Payment Policy: Provider Preventable Readmission

Reference Number: WA.CC.PP.501
Product Types: Medicaid
Date of Last Revision: 12/23
Effective Date: 01/01/24

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The purpose of this policy is to promote more clinically effective, cost efficient and improved healthcare through appropriate and safe hospital discharge of patients. Readmissions that are not medically necessary are not reimbursed. This policy defines criteria for defining a *medically necessary* readmission as provider preventable and therefore, not eligible for reimbursement.

Policy/Criteria
It is the policy of Coordinated Care of Washington, Inc., that readmissions within 14 days of a prior discharge from the same or an affiliated hospital will be reviewed. Those that are found to be related to conditions or care from the previous admission *and avoidable* will be deemed "Provider Preventable" and will not be reimbursed, in accordance with WAC 182-550-2950.

Professional claims submitted for services rendered in the inpatient setting during a readmission are excluded from this review.

I. To be defined as **Provider Preventable** all the following criteria must be met:
- **A.** The readmission occurs within 14 days of a prior discharge from the same or an affiliated hospital.
  1. Affiliated hospitals are part of a hospital system and operate under the same hospital agreement with Coordinated Care or
  2. Share the same tax identification number with one or more other hospitals.
- **B.** The readmission is clinically related to the previous admission.
- **C.** There is a reasonable expectation that the readmission would have been avoided had it not been for one or more of the following:
  1. Specific quality concern, knowable at the time of treatment during the first admission, resulted in the readmission
  2. Inadequate discharge planning with the first admission
  3. Inadequate post-discharge follow-up of the first admission
  4. Lack of coordination between inpatient and outpatient health care teams resulting in inadequate care post discharge of the first admission.
     NOTE: If issues with quality of care, discharge planning or follow up occurred but cannot be reasonably considered the cause of the readmission, the readmission cannot be deemed Provider Preventable.

II. The following readmissions **cannot be deemed Provider Preventable**:
- **A.** Admissions to Critical Access Hospitals (CAH) as defined in WAC 182-550-2598.
- **B.** Psychiatric admissions.
- **C.** Readmission for reasons unrelated toa conditions or care from the first admission.

D. Hospitalization with a discharge status of "left against medical advise" for prior admission
E. Planned readmission. Examples include:
1. Required treatments for cancer, including treatment related sequelae as well as care for advanced stage cancer,
2. Repetitive, planned treatments or procedures for conditions such as chronic anemia, burn therapy and renal failure,
3. Planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same admit

F. Planned admission to a different hospital or hospital unit for continuing care, such as mental health/substance use transfers, rehab transfers, etc.…
G. End of life and hospice care
H. Readmission due to patient non-adherence to the discharge lan, despite appropriate discharge planning and supports. This includes cases where the recommended discharge plan was refused by the patient, and a less ppropriate alternative plan was made to accommodate patient preferences; this must be clearly documented in the client's record
I. Obstetrical readmissions for birth after an antepartum admission
J. Admissions with a primary diagnosis of mental health or substance use disorder
K. Neonatal readmissions
L. Transplant readmissions with 180 days of transplant
M. Readmissions when the first admission occurred in a different hospital system
N. Coordinated Care does not fulfill its responsibility or a component of its shared responsibilities for post discharges services that would have prevented the readmission

Review Process

I. All reviews for Provider Preventable Readmission will be conducted post-payment.
II. Upon request from Coordinated Care a hospital must forward (and, if applicable, arrange for a related hospital to forward) all medical records and supporting documentation of the initial admission and readmission to Coordinated Care within 45 days of the request from Coordinated Care.
III. The initial review of the medical records will determine whether the readmission was clinically related to the initial admission. Once the readmission is determined to be clinically related, the readmission will be further evaluated to determine whether the readmission was preventable. A determination will be made within 30 days of receipt of records.
IV. Any finding of Provider Preventable Readmission will be communicated via template letters created by the Washington State Health Care Authority.

Dispute Process

I. Hospitals must follow the dispute process outlined in communications they receive regarding findings of PPR for the first two levels of re-review.
II. After exhausting both levels of Coordinated Care's re-review, if the hospital continues to dispute the findings, the hospital may request Coordinated Care appeal to the Health Care Authority (HCA) for a "Provider Preventable" case review.
A. Coordinated Care will submit all information submitted by the hospital, review notes and all letters to the HCA within 14 calendar days of the hospital's request.

B. The HCA may request additional information from either Coordinated Care or the hospital. Coordinated Care will respond within fourteen (14) calendar days to any request from HCA for readmission review information and data required in response to a concern for a pattern of inappropriate adjudication presented to HCA by a hospital. Once all information is available, the HCA will issue a determination within 30 days.

C. The Health Care Authority decision is final.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed. Previously WA.UM.02.02.01	10/19	11/19
Tweaked section II.b. and added II.k. to exactly mirror state policy. Updated reference.	02/20	03/20
Annual review. Updated re-review request process. Updated references	08/20	09/20
Minor edits to company name. Clarification of time frame for response to HCA.	12/20	01/21
Annual review. References updated. All instances of "member" replaced with "member/enrollee".	12/21	01/22
Annual review. References updated. Changed "Date" to "Revision Date" in Revision Summary table. Changed "Last Review Date" to "Date of Last Revision".	12/22	12/22
Annual review. Criteria resequenced to match HCA Billing Guideline. References updated.	11/23	12/23

References

1. Washington State Health Care Authority. Inpatient Hospital Services Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/Inpatient-hospital-bg-20240101.pdf Revision effective January 1, 2024.
2. Washington Administrative Code 182-550-2950 https://apps.leg.wa.gov/wac/default.aspx?cite=182-550-2950 Accessed 12/8/23.

Important Reminder

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Coordinated Care. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Coordinated Care

retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Coordinated Care has no control or right of control. Providers are not agents or employees of Coordinated Care.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.