Medicare Advantage

Prior authorization for home health services

Effective Oct. 1, 2023, UnitedHealthcare® Medicare Advantage and Dual Special Needs Plans (D-SNP) will require prior authorization for home health services for members enrolled in Alaska, Washington, D.C., Illinois, Maryland, North Dakota, Oregon and Virginia. We will delegate the initial authorization and concurrent review processes for home health services to naviHealth in these states, as well as the following states in which this has already been implemented:

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Florida*
- Georgia
- Idaho
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Massachusetts
- Nebraska
- Nevada
- New Mexico
- North Carolina
- Ohio
- Oklahoma
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee*
- Texas
- Utah
- Washington
- Wisconsin
- Wyoming

*In Florida and Tennessee, naviHealth is only designated for Medicare Advantage plan members.

Excluded plans

Plans not affected by this new requirement include:

- UnitedHealthcare commercial plan
- UnitedHealthcare Community Plan
- Institutional Special Needs Plans (I-SNP), Institutional Equivalent Special Needs Plans (I-ESNPs)
- Long-Term Support Services, Fully Integrated Dual-Eligible plans (e.g., FIDE, HIDE and MMP)
- Delegated provider medical groups

Requesting prior authorization

Use nH Access — **the naviHealth online portal** — to request prior authorization. After submitting your request, you'll receive an electronic notification of your request status through the naviHealth portal.

While portal requests are the preferred method for authorization requests, you can also fax the request using the standardized cover sheet and prior authorization documentation to 888-815-1808. You can find the cover sheet and additional information on the **naviHealth portal.**

If you don't obtain prior authorization from naviHealth before treating your patient, we may deny the claim(s).

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Required documentation

When submitting your initial request, please include the following:

- 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 followed by signed 485, when completed)
- Start of Care Home Health Outcome and Assessment Information Set (OASIS) within 7 days of the initial prior authorization to support the authorization request
- Initial therapy evaluation within 7 days of the initial authorization request

Completing a continuation of care request

Please provide the following required documentation when completing a continuation of care request:

- Start of Care OASIS (if not already submitted)
- Last 2 visit notes per discipline involved
- Any other relevant clinical documentation

Available training

Watch for an email from **connect@navihealth.com** to register for a webinar. Attending a webinar can help ensure a smooth transition for you, your teams and our members.

Questions?

If you have questions about the prior authorization process or need more information, please email **info@navihealth.com.**

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