UnitedHealthcare Community Plan of New Mexico readmission review process

Quick reference guide

Overview

Validating facility readmissions can help improve members' quality of care and may lower health care costs. To support this commitment, UnitedHealthcare Community Plan of New Mexico reviews acute care readmission claims to determine the appropriateness of the readmission and related billing. This review process follows CMS guidelines and the **New Mexico Administrative Code (NMAC)** and is used to reimburse network and out-of-network acute care facilities.

Questions? We're here to help.

Please contact your provider advocate.

Criteria for readmission review

We review a member's readmission to an acute care facility when all the following situations apply:

- The readmission occurred fewer than 31 days after the initial discharge date
- The readmission was not preplanned or scheduled
- The readmission occurred at the same facility or within the same tax identification number group

Readmission review process

When all the above criteria are met, we'll request and review medical records, supporting information and discharge documentation for the member's initial admission and subsequent readmission. From our review of both stays, we'll determine if:

- The readmission was clinically related to a premature discharge from the original admission involving the same condition, treatment and/or complications
- The readmission was preventable
- The readmission was correctly billed

We'll base our decision on how to pay the claim according to the **NMAC** guidelines.

Review of premature discharge

The reviewer considers whether a premature discharge caused a preventable readmission. Based on the requirements of the **CMS State Operations Manual, Appendix A §482.43**, some of the factors they review include, but are not limited to, the following:

- Inadequate discharge planning
- Clinical instability at the time of discharge
- Failure to address signs and symptoms during an admission
- Discharge to an inappropriate destination

Review of discharge planning

The reviewer follows CMS guidance when assessing discharge planning:

- Adequate outpatient follow-up or treatment – Discharge planning must consider the availability and criticality of outpatient follow-up visits and treatment. Communication with practitioners who will provide follow-up care is expected.
- Address rehabilitation needs – Significant decline in function and inability to perform activities of daily living is common following hospitalization. Failure to properly address rehabilitation needs related to an inability to self-care is an avoidable cause of readmission.
- Discharge to another facility – Failing to transfer the member to a skilled nursing facility, long-term care hospital, acute inpatient rehabilitation or similar facility can be an indicator of premature discharge. Discharges with expected readmissions are treated as leaves of absence. Errors made at the receiving facility that are unrelated to the transfer orders (e.g., falls, treatment delivery failure) will not lead to payment denial for the readmission.

Review of preventable readmission

When determining if a member's readmission was preventable, the reviewer considers multiple factors, including:

- Treatment interruptions for a chronic disease or not resuming chronic medications
- Medication errors
- Improper follow-up care and outpatient management – If accepted practice guidelines and treatment protocols are not followed, or if generally accepted treatments are not ordered, the reason must be documented in the medical record
- Premature discharge – A discharge is considered premature if either of the following occurs:
  - Symptoms from a previous admission worsen and require readmission
  - A member is discharged before the attending physician confirms the safety or efficacy of a new treatment regimen
- Inadequate discharge planning
- Clinical instability at the time of discharge
- Discharge to an inappropriate destination

Review of preventable readmission (cont.)

- Member noncompliance – Facilities will not be held accountable for our member's noncompliance to the physician's orders if all the following conditions are met and adequately documented in their medical records:
  - The facility appropriately communicated the physician's orders to the member
  - The member and/or caretaker are mentally competent and capable of following the instructions and made an informed decision not to follow them
  - The member has no financial, social or other barriers to following the instructions. The facility took reasonable efforts to address financial and social difficulties to the member's placement and access to treatment. They consulted with social services, used community resources and frankly discussed risks and alternatives.
  - The facility clearly documented the member's and/or caregiver's noncompliance. For example, if discharge to the home is considered unsafe, the member and/or caregiver must sign documentation indicating the member is leaving against medical advice. A comment stating "patient preference" is not sufficient.

Request for medical records

If the member's readmission meets the above criteria, the following next steps apply:

- We'll send a letter to the facility requesting medical records, supporting information and discharge documentation for the member's initial admission and subsequent readmission
- You must send complete medical records for both the initial and subsequent admissions within 60 calendar days. If we don't receive them within 60 days, the medical records will be incomplete, and the readmission claim may be denied.

Medical records required for review

Please send us all the member's medical records for their initial and subsequent hospital admissions. If you use any nonstandard abbreviations, include a reference key so we can understand the files. The following is a partial list of the required documents:

- Emergency room records, including diagnostic impression
- Admission sheets (e.g., face sheet, history, physical assessment)
- Hospital physician's notes (e.g., progress notes, orders, consults)
- Hospital nursing notes (e.g., assessments, progress notes)
- Treatment administration records
  - Ancillary reports (e.g., lab, radiology, operative, pathology, anesthesia)
  - Vital signs/respiratory/ventilation flowsheets
  - Medication administration records
  - Intake and output flowsheets
  - Therapy notes (e.g., occupational, physical, speech)

Medical records required for review (cont.)

- Coding and discharge summary
  - Discharge planning documents (e.g., social services, case management)
  - Discharge instructions
  - Discharge medication list
- Physician's signature and credentials for verification
- Itemized bill and UB04 form, including ICD-10-CM
- Any other documentation that supports the billed charges

Reason for incomplete medical records status

We require all documentation from the facility before we can complete our review. The following common errors will delay the process:

- Medical records were sent for 1 inpatient stay instead of for both the initial admission and readmission
- Nursing or therapy notes were omitted

Where to send medical records for review

Send the complete set of medical records for the member's initial stay and readmission within 60 calendar days from the date of our letter. Follow the submission instructions in the letter or the provider remittance advice notice on where to send the documentation.

How to appeal a claim denied after the medical record review

You can find specific information about your reconsideration or appeal rights in the letter we send you. The process depends on whether you're a contracted or noncontracted health care provider in our network:

- **Contracted health care providers –** You have reconsideration and appeal rights. Refer to the UnitedHealthcare Community Plan of **UnitedHealthcare Community Plan of New Mexico Care Provider Manual** and your facility contractual agreement for information. This excludes private fee-for-service plans.
- **Noncontracted health care providers –** You have appeal rights for denied claims

Resources

The CMS:

- **NMAC**
- **Quality Improvement Organization Manual**, Chapter 4, Section 4240 – Readmission Review
- **State Operations Manual**, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Section A-0799
- **Code of Federal Regulations 42, Section 482.43** – Condition of participation: Discharge planning

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