ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Readmission–Behavioral Health–OH MCD-AD-1018	05/01/2024
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 – 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 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, including SUD, often falls short of these recommendations.

CareSource strives to improve the quality of inpatient and transitional care, including communication between the member, caregivers, providers, 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. CareSource follows guidance from the Ohio Department of Medicaid (ODM) and Ohio laws and administrative rules for readmissions.

C. Definitions

- **Appropriate Care** – Care consistent with accepted care and industry standards.
- **Clinical Review** – Review of records by a health care professional with appropriate clinical expertise in the treatment of BH conditions, including member diagnoses, living situation, supports, and severity of the condition.
- **Diagnosis Related Groups (DRGs)** – A patient classification system that reflects clinically cohesive groupings of services that consume similar amounts of hospital resources in an inpatient setting used to assign cases for claims payment.
- **Hospital** – Defined by Ohio Administrative Code (OAC) 5160-2-01 and includes both general acute care facilities and Institutions of Mental Disease (IMD).
- **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** – An inpatient readmission as defined by OAC 5160-2-14(c) following a prior discharge from a hospital within 30 days that is clinically related and clinically preventable to the initial admission.

- **Readmission** – An admission to the same institution within 30 days of discharge for hospitals paid under ODM's prospective payment system as described in OAC 5160-2-65.
- **Same Day** – Midnight to midnight of a single day.

D. Policy
   I. Readmission Criteria
      A. CareSource considers a readmission a return hospitalization within 30 days of a prior discharge that meets **ALL** the following criteria:
         1. The readmission is potentially preventable by the provision of appropriate care consistent with accepted care standards in the prior discharge or during the post-discharge follow-up period.
         2. The readmission is for a condition or procedure clinically related to care provided during the prior discharge or resulting from inadequate discharge planning during the prior discharge, which can include the following (not an all-inclusive list):
            a. 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
               01. contact names, phone numbers and addresses with dates of contact & role/responsibility in treatment regimen and discharge plan
               02. organizations affiliated with contact, if applicable, including outpatient and community BH resources
            b. CareSource's assistance was not utilized or 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
            c. lack of review of social determinants of health (SDoH) and request for CareSource assistance with potential barriers to care (ie homelessness, telephone availability, transportation)
            d. medication reconciliation did not occur
            e. lack of assistance with prescriptions related to treatment regimen availability at discharge, when appropriate and/or safe for the member, including
               01. two weeks' worth of medication provided at the time of discharge, which is not to be included in the inpatient claim and must be a separate NCPDP claim
               02. transportation to the pharmacy or medication home-delivery scheduled
         3. One or more readmission may be clinical 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.
         4. The readmission is the same or to any other hospital.

B. Readmissions subject to administrative record review exclude the following circumstances:
   1. An original, patient-initiated against medical advice (AMA) discharge with circumstances of discharge and readmission documented in the medical record.
   2. Planned readmissions.
   3. The original discharge was for the purpose of securing treatment of a major or metastatic malignancy, major trauma, neonatal and obstetrical admission, transplant, human immunodeficiency virus (HIV), and other non-events.
   4. Transfers from out of network to in-network facilities or transfers to receive care not available at the first facility.

II. Review of Medical Necessity

Review of medical necessity for the initial or subsequent inpatient stays is conducted pre-service delivery using related medical necessity criteria. The review process and determination are 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).

III. Readmission Reviews and Payment Processes

A. Readmission Review Process

CareSource will conduct post-service clinical readmission reviews by examining medical records to determine if a readmission was a preventable, clinically related readmission. Reviews may be conducted pre- 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

CareSource manages the provider payment process for readmissions according to guidelines found in OAC 5160-2-65.

   1. 30-Day Readmissions
      a. If a clinical readmission review determines that the 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 readmission(s) that need collapsed into a single claim.

2. 1-calendar day readmissions (same day or next day readmissions) will be reimbursed as one diagnosis related group (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. Sentinel 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

I. CareSource Policies
   A. Behavioral Health Service Record Documentation Standards
   B. Sentinel Events and Provider Preventable Conditions

II. Regulations
   A. Ohio Administrative Code

1. Appeals and Reconsideration of Departmental Determinations Regarding Hospital Inpatient and Outpatient Services, OHIO ADMIN. CODE 5160-2-12 (2022).
2. Classification of Hospitals, OHIO ADMIN. CODE 5160-2-05 (2023).
3. Conditions and Limitations, OHIO ADMIN. CODE 5160-2-03 (2022).
4. Hospitals, OHIO ADMIN. CODE Chapter 3701-59-01 to 06 (2024).

B. Ohio Revised Code
Inspecting and Licensing of Hospitals for Mentally Ill Persons, OHIO REV. CODE § 5119.33 (2023).

C. Code of Federal Regulations
1. Condition of Participation: Discharge Planning, 42 C.F.R. § 482.43 (2024).
2. Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs, 42 C.F.R. §§ 441 Subpart D (2024).
3. Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases, 42 C.F.R. §§ 441 Subpart C (2024).
4. Special Contract Provisions Related to Payment, 42 C.F.R. § 438.6 (2024).

G. Review/Revision History

	DATES	ACTION
Date Issued	12/01/2021	Approved at PGC.
Date Revised	05/24/2023 01/17/2024	Annual review. Updated background, definitions, reference list. Added related policies. Approved at Committee. Updated definitions, added DRG. Added OAC references to policy body. Updated References. Approved at Committee.
Date Effective	05/01/2024	
Date Archived		

H. References

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2. Eligible Providers, OHIO ADMIN. CODE 5160-2-01 (2023).
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15. *Office of Policy Hospital Billing Guidelines*. Ohio Dept of Medicaid. Revised July 26, 2021. Accessed December 28, 2023. www.medicaid.ohio.gov
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Approved by Ohio Dept. of Medicaid 01/25/2024.