If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy 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. Blue Cross and Blue Shield of TX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. Blue Cross and Blue Shield of TX has 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 approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative 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 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: December 4, 2024

Effective Date: December 18, 2024

Description

The policy provides an explanation of the Plan's process for reviewing reimbursement of inpatient 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 unplanned or are not preventable.

The Plan will review claims for readmissions occurring after the initial discharge for the same, similar, or related diagnosis to the same hospital, in accordance with the provider's contract.

Background

A readmission is defined as a return hospitalization to an acute care hospital that follows a prior, clinically related, acute care admission.

The goal of the Plan's Inpatient Readmissions Review process is to support quality of care and outcomes to avoid potentially preventable readmissions/PPR.

Some readmissions may be avoided with improved communication to patients and caregivers, as well as education and engagement during the discharge process and recovery period.

Examples of PPR may include, but are not limited to, the following:

- Heart failure
- 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 for the same, similar, or related diagnosis may be denied, or the claim payment may be reduced based on this policy.

The plan reserves the right to request supporting documentation to determine eligible reimbursement. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Submission of any code should be fully supported in the medical documentation.

Review Criteria

The review criteria includes, but is not limited to, the following:

- Readmissions related to the first admission
- Preventable readmissions
- Premature hospital discharge
- 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
- Exacerbation of symptoms of a chronic illness

Exclusions

The following are excluded from the readmission review process:

- Psychiatric/Substance abuse admissions
- Transplant services admissions
- Readmission due to discharges against medical advice
- Multiple trauma
- Burns
- Neonatal and obstetrical admissions
- Staged procedures following commonly accepted practices

Claim Review Process

A claim review may occur pre-adjudication or post payment and may include, but is not limited to, the following:

- Provider contract assessment, if applicable
- Diagnosis related to initial admission
- PPR
- Prior admissions and discharge dates of service
- Coding and documentation review

Claim Adjudication

The initial admission and subsequent readmission(s) will be adjudicated with the following considerations:

- The first claim and all eligible subsequent claim(s) will be considered a single admission/claim when determining the DRG reimbursement and the resulting allowed amount will be applied accordingly.
- When multiple readmissions are not paid on a DRG methodology basis, this policy does not apply.

Policy Update History

Approval Date	Description
02/06/2020	New policy
12/01/2021	Annual Review
02/01/2023	Annual Review
06/28/2023	Revisions to verbiage
10/11/2023	Revisions to verbiage
12/04/2024	Annual Review