Medicare Readmission Review Program for Medicare Advantage plans

Frequently asked questions

Overview

The UnitedHealthcare Medicare Readmission Review Program reviews readmissions at facilities that are reimbursed through the Medicare Severity Diagnosis Related Group (MS-DRG) payment method.

This program applies to all UnitedHealthcare® Medicare Advantage plans and has 2 types of reviews:

- **Billing:** This review is based on the Centers for Medicare & Medicaid Services (CMS) billing guidelines for same-day readmissions and leave of absence episodes
- **Quality-of-care:** Incorporates readmission reviews into payment to facilities receiving MS-DRG payment, based on CMS guidelines

This program is based on MS-DRG reimbursement rules and isn't a review for medical necessity.

What are the criteria for the Medicare Readmission Review Program?

The readmission criteria for the program are as follows:

- The readmission occurred less than 31 days after the initial member discharge
- The readmission was for a diagnosis related to the initial member admission
- The readmission was at the same facility

If the criteria are met, we will request medical records and supporting documentation for the member's initial discharge and admission.

For more information on what materials and information we review for the program, please read the **Medicare Readmission Review Program guidelines** posted in the Tools and Resources section of each Medicare Advantage plan.

Questions

If you have questions or would like more information, please contact your provider advocate or visit **UHCprovider.com.**

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What information should I include in the medical record request?

We may ask you to submit the following type of medical records:

- Emergency room/admission records
- Medical history
- Consultations
- Physician orders
- Physician and nursing progress notes
- Ancillary reports (e.g., laboratory reports, X-rays, medication administration records or treatment administration records)
- Discharge summary

If you don't send us complete medical records, we'll issue an administrative denial letting you know which parts of the records are incomplete. If the requested records are still not complete in your second response, we'll issue another administrative denial, and we'll move the claim through the appeal process. During the appeal process you'll have another opportunity to submit the complete medical records.

How do I send the medical records for review?

Send the medical records using the instructions outlined in the provider remittance advice (PRA) or the medical record request letter we sent you. Please provide a complete set of medical records from the initial inpatient stay and readmission within 52 calendar days from the date of the original letter request.

Mail paper copies of medical records to:
UnitedHealthcare
P.O. Box 31362
Salt Lake City, UT 84131-0362

You can also send medical records in electronic formats, such as a CD or DVD. The records must include the member's name, identification number and group policy number. Accepted file formats on the CDs are tiff, txt, pdf, doc and xls.

CDs should be password-protected with the generic password we designate. If you don't know the password, please contact your provider advocate or Provider Services.

Mail electronic medical records to:
UnitedHealthcare
1355 S4700, W. Suite 100
Salt Lake City, UT 84104

Who reviews the claims?

The initial submitted inpatient facility claims are reviewed either by a licensed vocational nurse (LVN), licensed practical nurse (LPN) or registered nurse (RN). Then, an RN reviews the discharge summary and medical records. If the admissions appear to be unrelated or unavoidable, an LPN, LVN or RN will release the claim for payment.

For cases that involve potentially avoidable readmissions or billing determinations, the RN reviews the information and submits the case to a medical director for payment determination.

If the medical director determines that the readmission was avoidable, we'll deny payment for the readmission (second claim). In that case, we'll send you a letter that outlines the reason for the denial and will provide the reconsideration and appeal rights to the facility at the service location of the member.

If additional medical records are reviewed under reconsideration or appeal, a different medical director will review them.

If our claim is still denied after the review of medical records, how can we appeal?

Both contracted and non-contracted health care professionals have reconsideration and appeals rights for denied claims. You can find specific information about your reconsideration or appeal rights in the letter we sent you.

For health care professionals contracted with UnitedHealthcare Medicare Advantage plans, excluding private fee-for-service (PFFS) plans, the reconsideration and appeals process is overseen by the **Provider Administrative Guide** and the facility contractual agreement.

For health care professionals not contracted with UnitedHealthcare Medicare Advantage plans, including PFFS plans, the appeals process is overseen by CMS.

All claims denied under the Medicare Readmission Review Program are denied as a health care professional liability. This means a plan member isn't liable for these denied claims, and you can't balance bill a member for the denied claim.

Are our claims subject to the Medicare Readmission Review Program if we don't have UnitedHealthcare Medicare Advantage plans?

Yes. Federal regulations require us to reimburse health care professionals who don't have contracts for our Medicare Advantage plans the same amount they'd receive from original Medicare. For acute care hospitals, this means reimbursement in accordance with the CMS MS-DRG payment method.

Are other resources available with readmission review information?

Visit **CMS** or the **American Hospital Association** for more information about readmission reviews.

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