



Policy	REIMB_039
Effective Date	01/01/2026
Reviewed/Revised Date	10/27/2025
Next Review Date	10/27/2026
Origination Date	09/01/2024
Originated Department	Clinical Operations

Inpatient Readmission Review

Audience
Medical Management

Purpose
<p>Payment policies provide general support for applying Mountain Health CO-OP member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this payment policy. If there is a conflict between a member-specific policy document and the Mountain Health CO-OP payment policy, the member-specific policy document supersedes this policy. Any person(s) applying this payment policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this payment policy, including the existence of any state or federal guidance. Mountain Health CO-OP payment policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health CO-OP reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

Definition
<p>A readmission is defined as a return hospitalization to an acute care hospital that follows a prior, clinical related, acute care admission.</p> <p>Preventable and avoidable hospital readmissions can adversely impact patient outcomes. This policy aims to promote quality of care and outcomes to avoid preventable readmissions and encourage comprehensive discharge planning and care coordination. This inpatient readmission review policy outlines the conditions under which facility readmissions are reviewed and reimbursed by Mountain Health.</p>

This policy applies to all inpatient acute care facility claims and is designed to guide providers, health plan personnel, and utilization management teams in evaluating claims involving readmissions occurring within 30 days of discharge.

Policy/Procedure

If Mountain Health determines a provider has submitted a second claim within 30 days after a patient has been discharged from an acute inpatient stay, a post-payment audit of the initial readmission and subsequent readmission may occur.

Reimbursement may be denied or reduced for inpatient readmissions or inpatient observations, if it is determined that the member is being treated for the same, similar, or related condition as the initial admission and the services rendered are considered a continuation of the initial treatment.

Readmission Review Criteria

- Readmissions related to the first admission
- Preventable readmissions
- Premature hospital discharge
- Unplanned surgery resulting in a continuation of the initial admission
- Condition or procedure attributed to readmission due to a failed surgical procedure or interventional service
- Infection due to the initial admission
- Exacerbation of symptoms of a chronic illness

Exclusions

- Psychiatric/Substance abuse admissions
- Transplant services admissions
- Readmission due to discharges against medical advice
- Multiple trauma
- Burns
- Neonatal and obstetrical admissions
- Staged procedures following commonly accepted practices

Claim Review and Adjudication

A claim review process may occur including provider contract assessment, diagnosis related to initial admission, prior discharge dates of service, and coding and documentation review. A corrected claim to confirm diagnosis for the readmission may be requested if a member is readmitted within 30 days.

The first and subsequent claims will be considered a single admission when determining the DRG reimbursement. This policy does not apply when multiple readmissions are not paid on a DRG methodology basis.

References

1. Centers for Medicare and Medicaid Services (CMS), CMS Medicare Claims Process Manual; Chapter 3 - Inpatient Hospital Billing, Manual System and Other CMS publications and services

Vendors

- HPS

Review/Revision/Approval History

Date	Description
10/27/2025	Add admission to IP observation status, as well as readmission

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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