Reminder for hospital readmissions: What Pennsylvania facilities need to know about same-day and 30-day readmission reviews

30-day readmission review

When a member is readmitted to the same facility within 30 days of discharge for a diagnosis related to the first admission, the claims are subject to full clinical review. We'll request medical records and supporting documentation for both the initial and the subsequent admission.

Under 55 Pa. Code § 1163.57:

- No additional reimbursement is made beyond the original hospital's DRG payment
- If the combined stay qualifies as an outlier, an outlier payment will be made
- If the readmission is due to complications of the original diagnosis and results in a different DRG with a higher payment rate, the higher DRG rate is reimbursed instead of the original DRG rate

Same-day readmissions		
Scenario	**How to bill**	**What happens if billed incorrectly**
Same day, same or related condition	Combine both admissions on a single claim (1 episode of care).	Both the initial and subsequent admissions are denied for payment as separate DRGs. Resubmit as 1 combined claim.
Same day, unrelated condition	Bill separately and report condition code B4 on the readmission claim.	Without B4, the claim may be treated as a related readmission and denied.

Planned readmissions /leave of absence

When a readmission is planned or expected as part of the same episode of illness (e.g., additional work-up, staged surgery or surgery after conservative therapy fails), the admissions are not considered 2 separate admissions. Submit 1 bill for covered and leave-of-absence days after the final discharge. We may combine the admissions into a single claim with 1 combined DRG payment.

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What isn't subject to Pennsylvania readmission review

- Planned admissions, including staged or serial treatments such as chemotherapy
- Members who leave against medical advice
- Transfers to a different facility or outside the TIN group
- Transplant claims
- Admissions to skilled nursing, inpatient rehabilitation and long-term acute care facilities

Billing tips: Using condition code B4

- **What it means:** B4 tells us the same-day readmission was for a condition unrelated to the earlier admission
- **Paper UB-04:** Report B4 in the Condition Codes fields (Form Locators 18–28)
- **Electronic 837I:** Report B4 in Loop 2300, HI segment, with qualifier BG (condition information)
- **Use it only when it applies:** B4 should be supported by the medical record. Claims billed with B4 may still be reviewed.
- **Same/related condition:** Don't use B4. Bill the stay as 1 combined claim.

What to do if you received a readmission denial

Start by reviewing the denial reason on your remittance advice (835) or Provider Remittance Advice to see which scenario applies.

If the denial is because...	Recommended action
Same-day admissions were billed separately for a related condition	Void/replace the claims and submit 1 combined claim covering both admissions (frequency code 7 to replace or 8 to void, with the original claim number).
The same-day readmission was for an unrelated condition but B4 was missing	Submit a corrected claim that adds condition code B4 to the readmission claim.
The 30-day readmission was reviewed and determined to be related/preventable	If you disagree, submit a claim reconsideration with the medical records for both admissions explaining why the readmission was unrelated, unplanned or not preventable.
We requested medical records and didn't receive them	Submit the requested records for the initial and subsequent admissions as instructed in the records request letter.
You still disagree after reconsideration	File a formal provider appeal / dispute according to the **UnitedHealthcare Community Plan Provider Manual**.

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Frequently asked questions

Does this policy apply to every inpatient claim?

It applies to UnitedHealthcare Community Plan Medicaid inpatient claims billed on the UB-04 (or electronic equivalent) by facilities paid under DRG methodology for Pennsylvania admissions on or after Oct. 1, 2024. The exclusions listed above don't apply.

Does the readmission have to be at the same hospital?

The 30-day review applies to readmissions to the same facility. Transfers to a different facility or outside the TIN group aren't subject to the Pennsylvania review.

If I bill B4, will the claim automatically pay?

No. B4 makes an unrelated same-day readmission eligible for separate reimbursement, but the claim may still be reviewed and must be supported by the medical record.

Can other factors change how this policy is applied?

Yes. State and federal requirements, your provider contract, the member's benefits and other reimbursement or medical policies may supplement, modify or supersede this policy.

Resources

- **UnitedHealthcare Community Plan Reimbursement Policy: Readmission Policy, Facility**
- **UnitedHealthcare Community Plan of Pennsylvania Provider Manual – claims, reconsiderations, and appeals**
- 55 Pa. Code § 1163.57 – Pennsylvania Code, Readmissions
- Pennsylvania DHS Systems Notice SYS-2020-018: Hospital Related Readmission Encounter Submission

Questions?
We're here to help.
Contact Provider Services at 800-600-9007.

This bulletin is a summary for education purposes. The published reimbursement policy and your provider agreement govern. UnitedHealthcare Community Plan may update its reimbursement policies at any time by publishing a new version.

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