KAISER PERMANENTE®

PAYMENT POLICY

THIRTY DAY READMISSION

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington	☒ Kaiser Permanente Health Plan of Washington Options, Inc.	
☒ Commercial	☒ Medicare	☐ Medicaid

Policy

Original Effective Date: 07/01/2021

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) does not allow separate reimbursement for claims that have been identified as a readmission, within 30 days of a previous discharge, to the same hospital for the same or similar or related condition unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Per WAC 284-43-2000, "Health care services utilization review", Subsection (4)(h): *Each issuer when conducting utilization review must: […] not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider or facility*;"

Kaiser Permanente provider contracts, Section III, Subsection B., allows Kaiser Permanente to perform retrospective utilization and case management review and issue coverage denial notices for non-covered services. Kaiser Permanente will use the following standards:

a. Readmission within 30 days from discharge
b. Same diagnosis or diagnoses that fall into the same grouping

Kaiser Permanente 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. The same or closely related condition or procedure as the prior discharge
b. An infection or other complication of care
c. A condition or procedure indicative of a failed surgical intervention
d. An acute decompensation of a coexisting chronic disease
e. A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period
f. An issue caused by a premature discharge from the same facility
g. A reason that is medically unnecessary

The following exclusions will apply to the policy:

a. Admissions for the medical treatment of cancer
b. Primary psychiatric disease and rehabilitation care
c. Planned readmissions
d. Patient transfers from one acute care hospital to another

e. Patient discharged from the hospital against medical advice

Kaiser Permanente does not apply the inpatient readmission criteria to Critical Access Hospitals (CAH) and considers the following as exclusions for the Washington State region:

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

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

KP must apply commonly-accepted standards to determine what items or services are eligible for separate reimbursement. Commonly accepted standards include CMS guidelines, National Uniform Billing Committee (NUBC) standards, National Correct Coding Initiative (CCI) standards, and professional and academic journals and publications.

Policy Definitions

CMS – Centers for Medicare & Medicaid Services

CAH – Critical Access Hospital

DRG – Diagnosis Related Grouping - A unit of classifying patients by diagnosis, average length of hospital stay, and therapy received

DRG Reimbursement – a payment method intended to standardize hospital reimbursement, which takes into account hospital location, type of patient being treated, and other factors

Prerequisite(s)

Not applicable

References

Quality Improvement Organization Manual Chapter 4 Case Review

Washington State Regulation - WAC 284-43-2020

Centers for Medicare & Medicaid Services

National Correct Coding Initiative (CCI)

Frequently Asked Questions

Not applicable

Revision History

04/22/2022 – Updated to correct hyperlinks and formatting

07/01/2021 – New Policy

Note: This information is intended to serve only as a general reference resource regarding reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to our enrollees as legislative mandates, the provider contracts, the enrollee's benefit coverage documents, and the Provider Manual all may supplement or in some cases supersede this policy. This policy may be modified from time to time by publishing a new version of the policy on Kaiser Permanente provider website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.