

Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Readmission (Bridging of Claims) Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- Tufts Medicare Preferred HMO (a Medicare Advantage product)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the [Professional Services and Facilities Payment Policy](#).

Note: Audit and disclaimer information is located at the end of this document.

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 (SCO) 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. Identifying or Selecting Admissions for Review

- Tufts Health Plan will identify all readmissions to the same hospital within 14 and 30 days
- Readmission review will be performed as a matter of routine for all readmissions within 14 days
- Readmissions within 15-30 days will be reviewed on a case-by-case basis if identified as related to the index admission by a physician, care manager or other Tufts Health Plan employed or contracted staff

Requesting Review of General Acute Inpatient Readmission Claims

- All requests made by a primary care provider (PCP), care manager, medical director for the medical group, or the facility must be submitted in writing to THPMP_MCR_Program@tufts-health.com.
- All medical records and supporting documentation must be included with 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.
- A letter or determination will be sent to the requestor of the review within 60 days of the receipt of the case information.

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.

B. 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 but are not limited to:

- 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
- d. Hospital billing for two separate admissions for care that could have been provided during one admission:
 - i. When a definitive treatment has been decided and the patient is discharged only to be readmitted for that definitive treatment, without a medical reason for such a delay
 - ii. When a member is discharged for less than 48 hours with intention to resume treatment in the hospital upon the member's return; such breaks in care should be labelled as "leave of absence" and not billed as separate admissions

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.

C. Denials

Tufts Health Plan will 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)

Determination of these circumstances may be recommended by RNs, but denials will only be issued with the concurrence of a physician reviewer.

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.**

D. Hospital Appeal Process

The hospital may appeal any decision to deny separate payment for readmission. The hospital may submit the appeal within 120 days of receipt of the denial notice. 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.

Tufts Health Plan will have the case reviewed by an independent review team, considering the medical information, the rationale for the initial denial decision, the information provided by the hospital in the letter of appeal, and any other information provided during the appeal that was not available at the time of initial review.

REFERENCES

1. Medicare documentation – “Peer 4240” has been incorporated into this document (above)
2. Quality Improvement Organization Manual, Chapter 4 – [Case Review](#)

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s [audit policies](#), refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.