Readmission Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Readmission is typically defined as a subsequent admission to a hospital within a predetermined time limit following discharge from the same or an affiliated (if applicable) hospital.

Molina Healthcare reviews claim that they fall into any of the following four categories:

- Repeat Readmission
- Combined Payment Methodology Readmission
- Potentially Preventable Readmission
- Planned Readmission

Molina Healthcare considers repeat, non-separately reimbursable, and planned readmissions as part of a single episode of care for which a single Diagnosis-Related Group (DRG) payment is made. Potentially preventable readmissions are considered fully paid for both the initial (anchor) and subsequent (readmission) hospital admissions by the single payment made for the initial (anchor) admission.

Reimbursement Guidelines

Repeat Readmissions

Repeat readmissions happen when a patient is discharged and readmitted to the same or affiliated hospital within a specified time limit as mandated by State/Federal regulations, typically 24 hours. If a repeat readmission occurs, Molina Healthcare will extend the authorization from the initial admission as a single stay. The facility must submit a combined, corrected claim including the total length of stay; combined billed charges for both admissions; and the appropriate DRG from the first admission circumstances. Molina Healthcare will deny the subsequent admission claim for a separate DRG payment.

Not Separately Reimbursable Readmissions

Not separately reimbursable readmissions occur when a patient is discharged and subsequently readmitted to the same or an affiliated hospital within a predetermined time limit as directed by State or Federal regulations (refer to the State Specific Readmission grid below). This situation arises when the readmission relates to the same, similar, or related condition as the initial admission. In such cases, Molina Healthcare will deny the claim for subsequent readmission as a separate Diagnosis Related Group (DRG) payment. The facility must resubmit a single, combined, corrected claim that includes the total length of stay, the combined billed charges for both admissions, and the appropriate DRG that corresponds to the circumstances of the initial admission.

Potentially Preventable Readmissions

Potentially preventable readmissions occur when a patient is discharged and subsequently readmitted to the same or affiliated (if applicable) hospital within a predetermined time limit as mandated by State/Federal regulations (refer to the State Specific Readmission grid below). These readmissions involve conditions that are the same, similar, or related to the initial admission and can be attributed to one or more of the following factors: premature or inadequate discharge from the initial admission, issues with transition or coordination of care, an acute medical complication plausibly related to the care during the initial admission, or inappropriate transfer to a lower level of care (e.g., skilled nursing facility, long-term acute care hospital, acute inpatient rehabilitation, inpatient substance abuse treatment, home health, etc.). When a potentially preventable readmission occurs, Molina Healthcare will deny the authorization request for admission. Additionally, Molina Healthcare will deny the subsequent (potentially preventable) admission claim for a separate DRG (Diagnosis Related Group) payment, as the payment made for the initial (anchor) admission is considered full payment.

Please note that while a readmission may be medically necessary, it may still be deemed preventable and subject to clinical preventable readmission review.

Planned and/or Leave of Absence Readmissions

Planned and/or Leave of Absence (LOA) readmissions occur when a patient is discharged and readmitted to the same or affiliated hospital within a pre-determined time limit as directed by State/Federal regulations (see State Specific Readmission grid below) for a planned non-acute readmission for a scheduled procedure. When a planned and/or LOA readmission occurs, Molina Healthcare will deny the subsequent readmission claim for a separate DRG (Diagnosis Related Group) payment. The facility must resubmit a single combined, corrected claim with the following: correct revenue, value, and occurrence span codes required for billing an LOA claim; a combined length of stay (including zero charge days of leave when applicable); and combined billed charges of both admissions.

The following are common occurrences that constitute a planned and/or LOA readmission:

- Surgery was unable to be scheduled immediately for any reason (e.g., surgical team is unavailable, pre-operative testing and/or clearance is pending).
- Planned bilateral or staged procedures.
- Surgical interventions that are expected or planned if conservative and/or non-operative therapy fails.

The following are not considered to be planned and/or LOA readmissions:

- Obstetric delivery
- Transplant surgery
- Chemotherapy, transfusions, dialysis, or similar repetitive treatments

MARKETPLACE :

State/Plan	Applicable Readmission Time span (based on State Law)	Repeat Admissions (within 24 hours unless otherwise noted)	Potentially Preventable Readmissions	Combined Payment Methodology Readmission
ALL	30 Days	Yes	Yes	Yes

MEDICARE:

State/Plan	Applicable Readmission Time span (based on State	Repeat Admissions (within 24 hours unless otherwise	Potentially Preventable Readmissions	Combined Payment Methodology Readmission

	Law)	noted)		
ALL	30 Days	Yes	Yes	Yes

MEDCAID:

State/Plan	Applicable Readmission Time span (based on State Law)	Repeat Admissions (within 24 hours unless otherwise noted)	Potentially Preventable Readmissions	Combined Payment Methodology Readmission
Arizona	72 hours	Yes	Yes	Yes
California	30 days	Yes	Yes	No
Connecticut	30 days	Yes	No	No
Florida	30 days	Yes	Yes	No
Georgia	72 hours	Yes	Yes	Yes
Idaho	30 days	Yes	Yes	Yes
Illinois	30 days	Yes	Yes	Yes
Iowa	30 days	Yes	Yes	Yes
Kentucky	14 days	Yes	Yes	Yes
Massachusetts	15 days	Yes	Yes	Yes
Michigan	15 days	Yes	Yes	Yes
Mississippi	15 days	Yes	Yes	Yes
Nebraska	30 days	Yes	Yes	Yes
New Mexico	15 days	Yes	Yes	Yes
New York	30 days	Yes	Yes	No
Ohio	30 days	Yes	Yes	No
South Carolina	30 days	Yes	Yes	Yes
Texas	30 days	Yes	Yes 15 days	Yes 30 days
Utah	30 days	Yes	Yes	Yes
Washington	14 days	Yes	Yes	No
Wisconsin	30 days	Yes	Yes	No

Supplemental Information

Definitions

Term	Definitions
CMS	The Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services (CMS) is a federal entity under the United States Department of Health and Human Services (HHS). It oversees the Medicare program and collaborates with state governments to manage Medicaid, the Children's Health Insurance Program (CHIP), as well as health insurance portability regulations.
Same or affiliated hospital	f a hospital is part of a hospital system operating under the same hospital agreement, and/or if the hospital shares the same tax identification number with one or more other hospitals, then a readmission during the same readmissions look-back 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.

State Exceptions

State	Exception
Nevada	Nevada is exempt from this policy.

Documentation History

Type	Date	Action
Initial Creation Date	03/01/2023	New Policy
Revised Date	02/20/2025	Added IA and NE to the policy
Revised Date	08/07/2025	Updated format
Revised Date	08/19/2025	Updated Initial Creation Date
Revised Date	08/22/2025	Removed Virginia references; added Connecticut and Georgia.

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

State	Reference lanuage	Reference Link
CMS	The Hospital Readmissions Reduction Program 30-day risk standardized unplanned readmission measures capture unplanned readmissions that happen within 30 days of discharge from the index (that is, initial) admission. The readmission measures include patients who are readmitted to the same hospital, or another applicable acute care hospital, no matter the principal diagnosis. The measures exclude some planned readmissions.	Hospital Readmission
Arizona	1. Recipient must be readmitted to the same hospital within 72 hours, and 2. The base DRG assignment on the readmission claim must match the base DRG assignment on the initial claim (the base DRG assignment is identified by the first three digits of the DRG code), and 3. In the event that the claim has been prior authorized, the readmission claim may be considered to have already gone through medical review.	AHCCCS Payment Policies Pg.18
California	30-day inpatient readmissions in California hospitals	CalHHS
Connecticut	In Connecticut, a readmission is defined as an admission to a hospital within 30 days of discharge from the same or a similar hospital.	Medicaid Hospital Reimbursement

	This timeframe is subject to state approval and may vary. Connecticut Medicaid has established reimbursement methodologies for inpatient services, and readmission days may be adjusted based on specific circumstances and medical records.	
Florida	In Florida Medicaid, a readmission is defined as an admission to a hospital within 30 days of discharge from the same or a similar hospital. This timeframe is subject to state approval and may vary. If a patient is readmitted within this period for symptoms related to the prior stay, the original claim for the first admission may be adjusted to include the second admission. Additionally, some policies may allow for combined claims for readmissions, depending on the circumstances and provider contracts.	FL Medicaid Provider Manual
Georgia	With the exception of the limitation described in 904.6, there is no limit on the number of medically necessary inpatient hospital days a Medicaid member is allowed. Readmission for the same or related problem within three (3) days of discharge is considered the same admission. Medical justification is the only criterion forhospitalization for eligible members. Documentation to substantiate medicalnecessity and appropriateness of setting may be requested in a prepayment or post paymentreview by the Division. Lack of appropriate medical justification may be cause fordenial, reduction, or recoupment of reimbursement.	Georgia Provider handbook Pg 32 Section 910.28
Illinois	• A readmission is defined as an inpatient readmission within 30 days after discharge that is clinically related to the initial admission, as defined by the PPR • The readmission is potentially preventable by the provision of appropriate care consistent with accepted standards, based on the 3M software, in the prior discharge or during the post-discharge follow-up period. • The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge. • The PPR Chain may have one or more readmissions that are clinically related to the Initial Admission. The first readmission is within 30 days after the Initial Admission, but the 30 day timeframe begins again at the discharge	IL Amin. Code 89 152.300

	of either the Initial Admission or the most recent readmission clinically related to the Initial Admission. For example, a patient is discharged after being admitted for back surgery and readmitted two weeks after the discharge for a post-operation infection that is clinically related to the back surgery. The 30 day period begins again at the discharge for the post-operation infection. However, if the patient is readmitted for a broken leg within 30 days after the post-operation infection, there is no clinical relationship and therefore not considered a PPR. Should a readmission occur within 30 days that is clinically related to the broken leg, then that would create a new PPR Chain separate from the back surgery. ● The readmission is to the same or to any other hospital.	
Iowa	Inpatient readmissions within 30 days for same condition (IAC 441 79.1(5)g.(5)) will be under a single DRG for both stays. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.	Iowa HHS Chapter III Provider-Specific Pg 31
Kentucky	(1) An unplanned inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO. (2)Reimbursement for an unplanned readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.	Section 12 Readmission
Michigan	Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single case/episode for payment purposes. If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode. Readmissions within 15 days for unrelated conditions, whether to the same or a different hospital, are considered new admissions for payment purposes.	MI Department of Community Health

Mississippi	PPHRs identify potentially preventable inpatient readmissions plus return emergency department visits that occur within 15 days of an initial admission. Hospital return events are considered potentially preventable if they are clinically related to the initial admission and the reason for the visit (as identified by the stay's APR-DRG) is not one of the globally excluded conditions. The Quality Incentive Payment Program (QIPP) will measure performance on the PPHR actual-to-expected ratio	Provider Readmission hanbook Pg.3
Nebraska	Medicaid adopts Medicare peer review organization regulations to control increased admissions or reduced services. All Medicaid patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.	title 471 section 003.03(J)
New York	Readmission claims are submitted when a Medicaid recipient is discharged from an acute hospital and readmitted to the same acute hospital within thirty (30) days of the original discharge for the same or a related condition for which the patient was treated at the time of the original discharge. Note: The original admission claim should be adjusted, not voided, to submit the readmission claim.	Ny Provider manual Section 2.3.3.4
Ohio	Readmissions within 30 days, that are due to complications or other circumstances that arose because of an early discharge and/or other treatment errors, the two inpatient hospital stays will be combined into one claim, and the second admission would no longer be denied.	OH ODM Pg.2
South Carolina	A readmission occurs when a patient is admitted to the same or any other facility within 30 days of discharge for the same DRG or general diagnosis as the original admission. Readmissions are subject to post-payment review and may be paid as two separate admissions unless the postpayment reviewer denies one of the admissions.	Provider manual Pg.13
Texas	If a hospital admission or readmission occurs within 30 days of a discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity, quality, and DRG validation including POA indicators.Transfers from one facility to another and readmissions are also	Provider manual Pg.24 Section 3.6.1.1

	subject to review.	
Utah	The Hospital Utilization Review Program shall review all suspected readmissions within 30 days of a previous discharge to ensure that Medicaid criteria have been met for severity of illness, intensity of service, and appropriate discharge planning and financial impact to the Department as noted in Subsection R414-2A-10(3)	Utah Office of Administrative Rules
Washington	Provider preventable fourteen-day readmissions	WAC 182-550-2950
Wisconsin	A claim that is a potentially preventable readmission associated with an initial admission within 30 previous days	Provider manual

*__CODING DISCLAIMER.__ Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.