

Troy Medicare Policy and Procedure



Title: Inpatient Readmission		Policy Number: UM - 013/CLM - 013	
Primary Department: Medical Management; Operations - Claims	LOB: Medicare Advantage	Author: J Murphy/M Blake	
Effective Date: 05/01/2023	Original Date: 01/01/2023	Review Date(s): 5/15/2023; 12/7/2023; 11/20/2024; 11/11/2025	Archive Date:
Interactive Related Department(s)			
<input type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input checked="" type="checkbox"/> Medical Management <input checked="" type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing	<input checked="" type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Pharmacy <input type="checkbox"/> Member Services <input type="checkbox"/> Quality Management <input checked="" type="checkbox"/> Utilization Management	<input type="checkbox"/> Care Management <input type="checkbox"/> Enrollment <input type="checkbox"/> Plan Administration <input checked="" type="checkbox"/> Claims <input type="checkbox"/> Other	

Disclaimer: Disclaimer: Disclaimer: Troy Medicare Utilization Management applies CMS criteria and guidelines, National and Local Coverage Determinations (NCD/LCD), Clinix Internal Review Guidelines, Troy Utilization Review Policies, and MCG (Milliman Criteria Guidelines) Criteria. This suite of guidelines covers the spectrum of inpatient, outpatient, and rehabilitation, and care for medical, surgical, and behavioral health issues. In addition, Troy partners with vendors who provide clinical expertise for specific services.

POLICY PURPOSE

Troy Health, Inc. is committed to comply with all regulations and requirements for Medicare Advantage Plans. This policy provides guidance on how Troy Medicare’s Utilization Management and Claims Departments have established requirements for the Readmissions to acute care hospitals occurring less than 30 calendar days from date of discharge. These Readmissions are considered a Quality of Care issue and Readmissions will be reviewed as such - Troy Medicare will review a Readmission hospitalization to determine: (1) that it was medically necessary, (2) that it was not a result of premature discharge of the patient from the same hospital, (3) that it did not result due to a lack of coordination in the transition of care between the acute care facility and the outpatient setting, or (4) if the care rendered on Readmission could have been provided during the first initial admission.

Troy Medicare created this policy to align itself with CMS' Quality Improvement Organization (QIO) program. All Troy Medicare network participating Acute Care Facilities are required to

honor the Plan's determinations and must hold the Plan member harmless for the cost of any such denied Readmission Hospitalization. Facility may request peer-to-peer and/or submit a formal appeal of the denial of separate reimbursement for the Readmission Hospitalization.

Troy Health, Inc. is committed to complying with all regulations and requirements for Medicare Advantage Plans, and applicable federal and state laws, including health care fraud and identity theft laws.

SCOPE

This policy applies to hospitalizations at participating acute care facilities.

REFERENCES

1. Hospital Readmission Reductions Program - 42 CFR §§ [412.152](#) and [412.154](#).
2. [Social Security Act, Sections 1886\(q\) and \(d\)\(1\)\(B\)](#)
3. [Medicare Claims Processing Manual Chapter 3, Section 40.2.5-Repeat Admissions](#)
4. [Medicare Quality Improvement Organization Manual, Chapter 4, Section 4240](#)
5. CMS Hospital Readmissions Reduction Program (HRRP)
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program>. Updated: 8/8/2022.

RESPONSIBLE PARTIES

- Vice President, Health Services
- Vice President, Operations
- Chief Medical Officer

DEFINITIONS

Acute Care Facility: refers to an acute, general, short-term hospital. Referred to in this policy as a Hospital.

Centers for Medicare & Medicaid Services (CMS) is the Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program and oversees all Medicare Advantage (MA) organizations and Part D plan sponsors.

Index Hospitalization: the initial hospitalization at an Acute Care Facility (hospital) where the discharge date occurred less than 30 days prior to the admission of the Readmission hospitalization.

Member: An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).

NOA: Notice of Admission.

Plan: Troy Medicare; a Medicare Advantage Plan. also refers to employees of the Plan performing tasks and activities as indicated in the policy.

Premature Discharge of Patient That Results in Subsequent Readmission of Patient to Same Hospital: Occurs when a patient is discharged even though he/she should have remained in the acute care facility for further testing or treatment or was not medically stable at the time of discharge. A patient is not medically stable when, in the Plan's judgment, the patient's condition is such that it is medically unsound to discharge or transfer the patient.

Evidence such as elevated temperature, postoperative wound draining or bleeding, or abnormal laboratory studies on the day of discharge indicate that a patient may have been prematurely discharged from the acute care facility.

Prospective/Concurrent Review (CCR): refers to a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services.

Readmission Hospitalization: referred to in this policy as Readmission; a hospitalization at an Acute Care Facility (hospital) whose admission occurred less than 31 days after the index hospitalization's discharge date.

Readmission of Patient to Hospital for Care That Could Have Been Provided during First Admission: This prohibited action occurs when a patient is readmitted to an acute care facility for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission. This action does not include circumstances in which it is not medically appropriate to provide the care during the first admission.

Retrospective Review: refers to a request for coverage of medical care or services after a member has received the requested medical care or services.

Same day: refers to a time period defined as midnight to midnight of a single day.

Same or similar condition or diagnoses: refers to a condition or diagnosis, which is the same or similar when compared between the Index hospitalization and Readmission hospitalization.

Same, similar or related reason: refers to where the reason for readmission is for the same, similar or related condition as the Index Hospitalization.

POLICY

Troy Medicare's Utilization Management (UM) and Claims department/staff, as part of the Troy Medicare Operations organization, will conduct a Readmission review that involves admissions to an acute care facility occurring less than 31 calendar days from the date of discharge from the same care facility. Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred. Authorization of either hospitalization is not a guarantee of payment and Troy Medicare reserves the right to review and combine reimbursement payments for readmissions per CMS regulations. Reviews for readmission may be conducted prospectively, concurrently or retrospectively.

PROCEDURE

Prospective/Concurrent Review

1. For each Readmission hospitalization, the Notifications of Admissions (NOA) and/or clinical information provided for concurrent review will be reviewed for a Readmission hospitalization if:
 - a. Index hospitalization discharge occurs less than 31 calendar days from Readmission hospitalization, AND
 - b. Discharge is from the same facility
2. If the Readmission hospitalization in question is deemed reviewable, review will include:
 - a. The Readmission hospitalization notes available will be compared against the Index hospitalization notes in the medical management system for:
 - i. Premature discharge of member that results in subsequent readmission of

- patient to same hospital;
 - ii. Readmission of member to hospital for care that could have been provided during index admission; or
 - iii. Lack of coordination of care during the discharge transition.
 - b. In reviewing the Readmission hospitalization and Index hospitalization notes, the reviewer will investigate and apply criteria including but not limited to:
 - i. Same or similar condition or diagnoses;
 - ii. Same, similar or related reason;
 - 1. The same or closely related condition or procedure as the prior discharge
 - iii. An infection or other complication of care.
 - iv. A condition or procedure indicative of a failed surgical intervention.
 - v. An acute decompensation of a coexisting chronic disease.
 - vi. A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.
 - vii. An issue caused by a premature discharge from the same facility.
 - viii. Planned readmission; or
 - ix. Complication due to care, such as surgery, performed during index hospitalization.
 - 1. Excluded from Readmission review:
 - a. Discharge from Index hospitalization was against medical advice (AMA);
 - b. Readmission that is planned for repetitive treatments (for example, cancer chemotherapy);
 - c. Readmission is for scheduled elective surgery; and
 - d. Maternity readmission.
 - e. Involuntary admission (BH); and
 - f. Court mandated (BH)
 - c. With the available information, the reviewer will either:
 - i. Determine whether the Readmission hospitalization does not meet the criteria above and review the Readmission hospitalization for medical necessity as per normal concurrent review process.
 - ii. Where the Readmission hospitalization meets the criteria as noted above, the reviewer will refer the Readmission hospitalization to the Plan Medical Director and/or their designee for review.
- 3. The Plan Medical Director and/or their designee will make final determination regarding the Readmission hospitalization.
 - a. If it is determined that the Readmission hospitalization does not meet the criteria noted above, the denial will be issued as a Readmission hospitalization denial.
 - i. As a result of the denial, reimbursement for Readmission hospitalization will be combined with the Index hospitalization and the first payment will be considered payment in full for the two hospitalizations.

Retrospective Review

1. For each claim received for inpatient admission, the Claims team will review to determine if meets potential criteria for a Readmission hospitalization if:
 - a. Index hospitalization discharge occurs less than 30 calendar days from Readmission hospitalization, AND

- b. Discharge is from the same facility.
2. Medical records for both admissions will be requested and reviewed to determine if the Readmission hospitalization meets the criteria in the Prospective/Concurrent Review subsection.
3. Failure of the provider to provide complete medical records from the Index hospitalization and Readmission hospitalization may result in denial of claims payment.
4. When it is determined that the Readmission hospitalization met the criteria in the Prospective/Concurrent Review subsection, the reimbursement for Readmission hospitalization will be combined with the Index hospitalization and the first payment will be considered payment in full for the two hospitalizations.

Appeals/Provider Dispute Process

1. A Plan Network/Contracted Provider may submit a written dispute to appeal the decision of Readmission via the formal process. Submission must be submitted in writing and within 60 days of the notification of decision. Supporting medical records and documentation that indicates the reason why the hospitalization should not be considered as a Readmission as defined by this policy must be included.

Planned Readmission and Use of Leave of Absence

1. When a Readmission hospitalization is expected and the member does not require a hospital level of care during the interim period, the member may be placed on leave of absence by the provider.
 - a. Examples include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately.
2. The Plan expects providers to submit one claim for covered days and days of leave when the patient is ultimately discharged. The admissions are not considered two (2) separate admissions.
3. During the above the Plan's Claims department pends and reviews; the Plan may review cases for proper medical billing.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES/FORMS

- *Troy Medicare Policy – UM - 002 Clinical Guidelines for Inpatient Stays*

APPROVALS

Jennifer Murphy
Jennifer Murphy (Nov 30, 2025 14:13:33 EST)

Chief Clinical Officer

11/30/2025

Date

Sally Scott
Sally Scott (Nov 28, 2025 14:29:53 EST)

UM Committee

11/28/2025

Date

Revision History

Revision Date	Revised by Whom	Revisions Made
5.1.2023	J Murphy/M Blake	Initial policy
4.26.2023	J Murphy	Review by Policy Committee
12.7.2023	J Murphy	Annual review by Utilization Management Committee
11.20.2024	J Murphy	Revised disclaimer. Annual review by Utilization Management Committee
11.11.2025	J Murphy	Annual review by Utilization Management Committee. Revised policy purpose,