



BlueCross BlueShield of Vermont

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PREVENTABLE READMISSIONS **Corporate Payment Policy** **New Policy APPROVED 10.11.2019**

File Name: CPP_21 BCBSVT Payment Policy Preventable Readmissions

File Link: [CPP_21 BCBSVT Payment Policy 30 Day Readmission FINAL 10.11.19.docx](#)

Policy No.: CPP_21

Origination: Payment Policy Committee

Last Review: New Policy approved 10.11.2019

Next Review: 10.2021 (bi-annual)

Effective Date: 02.01.2020

Document Precedence

The Blue Cross and Blue Shield of Vermont (BCBSVT or Plan) Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT corporate medical policies, and BCBSVT's claim editing software logic. Document precedence is as follows:

- 1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
- 2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
- 3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
- 4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the BCBSVT's claim editing solution, the BCBSVT claim editing solution takes precedence.

Payment Policy

Description

Preventable readmissions contribute to unnecessary medical spending, increasing health care costs, and jeopardizing patient safety. BCBSVT identifies through claims, audits, quality of care complaints, and case management Preventable Readmissions, as defined in the Policy section, below. This policy's purpose is to: (1) promote more clinically effective, cost effective, and improved health care through appropriate and safe hospital and facility discharge of patients; and (2) document Plan's guidelines for identifying a Preventable Readmission and Plan's guidelines for payment for such admissions. The policy applies regardless of what payment methodology is used to compensate a provider for services (for example, discount off charge, DRG, etc.).



Policy

I. General

BCBSVT will not allow separate payment for claims that have been identified as a Preventable Readmission. A Preventable Readmission is defined as follows:

- A readmission that occurs at the same facility (in this context, the same facility includes all facilities that (1) operate under the same facility agreement with Plan; (2) have the same tax identification number as the facility where the original admission occurred; or (3) are under common ownership as the facility where the original admission occurred); and
- The readmission occurs within thirty (30) days of discharge of the original admission; and
- The readmission occurs for one of the following reasons, determined by licensed clinical medical review:
 - The same or a closely-related condition or procedure as the original admission;
 - An infection or other complication of care arising from the original admission or post-discharge care;
 - A surgical procedure to address a continuation or a recurrence of a problem causing the previous admission;
 - A condition or procedure indicative of a failed surgical intervention;
 - An acute decompensation of a coexisting chronic disease that may be related to care during the initial admission or follow up care after discharge; or
 - A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards during the original admission or during the post-discharge follow-up period (such as sufficiently stabilizing the patient's condition prior to discharge or providing proper coordination or discharge planning).

BCBSVT reserves the right to treat an observation stay as an "original admission" for purposes of this policy if the circumstances so warrant. In other words, if a facility admits a patient for observation and, subsequently, the patient is readmitted to the same facility (either for an inpatient stay or another observation stay) within thirty days for one of the reasons listed above, BCBSVT reserves the right to treat that as a Preventable Readmission.

BCBSVT will identify Preventable Readmissions both prospectively and retrospectively. Within ten (10) days of BCBSVT's written request, a facility must forward medical records related to a Preventable Readmission. A qualified clinician will review all clinical information from the admissions to determine if a Preventable Readmission occurred based on the guidelines listed above.

For readmissions identified on a prospective basis, BCBSVT reserves the right to (1) reject or deny a claim the facility submits or (2) direct the facility to not submit a claim.

For readmissions identified retrospectively through a review of claims that meet the criteria listed in this policy, BCBSVT reserves the right to recover amounts previously paid on a claim. In the case of a retrospective denial, BCBSVT will issue a written thirty (30) day notice to the facility, and BCBSVT will



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recover the applicable payment for the readmission by offsetting against future payments unless that recovery is expressly prohibited by law or by the facility's contract with BCBSVT.

II. Exceptions

This policy does not apply to readmissions involving the following:

- Admissions for chemotherapy or immunotherapy treatment
- Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy, transfusions, or staged surgical procedures
- Admissions to a substance use disorder treatment unit or facility
- Admissions to an inpatient rehabilitation unit
- Transfers from out-of-network to in-network facilities
- Transfers of patients to receive care not available at the first facility
- Elective admissions or staged procedures following commonly accepted practices
- Admissions for covered transplant services during the global case rate period for the transplant
- Obstetrical readmissions
- Admissions to non-acute care facilities, such as skilled nursing facilities and inpatient rehabilitation facilities
- Readmissions occurring more than thirty-one (31) days from the date of discharge from the first admission
- Readmissions where the first admission had a discharge status of "left against medical advice"
- Readmissions where the primary diagnosis is a mental health condition, but this exclusion does not apply to admissions where an individual has co-occurring medical/physical conditions that resulted in a Preventable Readmission.
- Readmissions due to malignancies (such as chemotherapy), burn treatments, or treatments for cystic fibrosis.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP)

Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP)

In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a



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member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at <http://www.bcbsvt.com/provider-home> for the latest news and communications.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Employer Group Exclusion(s)

N/A

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines

N/A

Related Policies

Never Events and Hospital Acquired Conditions

Policy Implementation/Update Information

New policy effective 02.01.2020



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Approved by

Date Approved: 10.11.2019

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