Agenda

- Service Model and Self-Service Tool Updates
- IA MedReview DRG Validation Process
- UnitedHealthcare Dual Complete (HMO SNP)
- Trending Issues
- Questions
Provider Service Model and Self-Service Tool Updates
Provider Service Model

Online or Provider Service Call Center:

**Link Self-Service Tools**
- To sign into Link, visit UHCprovider.com and click on the Link button in the top right corner
- Phone: 866-842-3278, option 1
- Email: providertechsupport@uhc.com

**Provider Service Call Centers**
- 888-650-3462 (MCO)
- 844-368-6883 (DSNP)
- 877-842-3210 (Commercial, Medicare)

If your issue is still not resolved:

**Contact your Provider Advocate**
- IA Provider Relations Email: iowa_pr_team@uhc.com
We’re continuously making improvements to Link tools to better support your needs. Among the enhancements:

**Prior Authorization and Notification tool**
- Required fields are now highlighted
- When you access Prior Authorization and Notification from eligibilityLink, the member information will be retained.
- Now you can enter additional contact details

**Document Vault**
- A Document Vault tile has been added to your dashboard

**eligibilityLink**
- When you access Prior Authorization and Notification from eligibilityLink, the member information will be retained.
- A “Help” hyperlink has been added to the right navigation and it links to UHCprovider.com/eligibilityLink for Quick Reference Guides and more.
Link Self-Service Updates and Enhancements

claimsLink
• Search by claim number or patient account number and get up to 24 months of claims history
• Flag reconsideration and pended tickets for easier follow-up
• If a claim is paid by check, you can see where and to whom it was sent
• Columns in the line item section have been reconfigured so more information fits on the screen without the need to scroll left or right.

referralLink
• A “Help” hyperlink has been added to the screen to connect to UHCprovider.com/referralLink for Quick Reference Guides and more.
• Print button has been added to referral status and referral confirmation pages
• Create a copy of a referral from the referral status page to use as the basis for a new referral submission.

Register for live training webinars at UHCprovider.com/training or watch short tutorials on demand on UHC On Air on Link.
IA MedReview DRG Validation Process
Claims Selection and Data Input

• Claim types selected for MedReview audits:
  - DRG payment claims

• MedReview receives claims submission feed electronically.
  - MedReview passes claims received against DRG focused software selection program.
  - Identifies claims warranting further review, as determined by proprietary algorithms.
Communication

- MedReview notifies UnitedHealthcare of all claims that warrant further review.

- MedReview notifies facility via mail or email of need to review claims on UnitedHealthcare’s behalf:
  - DRG Claims: Request medical chart documentation to be submitted within 47 business days as indicated in the Medical Record Request for Claim Coding and/or Readmission Review letter.
No Medical Records Received

• If MedReview does not receive the medical chart within 47 business days, MedReview will provide notice that claim will be adjusted to the assumptive DRG code (removal of complications and co-morbidities) rate via the DRG Reassignment – No Medical Record Received letter.

• Facility may submit medical records within 47 business days as indicated in the DRG Reassignment letter to have the claim reconsidered.
Record Review Process for DRG Claims

• MedReview Registered Health Information Technician (RHIT) reviews chart and validates correct coding. (All RHITs are Certified Coders)
  - If clinical issues are present, RHIT refers to a Physician Advisor (MRW Medical Director) for review.

• MedReview completes initial review within 30 business days.

• When not approved as billed, facility is notified via mail or email with indication of right to challenge with the Determination of Coding Review/DRG Reassignment letter.
  - The initial clinical rationale for DRG reassignment is provided for every denial.
  - MedReview utilizes Physician reviewers to make the final determinations.
Challenge and Dispute Process

• If MedReview’s initial decision is not challenged within 47 business days, MedReview advises UnitedHealthcare that the original decision is upheld.

• If provider files a challenge within 47 business days, claim is re-reviewed by a coder and/or clinician not involved in the original review.
  - Facility is notified within 30 business days of MedReview’s decision to sustain, modify or reverse initial decision and of further dispute processes via the Challenge Review Determination of DRG Reassignment letter.
  - UnitedHealthcare is advised of MedReview’s determination and claim is adjusted as appropriate.

• If a case is appealed, a different physician will review the case on appeal. All appeals are completed in physician specialty.
### Iowa Turn Around Times

<table>
<thead>
<tr>
<th>Days allowed for Facility to respond to first request for information</th>
<th>Days allowed for MedReview to review submitted information</th>
<th>Days allowed for MedReview to issue DRG by assumption when no records received</th>
<th>Days allowed for facility to submit Appeal / Challenge to MedReview</th>
<th>Days allowed for MedReview to respond to Appeal / Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forty-seven (47) business days</td>
<td>Thirty (30) business days</td>
<td>Fifteen (15) business days</td>
<td>Forty-seven (47) business days</td>
<td>Thirty (30) business days</td>
</tr>
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Final Notes

How to submit records to MedReview

• Portal@MedReview.us (preferred method)
• E-mail records directly to: Medreview-MedicalRecords@medreview.us
• MedReview can access facilities internal records through their portal.
  - MedReview can work with facility’s external vendor
• Mail chart and Label the package and send to:
  MedReview
  199 Water Street, 27th Floor
  New York, NY 10038
UnitedHealthcare Dual Complete (HMO SNP)
Key Points

- Medicare Advantage plan that is managed by UnitedHealthcare Community Plan of Iowa
- Primary payer on most acute health services and prescription drugs
- Expanded service area in Iowa effective Jan. 1, 2019
- Plan members may enroll, disenroll or switch plans once per calendar quarter during the first nine months of the year
- Referrals are not required if member seeks care from an in-network provider

Additional resources: [UHCprovider.com/IACommunityPlan](http://UHCprovider.com/IACommunityPlan)
Q. How will I be reimbursed for the UnitedHealthcare Dual Complete (HMO SNP) plan?

A. We will reimburse you according to your UnitedHealthcare Medicare Advantage network agreement. There is no balance billing for DSNP members whose Medicaid benefits cover all Medicare-associated premiums, copayments, coinsurance and deductibles.
Q. Is there cost sharing on UnitedHealthcare Dual Complete (HMO SNP)?

A. No. Once you receive our EOB, you can bill the Medicaid payer (the state agency or managed Medicaid plan) for the remaining balance. You should always verify benefits for both health insurance programs before you provide services.
Care Provider Reimbursement

Q. If the DSNP member has UnitedHealthcare Community Plan for both Medicaid and Medicare, will I have to submit the claim twice or will you coordinate the payment crossover?

A. If UnitedHealthcare Community Plan is managing both the member’s Medicaid and Medicare services, you won’t have to submit the claim twice. Our internal process will settle the secondary Medicaid claim once the Medicare claim is processed. You only need to submit claims to the secondary payer when UnitedHealthcare Community Plan is not the responsible payer for Medicaid services.
Q. Will this DSNP plan reimburse me for the additional 20% that is not covered by Medicare?

A. No. This program assumes responsibility for 80 percent of coverage for all eligible Medicare services. The remaining 20 percent falls to the member’s secondary health insurance carrier or the member.

As a Medicare Advantage plan, UnitedHealthcare Dual Complete (HMO SNP) is responsible for the management and payment of the Medicare-covered services. This plan replaces the traditional services provided by Medicare. To be reimbursed for any remaining balance after UnitedHealthcare Dual Complete (HMO SNP) reimburses you for the eligible Medicare services, you should submit reimbursement to the member’s secondary payer. Your Medicaid ID number may be required to be reimbursed for services to Medicaid members in Iowa.
Q. As a care provider, do I need to be enrolled in Medicaid to receive the remaining reimbursement?

A. Yes. The Centers for Medicare & Medicaid Services (CMS) requires states to deny claims from care providers who are not enrolled in the state’s Medicaid or Children’s Health Insurance Program (CHIP). These claims can include services, prescriptions and orders for lab work and tests.
Q. Will I be reimbursed if I don’t participate in the UnitedHealthcare Dual Complete (HMO SNP) plan?

A. No. Only care providers participating in the UnitedHealthcare Medicare Advantage network are considered participating for this DSNP plan and will be reimbursed. If you aren’t sure about your current participation status for our Medicare plans, please contact your Network Account Manager.
Q. As a care provider, do I need to be enrolled in Medicaid to receive the remaining reimbursement?

A. Yes. The Centers for Medicare & Medicaid Services (CMS) requires states to deny claims from care providers who are not enrolled in the state’s Medicaid or Children’s Health Insurance Program (CHIP). These claims can include services, prescriptions and orders for lab work and tests.
Trending Issues
Trending Issues

• Method II

• By Report codes on Addendum B pricing

• By Report Pricing for mammography codes

• Rebase Projects
Questions