HAP CareSource™

ADMINISTRATIVE POLICY STATEMENT
Michigan Medicaid

Policy Name & Number	Date Effective
Readmission-MI MCD-AD-1391	07/01/2026
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.

Table of Contents

A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 3
E. Conditions of Coverage 3
F. Related Policies/Rules 3
G. Review/Revision History 3
H. References 4

A. Subject
Readmission

B. Background
Following a hospitalization, readmission within 15 days is often a costly preventable event and a quality-of-care issue. It has been estimated that readmissions within 15 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 HAP 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 (ie, 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
  - other hospital acquired conditions
- **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.
- **Readmission** – Any admission within 15 days of a previous discharge, whether the readmission is to the same or a different hospital.
- **Related Medical Condition** – Medical condition or diagnosis that is related or associated to the original admission.

- **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 policy follows the Medicaid Provider Manual guidelines for readmission.
   A. Readmission or observational stay for a related condition within 15 days of discharge will be denied.
   B. Readmission or observational stay for an unrelated yet known pre-existing condition, documented in the member's history, within 15 days of discharge will be subject to administrative review.
   C. Readmissions within 15 days to a different hospital for the same condition will be considered separate for payment purposes.

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

III. 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.

IV. Pre/Post Service Review
HAP CareSource reserves the right to monitor and review claim submissions to validate appropriate billing practices.

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

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	Date	Action
Date Issued	11/20/2024	New policy. Approved at Committee.
Date Revised	04/08/2026	Annual review. Added D.I.C. and updated references. Approved at Committee.
Date Effective	07/01/2026	
Date Archived		

H. References

1. Case Review. Quality Improvement Organization Manual Chapter 4. US Centers for Medicare and Medicaid Services; 2014. Accessed March 23, 2026. www.cms.gov
2. Eliminating Serious, Preventable, and Costly Medical Errors – Never Events. Center for Medicare & Medicaid Services; 2006. Accessed March 23, 2026. www.cms.gov
3. Goldfield NI, McCullough EC, Hughes JS, et al. Identifying potentially preventable readmissions. *Health Care Financing Rev*. 2008;30(1):75-91. Accessed March 23, 2026. www.ncbi.nlm.nih.gov
4. Hospital-acquired conditions. Centers for Medicare & Medicaid Services. Updated February 12, 2026. Accessed March 23, 2026. www.cms.gov
5. Hospital Readmission Reduction Program (HRRP). US Centers for Medicare and Medicaid Services. Updated March 16, 2026. Accessed March 23, 2026. www.cms.gov
7. List of SREs. National Quality Forum. Accessed March 23, 2026. www.qualityforum.org
8. McIlvennan CK, Eapen ZJ, Allen LA. Hospital readmissions reduction program. *Circulation*. 2015;131(20):1796-1803. doi:10.1161/CIRCULATIONAHA.114.010270
9. Special circumstances for hospital readmissions and transfers. *Medicaid Provider Manual: Billing & Reimbursement for Institutional Providers*. Michigan Dept of Health and Human Services; January 1, 2026. Accessed March 23, 2026. www.mdch.state.mi.us