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

Clinical Payment and Coding Policy Committee Approval Date: February 1, 2023

Effective Date: June 1, 2023

Description

The purpose of this policy is to provide 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 within thirty (30) days, or the number of

days specified in the providers contract, if different, of the initial discharge for the same, similar, or related diagnosis to the same hospital.

Background:

A readmission is defined as a return hospitalization to an acute care hospital that follows a prior acute care admission within thirty (30) days, or the number of days specified in the provider contract, of discharge for a clinically related 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 are preventable such as, but not limited to, patient education pertaining to discharge and recovery. It is encouraged that providers improve communication and care coordination to better engage members and caregivers in the discharge process to reduce avoidable readmissions. 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 within 30 days, or the number of days specified in the provider contract of the initial stay for the same, similar, or related diagnosis may be denied or claim payment reduced based on this policy.

The plan reserves the right to request supporting documentation. Documentation may be used to validate services billed with care that was rendered to a member. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims are reviewed on a case-by-case basis. 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
- 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 readmissions will be adjudicated with the following considerations:

- The initial admission and readmission will be considered as a single admission
- If the authorized days from the readmission causes the combined admission to exceed the average length of stay determined for the assigned DRG, high-trim days will not be reimbursed in addition to the assigned DRG reimbursement, to the extent allowed under contract terms.
- If combining the initial admission and subsequent readmission claims results in additional outlier payment, the outlier payment amount (if any, to the extent allowed under contract terms) will only be reimbursed on the initial admission.
- All services for initial admission and readmission will be considered as a single claim for both inpatient stays
- Multiple readmissions will not be separately reimbursed when each stay is reimbursed per case/per admission
- If initial admission has been reimbursed, claims will be combined to determine reimbursement

Policy Update History:

Approval Date	Description
02/06/2020	New policy
12/01/2021	Annual Review
02/01/2023	Annual Review