ADMINISTRATIVE POLICY STATEMENT
INDIANA MARKETPLACE

Policy Name		Policy Number	Date Effective
Readmission		AD-0981	11/01/2021-11/30/2022
Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Readmission

B. Background

Following a hospitalization, readmission within 30 days is often a costly preventable event and is a quality of care issue. It has been estimated that readmissions within 30 days of discharge can cost health plans more than $1 billion dollars on an annual basis. Readmissions can result from many situations but most often are due to lack of transitional care or discharge planning. Readmissions can be a major source of stress to the patient, family and caregivers. However, there are some readmissions that are unavoidable due to the inevitable progression of the disease state or due to chronic conditions.

The purpose of this policy is to improve the quality of inpatient and transitional care that is being rendered to the members of CareSource. This includes but is not limited to the following: 1. improve communication between the patient, caregivers and clinicians, 2. provide the patient with the education needed to maintain their care at home to prevent a readmission, 3. perform pre discharge assessment to ensure patient is ready to be discharged, and 4. provide effective post discharge coordination of care.

C. Definitions

- **Diagnosis Related Groups (DRGs)** – Are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs have been established as the basis of Medicare's hospital reimbursement system.
- **Planned Readmission** – A non-acute admission for a scheduled procedure for limited types of care to include: obstetrical delivery, transplant surgery and maintenance chemotherapy/radiotherapy/immunotherapy.
- **Potentially Preventable Readmission (PPR)** – Readmission to a hospital for a reason that is considered unplanned and potentially preventable.
- **Readmission** – A subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date; excluding planned admissions.
- **Same or Similar Condition** – A condition or diagnosis that is the same or a similar condition as the diagnosis or condition that is documented on the initial admission.
- **Same Day** – CareSource delineates same day as midnight to midnight of a single day.

D. Policy

I. This is an administrative policy that defines the payment rules for hospitals and acute care facilities that are reimbursed for inpatient or observational services for the following categories:
   A. Same day readmission or observational stay for a related condition
   B. Same day readmission or observational stay for an unrelated condition
   C. Planned Readmissions and/or leave of absence

D. Unplanned admissions to an acute, general, short-term hospital occurring within 30 calendar days from the date of discharge from the same or another acute, general, short-term hospital.

II. Prior authorization of the initial or subsequent inpatient stay or admission to observation status is not a guarantee of payment and are subject to administrative review as well as review for medical necessity at the discretion of CareSource.
   A. All inpatient prior authorization requests that are submitted without medical records will automatically deny which will result in a denial of the claim.

III. An administrative review of all readmissions will take place based on the following Medicare readmission review criteria:
   A. Same day readmission or observational stay for a related condition criteria:
      1. CareSource will conduct an administrative review to ensure that billing guidelines were followed based on Chapter 3, Section 40.2.5 (Repeat Admissions) in the Medicare Claims Processing Manual which requires that the acute, general, short-term hospital combine the two admissions on one claim.
      2. If the member is readmitted during the same day as the initial admission for the same or a related condition and both the initial and the subsequent admission are billed separately, CareSource will deny the claim as separate DRG's. The facility must submit the initial admission and the subsequent admission on one claim to receive reimbursement.
   B. Same day readmission or observational stay for an unrelated condition criteria:
      1. CareSource will conduct an administrative review to ensure that billing guidelines were followed based on Chapter 3, Section 40.2.5 (Repeat Admissions) in the Medicare Claims Processing Manual which requires that the acute, general, short-term hospital to bill the claims separately but the claim that contains an admission date that is the same as the discharge date must include condition code B4 as indicated in the Medicare billing guidelines.
   C. Planned readmission and/or leave of absence criteria:
      1. When a readmission to the same acute care facility or inpatient hospital is expected and the member does not require a hospital level of care during the timeframe between the two admissions, the member may be placed on leave of absence by the provider.
         a. CareSource follows the Medicare Inpatient Hospital Services billing guidelines found in the Medicare Claims Processing Manual, Chapter 3 for leave of absence billing guidelines which requires that the facility submit one claim and receive one combined DRG payment for both admissions both are for the treatment of the same episode of illness.
         b. Examples of a planned readmission include, but are not limited to, situations where surgery could not be scheduled immediately due to scheduling availability, a specific surgical team that is needed for the procedure is not available, bilateral "staged" surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin at the time of initial admission.
         c. CareSource reserves the right to request medical records to determine if the claim was properly billed.

d. Leave of absence does not apply to cancer chemotherapy or similar repetitive treatments.

D. Determination of Unplanned Readmissions criteria:
   1. CareSource will review the clinical documentation on all potential readmissions to determine if the admission was a potentially preventable readmission (PPR) based on the following Medicare guidelines:
      a. Premature discharge of patient that resulted in subsequent readmission of patient to same hospital. Premature discharge includes when a patient is discharged even though he/she should have remained in the hospital for further testing or treatment or was not medically stable at the time of discharge. A patient is not medically stable when, in CareSource judgement, the patient's condition is such that it is medically unsound to discharge or transfer the patient. Evidence such as elevated temperature, postoperative wound draining or bleeding, or abnormal laboratory studies on the day of discharge indicate that a patient may have been prematurely discharged from the hospital;
      b. When a patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission. This action does not include circumstances in which it is not medically appropriate to provide the care during the first admission.
      c. The readmission is the result of a lack of documentation and/or coordination of care between the inpatient and outpatient team in regard to post discharge care and coordination with a CareSource Care Manager for the member.

E. The following readmission criteria listed below are excluded from this readmission policy and if billed appropriately, claims will be reviewed for payment:
   1. If the member is being transferred from an out-of-network to an in-network facility or if the member is being transferred to a facility that provides care that was not available at the initial facility;
   2. Transfers to distinct psychiatric units within the same facility. When transferring within the same facility, documentation must show that the diagnosis necessitating the transfer was psychiatric in nature and that the patient received active psychiatric treatment.
   3. If the readmission is part of planned repetitive treatments or staged treatments, such as chemotherapy or staged surgical procedures;
   4. Readmissions where the discharge status of the first discharge was “left against medical advice (AMA)”;
   5. Obstetrical readmissions.

IV. Post Service Review Process:
   A. CareSource reserves the right to monitor and review claim submissions to minimize the need for post service claim adjustments as well as review payments retrospectively.
      1. Medical records for both admissions must be included with the claim submission to determine if the admission(s) is appropriate or is considered a readmission.
         a. Failure from the acute care facility or inpatient hospital to provide complete medical records will result in an automatic denial of the claim.

2. If the included documentation determines the readmission to be an inappropriate or medically unnecessary, the hospital must be able to provide additional documentation to CareSource upon request or the claim will be denied.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

DATES		ACTION
Date Issued	04/01/2019	New policy
Date Revised	08/04/2021	Converted from PY-0725. D.V. changed post payment to post service. D.V.A. changed post payment to post service. D.V.B. removed peer to peer and appeals language. Updated definitions and references. Approved at PGC
Date Effective	11/01/2021	
Date Archived	11/30/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. McIlvennan, C. K., Eapen, ZJ, & Allen, LA (2015). Hospital readmissions reduction program. Circulation, 131(20): 1796-803.
2. CMS. Hospital Readmission Reduction Program (HRRP). (2020, August 24). Retrieved July 12, 2021 from www.cms.gov.
3. CMS. Medicare Claims Processing Manual, etc. (2021, June 11). Retrieved July 12, 2021 from www.cms.gov.

The Administrative Policy Statement detailed above has received due consideration as defined in the Administrative Policy Statement Policy and is approved.