SENIOR WHOLE HEALTH

Policy Name: In-Patient Admission Bridging Policy
Policy #: CL490

Policy Type: ☐Corporate (do not vary by state) ☒State (specific to a state -MA or NY)	**Approved By:** ☐QMC ☒MAC ☒MA ☐NY ☐EXECUTIVE COMMITTEE
Original effective date: March 15, 2020	**Current effective date/ last approval date:**
Previous Review Dates: N/A	**Previous Revision Dates: N/A**
Stakeholders: Provider Relations Utilization Management Medical Director	**State Plan/Product type(s):** ☒MA SCO (Medicaid) ☒MA MEDICARE ADVANTAGE (Medicare)
Department: ☐Administration ☐Analytics ☐Business Systems Configuration ☐Central Services ☐Claims ☐Client/Member Services ☒Clinical Services ☐ CM ☒ UM ☐ MP ☐Compliance ☐ HIPAA/Privacy ☐ HIPAA/Security ☐Contracts and Vendor Management ☐Corporate Marketing ☐Enrollment ☐Finance/Accounting ☐ ACC ☐ FM ☐Human Resources ☐Information Technology ☐Medical ☐Pharmacy ☐Provider Relations / Network Development ☐Quality Management ☐ GA ☐ CR ☐Risk Adjustment ☐Sales & Marketing	**Reference Documents:** • Social Security Act § 1154(a)(13) • Code of Federal Regulations (annual edition): Title 42 - Chapter - Subchapter D - PEER REVIEW ORGANIZATIONS Part 466 - UTILIZATION AND QUALITY CONTROL REVIEW
Policy Owner: Chief Medical Officer	**Corresponding Policies:**
This policy supersedes/retires the following policies:	

Policy Statement: Relevant to the Centers for Medicare and Medicaid Services (CMS) precedent and recommendations, Senior Whole Health (SWH) may deny payment for readmission to the same hospital (or hospital system) within 14 days if, through medical record

review, the admission was deemed preventable, medically unnecessary or was due to the premature discharge of the prior admission.

Purpose Statement: To establish a policy for the clinical review and claims processing related to members readmitted to the same hospital in 14 days.

Definitions:

Diagnosis-related Groups (DRG) – A patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives.

Prospective Payment System (PPS) – A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).

Medical Necessity—Medically necessary services are those health care services:

- That are reasonably calculated to prevent, diagnose, ameliorate, alleviate, correct or cure conditions in the Member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
- For which there is no comparable medical service or site of service available or suitable for the Member requesting the service that is more conservative or less costly; and
- Are of a quality that meets generally accepted standard of health care.
- SWH currently uses MCG Care Guidelines for medical necessity review of inpatient claims.

Procedures:

A. Readmission Request	SWH will identify all readmissions to the same hospital (or hospital group) within 14 days. The SWH Utilizations Management (UM) nurse care manger (NCM) will obtain the appropriate medical records related to the initial admission and readmission and perform case review on both stays. The case and appropriate records will be forwarded to the Medical Director for review. Using appropriate clinical guidelines, the Medical Director will determine if the readmission could have been prevented by: • Optimal provision of care during the initial admission • Optimal discharge planning and follow-up coordination and care • Common reasons for bridging readmissions include: • Diagnostic errors and delay in diagnosis and initiating treatment based on clinical findings and results of testing • Treatment mistakes

	• Prevention related failures which includes failure to provide prophylaxis treatment against complications and inadequate monitoring • Hospital billing for two separate admissions for care that could have ben provided during one admission: o Definitive treatment has been decided but patient discharged only to be readmitted for the definitive treatment, without a medical reason for such a delay o When member is discharged for a short period (48-72 hours) with the intention to resume treatment upon return (i.e. "leave of absence" for reasons not related to the treatment plan
B. Denial of Claim	The readmission will be denied if, after medical director review, the readmission: • Was deemed medically unnecessary • Resulted from a premature discharge from the same hospital (or hospital system), or • Was the result of circumvention of PPS by the same hospital Hospitals will be notified in writing of the decision and can dispute the denial as per the appropriate Claims Dispute process Senior Whole Members are NOT responsible for charges related to the denied claim as a result of this policy The denials of readmissions will be included in the annual review of UM by the Medical Advisory Committee (MAC) as part of the UM Program Evaluation

Approval: Yes	***Committee:*** Medical Advisory Committee ***Date:*** 1/9/2020