ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Readmission-GA MCD-AD-0978	02/01/2023-07/31/2023
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement 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 for the same or related problem within 3 days is often a costly preventable event and is a quality of care issue. It has been estimated that readmissions within 3 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 the patient is ready to be discharged, and 4. provide effective post discharge coordination of care.

C. Definitions

- **Readmission** - A subsequent inpatient admission to any acute care facility which occurs within 3 days of the discharge date for the same or related problem, excluding psychiatric services.
- **Same or a related problem** - A problem or diagnosis that is the same or a similar problem or diagnosis 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 policy defines the payment rules for hospitals and acute care facilities that are reimbursed for inpatient services.

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. All readmissions for the same or related problem within 3 days of the initial discharge is considered the same admission and will be reimbursed as one claim, EXCEPT for psychiatric services limited to short term acute care.

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IV. Readmissions greater than 3 days following a previous hospital discharge are treated as separate stays for payments purposes, but are subject to medical review Medical justification is required for hospitalization of eligible members. Medical necessity must be substantiated and documentation may be requested in a prepayment or post payment review. Lack of appropriate medical justification may be cause for denial, reduction, or recoupment of reimbursement.

V. Claim Payment Review and Appeal Requests:
   A. Claim Payment Review
      1. CareSource reserves the right to monitor and review claim submissions to minimize the need for post-payment claim adjustments as well as review payments retrospectively.
      2. Pertinent medical records for both admissions may be requested 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 when requested will result in an automatic denial of the claim.
      3. Medical records for both admissions must be submitted with the claim if both admissions originated from the same facility or Tax Identification Number (TIN).
         a. Failure from the acute care facility or inpatient hospital to provide complete medical records will result in an automatic denial of the claim
      4. If the included documentation determines the readmission to be an inappropriate, medically unnecessary potentially preventable admission, the hospital must be able to provide additional documentation to CareSource upon request or the claim will be denied.
      5. If the readmission is determined at the time of documentation review to be a preventable readmission, the reimbursement for the readmission will be combined with the initial admission and paid as one claim to cover both, or all, admissions.
   B. Appeal Requests
      1. All acute care facilities and inpatient hospitals have the right to appeal any readmission denial and request a peer-to-peer review or formal appeal.
      2. You have 30 calendar days from the date the adverse action, denial of payment, remittance advice or initial review determination was mailed to you to submit a claim appeal. If the appeal is not submitted in the required time frame, it will not be considered and will be denied. If the appeal is denied, you will be notified in writing.

E. Conditions of Coverage

NA

F. Related Policies/Rules

CareSource Georgia Medicaid Provider Manual

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G. Review/Revision History

	DATES	ACTION
Date Issued	06/01/2019	
Date Revised	09/17/2019 03/31/2021 09/01/2021 08/31/2022	Added IV., 1., a. & b. Changed from PY-0731. Updated readmission definition. Updated D. III., IV., and V. No changes to content. Updated reference dates.
Date Effective	02/01/2023	
Date Archived	07/31/2023	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. Georgia Department of Community Health Division of Medicaid. (2022, July). Part II Policies and Procedures for Hospital Services. Section 904: Limited Inpatient Services. Retrieved 08/15/2022 from www.mmis.georgia.gov.
2. Georgia Department of Community Health Division of Medicaid. (2022, July). Part II Policies and Procedures for Hospital Services. Hospital Services – Appendix T. Retrieved 08/15/2022 from www.mmis.georgia.gov.
3. Centers for Medicare & Medicaid Services. (2008, August 4). CMS Improves patient Safety for Medicare and Medicaid by Addressing Never Events. Retrieved 08/15/2022 from www.cms.gov.

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