

Medicare Readmission Review Program for UnitedHealthcare 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 Medicare reimbursement rules and isn't a review for medical necessity. Rather, we are reviewing to determine if the member was prematurely discharged from the first admission and thus whether the second admission should be reimbursed separately or incorporated into the reimbursement for the first admission.



Questions? We're here to help.

For chat options and contact information, visit UHCprovider.com/contactus.



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 (when not previously available) for the 2 hospital admissions to determine if the second admission should be reimbursed separately or incorporated into the reimbursement for the first 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.



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 may issue an administrative denial. During the appeal process, you'll have another opportunity to submit the complete medical records.



How do I send the medical records for review?

If medical records not previously accessed or submitted are needed, you can 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



If our claim is still not separately reimbursed 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.

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.