specifically to determine whether the patient was prematurely discharged from the first confinement, thus causing readmission. Consider the information available to the attending physician who discharged the patient from the first confinement. Do not base a determination of a premature discharge on information that the physician or provider could not have known or events that could not have been anticipated at the time of discharge."

When a provider takes an action that results in unnecessary admissions, premature discharges and readmissions, multiple readmissions, or other inappropriate medical or other practices with respect to beneficiaries or billing for services, certain actions are authorized, including denial of payment. Please refer to the Medicare Quality Improvement Organization Manual § 4240 and §4255.

Reimbursement for readmissions may be denied under the following circumstances (See §4240):

- If the readmission was medically unnecessary;
- If the readmission resulted from a premature discharge from the same hospital; or
- If the readmission was a result of circumvention of Prospective Payment System (PPS) by the same hospital.

Most of our readmission claims reviews focus on whether a second admission resulted from premature discharge and/or there is an indication that the facility was attempting to circumvent the PPS system. Such determinations require medical director review.

Premature Discharge:

A number of factors may be considered when classifying a discharge as premature, such as:

CMS' State Operations Manual, in Appendix A §482.43, outlines discharge planning requirements for hospitals. Discharge prior to completing adequate discharge planning is considered a premature discharge under this program.

Clinical instability at the time of discharge or failure to address signs and symptoms during an admission also provides evidence of premature discharge. The following factors related to clinical instability and discharge planning may be considered in determining whether discharge was premature.

- *Failed discharge to another facility:* Failed transfers to a Skilled Nursing Facility (SNF), Long Term Care Hospital (LTCH), Acute Inpatient Rehabilitation (AIR), or a similar facility is an indicator that a discharge was premature. Discharges with expected readmissions are treated as leave of absences with combined DRG reimbursement (see above). Errors made at the receiving facility unrelated to the orders they received upon transfer (falls, treatment delivery failure) will not result in a denial of the readmission.
- *Inadequate Outpatient follow-up or treatment:* Discharge planning must take into account the availability and criticality of outpatient follow-up visits and treatment. Communication with practitioners who will provide follow-up care is expected.
- *Failure to address rehabilitation needs:* Significant decline in function and inability to perform Activities of Daily Living (ADL)'s is common following hospitalization of the elderly. Failure to properly address rehabilitation needs related to an inability to self-care is an avoidable cause of readmission.
- *Emerging symptoms:* Symptoms that had onset or were present during a previous admission and subsequently worsened leading to readmission is a possible indicator of a premature discharge. Discharge prior to establishing the safety or efficacy of a new treatment regimen is also considered a premature discharge

Additional factors to be considered in making a decision include:

- Chronic disease: Chronic diseases vary in severity, and entry into the terminal phase of an illness can be gradual. When reviewing readmissions related to chronic disease, readmission within a short period of time should be assessed for adequacy of follow-up care and outpatient management using accepted practice guidelines and treatment protocols. Reasons for failure to order generally accepted treatments such as a prednisone taper for an exacerbation of Chronic Obstructive Pulmonary Disease (COPD) should be documented in the medical record. Interruption and failure to resume a chronic medication is a common error leading to a preventable readmission, as are other medication errors.
- Hospice: Decisions on whether or not to enter hospice are made by patients and their families. As a Medicare Advantage organization we encourage physicians to

- counsel terminally ill patients regarding treatment options including hospice. Until a patient enters hospice, is documented as Do Not Resuscitate (DNR), or refuses further treatment, treatment is expected to follow established guidelines.
- *Patient noncompliance*: Facilities will not be held accountable for patient noncompliance if **all** of the following conditions are met:
 - There is adequate documentation that physician orders have been appropriately communicated to the patient,
 - There is adequate documentation that the patient/caretaker is mentally competent and capable of following the instructions, and made an informed decision not to follow them
 - There were no financial or other barriers to following instructions. Note: The medical records should document reasonable efforts by the hospital 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.
 - The noncompliance is clearly documented in the medical record. 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). An unsafe discharge is not mitigated by a comment stating 'patient preference'.

United Healthcare is active in the development of related readmission programs intended to share local and national data with hospitals and support improved discharge planning for our members. Information gleaned through the Medicare readmission payment review contributes to enhancements in these programs and to improved outcomes for our members. Your support is appreciated.