

# UnitedHealthcare Medicare Readmission Review Program for Medicare Advantage Plans Frequently Asked Questions

## Key Points

- The UnitedHealthcare Medicare Readmission Review Program reviews readmissions at facilities reimbursed using Medicare Severity Diagnosis Related Group (MS-DRG) payment methodology.
- The program incorporates both billing review and quality of care review.
- This program applies to all of the UnitedHealthcare Medicare Advantage plans.
- Readmission review uses the Centers for Medicare & Medicaid Services (CMS) MS-DRG payment methodology.
- Medical records are required for both inpatient confinements within 30 days of each other. They can be submitted by mail to UnitedHealthcare using either paper copy or electronic format.

## Overview

Under the Readmission Review Program, we review readmissions at facilities reimbursed using MS-DRG payment methodology, incorporating both billing review and quality of care review. The UnitedHealthcare Readmission Review Program applies to all UnitedHealthcare Medicare Advantage plans. This document addresses common questions we get about the Readmission Review Program.

## Frequently Asked Questions and Answers

### Q1. What is the UnitedHealthcare Medicare Readmission Review Program?

- A1. The UnitedHealthcare Medicare Readmission Review program has two different types of review for Medicare Advantage plans: billing review and quality of care review.
- a. **Billing review** – Based on CMS billing guidelines for same-day readmissions and leave of absence episodes.
  - b. **Quality of care review** – Incorporates readmission review into payment to facilities receiving MS-DRG payment, based on CMS published guidelines.

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

### Q2. What criteria does UnitedHealthcare use for the Readmission Review Program?

- A2. The program is for readmissions at facilities reimbursed using MS-DRG payment methodology that meet this criteria:
- a. The readmission occurred fewer than 31 days after the initial member discharge.
  - b. The readmission was for a diagnosis related to the initial member admission.
  - c. The readmission was at the same facility.

If the criteria are met, UnitedHealthcare will request medical records and supporting documentation for the initial discharge and subsequent admission.

For more information on what materials and information UnitedHealthcare reviews for the program, please read the Readmission Review Program Guidelines available at **UHCprovider.com** > Health Plans by State > Choose your state > Medicare > Select plan name > Tools & Resources > Readmission Review Program Clinical Guidelines.

**Q3. Our facility isn't contracted for UnitedHealthcare Medicare Advantage plans. Are our claims subject to the Readmission Review Program?**

A3. Yes. Federal regulations require us to reimburse care providers 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 methodology.

Readmission review is an integral part of CMS MS-DRG payment methodology. In general, CMS policies are based on the Medicare beneficiary's experience. These policies are designed to help protect plan members and to avoid incentives for poor quality care.

As with Original Medicare, UnitedHealthcare is responsible for monitoring the quality of our plan member's care. This includes potentially avoidable readmissions under MS-DRG payment methodology. If a non-contracted health care provider provides covered services to a Medicare member, whether enrolled in Original Medicare or a Medicare Advantage plan, the services are still subject to CMS payment policies.

UnitedHealthcare reviews claims for all of our Medicare Advantage plans, including health maintenance organization (HMO), HMO-point of service (POS), preferred provider organization (PPO) and private fee-for-service (PFFS) plans, when the facility provider is reimbursed using MS-DRG payment methodology.

**Q4. Original Medicare doesn't review our claims for appropriate readmission. Why does UnitedHealthcare do something different for its Medicare Advantage members than Original Medicare does for non-Medicare Advantage members?**

A4. Medicare Advantage plans use tools to promote the quality and affordability of health services provided to Medicare beneficiaries. CMS holds Medicare Advantage plans accountable for quality measures through the CMS Star Ratings system. Preventable readmissions are one of the most important factors in evaluating quality of care, as indicated by the heavy weighting assigned to that Star measure. The Readmission Review Program offers a valuable opportunity to our Medicare Advantage plan members and the facilities serving them to evaluate the quality of services given.

CMS guidance about readmission applies to MS-DRG payment methodology nationwide. However, CMS contracts regionally with fiscal intermediaries to manage payments for Original Medicare member claims. While the fiscal intermediary in your market may not currently review your inpatient claims prospectively against a readmission review policy, UnitedHealthcare has

adopted a uniform review program consistent with CMS Medicare Claims Processing Manual, Publication 100-4, Chapter 3, Section 40.2.5.

**Q5. Why is UnitedHealthcare requesting medical records? What information should be included in the medical record request?**

A5. CMS regulations require a patient's complete medical record to perform a review. Original Medicare has tasked the Quality Improvement Organization (QIO) to perform quality reviews on Medicare members, which includes Readmission Review. You can find more details in the QIO Manual, chapter 4, section 4240.

CMS requires Medicare Advantage plans to perform quality reviews, similar to the role of the QIO. The QIO Manual "Quality of Care Review" chapter (section 5045.4) says to verify that "each medical record request contains the major documentation components, particularly, those relevant to the quality of care concern. Examples include, but are not limited to, the following: emergency room record/admission record; history and physical; consultations; practitioner orders; practitioner progress notes; nursing notes; ancillary reports (e.g., laboratory reports, X-rays, medication administration record, treatment administration record); discharge summary."

Complete medical records should be sent to us for any request. We may not be able to review for billing purposes or determine if a readmission was preventable if part or all of the medical record is missing. In this situation, an administrative denial will be issued stating which part of the records is incomplete. If the requested records are not received in the facility response, another administrative denial will be issued and the claim will begin to move through the reconsideration and/or appeal process. Additional opportunities will be provided at these levels for the facility to submit the missing medical record information and allow for a complete clinical review.

**Q6. How do I send medical records to UnitedHealthcare for review?**

A6. Medical records should be submitted using the instructions in either 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.

Paper copies of medical records can be submitted by mail to:

UnitedHealthcare  
P.O. Box 31362  
Salt Lake City, UT 84131-0362

You can also send medical records in electronic format such as a CD or DVD. The records must include the member name, member identification number and member's 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 designated by UnitedHealthcare. If you don't know the password, please contact your Provider Advocate or Provider Services. Please mail electronic records to:

UnitedHealthcare  
1355 S4700, W. Suite 100  
Salt Lake City, UT 84104

**Q7. Do physicians review claims associated with the Readmission Review Program?**

- A7. The initial submitted inpatient facility claims are reviewed by a Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN) or Registered Nurse (RN).

An RN performs a complete review of the medical records after the discharge summary and medical records are submitted for review. If the admissions appear to be unrelated or unavoidable, the LVN, LPN 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, payment for the readmission (second claim) is denied. In addition to an updated PRA, a letter that outlines the rationale for the denial and provides the reconsideration and appeal rights is sent 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 take a look.

**Q8. If our claim is still denied after the review of medical records, how can we appeal?**

- A8. Both contracted and non-contracted facility care providers have reconsideration and appeals rights for denied claims. You can find specific information about reconsideration and/or appeal rights in the adverse determination letter we sent you.

For facility care providers contracted with UnitedHealthcare Medicare Advantage plans (excluding PFFS plans), the reconsideration and appeals process is governed by the Provider Administrative Guide and the facility contractual agreement.

For facility care providers not contracted with UnitedHealthcare Medicare Advantage plans (including PFFS plans), the appeals process is governed by CMS.

All claims denied under UnitedHealthcare's Readmission Review Program are denied as care provider liability. A plan member isn't liable for these denied claims. Care providers aren't allowed to balance bill a member for the denied claim.

**Q9. Are other resources available with readmission review information?**

A9. Yes. You can find more information about readmission reviews at:

- **CMS.gov:** CMS website
- **AHA.org:** American Hospital Association website – may require user registration

**Q10. Who do I contact if I have questions?**

A10. If you have questions or would like more information, please contact your Provider Advocate or visit **UHCPProvider.com** > Health Plans by State > Choose your state > Medicare > Select plan name > Tools & Resources > Readmission Review Program Clinical Guidelines.