BIENVIVIR SENIOR HEALTH SERVICES
MEDICAL DEPARTMENT

MED: 2.04	EFFECTIVE DATE: 10/8/2024	REVISED DATE: -	CORRELATE: NO

SUBJECT: 30-Day Avoidable Readmissions

POLICY:
The Bienvivir Readmission Review Program is part of the payment methodology Bienvivir uses to pay for some facilities and services rendered. The Readmission Review Program applies to all acute care facilities that are paid based on the Medicare Severity Diagnosis Related Group (MS-DRG) payment methodology established by the Centers for Medicare & Medicaid (CMS) published guidelines. This includes facilities that participate in the Bienvivir provider network as well as those that do not. The Readmission Review Program is allowed by CMS requirements and guidelines.

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

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

Categories (1) – (3) involve whether billing requirements were followed. Category (4) will require a clinical review to determine whether the readmission was preventable.

PROCEDURE:

Same-Day / Planned Readmissions / Leave of Absence

CMS Medicare Claims Processing Manual (Chapter 3) establishes billing requirements for facilities that are reimbursed using the MS-DRG payment methodology. This document addresses proper billing for same-day readmissions and planned readmissions/leaves of absence. Any denial for preventable readmission that occurs less than 31 days after discharge remains subject to these billing guidelines if that denial is overturned.

Same-Day Readmissions for Same or Related Condition:

If a participant is readmitted to the same facility on the same day as a discharge for the same or related condition, facilities are required to combine the two admissions on one claim. “Same

Day" is defined as midnight to midnight of a single day. A new authorization for the second admission will not be created. Rather, the original admission will be used with the stay continuing. Refer to Medicare Claims Processing Manual, Chapter 3, Section 40.2.5 with the following guidance given:

"When a patient is discharged/transferred from an acute care Perspective 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…"

Bienvivir Utilization Management (UM) will review same-day readmissions to determine if the above CMS guidelines apply. In addition, Bienvivir may review claims for same-day readmissions and may include a request for medical records to determine if the claim was properly billed. If Bienvivir finds that a readmission was for the same or related condition, Bienvivir will deny both the initial and subsequent admissions for payment as separate DRGs. The facility must submit both admissions combined into a single claim to be reimbursed.

Same-Day Readmissions: Unrelated Condition

For a same-day readmission to qualify for a separate DRG payment, the medical record must support that the second admission was clinically unrelated to the first admission. In addition, the second admission must be billed using condition code "B4." Two properly coded claims must be submitted to Bienvivir. Refer to Medicare Claims Processing Manual, Chapter 3, Section 40.2.5 with the following guidance given:

"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 admission's discharge date."

Planned Readmission (Leave of Absence):

Participants who are readmitted to a facility as part of a planned readmission or leave of absence are not considered to have had two separate admissions. CMS requires the facility to submit one claim and receive one combined DRG payment for both admissions because they are for the treatment of the same episode of illness. Refer to Medicare Claims Processing Manual, Chapter 3, Section 40.2.5 with the following guidance given:

“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, treatment is indicated following diagnostic tests but cannot begin immediately.”

The medical record must document the additional work-up, treatment plan, or surgical procedure(s) that are planned or expected for the same episode of illness. When the participant is discharged from the second hospital stay (readmission), the facility is required to submit one bill for covered days and days of leave. Days of leave are included in “FL8—Non-Covered Days.” Bienvivir may not be billed for days of leave, and the facility is not permitted to charge the Participant for these days.

If a planned readmission occurs on a date that differs from what was originally planned, it is still to be billed as outlined above. If the Participant had to return early due to failed outpatient management or failed conservative treatment, it is still an expected readmission. Readmissions for surgical interventions are expected when conservative and/or non-operative therapy has failed to qualify for the Combined DRG review.

Bienvivir may review claims for planned readmissions and request medical records to determine if the claim was correctly billed. Bienvivir will not apply “Leave of Absence” billing guidelines to chemotherapy, transfusions for chronic anemia, or similar repetitive treatments. However, “Leave of Absence” billing guidelines will be applied when surgery is delayed while outpatient work-up is completed. This is consistent with CMS Billing requirements.

30-Day Readmission Review: Determination of Preventable Readmissions

The basis for this process in Law and Regulation:

Bienvivir, as a PACE Program, is required to provide all Medicare-covered services, all Medicaid-covered services as specified in the State’s approved Medicaid plan, and other services determined necessary by the Interdisciplinary Team (IDT) to improve and maintain the participant’s overall health status. Bienvivir is responsible for providing care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year. (§460.92(a) and §460.98(a)) In addition, a 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)…"

The Medicare Quality Improvement Organization (QIO) Manual (Chapter 4, Section 4240: Readmission Review) provides the following support:

"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.

As stated in the Medicare QIO Manual, Chapter 4, Section 4240, when completing 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.

When medical records support that a care provider undertook an action that resulted in an unnecessary admission, premature discharges, and readmissions, multiple readmissions, or other inappropriate medical or other practices with respect to participants or billing for services, CMS authorizes QIOs to take actions that may include denial of payment. CMS states reimbursement for readmissions may be denied if the readmission:

1. Was medically unnecessary;
2. Resulted from a premature discharge from the same hospital; or
3. Was the result of circumventing the PPS by the same hospital.

Additional details on prohibited actions that are intended to circumvent PPS are outlined in the Medicare QIO Manual, Section 4255:

1. *Premature Discharge of Patient that Results in Subsequent Readmission of Patient to Same Hospital:* This prohibited action occurs when a Participant is discharged even though s/he 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 Participant may have been prematurely discharged from the hospital.
2. *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.

Review Process and Clinical Guidelines:

Although Bienvivir is not a QIO, as a contracted program with CMS and in accordance with the MS-DRG payment methodology, Bienvivir has adopted a uniform Readmission Review Program that is consistent with CMS guidance. The Utilization Management (UM) Nurse will review the clinical information provided either as a part of the process that occurs with Notification of Admission (NOA) or may conduct a medical necessity review once a claim has been received for an admission that was deemed to be potentially avoidable.

If the UM Nurse reviews the case and determines that the subsequent admission was unrelated, s/he will authorize the second admission if reviewed as part of the Notification of Admission process or, if part of a claims review, will authorize the release of the claim for payment.

If the UM Nurse reviews the subsequent admission and determines that it was potentially related / preventable, the UM Nurse will submit the case to the Bienvivir Primary Care Provider (PCP) for further review.

To determine whether a participant's discharge was preventable, the Bienvivir PCP 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. CMS provides extensive guidance on this requirement in the Medicare QIO Manual, Chapter 4 Section 4240 – Readmission Review, State Operations Manual Appendix A – Survey Protocol, regulations and interpretive guidelines for Hospitals, Sections A-0799 – A-0843, 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 Bienvivir Clinical Staff, who will arrange and 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 manage self-care is an avoidable cause of readmission. Bienvivir participants have access to robust services to support their transition from the acute care hospital, and partnership around identifying these needs will be critical to avoiding readmission.
- ***Failed Discharge to Another Facility:*** Failed transfers to a Skilled Nursing Facility. (SNF), Long-Term Acute Care Hospital (LTACH), Acute Inpatient Rehabilitation Facility (IRF) or 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 deciding whether a 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 chronic medication is a common error leading to a preventable readmission as are other medication errors. Bienvivir Participants typically have multiple chronic diseases and will require close coordination as a part of their discharge planning.
- **Hospice:** Decisions on whether to enter hospice are made by patients and their families. As a PACE Program, we regularly have conversations with our participants around goals of care and advanced care planning. Oftentimes, a hospitalization will result in further deterioration of overall well-being, and discussions of updated goals of care are warranted. Therefore, we encourage treating clinicians to counsel terminally ill Participants about treatment options, including hospice. Until a patient enters hospice, is

documented as a “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 sufficient documentation that all physician orders have been appropriately communicated to the Participant and/or their family member(s).
  - There is sufficient documentation that the patient/caretaker has the capacity to follow the instructions and make an informed decision not to follow the treatment plan as prescribed.
  - Clinical documentation includes evidence that reasonable efforts were made by the facility to address any barriers to success, including consultation with the appropriate Bienvivir clinical staff along with frank discussions of risks and alternatives if the Participant voices their refusal to follow the treatment plan.
  - Non-compliance is clearly documented in the medical record. For example, if a Participant insists on a discharge to home but the facility believes this to be unsafe, the medical record should include a signature by the participant/caregiver that they chose to leave “Against Medical Advice” (AMA). Bienvivir will not consider statements such as “patient preference” to be an adequate substitute for signing out as an AMA.

STANDARDS:

- 42 CFR Part §460

ADDITIONAL GUIDELINES

- Social Security Act Sec 1862 [42 U.S.C. 14395y]
- 42 CFR Part §412
- Medicare Claims Processing Manual – Chapter 3 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf)
- CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-04 Medicare Claims Processing (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r311cp.pdf)
- Social Security Act Sec 1886 [42 U.S.C. 1395ww] www.ssa.gov/OP_Home/ssact/title18/1886.htm#:~:text=(D)%20For%20purposes%20of%20this,the%20market%20basket%20percentage%20increase
- Medicare Quality Improvement Organization Manual (https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019035)
- State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Sections A-0799 – A-0843 (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_a_hospitals.pdf)
- 42 CFR Part §482 (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.43)

Procedure Reviewed: _____ Date: 10/8/2024
Medical Director

Procedure Reviewed: _____ Date: 10/8/2024
Chief Executive Officer

Review/Revision History

Designated Committee Approval	Procedures Revised	Statement Amended	Attachment Titles	Correlates
P&P - 10/8/2024				
CCI - 9/5/2024				
-				
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Approval: _____ Date: 9/5/2024
Choose an item.

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Chief Executive Officer

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Medical Director