



# REIMBURSEMENT POLICY STATEMENT OHIO MEDICAID

Policy Name	Policy Number	Effective Date
Readmission	PY-0724	07/01/2019
Policy Type		
Medical	Administrative	Pharmacy
<b>REIMBURSEMENT</b>		

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management 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 federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy 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.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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## A. Subject Readmission

## B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims of Readmissions for our Medicare Advantage members may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

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.

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, 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:** a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date; excluding planned admissions.
- **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.
- **Clinically-Related Readmission Chain:** is a series of admissions for the same patient where the underlying reason for readmission is related to the care rendered during or within thirty days following a prior hospital admission. A clinically-related readmission may have resulted from improper or incomplete care during the initial admission or discharge planning process. The hospital where the initial admission occurred is responsible for the clinically-related readmission chain. Hospitalization resulting from an unpreventable or unrelated event occurring after discharge and planned readmissions are not considered clinically-related.
- **Potentially Preventable Readmission (PPR):** a readmission within a specific time frame that is clinically related and may have been prevented had appropriate care been provided during the initial hospital stay and discharge process. A PPR is



determined when, based on CareSource guidelines, it is determined that the patient was discharged prematurely. Premature discharge evidence can be described as, but not limited to, elevated fever at the time of discharge, abnormal lab results or evidence of infection or bleeding a wound.

- **Only admission:** an admission where there was neither a prior initial admission nor a clinically-related readmission within the thirty day readmission period
- **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.
- **Same Day:** CareSource delineates same day as midnight to midnight of a single day.

#### D. Policy

- I. This is a reimbursement policy that 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 (e.g., 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 (e.g., 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 is 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 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 thirty day timeframe may begin again at the discharge of either the initial admission or the most recent readmission clinically-related to the initial admission.
  - D. Readmission is to the same hospital or any facility.



- II. Any readmission that occurs within one calendar day (i.e. 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.
  
- III. Readmissions, for the purposes of determining PPRs, excludes the following circumstances when the diagnosis for the exclusion is in the admitting or the primary diagnosis position of the claim:
  - 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. The original discharge was for the purpose of securing treatment of a major or metastatic malignancy, major trauma, neonatal and obstetrical admission, transplant or HIV.
  - C. Only admissions, which are defined in the definitions of this policy. Planned readmissions are considered "only admissions."
  
- IV. 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 as well as review for medical necessity 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.
  
- V. Post Payment Review and Appeals Process:
  - 1. CareSource reserves the right to monitor and review claim submissions to minimize the need for post-payment claim adjustments as well as review payments retrospectively.
    - a. Medical records for both admissions may be requested to determine if the admission(s) is appropriate or is considered a readmission.
      - 01. Failure from the acute care facility or inpatient hospital to provide complete medical records when requested will result in an automatic denial of the claim.
    - b. Medical records for both admissions must be submitted with the claim if both admissions originated from the same facility or Tax Identification Number (TIN).
      - 01. Failure from the acute care facility or inpatient hospital to provide complete medical records will result in an automatic denial of the claim
    - c. If the included documentation determines the readmission to be an inappropriate, medically unnecessary or potentially preventable admission, the hospital must be able to provide additional documentation to CareSource upon request or the claim will be denied.
    - d. If the readmission is determined at the time of documentation review to be a preventable readmission, the reimbursement for the readmission will be combined with the initial admission and paid as one claim to cover both, or all, admissions.
  - 2. Appeals Process



- a. All acute care facilities and inpatient hospitals have the right to appeal any readmission denial and request a peer-to-peer review or formal appeal.

### E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting claims based on National Correct Coding Guidelines.

### F. Related Policies/Rules

### G. Review/Revision History

DATE		ACTION
<b>Date Issued</b>	04/01/2019	
<b>Date Revised</b>		
<b>Date Effective</b>	07/01/2019	

### H. References

1. McIlvennan, C. K., Eapen, Z. J., & Allen, L. A. (2015). Hospital readmissions reduction program. *Circulation*, 131(20), 1796-803. McIlvennan, C. K., Eapen, Z. J., & Allen, L. A. (2015). Hospital readmissions reduction program. *Circulation*, 131(20), 1796-803.
2. Hospital Readmission Reduction Program. (2018, December 04). Retrieved from <https://www.cms.gov>
3. Medicare Claims Processing Manual. (2018, November 9). Retrieved January 23, 2019, from <https://www.cms.gov>
4. Goldfield, N. I., McCullough, E. C., Hughes, J. S., Tang, A. M., Eastman, B., Rawlins, L. K., & Averill, R. F. (2008). Identifying potentially preventable readmissions. Retrieved from <https://www.ncbi.nlm.nih.gov>

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