POST-ACUTE CARE MANAGEMENT PROGRAM FOR MEDICARE ADVANTAGE MEMBERS

ADMINISTRATIVE GUIDE

Guidelines and Requirements for facility providers

This information is issued on behalf of Highmark Blue Shield and its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in 21 counties in central Pennsylvania. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides secure, web-based portal between providers and health insurance companies.

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INTRODUCTION

Introduction	Highmark partners with naviHealth, a national post-acute care management company, to bring a personalized approach to support our Medicare Advantage members across Pennsylvania and West Virginia.
Program description	Prior authorization must be obtained from naviHealth for any new admissions to and concurrent stays at skilled nursing facilities, long-term acute care hospitals, and inpatient rehabilitation facilities for Highmark's Medicare Advantage population in the Pennsylvania and West Virginia. Authorization requests should be submitted via NaviNet®. While naviHealth will manage those post-acute care services for Medicare Advantage members, Highmark will continue to directly manage authorizations for other post-acute services such as durable medical equipment, swing bed admissions, home health agency services, and other products and services provided in the member's home.
About naviHealth	naviHealth specializes in managing post-acute care services. They partner with health plans, health systems, and post-acute providers to manage the entire continuum of post-acute care. nnaviHealth's in-market clinicians work with skilled nursing facilities, long-term acute care, inpatient rehabilitation, and acute-care hospitals to maximize post-acute care outcomes for Highmark members. To oversee safe discharge transitions, naviHealth utilizes decision-support technology and post-acute analytic capabilities to coordinate long-term acute care, inpatient rehabilitation, and skilled nursing facility utilization. Through a highly collaborative process, this partnership enables us to increase member satisfaction, lower readmission rates and improve clinical outcomes. You can learn more about naviHealth by visiting their website.
Highmark's Business Associate Agreement (BAA) with naviHealth	Highmark and naviHealth have executed a Business Associate Agreement (BAA) to allow naviHealth access to patient records. naviHealth is a business associate of Highmark as defined by the Health Insurance Portability and Accountability Act (HIPAA). As such, naviHealth is required to protect, preserve, and maintain the confidentiality of any protected health information (PHI) they gather from clinical records provided by medical practice locations, as required under applicable law and outlined in their contract with Highmark. A separate BAA is not required with each provider.
Physician education	While this Administrative Guide focuses primarily on facility providers, professional providers have been educated on this program as well.

PROGRAM GUIDELINES AND REQUIREMENTS

Program overview

nnaviHealth generates an authorization for care delivered at:

- Skilled Nursing Facilities (SNF);
- Long-term Acute Care Facilities (LTAC);
- Transitional Care Units (TCUs); and
- Inpatient Rehabilitation Facilities (IRF).

This includes initial post-acute care facility admissions, additional lengths of stay, and next review dates. Highmark will retain responsibility to authorize all other post-acute care services, including:

- Swing bed admissions;
- Durable medical equipment;
- Home health agency services; and
- Other at-home or outpatient services.

Patient and care-giver engagement

naviHealth care coordinators will work closely with Medicare Advantage members, caregivers, and facility care managers to plan care transitions and provide authorizations on behalf of Highmark for post-acute care services. Where practical and appropriate, the naviHealth care coordinators may be on site to support your clinical team in the coordination, management, and discharge of our members. The goal is to ensure members receive evidence-based care at the least restrictive, most appropriate site to enable them to regain functional status most effectively.

On-site care coordinators

Based on patient volume and service intensity, naviHealth may be on-site at your facility. The volume of Highmark members at your facility will influence how frequently an on-site colleague may be present. Facilities will also be supported telephonically if volume and/or geographical location prohibit efficient on-site presence.

The purpose of naviHealth staff being on-site is to interact with your case managers and discharge planners to better facilitate the care provided to our members. Care coordinators are encouraged to engage with your care team in conversations with and about the patients and their caregivers, either in person or via telephone, where appropriate and when requested. naviHealth will discuss current course of care and/or the expectations for patients and families at their next level of care.

Post-acute care (PAC) Model: transitions from hospital to SNF

To determine the most appropriate PAC setting for that patient prior to discharge to a PAC facility, the naviHealth care coordinator will complete an initial nH Predict assessment, using naviHealth's proprietary, patient-centered, data-driven IT and workflow management platform.

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PROGRAM GUIDELINES AND REQUIREMENTS, Continued

Post-acute care (PAC) Model: transitions from hospital to SNF (continued)	This assessment generates an individualized patient-centered care plan based on an outcomes database containing more than 6 million patient records. The nH Predict assessment will be provided to the SNF team with five key elements: • Risk for readmission/rehospitalization; • Expected functional improvement; • Projected hours of therapy per day; • Estimated length of stay; and • Projected number of hours of caregiver support at discharge. When the member is transitioned to a SNF, the naviHealth care coordinator will then participate in weekly Interdisciplinary Care Team Meetings with the SNF either onsite and/or telephonically (depending on volume and census). Approximately every seven to ten (10) days, the care coordinator will complete an updated nH Predict assessment.
Long-term care residents	naviHealth will provide authorizations and manage members who require a skilled level of care in a post-acute care facility. If a long-term care patient requires a skilled level of care, naviHealth will review the authorization request and manage the services when the member transitions to a skilled level. **Note:** naviHealth only manages Medicare Advantage members within their Inpatient Part A benefit structure.

NAVIHEALTH ASSESSMENT TOOLS

naviHealth nH Predict tool

naviHealth utilizes a proprietary, patient-centered, data-driven IT and workflow management platform (nH Predict), combined with a smart-touch patient and provider engagement model to support improved outcomes.

nH Predict, originally developed by SeniorMetrix, leverages the actual experiences of millions 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, co-morbid conditions, and normal living situation to project outcomes in a highly reliable and evidenced based manner. In addition to projecting outcomes, the instrument can also provide care teams and members commonly identified barriers experienced upon discharge.

The functional measurement capability of nH Predict relies on the Activity Measure for PAC (AM-PAC™) which can be used for any individual, regardless of the functional capability. AM-PAC is a functional measurement tool designed by Boston University. It uses item response theory to determine a functional score which is setting agnostic. Several Academic Journal articles have been published about AM-PAC and nH Predict technology. naviHealth provides ongoing monitoring and reliability testing to ensure ongoing effectiveness of the tool.

nH Predict projections

Based on a database with over 6 million patient records, the nH Predict tool generates a report that provides the following projections:

- Appropriate PAC setting (while at the hospital);
- Length of stay;
- Therapy intensity;
- Expected functional improvement;
- Risk of readmission; and
- Caregiver burden at discharge from PAC facility.

nH Predict assessments

naviHealth's recommendations are evidenced-based, ensuring clinicians can be confident in these recommendations and has been validated by several scientific studies. The evidence-based database is composed of more than 6 million actual patient records across the nation and includes the entire care continuum, so you can be sure that the predictions are accurate. naviHealth conducts ongoing inter-rater reliability tests for all nH Predict raters to ensure the tool is being used consistently.

naviHealth's nH Predict assessment is intended to serve as a guideline for planning a member's transition and/or subsequent stay in a post-acute care setting. There

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NAVIHEALTH ASSESSMENT TOOLS, Continued

nH Predict assessments (continued)

are occasions where not all member information can be captured or assessed, but the nH Predict serves as a patient centric, objective starting point to begin care plans and generate further discussion.

The member's current diagnosis and the response to the nH Predict provides answers related to basic mobility, daily activity, and applied cognition and are factored into the nH Predict Outcome, described below.

nH Predict outcomes

Once completed, the nH Predict assessment results will be provided to the acute-care facility and to the post-acute care facility via the nH Predict Outcome Report. If clinical information is readily available in the acute-care setting, naviHealth can complete the nH Predict assessment early on during the inpatient admission so that discharge planners and case managers can incorporate this information into their discharge care plan for the member.

Once admitted to the post-acute care facility, naviHealth creates a new nH Predict assessment for the member based on provider therapy and nursing assessment information. The nH Predict Outcome Report is then shared with the care team as soon as practical (ideally within two (2) business days of receiving the facility assessments). The assessment can be utilized early in the member's stay to help guide the care plan and the discharge plan for the member.

nH Predict Outcome Report determines therapy intensity

The nH Predict Outcome Report determines the precise level of therapy intensity required to produce the highest level of function in a predictable period. The expectation is that the provision of service will align with the nH Predict Outcome. In most cases, naviHealth therapy intensity predictions will not vary during a member's course of care.

In circumstances where a member's clinical change in status warrants a change in reimbursement level, the naviHealth care coordinator and the SNF will collaboratively establish the date of the level of care change and the claim will reflect this determination. A high level of real-time engagement between naviHealth and your care team, as well as provision of therapy billing logs, will validate service delivery and outcomes.

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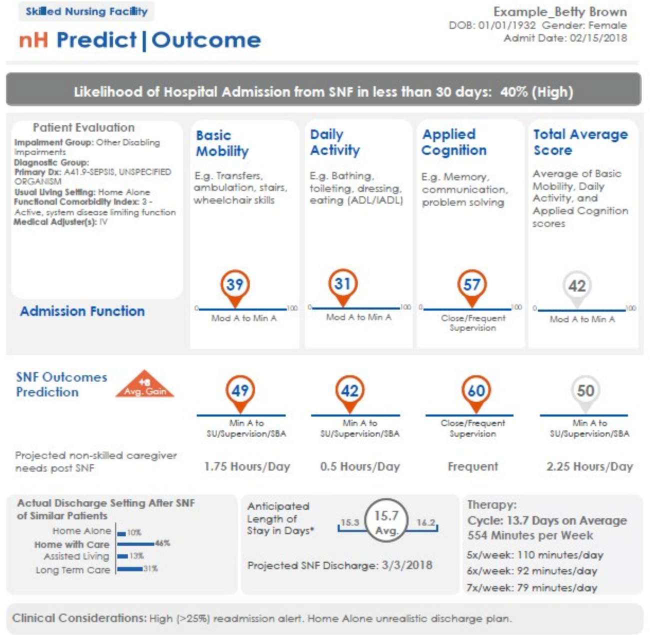
NAVIHEALTH ASSESSMENT TOOLS, Continued

Sample nH Predict Outcome Report

Below is a sample nH Predict Outcome Report for a member currently in an inpatient acute-care hospital. This report compares the projected results if the member is discharged to a SNF or home with home health care.



Interpreting the score on the nH Predict Outcome Report

The nH Predict score on the report helps naviHealth determine the most appropriate post-acute care setting.

You can request a Quick Reference Guide from naviHealth to compare nH Predict scores and assistance levels. This reference guide may be used to assist in understanding the discharge recommendations that naviHealth provides via the nH Predict Outcome Report.

Sharing the nH Predict Outcome Report

The nH Predict Outcome Report is a clinical document and is intended to be used by the care team. Certain information from the nH Predict Outcome Report can and should be shared with the member to set expectations. Page 2 of the report is designed to be shared with a member to communicate potential barriers that may exist upon discharge. A sample of this second page is provided below.

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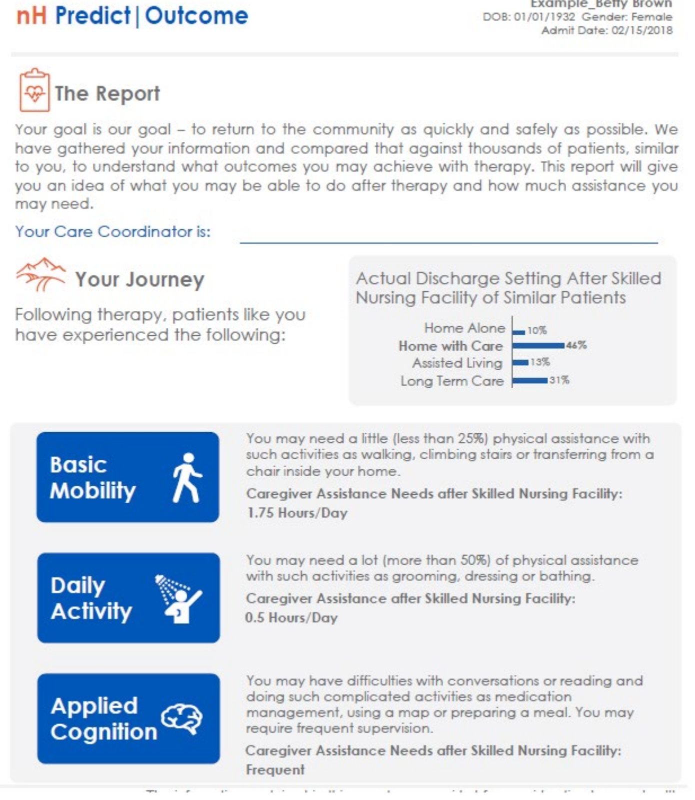
Sharing the nH Predict Outcome Report (continued)



Frequency of nH Predict assessments

Within most facilities, updates to a member's nH Predict assessment will be provided approximately every seven (7) to ten (10) days. Updates are provided in the form of functional score change, objectively identifying progress toward functional goals.

AUTHORIZATION REQUESTS

Introduction

The PAC Management Program requires pre-authorization for PAC admissions to a SNF, LTAC, or IRF for Highmark's Medicare Advantage population in the Pennsylvania and West Virginia.

Authorization criteria

Highmark encourages the continued use of NaviNet for providers currently using this service. Providers should also consider implementing NaviNet due to the efficiency the technology offers. Authorizations can, however, be handled via fax and phone if needed.

1-844-496-7206 (General, Prospective Review)	**1-844-838-0929*** *Telephonic requests should be limite to urgent requests as outlined above.

Initiating NaviNet requests

The Authorization Submission transaction in NaviNet is used to transmit the information to naviHealth. By automating the authorization request process, naviHealth expects to shorten the response time needed to initiate care and provide consistent decisions.

NaviNet hours of availability

NaviNet has extended hours of system availability for all your inquiry and transaction needs:

- Monday through Friday from 5 a.m. to 3 a.m.
- Saturday from 5 a.m. to 11 p.m. ET
- Sunday from 5 a.m. to 9 p.m. ET

NaviNet Survey collects clinical data

For initial authorization requests, the facility begins the process by selecting Inpatient Auth Submission via the Authorization Submission transaction in NaviNet. After completing the request form, the appropriate survey will automatically be “served” to you based on the member information submitted.

Our systems will recognize the member’s coverage and you will receive the appropriate survey for completion. Authorization requests for PAC, managed by naviHealth, will use the PAC Survey for Medicare Advantage to collect the information about the member's clinical condition.

Note: You may still utilize the Post-Acute Assessment Tool (PAAT) for some of your patients.

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AUTHORIZATION REQUESTS, Continued

Approved authorization requests

SNFs will be able to view the specific level of care that was approved via the Referral/Authorization Inquiry transaction in NaviNet. The approved level of care will be reflected in the Services Description under Level Care (see examples below).

RUGS

Request Information

Comments	Notes
DaysAuthorization	Start Date | Last Covered Day | Status / Reason | Number of Days | Level of Care
DaysAuthorization	02/23/2022 | 02/25/2022 | Approved/Meets Criteria/Guidelines | 3 | Rehab Very High B

Levels of Care

Request Information

Comments	Notes
DaysAuthorization	Start Date | Last Covered Day | Status / Reason | Number of Days | Level of Care
DaysAuthorization	02/22/2022 | 02/24/2022 | Approved/Meets Criteria/Guidelines | 3 | SNF Level 1

Episodic

Request Information

Comments	Notes
DaysAuthorization	Start Date | Last Covered Day | Status / Reason | Number of Days | Level of Care
DaysAuthorization	02/23/2022 | 02/25/2022 | Approved/Meets Criteria/Guidelines | 3 | Rehab Ultra High Extension

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IMPORTANT! Authorization is not a guarantee of payment

When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; it is not a guarantee of payment. Payment is dependent upon the member having coverage at the time the service is rendered and the type of coverage available under the member's benefit plan. It is the provider's responsibility to verify that the member's benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service.

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AUTHORIZATION REQUESTS, Continued

Turnaround time for an authorization decision	Responding quickly to authorization requests is as important to naviHealth as it is to the provider community. The goal is to get members transitioned to their most appropriate next level of care in an expedient but safe manner. Authorizations that have been requested with complete and accurate clinical information and administrative information should be completed within one 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 collaborate on-site in larger volume facilities, authorizations occur more quickly. Any denial, or case, that does not initially meet criteria or medical necessity requires a second level review and therefore may take longer.
Concurrent (continued stay) reviews for SNF	As you do today, you should submit the same type of information via NaviNet to ensure that updated clinical information is available for the concurrent review. Facilities need to first locate the initial authorization via the Referral/Authorization Inquiry transaction in NaviNet. Once the authorization is located, click on the Survey button to be taken to the Survey Menu. **Note:** SNFs will also continue to use the PAAT for Highmark's commercial members.
Urgent requests	You can call naviHealth at **1-844-838-0929** to support urgent or emergent requests for authorizations. naviHealth may ask a series of questions to determine if the case meets CMS criteria for expedited review. **Note:** For a complete list of naviHealth telephone and fax numbers, please refer to the appendix.
Authorization criteria for IRF/LTAC admission	naviHealth primarily uses InterQual® criteria to review the appropriateness of LTAC authorizations. Appropriateness of IRF authorizations is determined by CMS manual, chapter 1.
Criteria for members with medical needs ONLY	Clinical information should support the need for skilled care at the requested level of care. Sufficient detail about skilled medical care should be provided to verify medical necessity. For example, frequency/duration/dosage of IV medications, tube feedings, wound care measurements, etc. should be included along with appropriate labs and physician notes.

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PAC admissions from settings other than acute inpatient hospital

If a member is in the emergency department, community, or physician office etc. during business hours, the standard prior authorization process applies. If it is after hours and the provider has determined the member does not require acute care, the facility should do what is in the member's best interest — transferring the member to the most appropriate level of care, this includes direct transfers from LTC, ALF, home, physician office, etc.

If the member is transitioned to an inpatient PAC setting, the receiving 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.

Transfers to SNF from emergency room when therapist is unavailable for evaluation

The goal is to ensure members 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 describing the member's medical or physical need for a PAC transition should be included.

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

Initial authorization timeframes

Initial authorization requests are typically approved for three (3)-five (5) days. This is to allow the SNF, IRF, or LTAC time to appropriately assess the member for therapy/medical needs following the member's transition from the acute care setting. Following that initial authorization, additional authorizations will be based on the unique needs of the member and will be driven by updated clinical information.

For members in a SNF facility, the length of authorization will take into consideration the need to have the NOMNC (Notice of Medicare Non-Coverage) issued timely.

naviHealth hours of availability

naviHealth has the following regular hours of operation:

- Monday through Friday from 8:30 a. m. - 7:00 p. m. ET
- Saturday and Sunday from 8:30 a. m. - 4:30 p. m. ET

Please note that naviHealth will be closed in observance of the following national holidays: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day.

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AUTHORIZATION REQUESTS, Continued

Faxing requests

Providers can submit authorization requests via NaviNet via the following fax numbers:

- General, prospective reviews: **1-844-496-7206**
- Continued stay reviews for SNF/IRF/LTAC: **1-844-496-7209**
- Therapy treatments/visits submitted to naviHealth: **1-844-573-3167**

To effectively attach member information to the case management tool for review by the authorization team, naviHealth requests that you send information for one member per fax when submitting any patient information.

DISCHARGE CONSIDERATIONS FROM SNF

NOMNC issuance

The facility will continue to issue the NOMNC to the member upon discharge, under the direction of naviHealth. In addition, facilities are required to fax a copy of the completed NOMNC to naviHealth, the same day it was issued to **1-844-496-7209**.

Notification of QIO appeal determination

The QIO returns appeal decisions to Highmark, which in turn notifies naviHealth. naviHealth then notifies the provider of the next review date or the last covered day. For more information on appeals, please review the Highmark Provider Manual Chapter 5 Unit 5: Denials, Grievances, and Appeals.

To access the Highmark Provider Manual, go to the **Provider Resource Center**, select **Manuals** from the navigation bar, and click **Highmark Provider Manual**.

Billing logs and therapy discharge assessments

In addition to receiving a copy of the NOMNC, naviHealth requires therapy billing information and the therapy discharge assessment be conducted at the end of the member stay. Therapy billing information may be submitted via NaviNet or fax and is required within 24 hours of discharge.

Submission method	Instructions
NaviNet	Update the total visits and minutes for each appropriate therapy on the PAC Survey for Medicare Advantage for the member.
Fax	Submit the billing logs/Use toll free fax number: **1-844-573-3167**.

This information helps naviHealth create a complete member record and allows them to include this information to be included on the SNF dashboard database that is presented to the SNF community. The information contained in the dashboard is a direct reflection of the amount of complete member records naviHealth receives.

DENIALS OF COVERAGE

Introduction

A denial of post-acute care services will be issued by naviHealth, like the approval of services. Any potential pre-service denial is brought before a naviHealth Medical Director for review. naviHealth generates the notification of denial of coverage to both the provider and to the member. If requested, naviHealth offers the referring physician a peer-to-peer clinical conversation with the naviHealth Medical Director.

Peer-to-peer conversations

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 business day from the time of request.

naviHealth will provide access to a medical director for peer-to-peer reviews if desired by the facility. To initiate a peer-to-peer discussion, the provider should call the dedicated toll-free telephone number (**1-844-838-0929**) during the hours of operation.

Note: The peer-to-peer conversation should be used when additional clinical information may favorably impact the request for authorization that has been denied. SNFs that are requesting a level of care change should follow the process outlined in the RUG Reimbursement section of this Guide to have the determination reviewed by a naviHealth Medical Director.

Who conducts peer-to-peer reviews

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 member's direct care (e.g., a physiatrist at the IRF where the member has not yet been admitted).

DENIALS AND APPEALS

Appeals when a denial is received (post-service appeals)	naviHealth will handle appeals after the member has been discharged from the PAC facility and a denial has been received.
naviHealth SNF appeals	Facilities can contact naviHealth using the following numbers for post service appeals: • Phone: **1-844-838-0929** • Fax: **1-855-893-5963** • Appeals address: naviHealth Attention: provider appeals 210 Westwood Place Brentwood, TN 37027
Expedited appeals (pre-service appeals)	An appeal of the denial of services by naviHealth, prior to the member's admission, will be handled by Highmark. Highmark will continue to handle appeals when the member has not yet been admitted to a PAC facility or when the member is still inpatient. Appeals for these situations should be initiated by contacting Highmark's Medicare Advantage Expedited Appeals at: • Telephone **1-800-485-9610**. • If the appeal is being initiated by an MD it can also be faxed to **1-800-894-7947**. For more information on Highmark's appeals process please review the Highmark Provider Manual Chapter 5 Unit 5: Denials, Grievances, and Appeals. To access the Highmark Provider Manual, go to the **Provider Resource Center**, select **Manuals** from the navigation bar, and click **Highmark Provider Manual**.

RUG REIMBURSEMENT – PA ONLY

naviHealth assigns RUG level for members receiving rehabilitation therapy

The RUG level is assigned by naviHealth as part of the authorization process based on the member information provided. This is the RUG level that the facility will use when billing. By reviewing this prospectively, naviHealth ensures that all parties are in alignment on the level of therapy authorized for Highmark members. The minutes and visits entered in the MDS should align with the nH Predict Outcome Report and the RUG level authorized.

nH Predict tool determines RUG level

It has been proven 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 has been 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 naviHealth nH Predict tool, which houses over six (6) million actual member records. Serving as an evidence-based proactive tool, it assesses each member'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 assessment instrument allows the care team to focus on the amount of therapy that best ensures the member will obtain functional results.

Assigning the preliminary RUG level

Upon authorization for a SNF stay at a facility whose reimbursement is based on RUG rates, naviHealth will assign a preliminary RUG level based on the nH Predict assessment completed during the acute care stay.

naviHealth will reassess the preliminary RUG level based on the SNF admission nH Predict. THey may approve a different RUG Code based on member need and clinical assessment in this setting. If the member has nursing only needs, naviHealth will notify the SNF who will be responsible for determining the appropriate nursing RUG level.

Significant clinical change mid-stay

If there is a clinical change in member status (i.e., an increase or decrease in therapy intensity required), the SNF should contact the naviHealth care coordinator with the appropriate additional information. Based on the information provided, the RUG level may need to be re-evaluated. Any RUG level change will be effective as of the date the member's clinical change in status is identified.

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OBRA required assessments

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) requires that all Medicare and Medicaid Certified nursing homes (SNFs) conduct initial and periodic assessments together with OBRA-required tracking documents for all their residents. There is no change to the OBRA reporting requirements for Highmark members. Providers should follow CMS regulatory guidelines per the Minimum Data Set (MDS) 3.0 Resident Assessment instrument (RAI) Manual.

Members receiving skilled therapy

Highmark no longer requires that SNFs reimbursed under the RUG rates methodology complete the Medicare PPS assessment for Pennsylvania and West Virginia Medicare Advantage members **receiving skilled therapy or skilled therapy combined with skilled medical care**.

Members receiving skilled medical care only

naviHealth's nH Predict tool is used to predict several functional metrics including therapy levels. For members not requiring rehabilitation services, the SNF and the naviHealth care coordinator will collaborate to determine appropriate medical management.

Highmark requires that SNFs reimbursed under the RUG rates methodology complete the following Medicare PPS Assessment Schedule for members receiving skilled medical care (as applicable):

- 5-day
- 14-day
- 30-day
- 60-day
- 90-day
- Readmission Return
- CSA
- SCPA
- Swing Bed Clinical Change (CCA)

Members transitioning from skilled therapy to skilled medical care

If a member is admitted for therapy, and rehabilitation services are discontinued, the SNF must complete an EOT OMRA and an appropriate nursing RUG level will be determined to begin the first day that the member is no longer receiving therapy.

Highmark requires that SNFs reimbursed under the RUG rates methodology complete the End of Therapy (EOT) OMRA Medicare PPS Assessment Schedule (as applicable), then resume (at the appropriate time) the following assessments:

- 5-day

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Members transitioning from skilled therapy to skilled medical care (continued)	• 14-day • 30-day • 60-day • 90-day • Readmission return • CSA • SCPA • Swing Bed Clinical Change (CCA)
Members transitioning from skilled medical care to skilled therapy	As outlined above, if a member is admitted for medical management only, the facility must follow the traditional PPS MDS Assessment schedule. During care, if a member requires therapy services, the provider must notify the care coordinator and complete the therapy evaluations. The care coordinator will complete a nH Predict assessment and generate a nH Predict Outcome Report. **Note**: OBRA assessments are still required according to the federal guidelines.
When OBRA and Medicare PPS Assessment timeframes coincide	CMS continues to provide detailed information regarding the assessment timeframes on their website. Guidance for when the OBRA and Medicare PPS assessment time frames coincide can be found in Chapter 2 of the MDS 3.0 RAI Manual, titled ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI).
When a provider disagrees with a naviHealth recommended RUG level	The goal is to make the best RUG level determination based on individual need and informed by a strong evidence base. If a SNF believes that a different RUG level is appropriate for a member (than what is determined by naviHealth) based on the clinical and functional care assessment completed, the facility should contact naviHealth via their 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 will be reviewed by a naviHealth medical director. naviHealth will communicate the decision on the review to the facility.

LEVELS OF CARE REIMBURSEMENT

naviHealth assigns level of care	The level of care is assigned by naviHealth as part of the authorization process based on the member information provided. This is the level of care that the facility will use when billing, in alignment with naviHealth reviews, throughout the member's stay. By reviewing this prospectively, naviHealth ensures that all parties agree with the level of care authorized for Highmark members and the billing is supported by the care and therapy services provided.
How naviHealth assigns the level of care on SNF authorizations	The member is assigned a level of care from the nH Predict Outcome Report completed during the acute care stay. This will generate a target therapy intensity demonstrated to produce optimum functional outcomes. This target intensity will inform the level of care. The level of care approved and determined by acute clinical information will remain through the member's length of stay unless naviHealth approves a different level based on patient need.
When provider disagrees with naviHealth's recommended level of care	The goal is to make the best determination of the level of care based on individual need and informed by a strong evidence base. If a SNF feels that a different level of care is appropriate for a member, the facility should contact naviHealth via their care coordinator or via naviHealth's toll-free telephone 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 level of care will be reviewed by a naviHealth medical director. naviHealth will communicate the decision on the review to the facility.

EPISODIC REIMBURSEMENT – PA ONLY

naviHealth assigns a placeholder	naviHealth assigns a placeholder as part of the authorization process. The supporting clinical information should be supplied within 2-3 days of admission for naviHealth to complete the nH Predict Outcome Report. The SNF does not submit clinical updates to naviHealth, as the SNF determines the need for continued daily skilled services during the 30-day episode.
Recertification authorization	If member continues to meet Centers of Medicare and Medicaid Services (CMS) Chapter 8 criteria that will extend past the initial 30-day episode, at day 28 a Recertification authorization is required through naviHealth. The recertified episode begins on day 31. If member does not appear to meet CMS Chapter 8 criteria that will extend past the initial 30-day episode, the case will be reviewed and sent to a Medical Director for review of a NOMNC. If the SNF does not agree with the recommendation to issue the NOMNC, naviHealth will issue the NOMNC to the member on behalf of Highmark and no further authorization or payment will be given past day 30.
Discharge process	At the conclusion of the SNF Episode, the SNF determines when the patient no longer meets CMS Chapter 8 criteria for continued daily skilled services. The SNF issues the NOMNC and sends their SICC a valid, signed copy. naviHealth will confirm the member discharge from the SNF and requests discharge summaries and treatment logs. naviHealth then authorizes days through the NOMNC LCD in naviHealth Coordinate, updates all authorization detail, and closes the authorization.

CLAIM SUBMISSION AND REIMBURSEMENT

Introduction	Highmark will process claims for services managed by naviHealth and providers will receive payment from Highmark for eligible services. Highmark encourages electronic submission of claims via NaviNet or the applicable HIPAA transactions. Providers will follow normal procedures for submission of claims for PAC services managed by naviHealth.
Reporting the appropriate assessment indicators (when naviHealth assigns RUG)	naviHealth will be providing the RUG level which should be reported as the first three digits of the HIPPS code. The provider should report 60 as the Assessment Indicator for members receiving therapy. For members with nursing/medical care only, SNFs will continue to follow the MDS schedule to identify the appropriate RUG level and will report the applicable assessment indicators in conjunction with the assigned RUG.
Approved level to match submitted	The RUG level or Level of Care on the provider claim should match the level authorized by naviHealth. If the levels do not match (e.g. RUG level on claim is higher than RUG level approved by naviHealth in the authorization process), the claim may reject. SNFs should provide therapy consistent with the output from the nH Predict tool and report the corresponding RUG level on claims. **Note:** SNFs dissatisfied with the RUG level or level of care approved by naviHealth should follow the process outlined in the RUG Reimbursement section of this Guide to have the determination reviewed by a naviHealth medical director.

REPORTING/OUTCOMES

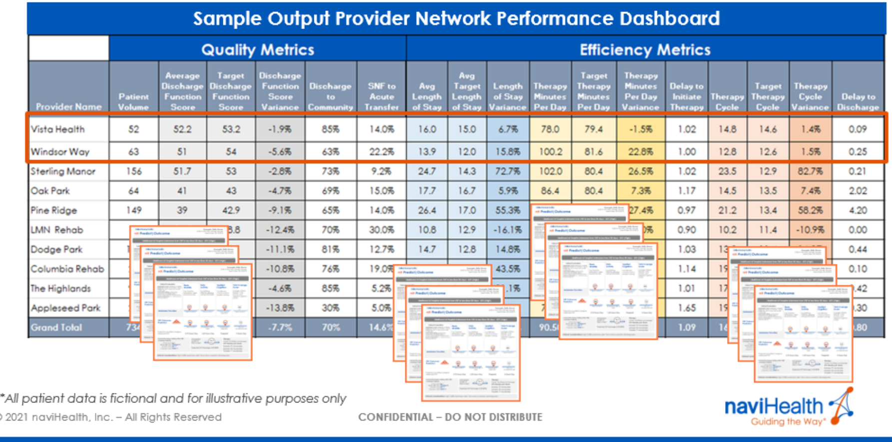
Introduction

naviHealth provides severity adjusted reporting on the quality and efficiency of SNFs within the discharge network while identifying opportunities for refinement and/or member education on the highest quality SNF providers.

Sample report

Below is a sample report with information including efficiency and quality comparisons for fictional facilities.

nH Predict | Pulse



Sample Output Provider Network Performance Dashboard

Provider Name	Quality Metrics						Efficiency Metrics										
	Patient Volume	Average Discharge Function Score	Target Discharge Function Score	Discharge Function Score Variance	Discharge to Community	SNF to Acute Transfer	Avg Length of Stay	Avg Target Length of Stay	Length of Stay Variance	Therapy Minutes Per Day	Target Therapy Minutes Per Day	Therapy Minutes Per Day Variance	Delay to Initiate Therapy	Therapy Cycle	Target Therapy Cycle	Therapy Cycle Variance	Delay to Discharge
Vista Health	52	52.2	53.2	-1.9%	85%	14.0%	16.0	15.0	6.7%	78.0	79.4	-1.5%	1.02	14.8	14.6	1.4%	0.09
Windsor Way	63	51	54	-5.6%	63%	22.2%	13.9	12.0	15.8%	100.2	81.6	22.8%	1.00	12.8	12.6	1.5%	0.25
Sterling Manor	156	51.7	53	-2.8%	73%	9.2%	24.7	14.3	72.7%	102.0	80.4	26.5%	1.02	23.5	12.9	82.7%	0.21
Oak Park	64	41	43	-4.7%	69%	15.0%	17.7	16.7	5.9%	86.4	80.4	7.3%	1.17	14.5	13.5	7.4%	2.02
Pine Ridge	149	39	42.9	-9.1%	65%	14.0%	26.4	17.0	55.3%	[illegible]	[illegible]	27.4%	0.97	21.2	13.4	58.2%	4.20
LMN Rehab	[illegible]	[illegible]	[illegible]	-12.4%	70%	30.0%	10.8	12.9	-16.1%	[illegible]	[illegible]	[illegible]	0.90	10.2	11.4	-10.9%	0.00
Dodge Park	[illegible]	[illegible]	[illegible]	-11.1%	81%	12.7%	14.7	12.8	14.8%	[illegible]	[illegible]	[illegible]	1.03	[illegible]	[illegible]	[illegible]	0.44
Columbia Rehab	[illegible]	[illegible]	[illegible]	-10.8%	76%	19.0%	[illegible]	[illegible]	43.5%	[illegible]	[illegible]	[illegible]	1.14	[illegible]	[illegible]	[illegible]	0.10
The Highlands	[illegible]	[illegible]	[illegible]	-4.6%	85%	5.2%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.01	[illegible]	[illegible]	[illegible]	[illegible]
Appleseed Park	[illegible]	[illegible]	[illegible]	-13.8%	30%	5.0%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.65	[illegible]	[illegible]	[illegible]	[illegible]
Grand Total	[illegible]	[illegible]	[illegible]	-7.7%	70%	14.6%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.09	[illegible]	[illegible]	[illegible]	[illegible]

Frequency

In part, the frequency in which you receive dashboard reports will depend on the volume of admissions in your facility and timely submission of billing information and discharge assessment. Once naviHealth has accumulated at least 20-25 completed records to review, naviHealth can review the information and the results with the PAC providers. This review will be facilitated with your existing provider relations professional.

Shared PAC results

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.

Shared with hospitals

Highmark will share this information with hospitals since we already track performance measures for PAC providers and this information can help augment their reviews of PAC providers that they utilize in their area or region.

APPENDIX: CONTACTING NAVIHEALTH

Authorization requests and status	Facilities can continue to submit authorization requests online via the Referral/Authorization Submission transaction on NaviNet®. naviHealth will interface with Highmark's systems to receive and respond to these requests electronically. Facilities can view the status of authorization requests using NaviNet's Referral/ Authorization Inquiry transaction.
Telephone numbers	If your facility does not use NaviNet to submit authorizations or if you have questions on the status of an authorization for Pennsylvania and West Virginia Medicare Advantage members for IRFs, LTACs or SNFs, contact naviHealth by calling **1-844-838-0929**.
Hours of availability	Normal business hours for naviHealth are: • Monday through Friday: 8:30 a.m. to 7:00 p.m. ET • Saturday & Sunday: 8:30 a.m. to 4:30 p.m. ET If a member is admitted to a SNF, LTAC or IRF outside of these designated business hours, naviHealth should be contacted as soon as possible on the next available business day.
Fax numbers	When working with naviHealth, you may be asked to fax clinical documentation. Please use the following fax numbers: • If unable to use NaviNet to obtain prior authorization: **1-844-496-7206** • Provider appeals: **1-855-893-5963** • Completed NOMNC forms: **1-844-496-7209** **Note**: naviHealth will handle provider appeals after the member has been discharged from the PAC facility and a denial has been received. All expedited member appeals will continue to be handled by Highmark.