

RB.018.B MEDICARE READMISSIONS

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Version [B] Date : 10/21/2025
Last Reviewed Date: 10/21/2025

PRODUCT VARIATIONS

This policy only applies to Jefferson Health Plans **Medicare Advantage** product line.

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

Decisions on readmission coverage for our Medicare Advantage Programs are based on Centers for Medicaid and Medicare (CMS) regulations and guidelines.

POLICY STATEMENT

Our Medicare Advantage Plans do not reimburse 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 a related condition within 31 days from the first admission's discharge day and when the readmission was preventable.

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 31 calendar days from the date of the discharge from the same facility.⁶ *Please also 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 inpatient appropriate care when the frequency of the needed services is medically appropriate. *For example, chemotherapy administration is most appropriate as an inpatient and occurs every 3 weeks according to acceptable oncologic protocol.*⁶

POLICY GUIDELINES

Our Medical Director will determine if the request is appropriate for the inpatient level of care using our Medical Necessity policy, CMS inpatient guidelines and InterQual Acute Module, our policy, CMS to reflect the current standards of practice. If an alternative setting is more appropriate, the request will be denied as not medically necessary.

For payment purposes, the second admission will not be reimbursed when deemed a readmission.

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	n/a

HCPCS Code	Description
N/A	n/a

ICD-10 Codes	Description
N/A	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.

We are responsible, as a Medicare Advantage Organization (MAO), to monitor the quality of the care our members receive. This includes potentially avoidable readmissions. CMS holds MAO's

accountable for quality measures through the CMS Star Rating System. One of the more heavily weighted Star measures is preventable readmissions.

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: "Admissions to an acute, general, short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, short-term hospital (See §1154(a)(13) and 42 CFR 476.71(a)(8)(ii)). Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred."

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."^{1c}

Planned readmission: A planned readmission is "a non-acute admission for a scheduled procedure within 31 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."⁶

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).

DEFINITIONS

N/A

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
2025 Review. Policy statement revised. Policy guidelines revised.	B	10/21/2025
2022 Review. No changes. Reissue as written.	A	01/01/2021
2020 Review: Policy # changed from AD.001.C to RB.018. A. Additional language added for clarity purposes.	A	01/01/2021
2018 Review: Readmission calendar days changed from 15 days to 30 days. A defined Review Process was added. Changed payment condition from being unrelated to being unavoidable. AD.001.C	C	04/01/2018
Language added for clarity. AD.001.B	B	11/16/2017
New policy: AD.001.A	A	01/01/2014

REFERENCES

1. Quality Improvement Organization Manual, Chapter 4, Case Review

- a) Section 4240 - Readmission Review.
- b) Section 4250 – Transfer Review.
- c) Section 4255 - Circumvention of Prospective Payment System (PPS) Electronically available at:
[Medicare \(cms.gov\)](https://www.cms.gov/Medicare/cms.gov)

2. Social Security Act, Title 18

Electronically accessible at: http://www.ssa.gov/OP_Home/ssact/title18/1886.htm

3. Social Security Act, Title 11

Electronically available at: http://www.ssa.gov/OP_Home/ssact/title11/1154.htm

4. 42 CFR 476.71 QIO Review Requirements

Electronically accessible at: <https://www.law.cornell.edu/cfr/text/42/476.71>

5. State Operations Manual

Electronically accessible at: [State Operations Manual Appendix PP](#)

6. Pub 100-16, Medicare Managed Care Manual

Chapter 4, Benefits and Beneficiary Protections, Section, Section 30.3 – Examples of Eligible Supplemental Benefits. Electronically accessible at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>

- 7. Pub 100-16, Medicare Managed Care Manual, Chapter 5, Quality Assessment, Section 20.1.2 - Quality Improvement Project (QIP). Electronically accessible at:**
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf>