

RB.048.A Readmissions - Medicaid and CHIP

Original Implementation Date : 06/11/2026
Version [A] Date : 06/11/2026
Last Reviewed Date: 06/11/2026

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 applies to Jefferson Health Plans EverWell and Jefferson Health Plans CHIP lines 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 contracts.

POLICY STATEMENT

This Policy establishes the reimbursement methodology for inpatient hospital readmissions occurring within thirty (30) days of discharge for Jefferson Health Plans EverWell and Jefferson Health Plans CHIP lines of business. The policy ensures compliance with Pennsylvania Code, consistency across Medicaid-related lines of business, and clear operational direction for reimbursement.

POLICY GUIDELINES

Clinically Determined Readmissions

When a second admission is clinically determined to be a readmission:

- The plan will issue a single inpatient reimbursement
- Payment will be based on the higher of the two DRG reimbursement amounts

- Duplicate inpatient payment for both admissions is not permitted

This methodology applies regardless of whether the readmission reflects delayed treatment or a clinical complication.

Unrelated Admissions

When a second admission is determined to be clinically unrelated:

- The admission is treated as a new inpatient stay
- Separate DRG reimbursement is permitted for each admission

Where applicable, inpatient services may be evaluated on a combined basis for outlier eligibility in accordance with Pennsylvania Code and Jefferson Health Plans reimbursement rules.

Preventable and Inappropriate Readmissions

Readmissions may be considered inappropriate or preventable when associated with:

- Medically unnecessary services
- Premature discharge
- Inadequate discharge planning
- Failure to coordinate post-discharge follow-up care

Such determinations support reimbursement limitations permitted under this policy.

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.

CPT® is a registered trademark of the American Medical Association.

CPT Code	Description
N/A	

HCPCS Code	Description
N/A	

ICD-10 Codes	Description
N/A	

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the members' 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

N/A

DEFINITIONS

Readmission

A subsequent inpatient admission to any acute care hospital occurring within 30 calendar days of discharge from a prior inpatient stay.

Related Readmission

A readmission that is clinically related to the conditions treated during the initial admission, including complications or services that could or should have been provided during the prior stay.

Unrelated Readmission

A readmission for a condition that is clinically distinct and unrelated to the diagnosis, treatment, or complications of the prior admission.

Diagnosis Related Group (DRG)

The classification system used to determine hospital reimbursement for inpatient services.

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 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
New Policy	A	06/11/2026

REFERENCES

1. **55 Pa. Code § 1163.57. Payment policy for readmissions:**
<https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1163/s1163.57.html&d=reduce#:~:text=According%20to%20the%20Pennsylvania%20Code%2C%20the%20Department,readmission%20a%20new%20admission%20for%20payment%20purposes>
2. Medical Assistance (MA) Bulletin [d_005743.pdf](#).
3. Medical Assistance (MA) Bulletin [d_005317.pdf](#)