



ADMINISTRATIVE POLICY STATEMENT

Ohio Medicaid

Policy Name & Number	Date Effective
Readmission-OH MCD-AD-0972	03/01/2024-02/28/2025
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.

Table of Contents

A.	Subject.....	2
B.	Background.....	2
C.	Definitions.....	2
D.	Policy.....	3
E.	Conditions of Coverage.....	6
F.	Related Policies/Rules.....	6
G.	Review/Revision History.....	6
H.	References.....	7

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 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.

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, improving communication between the patient, caregivers and clinicians, providing the patient with the education needed to maintain care in the home to prevent a readmission, performing pre discharge assessment to ensure 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.
- **Inpatient Services** – Services which are ordinarily furnished in a hospital for the care and treatment of patients. Inpatient services include all covered services provided to patients during the course of their inpatient stay.
- **Observation services** – Services furnished in an outpatient hospital setting, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate a patient's condition or determine the need for possible admission to the hospital as an inpatient.
- **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 preterm or post-partum complication, including but not limited to:
 - retained placenta
 - retained products of conception
 - post-partum sepsis
 - other acquired hospital-acquired condition
- **Potentially Preventable Readmission (PPR)** – Readmission to a hospital for a reason 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

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preventable by the provider through the application of procedures supported by evidence-based medical guidelines

- **Readmission** – An admission to the same institution within thirty days of discharge for hospitals paid under the Ohio Department of Medicaid’s prospective payment system, as described in rule 5160-2-65 of the Administrative Code.
- **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.
- **Sentinel Event (SE)** - A patient safety event, not primarily related to the natural course of a patient’s illness or underlying condition, resulting in death or severe or permanent harm, regardless of duration or severity of harm.
- **Serious Reportable Event (SRE)** - Serious and costly errors in health care services that are usually preventable and harmful clinical events to patients.

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 (eg, 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 (eg, 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 are clinically related to the care provided during the prior discharge or resulting from inadequate discharge planning during the prior discharge.

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- 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 30-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 (ie, 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. If the readmission is within 2-30 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 2-30 days is unrelated to the first admission, the claims will be treated as two separate admissions.
 - B. If it is determined that the readmission within 2-30 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.
- IV. 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:
 - A. The readmission is due to ineffective discharge planning. A discharge planning evaluation should be completed prior to discharge, including assessment of the following:
 - 1. the likelihood of the need for appropriate post-hospital services including addressing rehabilitation needs
 - 2. appropriate arrangements for post-hospital care
 - 3. availability of appropriate services, which would include services such as medical, transportation, meals, and household services
 - 4. need for and feasibility of specialized medical equipment or permanent physical modifications to the home
 - 5. capacity for self-care or alternatively to be cared for by others
 - 6. criticality of the appropriate services
 - 7. readmission risk score or severity score
 - 8. member's access to appropriate services

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- 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:
 - 1. cognitive status
 - 2. activity level and functional status
 - 3. current home and suitability for member's condition (ie, stairs)
 - 4. availability of family or community support
 - 5. ability to obtain medications and services
 - 6. ability to meet nutritional needs
 - 7. availability of transportation for follow up care
- C. Documentation should support the following discharge standards:
 - 1. 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
 - 2. all 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
 - 3. coordination and/or referrals with the providers responsible for follow up care
 - 4. completion of medication reconciliation/management
 - 5. needed durable medical equipment (DME) and supplies are in place prior to discharge
 - 6. scheduled appointments are listed with dates, times, names, telephone numbers, and addresses
 - 7. member/guardian and family engagement, as needed
- V. Exclusions to readmission clinical review (2-30 days) include:
 - A. scheduled, staged surgical procedures
 - B. routine obstetrical or neonatal readmissions (non-preventable)
 - C. readmissions associated with burns or cystic fibrosis
 - D. 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
 - E. acute rehab transfers
 - F. 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
 - G. the original discharge was for the purpose of securing treatment of a major or metastatic malignancy, major trauma, transplant, or HIV
 - H. transfers to distinct psychiatric units within the same facility
 - 1. 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.

VI. 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 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.

VII. 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. 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.
 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.

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

IX. 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

Readmission-Behavioral Health
Non-Emergent-Facility to Facility Transfers
Sentinel Events and Provider Preventable Conditions

G. Review/Revision History

DATES		ACTION
Date Issued	04/01/2019	
Date Revised	11/11/2020	Changed from PY-0724. Removed reference to Medicare Advantage, updated definitions, and updated per ODM guidance
	12/18/2020	Updated exclusions and revised V. 2.
	08/04/2021	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.
	08/31/2022	No change to content. Updated references.
	11/08/2023	Updated definitions. Added D. IV. Updated D. VII. and F. Updated references. Approved at Committee.
Date Effective	03/01/2024	

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Date Archived	02/28/2025	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.
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H. References

1. Case Review. *Quality Improvement Organization Manual Chapter 4*. US Centers for Medicare and Medicaid Services; 2014. Accessed October 1, 2023. www.cms.gov
2. *Eliminating Serious, Preventable, and Costly Medical Errors – Never Events* Center for Medicare & Medicaid Services; 2006. Accessed October 1, 2023. www.cms.gov
3. General Provisions: Hospital Services, OHIO ADMIN. CODE 5160-2-02 (2022).
4. Goldfield NI, McCullough EC, Hughes JS, et al. Identifying potentially preventable readmissions. *Health Care Financing Rev.* 2008;30(1):75-91. Accessed October 1, 2023. www.ncbi.nlm.nih.gov
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6. *Hospital Readmission Reduction Program (HRRP)*. US Centers for Medicare and Medicaid Services; 2022. Accessed October 1, 2023. www.cms.gov
7. Inpatient Hospital Reimbursement, OHIO ADMIN. CODE 5160-2-65 (2022).
8. List of SREs. National Quality Forum. Accessed October 13, 2023. www.qualityforum.org
9. McIlvennan CK, Eapen ZJ, Allen LA. Hospital readmissions reduction program. *Circulation.* 2015;131(20):1796-1803. doi:0.1161/CIRCULATIONAHA.114.010270
10. Potentially Preventable Readmissions, OHIO ADMIN. CODE 5160-2-14 (2022).

ODM Approved 01/11/2024

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