

Readmissions

Reimbursement Policy ID: RPC.0003.2400

Recent review date: 05/2025

Next review date: 05/2026

Select Health of South Carolina reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Select Health of South Carolina may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

Select Health of South Carolina will align with the South Carolina Health and Human Services guidelines to evaluate hospital readmissions within 30 days.

Exceptions

Never events are not reimbursable. See Health Care-Acquired Conditions policy RPC.0044.2400

Reimbursement Guidelines

Readmission Reviews

Select Health of South Carolina will evaluate inpatient claims with admission dates that are within 30 days following a discharge from the same or any other facility, to determine whether the subsequent admission was related to the initial admission.

A readmission occurs when a patient is admitted to the same or any other facility within 30 days of discharge for the same DRG or general diagnosis as the original admission. With limited exceptions, hospital readmissions occurring within 30 days of a prior discharge (or as otherwise stated by state law, regulation, contract, and/or provider contract) to the same facility or hospital system for the same or similar diagnosis or procedure are not payable.

Hospital readmissions within 30 days of discharge from an acute-care facility, that are due to complications, preventable clinically related conditions, or other circumstances that are related to the earlier admission will result in no additional payment.

*Preventable Clinically Related Admissions

Readmissions that are preventable and clinically related to the first admission include but not limited to:

- If the readmission is due to premature, inadequate, or incomplete discharge planning.
- If the readmission is due to inadequate coordination of care between facility, providers, and caregivers.
- If the readmission was the result of an acute complication related to care from the initial admission

The following readmissions are excluded from 30-day readmission review:

- The original discharge was initiated by the patient and was against medical advice (AMA) and the circumstances of that discharge are documented in the patients' medical record including the discharge status.
- Any planned or staged readmission including staged surgical procedures or treatments including chemotherapy.
- Transfers from an out-of-network facility to an in-network facility
- Transfers of patients to receive care not available at the first facility.
- Transplants
- Sickle-cell anemia
- Obstetrical readmissions
- Neonatal/Newborns
- Readmissions that occur greater than 30 days from the discharge date of the initial admission
- Readmission for members under 12 months old at the time of readmission
- Readmissions when a patient has any condition related to cancer, transplants, and major trauma.

Segmented Care/Leave of Absence

A Hospital may place a patient on a leave of absence (LOA) when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples include but are not limited to:

- situations where surgery could not be scheduled immediately,
- a specific surgical team was not available,
- bilateral surgery was planned,
- when further treatment is indicated following diagnostic tests but cannot begin immediately.

The Hospital stay must be billed as one admission and charges for the LOA days must be shown as non-covered.

Select Health of South Carolina will request medical records for both admissions for review to determine if the initial and subsequent admissions are related. While a readmission may be medically necessary, it may still be preventable and subject to review. Medical records should at a minimum include:

- Admission History and Physical
- Physicians' orders
- Progress notes
- Emergency room records
- Operative records
- Testing (laboratory and diagnostic)
- Discharge summary/summaries
- Discharge medications
- Medication Adjudication records

Post Payment Review:

- Select Health of South Carolina will review retrospectively, post-payment, through a medical record review to determine if the readmission is related to the previous admission.
 - Pertinent medical records for both admissions must be included with the claim submission to determine if the admission(s) is appropriate or is considered a readmission.
 - If the readmission is within 30 days, Select Health of South Carolina will determine, through a clinical review, if the readmission was related to the first admission.
 - If it is determined that the readmission within 30 days is unrelated to the earlier admission, the claims will be treated as two separate admissions.
 - If it is determined that the readmission within 30 days is related to the first, then the two inpatient stays will be combined into one claim and any overpayment will be recouped.
 - The hospital will be instructed to submit a new claim with both inpatient stays and will be reimbursed as one diagnosis-related group (DRG) payment. Any payment made for the separate admissions will be recouped.

Appeals Process

- All acute care facilities and inpatient hospitals have the right to appeal any readmission denial and request a peer-to-peer review or formal appeal.

Definitions

Readmission

Readmissions happening within 30 days of discharge from the initial admission. Includes patients who are readmitted to the same hospital, or another applicable acute care hospital for any reason.

Health Care-Acquired Conditions (HCACs)

HCACs are conditions that occur in an inpatient setting and that are high cost or high volume or both, may result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and could reasonably have been prevented through the application of evidence-based guidelines.

Never Event

Never events are serious and costly errors in the provision of health care services that should never happen. Never events which include surgeries performed on the wrong body part or transfusion of mismatched blood—cause serious injury or death to beneficiaries, and result in increased costs to the Medicare/Medicaid programs to treat the consequences of the error.

Provider Preventable Conditions (PPC)

PPCs are conditions that meet the definition of a Health Care-Acquired Condition (HCAC), a Never Event, or an Other Provider-Preventable Condition. Health Care-Acquired Conditions (HCACs), occur in inpatient hospital settings, and Other Provider-Preventable Conditions (OPPCs) may occur in either an inpatient or outpatient health care setting.

Edit Sources

- I. State Medicaid manuals, fee schedules and guidelines.
- II. <https://provider.scdhhs.gov/internet/pdf/manuals/Hospital/Manual.pdf>
- III. [https://www.federalregister.gov/documents/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-theCenters for Medicare and Medicaid Services \(CMS\)](https://www.federalregister.gov/documents/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-theCenters for Medicare and Medicaid Services (CMS)).

Attachments

N/A

Associated Policies

RPC.0044.2400 Healthcare Acquired Conditions

Policy History

06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
02/2025	Annual review No major changes
05/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by Select Health of South Carolina from Policy History section
01/2023	Template Revised - Preamble revised - Removal of Applicable Claim Types table - Coding section renamed to Reimbursement Guidelines - Added Associated Policies section