ADMINISTRATIVE POLICY STATEMENT Ohio MyCare	
Policy Name & Number	**Date Effective**
Readmission-OH MYCARE-AD-0974	01/01/2023-01/31/2025
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

B. Background
Within 3 weeks of discharge, approximately 20% of patients have adverse events. Many of these events that occurred are preventable. Among the preventable events are adverse drug events, hospital-acquired infections, and procedural complications. Systematic problems during the transition of care between inpatient and outpatient providers is often the basis for adverse events to occur after discharge.

Patients, families, and caregivers may not be adequately equipped after being discharged from the hospital. They may not have the proper resources or equipment, may not understand the medications changes, may go through a post-hospitalization syndrome making the patient vulnerable to falls or infections, or may be responsible to follow up on pending test results or on scheduling additional outpatient testing/appointments. Up to 50% of people are instructed to schedule an appointment after discharge; and due to the lack of understanding of the reasons or where to call, they do not schedule the appointment.

Pertinent information from the hospital may not have been provided to the patient's next provider(s) in a timely manner. This delay in transfer of patient information leaves the next provider not knowing information such as what conditions still need addressed, changes in medications, which tests were completed while in the hospital, and which test results were pending at the time of discharge. Around 40% of patients were discharged with test results pending.

The discharge plan/instructions may not have been patient specific as to their literacy level, social determinants, learning style, or current health status. Deficiencies in communication or understanding related to the discharge plan, can lead to confusion, non-adherence, and adverse events.

The purpose of this policy is to improve the quality of acute care 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. discharged, and 5. provide effective post discharge coordination of care.

C. Definitions
- **Appropriate Post-discharge Site of Care** – Determinants of appropriate site include, but are not limited to, assessment of the medical, functional, and social aspects of a member's illness.
- **Ineffective Discharge Planning** – Readmissions will be reviewed for adequacy of follow-up care and outpatient management using accepted practice guidelines and

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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 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 CareSource guidelines, it is determined that the patient was discharged prematurely or had ineffective transitional care.
- **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.
- **Same day** – CareSource delineates same day as midnight to midnight of a single day.
- **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.

D. Policy

I. **This policy is only applicable for CareSource MyCare Ohio <u>Opt-In members</u>** <u>(Medicare guidelines)</u>.

The Ohio Medicaid Readmission policy is applicable to CareSource MyCare Ohio <u>Opt-Out</u> members.

II. This administrative policy defines the payment rules 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.

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B. Same day readmission or observational stay for an unrelated condition.
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.

III. An administrative review of all readmissions will take place based on the following Medicare readmission review criteria:
A. Same day readmission or observational stay for a related condition criteria:
1. 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 two admissions on one claim.
2. If the member is readmitted during the same day as the initial admission for the same or a related condition and both the initial and the subsequent admission are billed separately, CareSource will deny the claim as separate DRG's. The facility must submit the initial admission and the subsequent admission on one claim to receive reimbursement.
B. Same day readmission or observational stay for an unrelated condition criteria:
1. 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 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 two admissions, the member may be placed on leave of absence by the provider.
a. 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 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 when further treatment is indicated following diagnostic tests but cannot begin at the time of initial admission.
c. 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.

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D. Unplanned readmission criteria:
   1. 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, or 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; and
               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 CareSource case manager, community agencies, and providers responsible for follow up care;
            (4). Completion of medication reconciliation/management;
            (5). Needed DME and supplies are in place prior to discharge;
            (6). Scheduled appointments are listed with dates, times, names, telephone numbers and addresses; and
            (7). Member/guardian and family engagement as needed.

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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; and
   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 listed below are excluded from this readmission policy and if billed appropriately, claims will be reviewed for payment:
   1. If the member is being transferred from an out-of-network to an in-network facility or if the member is being transferred to a facility that provides care that was not available at the initial facility;
   2. Transfers to distinct psychiatric units within the same facility. When transferring 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. If the readmission is part of planned repetitive treatments or staged treatments, such as chemotherapy or staged surgical procedures;
   4. Readmissions where the discharge status of the first discharge was "left against medical advice (AMA)";
   5. Obstetrical readmissions; and
   6. Behavioral health readmissions.

   NOTE: Errors made at the receiving facility unrelated to the orders it received upon transfer (e.g., 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 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:
   A. 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.
      1. Medical records for both admissions must be included with the claim submission to determine if the admission(s) is appropriate or is considered a readmission.
         a. Failure for the acute care facility or hospital to provide complete medical records will result in an automatic denial of the claim.
         b. If the included documentation determines the readmission to be an inappropriate or medically unnecessary, the hospital must be able to

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provide additional documentation to CareSource upon request or the claim will be denied.

c. 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.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Readmission-Ohio Medicaid

G. Review/Revision History

	DATES	ACTION
Date Issued	03/01/2019	New policy
Date Revised	11/11/2020 08/04/2021 08/31/2022	Changed from PY-0774, Updated background, definitions, D. I and II (added D., E., F. 6.) Changed post payment to post service in D. IV. and D.IV A. Removed peer to peer language and appeals in D. IV. B. Updated references. Approved at PGC. Definitions updated. D. I.D. updated. Updated references.
Date Effective	01/01/2023	
Date Archived	01/31/2025	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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The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

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6. Center for Medicare & Medicaid Services. MLN Matters Number: MM3389. (2004, July 30). Retrieved 08/15/2022 from www.cms.gov.
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The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.