UnitedHealthcare Medicare Solutions
30-Day Readmission Review Program for Medicare Advantage Plans

Frequently Asked Questions

This readmission program will apply to all UnitedHealthcare Medicare Advantage products carrying the SecureHorizons®, AARP® MedicareComplete® from SecureHorizons, and Evercare® name.

1. What is the UnitedHealthcare Medicare 30-Day Readmission Review Program?

UnitedHealthcare Medicare Solutions has established a quality of care program to incorporate readmission review into its payment to facilities receiving Medicare Severity Diagnosis Related Group (MS-DRG) payment based upon Centers for Medicare & Medicaid Services (CMS) published guidelines. This is a quality of care program based upon MS-DRG reimbursement rules, and is not a review for medical necessity.

2. What criteria does UnitedHealthcare Medicare use for the 30-Day Readmission Review Program?

The UnitedHealthcare 30-Day Readmission Review program targets readmissions at facilities reimbursed using MS-DRG payment methodology that meet the following criteria:

- Is it a readmission within 30 days of the initial discharge?
- Is it a same, similar, or related diagnosis?
- Is it the same hospital?

Discharges meeting these criteria are subject to request for discharge summary and medical records in order to perform the review.


3. Our facility is not contracted for UnitedHealthcare Medicare programs. Are our claims subject to this 30-Day Readmission Review Program?

Yes. Under federal regulations, UnitedHealthcare is required to reimburse providers who do not have contracts to participate in our Medicare Advantage plans the same as those providers would receive with Original Medicare. For acute care hospitals, this means
reimbursement in accordance with Centers for Medicare & Medicaid Services’ (CMS’) MS-DRG payment methodology. Under CMS guidance, readmission review is an integral part of the MS-DRG payment methodology.

In general, CMS policies are based on the Medicare beneficiary’s experience. These policies are designed to protect our members and avoid incentives for poor quality care. As with Original Medicare, UnitedHealthcare is charged with monitoring the quality of patient care which includes potentially avoidable readmissions under MS-DRG payment methodology. If a non-contracted health care provider provides covered services to a Medicare beneficiary, whether enrolled in Original Medicare or a Medicare Advantage plan, those services are subject to CMS payment policies.

UnitedHealthcare reviews claims for all of its Medicare Advantage plans, including HMO, HMO-POS, PPO, and PFFS, when the facility provider is reimbursed using MS-DRG payment methodology.

4. Original Medicare does not review our claims for appropriate readmission. Why is UnitedHealthcare doing something different for its Medicare Advantage members than Original Medicare does for non-Medicare Advantage members?

Medicare Advantage plans are able to use tools to promote the quality and affordability of health services rendered to Medicare beneficiaries. As such, the 30 day hospital readmission program offers a valuable opportunity to our Medicare members and the facilities serving them to evaluate the quality of services rendered. The CMS guidance regarding readmission applies to all MS-DRG payment methodology nationwide; however, CMS contracts regionally with Fiscal Intermediaries (FI) to administer claims payment for Original Medicare member claims. While the FI in your market may not currently review your inpatient claims prospectively against a readmission review policy, UnitedHealthcare, as a national company, has adopted a uniform review program consistent with CMS Medicare Claims Processing Manual, Publication 100-4, Chapter 3, Section 40.2.5.

5. How do I get medical records to UnitedHealthcare for review?

Medical records should be submitted per the instructions on either the Provider Remittance Advice (PRA) or the letter received from UnitedHealthcare with the request for discharge summary and medical records. Medical records may be stored in electronic format on either a CD or DVD and mailed. Records mailed in this manner must include the member name, member identification number, and member’s group policy number.

6. Are the claims associated with the 30-Day Readmission Review Program reviewed by physicians?

The initial triage of the submitted inpatient facility claim is done by a Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN) or Registered Nurse (RN).

A LVN, LPN or 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, the LVN, LPN or RN 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 Provider Remittance Advice (PRA), a letter is sent to the facility (at the service location of the member) which outlines the rationale for the denial and provides the reconsideration and appeal rights.

If additional medical records are reviewed under reconsideration or appeal, a different medical director is utilized.

7. If, after the review of medical records, our claim is denied, what are our appeal rights?

Both contracted and non-contracted facility providers have reconsideration and appeals rights for all denied claims.

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

For facility providers not contracted with UnitedHealthcare Medicare Advantage plans (including PFFS plans), the reconsideration and appeals process is governed by CMS. For more information on the non-contracted dispute process, go to website: UnitedHealthcareOnline.com: Tools & Resources > Products & Services > Medicare > click on “Medicare Non-Par Provider Appeal/Dispute Rights” document.

All claims denied under UnitedHealthcare’s 30-Day Readmission Review Program are denied as provider liability. The member is not liable for these denied claims. Providers are not permitted to balance bill the member for the denied claim.

8. Are other sources available with information about readmission reviews?

Yes, the following websites are available:

www.cms.gov – Centers for Medicare and Medicaid Services website
www.palmettogba.com – Palmetto GBA website
www.aha.org – American Hospital Association website (may require user registration)