

Subject:	Avoidable Readmission		
Policy Number:	PO-RE-094v2		
Effective Date:	01/01/2019	Last Approval Date:	4/20/2026

I. Policy Description

Healthfirst's Avoidable Readmission reimbursement policy is designed to reduce avoidable readmissions and improve quality of care. Healthfirst will deny any claims that meet the criteria for an avoidable readmission, as defined in this policy. Please note that this policy applies exclusively to inpatient claims.

The information below applies to the following lines of business:

• Child Health Plus (CHP)	• Essential Plan (EP)
• Integrated Benefit Dual Plan (IB-Dual)	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicaid Managed Care (MMC)	• Qualified Health Plan (QHP)
• Medicare Advantage HMO	• Personal Wellness Plan (HARP)
• Medicare PPO	

Policy Scope

Effective January 1, 2019, Healthfirst will deny any claim for an acute care hospital admission that meets the criteria for an Avoidable Readmission, as defined in this Policy.

Selected admissions to acute care hospitals occurring less than thirty (30) calendar days from the date of discharge from the initial index admission are considered a quality-of-care issue.

For purposes of this policy, all readmissions within the 30-day period will be anchored to the same initial index admission for a related condition. Subsequent admissions do not reset or create a new index admission within this 30-day period, and no rolling readmission logic is applied.

Admissions occurring outside of the 30-day period from the initial index admission discharge will not be considered readmissions and will not be subject to denial under this policy.

Reimbursement Guidelines

Subsequent admissions will not be subject to denial under this policy if any of the following is true:

- a. Patient transferred from out of network (OON) to in network (INN),
- b. Patient transferred to an inpatient rehabilitation facility,
- c. Patient transferred to a skilled nursing facility (SNF)
- d. Patient transferred to receive care not available at the first facility,
- e. The subsequent admission was a planned readmission for repetitive treatments (e.g., chemotherapy for cancer),
- f. The subsequent admission was a scheduled readmission for elective procedures,
- g. Patient left Against Medical Advice (AMA) from the index admission,
- h. Patient expired during the subsequent admission,
- i. Patient enrolled in hospice during the subsequent admission,
- j. The index admission and/or subsequent admission was for:
 - i. Trauma, burns, malignancies, cystic fibrosis, eye, mental health, substance use disorders, and sickle cell crisis,
 - ii. The subsequent admission was to a psychiatric/substance abuse unit or facility,
 - iii. The subsequent admission was related to treatment for pregnancy and/or newborns, or
 - iv. The subsequent admission occurred more than 30 days from discharge from the initial index admission.

Adjudication and Appeal Process

1. Initial Claims Denial
 - a. If Healthfirst determines that the admission is a Readmission of the index admission, the provider will be notified of the administrative denial.
 - b. Denial of payment for the claim will be upheld unless it can be shown that the admission does not meet the criteria for an Avoidable Readmission.
 - c. As part of the review and reconsideration process, Healthfirst requires:
 - i. Medical records from both admissions, 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.
 - ii. A clinical narrative containing the following elements:
 - An explanation of how the treatment of the member in the first hospitalization met the clinical needs of the member's condition.
 - 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).
 - 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

- d. Failure of the hospital to provide complete medical records from the index hospitalization and readmission hospitalization for review and reconsideration may result in an adverse determination under the reconsideration process.
 - e. If the readmission is determined to have not met the criteria for an avoidable readmission, the admission will be reimbursed in accordance with the terms of the applicable provider hospital agreement. For detailed information on the reconsideration and appeals process, please refer to section 17.6 in the Healthfirst Provider Manual.
 - f. Healthfirst reserves the right to look back within the maximum allowed recovery time frame per state guidelines or per specific provider contract to identify any claims that may be for an Avoidable Readmission
 - g. Healthfirst 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.
2. Members may not be charged for hospital admissions denied as Avoidable Readmissions under this policy.
 3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.
 4. This policy is a provider resource for understanding Healthfirst’s reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.
 5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17, “Billing and Claims Processing” in this section.*

II. Applicable Codes

Code	Description	Comment
N/A		

III. Definitions

Term	Meaning
Avoidable Readmission	Is an admission to an acute care hospital/system occurring within 30 days of discharge of the initial index (i.e., first) admission from the same hospital or

	<p>hospital system for a condition with the same, similar and/or related diagnosis group to the index admission; provided that no exceptions apply (see Section IV.C, below).</p> <p>A subsequent admission within the 30-day period are evaluated in relation to the same initial index admission and do not establish a new index admission eliminating rolling readmissions.</p> <p>A subsequent admission is considered to be related to the index admission if it is for the same Diagnostic Related Group (DRG).</p> <p>Admissions occurring more than 30 days after discharge from the initial index admission are not considered readmissions under this policy.</p>
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IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Hospital Readmissions Reduction Program CMS
Hospital Readmissions Reduction Program Overview
Potentially Preventable Readmissions
Inpatient Policy Guidelines.pdf
Subpart I—Adjustments to the Base Operating DRG Payment Amounts Under the Prospective Payment Systems for Inpatient Operating Costs
Social Security Act §1886 (ssa.gov)
Customer Service Portal - QualityNet

VI. Revision History

Revision Date	Summary of Changes
9/1/2026	<ul style="list-style-type: none"> • Index Admission Anchoring: Updated definition to clarify that all readmissions within the 30-day period are anchored to the initial index admission, rather than resetting the index with each subsequent admission. • 30-Day Readmission Window Clarification: Reinforced that the 30-day window is measured from the discharge date of the initial index admission only. Admissions occurring outside this window are not considered readmissions and are not subject to denial. • Elimination of Rolling Readmission Logic: Removed prior interpretation that allowed subsequent admissions to establish a new index admission within the 30-day period. • Standardization of Relatedness Criteria: Clarified that related readmissions are determined based on the same Diagnostic Related Group (DRG), removing prior references to Major Diagnostic Categories (MDC). • No Change to Exceptions or Adjudication Process: All existing exception criteria, reimbursement guidelines, and adjudication/appeal processes remain unchanged.

Disclaimer

Healthfirst’s claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst’s coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor’s revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider’s participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.