Guidelines for Bundling Admissions for Blue Medicare Advantage members

Re-admissions that occur within 14 days of discharge are reviewed by Blue Medicare Advantage for facilities that are reimbursed by DRGs when the member has the same or a similar diagnosis or related event. In some instances, Blue Medicare Advantage combines the two admissions into one for purposes of the DRG reimbursement. The guidelines Blue Medicare Advantage uses to determine whether two admissions will be combined for payment purposes are outlined in this document. These guidelines are subject to change. Additional information about bundling admissions is found in the Care Management section of the Kansas Preferred Blue Medicare Advantage Provider Manual.

Description of Discharge	Billing	Blue MA Financial Recovery	Provider Appeal Rights	Additional Information
Member leaves against medical advice and requires subsequent readmission.	Bill the admissions separately.	None	Cannot be appealed.	Any discharge of a member against medical advice is considered a regular discharge and the admissions will not be bundled. The hospital record should show that the member signed out against medical advice. Examples include: • Physician writes “discharged AMA” in physician orders. • Member signs AMA form when leaving facility. • Progress notes (by either a physician or a nurse) include written notation indicating that the member left AMA.
Member requests discharge because of uncertainty about undergoing further treatment or for other, personal reasons.	Bill the admissions separartely if the hospital record shows the member initiated the interruption.	None	Cannott be appealed.	The readmission is considered separate if the member needs to return home or requests time to make a major health care decision.
Member is discharged to allow resolution of a medical problem that, unless resolved, is a contraindication to the medically necessary care that will be provided during the second admission.	Bill the admissions separately.	None	Cannot be appealed.	The hospital record must clearly show why the interruption was medically necessary. Example — The member is discharged to await normalization of clotting times prior to a surgical intervention.

Guidelines for Bundling Admissions for Blue Medicare Advantage members

Re-admissions that occur within 14 days of discharge are reviewed by Blue Medicare Advantage for facilities that are reimbursed by DRGs when the member has the same or a similar diagnosis or related event. In some instances, Blue Medicare Advantage combines the two admissions into one for purposes of the DRG reimbursement. The guidelines Blue Medicare Advantage uses to determine whether two admissions will be combined for payment purposes are outlined in this document. These guidelines are subject to change. Additional information about bundling admissions is found in the Care Management section of the Kansas Preferred Blue Medicare Advantage Provider Manual.

Description of Discharge	Billing	Blue MA financial Recovery	Provider Appeal Rights	Additional Information
Member meets discharge criteria and has an appropriate discharge plan but requires readmission because of an unrelated condition or a new occurrence of the same condition.	Bill the admissions separately.	None	Cannot be appealed.	The hospital record must include a discharge plan that is appropriate and reasonable and that addresses the member's ability to follow the treatment plan after discharge.
Member is discharged before all medical treatment is rendered and care during the second admission should have been completed during the first admission.	Combine the admissions as a continuation of care unless plans were appropriately made for outpatient follow up for the medical conditions identified during the first `admission.(1) (2)	If a hospital bills the admissions separately, an audit adjustment is made to combine the admissions.	Can be appealed.	Example: The member is treated for pneumonia, responds and meets discharge criteria but a fecal occult blood test is positive at Hgb = 10.9 grams. The hospital record does not support that this was recognized and appropriately determined to require investigation during the first admission. No follow up of the fecal occult blood test is documented. The member is readmitted five days later with gastrointestinal bleeding.

(1) Criteria for bundling are assessed for the hospital re-admission when members are discharged to the following settings: Home, skilled nursing facility, inpatient rehabilitation facility, psychiatric facility, basic nursing home, or long-term acute care facility. (2) If the facility acknowledges that the member did not meet the discharge screens, the admissions can be combined without clinical review by Blue Medicare Advantage. If the facility does not acknowledge this, Blue Medicare Advantage must perform a clinical review to assess whether the member met the criteria/guidelines outlined in this document.

Guidelines for Bundling Admissions for Blue Medicare Advantage members

Re-admissions that occur within 14 days of discharge are reviewed by Blue Medicare Advantage for facilities that are reimbursed by DRGs when the member has the same or a similar diagnosis or related event. In some instances, Blue Medicare Advantage combines the two admissions into one for purposes of the DRG reimbursement. The guidelines Blue Medicare Advantage uses to determine whether two admissions will be combined for payment purposes are outlined in this document. These guidelines are subject to change. Additional information about bundling admissions is found in the Care Management section of the Kansas Preferred Blue Medicare Advantage Provider Manual.

Description of Discharge	Billing	Blue MA Financial Recovery	Provider Appeal Rights	Additional Information
Member is discharged without discharge screens being met, including the clinical and level-of-care criteria.	Combine the admissions as a premature discharge. (1) (2)	If a hospital bills the admissions separately, an audit adjustment is made to combine the admissions.	Can be appealed.	Example — The member is discharged from the first admission with documentatin that supports symptoms that do not meet discharge criteria, e.g. abnormal lab results, unstable vital signs, etc.
Member is discharged with a documented plan for re-admission for additional services within an appropriate time frame, based on the member's benefits or the provider's request	Combine the admissions as a planned re-admission. (1) (2)	If a hospital bills the admissions separately, an audit adjustment is made to combine the admissions.	Can be appealed.	The care rendered during the subsequent admission was anticipated. Example — The member is discharged for hospital or physician convenience because, perhaps, the surgeon is away or the operating room is booked until the following week.
Member is discharged after surgery but is re-admitted within 30 days with a direct or related complication from the surgery.	Combine the admissions. (1) (2)	If a hospital bills the admissions separately, an audit adjustment is made to combine the admissions.	Can be appealed.	The monitoring, evaluation and treatment of the member for a known sequel or for common complications following surgery are an expected part of the postoperative period of the first admission. Example — The member returns in three to five days with a wound infection that requires intravenous antibiotics.
Member is discharged but there was not a well-documented, reasonable and appropriate discharge plan.	Combine the admissions. (1) (2)	If a hospital bills the admissions separately, an audit adjustment is made to combine the admissions.	Can be appealed.	The hospital record does not show that the member had a well-documented, reasonable, and appropriate discharge plan.

(1) Criteria for bundling are assessed for the hospital re-admission when members are discharged to the following settings: Home, skilled nursing facility, inpatient rehabilitation facility, psychiatric facility, basic nursing home, or long-term acute care facility. (2) If the facility acknowledges that the member did not meet the discharge screens, the admissions can be combined without clinical review by Blue Medicare Advantage. If the facility does not acknowledge this, Blue Medicare Advantage must perform a clinical review to assess whether the member met the criteria/guidelines outlined in this document.