PAYMENT POLICY ID NUMBER: 16-050

Original Effective Date: 10/01/2016

Revised: 12/12/2024

Readmissions Review Quality Program

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO FLORIDA BLUE MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

Preventable hospital readmissions are a serious quality of care concern. Hospitals are expected to provide care consistent with accepted standards, both prior to discharge and post discharge, and to reasonably prevent subsequent readmissions.

This policy is intended to support Florida Blue's quality of care review process for certain subsequent admissions to the same hospital or a satellite of the hospital occurring less than 15 days from a prior admission's discharge, along with return transfers to the acute care hospital from the sub-acute care facility when the patient is returned to the originating hospital or satellite of the originating hospital.

A clinical team will review medical records to determine if the readmission is for treatment of the same or a related condition or procedure from the prior discharge, and whether the need for inpatient care could have been reasonably prevented by the provision of care consistent with accepted standards during the prior discharge planning and post discharge follow-up periods.

When determining the number of days between admissions, neither the day of discharge nor the day of admission is counted. This policy applies to contracted hospitals. Professional services related to the inpatient stay are not included in this policy. This policy will apply to all Florida Blue Insurance benefit plans.

REIMBURSEMENT INFORMATION:

To encourage better quality of care outcomes for our members, Florida Blue will not provide additional reimbursement for related subsequent admissions determined to be reasonably preventable after clinical review of the medical records. Inpatient stays not approved for additional reimbursement under this Readmission Policy will be the sole liability of the hospital. Compensation for the original admission constitutes the full reimbursement payable for both the original admission and the preventable readmission.

Florida Blue members are not to be held liable for these subsequent admissions. Specifically, hospitals are not allowed to bill members for the subsequent preventable admission. Examples include:

- A condition develops, or a procedure is required and related to the care provided to the initial hospitalization, including, but not limited to development of a complication of care after that initial hospitalization
- If the subsequent admission, or sub-acute care facility transfer back to the originating acute care hospital or satellite of the hospital, resulted from a premature discharge from the same hospital or satellite of the hospital
- If the initial transfer to sub-acute care is determined to have occurred too soon for the patient to be sent to the sub-acute care facility, the acute care readmission will not be reimbursed

Readmissions can occur on the same day or a different day as the date of discharge from an initial hospital stay. See the section titled "Billing/Coding Information" for how to submit a claim when a subsequent admission occurs on the same day as the discharge date for the prior admission.

Please note that there are circumstances when the subsequent readmission is considered the admission which is eligible for reimbursement. In such circumstances the original admission will be reprocessed, and any payments made will be recouped. The medical records should reflect why the first admission was not successful and related to the full course of treatment, or why there was a delay. These circumstances include:

- The patient was admitted for surgery that was later cancelled due to an operating room scheduling conflict
- There was a delay in acquiring a piece of equipment
- Surgery could not be performed because a surgical team was not available during the initial admission

EXCLUSIONS:

The following are examples of exclusions from the readmissions policy. This is not an all-inclusive list.

- Previous discharged against medical advice
- Planned-staged readmissions following commonly accepted procedures
- Hospice care
- Obstetrical care
- Psychiatric admissions
- Sickle Cell Crisis
- Transplant and transplant-related care
- Cancer treatment as a principal diagnosis
- Repetitive treatments such as cancer chemotherapy and/or transfusions
- Acute care for confirmed COVID-19
- Critical Access Hospitals
- Conditions unrelated to the initial admission

BILLING/CODING INFORMATION:

A patient may be placed on a leave of absence instead of discharging and readmitting the patient if there is known follow-up care or elective surgery needed. Submitting a claim that includes a leave of absence will not result in two claims or two payments.

A patient that is readmitted to the same hospital on the same day of discharge for the same condition or symptoms related to the prior stay should have a single bill, or a corrected bill of the original claim that

combines both admissions into a single bill. If two separate claims are filed, then our claims processing system may apply a systematic denial in such circumstances.

REFERENCES:

1. Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual.
2. Centers for Medicare and Medicaid Services, Quality Improvement Organization (QIO) Manual.

GUIDELINE UPDATE INFORMATION:

10/01/2016	New Payment Policy
11/09/2017	Annual Review
10/18/2018	Annual Review
05/28/2019	Update of Policy Rules
10/17/2019	Update of Policy Rules and name
12/05/2019	Approved by Payment Policy Governance Committee
03/15/2020	Policy suspended due to COVID-19
11/02/2021	Modified Exclusions
01/01/2022	Policy reinstated for Medicare Advantage, inclusion of Florida Blue and Health Options Inc., benefit plans.
01/01/2023	Annual Review
12/14/2023	Annual Review
12/12/2024	Annual Review no changes