POLICY

	Policy No: HCS-341
	Policy Title: Hospital Readmission Review
	Department: Healthcare Services (HCS) **Sub-Department:**
Entity: Molina Healthcare, Inc. **State(s): AZ, CA, FL, ID, IL, KY, MA, MI, MS, NE, NM, NV, NY, OH, SC, TX, UT, VA, WA, WI**	**Effective Date:** 10/18/2019
Name: Liz Miller **Title:** SVP, Clinical Operations	**Signature**: Liz Miller

Lines of Business:

☒ All ☐ Medicare ☐ Marketplace

☐ Medicaid ☐ Medicare-Medicaid Programs (MMP) ☐Other: _____

I. PURPOSE

The purpose of this policy is to ensure that Molina Healthcare members are receiving quality care that is compliant with nationally recognized guidelines as well as federal and state regulations.

II. POLICY

Molina Healthcare will conduct readmission reviews when the readmission occurs at the same acute inpatient hospital. When a subsequent approved admission to the same hospital with the same or similar diagnosis meets medical necessity for an inpatient level of care AND occurs within twenty-four (24) hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay. A single payment will be considered as payment in full for both the first and second hospital admissions. All subsequent approved admissions after 24 hours that meet medical necessity for an inpatient level of care will undergo a readmission review to determine if the readmission is considered Potentially Preventable.

A. A readmission is considered Potentially Preventable if it is clinically related to the prior admission and includes one of the following circumstances:
   1. Premature or inadequate discharge from the same hospital.
   2. Issues with transition or coordination of care from the initial admission.
   3. An acute medical complication plausibly related to care that occurred during the initial admission.

B. Readmissions that are excluded from consideration as Preventable readmissions include:
   1. Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
   2. Neonatal and obstetrical readmissions.
   3. Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
   4. Behavioral Health readmissions.
   5. Transplant related readmissions.

III. SCOPE

Clinical Management and Policy; Healthcare Services; MHI Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services (MCS)

IV. AREA(S) OF RESPONSIBILITY

Claims, Healthcare Services, Quality Improvement

V. DEFINITION(S)

Readmission: A subsequent admission to an acute hospital within a specified time interval.

VI. REFERENCE(S)

42 CFR 476.71(a)(8)(ii)

42 CFR 438.3(g)

Medicare Claims Processing Manual, Chapter 3 – Inpatient Hospital Billing, Section 40.2.5 – Repeat Admissions (Rev. 2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-12)

Medicare Quality Improvement Organization Manual, Chapter 4, Section 4240 (Rev. 2, 07-11-03)

HCS-341.01 Hospital Readmission Review Procedure

VII. VERSION CONTROL

Version No	Date	Revision Author/Title	Summary of Changes
1	1/6/2022	J. Cruz/VP Clinical Operations	Annual review, new P&P template (previous revision dates- 10/18/2019, 10/19/2020, 06/28/2021)
2	11/9/2022	J. Cruz/VP Clinical Operations	Annual Review
3	12/12/2023	J. Cruz/VP Clinical Operations	Annual Review; State section- removed IA, added NE, TX (for TX Medicare products); Reinstated for Medicare/MMP (applies to all LOB); Policy Section II. revised 1st sentence (added "meets medical necessity for an inpatient level of care AND") and 4th sentence (added "that meet medical necessity for an inpatient level of care"); Scope - added Office of CMO; Definition – revised Readmission; References - removed USC and ACA, added MC Manuals, and connected procedure); minor formatting changes.
4	11/13/2024	Christa Ross/AVP Clinical Operations	Annual Review; Scope: Office of CMO replaced with Clinical Policy and Mgmt., MHI CMO Policy & Benefit, and MCS; References: added 42 CFR 438.3(g)

PROCEDURE

	Procedure No: HCS-341.01
	Procedure Title: Hospital Readmission Review
	Department: Healthcare Services (HCS) **Sub-Department:**
Entity: Molina Healthcare, Inc. **State(s): AZ, CA, FL, ID, IL, KY, MA, MI, MS, NE, NM, NV, NY, OH, SC, TX, UT, VA, WA, WI**	**Effective Date:** 10/18/2019
Name: Liz Miller **Title:** SVP, Clinical Operations	**Signature**: Liz Miller

Lines of Business:

☒ All ☐ Medicare ☐ Marketplace

☐ Medicaid ☐ Medicare-Medicaid Programs (MMP) ☐ Other: _____

I. PURPOSE

The purpose of this procedure is to ensure that Molina Healthcare members are receiving quality care that is compliant with nationally recognized guidelines as well as federal and state regulations.

II. PROCEDURE

A. Readmissions Within 24 Hours of Discharge to the Same Hospital

1. When a subsequent admission to the same hospital with the same or similar diagnosis occurs within twenty-four (24) hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay. A single payment will be considered as payment in full for both the first and second hospital admissions.

B. Readmissions After 24 hours of Discharge to the Same Hospital

1. When a subsequent admission to the same hospital is identified within the Federal and/or State regulatory requirement dates and is not otherwise excluded for consideration as a preventable readmission, the clinician will review the case and send it to a Molina Healthcare medical director for case review of both stays to determine if the subsequent admission is clinically related to the index/anchor admission and if the readmission is Potentially Preventable. The Molina Healthcare medical director will consider the following items amongst any other relevant information:
    a. If the member was discharged before appropriate medical treatment was rendered.
    b. If any of the care rendered during the first admission was considered incomplete or substandard treatment.
    c. If the subsequent admission was due to a Hospital-Acquired Condition (HAC).
    d. If written discharge instructions and follow up needs (i.e., prescriptions, durable medical equipment, therapies, social assistance) were provided and explained to the patient/caregiver prior to discharge.
    e. Information available to the attending physician at the time of the discharge from the first admission.

2. Molina Healthcare may request the hospital to forward all medical records related to the first

admission and subsequent readmission for review. This may occur during the inpatient stay concurrent review, prepayment review process, or post-payment review of the claim.

3. Upon conclusion of the medical review, if it is determined that the second admission is a Preventable readmission, then a single payment will be considered as payment in full for both the first and second hospital admissions.

C. Provider Claims Reconsiderations
Non-approval of payment for readmissions will be governed by the provider claims reconsideration process as defined in the Hospital or Provider Services Agreement, Provider Manual, Health Plan policies and procedures, and governmental regulations.

D. Quality of Care Reviews
If there is a Quality of Care concern, then a referral to the Quality Improvement department will be made. Quality of Care reviews provide an opportunity for Molina Healthcare to collaborate with providers on patient safety and quality of care concerns. Such reviews are separate from clinical concurrent review performed by the medical director and have no impact on payment decisions.

III. SCOPE

Clinical Management and Policy; Healthcare Services; MHI Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services (MCS)

IV. AREA(S) OF RESPONSIBILITY

Claims, Health Care Services, Quality Improvement

V. DEFINITION(S)

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VI. REFERENCE(S)

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Medicare Quality Improvement Organization Manual, Chapter 4, Section 4240 (Rev. 2, 07-11-03) HCS-341

Hospital Readmission Review Policy

VII. VERSION CONTROL

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1	1/6/2022	J. Cruz/VP Clinical Operations	Annual review, new P&P template (previous revision dates- 10/18/2019, 10/19/2020, 06/28/2021)
2	11/9/2022	J. Cruz/VP Clinical Operations	Annual Review

3	12/12/2023	J. Cruz/VP Clinical Operations	Annual Review; State section - removed IA, added NE, TX (for TX Medicare products); Reinstated for Medicare/MMP (applies to all LOB); Section II.B.1. added "Federal and/or"; Scope - added Office of CMO; Definition – revised Readmission; References -removed USC and ACA, added MC Manuals,
			and connected policy; minor formatting changes.
4	11/13/2024	Christa Ross/AVP Clinical Operations	Annual Review; II.B.1. added "and is not otherwise excluded as a preventable readmission"; Scope: Office of CMO replaced with Clinical Policy and Mgmt., MHI CMO Policy & Benefit, and MCS; References: added 42 CFR 438.3(g); minor formatting and grammatical changes

STATE ADDENDUM

Procedure No: MHT-HCS 364.01	**Addendum No:** 14a
Procedure Title: Appropriate Professionals Making UM Decisions	**Health Plan (State):** TX
Name: Rebecca Stokes, RN BSN **Title:** AVP HCS UM	**Signature:**  **Date:** 02/19/2025
Corporate Policy: HCS-364 Appropriate Professionals Making UM Decisions Policy.pdf	**Corporate Procedure:** HCS-364.01 Appropriate Professionals Making UM Decisions Procedure.pdf

I. PURPOSE

To identify state specific requirements that differ from MHI procedure for compliance with Federal and/or State regulatory or contractual requirements applicable to Appropriate Professionals Making UM Decisions.

II. SCOPE

Health Care Services (HCS); Molina Clinical Services (MCS)

III. STATE VARIANCES REFERENCE TABLE

Procedure Citation	Requirement	Variance for Texas Medicaid/CHIP	Source of Decision
II	MHI document does not address	PA and concurrent review determinations are made and supervised by formally educated and currently licensed medical professionals with same or similar specialty as the ordering provider, such as physicians, nurses, or therapists, who have subject area knowledge and relevant patient care experience; and that these medical professionals work and supervise others only within the scope of their education and licensure.	Uniform Managed Care Contract 8.1.8 Utilization Management
II. D.	MHI document does not address. Add #9	Participate in individual case review; which may include consultation with external Texas licensed physicians.	Texas Administrative Code Chapter 19, Subchapter R, Division 1 Rule 19.1706 Requirements and Prohibitions Relating to Personnel
II. D.	MHI document does not address.	Prior Authorization (PA) determinations to deny or limit services are made by physicians licensed in Texas working under the direction of the medical director.	42 CFR 422.566(d)
II. I.	RN or LVN/LPN and Care Management (Clinical Case Managers and Complex Case Managers)	RN or LVN/LPN, Therapists (PT/OT/ST), Behavioral Health LPC, and Care Management (Clinical Case Managers and Complex Case Managers)	Utilization Management Program Description
V.	Definitions not in MHI document	**Request for experimental or investigational procedures** – Because each case is unique and the classification of a procedure or treatment as "experimental" or "investigational" can be a matter of interpretation with differing opinions between the organization and the treating practitioner, a medical necessity review is required of such requests unless the requested service or procedure is specifically listed as an exclusion in the member's benefit plan.	Texas Administrative Code Chapter 19, Subchapter R, Division 1 Rule 19.1703
VI.	References	Uniform Managed Care Contract (UMCC): 4.02 MCO's Key Personnel and 8.1.8 Utilization Management Texas Administrative Code (TAC) Title 28 Part 1 Chapter 19, Subchapter R, Rule §19.1706 Texas Insurance Code (TIC): Title 14, Chapter 4201, Subchapter D and Subchapter F Texas Insurance Code (TIC): Title 4, Subtitle I, Chapter 533, Sec. 533.0073.	

IV. VERSION CONTROL

Version No	Date	Revision Author/Title	Summary of Changes
1		Rebecca Stokes, RN BSN AVP HCS UM	Added statement that reviews and determinations are made by staff with knowledge in the area of service requested. Added MD may consult with physicians outside Molina. Added denials and limitations of service are determined by MD. Added therapists and behavioral health clinicians. Added definition for experimental or investigational procedures. Added state specific references.
1.1	02/19/2025		Approved through Texas Health Care Services Committee