POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

1.1.1 Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.

1.1.2 KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.

1.1.3 KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:

- American Academy of Professional Coders (AAPC)
- American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

1.2.1 This policy provides an overview of KFHP's review of institutional/facility claims that are readmissions for the same member to the same hospital or hospital system, that fall within 30 days of discharge. This policy applies to contracted and non-contracted providers across all lines of business, unless otherwise specified. Clinical Review will review the medical records to determine if the claim is a continuation of care or readmission, unrelated to the first claim for the same hospital or hospital system within 30 days for the same member with the same, similar or related diagnoses.

2.0 Rules

2.1 The Clinical Review department will request/ review medical records to determine if the readmission within 30 days was continuation of care or a readmission to the same hospital or health system. When medical records or clinical information is requested, all the specific information required to make the medical determination must be clearly documented in the records.

2.2 KFHP follows Centers for Medicare and Medicaid Services (CMS) guidelines for Readmissions within 30 calendar days of discharge from the initial admission. Payment for a readmission to the same hospital or hospital system within 30 calendar days may be denied if the admission was deemed preventable, medically unnecessary or was due to a premature discharge of the prior admission.

2.3 Reimbursement Guidelines

2.3.1 KFHP does not allow separate reimbursement for claims that have been identified as readmission to the same hospital or hospital system reimbursed by DRG pricing for the same, similar or related condition unless provider contracts, state, federal or CMS requirements indicate otherwise. In the absence of provider, federal, state and/or contract mandates, KFHP will use the following standards: (a) readmission within 30 days of discharge; (b) for the same member with the same, similar or related diagnoses.

2.3.2 KFHP will use clinical criteria and licensed clinical professionals as part of the review process for readmissions from day 2 to day 30 in order to determine if the second admission is for:

- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge.
- An acute decompensation of a coexisting chronic disease.
- An infection or other complication of care.
- An issue caused by a premature discharge from the same hospital or hospital system.
- Condition or procedure is indicative of a failed surgical intervention.
- The same, similar or related diagnoses or procedure as the prior discharge.

2.4 Preventable/Inappropriate Readmissions

2.4.1 Readmissions which are deemed preventable or considered inappropriate pursuant to the following criteria may be denied:

- A medical complication related to care during the previous admission.

- A medical readmission for a continuation or recurrence for the previous admission or closely related condition

- The readmission resulted from a failure of proper coordination between the inpatient and outpatient health care teams

- An unplanned readmission for surgical procedure to address:

  - Complication or recurrence of a problem causing this admission.

  - Complications related to Serious Reportable Events (SREs)

  - Suspected complication that was not treated prior to discharge.

  - Surgical procedure to address a complication resulting from care from the previous admission.

- The readmission resulted from a failure of proper and adequate discharge planning.

- The readmission resulted from a premature discharge or is related to the previous admission, or that the readmission was for services that should have been rendered during the previous admission.

- If a readmission falls under one of the criteria listed above and KFHP denies the claim, the hospital may not bill the member for the readmission

3.0 Guidelines

3.1 Exclusions

3.1.1 Exclusions from the criteria listed above may apply. Examples include but are not limited to:

- Admissions associated with malignancies (limited to those who are in an active chemotherapy regimen-both infusion and oral), burns, or cystic fibrosis.

- Admissions with a documented discharge status of "left against medical advice."

- Behavioral health readmissions.

- In-network facilities that are not reimbursed based on contracted DRG or case rate methodology (e.g., per diem).

- Obstetrical readmissions for birth after an antepartum admission.

- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, for similar repetitive treatments, or for elective surgery. These include:
    - Transfers from one acute care hospital to another.
    - Critical Access Hospitals (CAHs).
    - Exclusions for the Washington State region ONLY: (a) Readmission due to patient nonadherence; (b) End-of-life and hospice care; (c) Obstetrical readmissions for birth after an antepartum admission; (d) Neonatal readmissions; (e) Transplant readmissions within 180 days of transplant.
- Substance use readmissions.
- Transplant services (within 180 days of transplant), including organ, tissue, or bone marrow transplantation from a live or cadaveric donor.

4.0 Definitions

1.1 **Centers for Medicare & Medicaid Services (CMS)** Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

1.2 **Readmission** A subsequent inpatient admission to any acute care hospital which occurs within 30 days of the discharge date; excluding any exceptions or planned readmissions.

1.3 **Planned Readmissions** A non-acute admission for a scheduled procedure for limited types of care that may include, obstetrical delivery, transplant surgery, maintenance of chemotherapy/radiotherapy/immunotherapy.

1.4 **Preventable Readmissions** A readmission within a specific time frame that is clinically related and may have been prevented had appropriate care been provided during the initial hospital stay and discharge process.

5.0 References

1.5 Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 12/10/10. Available at: http://www.cms.gov/manuals/downloads/clm104c03.pdf. Accessed September 29, 2011.

1.6 Centers for Medicare & Medicaid Services (CMS). Medicare Learning Network. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. 12/17/10. Available

at: http://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf. Accessed September 29, 2011

1.7 Hospital-Acquired Condition Reduction Program | CMS

1.8 Medicare Claims Processing Manual (CMS-Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing)

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/2025)

Revision History

Approvals