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Origination: October 11, 2019
Last Review: May 08, 2025
Next Review: May 08, 2026
Effective Date: August 01, 2025

Description

The intent of this policy is to enhance quality of care outcomes for our members and to hold the member financially harmless for clinically related, same condition or preventable readmissions.
This payment policy describes how Blue Cross and Blue Shield of Vermont (Blue Cross VT) identifies and processes a claim for a readmission to the same hospital billed on a UB-04/837I claim form.

Definitions

Clinically Related: A readmission is clinically related when the underlying reason for hospital readmission is plausibly related to the care rendered during or immediately following a prior inpatient hospital admission.

Same Condition: Is determined by:

- the same diagnostic related group (DRG) classification as grouped by the diagnosis and procedure codes billed on a UB-04 or 837I claim for DRG reimbursed facilities, OR
- the same principal diagnosis code and admitting diagnosis (Field Locators 67 and 69 respectively) as billed on a UB-04 or 837I claim form for non-DRG reimbursed facilities.

Preventable Readmission: A readmission to the same hospital within thirty (30) calendar days, that could have been prevented. This means the readmission could potentially have been avoided with a later discharge, better care coordination, follow-up, adherence to treatment plans or similar clinical interventions. A preventable readmission is for the same condition or clinically related to the previous hospital admission.

- An observation stay shall be considered an 'original admission' for purposes of this payment policy. In other words, if a hospital admits a member for observation and, subsequently, the member is readmitted to the same inpatient hospital (either for an inpatient stay or another observation stay) within thirty (30) calendar days it shall be considered a preventable readmission.

Policy & Guidelines

Policy Statement

This payment policy is not intended to impact care decisions or medical practice of providers/facilities. Health care providers (facilities, physicians, and other health care professionals) are expected to exercise independent medical judgement in providing care to members.

Blue Cross VT does not separately compensate providers for clinically related, same condition or preventable readmissions to the same hospital within thirty (30) calendar days of discharge from the previous inpatient hospital stay.

Guidelines

Hospital readmissions contribute to unnecessary medical spending, increasing health care costs, and jeopardizing member safety. Hospital readmissions may be identified through claims, audits, member complaints, and case or utilization management. Blue Cross VT promotes clinically necessary, cost effective, and improved health care through appropriate and safe inpatient hospital discharge of members.

Readmission Within Five (5) Calendar Days of Discharge

Not Eligible

Readmission to the same inpatient hospital within five (5) calendar days of discharge from the previous inpatient hospital stay for any reason will be administratively denied.

This payment policy applies to inpatient readmission claims with an admission date on or after August 1, 2025. Each readmission, whether paid or denied, will be evaluated against the five (5) calendar day readmission criteria if a subsequent hospital stay occurs.

Upon receipt of the denial through a provider voucher, and within timely filing, the hospital may submit a reconsideration request with all required documentation included, as set forth in this payment policy.
The reconsideration request shall include the following and substantiate that the readmission was not clinically related, same condition or preventable:

- The submission shall outline sufficient evidence demonstrating that no additional interventions could have prevented the readmission.
- Medical records from both admissions (i.e. initial admission and readmission record)

which may include:

- Admission and discharge summaries (from the initial admission and readmission)
- Emergency room records (if applicable)
- Provider orders
- Daily progress notes
- Laboratory and diagnostic testing/results
- Surgical operative reports
- Case management notes (including member instructions, scheduled follow-up appointments, etc.)
- Discharge planning documentation, if not included in medical record.
- Post-discharge follow-up
- Transitions of care

It is the hospital's responsibility to substantiate that the readmission was not related or preventable and that sufficient evidence supports this assertion.

No more than one (1) reconsideration request is permitted for each denial. Failure to submit both admission records (i.e. initial admission and readmission) will result in denial of the request.

Note: A scheduled planned admission (i.e. scheduled chemotherapy, elective surgical admissions) is **NOT** considered a preventable readmission under this payment policy. In the event such a claim is denied, the scheduled planned admission shall be clearly identifiable in the member medical record, and the discharge summary must document and support the planned readmission. Proof of the scheduled planned admission must be provided in the reconsideration request.

Eligible

If the reconsideration request and supporting documentation substantiates the readmission could not be prevented, the readmission denial will be overturned, and the claim will be processed following all other guidelines, procedures, and benefit determinations.

Readmission Within (6-30) Calendar Days of Discharge

Readmission to the same hospital, within 6-30 calendar days may be subject to medical chart review. Medical records may be necessary to determine that the readmission was **NOT** related to the same condition or preventable from the initial inpatient hospital stay (e.g., same major diagnostic category, post-operative infection, sepsis, or complication diagnosis).

If the medical chart review indicates that the readmission was for the same condition or preventable, the readmission claim will be denied or recouped. The following criteria will be considered during the medical chart review:

- Acute decompensation of a coexisting chronic disease that may be related to care during the initial admission or follow up care after discharge (e.g., admission for uncontrolled diabetes after initial admission for asthma)
- An acute medical complication or post-operative complication related to care during the initial admission or post-discharge care (e.g., urinary tract infection as a result of urinary catheter placement at the initial admission, deep venous thrombosis following surgery to repair hip fracture, post-operative wound requiring drainage following initial admission for abdominal surgery)
- An unplanned surgery or admission to address a continuation or recurrence of the same problem as the initial admission (e.g., individual readmitted for cholecystectomy following initial admission for fever and elevated liver function tests or readmission for congestive heart failure after an initial admission for congestive heart failure)
- A condition or procedure indicative of a failed surgical or procedural intervention (e.g., repeat admission for an endoscopic intervention for gastrointestinal bleeding)
- 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 (e.g., readmission for heart failure if individual did not have sufficient follow-up instructions to refill diuretic prescription)
- An issue caused by a premature discharge from the same hospital

Once a preventable readmission has been identified retrospectively, Blue Cross VT shall request medical record for the initial and subsequent inpatient stays to review the clinical conditions, treatment and management and determine if the readmission criteria for the subsequent admission exists.

If available, medical records from both admissions (i.e. initial admission and readmission record) shall include:

- Admission and discharge summaries (from the initial admission and Readmission)
- Emergency room records (if applicable)
- Provider orders
- Daily progress notes
- Laboratory and diagnostic testing/results
- Surgical operative reports
- Case management notes (including member instructions, scheduled follow up appointments, etc.)
- Discharge planning documentation, if not included in medical record.
- Post-discharge follow-up
- Transitions of care.

It is the hospital's responsibility to substantiate that the readmission was not related or preventable and that sufficient evidence supports this assertion.

The medical records need to be provided within thirty (30) calendar days of a written request. It is the hospital's responsibility to substantiate that the readmission was not related or preventable and that sufficient evidence supports this attestation. Failure to submit requested medical records will result in a denial of the readmission.

Not Eligible

Upon review of the medical record if the readmission is determined to be for the same condition, clinically related or preventable to the initial inpatient hospital admission the readmission claim will be denied as provider liability

Exclusions

The following readmissions will not be considered avoidable and/or in scope, thus, will not be denied under this policy:

- Reason for initial discharge is against medical advice (AMA) (Discharge Status Code 07 located in UB-04/837I Form Locator FL 17)

Provider Billing Guidelines and Documentation

The need for the readmission must be supported in the medical records for the initial admission and the readmission. Such medical records shall indicate that the readmission could not be prevented by the treating providers.

Readmission On Same Day as Discharge

Readmission to the same hospital on the same day as discharge for the same or clinically related condition, is considered to be a continuation of treatment and the same admission. In this situation, the initial and readmission shall be considered a single admission. The admissions are considered to be one admission, and only one payment or diagnosis-related group (DRG) will be paid. If the hospital submits individual claims for both admissions the claims will be denied.

Multiple Readmissions

Multiple readmissions, under the thirty (30) calendar day readmission provision within this payment policy, are defined as two or more unplanned hospital admissions to the same hospital. Should any readmission be related to the most recent inpatient hospital stay (e.g., same major diagnostic category post-operative infection, sepsis, or complication diagnosis) the readmission will be determined to be considered for the same condition or preventable.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or hospital to ensure adherence with the guidelines stated in the payment policy. If an audit identifies

instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

N/A

Related Policies

Payment Policy: *Never Events and Hospital Acquired Conditions (CPP_23)*
Quality Policy: *Quality of Care Risk Investigations*

Document Precedence

The Blue Cross VT Payment Policy handbook was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented on October 11, 2019

Date of Change	Effective Date	Overview of Change
May 08, 2025	August 01, 2025	Payment policy updated to new template format. Policy name changed from 'Preventable Readmissions' to 'Inpatient Hospital Readmission'. New policy statements surrounding five (5) calendar day readmission policy and thirty (30) calendar readmission payment policy guidelines.

Approved by **Update Approved: 05/08/2025**

Tom Weigel, MD, Chief Medical Officer