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Reimbursement Policy
Inpatient Readmissions

Policy Number: **G-13001**
Policy Section: **Facilities**
Last Approval Date: **3/25/2025**
Effective Date: **3/25/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://www.anthem.com/va/provider**.

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The health plan does not allow separate reimbursement for claims that have been identified as an unplanned readmission to the same hospital for the same, similar, or related condition unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

The health plan will use the following standards:

- Unplanned readmission up to 30 days from discharge
- Same or similar principal diagnosis (similar diagnosis is defined as diagnosis codes possessing the same first three digits)

Clinical coding criteria and/or licensed clinical medical review will be used to determine if the subsequent admission is for:

- The same or closely related condition or procedure as the prior discharge.
- An infection or other complication of care.
- A condition or procedure indicative of a failed surgical intervention.
- An acute decompensation of a coexisting chronic disease.
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period.
- An issue caused by a premature discharge from the same facility.

The health plan reserves the right to deny the claim or to recoup and/or recover monies previously paid on a claim that falls within the guidelines of this policy.

Note: Readmissions occurring on the same day (same date of service) for the same, similar, or related condition of the prior stay's medical condition are considered to be a continuation of initial treatment and part of the original admission. Providers should submit both admissions on a single claim.

Exclusions:

- Admissions for the medical treatment of:
  - Cancer
  - Neonatal/newborn
  - Obstetrical deliveries
  - Behavioral health
  - Rehabilitation care
  - Sickle cell anemia
  - Transplants
- Critical access hospitals
- Transfers from one acute care hospital to another
- Member discharged from the hospital against medical advice
- Planned readmission/leave of absence

Leave of Absence

When a member is readmitted within 30 days as part of a planned readmission and/or placed on a leave of absence, the admissions are considered to be one admission, and only one DRG will be reimbursed.

Providers are to submit one bill for covered days and days of leave when the patient is ultimately discharged.

This policy applies to those facilities reimbursed for inpatient services by a DRG methodology.

Related Coding

Standard correct coding applies

Policy History

- 03/25/2025 — Review approved and effective: updated policy language for clarification purposes; clarified planned versus unplanned readmissions; reorganized exclusions to provide clarity
- 09/24/2021 — Review approved 9/24/2021 and effective 07/01/2022: planned readmission/LOA language added); definition section updated to include LOA and planned readmission; related policy section updated
- 11/16/2018 — Update due to regulatory directive: Critical access hospitals language added
- 06/01/2018 — Review approved: policy template updated
- 08/01/2016 — Review approved: policy template updated
- 04/01/2016 — Initial approval 08/04/2015 and effective 04/01/2016

References and Research Materials

This policy has been developed through consideration of the following:

- American Hospital Association
- CMS
- State contract
- State Medicaid

Definitions

- **Leave of Absence:** an interim period when readmission is expected, and the patient does not require a hospital level of care
- **Planned Readmission:** acute readmission for a scheduled procedure
- **Same Hospital System:** two or more hospitals owned, leased, sponsored, or contract managed by a central organization
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Diagnoses Used in DRG Computation
- Documentation Standards for Episodes of Care
- Preventable Adverse Events