AETNA BETTER HEALTH® of Illinois
Policy

Policy Name:	Readmission Process	Page:	1 of 10
Department:	Medical Management	Policy Number:	7200.06
Subsection:	Concurrent Review	Effective Date:	12/01/2020
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Aetna Better Health seeks to promote more clinically effective, cost efficient and improved health care through appropriate and safe discharge of patients.

STATEMENT OF OBJECTIVE:

The objective of this policy is to reduce avoidable hospital readmissions within the state-required [thirty (30)] days after discharge. As part of the Affordable Care Act (ACA), Congress mandated that CMS reduce hospital readmission through certain payment incentives. Section 3025 of the ACA added section 1886(q) to the Social Security Act, establishing the Hospital Readmission Reduction Program, which requires CMS to reduce payments to Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions, effective for discharges beginning on October 2, 2012. Similarly, Medicaid programs seek to reduce preventable readmissions. Preventable readmissions put members at risk for iatrogenic and other unnecessary complications, including death, create other hardships for members and caregivers, and serve as a marker of poor healthcare.

DEFINITIONS:

Diagnosis Related Group (DRG)	A diagnosis-related group is a system that is used to determine prospective payment rates for reimbursement of hospital care based on a patient's diagnosis. Medicare initiated this inpatient hospital prospective payment system. Payment is made for hospital services based on a predetermined rate for discharge based on a DRG. Patient cases are assigned to a DRG based on: • Principal diagnosis • Up to eight (8) additional (secondary) diagnoses • Up to six (6) procedures performed during the stay • Age • Sex • Discharge status of the patient Diagnosis and procedure information is reported by hospitals using the ICD 10- CM codes. The first step in the determination of a DRG is the assignment of a Major Diagnostic Category (MDC).

Hospital Readmission (Medicaid)	A readmission is a hospital admission which occurs within thirty (30) days from the date of discharge from a prior (index) admission and is clinically related to the index admission. A readmission can be determined to be potentially preventable if there was a reasonable expectation that it could have been prevented as evidenced by one (1) or more of the following: • The readmission resulted from premature discharge from the index admission at the same hospital or related hospital • The readmission was medically unnecessary • The readmission was the result of circumvention of the contracted rate by the hospital or a related hospital
Index Admission	The initial hospital admission from which readmission is measured.
Hospital System/Related Hospital	If a hospital is part of a hospital system operating under the same hospital agreement, and/or if the hospital shares the same tax identification number with one or more other hospitals, then a readmission during the same State-defined period to another hospital within the same hospital system, or to another hospital operating under the same tax identification number as the first hospital, will be treated as a readmission to the same hospital and, as such, subject to this policy.
Readmission	The subsequent acute admission for the same patient within the State-defined period from the time of discharge from the initial admission, and at least one (1) day between the discharge and new admission. Readmission occurs when a member is readmitted to the same or related facility within the State-defined time period from a previous admission for the same or similar symptoms/conditions, or for evaluation and management of the prior medical condition/symptoms.
Unavoidable Member Noncompliance	Unavoidable member non-compliance is member non-compliance that could not have directly or indirectly been managed by the provider. Facility documentation shall include detailed discharge instructions from the index admission, as well as detailed evidence of member non-compliance in readmission records. Some examples would include member/caregiver disregard of documentation of: clear communication of post discharge instructions, prescribing appropriate medication, appropriate discharge planning, facilitating post discharge physician

	follow up, and discharging physician providing relevant information regarding the hospitalization to the physician responsible for outpatient follow up care.

LEGAL CONTRACT REFERENCE:

- Department of Healthcare and Family Services Contract 2018-24-401
- Aetna Better Health of Illinois' contract agreements including those regarding the confidentiality of member information
- Applicable federal and state laws, regulations and directives, including the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans

EXCLUSIONS:

- Readmission unrelated to the initial symptoms/conditions
- Readmission due to an unavoidable complication
- Readmission due to unavoidable member non-compliance with the discharge plan
- Maternity related stays
- Index admissions and readmissions to long term acute care facilities, non-acute hospitals, rehabilitation hospitals and nursing homes
- Approved transfers such as transfers from out of network to in-network facilities and transfers of patients to receive care not available at the first facility
- Admissions with a discharge status of "left against medical advice"
- Readmission outside the State-defined time period from the index admission
- Discharges for primary mental health and/or substance use disorder diagnoses
- Admissions and readmissions to hospital facilities with contract language prohibiting the readmission review process
- Reimbursement for readmissions to facilities /hospital systems not wholly owned or operated by the facility /hospital system associated with the index admission
- Observation stays as defined by Aetna Better Health
- Critical Access Hospitals

- Planned readmissions to complete a course of treatment such as chemotherapy, or planned, staged, surgical procedures
- Readmissions for metastatic malignancy, multiple traumas, neonatal and obstetrical, sick cell anemia, certain HIV drugs, alcohol and drug detoxification
- Readmissions for behavioral health related primary diagnosis at discharge
- Non-acute admissions (SNF, IRF, LTACH)
- Readmissions for unrelated symptoms or services (e.g., acute trauma) ---defined as a readmission classified with a unique Major Diagnostic Category (MDC) when compared to the index admission
- Inadequate care coordination and/or poor discharge planning
- Denied Index admission *See Note below

***Note**: If the index admission was denied the clinician will create a note in the Non-Clinical section of QNXT. The clinician will document the following verbiage in the Non-Clinical note of the current authorization:
The following authorization # xxxxxxxxxxxx is not linkable to this current admission due to it being denied status.

RESPONSIBILITIES:

Aetna Better Health may review admission claims on a concurrent or post-service basis for acute care facility admissions which occur within the State-defined time period (or as otherwise required by state regulations and/or provider contracts):

- After discharge from the same, or another facility within the same hospital system
- To another hospital operating under the same tax identification number as the first hospital
- Contracted and non-contracted facilities
- When the readmission is for the same, similar, or related diagnosis as the initial admission.

Clinically-Related Admissions

A readmission is clinically related to the initial admission if at least one (1) of the following is true:

- Member is discharged before all medical treatment is completed. This includes a readmission related to the initial admission or closely related condition.

- Member is readmitted for an acute exacerbation of a chronic problem that was not related to the initial admission but was most probably related to care (or lack thereof) during or immediately after the initial admission.
- Member is discharged without discharge criteria being met, including the clinical level of care criteria.
- Member is discharged meeting discharge criteria, but non-clinical factors/barriers were not addressed prior to discharge (e.g., member is discharged to "home," but is homeless). Discharge planning beyond the typical is needed due to barriers.
- Member is discharged after inpatient stay and readmitted due to a continuation or recurrence of the problem causing the initial admission, or to manage a complication resulting from the care (or lack thereof) during the initial admission.
- Member is readmitted for a direct surgical complication.
- Member discharged with a documented plan to readmit for additional services that could have been conducted during the initial admission. (Physician or member requested).
- Member is discharged to allow resolution of a medical problem that, unless resolved, would be a contraindication to the medically necessary care that will be provided during the second admission (e.g., discharge to await normalization of clotting times prior to a surgical intervention).
- The readmission would have been potentially preventable by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period.

Once the potential readmission review is determined to be clinically related to the initial admission, further evaluation is performed to determine whether the readmission was potentially preventable. To determine whether a patient's readmission was potentially preventable, the medical director or their designee should consider multiple factors, including, but not limited to:

- Whether the patient meets inpatient or alternative setting criteria (as determined using the appropriate guidelines in combination with clinical judgment).
- Whether discharge plans were followed according to generally accepted medical standards. These are standards based on credible scientific evidence published in peer-reviewed medical literature, generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one (1) institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then

standards that are based on physician specialty society recommendations or professional standards of care may be considered.

- Documentation in the hospital record that an appointment was made within the first week or within an appropriate time frame after discharge from the initial admission.
- Whether a health care advocate/provider did an in-home safety assessment and appropriate follow up as needed.
- Whether written discharge instructions were provided and explained to the patient/caregiver prior to discharge.
- Documentation that all required prescriptions were given to the patient and the patient was educated in the appropriate use of the medication.
- Whether documentation supports that durable medical equipment has been arranged for the patient and the patient has been appropriately educated on its use.
- Whether documentation supports that all salient financial and social needs of the patient have been addressed.

Concurrent Review

The clinician, during an inpatient concurrent review, examines the dates of a member's prior admissions and discharges. If it is determined a readmission to the same hospital, a facility within the same hospital system, or another hospital operating under the same tax identification number as the first hospital, is potentially related to the index admission, the reviewer will notify the UM representative at the readmitting facility within three (3) calendar days.

Medical records may be requested from both the initial admission and subsequent readmission. Documents may include, but are not limited to:

- Physician discharge summary
- Patient discharge instructions
- Admission summary
- History and Physical
- Physician Orders
- ER Record
- Progress notes
- Nursing notes
- Diagnostic and laboratory testing

Aetna Better Health makes reasonable efforts to gather all information needed to make an accurate determination of whether readmission is warranted. Aetna Better Health documents all requests for information and maintains that documentation within the case file. Aetna Better Health clearly identifies the records, information, and documents needed when requesting information from a provider. Aetna Better Health will make three (3) attempts to obtain information from the provider on behalf of the enrollee. Providers are contractually obligated to provide requested clinical records and other needed information in a timely manner (as specified in the contract). Documentation by the Aetna Better Health Utilization Management (UM)clinician includes the following:

- A specific description of the required information
- The name, phone number, fax number, e-mail, and/or mailing address, as applicable, for the point of contact at the plan
- The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission, or e-mail. Call records must include specific information about who was contacted, what was discussed/requested, and what information was obtained by the plan. If Aetna Better Health does not obtain the requested information, determinations are made within the applicable timeframe based on the available clinical information.

If the stays are determined to be related (aka “linked”), Aetna Better Health will provide written notification of this to the admitting facility.

Practitioners/providers are notified in the denial letter (i.e., notice of action [NOA]) that they may request a peer-to-peer consultation to discuss denied or reduced service authorizations with the medical director reviewer by calling Aetna Better Health. All medical director discussions and actions, including discussions between medical directors and treating practitioners/providers, are to be documented in the Aetna Better Health authorization system.[1]

Post Payment/Adjustment Review-Need to review in meeting

All Diagnosis-Related Group (DRG) paid claims are extracted to a report that is then provided to the medical review team. The team compares their criteria to the DRG report. The team will verify whether the diagnoses are part of the excluded list and/or related to previous admissions. If it is determined that a claim may be related to a previous admission (thus could possibly be deemed a readmission), then medical records are requested from the facility for all related admissions. All claims and the related medical records, for all related admissions, are reviewed by a physician to make a final determination on whether the admission meets the criteria of a readmission. If it is determined to be a preventable readmission, written notification is sent to the facility and the appeals timeline begins. After all appeal timeframes are expired or appeals exhausted, the claim is returned to Claims for adjustment.

As part of the post-service/pre-payment readmission review process, Aetna Better Health of Illinois will request and review medical records and supporting documentation relating to the initial admission, including discharge plans, and the subsequent admission. Aetna Better Health of Illinois may deny payment to the facility for the subsequent admission, if it meets certain criteria and is determined to have been preventable based on those criteria.

Aetna Better Health of Illinois may look back within the maximum allowed recovery time frame per state guidelines or per specific provider contract to identify any claims that may be preventable readmissions.

Notice of Action/Adverse Benefit Determination Requirements

Aetna Better Health of Illinois provides the hospital with written notification (i.e., NOA/Adverse Benefit Determination) of any decision to deny payment, in whole or part, for a service.

The NOA/Adverse Benefit Determination must be in writing and must include:

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[1] NCQA HP 2020/2021 UM7 A and UM7 D

- The action that Aetna Better Health of Illinois has taken or intends to take, and the effective date of that action
- The specific reason for the action, customized to the member circumstances.
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which the denial decision was based[2]
- Notification that, upon request, the hospital will be provided with additional resources to obtain state policy information upon which this decision was based.
- Notification will include instructions for peer to peer/ reconsideration and practitioners/providers appeal process with a physician or other appropriate reviewer regarding the decision.

OPERATING PROTOCOL

Systems

The business application system has the capacity to electronically store and report all service authorization requests, decisions made by Aetna Better Health of Illinois regarding the service requests, clinical data to support the decision, and timeframes for notification of practitioners/providers and members of decisions.

MEASUREMENT

- Readmissions per 1000
- Readmissions within thirty (30) days
- Accuracy of claims payment through claims audit
- # determination overturns by P2P reconsideration
- # determination overturns by appeal
- Accuracy of application of readmission criteria and consistency of documentation by department file audits at least quarterly

REPORTING

Reports are submitted to the Aetna Better Health of Illinois C-suite and director of Medical Management, including:

- Monthly inpatient readmissions per 1000
- Monthly readmissions

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[2] NCQA HP 2020/2021 UM7 B2, UM7 E2

- Weekly reconciliation of discharges
- Consistency of documentation by department file audits at least quarterly

Aetna Better Health of Illinois