Medicare Readmission Review Program for Medicare Advantage Plans

General Clinical Guidelines for Payment Review

Introduction

The UnitedHealthcare Medicare Readmission Review Program is part of the payment methodology we use to pay some facilities for services rendered to our Medicare Advantage members. The Readmission Review Program applies to all UnitedHealthcare Medicare Advantage benefit plans and acute care facilities that are paid based on Medicare Severity Diagnosis Related Group (MS-DRG) payment methodology established by Centers for Medicare & Medicaid Services (CMS) published guidelines. This includes facilities that participate in UnitedHealthcare's Medicare Advantage care provider network as well as those that do not. The Readmission Review Program is allowed by CMS requirements and guidance.

As part of the Readmission Review Program, UnitedHealthcare reviews the following categories:

- Same-day readmission for a related condition
- Same-day readmission for an unrelated condition
- Planned readmission/leave of absence
- Unplanned readmission less than 31 days after the prior discharge

The first three categories generally involve a determination of whether billing requirements were followed. The fourth category involves a determination of whether the readmission was preventable.

Same-Day and Planned Readmission/Leave of Absence:

CMS has established billing requirements for facilities reimbursed pursuant to the MS-DRG payment methodology in Chapter 3 of the Medicare Claims Processing Manual. These administrative requirements address proper billing for same-day readmissions and planned readmissions/leaves of absence. Claims denied following review for preventable readmissions occurring less than 31 days after discharge remain subject to the billing guidelines if that denial is overturned.

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Same-Day Readmissions: Same or Related Condition

If a patient is readmitted to a facility on the same day as a prior discharge for the same or a related condition, CMS requires the facility to combine the two admissions on one claim. "Same day" is defined as midnight to midnight of a single day. The Medicare Claims Processing Manual, Chapter 3, Section 40.2.5 (Repeat Admissions) explains:

> *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...*

Consistent with CMS billing requirements, UnitedHealthcare may review claims for same-day readmissions and request medical records to determine if the claim was properly billed. If a patient was readmitted during the same day for the same or a related condition, UnitedHealthcare will deny both the initial and subsequent admissions for payment as separate DRGs. The facility must submit both admissions combined on a single claim to receive reimbursement. For a same-day readmission to qualify for separate reimbursement, the medical record must support that the conditions are clinically unrelated.

Same-Day Readmissions: Unrelated Condition

If a patient is readmitted to a facility on the same day as a prior discharge for symptoms unrelated to the prior stay's medical condition, CMS requires the facility to follow different billing requirements. In this situation, two claims are submitted, but the claim for the subsequent admission must contain condition code "B4." Chapter 3, Section 40.2.5 of the Medicare Claims Processing Manual explains:

> *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.*

Consistent with CMS billing requirements, if a patient is readmitted during the same day for an unrelated condition, two properly coded claims must be submitted to UnitedHealthcare.

Planned Readmission (Leave of Absence)

If a patient is readmitted to a facility as part of a planned readmission or leave of absence, the admissions are not considered two separate admissions. CMS requires the facility to submit one claim and receive one combined DRG payment for both admissions because both are for the treatment of the same episode of illness. Leaves of absence are described in Chapter 3, Sections

40.2.5 and 40.2.6 of the Medicare Claims Processing Manual. Section 40.2.5 describes situations where leave of absence billing is appropriate:

> *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.*

The medical records from the initial admission should indicate that additional work-up, treatment or surgical procedures are planned or expected for the same episode of illness. As required by Section 40.2.6, when the patient is ultimately discharged from the subsequent admission, the facility submits one bill for covered days and days of leave. Days of leave are included in FL 8, Non-Covered Days. The Medicare program may not be billed for days of leave, and the facility 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, with one claim and one combined DRG payment. If the patient had to return early due to failed outpatient management and/or failed conservative management, it is still an expected readmission. Readmissions for surgical interventions that are expected when conservative and/or non-operative therapy have failed qualify for the Combined DRG review.

Consistent with CMS billing requirements, UnitedHealthcare may review claims for planned readmissions and request medical records to determine if the claim was properly billed. UnitedHealthcare does not apply the leave of absence billing guidelines to cancer chemotherapy, transfusions for chronic anemia, or similar repetitive treatments. However, surgery that is delayed while outpatient work-up is completed does fall under the leave of absence billing guidelines.

30-Day Readmission Review: Determination of Preventable Readmissions

Basis in Law and Regulation

To improve the quality of care provided to our members, and as allowed by CMS, UnitedHealthcare reviews acute care hospital admissions occurring fewer than 31 days following a prior discharge. Readmission review for 30 days is inherent in the CMS MS-DRG payment methodology. Congress directed the Secretary of Health and Human Services to establish the MS-DRG payment methodology as part of the Inpatient Prospective Payment System (IPPS) in §1886(d) of the Social Security Act.

Congress also authorized CMS to deny MS-DRG payment for unnecessary readmissions under §1886(f) of the Social Security Act, stating if CMS determines "that a hospital, in order to circumvent the [MS-DRG] payment method ..., has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals," CMS may "deny payment (in whole or in part) ..."

CMS guidance specifically addresses 30-Day Readmission Review. Chapter 4, Section 4240 (Readmission Review) of the Medicare Quality Improvement Organization (QIO) Manual states:

> *Readmission review involves 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)).*

QIOs have the authority to review such repeat admissions "if it appears the two confinements could be related," according to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.5.

In performing the readmission review, CMS instructs QIOs to:

> *Perform case review on both stays. Analyze the cases specifically to determine whether the patient was prematurely discharged from the first confinement, thus causing readmission. Perform an analysis of the stay at the first hospital to determine the cause(s) and extent of any problem(s) (e.g., incomplete or substandard treatment). 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.*
> Medicare QIO Manual, Chapter 4, Section 4240.

When a care 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, CMS authorizes QIOs to take certain actions, including denial of payment (see Medicare QIO Manual, Chapter 4, Sections 4240 and 4255). CMS states reimbursement for readmissions may be denied (see Medicare QIO Manual, Chapter 4, Section 4240) if the readmission:

- Was medically unnecessary
- Resulted from a premature discharge from the same hospital
- Was a result of circumvention of the PPS by the same hospital

Section 4255 of the Medicare QIO Manual provides additional detail on prohibited actions that circumvent PPS, including:

- **Premature Discharge of Patient that Results in Subsequent Readmission of Patient to Same Hospital** – This prohibited action occurs when a patient is discharged even though he/she should have remained in the hospital for further testing or treatment, or was not medically stable at the time of discharge. A patient is not medically stable when the patient's condition is medically unsound to discharge or transfer the patient. Evidence such as elevated temperature, post-operative wound draining or bleeding, or abnormal laboratory studies on the day of discharge indicate that a patient may have been prematurely discharged from the hospital.
- **Readmission of Patient to Hospital for Care that Could Have Been Provided during First Admission** – This prohibited action occurs when a patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission. This action does not include circumstances in which it is not medically appropriate to provide the care during the first admission.

CMS contracts regionally with Fiscal Intermediaries and Medicare Administrative Contractors (MAC) to administer claims payment for original Medicare member claims. It is possible that the Fiscal Intermediary or MAC in your market may not conduct a review of hospital readmissions or may conduct it differently than the UnitedHealthcare Readmission Review Program.

Review Process and Clinical Guidelines

Although UnitedHealthcare is not a QIO, as a contractor for CMS and in accordance with the MS-DRG payment methodology, we have adopted a uniform Readmission Review Program that is consistent with CMS guidance. A Licensed Vocational Nurse (LVN), a Licensed Practical Nurse (LPN), or a Registered Nurse (RN) reviews the initial claims and determines whether the facility and the subsequent admission meet the following criteria:

- The facility participates in UnitedHealthcare's Medicare Advantage care provider network or is paid using the MS-DRG payment methodology.
- The subsequent admission occurred fewer than 31 days after the initial discharge.
- The subsequent admission was for a diagnosis related to the initial admission.
- The subsequent admission was to the same facility.

If the criteria are met, UnitedHealthcare will request medical records and supporting documentation relating to the initial admission, including the initial discharge and subsequent admission. An LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related. If the LVN, LPN or RN determines the subsequent admission was either unrelated to the initial admission or unpreventable, the LVN, LPN or RN will release the claim for payment. If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.

The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system.

To determine whether a patient's discharge was preventable, the medical director will consider multiple factors including, but not limited to, premature discharge, inadequate discharge planning, clinical instability at the time of discharge, and discharge to an inappropriate destination. In accordance with the requirements set out in the CMS State Operations Manual, Appendix A §482.43, discharge prior to completing adequate discharge planning will be considered a premature discharge and a preventable readmission. Clinical instability at the time of discharge or failure to address signs and symptoms during an admission is also evidence of premature discharge and a preventable readmission.

The following factors related to discharge planning may be considered to determine if the discharge plan was inadequate and the subsequent admission was preventable. CMS provides guidance concerning proper discharge planning (see Medicare QIO Manual, Chapter 4, Section 4240 – Readmission Review, State Operations Manual Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Section A-0799 and the Code of Federal Regulations 42, Section 482.43 – Discharge Planning).

- **Inadequate Outpatient Follow-Up or Treatment:** Discharge planning must consider 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) 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.
- **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 can be an indicator of premature discharge. Discharges with expected readmissions are treated as leaves of absence with combined DRG reimbursement. Errors made at the receiving facility unrelated to the orders it received upon transfer (e.g., falls, treatment delivery failure) will not result in a payment denial for the readmission.

Additional factors to be considered in making a decision about whether subsequent admission was preventable include:

- **Emerging Symptoms:** Symptoms that had onset or were present during a previous admission and subsequently worsened, leading to readmission, are 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.

- **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 to enter hospice are made by patients and their families. As a Medicare Advantage organization, we encourage physicians to counsel terminally-ill patients about 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 Non-Compliance:** 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. The medical records should document reasonable efforts by the facility 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 develops preventable readmission programs that share local and national data with facilities and support improved discharge planning for our members. Information gathered through the Readmission Review Program is intended to contribute to enhancements in these programs and improved outcomes for our members.

For more information on this program, please contact your provider advocate or read the **Readmission Review Program frequently asked questions** posted in the Tools and Resources section of each Medicare Advantage plan.

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