ADMINISTRATIVE POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Date Effective
Readmission		AD-0972	12/01/2021
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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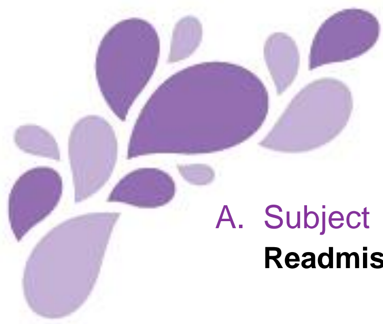


A. Subject

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

- **Readmission** – An admission to the same hospital within thirty days of discharge; excluding planned admissions.
- **Same hospital** – The original admission and the readmission are from the same hospital.
- **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.
- **Clinically-Related Readmission Chain** – Is a series of admissions for the same patient where the underlying reason for readmission is related to the care rendered during or within thirty days following a prior hospital admission. A clinically related readmission may have resulted from improper or incomplete care during the initial admission or discharge planning process. The hospital where the initial admission occurred is responsible for the clinically related readmission chain. Hospitalization resulting from an unpreventable or unrelated event occurring after discharge and planned readmissions are not considered clinically related.
- **Potentially Preventable Readmission (PPR)** – A readmission within a specific time frame that is clinically related and may have been prevented had appropriate 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. Premature discharge evidence can be described as,

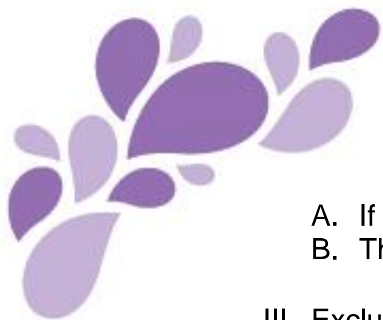
but not limited to, elevated fever at the time of discharge, abnormal lab results or evidence of infection or bleeding a wound.

- **Only admission** – An admission where there was neither a prior initial admission nor a clinically-related readmission within the thirty-day readmission period.
- **Same Day** – CareSource delineates same day as midnight to midnight of a single day.
- **Appropriate care** – Is consistent with accepted care standards in the prior discharge or during the post-discharge follow-up period.

D. Policy

I. This policy defines the payment rules for hospitals and acute care facilities that are reimbursed for inpatient or observational services for the following:
   A. Readmissions that are potentially preventable as determined by the provision of appropriate care consistent with the criteria outlined below:
      1. A medical readmission for a continuation or recurrence of the reason for the initial admission due to lack of care, or for a closely related condition (e.g., a readmission for diabetes following an initial admission for diabetes).
      2. A medical readmission for an acute decompensation of a chronic problem that was not the reason for the initial admission, but was potentially related to the lack of care rendered either during or immediately after the initial admission (e.g., a readmission for diabetes in a patient whose initial admission was for an acute myocardial infarction).
      3. A medical readmission for an acute medical complication potentially related to the lack of care rendered during the initial admission (a patient with a hernia repair and a perioperative Foley catheter readmitted for a urinary tract infection 10 days later).
      4. A readmission for a surgical procedure to address a continuation or a recurrence of the problem causing the initial admission (a patient readmitted for an appendectomy following an initial admission for abdominal pain and fever).
      5. A readmission for a surgical procedure to address a complication resulting from the lack of care rendered during the initial admission (a readmission for drainage of a post-operative wound abscess following an initial admission for a bowel resection).
   B. Readmissions for a condition or procedure that is clinically related to the care provided during the prior discharge or resulting from inadequate discharge planning during the prior discharge.
   C. Readmissions when the PPR chain may contain one or more readmissions that are clinically related to the initial admission. If the first readmission is within thirty days after the initial admission, the thirty-day timeframe may begin again at the discharge of either the initial admission or the most recent readmission clinically related to the initial admission.

II. A readmission that occurs within one calendar day (i.e. same day or next day), to the same institution, is considered one discharge for payment purposes and will be reimbursed as one DRG payment per the OAC 5160-2-65.



A. If two claims are submitted, the second claim processed will be rejected.
B. The hospital will need to submit an adjusted claim for the entire hospitalization.

III. Exclusions to readmission clinical review include:
A. Scheduled, staged surgical procedures
B. Neonatal and obstetrical
C. Psychiatric/ behavioral health
D. Transfers to distinct psychiatric units within the same facility
E. Readmissions associated with burns or cystic fibrosis
F. 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
G. Acute rehab transfers
H. The original discharge was a patient-initiated discharge, was against medical advice (AMA), and the circumstances of such discharge and readmission are documented in the patient's medical record
I. The original discharge was for the purpose of securing treatment of a major or metastatic malignancy, major trauma, neonatal and obstetrical admission, transplant or HIV
J. Only admissions, which are defined in the definitions of this policy. Planned readmissions are considered "only admissions"

IV. 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.

V. Post Service Review Process:
A. CareSource will review post service through a medical record review to determine if the readmission is related to the previous admission
1. Pertinent medical records for both admissions must be included with the claim submission
2. Failure for the acute care facility or inpatient hospital to provide complete medical records will result in an automatic denial of the claim 30 days allowed with 3 notifications.

VI. If the readmission is within 30 days, CareSource will determine, through a clinical review, if the readmission was related to the first admission.
A. If it is determined that the readmission within 30 days is unrelated (CareSource will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization) to the first admission:
1. The claims will be treated as two separate admissions.
B. If it is determined that the readmission within 30 days is related to the first admission due to complications or other circumstances that arose because of an early discharge and/or other treatments errors
1. The two inpatient stays will be combined into one claim.

2. The hospital will need to submit a new claim with both inpatient stays and will be reimbursed as one DRG payment.

C. If it is determined that the readmission does not meet the standard of care (inappropriate), then any payment made for the separate admissions will be recouped. A new payment amount will be determined by collapsing any affected admissions into one payment.

VII. Never events are not reimbursable.

E. Conditions of Coverage

F. Related Policies/Rules

G. Review/Revision History

	DATES	ACTION
Date Issued	04/01/2019	
Date Revised	11/11/2020 12/18/2020 08/04/2021	Changed from PY-0724. Removed reference to Medicare Advantage, updated definitions, and updated per ODM guidance Updated exclusions and revised V. 2. Changed post payment to post service in D. IV. And D.IV A. Removed appeals and peer to peer language in D. V. and D. IV. B. Updated references. Approved at PGC.
Date Effective	12/01/2021	
Date Archived		

H. References

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4. Goldfield, N. I., McCullough, E. C., Hughes, J. S., Tang, A. M., Eastman, B., Rawlins, L. K., & Averill, R. F. (2008). Identifying potentially preventable readmissions. Retrieved from www.ncbi.nlm.nih.gov
5. Ohio Administrative Code. (2016, January 1). 5160-2-02 General provisions: hospital services. Retrieved July 12, 2021 from www.codes.ohio.gov
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7. Ohio Administrative Code (2018, September 1). 5160-2-65 Inpatient hospital reimbursement. Retrieved July 12, 2021 from www.codes.ohio.gov

8. Center for Medicare & Medicaid Services (2006, May 18). Eliminating serious, preventable, and costly medical errors – never events. Retrieved July 12, 2021 from www.cms.gov
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10. Ohio Administrative Code (2017, January 1). 5160-2-14 Potentially preventable readmissions. Retrieved July 12, 2021 from www.codes.ohio.gov

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