Readmission Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities that are paid based on Diagnosis Related Grouping (DRG) payment methodology.

Policy

Overview

Consistent with the Centers for Medicare and Medicaid Services (CMS), UnitedHealthcare Community Plan recognizes that the frequency of Readmission to an acute care hospital shortly after discharge is an indicator for quality of care, and thus has implemented a process for reviewing such Readmissions.

UnitedHealthcare Community Plan will review all Readmissions to an acute care hospital within 30 days of discharge (or as otherwise stated by State and/or provider contract) pursuant to this policy through the process outlined below. The following states will be reviewed through this process:

Arizona
Hawaii
Kansas
New York
North Carolina
Ohio
Rhode Island
Tennessee
Virginia (termed 7/1/2020)
Washington DC
Wisconsin

The following states are subject to state-specific review processes and are therefore not subject to the review process in this policy: California, Florida, Hawaii, Michigan, Mississippi, Nebraska, New Jersey, Pennsylvania, Texas and Washington.

To link to the applicable state specific process for each state, click here.

Note: The following states are excluded from this policy: Maryland, Massachusetts, Missouri.

Reimbursement Guidelines

Clinical Medical Record Review, Applicable to the following states:

State	Effective date (based on the received date of the readmission claim)	Applicable Preventable Readmission Time Span (based on state law and/or contractual requirements)	Applicable Same Day and Planned Readmission Time Span
Arizona (see Q&A #1)	12/9/2018	72 Hours	Excluded
Hawaii	7/01/2022	30 Days	30 Days
Kansas	3/1/2019	15 Days	15 Days
New York	2/23/2011	14 Days Per NYS DFS Readmission Rules and Regulations	14 Days Per NYS DFS Readmission Rules and Regulations
North Carolina	6/1/2024	72 hours	72 hours
Ohio	2/1/2019	30 Days	30 Days
Pennsylvania	10/1/2024	30 Days	Excluded
Rhode Island	02/01/2025	30 Days	30 Days
Tennessee	3/1/2019	30 Days	30 Days
Virginia *	3/1/2019 - 7/1/2020* *See additional information below	5 Days *See additional information below	5 Days
Washington DC	08/01/2022	30 days	30days
Wisconsin	3/1/2019	30 Days	30 Days

UnitedHealthcare Community Plan reviews claims that fall into any one of the following three categories:

- Same-day Readmission for a related condition
- Planned Readmission
- Unplanned Readmission less than 31 days after the prior discharge (or as otherwise stated by State law or contract and/or provider contract)

Same-Day Readmissions: Same or Related Condition

UnitedHealthcare Community Plan will review claims for same-day Readmissions and request Medical Records to determine if the claim was properly billed. If a patient was readmitted during the same day for the same or a related condition, UnitedHealthcare Community Plan will deny both the initial and subsequent admissions for payment as separate DRGs. The facility must resubmit both admissions combined on a single claim to receive reimbursement.

Planned Readmission / Leave of Absence

When a patient is readmitted in less than 31 days to a facility as part of a planned Readmission, the admissions are not considered two separate admissions. The Medical Records from the initial admission should indicate that additional work-up, treatment or surgical procedures are planned or expected for the same episode of illness, including bilateral procedures. When a Readmission or procedure is expected (even if the date of Readmission is different from that initially planned), the Readmission will be treated as one claim and one episode of care combined DRG payment. Readmissions for surgical interventions that are expected or planned when conservative and/or non-operative therapy have failed also qualify for the combined DRG review. When the patient is ultimately discharged from the subsequent admission, the facility should submit one bill for covered days and days of leave. If a planned readmission or Leave of Absence is identified, UnitedHealthcare Community Plan may combine the initial and subsequent admissions into a single claim resulting in a combined DRG payment.

UnitedHealthcare Community Plan does not apply Planned Readmission guidelines to cancer chemotherapy, transfusions for chronic anemia, dialysis or similar repetitive treatments. However, surgery that is delayed while outpatient work-up is completed does fall under the leave of absence billing guidelines.

30-Day Readmission Review: Determination of Preventable Readmissions

UnitedHealthcare Community Plan reviews acute care hospital admissions occurring fewer than 31 days (or as otherwise stated by State law or contract and/or provider contract) following a prior discharge to the same facility. UnitedHealthcare Community Plan will review the initial claims and determine whether the subsequent admission meets the following criteria:

- The subsequent admission occurred fewer than 31 days (or as otherwise stated by State and/or provider contract) after the initial discharge.
- The subsequent admission was for a diagnosis related to the initial admission.
- The subsequent admission was to the same facility.

If the criteria are met, UnitedHealthcare Community Plan will request Medical Records and supporting documentation relating to the initial admission, including the initial discharge and subsequent admission.

To determine whether a patient's readmission was preventable, multiple factors are taken into consideration, including, but not limited to: premature discharge due to clinical instability, inadequate medication management and discharge planning. Please note that a readmission may be medically necessary, but nonetheless preventable and would still be subject to the clinical preventable readmission review.

- Inadequate Outpatient Follow-Up or Treatment: Discharge planning must take into account the availability and criticality of outpatient follow-up visits and treatment. Communication with practitioners who will provide follow-up care is expected.

- Failure to Address Rehabilitation Needs: Significant decline in function and inability to perform Activities of Daily Living (ADL) is common following hospitalization of the elderly. Failure to properly address rehabilitation needs related to an inability to self-care is an avoidable cause of Readmission.
- Failed Discharge to Another Facility: Failed transfers to a Skilled Nursing Facility (SNF), Long Term Care Hospital (LTCH), Acute Inpatient Rehabilitation (AIR) or a similar facility can be an indicator of premature discharge. Discharges with expected Readmissions are treated as leaves of absence with combined DRG reimbursement. Errors made at the receiving facility unrelated to the orders it received upon transfer (e.g., falls, treatment delivery failure) will not result in a payment denial for the Readmission.

Additional factors to be considered in making a decision about whether subsequent admission was preventable include:

- Emerging Symptoms: Symptoms that had onset or were present during a previous admission and subsequently worsened, leading to Readmission, are a possible indicator of a premature discharge. Discharge prior to establishing the safety or efficacy of a new treatment regimen is also considered a premature discharge.
- Chronic Disease: Chronic diseases vary in severity, and entry into the terminal phase of an illness can be gradual. When reviewing Readmissions related to chronic disease, Readmission within a short period of time should be assessed for adequacy of follow-up care and outpatient management using accepted practice guidelines and treatment protocols.
- Patient Non-Compliance: Facilities will not be held accountable for patient noncompliance if all of the following conditions are met:
    - There is adequate documentation that physician orders have been appropriately communicated to the patient.
    - There is adequate documentation that the patient/caretaker is mentally competent and capable of following the instructions, and made an informed decision not to follow them.
    - There were no financial or other barriers to following 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.
    - The noncompliance is clearly documented in the medical record. For example, documentation for a discharge to the home when the discharge is felt to be unsafe should include signature by the patient/caregiver as leaving Against Medical Advice (AMA). An unsafe discharge is not mitigated by a comment stating, “patient preference.”

If the Readmission stay is determined to have been preventable, (regardless of whether the admission, at the time it occurred, was medically necessary), UnitedHealthcare Community Plan will deny payment for the Readmission claim.

State Exceptions: States exempt from Policy, with other specific Readmission processes

State	Applicable Readmission Time Span (based on state law and/or contractual requirements)	Process	Exceptions
California	30 days	Effective 11/1/2018 When a patient is discharged from an acute care hospital and is readmitted as an inpatient to a facility in the same hospital system within the applicable time frame for the same DRG, the Readmission claim will deny. An adjusted claim for the first admission will need to be submitted to	• Planned Readmissions • Admissions for cancer or chemotherapy treatment as the principal condition • Admissions for Obstetric diagnoses as the principal condition

		include the additional services from the Readmission stay.	
Florida	30 days	Effective 10/1/2018 When a patient is discharged from an acute care hospital and is readmitted as an inpatient to a facility in the same hospital system within the applicable time frame for the same DRG, the Readmission claim will deny.	• Planned Readmissions • Admissions for cancer or chemotherapy treatment as the principal condition
Hawaii	30 Days	Effective 07/01/2022: Hawaii utilizes an outside vendor for Readmission reviews on a post-payment basis.	
Indiana	30 Days	When a patient is discharged from an acute care hospital, Psychiatric or Inpatient Addiction Treatment Facility and is readmitted as an inpatient to a facility in the same hospital system within the applicable time frame for the same or alike diagnosis code/codes.	
Kentucky	14 Days	Effective 01/01/2022: In accordance with 907 KAR 10:830 Claims for a member who is discharged from a facility and readmitted for a same primary diagnosis (first 3 digits) to the same facility within 14 days will be denied. An adjusted claim for the first admission will need to be submitted to include the additional services from the Readmission stay. Clinical review is not performed.	• Planned Readmissions. • Admissions for cancer or chemotherapy • Transfers • Claims for members who leave AMA (Against Medical Advice) • Obstetrical Readmissions • Transplant claims
Louisiana	Louisiana is exempt from this policy.		
Michigan	15 days	According to MI State Regulations and the MDHHS Medicaid Provider Manual located in the Hospital Reimbursement Appendix. Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single episode for payment purposes. If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode. Readmissions for an	

		unrelated condition, whether to the same or a different hospital, are considered separate episodes for payment purposes.	
Mississippi	30 days	Effective 10/8/2018 Mississippi utilizes an outside vendor for Readmission reviews on a post-payment basis.	
Nebraska	30 days	Effective 10/2/2018 Nebraska utilizes an outside vendor for Readmission reviews on a post-payment basis.	
New Jersey	7 days The Readmission time frame may vary by contract, participation status and state; New York hospitals within 30 days and Pennsylvania hospitals within 31 days.	Effective 1/1/2018 When a patient is readmitted to the same hospital within the applicable time frame for the same or similar diagnosis, the Readmission claim will deny. An adjusted claim for the first admission will need to be submitted to include the additional services from the Readmission stay. Effective 3/5/21 7 day readmission timeframe will apply to OON NJ providers.	• Planned Readmissions • Admissions for cancer or chemotherapy treatment as the principal condition
North Carolina	72 Hours	If a beneficiary is readmitted within 72 hours of being discharged as an acute hospital inpatient and the readmission is for the same or related conditions as the original admission, the claim is subject to review by DHHS or its designee for medical necessity and quality of care. When indicated, provider recoupments are made.	
Ohio	15 days	As defined in OAC 5160-2-02, 5160-2-65, and 5160-2-07.13: For claims with an admission date prior to 2/1/2019, All inpatient facility claims submitted for a UnitedHealthcare Community Plan member, which would qualify as a Readmission within 30 days of a discharge(or as otherwise stated by State and/or provider contract)from an acute care hospital (the same OR different facility) will be subject for review in one of two ways: • If submitted with medical records the claim will pend for Medical Claims Review (MCR); or	

		• If not submitted with medical records, the claim will deny indicating that records are required. Submitted medical records must include all documentation from EACH related inpatient stay, even if at different, unrelated facilities. Upon medical records review, if both admissions are deemed to be related, the claims will be bundled into one episode of care, and one DRG applied. Effective for claims with an admission date on or after 2/1/2019, claims are subject to the full Clinical Review process as indicated in the policy.	
Pennsylvania	30 days	Effective 10/1/2024: In accordance with PA State Code 55 § 1163.57, effective for claims with an admission date on or after 10/1/2024, claims are subject to the full Clinical Review process as indicated in the policy. If all the above criteria are met, UnitedHealthcare will request medical records and supporting documentation relating to the initial and subsequent admission. If a recipient is readmitted to a hospital within 30 days of discharge, no additional reimbursement is made in addition to the original hospital's DRG payment. If the combined hospital stay qualifies as an outlier, an outlier payment will be made. If a patient is readmitted to the hospital due to complications of the original diagnosis and this results in a different DRG with a higher payment rate, the higher DRG payment rate is reimbursed rather than the original DRG rate.	• Planned admissions, including those for staged or serial treatments, i.e. chemotherapy • Claims for members who leave Against Medical Advice (AMA) • Transfers to a different facility or outside the TIN group • Transplant claims • Admissions to Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long Term Acute Care facilities, (SNF, IRF, and LTAC)
Texas	24 hours	Clinical review is not performed. Claims are evaluated for provider	

		contract, diagnosis, and facility applicability.	
*Virginia	30 days	Effective 7/1/2020: Clinical review is not performed. Claims for a member who is discharged from a facility and readmitted for a same or similar diagnosis to the same facility within 5 days will be denied. An adjusted claim for the first admission will need to be submitted to include the additional services from the Readmission stay. Claims for a member who is discharged from a facility and readmitted for a same or similar diagnosis to the same facility within 6-30 days are subject to a reimbursement reduction of 50%.	• 0-5 days Readmissions as indicated above, prior to 7/1/2020 • Planned Readmissions. • Transfers • Claims for members who leave AMA (Against Medical Advice) • Obstetrical Readmissions • Critical Access Hospitals (CAH) Transplant claims
Washington	14 days	Effective 1/1/2018 The Readmission process follows the Clinical Review process for Preventable Readmissions, but is performed on a post-payment basis.	
Wisconsin	31 days	For claims with an admission date prior to 3/1/2019, The Readmission process follows the Clinical Review process, but is performed on a post-payment basis. Effective for claims with an admission date on or after 3/1/2019, claims are subject to the full Clinical Review process as indicated in the policy.	

Definitions	
Leave of Absence	A leave of absence for the purposes of this policy is a situation where readmission is expected, and the patient does not require a hospital level of care during the interim period.

Medical Records	Major documentation components of the Medical Record from both stays, particularly those relevant to the quality of care concern, including, but not limited to the following: • Face sheet • Admission history and physical • Physicians' orders • Emergency room records • Operative notes • Progress notes • Nursing notes • Diagnostic and laboratory testing • Discharge summaries • Discharge medication list • Intake and output flowsheets • Vital signs flow sheets • Physical/Occupational/Speech Therapy notes • Social work/discharge planning notes • Medication Adjudication Record (MAR)
Readmission	A return hospitalization to an acute care hospital that follows a prior acute admission within a specified time period, which is clinically related to that prior admission.

Questions and Answers

1	**Q:** What criteria prompts a medical review for Arizona? **A:** A recipient may be readmitted to a hospital after receiving a service or treatment. For claims paid via the DRG methodology, UnitedHealthcare Community Plan will identify certain readmission cases and conduct a medical review prior to finalizing payment associated with the readmission. The following criteria will prompt a medical review: **1.** Recipient must be readmitted to the same hospital within 72 hours, AND **2.** The base DRG assignment on the readmission claim must match the base DRG assignment on the initial claim (the base DRG assignment is identified by the first three digests of the DRG code); AND **3.** In the event that the claim has been prior authorized, the readmission claim may be considered to have already gone through medical review. If the claim associated with the readmission meets the criteria above, the claim will be pended for medical review. The payment associated with the readmission claim will be held until the completion of the medical review process. Upon the medical review, if the readmission is determined to have been preventable by the hospital, the payment associated with the readmission claim will be disallowed. Alternatively, if upon the medical review it is determined the hospital would not have been able to prevent the readmission the claim will be paid under DRG methodology.

Resources

Individual state Medicaid regulations, manuals & fee schedules

Quality Improvement Organization Manual; Chapter 4 Case Review

CMS Medicare Claims Process Manual; Chapter 3 - Inpatient Hospital Billing

Social Security Act, §1886(d)

History	
2/1/2025	Policy Version Change State Exceptions Section: Rhode Island Updated
12/12/2024	Policy Version Change State Exceptions Section: Indiana Updated
12/08/2024	Policy Version Change Policy Section: North Carolina Updated State Exceptions Section: North Carolina Updated
12/03/2024	Policy Version Change Overview section: Washington DC added Updated Reimbursement guidelines
11/19/2024	Policy Version Change State Exceptions Section: Pennsylvania Updated
10/27/2024	Policy Version Change State Exceptions Section: Michigan Updated
7/14/2024	Policy Version Change Policy Section: North Carolina Updated State Exceptions Section: North Carolina Updated
6/9/2024	Policy Version Change Policy Section: New York Updated History Section: Entries prior to 6/9/2022 archived
12/29/2023	Policy Version Change State Exceptions Sections: Indiana Updated
11/1/2023	Policy Version Change State Exceptions Sections: Ohio Updated
7/23/2023	Policy Version Change State Exceptions Sections: New Jersey Updated
7/7/2023	Policy Version Change State Exceptions Sections: Removed New York Updated Resources section
4/30/2023	Policy Version Change State Exceptions Section: Updated verbiage for New Jersey Header: Updated Branding
11/14/2011	Policy implemented by UnitedHealthcare Community & State