30-Day Readmission Policy

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Background

The Affordable Care Act (ACA) requires that CMS reduce hospital readmissions using payment incentives. The ACA added the Hospital Readmissions Reduction Program, requiring CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.
CareOregon is instituting readmission reduction efforts based on CMS's initiative, while meeting Oregon's Medicaid requirements. Potentially preventable readmissions to hospitals are recognized as a measure of quality of care. Many Medicaid programs and other payers have policies under which they may deny payment for specific readmissions that result from sub-standard care that was provided in the initial admission. In principle, denial of payment for these specific cases motivates the hospital to bring its care up to standard.

Purpose

The purpose of this policy is to promote safe discharge for our CareOregon members and to ensure payments align with CMS and OHA intention and requirements.

Scope

This policy applies to individual hospitals or hospitals within the same hospital system.

Policy

Readmissions determined to have been inappropriate or preventable according to the clinical review guidelines set forth below, CareOregon will deny payment or reimbursement.

A readmission will be considered clinically inappropriate and/or preventable when the readmission:

- was not medically necessary;
- resulted from a prior premature discharge from the same hospital or hospital system;
- resulted from a failure to have proper and adequate discharge planning including failure to have proper coordination between the inpatient and outpatient health care teams; and/or
- was the result of circumvention of the contracted rate by the hospital or hospital system.

30-day readmission excluded from review:

- Transfers from out-of-network to in-network facilities;
- Transfers of patients to receive care not available at the first facility;
- Readmissions that are planned for repetitive or staged treatments, such as cancer, chemotherapy, or staged surgical procedures;

- Readmissions associated with malignancies, burns, or cystic fibrosis;
- Admissions to Skilled Nursing Facilities, Long Term Acute Care facilities, and Inpatient Rehabilitation Facilities (SNF, LTAC, and IRF);
- Readmissions where the first admission had a discharge status of "left against medical advice".
- Obstetrical readmissions
- Readmissions ≥ 31 days from the date of discharge from the first admission.
- Age ≤1
- Conditions excluded per OHA billing guidance

Readmissions during the 30-day period to hospitals which are a part of a hospital system under the same contract and/or sharing the same tax identification number within the same system as the first hospital will be subject to this policy.

A hospital must provide, for review, all supporting medical records for the initial and readmission stay if CareOregon does not have electronic access to the records. The review will include:

- Determining whether the readmission was clinically related to the initial admission
- Determining whether the readmission was preventable and/or medically appropriate
- Evaluation of the discharge, including the quality of the discharge plan

Pre-Payment Review

CareOregon may conduct pre-payment reviews for readmissions within 30 days of discharge from the same facility or system.

All hospital claims submitted for a CareOregon member and not excluded from review are subject to clinical review.

- Medical records for both the original and subsequent admission(s) will be requested, if electronic access isn't available for a claim selected for clinical review. If medical records are not received or made available, the second claim will be denied.
- If a denial is issued, the hospital may submit a claim reconsideration with supporting medical records for both initial and readmission claims. If CareOregon does not receive supporting medical records for both admissions CareOregon will deny the reconsideration request.
- Supporting medical records will be reviewed by a qualified clinician to determine if the readmission was inappropriate and/or preventable based on the above guidelines.
- If a readmission is determined to be not medically necessary, not medically appropriate, unnecessary, and/or preventable, written notification of the determination will be sent to the hospital and/or related hospital and payment for the readmission will be denied.

Post-Payment Review

CareOregon will make efforts to monitor claim submissions by minimizing the need for post payment reviews and adjustments; however, CareOregon may review payments retrospectively if a prepayment review was not conducted.

- If a claim is determined to be related to a previous admission the hospital must forward supporting medical records for all related admissions to CareOregon upon request. All clinical information from the admissions will be reviewed by a qualified clinician to determine if any readmission was inappropriate,

unnecessary, or preventable based on the above guidelines.

- If a readmission is determined to be inappropriate, unnecessary, or preventable, written notification of such determination will be sent to the hospital or related hospital, along with a request to the hospital to refund the applicable payment(s) for the readmission. If a hospital or related hospital fails to refund the applicable payment(s). CareOregon may recover the applicable payment for the readmission by offset against future payments, unless expressly prohibited by law from doing so, or as stipulated in the hospital's contract.

Documentation Requirements

A hospital or related hospital must forward all supporting medical records and supporting documentation of the first and subsequent admission(s) to CareOregon for review, upon request.

Definitions

Clinically Related: An underlying reason for a subsequent admission that is plausibly related to the care rendered during or immediately following a prior hospital admission. A clinically related readmission may have resulted from the process of care and treatment during the prior admission (e.g., readmission for a surgical wound infection) or from a lack of post admission follow-up (lack of follow-up arrangements with a primary care physician) rather than from unrelated events that occurred after the prior admission (broken leg due to trauma) within a specified readmission time interval.

CMS: Centers for Medicare and Medicaid Services.

Initial Admission: An inpatient admission at an acute, general, or short-term hospital, or another hospital in the same hospital system (referred to as a "related hospital") and for which the date of discharge for such admission is used to determine whether a subsequent admission at that same hospital or a related hospital occurs within 30 days.

OHA: Oregon Health Authority

Potentially Preventable Readmission (PPR): A potentially preventable readmission is a readmission (re-hospitalization within a specified time interval) that is clinically related (as defined above) and may have been prevented had adequate care been provided during the initial hospital stay.

Readmission: An admission to a hospital occurring within 30 days of the date of discharge from the same hospital or a related hospital. Intervening admissions to non-acute care facilities (e.g., a skilled nursing facility) are not considered readmissions and do not affect the designation of an admission as a readmission. For the purpose of calculating the 30-day readmission window, neither the day of discharge nor the day of admission is counted.

References

- *42 CFR part 412 subpart I (§412.150 through §412.154)*
- *Social Security Act section 1886(q)*
- *Affordable Care Act (ACA) section 3025*
- *Quality Improvement Organization Manual, CMS Publication 100-10, Chapter 4, Section 4240*
- *Oregon Medicaid Diagnosis Codes Exempt from 30-Day Readmission Policy | data.oregon.gov |*
- *Oregon's Open Data Portal | Oregon.gov*

This document is provided for informational purposes only and should not be construed as legal advice. Any cited statutes are current as of the date of publication of this guide.

These guidelines have been developed to accompany and complement the official conventions and instructions provided within the American Medical Association's Current Procedural Terminology (CPT®) itself. Additions and deletions conform it to the most recent publications of CPT® and HCPCS Level II and to changes in CareOregon and its affiliates coverage policy and payment status, and as such these guidelines are current as of 01/01/2026. Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. CareOregon and its affiliates make no claim, promise, or guarantee of any kind about the accuracy, completeness, or adequacy of the content for a specific claim, situation, or provider office application, and expressly disclaim liability for errors and omissions in such content. As CPT® codes change annually, you should reference the current version of published coding guidelines and/or recommendations from nationally recognized coding organizations for the most detailed and up-to-date information.