ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Readmission–Behavioral Health–OH MCD-AD-1018	09/01/2023
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.

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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 – Behavioral Health

B. Background

In 2019, Medicaid and the Children's Health Insurance Program (CHIP) covered nearly 200 million behavioral health (BH) services, including 150 million BH services and almost 43 million substance use disorder (SUD) services. Following a hospitalization, readmission within thirty (30) days is often costly, preventable, and a quality-of-care issue that can cost health plans more than $1 billion dollars annually.

Readmissions result from many factors but, most often, are due to lack of transitional care or discharge planning. Members with schizophrenia, depression, medical comorbidities, and substance use disorder are more likely to be readmitted after hospitalization. For individuals hospitalized for BH conditions, including SUD, recommended post-discharge treatment includes a visit with a mental health provider within 30 days of discharge, and ideally, within 7 days of discharge. However, use of follow-up care within members with BH diagnoses and SUD often falls short of these recommendations.

CareSource strives to improve the quality of inpatient and transitional care, including communication between the patient, caregivers, providers and the Managed Care Organization (MCO), providing the patient with education to maintain care at home to prevent readmission, performing predischarge assessment to ensure readiness for discharge, and providing effective post discharge coordination of care.

C. Definitions

- **Appropriate Care** - Care that is consistent with accepted care standards in the prior discharge or during the post-discharge follow-up period.
- **Clinical Review** - Review of records by a health care professional with appropriate clinical expertise in the treatment of behavioral health conditions, including member diagnoses, living situation, supports, and severity of the condition.
- **Hospital** - As defined by Ohio Administrative Code 5160-2-01 and includes both general acute care facilities and Institutions of Mental Disease (IMD).
- **Never Events** - Serious and costly errors in the provision of health care services causing serious injury or death to patients.
- **Planned Readmission** - A non-acute admission for a scheduled procedure for limited types of care when further treatment is indicated following diagnostic tests but cannot begin at the time of initial admission.
- **Potentially Preventable Readmission** - A readmission within 30 days of a prior discharge to the same or any other hospital 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.
- **Readmission** - An admission to a hospital within thirty days of the date of discharge from the same hospital.

- **Same Day** - Midnight to midnight of a single day.

D. Policy
   I. CareSource considers the following preventable, clinically related readmissions to the first admission**:**
      A. an acute complication related to lack of care provided during the initial admission
      B. acute decompensation of a chronic problem that was not the reason for an initial admission but was related to lack of care or care decisions provided during, or immediately after, an initial admission
      C. readmission for a condition/procedure clinically related to care provided or resulting from inadequate or incomplete discharge planning during the prior discharge
      D. premature discharge due to clinical instability, inadequate medication management, and/or inadequate or incomplete discharge planning
      E. during prior admission and noted in the medical record, indication of inadequately coordinated, direct communication between the hospital, MCO, outpatient provider(s), caregivers/supports, and the member regarding treatment and/or discharge planning occurred, including the following (not all-inclusive):
         1. contact names, phone numbers and addresses with dates of contact & role/responsibility in treatment regimen and discharge plan
         2. organizations affiliated with contact, if applicable, including outpatient and community behavioral health resources
         3. CareSource's assistance was requested connecting with appropriate outpatient resources to review recent outpatient treatment history, schedule follow-up appointments within 7 calendar days of discharge, and/or coordinate transportation to follow-up appointments
         4. review of social determinants of health (SDoH) and request for CareSource assistance with potential barriers to care (i.e., homelessness, telephone availability, transportation, etc.)
         5. medication reconciliation did not occur
         6. prescriptions related to treatment regimen availability at discharge, including:
            a. two weeks' worth of medication was provided to the member at the time of discharge, which is not to be included in the inpatient claim and must be a separate NCPDP claim
            b. transportation to the pharmacy or medication home-delivery was scheduled

   II. The following are excluded from a readmission review:
      A. an original discharge that was patient-initiated against medical advice (AMA) with circumstances of such discharge and readmission documented in the medical record
      B. planned readmissions
      C. readmissions to other hospitals/facilities outside the hospital system (i.e., different Tax Identification Number)

D. readmissions to another hospital from within the same hospital system (i.e., same Tax Identification Number), except for 1-day readmission (refer to IV. B. 2.)
E. transfers from out-of-network to in-network facilities
F. transfers to receive care not available at the first facility or unit
G. readmissions for members are under the age of 21
H. readmissions for patients with conditions related to cancer, transplants, HIV infection, pregnancy, or poisoning in addition to behavioral health conditions

III. Review of Medical Necessity

Review of medical necessity for the initial or subsequent inpatient stay is conducted pre-service delivery using related medical necessity criteria. The review 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 at CareSource's discretion.
B. Inpatient medical necessity review requests submitted without complete clinical or medical records necessary for adequate review will be denied, resulting in the denial of any related claim(s).

IV. Readmission Reviews and Payment Processes

A. Readmission Review Process

CareSource will conduct post-service clinical readmission reviews by reviewing medical records to determine if a readmission was a preventable, clinically related readmission. Reviews may be conducted pre- and/or post-payment. Pertinent and complete medical records for both admissions must be included with claim submission to determine appropriateness of the admission(s). Failure to provide complete medical records for a post-service clinical readmission review will result in an automatic denial of the claim for the readmission.

B. Payment Process
   1. 30-Day Readmissions
      a. If a clinical readmission review determines that readmission was unavoidable or unrelated to the first admission, related claims will be treated as, and adjudicated as, two separate admissions.
      b. If a clinical readmission review determines that the readmission is related to the first admission and is a preventable, clinically related readmission, then the two admissions must be collapsed into one claim and resubmitted by the institution for payment, which will be reimbursed as one DRG payment. Any days between admissions should be billed as non-covered days. 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) will be reimbursed as one DRG payment. If an institution submits claims for both admissions, the second claim processed will be rejected. The two admissions must be collapsed into one claim and resubmitted for payment.
   3. Never events are not reimbursable.

Per Ohio Department of Medicaid, the following are related to inpatient behavioral health admissions. For psychiatric admissions, the DRG assigned to the claim 740, 750-760 (ICD-10) and diagnoses codes, including 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.

Psychiatric Diagnosis Related Groups (DRGs)	
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
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

E. Conditions of Coverage

NA

F. Related Policies/Rules

Behavioral Health Service Record Documentation Standards
Sentinel Events and Provider Preventable Conditions

G. Review/Revision History

	DATES	ACTION
Date Issued	12/01/2021	Approved at PGC.
Date Revised	05/24/2023	Annual review. Updated background, definitions, reference list. Added related policies. Approved at Committee.
Date Effective	09/01/2023	
Date Archived		

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

H. References

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