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INPATIENT READMISSIONS REIMBURSEMENT POLICY FAQ

Notice date: 9/15/2023
Effective: 11/15/2023

Q: What is changing and is not changing with the PHP/PHA Inpatient Readmissions Policy?
A:

- ***(Change)*** For facilities reimbursed under DRG payment methodology: if clinical review determines the readmission was preventable or due to premature discharge, the readmission will be considered a continuation of the previous admission and **combined into a single DRG payment**. The final combined payment will be based on the DRG with the highest relative weight.

- ***(No Change)*** If the readmission is determined to be not medically necessary or related to a procedural complication or failed procedural intervention from the previous admission, the readmission will be **denied as not separately reimbursable**. This applies to facilities paid under all reimbursement methodologies.

- ***(No Change)*** Planned readmissions/leave of absences will be combined into a single DRG payment. The final combined payment will be based on the DRG with the highest relative weight.

- ***(No Change)*** Readmissions on the same day of discharge from the previous admission will be combined into a single DRG payment. The final combined payment will be based on the DRG with the highest relative weight.

- ***(No Change)*** Readmissions for certain conditions are excluded from the policy. These include, but are not limited to: pre-delivery obstetric care, cancer chemotherapy, transfusions for chronic anemia, or dialysis.

Q: Policy application?
A: This policy will apply to commercial and Medicare lines of business and all reimbursement methodologies (e.g., DRG, per diem, percent billed).

Q: When are the changes taking effect?
A: The effective date is 11/15/2023. A final version of the policy will be available on ProvLink and here on 10/1/2023.

Q: Additional notes?
A: The Plan is dedicated to widely communicating the policy changes to all in-network facilities and providers who will be impacted by this change. This FAQ serves as 60-day notice to ensure adequate communication and time for facilities to assess and incorporate the policy changes. As per our Plan policy and standard practice, facilities and providers may submit for a reconsideration (commercial members) or appeal (Medicare members) to obtain review of any disputed denial.