Tufts Health Plan Medicare Preferred Readmission (Bridging of Claims) Policy

PURPOSE
To establish a policy for the clinical review and claims processing guidelines relating to Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options members readmitted to the same acute facility within 30 days.

POLICY
The “Peer 4240” appearing below in pertinent part is the process followed by the Centers for Medicare and Medicaid Services (CMS) with respect to persons who are enrolled in conventional Medicare. Except as noted, we will follow this process for general acute inpatient claims. As stated in greater detail below, payment for a readmission to the same acute facility within 30 days may be denied if, through medical record review, the admission was deemed preventable, medically unnecessary or was due to a premature discharge of the prior admission.

PEER 4240 READMISSION REVIEW ORGANIZATION MANUAL
Readmission review involves admissions to an acute, general, short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, short-term hospital (see § 1154(a)(13) and 42CFR466.71(a)(8)(ii)). Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred.

A. Medical Review Procedures
Obtain the appropriate medical records for the initial admission and readmission. Perform case review on both stays. Analyze the cases specifically to determine whether the patient was prematurely discharged from the first confinement, thus causing readmission. Perform an analysis of the stay at the first hospital to determine the cause(s) and extent of any problem(s) (e.g., incomplete or substandard treatment). Consider the information available to the attending physician who discharged the patient from the first confinement. Do not base a determination of a premature discharge on information that the physician or provider could not have known, or events that could have not been anticipated at the time of discharge. Review both the initial admission and the readmission at the same time unless one of them has previously been reviewed, In these cases, use, at a minimum, the Physician Reviewer Assessment Format (PRAF) case summary of the other admission, in addition to the medical records of the case under review.

Some of the common reasons for bridging the readmissions include

a. Diagnostic errors including:
   i. Error of delay in diagnosis
   ii. Failure to employ indicated tests
   iii. Use of outmoded tests or therapy
   iv. Failure to act on results of monitoring or testing
b. Treatment mistakes:
   i. Error in performance of operation, procedure or test
   ii. Error in administration of treatment
   iii. Error in dose or method of using a drug
   iv. An avoidable delay in treatment or in responding to an abnormal test
   v. Inappropriate (not indicated) care
c. Prevention related failures:
   i. Failure to provide prophylactic treatment
   ii. Inadequate monitoring or follow up of treatment
   iii. Failure to get appropriate consultation

*Acknowledgement: Massachusetts Medical Society; The Institute of Medicine (IOM) 2000 landmark report “To Err is Human: Building a Safer Health System.”
The Concern Source Bridge Legend is a categorization tool, a listing of categorization codes pertaining to admission, diagnosis and quality and is referenced when reviewing cases for potential bridging. Attachment referenced is found in the Massachusetts Medical Society; the Institute of Medicine (IOM) 2000 landmark report, “To Err is Human: Building a Safer Health System.”

Denial, appeal, and/or grievance procedures are followed for these circumstances if the readmission was medically unnecessary, resulted from a premature discharge from the same hospital and/or was a result of circumvention of PPS by the same hospital. The appeal bridge letter received from the facility must specifically address the concern in our rationale for bridge. On the bridge decision written determination we will inform the hospital and attach the appropriate rationale code for their reference.

B. Denials
Deny a readmission under the following circumstances:
- if the readmission was medically unnecessary
- if the readmission resulted from a premature discharge from the same hospital, or
- if the readmission was a result of circumvention of PPS by the same hospital (see §4255)

TO REQUEST REVIEW OF PAYMENT/DENIAL OF PAYMENT FOR GENERAL ACUTE INPATIENT READMISSION CLAIMS
A. All requests made by a primary care provider (PCP), care manager, medical director for the medical group, or the facility must be put in writing and sent to the following email address: THPMP_MCR_Program@tufts-health.com.
B. All medical records and supporting documentation must be submitted within the request for review. The review request must clearly state the reason that the medical group feels that payment for the readmission should be denied. This must include which of the criteria in “4240” applies and cite that portion of the medical record that directly supports the request.
C. A letter or determination will be sent to the requestor of the review within 60 days of the receipt of the case information.
D. Please be advised that regardless of whether a determination is made to “bridge” the claim, the member cannot be held liable for any charges relating to the services provided during the readmission.

Note: The above guidelines are only applicable for review if the member entered the same acute facility within 30 days.

REFERENCES
1. Medicare documentation – “Peer 4240” has been incorporated into this document (above)