ADMINISTRATIVE POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Readmission-NV MP-AD-1592	01/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract 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 a quality-of-care issue. It has been estimated that readmissions within 30 days of discharge can cost health plans more than $1 billion 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 acute care and transitional care rendered to CareSource members on initial admission that are paid using the DRG methodology, including, but not limited to, improving communication between the patient, caregivers and clinicians, providing patient education needed to maintain care at home to prevent a readmission, performing pre-discharge assessment to ensure the patient is ready to be discharged, and providing effective post-discharge coordination of care.

C. Definitions

- **Diagnosis Related Groups (DRGs)** – 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 Obstetrical Readmissions** – A readmission due to a pre-term or post-partum complication, including but not limited to:
  - Retained placenta
  - Retained products of conception
  - Post-partum sepsis; or
  - Other acquired hospital acquired condition
- **Potentially Preventable Readmission (PPR)** – Readmission to a hospital for a reason that is considered unplanned and potentially preventable.
- **Pre-Existing Condition** – A chronic health condition the patient had before the date of the admission.
- **Provider Preventable Condition (PPC)** – A condition with a negative consequence for the member occurring in any healthcare setting found to be reasonably preventable by the provider through the application of procedures supported by evidence-based medical guidelines

- **Readmission** – Admissions to an acute, general, inpatient facility (IPF) occurring within 30 days from the date of discharge from the same facility. Neither the day of discharge nor the day of admission are counted when determining whether a readmission has occurred.
- **Related Medical Condition** – Medical condition or diagnosis that is related or associated to the original admission.
- **Same day** – CareSource delineates same day as midnight to midnight of a single day.
- **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.
- **Unrelated Medical Condition** – Medical condition or diagnosis that is not related or associated to the original admission.

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. Readmission or observational stay for a related condition within 3 days of discharge.
   B. Readmission or observational stay for an unrelated yet known pre-existing condition, documented in the member's history, within 3 days of discharge.
   C. Potentially preventable unplanned admissions to an acute, general, short-term hospital occurring within 30 days from the date of discharge from the same wholly owned healthcare system inpatient facility (IPF) an administrative review will occur.

      Note: A related condition can be a complication as a result of first diagnosed condition (example: Retained placenta following a delivery)

II. Prior authorization of the initial or subsequent inpatient stay or admission to observation status is not a guarantee of payment and is subject to administrative review.

III. An administrative review of all readmissions will take place based on the following readmission review criteria:
   A. Readmission or observational stay for a related condition criteria within 3 days of discharge:
      1. CareSource will conduct an administrative review to ensure that billing guidelines were followed, which requires that the acute, general, short-term hospital combine the two admissions on one claim.
      2. If the member is readmitted within 3 days of discharge of 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. Readmission or observational stay for an unrelated yet known pre-existing condition within 3 days of discharge will result in an administrative review to ensure that billing guidelines were followed. If the claim contains an admission date that is the same as the discharge date, then the claim must include condition code B4.

C. Planned readmission and/or leave of absence criteria:
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.
   1. 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.
   2. 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.
   3. CareSource reserves the right to request medical records to determine if the claim was properly billed.
   4. Leave of absence does not apply to cancer chemotherapy or similar repetitive treatments.

D. Determination of Unplanned Readmissions criteria:
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 guidelines:
      1. The readmission is due to ineffective discharge planning. A discharge planning evaluation should be completed prior to discharge, including assessment of the following:
         a. The likelihood of the need for appropriate post-hospital; services including addressing rehabilitation needs
         b. Appropriate arrangements for post-hospital care
         c. Availability of appropriate services, which would include services such as medical, transportation, meals, and household services
         d. Need for and feasibility of specialized medical equipment or permanent physical modifications to the home
         e. Capacity for self-care or alternatively to be cared for by others
         f. Criticality of the appropriate services
         g. Readmission risk score or severity score and
         h. Member's access to appropriate services

2. A provider should take into account a number of factors when determining if a member is ready for discharge, including, but not limited to:
   a. cognitive status
   b. activity level and functional status
   c. current home and suitability for member's condition (i.e., stairs)
   d. availability of family or community support
   e. ability to obtain medications and services
   f. ability to meet nutritional needs
   g. availability of transportation for follow up care and
3. Documentation should support the following discharge standards:
   a. a discharge plan that includes the provider(s) responsible for follow up care. The discharge planning evaluation should be used as a guide in the development of the discharge plan
   b. all necessary medical information pertinent to illness, treatment, and post-discharge goals of care was provided to the appropriate post- acute care service providers at the time of discharge
   c. coordination and/or referrals with the providers responsible for follow up care
   d. completion of medication reconciliation/management
   e. needed durable medical equipment (DME) and supplies are in place prior to discharge
   f. scheduled appointments are listed with dates, times, names, telephone numbers and addresses and
   g. member/guardian and family engagement, as needed

E. The following readmission criteria listed below are excluded from a readmission:
   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. routine obstetrical readmissions (non-preventable)

IV. Post Service Review Process:
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.
   A. 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.

Failure from the acute care facility or inpatient hospital to provide complete medical records will result in an automatic denial of the claim.

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

V. Provider preventable conditions, sentinel events and serious reportable events are not reimbursable.

VI. In the event of any conflict between this policy and a provider's agreement with CareSource, the provider's agreement will be the governing document.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	Date	Action
Date Issued	07/16/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

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