Effective 3/1/2026

Area Clinical Services - Medical Management

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Hospital Readmissions

PURPOSE:

The purpose of this policy is to address general medical coverage guidelines related to preventable hospital readmissions occurring within 30 days at participating in network short term acute care hospital that are reimbursed by a DRG methodology.

DEFINITIONS:

Anchor admission: The first inpatient admission and the related claim for services at an acute, general or short-term hospital and for which the date of discharge for such admission is used to determine whether a subsequent admission at that same hospital occurs within 30 days.

Preventable readmission: Medicare defines a potentially preventable readmission (PPR) as a hospital readmission that is clinically related to a prior admission and occurs within a specified time interval.

Standard of Care: The benchmark that determines whether professional obligations to patients have been met... It is the degree of care a prudent and reasonable person would exercise under the circumstances.[1]

Standard of Care: Is the minimum acceptable conduct or performance related to a given activity or relationship. [2]

Standards of Practice: Standards of practice in the context of Nursing and Health Professions refer to the established guidelines and expectations that ensure the delivery of high-quality care to patients. These standards provide a framework for health care professionals to base their practice and decision-making on, regardless of their experience level, and serve as teaching tools to support learning and promote patient safety.[3]

Standards of Practice may not rise to Standard of Care in those cases Standard of Care will be the prevailing standard.

POLICY:

Unless there is an overriding rule, regulation, or contract, The Health Plan will not reimburse a hospital readmission within 30 days for the same, similar, or related condition.

PROCEDURE:

The Health Plan Utilization Management Team will review the submitted documentation of the subsequent admission for the following:

- Primary reason for subsequent involves a same or closely related condition.
- Admission is medically necessary.
- Subsequent readmission resulted from premature discharge from the previous admission.
- There was a failure of proper/adequate discharge planning, including but not limited to obtaining appropriate home health or other outpatient post care.
- An issue resulting from previous admission, such as infection or adverse affect.
- Failure to address coexisting conditions, such as chronic disease within acceptable standards of practice and standards of care.
- Failure to provide timely/appropriate surgical intervention.
- Acceptable standards of practice and standards of care enforced during the previous admission.

Excluded from 30 day readmission review:

- Transfers from out-of-network to in network facilities.
- Transfers for care not available at the first acute care facility or unit. (If discharge status is "transfer, " the transferring facility/stay is not considered an anchor admission.)
- Readmissions to other facilities.
- Readmissions to another hospital from within the same hospital system.
- Planned readmissions for repetitive or staged treatments, such as chemotherapy or surgical procedures.
- Transplants and associated complications.
- Obstetrical readmissions (OB related conditions only).
- Members under 12 months old on the date of service.

- Readmissions associated with major or metastatic malignancies, opportunistic infections related in HIV, major trauma, or poisoning.
- Behavioral health conditions and Substance Use Disorder (SUD).
- Cases where the prior admission had a discharge status of "left against medical advice".
- Member left Against Medical Advice (AMA) or member non-compliance: Facilities will not be held accountable when noncompliance is clearly documented in the medical record including all of the following:
    - There is adequate documentation that the treatment plan was appropriately communicated to the member.
    - There is adequate documentation that the member/caretaker is mentally competent and capable of following instructions and made an informed decision not to follow them.
    - There were no financial or other barriers to following the instructions.
        - The Medical Records should document reasonable efforts by the facility to address placement and access-to-treatment difficulties due to financial constraints or social issues, including consultation with social services, use of community resources, and frank discussions of risks and alternatives.

POST PAYMENT AUDIT STATEMENT:

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by The Health Plan at any time pursuant to the terms of your provider agreement.

REFERENCES:

1.Vanderpool, Donna. " The Standard of Care." Innovations in clinical neuroscience vol.18, 7-9 (2021): 50-51. Last accessed 12/10/2025

2. Comodeca, James Schaefer, Jeffrey "Standard of Care v. Standard of Practice: An Important Distinction." CAPS MATTERS Autumn 1997. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/ https://bpb-us-e1.wpmucdn.com/sites.psu.edu/dist/8/12504/files/2014/05/Standard-of-Care-Standard-of-Practice.pdf. Last accessed 09/10/2024.

3. Jeanette Ives Erickson, Marianne Ditomassi. " Professional Practice Model: Strategies for Translating Models into Practice".
Nursing clinics of north america." vol. 46, 1(2011): 35-44. (https://www.sciencedirect.com/science/article/pii/S0029646510001040). Last accessed 12/10/2025

Centers for Medicare and Medicaid Services(CMS). Inpatient Hospital Billing. "Repeat Admissions" Medicare Claims Processing Manual, Chapter 3, Section 40.2.5, page 114. (Rev. 13364; Issued: 08-14-25) https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf. Last accessed 12/10/2025

Goldfield, Norbert I etal. "Identifying potentially preventable readmissions," Health care financing review vol. 30,1 (2008): 75-91. Last accessed 09/16/2024.

DISCLAIMER

This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy is intended to address medical necessity guidelines that are suitable for most individuals. Each individual's unique clinical situation may warrant individual consideration based on medical records. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and The Health Plan's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Unless otherwise noted within the policy, The Health Plan's policies apply to both participating and non-participating providers and facilities. The Health Plan reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by The Health Plan. The Health Plan has full and final discretionary authority for its interpretation and application. Accordingly, The Health Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.