

HOSPITAL READMISSIONS

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INSTRUCTIONS FOR USE

This Quality of Care Guideline provides assistance interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage or Summary Plan Description) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this Guideline. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Guideline. Other policies and guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its policies and guidelines as necessary. This Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

INTRODUCTION

Essential Health Benefits for Individual and Small Group:

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the enrollee’s specific plan document to determine benefit coverage.

Promoting Safe Hospital Discharge

The purpose of this guideline is to support Quality of Care reviews of hospital readmissions.

The problems associated with hospital discharge have been well researched and well described. Approximately 19 % of Medicare patients are readmitted within 30 days. A few examples of some of the findings are:

- Only 37% of patients are able to state the purpose of all of their medications. ⁽¹⁾⁽³⁾
- Only 14% of patients knew their medications' common side effects.
- Only 42% of patients are able to state their diagnosis. ⁽¹⁾⁽³⁾
- 25% of discharged patients require additional outpatient work-ups with greater than one of three work-ups not completed. ⁽¹⁾⁽³⁾
- As many as 41% of patients are discharged with test results still pending with 37% of the results actionable. Two out of three doctors are unaware of results. ⁽¹⁾⁽³⁾
- Documentation of pending tests in discharge summaries were noted only 16% of the time. All patients had at least one pending result though only 25% of discharge summaries mentioned a pending result. ⁽¹⁾⁽³⁾
- Discharge summaries are available at first post-discharge appointment only 12-34% of the time. ⁽¹⁾⁽³⁾
- The time spent during discharge encounters between practitioners and patients averaged eight minutes. ⁽¹⁾⁽³⁾

Programs to reduce these defects have been developed and in many cases shown to have proven effect:

- Re-Engineered Discharge Project (Project RED) ⁽¹⁾⁽³⁾
- Better Outcomes for Older Adults through Safe Transitions (Project BOOST)

GUIDING PRINCIPLES

Readmission Review Overview

UnitedHealthcare Commercial (Employer & Individual Plan Readmissions) UnitedHealthcare Community and State (Medicaid Readmissions)

Admissions to an acute, general, short-term hospital occurring within 30 days of the date of discharge from the same acute, general, short-term hospital or hospital system for the same, similar, or related diagnosis may be subject to readmission review.

UnitedHealthcare and its affiliates may conduct readmission reviews to determine if there was an admission that was considered clinically related with a reasonable expectation that it could have been prevented by one of more of the following: ⁽¹⁰⁾

- Optimal provision of quality care during the initial hospitalization ⁽¹⁰⁾
- Optimal discharge planning ⁽¹⁰⁾
- Optimal post-discharge follow-up ⁽¹⁰⁾
- Improved coordination between inpatient and outpatient health care teams ⁽¹⁰⁾

A. Excluded from readmission review are: ⁽¹⁰⁾

- Transfers from out of network to in-network facilities
- Transfers of patients to receive care not available at the first facility
- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, other similar repetitive treatments or for scheduled elective surgery
- Skilled Nursing and Rehabilitation facilities (SNF and Rehab)
- Admits associated with malignancies, burns, and cystic fibrosis
- Admissions with a discharge status of left against medical advice
- Obstetrical readmissions
- Readmissions > = 30 days from the initial admission

B. Documentation for Determination:

Upon request from the Health Plan, the facility and/or facilities agree to forward all medical records and supporting documentation of the first and subsequent admissions to UnitedHealthcare or one of its affiliates. This can occur either concurrently during the inpatient stay, prepayment or post-payment review of the claim.

C. Review Process:

Review of the facility contract to determine if readmission review is applicable.

At the request of UHC, the hospital must submit medical records pertaining to the readmission as well as the index/anchor admission to first identify whether the case is a potentially preventable readmission. Initial review should determine whether the readmission was **clinically related** to the index/anchor admission. A readmission is considered to be clinically related to the initial admission if it belongs to one of five different categories: ⁽¹⁰⁾

- A medical readmission for a continuation or recurrence of the reason for the initial admission or closely related condition. (e.g., readmission for diabetes following an initial admission for diabetes) ⁽¹⁰⁾
- A medical readmission for an acute decompensation of a chronic problem that was not related to the initial admission but was plausibly related to care either during or immediately after the initial admission (e.g., a readmission for previously diagnosed diabetes in a patient whose initial admission was for an acute myocardial infarction) ⁽¹⁰⁾
- A medical readmission for an acute medical complication plausibly related to care during the initial admission (e.g., a patient with a hernia repair discharged with a urinary catheter readmitted for treatment of a urinary tract infection) ⁽¹⁰⁾
- An unplanned readmission for surgical procedure to address a continuation or a recurrence of the problem causing the initial admission (e.g., a patient readmitted for an appendectomy following and initial admit for abdominal pain and fever) ⁽¹⁰⁾
- An unplanned readmission for a surgical procedure to address a complication resulting from care during the initial admission (e.g., a readmission for drainage of a post-operative wound abscess following an initial admission for a bowel resection) ⁽¹⁰⁾

Once the initial review has determined to be **clinically related**, further evaluation would determine whether the readmission was **potentially preventable**. The review shall focus on the following:

- Whether the patient meets inpatient or alternative setting criteria using the appropriate MCG™ 18 edition.
- Whether discharge plans were followed according to generally accepted medical standards (*Generally Accepted Standards of Medical Practice, 2011 Certificate of Coverage*). These are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered.
- Documentation in the hospital record that an appointment was made within the first week or within an appropriate time frame after discharge from the initial admission. ⁽¹¹⁾
- Whether appropriate telephone numbers have been given to the patient for calls to the hospital or primary care provider for related discharge questions. ⁽¹¹⁾
- Whether a health care advocate/provider did an in-home safety assessment and appropriate follow up as needed.
- Whether written discharge instructions were provided and explained to the patient/caregiver prior to discharge (Project Boost).
- Documentation that all required prescriptions were given to the patient and the patient was educated in the appropriate use of the medication. ⁽⁹⁾⁽¹¹⁾

- Whether documentation supports that durable medical equipment has been arranged for the patient and the patient has been appropriately educated on its use.
- Whether documentation supports that all salient financial and social needs of the patient have been addressed.

APPENDIX

UnitedHealthcare Clinical Programs for Facility Safe Discharge

UnitedHealthcare has nurses and physician medical directors who operate clinical programs that can assist hospital staff with discharging patients safely.

Program	Description	Type of Discharge Assistance
Inpatient Care Management	Registered nurse (RN) reviews cases at the hospital on a daily basis.	<ul style="list-style-type: none"> ▪ Available to match patient needs to plan benefits. ▪ Can refer to other plan programs.
Transitional Case Management	RN makes post discharge follow-up call for high risk patients being discharged from the hospital.	<ul style="list-style-type: none"> ▪ Can ensure that required services are delivered & reinforce discharge plan.
Heart Failure Telemetry & Disease Management	Offers remote telemeterized monitoring including electronic scale with RN telephonic support, disease information and physician contact when baseline parameters are exceeded.	<ul style="list-style-type: none"> ▪ Monitors symptoms & weight on daily basis. ▪ RN places outbound call when parameters are exceeded. ▪ Will assist patient with contacting physician, when necessary.
Complex Case Management	RN works with the patient on long term ongoing basis to assist with optimal utilization	<ul style="list-style-type: none"> ▪ Ongoing relationship can help patients obtain non-hospital care prior to problem escalating and requiring hospitalization.
Home Health Care	Clinically trained non-physician health providers who provide skilled care in the home.	<ul style="list-style-type: none"> ▪ Assistance in understanding and better utilizing the home health care benefit for a specific patient.

Physicians and hospital staff can refer to and work with these case management and disease management programs.

DEFINITIONS

Readmission is defined as:

- The subsequent acute admission for the same patient within 30 days of discharge of the initial admission and at least one day between the discharge and new admission (to ensure transfers are not counted as readmissions).
- Readmissions can be both categorized as planned and emergency admissions.
- Applies to acute inpatient admissions only.

REFERENCES

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8. Identifying Potentially Preventable Readmission Using a Present on Admission Indicator, Health Care Finance Review Spring 2006.
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11. Report on Medicare Compliance – Volume 17, Number 24, June 30, 2008
12. www.cms.gov (use search term “readmissions”)
13. MCG™ 18th Edition

HISTORY/REVISION INFORMATION

Date	Action/Description
08/01/2014	<ul style="list-style-type: none"> • Updated review process guidelines for determining if a patient meets inpatient or alternative setting criteria; replaced reference to “MCG™ Care Guidelines, 17th edition, 2013” with “MCG™ Care Guidelines, 18th edition, 2014” • Archived previous policy version QoC - 01