Medicare Advantage

Prior authorization for home health services

Effective June 1, 2022, UnitedHealthcare will require prior authorization for home health services with service dates on June 1 or after for members enrolled in UnitedHealthcare® Medicare Advantage and Dual Special Needs Plans who reside and receive services in Arkansas, South Carolina and Texas.

UnitedHealthcare will be delegating prior authorization for home health services to naviHealth for plans in Arkansas, South Carolina and Texas. Plans that are out of scope for this new requirement include:

- UnitedHealthcare commercial
- UnitedHealthcare Community Plan (Medicaid)
- Delegated provider medical groups
- Institutional Special Needs Plans
- Long-Term Support Services Fully Integrated Dual Eligible Plans

For states and plans not mentioned, current existing requirements and processes remain unchanged.

Important points

- Start-of-Care visits will not require preauthorization — you can perform a comprehensive evaluation of your patient in their home setting. This visit should be conducted before contacting naviHealth.
- After the Start-of-Care visit, providers must contact naviHealth for authorization for all subsequent services with dates of service on or after June 1, including:
  - Continuation of care requests
  - Resumption of care requests
  - Recertifications
- If you do not obtain authorization from naviHealth before services are rendered, claims may be denied

Completing the initial authorization process

You can request authorization using the naviHealth **nH Access – naviHealth** online portal, and you will receive an electronic notification of your request status via the portal. Portal requests are the preferred method for authorization requests, but if needed, naviHealth can accept requests by faxing the standardized cover sheet and documentation to 888-815-1808. Regardless of the method of submission, you will be required to submit the following information upon initial review:

- Provider demographic information
- Member demographic information
- Attestation to member meeting Centers for Medicare & Medicaid Services (CMS) criteria for home health eligibility
- Name of ordering physician
- Member primary diagnosis
- CMS-485 form/signed plan of care by ordering physician (or verbal start of care order with signed 485 to follow when completed)
- Start of Care OASIS will be required within 7 days of initial authorization to support the authorization request
- Initial therapy evaluation within 7 days of the initial authorization request

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Completing a continuation of care request

- Continuation of care requests for authorization can be made through the naviHealth **nH Access online portal** by faxing one of the standardized cover sheets to 888-815-1808
- Regardless of the method of submission, you will be required to submit clinical documentation to support medical necessity criteria. This documentation includes:
  - Start of care OASIS (if not already submitted)
  - Last 2 visit notes per discipline involved
  - Any other relevant clinical documentation

What happens next?

Watch for an email from **connect@navihealth.com** for an opportunity to register for a webinar with details about what's changing and the support for the patient journey that's available as a result of this collaboration. Attending a webinar can help ensure a smooth transition for you, your teams and our members. If you have questions, please email **info@navihealth.com**

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