Avoidable Medicare Advantage Readmissions May Lead to Administrative Claim Denials

To help encourage the best possible quality of care outcomes for our Medicare Advantage members and in support of the clinical quality issue that is being driven by CMS’ Readmission Quality Improvement Program (QIP), we have an obligation to review readmissions for clinical relatedness. In accordance with the Diagnosis Related Groups (DRG) payment methodology, WellPoint will be following a uniform 30-Day Readmission Review Program for our Medicare Advantage program that is consistent with Centers for Medicare & Medicaid Services (CMS) quality improvement guidance.¹

Payment for a Medicare Advantage member’s DRG readmission to the same acute facility within 30 days of the first admission may be administratively denied if the readmission is determined to be related to the previous admission.

This Program will apply to facilities’ claims only. We will not administratively deny professional or ancillary claims based upon the 30-Day Readmission Review Program. The administrative denial of these claims will apply to participating and non-participating facilities.² As a reminder, all claims denied administratively under this Readmission Review Program are denied as provider liability. Our member is not liable for these denied claims. Providers are not permitted to balance bill the member for the denied claim.

Additional information can be found in the Anthem BlueCross BlueShield's Medicare Advantage Guidebook.

Please share this information with clinical staff and others involved with admissions.

¹ Chapter 4, Section 4240 (Readmission Review) of the Medicare Quality Improvement 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 42 CFR 476.71(a)(8)(iii)).

² Medicare QIO Manual, Chapter 4, Section 4240: 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 not have been anticipated at the time of discharge.

2. Subject to explicit language that sets forth a different payment methodology