

WAC 182-550-2950 Payment limits—Provider preventable fourteen-day readmissions. (1) **Introduction.** The rules in this section establish the medicaid agency's payment policy for inpatient claims for provider preventable fourteen-day readmissions and do not apply to any other rules regarding payment for hospital admissions.

(2) **Applicability.** The rules in this section apply to inpatient hospital claims made for clients enrolled in the fee-for-service program and to clients enrolled in an agency-contracted managed care organization (MCO).

(a) The rules in this section do not apply to:

(i) Professional claims submitted for services rendered in the inpatient setting during a readmission; or

(ii) Claims submitted by critical access hospitals.

(b) The rules in this section apply only to provider preventable readmissions and not to other types of fourteen-day hospital inpatient readmissions that do not qualify for payment for other reasons.

(3) **Provider preventable readmission.**

(a) For the purpose of this section, readmission means an inpatient hospital admission to the same or an affiliated hospital within fourteen calendar days of a discharge from a prior admission and clinically related to the prior admission.

(b) Inpatient claims from hospitals for fourteen-day readmissions that the agency or the agency's designee considers to be provider preventable do not qualify for payment.

(c) A readmission is provider preventable if the agency or the agency's designee determines there is a reasonable expectation the hospital could have prevented the readmission by one or more of the following:

(i) Quality of care provided during the index (initial) hospitalization. The quality of care provided during the index hospitalization must follow current, evidence-based standards of care for the health care specialty at issue and must be:

(A) Safely administered without physically harming the client;

(B) Free from medical error that subsequently results in readmission due to that error;

(C) Evidence based, producing outcomes that are supported by evidence and effective in treating the client. The quality of care must follow the hospital's current standards for care of the client's diagnosis during that treatment period;

(D) Client-centered, focusing on the client's individual needs. The quality of care must be appropriate for the diagnosis and involve the patient in the planning of their care;

(E) Timely, with treatment that did not result in a delay of care, and the client was not prematurely discharged;

(F) Medically necessary for treatment of a diagnosis recognized by the current International Statistical Classification of Diseases and Related Health Problems (ICD); and

(G) Equitable in quality for all clients, regardless of differences in personal characteristics or beliefs.

(ii) Discharge planning. Discharge planning must occur as directed in the Centers for Medicare and Medicaid Services' (CMS) interpretive guidelines for 42 C.F.R. Sec. 482.43, in Publication #100-07 State Operations Manual (Rev. 183, October 12, 2018), Appendix A, Section 482.43, Conditions of Participation: Discharge planning (CMS Manual). Discharge planning must include, but is not limited to:

(A) A clearly written discharge plan that actively involves the client or client's representative in the discharge process; and

(B) An assessment of the client's capability for postdischarge care and follow up including, but not limited to:

(I) The client's functional status and cognitive ability;

(II) The type of posthospital care the client requires, and whether such care requires the services of health care professionals or facilities;

(III) The availability of the required posthospital health care services to the client; and

(IV) The availability and capability of family, or friends, or both to provide follow-up care in the home.

(iii) Discharge process. Upon discharge, the provider must meet the following discharge components:

(A) Provide the client with all required prescriptions and provide education regarding the appropriate use of these medications; and

(B) Provide the client with written instructions in the client's primary language.

(I) If written instructions cannot be provided, the hospital must provide verbal instructions through an interpreter and document that the client's questions were answered.

(II) Written instructions must include home care instructions including, but not limited to:

- Contact numbers for discharge-related questions;
- Information describing when the client should call the provider with concerns and when to call 911;
- Dietary restrictions;
- Wound care, when applicable; and
- Activity limitations.

(iv) Postdischarge follow-up. Postdischarge follow-up documents must include:

(A) A complete discharge summary, including case management discharge summaries and a risk assessment score that is accessible by outpatient clinics for ease in care coordination.

(B) Dates and contact numbers for follow-up appointments arranged with the primary care provider for all intensive and high-risk clients before the client leaves the hospital.

(C) Arrangements for medical supplies, equipment, and home care services, as needed, before the client leaves the hospital.

(4) **Exclusions.** The following types of inpatient readmission claims are exempt or do not qualify as provider preventable readmissions:

(a) Inpatient psychiatric care;

(b) Readmissions not clinically related to the index (initial) admission;

(c) Readmissions that are planned or scheduled including, but not limited to:

(i) Admissions for repetitive treatments such as cancer chemotherapy or other required treatments for cancer, transfusions for chronic anemia, burn therapy, dialysis, or other planned treatments for renal failure;

(ii) Planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same case; or

(iii) Planned admissions on the same day to a different hospital unit for continuing care (including transfers for mental health, chem-

ical dependency, rehabilitation, and similar transfers that may be technically coded as discharge/admission for billing purposes).

(d) Admissions for required cancer treatments, including treatment-related toxicities or care for advanced-stage cancer;

(e) End of life and hospice care;

(f) Claims for clients who left against medical advice from index admission;

(g) Obstetrical claim admissions after an antepartum admission;

(h) Claims for readmission with a primary diagnosis of mental health or substance use disorder;

(i) Neonatal inpatient services;

(j) Transplant services, when the admission occurs within one hundred eighty days of transplant;

(k) Claims from a different hospital system other than where the index admission occurred;

(l) Claims to resume care for a client because the client did not comply with the discharge plan; or

(m) Readmissions resulting from the client's refusal of the recommended discharge plan and the index hospital making a less appropriate alternative plan to accommodate client preferences.

(5) **Postpayment utilization review.** The agency or the agency's designee performs a postpayment utilization review of the index hospital admission and all fourteen-day readmissions to determine what claims may qualify for recovery.

(6) **Client financial responsibility.** Clients are not financially liable for claims denied based on provider preventable fourteen-day readmissions that would have otherwise been paid by the agency or the agency's designee.

(7) **Dispute resolution.**

(a) Fee-for-service readmissions. If a hospital disputes a determination regarding fee-for-service readmissions, the agency follows the process in chapter 182-502A WAC and the administrative hearing procedure described in chapter 182-526 WAC.

(b) Managed care organization readmissions. MCOs must have an internal dispute resolution process for disputes arising out of a readmission. A hospital must access the MCO's internal dispute resolution process to dispute a provider preventable readmission determination by the MCO, as described in the hospital's individual contract with the MCO.

(c) Final determination review process. If the hospital has exhausted the MCO's internal dispute resolution process and the hospital continues to dispute the determination, the MCO and agency will follow the process regarding the fourteen-day readmission review program as described in the apple health managed care contract.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-13-006, § 182-550-2950, filed 6/6/19, effective 7/7/19.]