PROVIDER REIMBURSEMENT GUIDANCE		
Readmission Within 30 Days		
Original Date Approved	Effective Date	Revision Date
12/18/2018	10/20/2024	09/17/2024

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options MA
☒ Medicare Advantage MA Plans
☒ One Care MA
☒ Medicare Advantage RI Plans
☒ DSNP RI

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance® and its affiliates (collectively "CCA") follow Centers for Medicare and Medicaid Services (CMS) guidelines for Readmissions within 30 calendar days of discharge from the initial admission. Payment for a readmission to the same acute facility within 30 calendar days may be denied if the admission was deemed preventable, medically unnecessary or was due to a premature discharge of the prior admission.

AUTHORIZATION REQUIREMENTS:

Prior authorization is required for select inpatient admissions. Notification is required for all emergent inpatient admissions. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the Provider Manual.

REIMBURSEMENT GUIDELINES:

1. General

   Payment for a readmission to the same acute facility within 30 calendar days may be denied if the admission was deemed preventable, medically unnecessary or was due to a premature discharge of the prior admission. Please note that day of discharge from the initial hospital stay is not counted, when determining the number of days between admissions.

2. Criteria for Preventable/Inappropriate Readmissions

   CCA may conduct a medical record review to determine, if the subsequent hospital admission/readmission is related to the most recent previous hospital admission. Readmissions which are deemed preventable or considered inappropriate pursuant to the following criteria may be denied:

   - The readmission was medically unnecessary.
   - The readmission resulted from a premature discharge or is related to the previous admission, or that the readmission was for services that should have been rendered during the previous admission.

- The readmission resulted from a failure to have proper and adequate discharge planning.
- The readmission resulted from a failure to have proper coordination between the inpatient and outpatient health care teams;
- The readmission was the result of circumvention of the contracted rate by the facility or a related facility.
- A medical readmission for a continuation or recurrence for the previous admission or closely related condition.
- A medical complication related to an acute medical complication related to care during the previous admission.
- An unplanned readmission for surgical procedure to address a continuation or recurrence of a problem causing the previous admission.
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the previous admission.
- An unplanned readmission related to a suspected complication that was not treated prior to discharge.
- Complications related to Serious Reportable Events (SREs).

In the event that a readmission falls under one of the criteria listed above, the hospital may not bill a member for the readmission. CCA will not reimburse for services submitted under Observation services when an inpatient level of care is warranted and would have resulted in a readmission.

3. Exclusions

CCA may consider as excluded from the criteria in Section 2 above, readmissions related to certain conditions or situations, including, but not limited to:

- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, for similar repetitive treatments, or for elective surgery.
- Admissions associated with malignancies (limited to those who are in an active chemotherapy regimen-both infusion and oral), burns, or cystic fibrosis.
- Transplant services, including organ, tissue, bone marrow transplantation from a live or cadaveric donor.
- Admissions with a documented discharge status of “left against medical advice.”
- Obstetrical readmissions.
- Behavioral health readmissions.
- Substance use readmissions.
- In-network facilities that are not reimbursed based on contracted DRG or case rate methodology (e.g., per diem).

4. Intent to Audit

   Claims which are identified as readmissions to the same acute facility within 30 calendar days and that are not subject to an exclusion under Section 3 above are reviewed by CCA. CCA will send to the provider an Intent to Audit Letter regarding the readmission, including a request for medical records. The provider is required to supply all documentation related to the initial admission and subsequent admission within 60 calendar days from the date of original Intent to Audit Letter. Medical records must be accompanied by the copy of the Intent to Audit Letter. If medical records are not received in the requested time frame, payment for the subsequent admission claim may be reversed.

5. Review of Records:

   CCA will review the medical records and appropriate summary documents submitted by the provider for the admission(s) in question. If it is determined that the readmission was not preventable, was medically necessary or was *not* due to a premature discharge of the prior admission, the audit will be closed, with no further action required from the provider. If the readmission is deemed preventable, medically unnecessary or otherwise inappropriate consistent with the criteria in Section 2 above, payment for the readmission will be subject to recovery or denial. A detailed Finding Notice will be sent to the provider for review within 30 calendar days of receipt of the medical records and appropriate summary documents.

6. Provider Dispute Readmission Determinations:

   When CCA issues a Finding Notice to a provider, the provider is entitled to submit a provider dispute. Disputes must be submitted within 60 calendar days of the date on the Finding Notice and must be sent directly to CCA as instructed in the Finding Notice. The request to dispute must include evidence to support that the readmission met requirements for reimbursement.

   The following data elements should be included in the dispute:

   - A copy of the detailed Finding Notice
   - All relevant evidence for reconsideration

   In lieu of a copy of the detailed Finding Notice, disputes must include:

   - Member Name and Date of Birth
   - Dates of Service
   - Claim number(s)
   - Date of the Finding Notice

   Non-contracted providers must also include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the dispute per the

CCA Provider Manual. This form must be accompanied by the claim dispute. The Waiver of Liability form is not required for contracted providers.

Providers can expect a mailed response to their dispute within 60 calendar days of receipt of the medical records and appropriate summary documents.

If a provider dispute is not received within 60 calendar days from the date the Finding Notice is issued, payment for the subsequent admission claim may be reversed.

BILLING and CODING GUIDELINES:

N/A

RELATED SERVICE POLICIES:

- Observation Services
- Prior Authorization
- Serious Reportable Events (SRE)

AUDIT and 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. Please refer to CPT/HCPCS for the complete and updated list of codes. 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, procedures, and claims editing logic. CCA has the right to conduct audits on any contracted 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:

- CMS-Hospital-Acquired Condition Reduction Program
- CMS-Hospital Readmissions Reduction Program (HRRP)
- CMS-Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing
- Payment Policies: Massachusetts
- Provider Manuals: Massachusetts

POLICY TIMELINE DETAILS:

1. Effective: 12/18/2018
2. Revision: August 2019; annual review and format revision
3. Revision: January 2021; policy suspended
4. Revision: May 2021; updated process and guidance
5. Revision: September 2024; updated process, criteria and exclusions