Clover

Clover Health Readmission Review and Reimbursement Policy

Policy # RP-004

Policy Title	30 Day Readmission Review and Reimbursement Policy
Policy Department	Payment Strategy and Operations
Effective Date	1/1/2022
Revision Date(s)	1/1/2022
Next Review Date	

Disclaimer:

Clover Health 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' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

This policy addresses preventable inpatient readmissions within a defined number of days for all Clover Health lines of business. Claims that qualify for 30 Day Readmission Review can be reviewed both prepayment and post payment to determine if the admission was avoidable. The process for reviewing readmission claims, including clinical requirements are supplied in this document. The Readmission Review Program is allowed by CMS requirements and guidance.

Definitions:

- **Readmission**
  - An acute inpatient claim that has an admission date within 30 days of discharge from a previous acute inpatient claim from the same facility
- **Avoidable Readmission**
  - A readmission reviewed by a medical director and determined to have been preventable due premature discharge from the hospital, if the readmission was a result of inappropriate care provided to improve the patient's clinical condition on the first admission, if the readmission was due to inadequate discharge

planning, if the readmission is due to a transfer that was not appropriate or the readmission was a result of any violation of Standard of Care

- **Unavoidable Readmission**
  - A readmission reviewed by a medical director and determined to have not been preventable
- **Diagnosis Related Group (DRG)**
  - This is a three digit billing code used for inpatient acute care claims. Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

Policy:

As a Medicare Advantage plan, Clover is responsible for monitoring the quality of our plan member's care and is held accountable by CMS. This includes potentially avoidable readmissions under DRG payment methodology. When an inpatient claim is received by Clover and there exists a previous admission with a discharge date from the same facility within 30 days of the new admission (one hospital, two claims billed with discharge/admission dates within 30 days), the claim will be flagged for the 30 Day Readmission Review program.

The process is designed to identify instances where a facility takes an action, or there is a lack of action, that results in unnecessary admissions, premature discharges, multiple readmissions, or other inappropriate medical services or billing practices for our members.

CMS authorizes health plans to take certain actions, including denial of payment. Clover's readmissions review program is consistent with CMS methodology and CMS Medicare Claims Processing Manual, Publication 100-4, Chapter 3, Section 40.2.5. As such, Clover will deny payment for avoidable readmissions occurring within 30 days of discharge with the exception of the following cases:

- Claims for the treatment of cancer (not just a cancer diagnosis, it has to be an admission for the treatment of cancer)
- Inpatient Psych Claims (excluding substance abuse rehab claims)
- LTACH Claims
- IRF Claims
- Claims where the prior admission is denied, thus no payment has been made for the index claim
- Readmissions where the member expired
- Readmissions where the member previously left against medical advice

- Readmissions that are due to an inpatient hospital to hospital transfer

Medical Review Procedures:

- Clover Health will triage readmission claims, and if the readmission is not exempt from review, a request for medical records will be sent for both the initial admission and the readmission
- A Registered Nurse will perform an initial clinical case review on both stays. The RN will determine if enough information has been received to make a decision on whether or not a readmission was avoidable or unavoidable. If all requested records are not received, a Technical Denial will be issued for the readmission
- Once the RN has made a recommendation, the case is sent to the Medical Director for the final determination

The Medical Director will recommend denying readmission claims under the following circumstances:

- If the readmission resulted from a premature discharge from the hospital
- Or if the readmission was a result of inappropriate care provided to improve the patient's clinical condition on the first admission
- Or if the readmission was due to inadequate discharge planning
- Or a transfer that is not appropriate
- Or if the readmission was a result of any violation of Standard of Care

Once the request for medical records is sent, Clover will process the initial claim and allow $0.00 pending records. The message code stating "*An attachment/other documentation is required to adjudicate this claim/service.*", will be appended on the remittance.

In order for a complete readmission review to occur, Clover must receive records for both the prior admission and the readmission - this information is located in the medical record request letter. Important documents for both admissions include:

- History and Physical
- Hospital Course
- Discharge summary
- Plan of Care
- Relevant Labs

If complete records are not received by the period outlined in the letter for both the initial admit and readmission claim, Clover will reprocess the claim with a Technical Denial for medical records requested and not received. Denial decisions under this policy may be disputed by the provider within the CMS or contractually allowed timeframe.

References
Policy # UM-003 - 30 Day Readmission Policy
https://innovation.cms.gov/files/fact-sheet/bpciadvanced-fs-nqf1789.pdf
Social Security Act Title 18, Section 1886
The CMS Quality Improvement Organizations Manual Chapter 4
Medicare Claims Processing Manual Chapter 3
30-day All-Cause Hospital Readmission measure
Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing
Medicare Claims Processing Manual Chapter 4 - Case Review

Version History
6/30/2022 - Policy was updated to specify the medical records required for readmission review.