CareSource

ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

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

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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. 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 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.

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.

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.
- **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 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 preventable by the provider through the application of procedures supported by evidence-based medical guidelines.
- **Readmission** – An admission to the same institution within 30 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 (eg, 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 (eg, 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 (eg, 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.

C. Readmissions when the PPR chain may contain 1 or more readmissions that are clinically related to the initial admission. If the first readmission is within 30 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 1 calendar day (ie, same day or next day) to the same institution is considered 1 discharge for payment purposes and will be reimbursed as 1 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 administrative 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, that claim will be denied and the provider may resubmit a corrected claim for the entire length of stay.

C. If the readmission is determined at the time of documentation review to be preventable, CareSource will deny the claim and the provider may resubmit a corrected claim for the entire length of stay.

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
    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 administrative 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 with documentation that shows 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. 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.

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. 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 Committee.
	08/04/2021	No change to content. Updated references. Approved at Committee.
	08/31/2022	No change to content. Updated references. Approved at Committee.
	11/08/2023	Updated definitions. Added D. IV. Updated D. VII. and F. Updated references. Approved at Committee.

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

	11/06/2024	Annual review. Updated background, definitions, D. V. and VI. Updated references. Approved at Committee.
Date Effective	03/01/2025	
Date Archived		

H. References

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7. Inpatient Hospital Reimbursement, OHIO ADMIN. CODE 5160-2-65 (2024).
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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 (2017).

Approved by ODM 11/21/2024