naviHealth
Guiding the Way®

UnitedHealthcare Partnership with naviHealth

Home health services utilization management
Frequently asked questions

May 2023

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Frequently asked questions

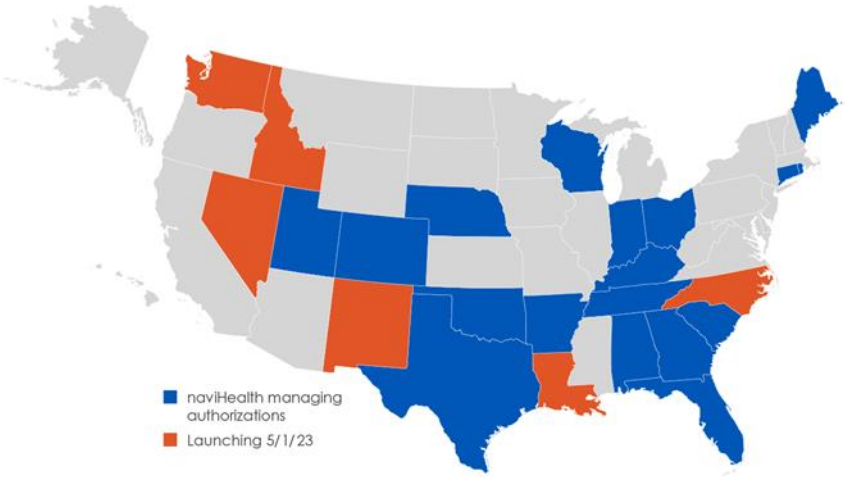
UnitedHealthcare partnership with naviHealth

Q1 What is happening?

UnitedHealthcare has delegated to naviHealth the approval or denial of all initial authorization requests and requests for additional services for post-acute care (PAC) services with home health agencies for certain Medicare Advantage. This will include providing authorization for home health services requested by the following disciplines: physical therapy, occupational therapy, speech therapy, nursing, social work and home health aides.

Q2 What plans are affected by this change?

The delegation applies to members enrolled in UnitedHealthcare Medicare Advantage plans and Dual Special Needs Plans (DSNP). On May 1, 2023, members receiving care in the following states will be delegated to naviHealth: Idaho, Louisiana, Nevada, New Mexico, North Carolina and Washington.



Q3 What plans are excluded from this change?

Plans currently **not included** in this program are listed below. Therefore, existing requirements and processes for these populations remain unchanged.

- UnitedHealthcare Commercial
- United Healthcare Community
- Delegated provider medical groups (i.e., WellMed, OptumCare)
- Institutional Special Needs Plan (ISNP) & Institutional Equivalent Needs plans (IESNPs)
- Long-Term Support Services Fully Integrated Dual Eligible plans (HIDE, FIDE and MMP)

Q4 Why has UnitedHealthcare made this change?

Through this partnership with naviHealth, UnitedHealthcare seeks to improve the member experience with a more coordinated, member-focused approach to post- acute care recovery.

Q5 Does this partnership change members' benefits or premiums?

No. There is no change to benefit plans and no additional charge to the member associated with this change.

Q6 What home health services require a request for prior authorization from naviHealth?

The **Start-of-Care (SOC) assessment should be completed prior** to submitting an initial authorization request. The SOC assessment will be covered in the initial authorization request.

All visits beyond the SOC assessment require prior authorization. Authorization must be obtained before visits are conducted.

Requests for additional services and recertification requests require prior authorization.

Retrospective authorization requests for emergent situations may be considered.

Q7 What does UnitedHealthcare continue to manage?

UnitedHealthcare continues to internally manage — and has not delegated to naviHealth — all other services, which include, for example:

- Durable Medical Equipment ("DME") referrals: *Hospital bed, pumps and enteral feeds, wheelchairs, commode chairs, canes, continuous passive motion, crutches, adaptive equipment, walkers, patient lifts, sleep apnea devices, oxygen equipment
- Home infusion services covered under the home infusion therapy benefit furnished by a qualified home infusion therapy supplier
- Member satisfaction surveys
- Case management
- Ambulance authorizations
- Inpatient psych unit referrals/authorizations
- High-cost drug carve outs
- Bariatric equipment carve outs
- Single case agreements
- Claims payments
- Claims disputes
- Provider network management

Initial authorization – home health setting

Q8 Do initial authorization and notification processes change?

Yes. Initial authorization requests may be submitted to naviHealth via:

- Online portal: **nH Access**.
  - To enroll, please visit: https://naviHealth.com/partners/nHaccess/resources/
- Fax: 1-888-815-1808
- Phone: 1-855-851-1127; Option 3

Please see **Q15** to learn more. The request for initial authorization is submitted by the home health agency (HHA) after the SOC assessment

has been completed and before any further services are provided. The SOC assessment will be covered in the initial authorization request.

Q9 Who submits requests to naviHealth for home health services?

While it is ultimately incumbent upon the home health provider to ensure an authorization is obtained, a member may also request services.

Q10 What are the hours of operation for naviHealth?

The following are naviHealth hours of operation for all request types:

- 8 a.m.-8 p.m. ET Monday-Friday

Nationally recognized holidays are observed by naviHealth.

Q11 When will home health authorizations submitted on a weekend be reviewed?

If a HHA submits a request for authorization on Saturday or Sunday, it will be reviewed the next business day.

Q12 When will home health authorizations be reviewed for patients admitted after hours or on a holiday?

Off-hour home health admissions/SOC assessments do not require prior authorization. The services requested must meet medical necessity criteria before services are rendered. Upon review, if services provided are found to not meet medical necessity criteria, they may be denied. Providers should use discretion and only provide services over the weekend for new cases that clearly meet CMS Medicare Benefit Policy Manual Chapter 7 criteria. Please see **Q6.**

Q13 How do I reach naviHealth?

Contact information for naviHealth:

- Send a message via **nH Access**. Please see **Q25** to learn more.
- Call toll-free phone number: 1-855-851-1127; Option 3
- Fax number for all requests and documentation: 1-888-815-1808

Q14 How will the cases be handled for admission to home health on or around May 1, 2023?

For UHC members in ID, LA, NV, NM, NC and WA that are requesting home health services on or after May 1, 2023, requests for home health services will be managed by naviHealth.

A SOC assessment will need to be completed prior to submitting the initial authorization request.

For all home health services that are already in-process prior to May 1, 2023, naviHealth review or authorization will not be required until Recertification or Resumption of Care is needed.

Q15 What is the most efficient way for the home health agency to submit clinical information for an authorization review?

naviHealth has created an easy-to-use platform — **nH Access** — that enhances your naviHealth patient documentation exchange and authorization tracking experience. We highly recommend the **nH Access** portal for faster service and additional integrated features.

To learn more about **nH Access** or to enroll, visit our **nH Access** Resource Center: https://www.naviHealth.com/nHaccess

- **nH Access** is the preferred method for requesting authorizations; however, documentation may also be submitted:
  - Fax: 1-888-815-1808
    - Note: For all faxed requests, please utilize the naviHealth Home Health Prior Authorization request form located on our partner resource site: UHC-naviHealth Home Health Provider Resource page
  - Phone: 1-855-851-1127; Option 3

Q16 Does naviHealth process authorizations for UHC members delegated to a medical group?

No. Delegated provider medical groups are out of scope for naviHealth. Please see **Q3** for a list of UHC plans that are out of scope for naviHealth.

Q17 What if the prior authorization request for home health services is denied?

When a denial of services is issued, upon review by a medical director, the naviHealth care coordinator contacts the requestor via phone to provide the denial determination and the information necessary for an appeal to UnitedHealthcare. naviHealth supports a member's right to appeal. All prior authorization appeals are adjudicated by the health plan.

Home health services – authorization requests

Q18 How does naviHealth make home health determinations?

naviHealth conducts medical necessity reviews on all members referred to home health based on criteria presently utilized by UnitedHealthcare. This criteria includes the CMS Medicare Benefit Policy Manual Chapter 7 criteria for home health and InterQual® criteria. All potential denials receive physician review.

Q19 What are the CMS guidelines for home health used by naviHealth?

naviHealth uses the Medicare Benefit Policy Manual Chapter 7 criteria for home health services in Sections 10 through 110. CMS medical necessity criteria for home health considers:

- Is the patient confined to their home?
    - Does leaving the home require considerable and taxing effort as defined by Medicare §§1814(a)(2)(C) and 1835(a)(2)(A))?
- Is the patient under a doctor's care?
- Is the patient receiving services under a plan of care established and periodically reviewed by a physician?
- Does the patient need intermittent skilled nursing care, physical therapy, occupational therapy or speech-language therapy on an intermittent basis?

Q20 What documentation does naviHealth require to authorize home health services?

Referral basics submitted via **nH Access**:

- Home health agency and ordering physician's contact information

- Attestation to the following:
    - Physician order received by HHA
    - Plan of care that is overseen by a physician
    - Homebound status validated
    - Intermittent skilled need verified
- Admitting diagnosis
- SOC Outcome and Assessment Information Set (OASIS) within 7 days of request
- Plan of Care – CMS Form 485 "Home Health Certification and Plan of Care"

For requests for additional services and recertification* requests to be processed:

- Plan of Care – CMS Form 485 "Home Health Certification and Plan of Care" (if not already submitted)
- Most recent clinical notes (24-48 hours)
    - Including wound care treatment, if applicable

NOTE: *Recertification requests should occur at day 56 to 60.

If submitting via fax, the completed fax cover sheet is also required.

NOTE: The SOC visit does not require prior approval; however, all required documentation to support the request must be submitted prior to further care being rendered.

Q21 Is there a maximum number of visits per discipline that may be requested at SOC?

Yes. Based on medical necessity per documentation review after the SOC assessment: Up to the following number of visits per discipline may be requested/approved:

- Six (6) nursing visits or eight (8) nursing visits for wound care
- Six (6) physical therapy visits
- Five (5) speech therapy visits
- Five (5) occupational therapy visits

- Two (2) social worker visits
- Six (6) home health aide visits

Additional visits may be requested once initially approved visits near completion. See **Q22** regarding requests for additional visits. Requests are subject to approval based on evidence in the submitted updated clinical documentation of medical necessity supporting continued intermittent skilled needs and homebound status.

Q22 How does naviHealth manage requests for additional services in home health?

If additional services or visits are medically necessary, please make the request for additional visits when only 2 or 3 visits remain from the initial authorization to maintain continuity in the member's plan of care. Requests for additional visits require submission of the Form 485 Plan of Care (POC) and updated clinical information from the member's medical record.

Requests for additional services can be submitted:

- **nH Access** is the preferred method for requesting authorizations; however, documentation may also be submitted:
  - Fax: 1-888-815-1808 (please include completed fax cover sheet with requested disciplines selected)
  - Phone: 1-855-851-1127; Option 3

Required documentation:

- Form 485 POC
- SOC OASIS if not already submitted
- Last two visit notes per discipline involved
- Most recent medication profile

Q23 Are InterQual® criteria used for home health determinations?

Yes. InterQual criteria is applied for continued services authorization requests to determine medical necessity of additional home health services.

InterQual criteria is based on current evidence-based medical literature and accepted best-practice standards of care with updates published up to four

times per year. Criteria also incorporates regulatory requirements including joint commission standards and NCQA quality measures.

InterQual's rule-based application allows for consistent and reliable reviews based on clinical information entered from the documentation sent by the home health agency.

Q24 What is required when a member discharges from home health services?

The home health agency contacts naviHealth within 48 hours of discharge from services to inform of the member's discharge date and submit a copy of the validly signed Notice of Medicare Non-Coverage (NOMNC).

nH Access portal for authorization requests

Q25 What is **nH Access**? What does it do?

nH Access is the naviHealth secure online portal to facilitate real-time, two-way communication among health care providers and naviHealth clinicians, including providers who work with naviHealth with multiple health plans.

With **nH Access** you may:

- Submit authorization requests for your members and see authorization status in real time
- Submit member records requested by naviHealth clinicians
- Communicate with naviHealth clinicians via instant messaging
    - Send and receive updates on authorization status
- Access authorization status
    - Receive alerts via instant messaging or emails sent from **nH Access**

Q26 Is the **nH Access** portal the same as the UHC link/PAAN portal?

No. **nH Access** is a different portal with additional functionality but can be accessed via a link in PAAN.

Q27 Is there a fee to the provider for using **nH Access**?

No. There is no fee to use **nH Access**.

Q28 When can we expect notification for enrollment in **nH Access**?

Enrollment emails will begin to be distributed within 30 days of launch.

Q29 How do I learn more about enrolling in **nH Access**?

To learn more about **nH Access** or to enroll, visit our **nH Access** Resource Center: https://www.naviHealth.com/nHaccess

If you are unable to find the answer to your question within the resources on the **nH Access** page, please call the customer service number: (888) 276-5777 or contact customer service via email at: support.nHaccess@naviHealth.com

Q30 Do I need a business email address to utilize **nH Access**?

Yes. When enrolling in **nH Access**, you will need to provide a business email address upon registration. For security reasons, registrations using a non-business domain email address (e.g., gmail.com, outlook.com, yahoo.com, etc.) will result in an error.

General operational questions

Q31 Does the HHA need to wait until a UHC member discharges from care before sending a claim to UHC?

With the UHC-naviHealth partnership, provider claims will continue to be managed by UHC. There are no changes to UHC claims submission or payment practices.

Q32 Which states are included for naviHealth-managed UnitedHealthcare members as it pertains to home health services authorizations?

naviHealth is currently managing home health authorizations in the following states: AL, AR, CO, CT, FL, GA, IN, KY, ME, NE, OH, OK, RI, SC, TN, TX, UT and WI. On May 1, 2023,

members receiving care in the following states will be delegated to naviHealth: ID, LA, NV, NM, NC and WA. Please see **Q2** and **Q3** for further details.

Q33 How do I learn more about naviHealth?

To learn more about naviHealth and find useful resources, please register on the UHC-naviHealth Home Health Provider Resource page at:

UHC-naviHealth Home Health Provider Resource page

Please note: When enrolling in **nH Access** and the Provider Resource page, you will need to provide a business email address upon registration. See **Q30** for further details.