blue california
Promise Health Plan

Policy Title: Inpatient Readmissions			Policy #: PI0060 Line of Business: Medi-Cal
Department Name: Claims Processing	Original Date: 10/1/2024	Effective Date: 1/1/2025	Revision Date: 5/23/2025
VP Approval: Taylor Ballou DocuSigned by: Taylor Ballou 05E809637FC9446...			Date of Approval: 7/25/2025
CMO Approval: Jennifer Nuovo, MD			Date of Committee: 5/23/2025

A. PURPOSE

This policy aims to ensure accurate provider reimbursement and functions as a general guide for Blue Shield Promise's reimbursement practices concerning the services outlined herein. It does not cover every detail of reimbursement scenarios, nor does it influence clinical decision-making. This policy was crafted based on widely accepted industry standards and coding practices. Coverage may be subject to legal requirements set by state or federal authorities, including the Centers for Medicare and Medicaid Services (CMS). All references were accurate as of the policy's approval date.

B. DEFINITIONS

I. Readmission is generally defined as a second inpatient admission to a hospital within a set, pre-determined time frame of a discharge (30 days) from the same or affiliated hospital.

II. Anchor Admission is the initial inpatient stay that precedes a readmission

III. Potentially Preventable Readmission (PPR) is a readmission that occurs as a result of factors such as premature or inadequate discharge, problems with transition or coordination of care from the anchor admission, acute medical complications likely linked to the care received during the anchor stay, or inappropriate transfer to a lower level of care (e.g., skilled nursing facility, long-term acute care hospital, acute inpatient rehabilitation, inpatient substance abuse treatment, home health care, etc.).

C. POLICY

I. Blue Shield Promise does not allow separate reimbursement for claims that have

been identified as a readmission to the same hospital within 30 days of discharge for the same, similar, or related condition unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

II. Blue Shield Promise views unplanned, non-separately reimbursable readmissions as part of a single episode of care, for which only one reimbursement payment is issued. Both the initial admission (anchor admission) and a subsequent admission (readmission) are considered fully covered by the payment made for the anchor admission. Blue Shield Promise will review claims for denial if a suspected readmission has occurred and a separate reimbursement payment is billed, as the payment for the anchor admission is considered comprehensive.

D. PROCEDURE

I. While a readmission may be medically necessary, it can still be deemed preventable and will be reviewed accordingly for clinical preventability. The provider may follow the claim reconsideration process to provide additional supporting clinical documentation for the Anchor Admission and Readmission(s) which should include the Anchor Admission treatment and discharge plan. Blue Shield Promise will utilize clinical coding criteria or licensed clinical medical review to determine if a subsequent readmission is a potentially preventable readmission (PPR). Claim dispute timelines will apply.

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

- Planned surgical readmissions (e.g. any surgeries unable to be scheduled immediately due to the availability of surgical team/preoperative testing, surgical interventions that are expected or planned, planned bilateral or staged procedures)
- Readmissions that are planned for repetitive or staged treatments such as chemotherapy, transfusions, dialysis, or similar repetitive treatments
- Obstetrical readmissions
- Malignancies, burns, Cystic Fibrosis, opportunistic infections related to HIV, major trauma, or poisoning
- Transplants and associated complications
- Admissions to Skilled Nursing Facilities, Long Term Acute Care Facilities, and Inpatient Rehabilitation Facilities
- Patients discharged Against Medical Advice (AMA) / Patient 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 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

- 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 detailed discussions of risk and alternatives

E. ATTACHMENTS

1.1	Quality Improvement Organization Manual
1.2	Hospital Readmissions Reduction Program (HRRP)
1.3	DHCS All-Cause Readmissions Report
1.4	California Legislative Information

F. REFERENCES

I. This policy is based, in part, on the methodology set forth in the Quality Improvement Organization Manual, CMS Publication 100-10, Chapter 4, Section 4240, for determining an inappropriate Readmission:

"*Analyze the cases specifically to determine whether the patient was prematurely discharged from the first confinement, thus causing readmission. Perform an analysis of the stay at the first hospital to determine the cause(s) and extent of any problem(s) (e.g., incomplete or substandard treatment). Consider the information available to the attending physician who discharged the patient from the first confinement. Do not base a determination of a premature discharge on information that the physician or provider could not have known or events that could not have been anticipated at the time of discharge.*"

"*Deny readmissions under the following circumstances:*

- *If the readmission was medically unnecessary;*
- *If the readmission resulted from a premature discharge from the same hospital; or*
- *If the readmission was a result of circumvention of PPS by the same hospital (see §4255)*"

G. REVISION HISTORY

The original document is always listed first. Each review or revision should be listed. For revisions, include a list of sections that were modified and brief explanation.

Date (Descending Order)	Modification (New, Reviewed and/or Revised. Provide detail when revised.)
5/23/2025	Condition exclusion list expanded

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Date (Descending Order)	Modification (New, Reviewed and/or Revised. Provide detail when revised.)
1/1/2025	New policy and procedure.