400.80.3 30-Day Readmission Review

Department: Utilization Management

Effective Date: January 2024

Revision Date: January 2026

Purpose:

To provide a clinical process for the concurrent review of 30-day hospital readmissions of plan members.

Policy:

It is the policy of the plan to perform a clinical review 30-day readmissions. This applies to contracted and noncontracted facilities, who are not exempt from Diagnosis-Related Group (DRG) reimbursement.

A readmission is defined as:

- Admission(s) to the same facility (based on TAX ID NUMBER); AND
- Within 30 days from discharge of the previous admission; AND
- During an episode of care. An episode of care is defined as 60 days from the original admission date.

Procedure:

1. The facility notifies the plan of a hospital admission and supplies all necessary clinical information needed to make a medical necessity determination, unless the plan has obtained EMR access.
2. The Utilization Management (UM) Nurse identifies the case as a readmission. At that time, the plan will utilize clinical judgment to determine if the subsequent admission is for any of the following:
    a. Care provided for the same or closely related clinical condition as the prior admission;
    b. Potential issues related to premature discharge;
    c. Clinical concerns which may have been prevented by appropriate discharge follow-up;
    d. Potential complications related to a previous procedure or service, including medications prescribed;
    e. The plan's process excludes the following from readmission review:

- Oncology related services
- Behavioral Health related services
- Transplant related services
- Patients who leave the facility against medical advice (AMA)

3. The authorization will be processed by the UM staff as follows:
    a. The original admission will be reinstated for applicable readmissions. This is not considered a reopening. The UM Nurse will adjust appropriate dates of service to represent both the original and subsequent admissions. In effect, on authorization represents the original applicable readmission;
    b. If the UM Nurse determines this is not a readmit, a new authorization will be created for the subsequent admission. (See Policy 400.00 Utilization Review of Hospital Admissions
4. The UM Nurse communicates the decision back to the facility and notifies the member, following Medicare Managed Care Manual Part C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40.
5. For reimbursement, see Policy 300.73 titled Readmission Payment Policy.

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