REIMBURSEMENT POLICY & PROCEDURE (MEDICAID)

Title: Inpatient Readmission Medicaid Reimbursement Policy (the "Policy")

Applies to: This Policy applies to individual hospitals, hospitals within the same hospital system, a related hospital, and facility groups (individually and collectively the "Same Hospital").[1]

Scope: Medicaid Product Lines (SelectHealth)

Policy Owner: Claims Operations

First Issued: August 6, 2026

A. Purpose

The purpose of this Policy is to ensure the quality of care received by the Plan's Members in reducing Potentially Preventable Readmissions. Reimbursement for claims identified as a Readmission to the Same Hospital is not allowed by the Plan unless provider, state or federal contracts and/or guidelines dictate otherwise. This Policy sets forth the guidelines used by the Plan to determine what qualifies as a Readmission and reserves the Plan's rights to deny/reduce the claim or to recoup and/or recover monies paid on a claim that falls within those guidelines.[2]

B. Reimbursement Policy

Under this Policy, the Plan may deny, consolidate, reduce, recoup or otherwise adjust payment on claims when the following is met:

1. The Member had an unplanned Readmission:
    a. up to fourteen (14) calendar days from discharge of the Initial Admission;
    b. to the Same Hospital; and
    c. for a Potentially Preventable Readmission.
2. No exclusion applies.
3. Denial, consolidation, and/or payment adjustment/recoupment is permitted and not restricted under the applicable provider contract, and the Plan's

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[1] If a hospital is part of a hospital system operating under a single hospital agreement, and/or if the hospital shares the same tax identification number with one or more other hospitals, then a Readmission during the 14-day period to another hospital within the same hospital system, or to another hospital operating under the same tax identification number as the first hospital, will be treated as a Readmission to the same hospital and, as such, is subject to this Policy.

2 This Policy is not related to determinations of Medical Necessity.

policies and regulatory guidelines/requirements otherwise permit denial, consolidation, or payment adjustment/recoupment.

C. **Exclusions:**
A claim will not be denied, adjusted, or recouped if any of the following Exclusions applies:

1. Planned Readmission
2. Transfer from one acute facility to another
3. Emergency/Post-stabilization care
4. Subsequent admission was for a condition unrelated to the Initial Admission
5. Cancer-related treatment, e.g., chemotherapy, radiation, planned care, active malignancy protocols
6. Transplant admission or transplant-related planned care
7. Obstetric/neo-natal care for delivery, newborn/neonatal complications, pregnancy-related admissions
8. Behavioral Health/Substance Use Disorder treatment
9. Rehabilitation or distinct rehabilitation level of care
10. Patient initiated discharge against medical advice
11. Patient transferred from out-of-network to in-network
12. Critical Access Hospitals

D. **Adjudication and Appeal Process**
Denial of payment for the claim will be upheld unless it can be shown that the Readmission does not meet the criteria for a Potentially Preventable Readmission, based on the review and reconsideration process. As part of the review and reconsideration process, the Plan requires:

1. Medical records from both the Initial Admission and the Readmission, and a letter or summary document identifying the pages in the applicable medical records that contain information pertinent to the review and supporting information that affirms that any of the exception criteria listed above are met, if relevant.
2. A clinical narrative containing the following elements:
    a. An explanation of how the treatment of the member in the first hospitalization met the clinical needs of the member's condition;
    b. An explanation of how the member's condition during the first hospitalization was stabilized prior to discharge (i.e., improvement in the member's condition upon discharge compared to presentation to the emergency department); and

c. A demonstration that an adequate discharge plan was developed and set up timely for the member with any necessary services, medication, and follow-up treatment needed to avoid re-hospitalization.

3. Failure of the provider to provide complete medical records from the Initial Admission and subsequent admission for review and reconsideration may result in an adverse determination under the reconsideration process.

If the Plan determines that the subsequent admission is a Potentially Preventable Readmission, the provider will be notified of the administrative denial.

If the subsequent admission is determined not to be a Readmission or a Potentially Preventable Readmission, the subsequent admission will be reimbursed in accordance with the terms of the applicable provider agreement.

For detailed information on the reconsideration and appeals process, please refer to the Provider/Billing section on our website at Claims and Payment Information and Resources - VNS Health | Health Plans and the Claims Disputes and Appeals Process in the Provider Manual at Resources for Health Professionals - VNS Health | Health Plans.

The Plan reserves the right to look back within the maximum allowed recovery time frame per state/federal guidelines or per specific provider contract to identify any claims that may be a Potentially Preventable Readmission.

The Plan reserves the right to deny the claim or to recoup and/or recover monies previously paid on a claim that is within the guidelines of this Policy.

E. Member Hold-Harmless

Members may not be charged and/or balance billed for hospital admissions deemed as Readmissions under this Policy.

F. No Guaranty of Payment

This Policy, and any related policies, serve as a guide in understanding the Plan's reimbursement guidelines. Final reimbursement decisions are dependent upon benefit coverage, state/federal requirements, and the applicable provider contract.

G. Timely Filing Rules Apply

All claims submissions are subject to timely filing requirements as set forth in the provider contract and in the Provider Manual.

H. Related Coding
Standard correct coding rules apply.

Definitions

Initial Admission shall mean an inpatient admission at an acute, general, or short-term hospital.

Readmission shall mean a subsequent admission to the Same Hospital as the Initial Admission within fourteen (14) calendar days of the date of discharge from the Initial Admission.

Potentially Preventable Readmission shall mean a Readmission that is related to the Initial Admission as determined by the Plan's diagnosis matching methodology, e.g. is a continuation of the Initial Admission or related to premature discharge, due to insufficient stabilization, is a complication of care, due to a failed procedure, relapse or avoidable clinical deterioration and that may have been avoided through appropriate discharge planning, adequate stabilization, timely follow-up, appropriate treatment during the Initial Admission or prevention/management of complications.

Related Policies and Materials
N/A

References:

CMS Hospital Readmissions Reduction Program (HRRP)
Centers for Medicare & Medicaid Services

Hospital Readmissions Reduction Program Overview
Hospital Readmissions Reduction Program Overview

Federal Payment Adjustment Under the Hospital Readmissions Reduction Program
42 CFR § 412.150 - § 412.154 sets forth CMS' payment adjustment methodology for excess readmissions under HRRP.

NYS Readmissions
10 N.Y.C.R.R. §§ 86-1.37

The Plan's Provider Manual
Resources for Health Professionals - VNS Health | Health Plans