UnitedHealthcare Community Plan Readmission Review
Frequently Asked Questions

Q1. Why does UnitedHealthcare Community Plan perform readmission review?

A. As part of our quality initiatives, UnitedHealthcare Community Plan has implemented readmission review for contracted and non-contracted facilities based on state and the Centers for Medicare & Medicaid Services guidelines, as well as individual provider contract agreements. Readmission review does not involve a review for medical necessity, but rather a determination of whether unplanned readmissions meeting certain criteria were preventable. Readmission review helps ensure members receive appropriate care and discharge planning during an initial admission, and improve patients' health outcomes.

Q2. What are the components of the UnitedHealthcare Community Plan readmission review?

A. We review claims on a concurrent, pre-payment review and post-service basis for facility admissions which occur within 30 days (or as otherwise required by state regulations and/or provider contracts) after discharge from the same hospital, and which have the same, similar, or related diagnosis as the initial admission. Definitions of concurrent, prepayment, and post-service reviews are:

Concurrent review – monitors medical treatment while the member is an inpatient

Pre-payment review – before claim is paid

Post-service payment review – after claim is paid

As part of the post-service/pre-pay readmission review process, we will request and review medical records and supporting documentation relating to the initial admission, including discharge, and the subsequent admission. Readmission review applies to all dual-eligible, long term care, Medicaid and CHIP plans. We may deny payment to the facility for the subsequent admission if it meets certain criteria and is determined to have been preventable.

Q3. What criteria does UnitedHealthcare Community Plan use for readmission review?

A. Readmission review focuses on subsequent admissions to participating and non-participating facilities that meet all of the following criteria:

- Did the subsequent admission(s) occur within30 days (or as specified by state regulations or provider contract) after the initial discharge?
- Is the subsequent admission(s) for the same, similar, or related diagnosis as the initial admission?
- Is the subsequent admission(s) to the same hospital or hospital system?

When we identify readmissions meeting the above criteria (excluding certain conditions where repeat admissions are expected, such as pregnancy and chemotherapy), a request for medical records will be made for the **initial and all related subsequent admissions** from the remittance advice.

Information that may be requested for medical record reviews
Patient medical records containing the admit through discharge information for the hospital stays beginning on admit dates of service (initial admission date and subsequent admission date) need to include: • History and physical • Admission and discharge summaries • Physicians' orders • Emergency room records • Progress notes • Nurses' notes • Diagnostic and laboratory testing

For more details on the clinical guidelines, refer to the Readmission Policy (reference number F7001) available at UHCCommunityPlan.com. Select For Health Care Professionals, then click "Reimbursement Policy" on the left navigation bar.

Q4. What is the process for submitting medical records to UnitedHealthcare Community Plan for review?

A. Medical records should be submitted according to the instructions in either the Provider Remittance Advice (PRA) or the letter received from UnitedHealthcare Community Plan. Medical records may be submitted by paper copy or stored in electronic format on either a CD or DVD and mailed. Records mailed in this manner must include the member name, member's UnitedHealthcare Community Plan identification number, and meet federal privacy laws.

Q5. Who reviews the claims associated with readmission review?

A. If the claim is subject to readmission review, UnitedHealthcare Community Plan will request medical records and supporting documentation related to the readmission, including the prior admission and discharge planning.

   A UnitedHealthcare nurse will perform an initial review and makes a determination of whether the admissions appear related. In the event that it is determined that they were unrelated, the nurse will release the claim for payment. Cases that involve potentially preventable readmissions are then reviewed by a UnitedHealthcare Community Plan medical director.

   If the medical director determines that the subsequent admission was preventable, payment will be denied. In addition to an updated PRA, we will send a letter to the facility, which outlines the rationale for the denial and provides the reconsideration and appeal rights for the facility.

Q6. If, after the review of medical records, the facility's claim is denied, what appeal rights are available?

A. Both contracted and non-contracted facility providers have reconsideration, dispute, and/or appeal rights for all denied claims.

For contracted facilities participating in UnitedHealthcare Community Plan network, reconsideration and appeal rights are listed in the Provider Administrative Manual and the facility's participation agreement. If the facility requests a reconsideration or appeal of the payment denial per the terms of the facility's participation agreement, a different UnitedHealthcare Community Plan medical director will conduct the next level of review.

For facilities that do not participate in the UnitedHealthcare Community Plan network, the reconsideration, dispute, and/or appeals process for payment disputes is governed by CMS, State regulations, and/or UnitedHealthcare Community Plan contract with the State. For more information on the non-contracted provider dispute process, go to the UHCCommunityPlan.com. Select Health Care Professionals, choose your state. From the left navigation bar, select the Provider Administrative Manual applicable to the member's benefit plan when more than one manual is available.

Q7. Can members be billed if the facility subsequent admission is denied for payment?

A. No. All claims denied as a result of readmission review are denied as provider liability and the member cannot be balance billed for the denied claim.

Q8. What is UnitedHealthcare Community Plan doing to reduce preventable readmissions and improve quality outcomes?

A. We have a number of initiatives, some national and some market-specific, to assist facilities in understanding their readmissions rates and trends, and collaborate to improve discharge plans and post-acute care follow-up for patients. For information on initiatives available in your market, please contact your provider advocate.

Q9. Are other resources available with information about readmission reviews?

A. The following websites are available for more information about Readmission Reviews:
- UHCCommunityPlan.com, Select For Health Care Professionals, choose the State, then click on "Reimbursement Policy" on the left navigation bar
- Your State-specific Medicaid website (as applicable)
- cms.gov – Centers for Medicare &Medicaid Services website
- aha.org – American Hospital Association website