Policy Title	**30 Day Readmission Policy**
Policy Department	**Utilization Management**
Effective Date	**10/27/2019**
Revision Date(s)	**3/10/20, 4/1/21**
Next Review Date	**4/1/22**

Disclaimer:

Clover Utilization Management applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgement in rendering services. Providers are expected to provide care based on best practices and use their medical judgement for appropriate care.

Purpose:

Clover Health Clinical Policy for readmission reviews includes 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. Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred.

Scope:

The Readmission Review Program applies to all Clover Health Medicare Advantage benefit plans and acute care facilities paid based on Medicare Severity Diagnosis Related Group (MS-DRG) payment methodology established by Medicare & Medicaid Services (CMS) published guidelines.
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Reviews will consider the below exclusions:

- died during the admission
- was not continuously enrolled in Medicare Part A FFS for at least 30 days following discharge from the index admission
- lacked complete Medicare Part A and Part B FFS enrollment history for the 12 months prior to the index admission
- was discharged against medical advice
- was transferred from the admission to another acute care hospital
- was hospitalized in a prospective payment system-exempt cancer hospital
- was hospitalized for medical treatment of cancer
- was hospitalized for a primary psychiatric disease

* **NOTE: Patient Non-compliance:** Facilities will not be held accountable for patient noncompliance if all of the following conditions are met:

- There is adequate documentation that physician orders have been appropriately communicated to the patient.

- There is adequate documentation that the patient/caretaker is mentally competent and capable of following the instructions, and made an informed decision not to follow them.
- There were no financial or other barriers to following instructions. The medical records should document reasonable efforts by the facility to address placement and access-to-treatment difficulties due to financial constraints or social issues, including consultation with social services, use of community resources, and frank discussions of risks and alternatives.
- The noncompliance is clearly documented in the medical record. For example, documentation for a discharge to the home when the discharge is felt to be unsafe should include signature by the patient/caregiver as leaving Against Medical Advice (AMA). An unsafe discharge is not mitigated by a comment stating "patient preference."

A. Medical Review Procedures Obtain the appropriate medical records for the initial admission and readmission. 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. Review both the initial admission and the readmission at the same time unless one of them has previously been reviewed.

B. Deny readmissions under the following circumstances:

- If the readmission was medically unnecessary
- If the readmission resulted from a premature discharge from the same hospital
- or If the readmission was a result of ineffective care provided to improve the patient's clinical condition on the first admission

C. Reasons for possible denials:

- **Inadequate Outpatient Follow-Up or Treatment:** Discharge planning must take into account the availability and criticality of outpatient follow-up visits and treatment. Communication with practitioners who will 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 self care is an avoidable cause of readmission.

- **Failed Discharge to Another Facility:** Failed transfers to a Skilled Nursing Facility (SNF), Long Term Care Hospital (LTCH), Acute Inpatient Rehabilitation (AIR) or a 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. Some factors to be considered in making a decision about whether 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 followup 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 a chronic medication is a common error leading to a preventable readmission, as are other medication errors.

- **Hospice:**
    - Decisions on whether to enter hospice are made by patients and their families. As a Medicare Advantage organization, we encourage physicians to counsel terminally ill patients regarding treatment options, including hospice. Until a patient enters hospice, is documented as Do Not Resuscitate (DNR), or refuses further treatment, treatment is expected to follow established guidelines.

References
Quality Improvement Organization Manual Chapter 4 - Case Review
30-day All-Cause Hospital Readmission measure
Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing
Medicare Claims Processing Manual Chapter 4 - Case Review
Social Security Act §1886(d)