| | Inpatient Readmission | |
|---|---|---|
| Kansas City | **Policy Number: POL-PP-239** | **Original Creation Date 5/1/2023** |
| | **Version Number: 007** | **Version Effective Date 5/1/2023** |
| | **Policy Status: Active** | **Next Review Date 5/1/2027** |



| PROVIDER/ENTITY IMPACTED | | | | | |
|---|---|---|---|---|---|
| ☒ PROFESSIONAL | ☒ FACILITY | ☐ DME | ☐ AMBULATORY SURGERY | ☒ LAB | ☒ OTHER |

| LINES OF BUSINESS IMPACTED | | | | | | |
|---|---|---|---|---|---|---|
| ☒ COMMERCIAL | ☐ BLUE MEDICARE ADVANTAGE | ☒ ACA QHP[1] | ☒ SMALL GROUP ACA | ☒ JAA[2] | ☒ FEP[3] | ☐ DENTAL |

[1] ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family [2] JAA: Joint Administrative Account [3] FEP: Federal Employee Program

## Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

## Description/Application

Blue KC will not separately reimburse acute care hospitals for admission to an acute care hospital within fifteen (15) days of discharge from the same or another acute care hospital in the same system for

the same Member for a related admission. For purposes of this Policy "same system" is defined as an acute care hospital that directly controls, is controlled by, or is under common control with the discharging acute care hospital including but not limited to acute care wholly owned or wholly operated by a health system parent or parents. The readmission policy is based on fifteen (15) calendar days, not hours.

Note: Please be advised, per your participating provider agreement, you are responsible for reporting the most appropriate code(s) and to accurately document the service(s) provided. Blue KC reserves the right to validate the accuracy of the coding of each claim in an investigation to determine if the Readmission was related to the previous inpatient stay

## Policy

**Effective date 11/1/2026**

**Required Documentation**

The hospital must submit relevant medical records and supporting documentation, e.g., Discharge Summary from previous discharge, admission History & Physical from readmission, physician orders, emergency records, progress notes, etc., with the inpatient authorization request pertaining to the readmission to determine whether the readmission is related to the most recent inpatient hospital stay .

**Claim Submission**

When Blue KC's Medicare Advantage or Commercial members are readmitted under qualifying conditions and within fifteen (15) days of a prior inpatient discharge, the Blue KC will reimburse the combined admission claim as a single DRG payment in accordance with the hospital's agreement. Providers may combine the two (2) admissions into one (1) claim if the discharge date from the first claim and the admission date from the second claim are the same, that is, same day readmission. Otherwise, the Blue KC requests that providers submit two (2) claims separately under the hospital billing information of the original admitting hospital.

**Note:** This policy is not based on nor intended to address medical necessity. Claims will be subject to review by the Plan for appropriate billing and payment and the member held harmless for any payment denials.

**DEFINITIONS:**

Readmission: For the purposes of this policy, a readmission is an unplanned inpatient acute care hospital readmission for the same patient within fifteen (15) days of discharge of the previous inpatient hospital stay for a condition related to the most recent inpatient hospital stay.

Related Readmission Reasons (not intended to be an exhaustive list):

- The same or a closely related condition or procedure as the original admission;
- An infection or other complication of care arising from the original admission or post-discharge care;
- A condition or procedure indicative of a failed surgical intervention;
- An acute decompensation of a coexisting chronic disease that may be related to care during the initial admission or follow up care after discharge; or
- Clinical instability of the patient's condition prior to discharge (premature discharge) or not

providing proper care coordination or discharge planning during the admission or during the post discharge follow-up period.

## Coding

| CPT/HCPCS | Definition |
|---|---|
| N/A | |

## References and Resources


Novotny, N. & Anderson, M. (2008). Prediction of early readmission in medial inpatients using the probability of repeated instrument. Nursing Research 57(6), 406-415.

Lovejoy, M. (2012). 30-day patient readmissions in a small community hospital. Unpublished manuscript, Montana State University, Bozeman.

Centers for Medicare and Medicaid Readmission Reduction Program https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Gerard F. Anderson and Earl P. Steinberg, "Hospital Readmissions in the Medicare Population," New England Journal of Medicine, 311:21 (Nov. 22, 1984), 1349-1353.

Centers for Medicare and Medicaid Publication 100-10 (Quality Improvement Organization Manual) Chapter 4, Section 4240


## Related Documents

NA

## Revision History

| Version | Date | Summary of Revisions |
|---|---|---|
| 001 | 5/1/2023 | Initial Version |
| 002 | 7/31/2023 | Update - Updated language regarding payment for higher DRG when a preventable readmission occurs; removed "same or similar hospital." |
| 003 | 11/29/2023 | Update - Updated language regarding readmissions occurring within zero and one day to apply whether patient was discharged to home or post-acute facility. |
| 004 | 5/1/2024 | Annual review, no updates, or changes were made to the policy |
| 005 | 5/1/2025 | Annual review, no updates, or changes were made to the policy |
| 006 | 5/1/2026 | Annual review, no updates, or changes were made to the policy |
| 007 | 8/6/2026 | Update – Payment Policy name changes to "Inpatient Readmission". Readmittance time frame changed from 30 days to15 days |