

RB.037.B Readmissions - (Individual and Family Plans)

Original Implementation Date : 01/01/2024
Version [B] Date : 11/13/2025
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Thank you for being a valued provider for members in one or more of our health plans: Jefferson Health Plans Medicare Advantage, Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans CHIP, and/or Jefferson Health Plans EverWell (our Medicaid plan).

PRODUCT VARIATIONS

This policy only applies to Jefferson Health Plans Individual and Family Plans line of business.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual provider contractual arrangements.

POLICY STATEMENT

The plan does not separately reimburse for inpatient readmission claims to the same inpatient acute care hospital, or an inpatient acute care hospital within the same health system for the same, similar or related condition within 30 days of discharge from the first admission's discharge day and when the readmission was preventable.

For reimbursement purposes the plan will treat both inpatient hospital admissions as a single clinical event. The claim with the higher payment will remain in place, and the claim for the other related admission will be retracted post payment. This will eliminate the payment of multiple case rates for a single clinical event.

Our Medical Director will perform a medical review of each case to determine if the readmission is for a same, similar, or related condition. Inpatient payment for the readmission **may be denied under the following circumstances:**

- The readmission was not medically necessary

- The readmission resulted from a premature discharge from the same hospital
- The patient was readmitted for care that could have been provided during the initial admission
- There was an inappropriate transfer of the patient from an acute inpatient setting to a rehabilitation facility, skilled nursing facility (SNF), or subacute care
- There was an inappropriate transfer of the patient from a rehabilitation facility, SNF, or subacute care back to an acute inpatient setting

Exclusions

The following readmission scenarios are excluded from the above listed payment limitations:

(Note: Usual preauthorization and notification requirements apply to all exclusions.)

1. Planned unrelated readmissions when the readmission occurs less than 30 calendar days from the date of the discharge from the same facility. *(See definition of Planned Readmission).*

Examples:

1. Planned admission for lung volume reduction surgery after a motor vehicle accident admission for loss of consciousness.
2. Planned total knee replacement admission after syncope admission.
3. Staged inpatient procedure(s) after the initial surgical admission when a staged procedure is medically acceptable AND warranted.
4. Planned related readmissions for appropriate inpatient care when the frequency of the needed services is medically appropriate.

POLICY GUIDELINES

The Medical Director makes the determination to combine admissions for a single clinical event. Prior authorizations are based on medical necessity, covered services under a given plan benefits package and clinical appropriateness using clinical criteria and guidelines that are the accepted standard of care in the medical community. In addition, the physician reviewer may override the criteria

when in his/her professional judgment, the requested service is medically necessary. Individual member assessment must occur.

A “30-day readmission letter” will be generated and sent to the admitting hospital of the second/consecutive admission.

The plan will issue all determinations via fax in accordance with regulatory guidelines and notification timeframes.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

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CPT Code	Description
N/A	

HCPCS Code	Description
N/A	

ICD-10 Code	Description
N/A	

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DESCRIPTION OF SERVICES

Some readmissions are unavoidable, but they may also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care.

Multiple factors affect readmission rates and other measures including: the complexity of the medical condition and associated therapies; effectiveness of inpatient treatment and care transitions; patient understanding of and adherence to treatment plans; patient health literacy and language barriers; and the availability and quality of post-acute and community-based services, particularly for patients with low income. Readmission measurement should reinforce national efforts to focus all stakeholders' attention and collaboration on this important issue.

Determination of Medical Necessity for covered care and services; whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing:

The determination is based on medical information provided by the Member, the Member's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, and agencies that have evaluated the Member

Readmission: An additional inpatient admission within 30 days of a prior DRG discharge to the same facility or facility that shares the same tax identification number.

Premature discharge: This occurs 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 [the reviewer's] judgment, 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.

Planned readmission: A planned readmission is “a non-acute admission for a scheduled procedure within 30 days of discharge from the Same Facility.

1. A few specific, limited types of care are always considered planned (obstetrical delivery, transplant surgery, maintenance chemotherapy/radiotherapy/immunotherapy, rehabilitation).
2. Admissions for acute illness or for complications of care are never planned.”

Same Hospital/Facility: A hospital is considered the “Same Hospital” for purposes of determination of readmissions, when the hospital shares the same Tax ID Number (TIN).

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed by us to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2025 Review. Policy Statement and Policy Guidelines revised.	B	11/13/2025
This is a new policy.	A	01/01/2024

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). *Medicare Claims Processing Manual*. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 07/08/19. Available at: <http://www.cms.gov/manuals/downloads/clm104c03.pdf>.
2. Centers for Medicare & Medicaid Services (CMS). *Medicare Learning Network*. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. February 2019. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html>