

SMSO Policy Manual

INPATIENT READMISSION AUTHORIZATION POLICY

Commercial and Medicare

Executive Sponsor: Chief Executive Sponsor

Issuing Department: Clinical Management

Gate Keeper: Director, HSM Clinical Management

COMPLIANCE STATEMENT:

Enforcement: All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.

Review Schedule: This policy will be reviewed and updated as necessary and no less than every two years.

Monitoring and Auditing: The Issuing/Collaborating Department(s) is responsible for monitoring and compliance with this policy.

Documentation: Documentation related to this policy must be maintained for a minimum of 10 years.

Applies To:	
☒ SummaCare	☒ Apex
Summa Management Service Organization (SMSO)	☒ Summa Insurance Company
checkbox	
Line of Business:	
☒ Commercial Groups	☒ Medicare
Medicare Supplemental	☒ On-Exchange
☒ Off-Exchange	☒ Self-Funded

1.0 Purpose:

- 1.1 This policy documents the Health Plan's guidelines used to identify a readmission and the Health Plan's guidelines for reimbursement related to a readmission.

2.0 Policy:

- 2.1 SummaCare does not allow separate authorization and reimbursement for admissions that have been identified as a readmission within 30 days of a previous discharge to the same facility, or another facility that (i) operates under the same Facility Agreement, (ii) has the same tax identification number as Facility, or (iii) is under common ownership of one or more acute care hospitals/facilities.

3.0 Procedure:

- 3.1 This policy applies to hospitals and hospital health systems reimbursed per DRG, case rate, percent of charges, or any other payment methodology for inpatient hospital stays.
- 3.2 For purposes of this policy, readmission is defined as:
 - 3.2.1 Admission to the same facility, or another facility that (i) operates under the same Facility Agreement, (ii) has the same tax identification number as Facility, or (iii) is under common ownership of one or more acute care hospital/facilities, within 30 days from previous discharge, (of the original admission) and
 - 3.2.2 Such subsequent admission is for the same, similar or related diagnosis or for a complication arising out of the previous admission, and
 - 3.2.3 (Original) Prior admission is reimbursed using DRG/Case Rate, percent of charges, or any other payment methodology.
- 3.3 Readmission to the same inpatient acute care hospital, or an inpatient acute care hospital within the same health system of hospitals, within 30 days will be subject to medical chart review to determine if the readmission was related to the original inpatient hospital stay, post-operative infection, sepsis, or complication diagnosis, and determined to be preventable or avoidable. The following criteria will be considered when performing the medical chart review:
 - 3.3.1 The same or closely related condition or procedure as the prior discharge. The readmission was clinically related if one of the following is met:
 - 3.3.1.1 A medical readmission for continuing or recurring reason for the initial admission or closely related to the condition
 - 3.3.1.2 A medical readmission for acute decompensation of a coexisting chronic problem/condition that was not related to the initial admission but was reasonably related to care either during or immediately after the initial admission.
 - 3.3.1.3 A medical readmission for an acute medical complication reasonably related to care during the initial admission.
 - 3.3.1.4 An unplanned readmission for surgical procedure to address a continuation or a recurrence of the problem causing the initial admission.
 - 3.3.1.5 An unplanned readmission for a surgical procedure to address a complication resulting from care during the initial admission.
 - 3.3.2 An infection or other complication of care

- 3.3.3 A condition or procedure indicative of a failed surgical or procedural intervention.
- 3.3.4 A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period. The following may indicate a premature discharge, but are not exclusive of a possible premature discharge:
 - 3.3.4.1 Symptoms that had onset or were present during a previous admission and subsequently worsened leading to readmission are a possible indicator of a premature discharge.
 - 3.3.4.2 Discharge prior to establishing the safety or efficacy of a new treatment regimen is also considered a premature discharge.
 - 3.3.4.3 Clinical instability at the time of discharge or failure to address signs and symptoms during an admission also provides evidence of premature discharge and/or a preventable readmission.
 - 3.3.4.4 There was inadequate discharge planning in place for a reasonable expectation that a readmission could be avoided by one or more of the following:
 - Discharge prior to completing adequate discharge planning in accordance with accepted standards for acute care discharge planning.
 - Failed discharge planning to another facility: Failed transfers to a Skilled Nursing Facility (SNF), Long Term Acute Care (LTAC), Acute Inpatient Physical Rehabilitation (IPR), or a similar facility are treated as leave of absences.
 - Inadequate outpatient follow-up or treatment must be considered for availability and criticality of outpatient follow-up visits and treatment. Communication with practitioners who will follow-up care is expected.
 - Discharge to an inappropriate destination such as home instead of SNF.
 - Failure to address rehabilitation needs such as decline in function and inability to perform activities of daily living (ADL) is common following hospitalization. Failure to properly address rehabilitation needs related to an inability to perform self-care is an avoidable cause of readmission.
 - Readmission of patient to a hospital for care that could have been provided during the initial admission as identified by professionally recognized standards of health care. This does not include circumstances in which it is not medically appropriate to provide the care during the initial admission.
- 3.4 Facilities shall not be separately reimbursed for the subsequent admission. Reimbursement shall be considered as included in the reimbursement for the original admission. In no circumstances shall the admissions be combined to qualify for outlier reimbursement. Note: Coverage is subject to the terms, conditions, and limitations of an individual member's programs or products and policy criteria listed below. Applications to self-funded groups may vary.
- 3.5 SummaCare reserves the right to reject or deny the claim or to recoup and/or recover monies previously paid on a claim that falls within the guidelines of this Policy.
- 3.6 This policy does not apply to the services listed below:
 - 3.6.1 Maternity and newborn care, with the exception of post-delivery admissions when the readmission is for a condition directly related to the delivery such as infection, post C-section ileus, or other C-section or vaginal delivery complications
 - 3.6.2 Chemotherapy, which includes the treatment of malignant disease by chemical or biological

- antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetic agents, and other related biotech products
- 3.6.3 Transplant services, including organ and tissue transplantation from a live or cadaveric donor during the global case rate period for transplant.
 - 3.6.4 Transfers from one institution to another for medically necessary care not available at the transferring hospital
 - 3.6.5 Individual discharged from the hospital against medical advice, for the initial episode of care (for readmissions within the 30-day provision)
 - 3.6.6 Admission to a substance abuse unit or facility
 - 3.6.7 Admission to an inpatient rehabilitation unit
- 3.7 SummaCare reserves the right to request additional documentation as part of its reimbursement process.
- 3.8 SummaCare may include reimbursement as part of the reimbursement of the previous admission when it is determined that the services performed/billed are not separately payable regardless of coding used and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation must be made available upon request of SummaCare. Documentation requested may include:
- 3.8.1 Admission and discharge summaries (prior admission)
 - 3.8.2 Physician's orders
 - 3.8.3 Emergency room records
 - 3.8.4 Progress notes
 - 3.8.5 Nurse's notes
 - 3.8.6 Laboratory and diagnostic testing
 - 3.8.7 Patient history and physical
 - 3.8.8 Credentials of the provider ordering or performing a service
 - 3.8.9 Itemized bills and justification of level of operating room billed.
- 3.9 After reviewing the relevant documentation, SummaCare reserves the right to apply this policy to the procedure performed regardless of how the procedure was coded by the provider.
- 3.10 SummaCare also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.
- 3.11 This policy will not supersede any individual facility contract provisions or state or federal guidelines.

ORIGINAL *EFFECTIVE DATE*:
REVIEWED: 2/6/20; 10/28/25
REVISED: 2/6/20; 10/30/25