ADMINISTRATIVE POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Readmission-MP-AD-1233	02/01/2025
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.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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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 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 and established as the basis of Medicare's hospital reimbursement system.
- **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 pre-term or post-partum complication, including but not limited to:
  - Retained placenta
  - Retained products of conception
  - Post-partum sepsis
  - Other acquired hospital acquired condition
- **Potentially Preventable Readmission (PPR)** – Readmission to a hospital for a reason that is considered unplanned and potentially preventable.
- **Pre-Existing Condition** – A chronic health condition the patient had before the date of the admission.
- **Provider Preventable Condition (PPC)** – A condition with a negative consequence for the member occurring in any healthcare setting found to be reasonably preventable by the provider through the application of procedures supported by evidence-based medical guidelines.
- **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 related or associated to the original admission.
- **Same or Similar Condition** – A condition or diagnosis that is the same or a similar condition as the diagnosis or condition documented on the initial admission.
- **Unrelated Medical Condition** – Medical condition or diagnosis not related or associated to the original admission.

D. Policy

I. This administrative policy defines the payment rules for hospitals and acute care facilities that are reimbursed for inpatient or observational services:
   A. Readmission or observational stay within 3 days of discharge will be denied.
   B. Readmissions to an acute, general, short-term hospital occurring within 4-30 days from the date of discharge from the same wholly owned healthcare system inpatient facility (IPF) may result in an administrative review.

II. Prior authorization of the initial or subsequent inpatient stay or admission to observation status is not a guarantee of payment and claims are subject to administrative review.

III. Planned readmission and/or leave of absence criteria
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 is needed for the procedure but not available, bilateral "staged" surgery was planned, or further treatment is indicated following diagnostic tests but cannot begin at the time of initial admission. 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 2 admissions, the member may be placed on leave of absence by the provider. Leave of absence does not apply to cancer chemotherapy or similar repetitive treatments.
   1. 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.
   3. CareSource reserves the right to request medical records to determine if the claim was properly billed.

   D. Determination of unplanned readmissions criteria
   CareSource will review the clinical documentation on all potential readmissions to determine if the admission was a PPR based on the following guidelines:
      1. The readmission is due to ineffective discharge planning. A discharge planning evaluation should be completed prior to discharge, including assessment of the following:

   a. The likelihood of the need for appropriate post-hospital services, including addressing rehabilitation needs
   b. Appropriate arrangements for post-hospital care
   c. Availability of appropriate services, which would include services such as medical, transportation, meals, and household services
   d. Need for and feasibility of specialized medical equipment or permanent physical modifications to the home
   e. Capacity for self-care or alternatively to be cared for by others
   f. Criticality of the appropriate services
   g. Readmission risk score or severity score
   h. Member's access to appropriate services
2. A provider should take into account a number of factors when determining if a member is ready for discharge, including, but not limited to:
   a. cognitive status
   b. activity level and functional status
   c. current home and suitability for member's condition (ie, stairs)
   d. availability of family or community support
   e. ability to obtain medications and services
   f. ability to meet nutritional needs
   g. availability of transportation for follow up care
3. Documentation should support the following discharge standards:
   a. plan includes provider(s) responsible for follow up care, using the evaluation as a guide in the development of the discharge plan
   b. all necessary medical information pertinent to illness, treatment, and post-discharge goals of care was provided to the appropriate post- acute care service providers at the time of discharge
   c. coordination and referrals with provider(s) responsible for follow-up care
   d. completion of medication reconciliation/management
   e. durable medical equipment (DME) and supplies are in place prior to discharge
   f. scheduled appointments are listed with dates, times, names, telephone numbers and addresses
   g. member/guardian and family engagement, as needed

E. The following readmission criteria listed below are excluded from a readmission:
   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. transfers to distinct psychiatric units within the same facility with documentation showing that the diagnosis necessitating the transfer was psychiatric in nature and the patient received active psychiatric treatment
   3. the readmission is part of planned repetitive treatments or staged treatments, such as chemotherapy or staged surgical procedures
   4. readmissions in which the discharge status of the first discharge was "left against medical advice (AMA)"
   5. routine obstetrical readmissions (non-preventable)

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 recoup payments retrospectively.
      1. Medical records for both admissions must be included upon request for claim review.
         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 the claim will be denied.
         c. If the readmission is determined at the time of documentation review to be preventable, CareSource will deny the claim and the provider may resubmit a corrected claim for the entire length of stay.

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

VI. In the event of any conflict between this policy and a provider's agreement with CareSource, the provider's agreement will be the governing document.

E. State-Specific Information
NA

F. Conditions of Coverage
NA

G. Related Policies/Rules
NA

H. Review/Revision History

	Date	Action
Date Issued	08/31/2022	New policy. Combined individual state readmission administrative policies.
Date Revised	04/12/2023 11/06/2024	Updated definitions. Changed readmission timeframe from same day to within 3 days. Modified D.1.a. Updated references. Updated background, definitions, D.I. Added V. Updated references. Approved at Committee.
Date Effective	02/01/2025	
Date Archived		

I. References

1. Case Review. *Quality Improvement Organization Manual Chapter 4*. US Centers for Medicare and Medicaid Services; 2014. Accessed October 1, 2024. www.cms.gov
2. *Eliminating Serious, Preventable, and Costly Medical Errors – Never Events* Center for Medicare & Medicaid Services; 2006. Accessed October 1, 2024. www.cms.gov

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

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4. Hospital-acquired conditions. Centers for Medicare & Medicaid Services. Updated September 10, 2024. Accessed October 1, 2024. www.cms.gov
6. *Hospital Readmission Reduction Program (HRRP)*. US Centers for Medicare and Medicaid Services. Updated September 10, 2024. Accessed October 1, 2024. www.cms.gov
7. List of SREs. National Quality Forum. Accessed October 1, 2024. www.qualityforum.org
8. McIlvennan CK, Eapen ZJ, Allen LA. Hospital readmissions reduction program. *Circulation*. 2015;131(20):1796-1803. doi:0.1161/CIRCULATIONAHA.114.010270
9. Pre-existing condition. Accessed October 1, 2024. www.healthcare.gov