HIGHMARK POST-ACUTE CARE MANAGEMENT FOR MEDICARE ADVANTAGE MEMBERS

Frequently Asked Questions

Revised September 6, 2019

ABOUT THE POST-ACUTE CARE (PAC) MANAGEMENT PROGRAM

Q1: What was the effective date of the Highmark/naviHealth partnership?

A1: The Highmark/naviHealth partnership was effective August 1, 2014.

Q2: Which Highmark members are included in the program?

A2: naviHealth works with the Highmark Medicare Advantage population residing in Pennsylvania and West Virginia as well as Freedom Blue members who permanently reside out of state.

Q3: What is the nature of the partnership?

A3: Effective August 1, 2014, any authorization for PAC services resulting in new admissions to an inpatient rehabilitation facility (IRF), long-term acute care (LTAC), skilled nursing facility (SNF), and to swing beds will be handled by naviHealth for all Pennsylvania and West Virginia Highmark Medicare Advantage members. Behavioral health services are not authorized by navHealth.

Q4: What services will naviHealth authorize?

A4: naviHealth generates an authorization for care delivered at a SNF, LTAC, and IRF, including initial skilled nursing facility admissions, additional lengths of stay, and next review dates. Highmark will retain responsibility to authorize all other post-acute care services, including durable medical equipment, home health agency services, and other at-home or outpatient services.

Q5: Does Highmark's Business Associate Agreement (BAA) in place with naviHealth allow naviHealth to access a patient's electronic medical records?

A5: Yes, Highmark and naviHealth have executed a BAA to allow access for the patient records. Be assured that protecting patient information is important to both Highmark and naviHealth.

NAVIHEALTH AND THEIR ROLE

Q1: Who is naviHealth?

A1: naviHealth is an industry leader in post-acute care management and care transitions. naviHeath specializes in managing post-acute care services. naviHealth partners with health plans, health systems, and post-acute care providers to manage the entire continuum of post-acute care. naviHealth health care professionals work with skilled nursing facilities, long-term acute care, inpatient rehabilitation, and acute care hospitals to maximize post-acute care outcomes for Highmark members. Evidence-based protocols optimize care, resulting in reduced hospital readmissions, increased patient satisfaction, and improved patient outcomes. Learn more at **www.navihealth.com**.

Q2: What are naviHealth's hours of operation?

A2: naviHealth has regular hours during the week and weekend hours of operation as well, excluding national holidays (New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, Christmas Day):

- Monday – Friday 8:30 a.m. to 7 p.m. EST
- Saturday & Sunday 8:30 a.m. to 4:30 p.m. EST

Q3: Will naviHealth come on-site to our hospital or SNF, IRF or LTAC?

A3: Based on patient volume and service intensity, naviHealth may be on-site at your facility. The volume of Highmark patients at your facility will influence how frequently an on-site colleague would be present. The purpose of naviHealth staff being on-site is to interact with your care coordinators to better facilitate the care provided to your patients, our members. Facilities will also be supported telephonically if volume and/or geographical location prohibit efficient on-site presence.

Q4: Will the naviHealth care coordinator be available to have conversations with patients and/or their families in acute care facilities, SNFs, IRFs, or LTACs?

A4: Yes, care coordinators are encouraged to engage with your care team in conversations with the patients and their caregivers either in person or via telephone where appropriate and requested by your care teams. naviHealth will discuss current course of care and/or the expectations of patients for patients and families at their next level of care.

Q5: What is the nH Predict/Outcome report?

A5: The report **nH Predict/Outcome** leverages the actual experiences of hundreds of thousands of individuals through a web-based assessment to project an optimal plan of care after a hospitalization. The instrument utilizes information about a person's functional status, primary medical diagnosis, functional comorbidity index, usual living setting medical adjusters, and social determinants of health to project outcomes in a highly reliable and evidence-based manner.

In addition to projecting outcomes, the instrument can also provider care teams and patients commonly identified barriers experienced upon discharge and likelihood of hospital admission from SNF. The functional measurement capability of the **nH Predict/Outcome** report relies on the Activity Measure for Post-Acure Cate (AM-PAC), which can be used for any individual regardless of the functional capability. Several Academic Journal articles have been published about AM-PAC. naviHealth provides ongoing monitoring and reliability testing to ensure ongoing effectiveness of the tool.

Q6: How do you know the recommendations from nH Predict/Outcome are accurate and legitimate?

A6: Clinicians can be confident in naviHealth's recommendations because it is evidence-based and has been validated by several scientific studies. The evidenced-based database is composed of more than 4 million actual patient records across the nation and including the entire continuum of care, so you can be sure that the predictions are accurate. naviHealth conducts ongoing inter-rater reliability tests for all **nH Predict/Outcome** reports to ensure the tool is being used consistently.

Q7: Is the recommendation from the nH Predict/Outcome assessment final?

A7: **nH Predict/Outcome** assessment is intended to serve as a guideline for planning a patient's transition and/or subsequent stay in a post-acute care setting. There are occasions where not all patient information can be captured or assessed, but the **nH Predict/Outcome** serves as a patient centric, objective starting point to begin care plans and generate further discussion.

Q8: Will naviHealth provide the results from the nH Predict/Outcome assessment to both the acute care facility and the post-acute care facility?

A8: Yes, naviHealth will provide both an Acute **nH Predict/Outcome** report while the member is in the acute care setting and is also forwarded to the post-acute care setting during the admissions process. A separate SNF **nH Predict/Outcome** is provided based on clinical documentation within the skilled nursing setting.

If clinical information is readily available in the acute care setting, naviHealth typically provides this information early on during the inpatient admission so that discharge planners and case managers can incorporate this information into their discharge care plan for the patient.

Once admitted to the post-acute care facility, naviHealth creates a new **nH Predict/Outcome** report for the member and shares the report with the care team typically after the initial therapy evaluation has been conducted on the patient in the post-acute care setting. Again, early in the patient stay, the assessment can be utilized to help guide the care plan and the discharge plan for the patient.

Q9: Will naviHealth share the results of the nH Predict/Outcome with the patient and/or family?

A9: The first page of the **nH Predict/Outcome** is intended to be used by the care team. The subsequent pages are patient facing and uses 8th grade language, icons, and predicted care giver time rounded to the quarter hour to aid in understanding. The report can be personalized with the Skilled Inpatient Care Coordinator (SICC) name and contact information.

Q10: How can I interpret the score on the nH Predict/Outcome report?

A10: The **nH Predict** function score on the Acute **nH Predict/Outcome** helps naviHealth determine the most appropriate post-acute care setting.

Q11: Is a member's speech needs included in the nH Predict/Outcome report?

A11: Yes, based on the member's current diagnosis and the response to the **nH Predict** assessment answers related to ADL and cognition, speech needs are factored into the **nH Predict/Outcome** therapy intensity prediction.

Q12: How often will PAC providers receive updates to the nH Predict/Outcome?

A12: Within most facilities, updates to a patient's **nH Predict/Outcome** assessment will be provided approximately every 7 days.

THE AUTHORIZATION PROCESS

Q1: How can we request urgent or emergent authorizations?

A1: naviHealth has the following contact number to support urgent or emergent requests for authorizations: **1-844-838-0939**.

Q2: Can providers submit authorizations to naviHealth via fax?

A2: Yes, providers can fax authorization requests as follows:

- Preservice Authorization Request: **1-844-496-7206**
- New Authorization for AHN Facility Only: **1-844-206-7050**
- Admission Review/First and Interim Review/Subsequent Continued Stay Authorization Request: **1-844-496-7209**

Q3: Is there a preference for how information should be faxed to naviHealth?

A3: naviHealth utilizes an electronic fax solution. They do not print or scan patient information when received by their centralized Utilization Management team. In order to effectively attach patient information to the case management tool for review by the authorization team, naviHealth requests that you send one patient per fax when submitting any patient information via fax to naviHealth.

Q4: Will this process increase length of stay in an acute care facility?

A4: Close collaboration with hospital partners creates the ability to plan and request the authorization earlier in the process to avoid delays caused by authorizations requested with less notice. naviHealth does not anticipate any increase in length of stay at the acute care facility and is sensitive to the desire for hospitals to have a timely transition of patients when ready to be discharged to a post-acute care facility.

Q5: What length of time can we expect with initial SNF authorizations?

A5: Initial authorizations are typically three days. This is to allow the SNF, IRF, or LTAC to appropriately assess the member for therapy/medical needs interventions following the patient transition. Following that initial authorization, additional authorizations will be based on unique needs of the member and will be driven by updated clinical information. For patients in a SNF, the length of authorization will take into consideration the need to have the Notice of Medical Non-Coverage (NOMNC) issued timely.

Q6: Who is responsible for issuing the NOMNC to the member?

A6: The facility will continue to issue the NOMNC to the member upon discharge. A signed and validated copy of the completed NOMNC is to be faxed to naviHealth at **fax# 1-844-496-7209**.

Q7: Once the patient has been discharged, is there any other information that naviHealth needs or would like to see?

A7: Yes, naviHealth requires submission of therapy treatment logs and therapy discharge summaries completed at the end of the patient's stay. The documents should be submitted together as an attachment, not in the body, via secure email. The email submission should include at least two patient identifiers, including patient full name, DOB, and/or Member ID.

A best practice is to also copy the facility assigned Care Coordinator to each email submission to ensure receipt and timely follow through. This information helps naviHealth create a complete patient record and allows them to include this data on the SNF that is presented to the SNF community. The information contained in the review is a direct reflection of the amount of complete patient records naviHealth receives.

- Email to: **NE_DISCHARGE_INFO@navihealth.com** (please note underscores in email address)
- Faxed submissions of therapy treatment logs/summaries are also accepted; however, faxing is not preferred: fax# 1-844-573-3167

Q8: What criteria does naviHealth use for inpatient rehab and long-term acute care?

A8: naviHealth primarily uses InterQual® criteria to review the appropriateness of IRF/LTAC authorizations.

Q9: What are the criteria for an authorization if a patient has medical needs only (e.g., IV therapy)?

A9: Clinical information should support the need for skilled care at the requested level of care. Frequency/duration/dosage of IV medications, tube feedings, wound care measurements, etc. should be included along with appropriate labs, physician notes, etc.

Q10: What is the expected turnaround time naviHealth anticipates on authorization requests?

A10: Responding quickly to authorization requests is as important to naviHealth as it is to the provider community. The goal is to get patients transitioned to their most appropriate next level of care in an expedient but safer manner.

Authorizations that have been requested with complete and accurate clinical information and administrative information should be completed within one (1) day from receipt and validation.

naviHealth monitors the processing of every authorization received and is committed to a rapid and accurate process. When care coordinators are able to collaborate on-site in larger volume facilities, authorizations occur more quickly.

Any denial or case that does not initially meet criteria or medical necessity does require second level review and, therefore, takes longer.

Q11: What are naviHealth's requirements regarding PAC admissions from the emergency room, physician's office, home, observation status, etc.?

A11: If the member is in the emergency department during business hours, the standard prior authorization process applies. If it is after hours and transition cannot wait until the next day, the facility should do what is in the member's best interest.

If the member is transitioned under urgent/emergent circumstances, the skilled nursing facility must inform naviHealth of the admission within 24 hours or the next business day and request authorization using the standard process. Admissions will be evaluated on a case-by-case basis for medical necessity and appropriateness by naviHealth.

Q12: What are the main criteria when a patient transitions from the emergency room to a SNF when the physical therapist or occupational therapist is not available to evaluate and confirm patient needs to go to SNF? Without that evaluation, the patient must sometimes stay overnight because a therapist is not available to conduct an evaluation. Will an evaluation performed by the nursing staff be sufficient to allow the transfer to a SNF?

A12: naviHealth's goal is to ensure patients are placed in the right care setting at the right time. All applicable information should be submitted to naviHealth for consideration of appropriate PAC placement. If therapy information is not available, supporting documentation should be included describing the patient's medical or physical need for a PA transition.

Depending on the unique circumstance, naviHealth may use alternative methods to obtain the necessary information in collaboration with the care team.

REIMBURSEMENT METHODOLOGY/RUG PROCESS

Q1: What, if anything, changes with the Resource Utilization Group (RUG) process?

A1: The RUG is assigned by naviHealth as part of the authorization process based on the patient information provided. This is the RUG level the facility will use when billing. By reviewing this prospectively, naviNet ensures that all parties are in alignment on the level of therapy authorized for Highmark members.

Q2: How does naviHealth assign the RUG level on SNF authorizations?

A2: Upon authorization for skilled nursing facility stay at a facility whose reimbursement is based on RUG rates, the member will be authorized for the appropriate RUG level of therapy based on the **nH Predict/Outcome** completed during the acute care stay. The member's appropriate therapy level will inform the therapy-based RUG level. The RUG level approved and determined by acute clinical information will remain through the member's length of stay unless naviHealth approves a different level on patient need. If the member has nursing only needs, naviHealth will notify the SNF who will be responsible for determining the appropriate nursing RUG.

Q3: How does the nH Predict/Outcome determine the RUG level?

A3: It has been demonstrated that not having enough therapy can lengthen the amount of time a member is in a skilled nursing facility and hinder the member's overall functional improvement. Conversely, overutilization of therapy services as shown to produce unnecessary fatigue in the elderly population and has not demonstrated a more rapid gain in functional mobility.

The above rationale is based on the **nH Predict/Outcome**, which houses over 4 million actual member records. Serving as an evidence-based proactive tool, it assesses each patient's medical condition and establishes guidelines for the "right amount" of therapy to maximize functional recovery in the most predictable period of time. Aligning the RUG level with the **nH Predict/Outcome** instrument allows the care team to focus on the amount of therapy that best ensures the member will obtain functional results.

Q4: What will happen to the RUG level if there is a significant clinical change in the middle of the patient stay in the SNF?

A4: If there is a significant clinical change in the patient status, the SNF should contact the naviHealth Care Coordinator with additional information that will allow another to be generated and the RUG level to be reevaluated. If a change to the RUG is required, the new RUG level will be effective as of the date of the change.

Q5: Now that naviHealth will be assigning the RUG level for members receiving therapy, should I continue to follow the MDS schedule for assessments?

A5: Effective August 1, 2014, for members receiving skilled rehabilitation services rendered in a skilled nursing facility, Highmark no longer requires SNFs to complete the Minimum Data Set (MDS) assessment schedule (this includes COT/change of therapy OMRAs) for their Pennsylvania Medicare Advantage members. This change applies only for members admitted to SNFs on August 1, 2014, or later, who will have their post-acute care rehabilitation services managed by naviHealth and who require therapy services on a daily basis.

There is no change in the required MDS or COT assessment schedule for Highmark commercial members or Medicare Advantage members with a permanent address outside of Pennsylvania.

This change has no impact on the Department of Health guidelines as facilities will still be required to complete the Comprehensive MDS Admission Assessment and Discharge Assessment under OBRA regulations.

Q6: What if the member changes from nursing only/medical skilled to receiving therapy mid-stay? How should I start/stop the PPS schedule when the member's care changes?

A6: If a member is admitted for medical management only, the facility would follow the traditional PPS MDS Assessment Schedule. During the course of care, if a member requires therapy services, the provider notifies the Care Coordinator, completes the therapy evaluations and a **nH Predict/Outcome** is generated. At that point, the MDS Assessment Schedule stops and the member would be assigned an appropriate RUG level based on the **nH Predict/Outcome**, effective the day therapy starts.

Conversely, if a member is admitted for therapy and rehabilitation services stop, the SNF would complete an EOT OMRA and an appropriate nursing RUG level would be determined to begin the first day the member is no longer receiving therapy. From there, the SNF would follow the traditional PPS MDS Assessment schedule. If there is an opportunity to combine the EOT OMRA with a scheduled assessment, the provider may do so.

Q7: What is the process if naviHealth recommends one RUG level or level of care but the therapist disagrees with the recommendation?

A7: naviHealth's goal is to make the best determination based on individual need and informed by a strong evidence base. If a SNF feels that a different RUG level or level of care is appropriate for the member, the facility should contact naviHealth via their on-site Care Coordinator or toll-free number. The supporting clinical information should be supplied to document the request; this will be further reviewed by the naviHealth team.

Clinical scenarios that do not appear to need an adjusted RUG level or level of care will be reviewed by a naviHealth Medical Director. naviHealth will communicate the decision on the review to the facility.

Q8: How will the approved RUG level be communicated to the SNFs?

A8: SNFs will be able to view the specific RUG level approved via the **Auth Inquiry and Reports** transaction in NaviNet®. The RUG level will be reflected in "Services Description" under **Level Care**.

Services Description:

TYPE OF SERVICE: SKILLED NURSING CARE
PROCEDURE CODE:
PROCEDURE DESCRIPTION:
DISCHARGE DISPOSITION:

SERVICE DETAIL	FROM	TO	DAYS	LEVEL CARE	REASON
EXTENSION APPROVAL	08/22/2014	08/25/2014	4	RVB	MEETS CRITERIA/GUIDELINES

Q9: Will naviHealth also be assigning the Assessment Indicators?

A9: naviHealth will only be providing the RUG level, which should be reported as the first three digits of the 5-digit HIPPS code. For members receiving therapy, the provider should report 60 as the Assessment Indicator, which occupies the last two positions of the HIPPS code.

For members with nursing/medical care only, SNFs will continue to follow the MDS schedule, with assessments at days 5, 14, 30, 60, and 90, to identify the appropriate RUG level. SNFs will also assign the applicable Assessment Indicators in conjunction with the assigned RUG to identify the HIPPS code for reporting on the claim.

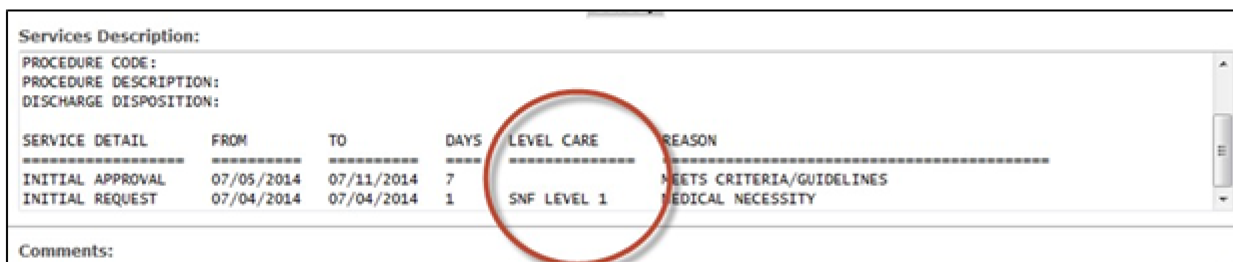
Q10: What happens if a provider attaches a different RUG level to the claim and it does not match the RUG level authorized by naviHealth?

A10: The RUG level on the provider claim should match the RUG level authorized by naviHealth. If the RUG levels do not match (e.g., RUG level on claim is higher than RUG level approved by naviHealth in the authorization process), the claim will reject. SNFs should provide therapy consistent with the output from the **nH Predict/Outcome** tool and report the corresponding RUG level on claims.

Note: If the SNF disagrees with the authorized RUG level, the SNF should follow the instructions in Question 7 in this section to have the determination reviewed by a naviHealth Medical Director.

Q11: My SNF is reimbursed based on levels of care, not RUG rates. How will the approved level be communicated?

A11: SNFs will be able to view the specific room level that was approved via the **Auth Inquiry and Reports** transaction in NaviNet. The approved level of care will be reflected in "Services Description" under **Level Care**.



DENIALS AND APPEALS

Q1: What if we would like to have a peer-to-peer conversation?

A1: The purpose of the peer-to-peer conversation is to allow the ordering or treating provider an opportunity to discuss a denial determination. This process is typically initiated when a peer-to-peer conversation did not occur prior to the initial denial determination. The clinical peer reviewer who made the determination (or an appropriate designee) will be available within one (1) business day from the time of request.

naviHealth will provide access to a Medical Director for peer-to-peer review if desired by the facility. To initiate a peer-to-peer discussion, the provider should call the dedicated toll-free phone number during the hours of operation: **1-844-838-0929**.

Note: The peer-to-peer conversation should be used when a request for authorization has been denied. SNFs that disagree with the RUG level or level of care that was approved by naviHealth should follow the process outlined in Question 7 under the **REIMBURSEMENT METHODOLOGY/RUG PROCESS** category of this FAQ document.

Q2: What if facility clinicians are not in agreement with the discharge setting (e.g., believe a higher level of therapy is necessary)?

A2: The first point of contact will be the naviHealth Care Coordinator; but in the event that a further conversation is necessary, a naviHealth Medical Director would be consulted.

Q3: What is the process for denials and appeals?

A3: A denial of post-acute care services will be issued by naviHealth, similar to the approval of services. naviHealth generates the notification of denial coverage to both the provider and to the patient. If requested, naviHealth offers a peer-to-peer clinical conversation with the naviHealth Medical Director as mentioned above.

Any appeal of the denial of services rendered by naviHealth will be handled by Highmark, just as appeals are currently handled. Highmark will continue to handle appeals when the member has not yet been admitted to a post-acute care facility or when the member is still inpatient. Appeals for these situations should be initiated by contacting **Medicare Advantage Expedited Appeals** at **1-800-485-9610**.

naviHealth will handle appeals after the member has been discharged from the post-acute care facility and a denial has been received. The naviHealth provider appeals information for post-service appeals is:

- Phone: **1-844-838-0929**
- Address for appeals:
  naviHealth
  210 Westwood Place, Suite 400
  Brentwood, TN 37027
  Attn: Provider Appeals

Q4: Does the attending physician need to be the one who participates in peer-to-peer conversations?

A4: The attending physician, ordering physician, or primary care physician needs to complete the peer-to-peer conversation. Peer-to-peer requests should not be completed by a physician who is not yet involved in the patient's direct care (e.g., a physiatrist at the IRF where the member has not yet been admitted).

Q5: What happens when Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) appeals are overturned? Does naviHealth or Highmark call the facility about the outcomes?

A5: If member appeal is overturned by the BFCC-QIO, the BFCC-QIO will return that decision to Highmark who in turn will notify naviHealth. naviHealth will then notify the provider of the next review date or the last covered day.

MISCELLANEOUS

Q1: What about long-term care residents? Will naviHealth be managing those patients as well?

A1: naviHealth will provide authorizations and manage patients who require a skilled level of care in a facility. If a long-term care patient requires a skilled level of care, naviHealth would review the authorization request and manage the services when the patient transitions to a skilled level. naviHealth manages Medicare Advantage patients within their Part A benefit structure. Requests related to Part B services should be directed to Highmark.

Q2: Will length of stay in the post-acute care setting decrease as a result of this initiative?

A2: It is a reasonable and appropriate expectation that the overall utilization of post-acute care services will decrease with naviHealth management. As decisions are better informed and patient focused, variation from best practice recommendations will decrease.

Delivering services that are focused on the best possible outcome for the patient typically does result in reduced utilization as more efficient and effective approaches are implemented. This utilization reduction will be more significant for those facilities with greater variation than for those that are already high-performing facilities.

REPORTING/OUTCOMES DASHBOARD

Q1: How frequently will information/results be shared with post-acute care providers?

A1: In part, the frequency will depend on the volume of admissions you see in your facility. Once naviHealth has at least 20-25 completed records to review, naviHealth can review the information and the results with the post-acute care providers. This review will be facilitated with your existing Network Manager/Director.

Q2: Will our results be shared with other post-acute care providers in the area?

A2: You will receive your results compared to others in your area, although the other facilities will be blinded. naviHealth will also share information on how each facility is doing relative to Highmark performance as a plan statewide.

Q3: Will Highmark share the results with hospitals?

A3: Highmark intends to share this information with hospitals since we already track performance measures for post-acute care providers and this information can help augment their reviews of post-acute care providers that they utilize in their area or region.