Reimbursement Policy

Inpatient Hospital Readmissions

REIMBURSEMENT POLICY NUMBER: 54

Effective Date: 2/1/2026

Last Review Date: 1/2026

Next Annual Review: 1/2027

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

☐ Professional Claims

☐ DMEPOS Suppliers

☐ All health care services billed on CMS 1500 forms

☐ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☒ Facilities

Plan Product:

☒ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

☒ All health care services billed on UB04 forms (CMS 1450)
Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

☒ DRG

☒ Modified DRG

☒ Percentage of billed charges/per diem (applies only to criterion II.)

POLICY STATEMENT

NOTE: This policy does not apply to the following:

- Readmissions for a condition *unrelated* to the initial admission. Expected repetitive inpatient treatment, such as: cancer chemotherapy, transfusions for chronic anemia, or dialysis.
- Readmissions for pre-delivery obstetric care.
- Transfer from one inpatient hospital to another.
- Long-term acute care (LTAC) facilities, skilled nursing facilities (SNF), or inpatient rehabilitation stays.
- Patient non-compliance (see criterion III. below) or patient discharge against medical advice (AMA).

I. Inpatient hospital readmissions are considered a continuation of initial treatment and **combined into a single DRG payment** when **all** of the following (A.-C.) criteria are met:

A. The readmission occurs less than 31 calendar days***** from the date of the previous inpatient discharge (neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred); **and**
B. The admissions occurred at the *same,* acute, general, short-term hospital or *another* acute, general, short-term hospital that has the same Tax ID number, is under common ownership as the initial facility, and operates under the same facility contract; **and**
C. Clinical review determines the readmission is for a same, similar, or related condition treated during the previous admission (except for complications arising from a previous admission; see Criterion III below).

*****Readmissions beyond 31 calendar days may still be subject to review.

II. Inpatient hospital readmissions will also be **combined into a single DRG payment** when **either** of the following (A. or B.) criteria are met:

A. Readmission is planned or due to a leave of absence in which the member does not require a hospital level of care (see Policy Guidelines for examples of when a leave of absence may be necessary); **or**
B. Readmission is on the same calendar day as the date of discharge.

Notes:

- Criteria I and II. do not apply to facilities reimbursed at a percent of billed charges or per diem payment methodology.
- The final combined payment will be based on the DRG with the highest relative weight.

III. Inpatient hospital readmissions are **not reimbursable** when the readmission is related to or the result of **any** of the following (A.-C.):

A. The readmission was not medically necessary; **or**
B. A procedural infection or complication related to the initial inpatient admission; **or**
C. Indications of a failed procedural intervention.

Patient Non-Compliance

IV. Inpatient hospital readmission review is not applicable in instances of patient non-compliance when **all** of the following (A.-D.) criteria are clearly documented in the medical record:

A. Discharge instructions were adequately reviewed and discussed with the patient and/or patient representative; **and**
B. The patient and/or patient representative was competent and capable of following the discharge instructions; **and**
C. The patient and/or patient representative made an informed decision not to follow the discharge instructions; **and**
D. There were no barriers to complying with the discharge instructions or if there are barriers, the medical records document efforts by the facility to alleviate these barriers (e.g., social services, community resources, etc.).

POLICY GUIDELINES

DEFINITIONS

Unplanned Readmission

The following definition was obtained from the Centers for Medicare & Medicaid (CMS) Quality Improvement Organization Manual, Chapter 4—Case Review, §4240 – Readmission Review:

> "Readmission review involves 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. Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred."[1]

Planned Readmission/Leave of Absence

The following definition was obtained from the Centers for Medicare & Medicaid (CMS) Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.5—Repeat Admissions:

> "A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence. Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period."[2]

Examples of a planned readmission/leave of absence, include, but are not limited to:

- Situations where surgery could not be scheduled immediately; **or**
- A specific surgical team was not available; **or**
- Bilateral surgery was planned; **or**
- Further treatment is indicated following diagnostic tests but cannot begin immediately; **or**
- Readmission for surgical intervention is planned if non-operative therapy fails.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 12/8/2025, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses inpatient hospital readmissions:

- Quality Improvement Organization Manual, Chapter 4—Case Review, §4240 – Readmission Review[1]
- Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.5—Repeat Admissions[2]
- Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.6—Leave of Absence[3]
- Centers for Medicare & Medicaid Services (CMS). Hospital Readmission Reduction Program (HRRP)[4]
- Social Security Administration (SSA). Payment to Hospitals for Inpatient Hospital Services, Title 18, § 1886[5]
- Noridian web page for Inpatient Hospital Billing Guide[6]
- Noridian web page for Counting Inpatient Days[8]

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding inpatient hospital readmissions.

BILLING AND CODING GUIDELINES

UNPLANNED READMISSIONS

Unplanned Readmission Related to the Medical Condition of the Prior Stay

According to Medicare Claims Processing Manual, Ch. 3, 40.2.5 - Repeat Admissions:

> "When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim."

Therefore, when a member discharges and readmits on the same day for a **related** condition, hospitals should combine the original stay and subsequent stay onto a single claim for submission.

For the purposes of this policy, the Plan defines "same day" as same calendar day. This is based on the above Medicare Manual, and the Noridian website:

> "When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall place condition code (CC) B4 on the claim that **contains an admission date equal to the prior admissions discharge date**."[2]

And-

> "A day begins at midnight and ends at 11:59 p.m." *(Noridian website[8])*

Unplanned Readmission Unrelated to the Medical Condition of the Prior Stay

From the same Medicare manual, CMS states:

> "When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall place condition code (CC) B4 on the claim that contains an admission date equal to the prior admissions discharge date."

Thus, when a member discharges and readmits on the same day for an **unrelated** condition, hospitals are able to submit separate claims, but should bill them in a manner to indicate they are **not** related. Condition Code (CC) B4 is defined as "Admission unrelated to discharge on same day."

In summary, if the original discharge and return readmission are for a related diagnosis, then they should be billed on one continuous claim. If a return readmission is for an unrelated diagnosis, then both claims can be billed separately, using B4 condition code on second claim.

If the combined DRG exceeds the total amount of the two separate inpatient stays, then they will not be combined.

PLANNED READMISSIONS

When the patient is ultimately discharged from the subsequent admission, the facility should submit one bill for covered days and days of leave. Facilities must follow correct billing and coding rules and indicate inpatient stay days versus leave of absence days. The claim should include both covered days of services rendered and the days of leave, with the latter billed as noncovered days.

If claims are submitted separately and a planned readmission is identified, the initial and subsequent admissions will be combined into a single DRG payment.

CROSS REFERENCES

- Transfers Between Hospitals, RP75
- Preventable Adverse Events, RP73

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). Quality Improvement Organization Manual, Chapter 4—Case Review, §4240 – Readmission Review. Published 2014. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf. Accessed 12/8/2025.
2. CMS. Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.5—Repeat Admissions. Published 2003. Updated 2012. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf. Accessed 12/8/2025.
3. CMS. Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.2.6—Leave of Absence. Published 2003. Updated 2012. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf. Accessed 12/8/2025.
4. CMS. Hospital Readmission Reduction Program (HRRP). Last Updated: 8/11/2025. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program. Accessed 12/8/2025.
5. Social Security Administration (SSA). Payment to Hospitals for Inpatient Hospital Services, Title 18, § 1886. https://www.ssa.gov/OP_Home/ssact/title18/1886.htm. Accessed 12/8/2025.
6. Noridian web page for Inpatient Hospital Billing Guide. Updated 9/24/2024. https://med.noridianmedicare.com/web/jea/provider-types/acute-ipps-hospital/inpatient-hospital-billing-guide. Accessed 12/8/2025.
7. UpToDate. Hospital Discharge and Readmission. Updated May 2025. https://www.uptodate.com/contents/hospital-discharge-and-readmission. Accessed 12/8/2025.
8. Noridian Healtcare solutions, Inc. Counting Inpatient Days. Updated 6/2025. https://med.noridianmedicare.com/web/jea/topics/claim-submission/counting-inpatient-days. Accessed 12/8/2025.
9. CMS. 2015 Measure Information About The 30-Day All-Cause Hospital Readmission Measure, Calculated For The Value-Based Payment Modifier Program. Updated March 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf. Accessed 12/8/2025.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
5/2023	Annual Review. No change.
11/2023	Updated reimbursement methodology for unplanned readmissions.
4/2024	Annual review. Update formatting and language.
4/2025	Annual review.
7/2025	Updated criteria for unplanned readmissions.
2/2026	Annual review.