ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Readmission – Behavioral Health – OH MCD-AD-1018	01/15/2022-08/31/2023

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 tre atment 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 – Behavioral Health

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. Members with schizophrenia, depression, medical comorbidities, and substance use disorder are more likely to be readmitted after hospitalization.
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 and the MCO, 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.
- **Clinical Review** – Takes into consideration factors specific to behavior health, including: the member's diagnoses, living situation, supports, and severity of the condition resulting in the readmission. Reviews are completed by a health care professional who has appropriate clinical expertise in treating the member's behavioral health condition.
- **Hospital** – Includes both general acute care facilities and Institutions of Mental Disease (IMD)
- **Same Hospital** – The original admission and the readmission are from the same hospital.
- **MCO** – Managed Care Organization
- **Never Events (Sentinel Events)** – Serious and costly errors in the provision of health care services that cause serious injury or death to beneficiaries. Examples are: death associated with a fall, suicide or serious disability associated with a medication error.
- **Planned Readmission** – A non-acute admission for a scheduled procedure for limited types of care to include when further treatment is indicated following diagnostic tests but cannot begin at the time of initial admission.
- **Preventable Clinically Related Readmission –** A readmission within a specific time frame (30-days) that is clinically related and may have been prevented had appropriate care and/or discharge planning/coordination been provided during the initial hospital stay and discharge process.

- **Premature Discharge** – Occurs when a member is discharged even though they should have remained in the hospital for further medically necessary testing or treatment, was not clinically stable at the time of discharge, medication management was inadequate or discharge planning was inadequate, or the developed treatment/discharge plan was not able to be implemented because of unaddressed social determinant of health needs. 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.
- **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.
- **Inpatient Hospital Behavior Health Admissions** (per Ohio Department of Medicaid) –
  - Psychiatric DRGs (Diagnosis Related Group)
    - 740 Mental Illness Diagnosis W O.R. procedure
    - 750 Schizophrenia
    - 751 Major depressive disorders & other/unspecified psychoses
    - 752 Disorders of personality & impulse control
    - 753 Bipolar disorders
    - 754 Depression except major depressive disorder
    - 755 Adjustment disorders & neuroses except depressive diagnoses
    - 756 Acute anxiety & delirium states
    - 757 Organic mental health disturbances
    - 758 Behavioral disorders
    - 759 Eating disorders
    - 760 Other mental health disorders

    (For psychiatric admissions, the DRG assigned to the claim is DRG 740, 750 to 760 due to the admitting international classification of diseases, 10th revision (ICD-10) diagnosis code is F0150-F99, G4700, G479, H9325, Q900-Q902, Q909-Q917, Q933-Q935, Q937, Q9388-Q9389, Q939, Q992, R37, R4181, R41840-R41841, R41843-R41844, R440, R442-R443, R450-R457, R4581-R4582, R45850-R45851, R4586-R4587, R4589, R4681, R4689, R480-R482, R488-R489, R54, Z72810-Z72811, Z87890 or Z91830.)
  - Detoxification DRGs (principal diagnosis codes beginning with “F”-only)
    - 773 Opioid abuse & dependence
    - 774 Cocaine abuse & dependence
    - 775 Alcohol abuse & dependence
    - 776 Other drug abuse & dependence

D. Policy

I. **Preventable Clinically Related Readmissions:** BH Readmissions that are preventable and clinically related to the first admission, include the following types of readmissions:

A. For an acute complication related to the lack of care rendered during the initial admission,
B. For an acute decompensation of a chronic problem that was not the reason for the initial admission, but was related to the lack of care rendered or care decisions either during or immediately after the initial admission, but directly related to the care provided,
C. For a readmission for a condition or procedure that is clinically related to the care provided during the prior discharge or resulting from inadequate/incomplete discharge planning during the prior discharge,
D. Prior admission discharge was premature due to clinical instability, inadequate medication management, and/or inadequate/incomplete discharge planning,
E. During prior admission, in the medical record, inadequate indication of coordinated direct communication between the hospital, the MCO, the outpatient provider(s), caregivers/supports, and the member regarding the treatment regimen and/or discharge planning, including: contact names, dates of contact, contact phone numbers, contact addresses, role/responsibility in treatment regimen and discharge plan, and/or organization that contact is affiliated with, as applicable,
F. During prior admission, in the medical record, inadequate indication that medically necessary and appropriate treatment regimen was established and/or discharge plan connections were made with appropriate outpatient behavioral health resources, including community behavioral health resources, or that assistance was sought from the MCO in connecting to the appropriate outpatient behavioral health resources, for the purposes of: reviewing of recent outpatient treatment history, scheduling of follow-up appointments with-in 7-calendar days of discharge, provision of the discharge plan, and/or coordinating transportation to follow-up appointments,
G. During prior admission, in the medical record, inadequate indication that review of social determinants of health (SDoH) and request for assistance from CareSource with potential barriers to care identified during the SDoH review (homelessness, telephone availability, transportation, etc.) occurred,
H. During prior admission, in the medical record, inadequate indication that medically necessary:
    1. medication reconciliation occurred and/or
    2. prescriptions related to treatment regimen were available at discharge and/or
    3. two weeks' worth of medication was provided to the member at the time of discharge (not to be included in the inpatient claim, must be a separate NCPDP claim) and/or
    4. transportation to the pharmacy or medication home-delivery was scheduled.

II. **Exclusions:** The following are excluded from a readmission review:
A. 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;
B. Planned readmissions;
C. Readmissions to other hospitals/facilities outside of the hospital system;
D. Readmissions to another hospital from within the same hospital system;

E. Transfers from out-of-network to in-network facilities;
F. Transfers of patients to receive care not available at the first facility or unit
G. Readmissions greater than 30 days from the date of discharge from the previous/initial admission;
H. Readmissions for members are under the age of 21; and
I. Readmissions when a patient has any of the following conditions related to cancer, transplants, HIV infection, pregnancy, and poisoning in addition to their behavioral health condition.

III. **Prior Authorizations:** Prior Authorization of the initial or subsequent inpatient stay is conducted pre-service delivery using related medical necessity criteria. The Prior Authorization process and determination is separate from any readmission review process and determination.
   A. Prior Authorization is not a guarantee of payment and is subject to administrative review as well as additional reviews for medical necessity at the discretion of CareSource.
   B. Inpatient Prior Authorization requests that are submitted without complete clinical/medical records necessary to review for medical necessity of the service will administratively deny which will result in an administrative denial of any related claim(s).

IV. **Readmission Reviews & Payment Processes:**
   A. **Readmission Review Process:** CareSource will conduct clinical readmission reviews post-service delivery through a medical record review to determine if the readmission was a Preventable Clinically Related Readmission. While readmission reviews are done post-service delivery, they may be conducted pre and/or post payment.
      1. Pertinent and complete medical records for both admissions must be included with the claim submission to determine if the admission(s) is appropriate or is considered a Preventable Clinically Related Readmission.
      2. Failure to provide complete medical records for a post-service clinical readmission review will result in an automatic administrative denial of the claim for the readmission.
   B. **Payment Process:**
      1. 30-Day Readmissions
         a. If a clinical readmission review determines that the readmission is unavoidable or unrelated to the first admission, related claims will be treated as and adjudicate as two separate admissions.
         b. If a clinical readmission review determines that the readmission is <u>related</u> to the first admission and is a Preventable Clinically Related Readmission
            01. The two admissions must be collapsed into one claim and resubmitted by the hospital for payment. Any days in-between admissions should be billed by the hospital as non-covered days.
            02. CareSource will reimburse the collapsed claim as one DRG payment.
            03. CareSource may recoup any payments made for claims for readmission(s) that need to be collapsed into a single claim.
      2. 1-Calendar Day Readmissions (i.e. same day or next day readmissions)
         a. 1-calendar day readmissions will be reimbursed as one DRG payment.

b. If a hospital submits claims for both admissions, the second claim processed will be rejected.
c. The two admissions must be collapsed into one claim and resubmitted by the hospital for payment.

3. Never events are not reimbursable.

E. Conditions of Coverage

F. Related Policies/Rules

G. Review/Revision History

DATES		ACTION
Date Issued	12/01/2021	Approved at PGC.
Date Revised		
Date Effective	01/15/2022	
Date Archived	08/31/2023	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.

H. References

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3. Hospital Readmission Reduction Program. (2018, December 04). Retrieved from www.cms.gov
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The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

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