Delivering Home Health Services
Frequently Asked Questions

Key Points
• We use the Centers for Medicare & Medicaid Services (CMS) Medicare coverage criteria; participating home health agencies should meet CMS coverage guidelines and maintain CMS-compliant documentation for each member. • Home health agencies can use UnitedHealthcare online tools to verify member eligibility and coverage options. • As of Jan. 1, 2018, most health benefit plans no longer require a completed notification/prior authorization request for home health services.

Overview

UnitedHealthcare is dedicated to providing innovative health and well-being solutions to help our Medicare Advantage members live healthier lives.

One way we do that is by helping home health agencies coordinate home health services ordered by a member's care provider. We have policies, tools and procedures to support you as you deliver home health services to our Medicare Advantage members. To help you better understand some of the administrative process and eligibility requirements for home health services, we've gathered common questions and answers about:

- Eligibility for Home Health Services
- Notification/Prior Authorization
- Claims
- Start of Care
- Notice of Medicare Non-Coverage
- Therapy Services

Need More Information?

You can find general home health service information, including CMS policies and manuals, at **cms.gov/center/hha.asp**.

If you have other questions about delivering home health services, please contact your Provider Advocate or look up your Provider Relations contacts at **UHCprovider.com** > Contact Us.

Frequently Asked Questions and Answers

Eligibility for Home Health Services

Q1. Does UnitedHealthcare require participating home health agencies to follow CMS criteria for home health services?

A1. Yes. Home health agencies are expected to provide services according to CMS Medicare coverage guidelines and must maintain CMS-compliant documentation for each member. In addition, all home health agencies must be Medicare-certified to provide services.

Q2. What types of home health services may be delivered by a home health agency to UnitedHealthcare Medicare Advantage members?

A2. Home health services may be covered when the UnitedHealthcare Medicare Advantage member is:

- Confined to the home
- Needing intermittent skilled nursing care, physical therapy or speech-language pathology services, or has continuous need for occupational therapy
- Under the care of the physician
- Skilled nursing and home health aide services are covered when the combined service total is less than eight hours per day, and less than 35 hours per week

You can find Medicare and coverage criteria at **UHCprovider.com/policies** > Medicare Advantage Policies > Coverage Summaries for Medicare Advantage Plans > Home Health Services and Home Health Visits.

Q3. What's included in a member's home health services plan of care?

A3. The care provider's orders on the plan of care must indicate:

- The type of services to be provided to the member
- The home health professional who will provide them
- The frequency and duration of the services

Q4. Does UnitedHealthcare require care providers to meet face to face with members before certifying eligibility for home health services?

A4. Yes. Before certifying a patient's eligibility for the home health benefit, the certifying physician must document that they or an allowed non-physician practitioner has had a face-to-face encounter with the patient related to the primary reason for the home health admission.

Q5. How can I check a UnitedHealthcare member's eligibility?

A5. You can submit your request online or by phone:

Online: Use the eligibilityLink tool in Link to check member eligibility and review detailed benefits information. You may also use eligibilityLink to find out if referrals, notifications and prior authorizations are required for the member's plan. To access eligibilityLink, sign in to Link by clicking on the Link button in the top right corner of **UHCprovider.com.**

Phone: Call the Provider Services number on the back of the member's ID card.

Q6. Does UnitedHealthcare request OASIS data from the home health agency before the start of care?

A6. No, we don't require OASIS data at the start of care. However, you're required to keep CMS documentation, which includes OASIS data, in each member's file.

Notification/Prior Authorization

Q7. When is an approved notification/prior authorization required for home health services?

A7. As of Jan. 1, 2018, most health benefit plans no longer require a completed notification/prior authorization request for home health services.

Approved prior authorizations are required for certain plans. For the current list of notification/prior authorization requirements, including those states and plans in which UnitedHealthcare requires a prior authorization for home health care services, please go to **UHCprovider.com** > Prior Authorization and Notification > Advance Notification and Plan Requirement Resources > Medicare Advantage and UnitedHealthcare Community Plan (Dual Special Needs Plan) Prior Authorization Requirements.

You can find more information about these requirements at **UHCCommunityPlan.com** > For Health Care Professionals > choose your state > Prior Authorization.

Once we receive a notification request, we'll review the request. We may request clinical documentation to determine coverage for these services, and we'll let you know if the requested services are covered.

Remember, home health aide services are only covered when you're also delivering a skilled service.

Q8. How do I submit a request for a notification/prior authorization?

A8. You can submit your request online or by phone:

Online: Use the Prior Authorization and Notification tool in Link. To access the tool, sign in to Link by clicking on the Link button in the top right corner of **UHCprovider.com.** We have detailed instructions for using the tool at **UHCprovider.com** > Prior Authorization and Notification Resources.

Phone: Call 877-842-3210, option 3, or the number on the member's health plan ID card.

When submitting your notification/prior authorization request, please provide the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and associated units. Our system can't accept revenue codes.

Q9. Why does my authorization show a different number of units than I requested?

A9. If the authorization letter shows different units than you requested, please review the total unit count. The total authorized units should be the same as the total you requested. If you have questions about the authorized units, please call the contact number on the authorization letter or the Provider Services number on the member's health plan ID card.

Claims

Q10. How does UnitedHealthcare reimburse home health services?

A10. Home health agencies are reimbursed according to their Participation Agreement. Your agency's Participation Agreement will have details about your reimbursement structure and instructions on how to submit claims based on your method.

Q11. What information should I include on the claim?

A11. In addition to the general policies outlined in the UnitedHealthcare Administrative Guide at **UHCprovider.com/guides**, for home health services, include:

- Bill type 032X for home health services.
- The appropriate Health Insurance Perspective Payment System (HIPPS) code
- The appropriate HCPCS code

- The number of units tied to that revenue code
- The date of the start of care

Example:

LINE #	REV CODE	RATE/ DATE	DESCRIPTION	DAYS/ UNITS	CHARGE	HIC PIC
001	0023	01/01	HH PPS (HRG)	1.0	X.xx	1CGP1
002	0551	01/01	SKILLED NURS/VISIT	1.0	XXX.XX	G0299

Q12. What do I need to know to follow the CMS HIPPS regulatory requirement when billing for UnitedHealthcare Medicare Advantage members?

A12. To comply with the CMS HIPPS regulatory requirement, UnitedHealthcare requires home health agencies to submit HIPPS codes for home health care services provided to our Medicare Advantage members for the 837I electronic submission or UB-04 paper submission. HIPPS code should be submitted from the initial start of care encounter.

For home health services, the revenue code is 0023 and should be billed on line 1 of the claim.

Q13. If I disagree with a claim payment, what can I do?

A13. You may submit a claim reconsideration request asking us to review your claim payment. Your claim reconsideration request must be submitted within 12 months (or as required by law or your Participation Agreement) from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA).

You can submit a reconsideration request in the following ways:

- **Online**: Use the claimsLink tool to submit a corrected claim or claim reconsideration and track claim reconsideration requests. To access claimsLink, sign in to Link by clicking on the Link button in the top right corner of UHCprovider.com. More information is available at UHCprovider.com/claims.
- **Phone**: Call the number on the member's health plan ID card to request an adjustment for a claim that doesn't require written documentation. If you have a request involving 20 or more paid or denied claims and attachments are not required, aggregate these claims online. More information is at **UHCprovider.com/claims** > Submit Reconsideration Requests for Multiple Claims.
- **Mail**: Find the form and instructions at **UHCprovider.com/claims** > Submit a Corrected Claim, Claim Reconsideration/Begin Appeal Process.

Start of Care

Q14. What defines a new 60-day start of care date?

A14. A new 60-day start of care occurs when there has been a 60-day lapse between home health services.

For example, a member starts receiving home health services on Jan. 1. They complete their plan of care on Jan. 30. The same member falls on May 1 and their physician prescribes home health services. Since the member's last home health care visit was more than 60 days ago, May 1 is considered the first day of service for the new plan of care.

Notice of Medicare Non-Coverage

Q15. What's a Notice of Medicare Non-Coverage (NOMNC)?

A15. The NOMNC informs members of their rights to an immediate, independent review of the proposed end of covered services. CMS requires that a health provider gives the Medicare enrollee a completed NOMNC no later than two days before the end of Medicare-covered home health services.

Home health agencies that don't issue the NOMNC to Medicare Advantage members may be denied full or partial payment according to the language in their UnitedHealthcare Participation Agreement.

The NOMNC is available at **cms.gov** > Medicare > Beneficiary Notices Initiative (BNI) > MA Expedited Determination Notices.

Therapy Services

Q16. What is the CMS policy on therapy services?

A16. To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury.

For guidelines and principles governing reasonable and necessary physical therapy, speech-language pathology services and occupational therapy, and specific examples, see the Medicare Benefit Policy Manual, Chapter 7, 40.2.1 General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language, Pathology Services, and Occupational Therapy at **cms.gov** > Regulations & Guidance > Manuals > Internet-Only Manuals (IOMs) > 100-02 > Chapter 7.

CMS skilled nursing and home health aide services are covered when the combined service total is less than eight hours per day, and less than 35 hours per week.