ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Readmission-IN MCD-AD-0979	02/01/2023
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

Approximately 20% of patients have adverse events within three weeks of hospital discharge. Many of these are preventable events related to adverse drug reactions, hospital-acquired infections, and procedural complications. Systematic problems during the transition of care between inpatient and outpatient providers are often the basis for adverse events to occur after discharge.

Patients, families, and caregivers may lack access to proper resources and equipment or lack understanding of the plan of care following discharge from the hospital. Patient education should include interventions to prevent infections or complications, changes to medications, and important follow up on tests and outpatient appointments. Changes in medications during hospitalization is a high-risk factor for post-discharge falls in the home. At least 50% of patients are instructed to schedule an appointment after discharge. However, confusion about who/how to schedule these appointments can be a barrier to follow-up scheduling.

Delay in transfer of patient information following hospitalization can leave the next provider unaware of which conditions are still needing to be addressed, changes in medications, and pending test results at time of discharge. Studies show around 40% of patients were discharged with test results pending, which may result in delay in implementation of interventions or the start of new medications.

Patient literacy, social determinants of health, learning style, and current health status are important factors to consider when developing the discharge plan. Inefficient communication by the healthcare provider or lack of understanding of the discharge plan from the patient can lead to possible confusion, non-adherence, and adverse events.

The purpose of this policy is to improve the quality of acute care and transitional care rendered to CareSource members This includes but is not limited to the following: 1. improve communication between the patient, caregivers and clinicians, 2. provide patient education needed to maintain 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

- **Appropriate Post-discharge Site of Care -** Determinants of appropriate site include, but are not limited to, assessment of the medical, functional, and social aspects of a member's illness.
- **Ineffective Discharge Planning -** Readmissions will be reviewed for adequacy of follow-up care and outpatient management using accepted practice guidelines and treatment protocols. Documentation should support that reasonable attempts by the hospital were taken to address placement and access-to-treatment difficulties, including but not limited to collaboration with social services and connecting member to community resources. Examples of ineffective discharge planning include, but are

not limited to, inadequate medication management, lack of communication with providers delivering the follow-up care, inadequate outpatient follow up or treatment, failure to address rehabilitation needs such as inability to provide self-care, and failed discharge/transfer to another facility, such as lack of orders or medication reconciliation.

- **Never Events -** Serious and costly errors in the provision of health care services that cause serious injury or death to beneficiaries. Examples are surgery on the wrong body part or mismatched blood transfusion.
- **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) -** A readmission within a specific time frame that is clinically related and may have been prevented had appropriate care and/or transitional follow-up care been provided during the initial hospital stay and discharge process. A PPR is determined when, based on CareSource guidelines, it is determined that the patient was discharged prematurely or had ineffective transitional care.
- **Premature Discharge -** Occurs when a member is discharged even though they should have remained in the hospital for further testing or treatment or was not medically stable at the time of discharge. A member is not medically stable when the member'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 member may have been prematurely discharged from the hospital. Symptoms that had onset or were present during a previous admission and subsequently worsened, leading to a readmission are a possible indicator of a premature discharge. Discharge prior to establishing the safety or efficacy of a new treatment regimen is also considered a premature discharge.
- **Readmission -** A hospital admission within three days following a previous hospital admission and discharge to the same hospital for the same or a related condition.
- **Same or Related Condition -** Refers to the principal diagnosis code and is based on the first three digits of the ICD code.

D. Policy

I. This policy defines the payment rules for hospitals and acute care facilities that are reimbursed for inpatient services.

II. Readmissions

A. If the initial admission was paid on a per diem basis, the readmission should be considered a new admission and billed accordingly. The readmission is treated as a separate stay for payment purposes but is subject to medical review.

B. If the initial admission was paid using the DRG methodology, providers should bill one inpatient claim when a member is readmitted to their facility within three days of a previous inpatient discharge (the stays should be consolidated on one claim) for the same or a related diagnosis.

C. If a second inpatient claim is billed for the same member with the same or related principal diagnosis code within three days of a previous inpatient discharge from the same hospital, the second claim will be denied.

III. Unplanned readmission criteria:
A. CareSource will review the clinical documentation on all readmissions to determine if the second admission was a potentially preventable readmission based on the following guidelines:
1. The readmission is due to a premature discharge of patient.
2. Based on medically appropriate professionally recognized standard of health care, the member could have received the care from the readmission during the first admission.
3. The readmission is due to ineffective discharge planning.
a. A discharge planning evaluation should be completed prior to discharge, including assessment of the following:
01. The likelihood of the need for appropriate post-hospital; services including addressing rehabilitation needs;
02. Appropriate arrangements for post-hospital care;
03. Availability of appropriate services, which would include services such as medical, transportation, meals, and household services;
04. Need for and feasibility of specialized medical equipment or permanent physical modifications to the home;
05. Capacity for self-care or alternatively to be cared for by others;
06. Criticality of the appropriate services;
07. Readmission risk score or severity score; and
08. Member's access to appropriate services.
b. A provider should take into account a number of factors when determining if a member is ready for discharge, including, but not limited to:
01. Cognitive status;
02. Activity level and functional status;
03. Current home and suitability for member's condition (i.e., stairs);
04. Availability of family or community support;
05. Ability to obtain medications and services;
06. Ability to meet nutritional needs
07. Availability of transportation for follow up care; and
08. Availability of community services.
c. Documentation should support the following discharge standards:
01. 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;
02. 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;
03. Coordination and/or referrals with the CareSource case manager, community agencies, and providers responsible for follow up care;
04. Completion of medication reconciliation/management;

05. Needed durable medical equipment (DME) and supplies are in place prior to discharge;
06. Scheduled appointments are listed with dates, times, names, telephone numbers and addresses; and,
07. Member/guardian and family engagement, as needed.

B. Member non-adherence with treatment plan will be considered for payment if **all** of the following criteria is adequately documented:
   A. Physician orders were appropriately communicated to the member;
   B. The member or guardian is mentally competent and capable of following the discharge instructions;
   C. The member or guardian made an informed decision not to follow the discharge instructions; and
   D. The non-adherence is clearly documented in the medical record.

   NOTE: A readmission may be medically necessary but may also be deemed preventable.

   NOTE: Errors made at the receiving facility unrelated to the orders it received upon transfer (e.g., falls, treatment delivery failure) will not result in a payment denial for the readmission.

IV. Authorizations for inpatient hospital/acute care stays are not a guarantee of payment and are subject to medical necessity review.

V. Dispute and Appeals Process:
   A. Dispute Process
      1. Providers may dispute the readmission denial.
      2. Medical records are required at the time of dispute submission. If the outcome of the dispute process is unfavorable to the providers, then there is an option to appeal.
   B. Appeals Process
      1. All acute care facilities and inpatient hospitals have the right to appeal any readmission denial.
      2. Medical records are required at the time of appeals submission.

VI. Never events are not reimbursable.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Healthcare Acquired Conditions/Provider Preventable Conditions
Medical Necessity Determinations

G. Review/Revision History

DATES		ACTION
Date Issued	08/01/2019	
Date Revised	3/31/2021 07/21/2021 08/31/2022	Changed to administrative policy. Updated background, definitions, D. II., IV., V., and VI. Added D. III. Removed peer to peer language. Approved at PGC. No changes to content. Updated reference dates.
Date Effective	02/01/2023	
Date Archived		

H. References

1. Center for Medicare & Medicaid Services (2006, May 18). Eliminating serious, preventable, and costly medical errors – never events. Retrieved 08/15/2022 from www.cms.gov.
2. Indiana Health Coverage Programs (IHCP) provider reference module (2022, April 12). Inpatient Hospital Services. Policies and Procedures version 5.0. Retrieved 08/15/2022 from www.in.gov.
3. Indiana Health Coverage Programs (IHCP) provider reference module (2022, April 12). Inpatient Hospital Services. Readmissions. Policies and Procedures version 5.0. Retrieved 08/15/2022 from www.in.gov.