REIMBURSEMENT POLICY STATEMENT
OHIO MYCARE

Policy Name	Policy Number	Effective Date
Readmission	PY-0775	4/1/2019

Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

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.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

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.
- **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.

- **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 Medicare and Medicaid Dual member claims from 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
   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 calendar days from the date of discharge from the same or another acute, general, short-term hospital

II. 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.

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 inpatient 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 both are for the treatment of the same episode of illness.
    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.

D. Determination of Unplanned Readmissions criteria:
    1. CareSource will review the clinical documentation on all potential readmissions to determine if the admission was a potentially preventable readmission (PPR) based on the following Medicare guidelines:
        a. Premature discharge of patient that resulted in subsequent readmission of patient to same hospital. Premature discharge includes when a patient is discharged even though he/she should have remained in the hospital for further testing or treatment or was not medically stable at the time of discharge. A patient is not medically stable when, in CareSource judgement, the patient'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 patient may have been prematurely discharged from the hospital;
        b. When a patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission. This action does not include circumstances in which it is not medically appropriate to provide the care during the first admission.
        c. The readmission is the result of a lack of documentation and/or coordination of care between the inpatient and outpatient team in regards to post discharge care and coordination with a CareSource Care Manager for the member.

E. The following readmission criteria listed below are excluded from this readmission policy when the diagnosis for the exclusion is in the admitting or the primary diagnosis position of the claim:

a. 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;
b. 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.
c. If the readmission is part of planned repetitive treatments or staged treatments, such as chemotherapy or staged surgical procedures;
d. Readmissions where the discharge status of the first discharge was “left against medical advice (AMA)”;
e. Obstetrical readmissions.

IV. 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 CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the CMS fee schedule for appropriate codes.

F. Related Policies/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued	3/1/2019	
Date Revised		
Date Effective	3/1/2019	

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

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