Overview

Facilities providing post-acute inpatient services have been required since Jan. 1, 2019, to request prior authorization, and receive a determination, before UnitedHealthcare Medicare Advantage plan members can be admitted to a post-acute care facility or a post-acute care bed in a facility. We may deny claims if one of these members is admitted to a post-acute care facility without an approved prior authorization request. Prior authorization is not required for emergency or urgent care for members.

Prior authorization requirements are part of our commitment to the Triple Aim of better quality, improved health outcomes and better cost for our members. We regularly evaluate our policies using objective, evidence-based criteria to guide coverage decisions and support patient care.

We also support the facilities by streamlining the prior authorization request process. If you use the Prior Authorization and Notification tool on Link to submit your prior authorization request, you’ll be asked a series of questions to guide you through the review process. Go to UHCprovider.com/paan to get started. Clinical information, if required, can be uploaded through the tool. If you’re unable to use the Prior Authorization and Notification tool on Link, you can call 877-842-3210.

Key Points

Since Jan. 1, 2019, facilities providing post-acute inpatient services have needed to request prior authorization, and receive a determination, before UnitedHealthcare Medicare Advantage plan members can be admitted to a post-acute care facility or a post-acute care bed in a facility.

This change applies to members enrolled in all UnitedHealthcare Medicare Advantage plans, including UnitedHealthcare Dual Special Needs Plans (DSNP).

Frequently Asked Questions

Why does UnitedHealthcare require prior authorization for post-acute inpatient services?

Changes to prior authorization requirements are part of UnitedHealthcare’s ongoing responsibility to evaluate our medical policies, clinical programs and health benefits compared to the latest scientific evidence and specialty society guidance. These regular evaluations are part of our commitment to the Triple Aim of better quality, improved health outcomes and lower cost for our members. Following the prior authorization process will also help ensure continuity of care for your patients who are our members.

Scope

Which UnitedHealthcare Medicare Advantage plans are included in this requirement?

This change applies to members enrolled in all UnitedHealthcare Medicare Advantage plans, including UnitedHealthcare Dual Special Needs Plans (DSNP).
**What types of facilities must follow this prior authorization process?**
This prior authorization process is required for any facility that provides post-acute inpatient services for UnitedHealthcare Medicare Advantage plan members. This includes acute inpatient rehabilitation facilities, long-term acute care, critical access and acute care hospitals, and skilled nursing facilities.

**Who is responsible for requesting prior authorization for a member’s admission to a post-acute inpatient services facility?**
The care provider who is admitting the member for post-acute inpatient services is responsible for requesting prior authorization. This requesting care provider will also be the one who receives the approval before admission to a post-acute inpatient services facility.

**Does the discharging hospital or facility care provider play a role in the prior authorization process?**
When UnitedHealthcare Medicare Advantage plan members are transitioning from a hospital or other facility to a facility providing post-acute inpatient services, the hospital or discharging facility will coordinate the discharge planning process as early as possible to avoid delays in discharge and help the member make a smooth transition. The receiving facility will request a prior authorization.

**Are integrated health systems that bundle post-acute services exempt from this prior authorization process?**
No. All care providers and facilities must follow this prior authorization process.

**How does this change affect non-participating post-acute facilities?**
Non-participating facilities that provide post-acute inpatient services are encouraged to request prior authorization and receive a determination, before UnitedHealthcare Medicare Advantage plan members are admitted to a post-acute care facility or a post-acute care bed in a facility.

**Which services require an approved prior authorization request?**
Prior authorization is required for any post-acute inpatient services provided in acute inpatient rehabilitation facilities, long-term acute care hospitals, skilled nursing facilities, skilled nursing home care facilities and acute care facilities with post-acute beds. Prior authorization is not required for emergency or urgent care.

**Is the prior authorization request required if UnitedHealthcare facilitates the member’s discharge?**
Yes. Following the prior authorization process will also help ensure continuity of care for your patients who are our members, even when UnitedHealthcare is helping to manage the member’s discharge from a different facility.
Requesting Prior Authorization

How do I request prior authorization?
Care providers can request prior authorization using the Prior Authorization and Notification tool on Link. Go to UHCprovider.com/paan to get started. Clinical information, if required, can be uploaded through the tool. If you’re unable to use the Prior Authorization and Notification tool on Link you can call 877-842-3210. By using the Prior Authorization and Notification tool to submit your prior authorization request, you’ll be able to answer a series of questions that can help streamline the review process. You can find instructions and training to help you use the Prior Authorization and Notification tool at UHCprovider.com/paan.

Can I request prior authorization on weekends and holidays?
Yes. You can use the Prior Authorization and Notification tool on any day of the week, including weekends and holidays. When you submit your request online, you may receive approval through the tool when you complete your submission. If you’re unable to use the Prior Authorization and Notification tool on Link, you can call us at 877-842-3210. If you call on the weekend or on a holiday, we’ll usually give you a call back with our decision in one business day.

How will I know that the prior authorization request was received?
You’ll receive a reference number that you can use to track the status of your request. This reference number is not an approval or a determination of coverage, or a guarantee of payment. When you submit your request through the Prior Authorization and Notification tool, this reference number is shown on your confirmation screen.

Receiving a Prior Authorization Decision

How long will it take to receive a decision after I complete the prior authorization request?
While not a guarantee, you can expect a decision within one business day. If you submitted the request for prior authorization using the Prior Authorization and Notification tool, you may receive approval when you complete the submission.

How will I know if you need more information?
We’ll let you know when you submit the request. If you submit your request through the Prior Authorization and Notification tool on Link, you’ll be prompted to upload clinical information, if required. If you have trouble with the tool, you can call Provider Services at 877-842-3210. When you call in your request, we’ll let you know if clinical information is required.

What type of clinical information might be requested?
If required, we might ask you for:

- A copy of the physician’s orders
- The discharging hospital’s name and number
- A list of the member’s medications
- Initial physical, occupational or speech therapy evaluation and any pertinent progress notes from the referring hospital or physician
- Proposed length of the member’s stay or treatment plan
• Other medical information, such as lab and radiology results, diagnostics, wound care assessments, pertinent progress notes from the hospital or referring physician, or psychosocial assessments that would assist our clinical staff in making a determination

**How will I be notified of the coverage determination?**

In the Prior Authorization and Notification tool, if the request is approved you’ll see “Your Notification/Prior Authorization submission has been approved and no further action is required for this request”. This means the prior authorization request is approved and the facility should proceed with scheduling the admission. We’ll also call you and give you the name of the UnitedHealthcare nurse who will be following the member throughout their stay.

If you don’t receive an automatic approval through the Prior Authorization and Notification tool or if you called us to submit the request, we’ll call you as soon as we’ve made a decision. You can always sign into the Prior Authorization and Notification tool to check the status of an existing request at any time.

**If my prior authorization request is approved, do I need to notify UnitedHealthcare when the member is admitted to the post-acute facility?**

Yes. This change doesn’t affect admission notification requirements. You’re still required to provide admission notification according to our Admission Notification protocol. Payment penalties will remain in effect for late admission notifications. For more information about admission notification, go to UHCprovider.com/guides.

**How do I notify UnitedHealthcare when the member is admitted to the post-acute facility?**

The easiest way to notify us is to update the admission date in the Prior Authorization and Notification tool on Link. If you’re unable to use the Prior Authorization and Notification tool, you can call us at 877-842-3210.

**How long is a prior authorization approval valid?**

A prior authorization approval is valid for seven days from the approval date. If a prior authorization expires, you must request a new prior authorization and receive approval before the member can be admitted to your facility.

**Member Effect**

**Will this requirement change how I care for my patients?**

We support informed patient choice and respect that care decisions should be made by a patient and their physician. Coverage determinations only reflect whether a service is covered by the member’s health benefit plan. It’s not meant to replace care decisions made by physicians and their patients.

**Can a member appeal if a prior authorization request is denied?**

If a prior authorization request is denied, the member will receive an Integrated Denial Notice that lists their appeal rights.
Can a member choose to receive services at a post-acute facility even if prior authorization for that facility is denied?
If a prior authorization request is denied, you and the member will both receive an Integrated Denial Notice that lists the member’s appeal rights.

Who do I contact if I have questions?
If you have questions, please call Provider Services at 877-842-3210.