HAP CareSource™

ADMINISTRATIVE POLICY STATEMENT
Michigan Coordinated Health

Policy Name & Number	Date Effective
Readmission-MI Coordinated Health-AD-1604	11/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements contain supplemental information regarding standard benefit administration and coverage details. Administrative Policy Statements do not guarantee an authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage, Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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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 HAP 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.

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.
- **Ineffective Discharge Planning** – Readmissions will be reviewed for adequacy of follow-up care and outpatient management using accepted practice guidelines and treatment protocols. Documentation should support that reasonable attempts by the hospital were taken to address placement and access-to-treatment difficulties, including but not limited to, collaboration with social services and connecting member to community resources. Examples of ineffective discharge planning include, but are not limited to, inadequate medication management, lack of communication with providers delivering the follow-up care, inadequate outpatient follow up or treatment, failure to address rehabilitation needs such as inability to provide self-care, and failed discharge/transfer to another facility such as lack of orders or medication reconciliation.
- **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
  o retained placenta
  o retained products of conception
  o post-partum sepsis
  o other acquired hospital acquired condition

- **Potentially Preventable Readmission (PPR)** – A readmission within a specific time frame that is clinically related and may have been prevented had appropriate care and/or transitional follow-up care been provided during the initial hospital stay and discharge process. A PPR is determined when, based on HAP CareSource guidelines, it is determined that the patient was discharged prematurely or had ineffective transitional care.
- **Pre-Existing Condition** – A chronic health condition the patient had before the date of the admission.
- **Premature Discharge** – Occurs when a member is discharged even though they should have remained in the hospital for further testing or treatment or was not medically stable at the time of discharge. A member is not medically stable when the member's condition is such that it is medically unsound to discharge or transfer the patient. Evidence such as elevated temperature, postoperative wound draining or bleeding, or abnormal laboratory studies on the day of discharge indicate that a member may have been prematurely discharged from the hospital. 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.
- **Readmission** – Admissions to an acute, general, inpatient facility (IPF) occurring within 30 days from the date of discharge from the same facility. Neither the day of discharge nor the day of admission are counted when determining whether a readmission has occurred.
- **Related Medical Condition** – Medical condition or diagnosis that is related or associated to the original admission.
- **Same day** – HAP CareSource delineates same day as midnight to midnight of a single day.
- **Unrelated Medical Condition** – Medical condition or diagnosis that is not related or associated to the original admission.

D. Policy

I. The following payment rules are defined for hospitals and acute care facilities that are reimbursed for inpatient or observational services for the following categories:
   A. same day readmission or observational stay for a related condition within 1 day of inpatient discharge
   B. same day readmission or observational stay for an unrelated condition within 1 day of inpatient discharge
   C. planned readmissions and/or leave of absence.
   D. unplanned admissions to an acute, general, short-term hospital occurring within 30 days from the date of discharge from the same IPF.

II. An administrative review of all readmissions will take place based on the following Medicare readmission review criteria:
   A. Readmission or observational stay within 2-30 days of inpatient discharge for a related condition:

1. HAP CareSource will conduct an administrative review to ensure that billing guidelines were followed based on Chapter 3, Section 40.2.5 (Repeat Admissions) in the *Medicare Claims Processing Manual,* which requires that the acute, general, short-term hospital combine the 2 admissions on 1 claim.
2. If the member is readmitted within 1 day of inpatient discharge HAP CareSource will deny the claim as separate DRG's. The facility must submit the initial and the subsequent admission on 1 claim to be considered for reimbursement.

B. Same day readmission or observational stay for an unrelated condition criteria within 1 day of inpatient discharge:
   1. HAP CareSource will administratively deny within 1 day of discharge date of an inpatient claim. An administrative review will be conducted for readmissions that occur within 2-30 days of a previous discharge to ensure that billing guidelines were followed based on Chapter 3, Section 40.2.5 (Repeat Admissions) in the *Medicare Claims Processing Manual* which requires that the acute, general, short-term hospital to bill the claims separately but the claim that contains an admission date that is the same as the discharge date must include condition code B4 as indicated in the Medicare billing guidelines.

C. Planned readmission and/or leave of absence criteria:
   1. When a readmission to the same acute care facility or hospital is expected and the member does not require a hospital level of care during the timeframe between the 2 admissions, the member may be placed on leave of absence by the provider.
      a. HAP CareSource follows the Medicare Inpatient Hospital Services billing guidelines found in the *Medicare Claims Processing Manual*, Chapter 3 for leave of absence billing guidelines which requires that the facility submit one claim and receive one combined DRG payment for both

   1. admissions.

      b. Examples of a planned readmission include, but are not limited to, situations where surgery could not be scheduled immediately due to scheduling availability, a specific surgical team that is needed for the procedure is not available, bilateral "staged" surgery was planned, or

   2. when further treatment is indicated following diagnostic tests but cannot begin at the time of initial admission.

   3. c. HAP CareSource reserves the right to request medical records to determine if the claim was properly billed.

      d. Leave of absence does not apply to cancer chemotherapy or similar repetitive treatments.

D. Unplanned readmission criteria:
   1. HAP CareSource will review the clinical documentation on all readmissions to determine if the second admission was a potentially preventable readmission (PPR) based on the following guidelines:
      a. The readmission is due to a premature discharge of patient.
      b. Based on medically appropriate professionally recognized standard of

health care, the member could have received the care from the readmission during the first admission.

c. The readmission is due to ineffective discharge planning.
   01. The following should be completed prior to discharge:
      1) A discharge planning evaluation including, but not limited to assessment of the following:
         i. the likelihood of the need for appropriate post-hospital services including addressing rehabilitation needs
         ii. appropriate arrangements for post-hospital care
         iii. availability of appropriate services which would include services such as medical, transportation, meals, and household services
         iv. need for and feasibility of specialized medical equipment permanent physical modifications to the home
         v. capacity for self-care, or alternatively to be cared for by others
         vi. criticality of the appropriate services
         vii. readmission risk score or severity score
         viii. member's access to appropriate services
   02. A provider should take into account a number of factors when determining if 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 (i.e. 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 and
      8) Availability of community services
   03. 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 necessary medical information pertinent to illness and treatment, 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 HAP CareSource case manager, community agencies, and providers responsible for follow up care
      4) completion of medication reconciliation/management
      5) needed DME and supplies in place prior to discharge
      6) scheduled appointments listed with dates, times, names, telephone numbers and addresses
      7) member/guardian and family engagement as needed

E. Member non-adherence with treatment plan will be considered for payment if all

of the following criteria is adequately documented:

1. Physician orders were appropriately communicated to the member.
2. The member or guardian is mentally competent and capable of following the discharge instructions.
3. The member or guardian made an informed decision not to follow the discharge instructions.
4. The nonadherence is clearly documented in the medical record.

NOTE: A readmission may be medically necessary but may also be deemed preventable.

F. The following readmission criteria are excluded from administrative review:

1. The member is being transferred from an out-of-network to an in-network facility, or the member is being transferred to a facility that provides care that was not available at the initial facility.
2. The member was transferred to a distinct psychiatric unit within the same facility. Documentation must show that the diagnosis necessitating the transfer was psychiatric in nature and that the patient received active psychiatric treatment.
3. The readmission is part of planned repetitive treatment or staged treatments, such as chemotherapy or staged surgical procedures.
4. The discharge status of the first discharge was “left against medical advice (AMA).”
5. Obstetrical readmissions.
6. Behavioral health readmissions.

NOTE: Errors made at the receiving facility unrelated to the orders the facility received upon transfer (eg, falls, treatment delivery failure) will not result in a payment denial for the readmission.

III. 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 HAP 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.

IV. Post Service Review Process:
HAP CareSource reserves the right to monitor and review claim submissions to minimize the need for post service claim adjustments, as well as review payments retrospectively.

A. Medical records for both admissions must be included upon request of claim review to determine if the admission(s) is appropriate or is considered a readmission. Failure from the acute care facility or inpatient hospital to provide complete medical records will result in an automatic denial of the claim.

V. Provider preventable conditions, sentinel events and serious reportable events are not reimbursable.

E. Conditions of Coverage

Per Michigan bulletin MMP 26-24, when a contract is not in place between a hospital and HAP CareSource, then the readmission Michigan Department of Health and Human Services (MDHSS) *Medicaid Provider Manual* for hospitals applies.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	07/16/2025	New policy. Approved at Committee.
Date Revised	08/12/2026	Periodic review. Updated Conditions of Coverage. Updated references. Approved at Committee.
Date Effective	11/01/2026	
Date Archived		

H. References

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4. Hospital-acquired conditions. Centers for Medicare & Medicaid Services. Updated September 10, 2024. Accessed August 3, 2026. www.cms.gov
5. Hospital Readmission Reduction Program (HRRP). US Centers for Medicare and Medicaid Services. Updated September 10, 2024. Accessed August 3, 2026. www.cms.gov
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