



**POST-ACUTE CARE MANAGEMENT  
PROGRAM FOR MEDICARE  
ADVANTAGE MEMBERS  
ADMINISTRATIVE GUIDE**

**Guidelines and Requirements for facility providers**

**CONFIDENTIAL**

**Program effective with new post-acute care admissions beginning August 1, 2014**

# TABLE OF CONTENTS

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<b>Topic</b>	<b>See Page</b>
<a href="#"><u>INTRODUCTION</u></a>	<a href="#"><u>3</u></a>
<a href="#"><u>PROGRAM GUIDELINES AND REQUIREMENTS</u></a>	<a href="#"><u>5</u></a>
<a href="#"><u>NAVIHEALTH ASSESSMENT TOOLS</u></a>	<a href="#"><u>7</u></a>
<a href="#"><u>AUTHORIZATION REQUESTS</u></a>	<a href="#"><u>11</u></a>
<a href="#"><u>DISCHARGE CONSIDERATIONS</u></a>	<a href="#"><u>16</u></a>
<a href="#"><u>DENIALS OF COVERAGE</u></a>	<a href="#"><u>17</u></a>
<a href="#"><u>DENIALS AND APPEALS</u></a>	<a href="#"><u>18</u></a>
<a href="#"><u>RUG REIMBURSEMENT</u></a>	<a href="#"><u>19</u></a>
<a href="#"><u>LEVELS OF CARE REIMBURSEMENT</u></a>	<a href="#"><u>25</u></a>
<a href="#"><u>CLAIM SUBMISSION AND REIMBURSEMENT</u></a>	<a href="#"><u>26</u></a>
<a href="#"><u>REPORTING/OUTCOMES</u></a>	<a href="#"><u>27</u></a>
<a href="#"><u>APPENDIX: CONTACTING NAVIHEALTH</u></a>	<a href="#"><u>28</u></a>
<a href="#"><u>APPENDIX: NAVIHEALTH SURVEY</u></a>	<a href="#"><u>29</u></a>

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## INTRODUCTION

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### **Introduction**

Highmark has initiated a partnership with naviHealth, a national post-acute care management company, to bring a personalized approach to support our Medicare Advantage members across Pennsylvania.

According to patient needs, naviHealth will utilize decision-support technology and its post-acute analytics capabilities to coordinate long-term acute care, inpatient rehabilitation and skilled nursing facility utilization and will oversee proper care transitions to and from these facilities. Through a highly collaborative process, this partnership enables us to increase member satisfaction, lower readmission rates and improve clinical outcomes.

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### **Program description**

Effective August 1, 2014, 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 Commonwealth of Pennsylvania. 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 patient's home.

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### **About naviHealth**

naviHealth specializes in managing post-acute care services. naviHealth partners with health plans, health systems and post-acute 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. You can learn more about naviHealth by visiting their website at [www.navihealth.us](http://www.navihealth.us).

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## INTRODUCTION, Continued

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### **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. Be assured that protecting patient information is important to both Highmark and naviHealth.

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.

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### **Physician education**

While this Administrative Guide focuses primarily on facility providers, physicians have been educated on this program as well. Highmark published an online communication titled [Post-Acute Care Management for Medicare Advantage Members Begins Aug. 1, 2014](#) on August 4, 2014 for professional providers.

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## PROGRAM GUIDELINES AND REQUIREMENTS

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### **Program overview**

naviHealth generates an authorization for care delivered at :

- Skilled Nursing Facilities (SNF),
- Long Term Acute Care (LTAC) Facilities,
- 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**

Through this effort, 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.

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### **On-Site Care Coordinators**

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 may be present. Facilities will also be supported telephonically if volume and/or geographical location prohibit efficient onsite 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 your patients, 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.

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## PROGRAM GUIDELINES AND REQUIREMENTS, Continued

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### **Post-Acute Care (PAC) Model: transitions from hospital to SNF**

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

This assessment generates an individualized patient centered care plan based on an outcomes database containing more than 780,000 patient records. The LiveSafe assessment will be provided to the SNF team with five key elements:

- Risk for rehospitalization
- Expected functional improvement
- Projected hours of therapy per day (RUG Level or Level of Care authorized)
- Estimated length of stay
- 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 days, the care coordinator will complete an updated LiveSafe assessment.

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### **Long-term care residents**

naviHealth will provide authorizations and manage patients 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 patient transitions to a skilled level.

**Note:** naviHealth manages Medicare Advantage patients within their Part A benefit structure. Requests related to Part B services should be directed to Highmark.

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## NAVIHEALTH ASSESSMENT TOOLS

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### **naviHealth's LiveSafe tool**

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

LiveSafe, originally developed by SeniorMetrix, 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, 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 patients commonly identified barriers experienced upon discharge.

The functional measurement capability of LiveSafe relies on the Activity Measure for Post Acute Care (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 LiveSafe technology. naviHealth provides ongoing monitoring and reliability testing to ensure ongoing effectiveness of the tool.

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### **LiveSafe projections**

Based on a database with over 780,000 patient records, the LiveSafe 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
  - Caregiver burden at discharge from PAC
- 

### **LiveSafe assessments**

Clinicians can be confident in naviHealth's recommendations because it is evidenced-based and has been validated by several scientific studies. The evidence base database is composed of more than 780,000 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 LiveSafe raters to ensure the tool is being used consistently.

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## NAVIHEALTH ASSESSMENT TOOLS, Continued

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### **LiveSafe assessments (continued)**

naviHealth's LiveSafe 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 LiveSafe 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 LiveSafe answers related to basic mobility, daily activity and applied cognition are factored into the Outcomes Prediction Tool (OPT), described below.

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### **LiveSafe Outcomes Prediction Tool (OPT) Report**

Once completed, the LiveSafe assessment results will be provided to the acute care facility and to the post-acute care facility via the Outcomes Projection Tool (OPT) report. If clinical information is readily available in the acute care setting, naviHealth is able to complete the LiveSafe 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 patient.

Once admitted to the post-acute care facility, naviHealth creates a new LiveSafe assessment for the member based on provider therapy and nursing assessment information and shares the OPT with the care team as soon as practical (ideally within 2 business days of receiving the facility assessments). Again, early in the patient stay, the assessment can be utilized to help guide the care plan and the discharge plan for the patient.

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### **OPT Report determines therapy intensity**

The naviHealth OPT determines the precise level of therapy intensity required to produce the highest level of function in a predictable period of time. The expectation is that the provision of service will align with the OPT. In most cases, naviHealth therapy intensity predictions will not vary during a member's course of care and the authorized RUG level on admission will remain as the billable RUG level during a member's skilled stay.

In circumstances where a member's clinical change in status warrants a change in the RUG level, the naviHealth Care Coordinator and the SNF will collaboratively establish the date of the RUG 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 OPT Report

Below is a sample OPT 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.





RESULTS

**Patient Name:** \_\_\_\_\_ **Admit Date:** 2/22/2012

	BM	DA	AC	TOTAL
<b>Admission Scores:</b>	57	25	51	44
<b>Acute Discharge Score:</b>	56	29	52	45
<b>Acute DC CG Hrs/Day:</b>	0.1	3.8	24/7	3.9

<b>Impairment Group:</b> Stroke	<b>Diagnostic Group:</b> Not Selected
<b>Group Status:</b> None	<b>Usual Living Setting:</b> Home with Family
<b>Medical Complexity:</b> 3	

**Likelihood of Hospital Readmit in < 30 days**

9%

LIVESAFE SNF RESULTS

Average Gain: **9 (LiveSafe)**  
Projected Last Covered Day: **3/6/2012**

**ELOS (days)**

Low:*	12.2
Average:	12.5
High:*	12.8

**Therapy Cycle (days)**

Low:*	11.1
Average:	11.3
High:*	11.6

**Therapy Hours/Day**

7 Days/Week:	1.52
6 Days/Week:	1.77
5 Days/Week:	2.13

**Projected DC Functional Score**

	BM	DA	AC	TOTAL
<b>Low:*</b>	65	40	53	53
<b>Average:</b>	66	41	54	54
<b>High:*</b>	66	41	54	54
<b>CG Hrs/Day:</b>	0.0	0.8	24/7	0.8

**Discharge Setting**

Home Alone:	12%
Home w/Caregiver:	65%
Assisted Living/Board & Care:	11%
Institutional:	12%

LIVESAFE HOME HEALTH RESULTS

Average Gain: **11 (LiveSafe)**

**Visits Per Case**

Low:*	9.92
Average:	11.95
High:*	13.98

**Projected DC Functional Score**

	BM	DA	AC	TOTAL
<b>Low:*</b>	65	37	55	52
<b>Average:</b>	67	41	58	55
<b>High:*</b>	68	44	60	57
<b>CG Hrs/Day:</b>	0.0	0.8	FREQ 0.8	

Hide LiveSafe HH Results on Report

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## NAVIHEALTH ASSESSMENT TOOLS, Continued

### Interpreting the score on the LiveSafe OPT Report

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

Access this [Quick Reference Guide](#) to compare LiveSafe scores and assistance levels. This reference guide may be used to assist in understanding the discharge recommendations that naviHealth provides via the OPT report.

### Sharing the LiveSafe OPT Report

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



Patient:  
Admit Date:

#### Projected SNF Discharge LiveSafe Levels:

May need partial to no assistance with:

- Basic communication
- Following a recipe
- Remembering calendar events
- Remembering to do 4 to 5 errands

May need partial to little assistance with communication, memory and social tasks including:

- Shopping and doing price/budget calculations
- Getting household items repaired or installed
- Managing household finances
- Navigating in the community

May need a lot (mod/max) of assistance with:

- Ascending or descending three to five steps using a handrail
- Standing for extended periods of time (more than 10 or 15 minutes) while completing a task (grooming, cooking, etc.)
- Transferring into/out of a standard tub or stepping into a standard shower stall without a rail

May need a little (min/contact guard) assistance with mobility activities such as

- Using his/her assistive device when transferring to chair, sofa, toilet or shower bench
- Standing from any chair or surface without an armrest, rail, or grab bar
- Transferring in/out of a car to attend any function outside the home
- Standing for even short time periods, for example during transfers
- Advancing with and maneuvering his/her assistive device around the home
- Ascending or descending one step/curb using an assistive device

May need a little (min/contact guard) assistance with:

- Completing errands outside the home (shopping, driving, etc.)
- Lifting heavy objects around the home (boxes, moving furniture, etc.)
- Performing home care tasks that require strength, stamina or balance (overhead painting, extended work while standing on a step stool, tree pruning, etc.)

#### Recommendations:

Upon discharge from the Skilled Nursing Facility the LiveSafe OPT projects that the patient will require SBA/CTGA assistance with the basic mobility activities, CTGA/MINA with ADL's and good basic decision making ability with applied cognitive activities. Individualized and specific activities and functional levels are described above.

It is also projected that the patient will require 2.5 hours of non-skilled caregiver assistance per day.

Medical documentation indicates that this level and hours of assistance can be provided by family, friends, paid caregiver upon discharge. Discharge planning must include this consideration for a safe discharge.

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## NAVIHEALTH ASSESSMENT TOOLS, Continued

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**Frequency of  
LiveSafe  
assessments**

Within most facilities, updates to a patient's LiveSafe assessment will be provided approximately every 7 days. Updates are provided in the form of functional score change, objectively identifying progress toward functional goals.

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## AUTHORIZATION REQUESTS

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### Introduction

The Post-Acute Care Management Program requires pre-authorization for post-acute care (PAC) admissions to a SNF, LTAC, or IRF for Highmark's Medicare Advantage population in the Commonwealth of Pennsylvania.

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

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### 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.

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### NaviNet hours of availability

NaviNet has extended hours of system availability for all of 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.
  - Sunday from 5 a.m. to 9 p.m.
- 

### 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 see the Post Acute Assessment Tool (PAAT) survey for some of your patients. The PAAT survey will continue to be used for Highmark's commercial members.

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## AUTHORIZATION REQUESTS, Continued

### Survey questions

Click [here](#) to access the questions included on the PAC Survey for Medicare Advantage. These questions can also be located in the Appendix of this Guide for easy reference.

Providers are encouraged to submit complete responses appropriate to the member's condition to reduce the volume of subsequent faxes to provide supporting details.

**Note:** The survey does not have a systematic save capability to access the information at a later date. The information within the survey must be submitted in its entirety prior to submitting the request.

### 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.

Below is an example which reflects RVB in the Level Care field. This example is for a SNF reimbursed under RUG methodology.

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	
<input type="button" value="Exit"/>						

Below is an example which reflects SNF LEVEL 1 in the Level Care field. This example is for a SNF reimbursed based on levels of care.

Services Description:						
PROCEDURE CODE:						
PROCEDURE DESCRIPTION:						
DISCHARGE DISPOSITION:						
SERVICE DETAIL	FROM	TO	DAYS	LEVEL CARE	REASON	
INITIAL APPROVAL	07/05/2014	07/11/2014	7		MEETS CRITERIA/GUIDELINES	
INITIAL REQUEST	07/04/2014	07/04/2014	1	SNF LEVEL 1	MEDICAL NECESSITY	
Comments:						

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## AUTHORIZATION REQUESTS, Continued

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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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### Turnaround time for authorization decisions

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 safe manner. Authorizations that have been requested with complete and accurate clinical information and administrative information should be completed within 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 requires a second level review and therefore may take longer.

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### 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. For members admitted on or after August 1, 2014, SNFs should select PAC Survey for Medicare Advantage. To request continued stay reviews for Medicare Advantage members admitted prior to August 1, 2014, SNFs will continue to use the PAAT survey.

**Note:** SNFs will also continue to use the PAAT survey for Highmark's commercial members.

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### Urgent requests

naviHealth has the following contact number to support urgent or emergent requests for authorizations:

- Toll free phone number: **1-844-838-0929**

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's telephone and fax numbers, please refer to the APPENDIX at the end of this Guide.

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## AUTHORIZATION REQUESTS, Continued

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**Authorization criteria for IRF/LTAC admissions**

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

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**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 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 and transfer the member to the most appropriate level of care. 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.

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

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 PAC transition.

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

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## AUTHORIZATION REQUESTS, Continued

**Initial authorization timeframes**

Initial authorization requests are typically approved for 3 days. This is to allow the SNF, IRF, or LTAC time to appropriately assess the member for therapy/medical needs interventions following the patient 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 patients 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.

**If the NaviNet option is not available**

NaviNet is the preferred method for submitting your authorization requests under the Post-Acute Care Management Program. If you are not able to access NaviNet or the NaviNet *Authorization Submission* transaction, you may contact naviHealth by telephone or via fax.

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

**Note:** For a complete list of naviHealth's telephone and fax numbers, please refer to the APPENDIX at the end of this Guide.

**naviHealth hours of availability**

naviHealth has the following regular hours of operation:

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

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

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### **Faxing requests**

Providers can submit authorization requests via NaviNet or via fax.

- Toll free fax (General, Prospective Review): 1-844-496-7206
- Toll free fax (Continued stay review for SNF/IRF/LTAC): 1-844-496-7209
- Toll free fax (Therapy treatments/visits submitted to naviHealth): 1-844-496-7210

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.

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## DISCHARGE CONSIDERATIONS

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**NOMNC issuance**

The facility will continue to issue the NOMNC to the member upon discharge. In addition, facilities are required to fax a copy of the completed NOMNC to naviHealth.

- Toll free fax: **1-844-496-7209**
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**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.

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**Billing logs and therapy assessments**

In addition to receiving a copy of the NOMNC, naviHealth requires therapy billing information and the therapy assessment conducted at the end of the patient stay. Therapy billing information may be submitted via NaviNet or fax, and is appreciated 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: 1-844-496-7210.

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

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## DENIALS OF COVERAGE

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**Introduction** A denial of post-acute care services will be issued by naviHealth, similar to 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 patient. If requested, naviHealth offers the referring physician a peer-to-peer clinical conversation with the naviHealth Medical Director.

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**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 a request for authorization has been denied. SNFs that are requesting a RUG level or level of care change should follow the process outlined on pages 25 and 26 of this Guide to have the determination reviewed by a naviHealth Medical Director.

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

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## DENIALS AND APPEALS

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### Appeals when denial received (post-service appeals)

naviHealth will handle appeals after the member has been discharged from the PAC facility and a denial has been received.

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### naviHealth appeals

Facilities can contact naviHealth using the following numbers for **post service** appeals:

- Toll free telephone **1-844-838-0929**
  - Toll free fax **1-855-893-5963**
  - Appeals address:  
     naviHealth  
     Attention: provider appeals  
     10 Cadillac Drive, suite 400  
     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**.
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## RUG REIMBURSEMENT

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### **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 patient 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 into the MDS should align with the OPT and the RUG level authorized.

---

### **LiveSafe tool determines RUG level**

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 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 LiveSafe tool, which houses over 780,000 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 LiveSafe 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 skilled nursing facility stay at a facility whose reimbursement is based on RUG rates, naviHealth will assign a preliminary RUG level based on the LiveSafe assessment completed during the acute care stay.

naviHealth will reassess the preliminary RUG level based on the SNF admission OPT. naviHealth may approve a different RUG Code based on patient 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 patient 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 of the member's clinical change in status is identified.

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*Continued on next page*

## RUG REIMBURSEMENT, Continued

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### When to follow the MDS schedule for assessments

Effective August 1, 2014, for Pennsylvania Medicare Advantage members receiving **skilled rehabilitation services** rendered in a Skilled Nursing Facility, Highmark no longer requires SNFs to complete the Medicare Prospective Payment System (PPS) Assessments. This change has no impact on the federal OBRA Assessment guidelines, as facilities will still be required to complete all of the OBRA required assessments and tracking records.

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. This change has no impact for Highmark Medicare Advantage members with a permanent address outside Pennsylvania or for commercial members. For members receiving **skilled medical services only**, SNFs are required to follow a modified Medicare PPS Assessment schedule (outlined below).

---

### 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. The OBRA required assessments include:

#### Tracking Records:

- Entry
- Death in Facility

#### Assessments:

- Admission (comprehensive)
  - Quarterly
  - Annual (comprehensive)
  - SCSA (comprehensive)
  - SCPA (comprehensive)
  - SCQA
  - Discharge (return not anticipated or return anticipated)
- 

*Continued on next page*

## RUG REIMBURSEMENT, Continued

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### Medicare required PPS Assessments

The PPS assessments have been used historically to provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the Medicare PPS.

The Complete list of Medicare-Required PPS Assessments is:

- 5-day
  - 14-day
  - 30-day
  - 60-day
  - 90-day
  - Readmission Return
  - CSA
  - SCPA
  - Swing Bed Clinical Change (CCA)
  - Start of Therapy (SOT) Other Medicare Required (OMRA)
  - End of Therapy (EOT) OMRA
  - Both Start and End of Therapy OMRA
  - Change of Therapy (COT) OMRA
- 

### Members receiving skilled therapy

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

**Note:** There is no change to the OBRA reporting requirements for Highmark members. OBRA assessments are still required according to the federal guidelines.

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*Continued on next page*

## RUG REIMBURSEMENT, Continued

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### **Members receiving skilled medical care only**

The OPT 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 (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 following Medicare PPS Assessment Schedule (as applicable):

- End of Therapy (EOT) OMRA, then resume (at the appropriate time) the following assessments:
    - 5-day
    - 14-day
    - 30-day
    - 60-day
    - 90-day
    - Readmission Return
    - CSA
    - SCPA
    - Swing Bed Clinical Change (CCA)
- 

*Continued on next page*



## RUG REIMBURSEMENT, Continued

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### **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 the course of 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 LiveSafe assessment and generate an OPT Report.

Highmark will require that SNFs reimbursed under the RUG rates methodology discontinue submitting the Medicare PPS Assessment Schedule and instead, submit Physical Therapy/Occupational Therapy/Speech Therapy evaluations to naviHealth for determination of the RUG level effective the day therapy begins.

**Note:** There is no change to the OBRA reporting requirements for Highmark members. 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 [www.cms.gov](http://www.cms.gov).

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).

---

### **SCIO audits discontinued for SNFs reimbursed based on RUG rates**

As a result of the modified assessment schedules, Highmark will no longer conduct SNF audits by a contracted vendor (currently SCIO) for Pennsylvania Medicare Advantage member claims paid at RUG rates for admissions beginning August 1, 2014.

---

### **When provider disagrees with naviHealth's recommended RUG level**

naviHealth's 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.

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## LEVELS OF CARE REIMBURSEMENT

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**naviHealth  
assigns  
Level of Care**

The level of care is assigned by naviHealth as part of the authorization process based on the patient 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.

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**When provider  
disagrees with  
naviHealth's  
recommended  
level of care**

naviHealth's 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.

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## CLAIM SUBMISSION AND REIMBURSEMENT

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**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 post-acute care services managed by naviHealth.

---

**Occurrence Code 50 and corresponding Assessment Date (when naviHealth assigns RUG)** Version 5010 requires SNFs to report the Assessment Date via Occurrence Code 50 and the corresponding Occurrence Date for RUG claims. When naviHealth has assigned the RUG level, the SNF should report the Occurrence Date as the admission date when reporting Occurrence Code 50.

As a reminder, for patients receiving nursing care, SNFs continue to follow the MDS schedule and should report the appropriate Occurrence Date based on the assessments completed.

---

**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 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 may reject.

SNFs should provide therapy consistent with the output from the OPT 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 on pages 25 and 26 of this Guide to have the determination reviewed by a naviHealth Medical Director.

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## 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.

Facility	Efficiency Measures							Quality Measures							
	Cases in LiveSafe	Rehab Start Lag (days)	Actual Therapy Cycle (days)	Rehab End Lag (days)	Actual ELOS	Target ELOS	ELOS Variance	Actual Discharge Function	Targeted Discharge Function	Function Discharge Variance	Therapy Hours / Day	Targeted Therapy Hours / Day	Therapy Hours / Day Variance	Discharge to Community Rates	Readmit Variance
Jefferson Avenue	45	1.4	10.2	1.1	12.7	10.6	20%	44.0	49.0	-10%	1.00	1.29	-25%	83%	7.1%
Mercy Court	67	1.3	12.1	0.8	14.2	13.5	5%	33.6	34.0	-1%	1.40	1.30	10%	83%	2.3%
St. Allen's	19	1.3	9.5	1.1	11.9	13.7	-13%	35.0	40.6	-14%	1.50	1.31	11%	79%	11.5%
Garden Ridge	101	1.6	11.3	4.9	17.8	14.7	21%	31.6	38.0	-17%	1.10	1.32	-14%	66%	9.3%
San Angelo Rehab	129	1.2	11.4	3.1	15.7	12.5	26%	36.0	40.0	-10%	0.90	1.30	-31%	80%	-40.0%
Pacific Crest	17	1.1	16.4	1.1	18.6	15.3	22%	39.6	42.0	-6%	1.20	1.30	-12%	45%	5.5%
Care Brook Skilled	98	0.7	11.6	1.4	13.7	11.8	16%	36.0	39.3	-8%	1.40	1.27	7%	80%	13.1%
<b>Total / Average</b>	<b>473</b>	<b>1.2</b>	<b>11.6</b>	<b>2.5</b>	<b>15.3</b>	<b>12.6</b>	<b>21%</b>	<b>36</b>	<b>40</b>	<b>-10%</b>	<b>1.2</b>	<b>1.3</b>	<b>-8%</b>	<b>69%</b>	<b>5.9%</b>

Measuring lag time between admission/discharge and therapy start/end

By facility, comparing actual length of stay to data supported target

Track quality providers by measuring impact of therapy thru patient's functional improvement

Track quality by measuring therapy intensity versus targets

Assessing readmissions thru measurement of actual versus expected

**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

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### 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.

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### 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 Medicare Advantage members for inpatient rehabilitation facility (IRF), long term acute care facility (LTAC), or skilled nursing facility services, contact naviHealth using the following toll-free number:

- **Telephone: 1-844-838-0929**
- 

### Hours of availability

Normal business hours for naviHealth are:

- **Monday through Friday:** 8:30 AM to 7:00 PM (EST)
- **Saturday & Sunday:** 8:30 AM to 4:30 PM (EST)

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.

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### Fax numbers

When working with naviHealth, you may be asked to fax clinical documentation via fax. Please use the following fax numbers:

If unable to use NaviNet, to obtain prior authorization, use fax: **1-844-496-7206**

For provider appeals, use fax: **1-855-893-5963**

To fax completed NOMNC forms, use fax: **1-844-496-7209**

*Note:* naviHealth will handle appeals after the member has been discharged from the PAC facility and a denial has been received. All expedited appeals will continue to be handled by Highmark.

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## APPENDIX: NAVIHEALTH SURVEY



AUTHORIZATION REQUEST:     PRE-SERVICE     CONTINUED STAY     DISCHARGE

**Referral Information**

**Current Setting:**

- Acute
- IRF
- LTAC
- SNF
- ER
- MD Office
- Home

**Referral Setting:**

- IRF
- LTAC
- SNF

**Previous Hospitalizations:**

- N
- Y

Date of Last Hospital Discharge: (mm/dd/yyyy)  
 Number: (1-6+ drop down)

**History Present Illness / Reason for Referral:**

*(Required field)*

**Helpful Hint:** Use this text box to summarize current medical course of care – up to 4,000 characters.

**Comorbidities:**

*(Required field)*

**Helpful Hint:** Use this text box to identify all current medical conditions – up to 4,000 characters.

**Pertinent Lab Values:**

- N
- Y

Date: (mm/dd/yyyy)  
 Values:

Interventions:

**X-Ray other Diagnostics:**

- N
- Y

Date: (mm/dd/yyyy)

Findings/Interventions:

**Future MD F/U Appointments:**

- N
- Y

**Usual Living Situation – Prior Level of Function**

PCP:

**Responsible Party/ DPA/ HCP:**

- N
- Y

Responsible Party:

Name:

Phone:

Durable Power Attorney:

Name:

Phone:

Health Care Proxy:

Name:

Phone:

**Challenges to Discharge:**

*(Required field)*

- N
- Y

- Cultural Barriers
- HOH/Hearing Aide
- Transportation Issues
- Non-Compliance
- Language Barrier
- Vision/Glasses
- No Caregiver
- Needs Teaching
- Other

**Home:**

- House

Stairs:

- N

Y

Outdoor:

N

Y

Number:

Rail:

N

Y

From bottom:

Right

Left

Indoor:

N

Y

Number:

Rail:

N

Y

From bottom:

Right

Left

Bed/Bedroom Main Floor:

No

No but Possible

Yes

Full Bathroom Main Floor:

No

No but Possible

Yes

Apartment:

Stairs:

N

Y

Outdoor:

N

Y

Number:

Rail:

N

Y

From bottom:

Right

Left

Indoor:

N

Y

Number:

Rail:

N



- Y
- From bottom:
- Right
- Left

- Bed/Bedroom Main Floor:
- No
  - No but Possible
  - Yes

- Full Bathroom Main Floor:
- No
  - No but Possible
  - Yes

- Assisted Living
- Custodial LTC
- Other

**Lives Alone:**

- N
- Y
- Lives with:
- Spouse
- Child
- Caregiver
- Other/Comments

**Non-skilled Care-giver Hours Available:**

- N
- Y
- Number of hours: (drop down 1-24)

**Skilled Care-giver Services Prior to Admit:**

- N
- Y
- PT
- OT
- Nursing
- HH Aide
- N
- Y
- Number of hours: (drop down 1-24)
- Private Pay Assist
- N
- Y

Number of hours: (drop down 1-24)

**Assistive Device Prior to Admit:**

- N
- Y
  - Bed Bound
  - W/C Primary
  - Front Wheeled Walker
  - Quad Cane/Straight
  - Standard Walker
  - Other

**Please select if request is for: Rehab and/or Medical**

- Rehab**
- Medical**

**Patient is Independent with Sit to Stand:**

- N
- Y
  - Modified Independent
  - Supervision/Standby Assist
  - Contact Guard
  - 1 Person - Minimum Assist
  - 2 Person - Minimum Assist
  - 1 Person - Moderate Assist
  - 2 Person - Moderate Assist
  - 1 Person – Maximum Assist
  - 2 Person – Maximum Assist
  - Dependent
  - Not Tested

**Patient is Independent in Bed Mobility:**

- N
- Y
  - Modified Independent
  - Supervision/Standby Assistant
  - Contact Guard
  - 1 Person - Minimum Assist
  - Person - Minimum Assist
  - 1 Person - Moderate Assist
  - 2 Person - Moderate Assist
  - 1 Person – Maximum Assist
  - 2 Person – Maximum Assist
  - Dependent
  - Not Tested

**Patient is Independent with Bed to Chair:**

- N
- Y

- Modified Independent
- Supervision/Standby Assist
- Contact Guard
- 1 Person - Minimum Assist
- 2 Person - Minimum Assist
- 1 Person - Moderate Assist
- 2 Person - Moderate Assist
- 1 Person – Maximum Assist
- 2 Person – Maximum Assist
- Dependent
- Not Tested

***Patient is Independent with Chair to Bed:***

- N
- Y

- Modified Independent
- Supervision/Standby Assist
- Contact Guard
- 1 Person - Minimum Assist
- 2 Person - Minimum Assist
- 1 Person - Moderate Assist
- 2 Person - Moderate Assist
- 1 Person – Maximum Assist
- 2 Person – Maximum Assist
- Dependent
- Not Tested

***Patient is Independent with Ambulation:***

- N
- Y

Quality of Gait:

- Modified Independent
- Supervision/Standby Assist
- Contact Guard
- 1 Person - Minimum Assist
- 2 Person - Minimum Assist
- 1 Person - Moderate Assist
- 2 Person - Moderate Assist
- 1 Person – Maximum Assist
- 2 Person – Maximum Assist
- Dependent
- Not Tested

**Patient Uses Assistive Device to Ambulate**

- N
- Y
  - W/C Primary
  - Front Wheeled Walker
  - Quad Cane/Straight
  - Standard Walker
  - Other

**Patient Can Ambulate over 150 Feet**

- N
- Y
  - 100-149 feet
  - 75-99 feet
  - 50-74 feet
  - 25-49 feet
  - 10-24 feet
  - 0-10 feet
  - Not Tested

**Patient is Independent with Wheelchair Mobility:**

- N
- Y
  - Modified Independent
  - Supervision/Standby Assist
  - Contact Guard
  - 1 Person - Minimum Assist
  - 2 Person - Minimum Assist
  - 1 Person - Moderate Assist
  - 2 Person - Moderate Assist
  - 1 Person – Maximum Assist
  - 2 Person – Maximum Assist
  - Dependent
  - Not Tested

**Patient is Independent with Stairs Climbing:**

- N
- Y
  - Modified Independent
  - Supervision/Standby Assist
  - Contact Guard
  - 1 Person - Minimum Assist
  - 2 Person - Minimum Assist
  - 1 Person - Moderate Assist
  - 2 Person - Moderate Assist
  - 1 Person – Maximum Assist
  - 2 Person – Maximum Assist

- Dependent
- Not Tested

***Patient can climb a full flight of stairs:***

- N
- Y
  - 6-12 stairs
  - 3-5 stairs
  - 1 stairs
  - with rail
    - right
    - left
    - both
  - without rail
  - Unable
  - not tested

***Patient can stand independently with or without a device for > 10 minutes***

- N
- Y
  - 1-10 minutes
  - <1 minute
  - Unable
  - Not Tested

***Patient can bathe and dress upper body independently:***

- N
- Y
  - Modified Independent
  - Supervision/Standby Assist
  - Contact Guard
  - 1 Person - Minimum Assist
  - 2 Person - Minimum Assist
  - 1 Person - Moderate Assist
  - 2 Person - Moderate Assist
  - 1 Person – Maximum Assist
  - 2 Person – Maximum Assist
  - Dependent
  - Not Tested

***Patient can Bathe and Dress Lower Body Independently:***

- N
- Y
  - Modified Independent
  - Supervision/Standby Assist
  - Contact Guard
  - 1 Person - Minimum Assist

- 2 Person - Minimum Assist
- 1 Person - Moderate Assist
- 2 Person - Moderate Assist
- 1 Person – Maximum Assist
- 2 Person – Maximum Assist
- Dependent
- Not Tested

***Patient can Use Toilet Independently:***

- N
- Y

Toilet Transfer is Independent:

- N
- Y
  - Modified Independent
  - Supervision/Standby Assist
  - Contact Guard
  - 1 Person - Minimum Assist
  - 2 Person - Minimum Assist
  - 1 Person - Moderate Assist
  - 2 Person - Moderate Assist
  - 1 Person – Maximum Assist
  - 2 Person – Maximum Assist
  - Dependent
  - Not Tested

Toilet Hygiene as Independent:

- N
- Y
  - Modified Independent
  - Supervision/Standby Assist
  - Contact Guard
  - 1 Person - Minimum Assist
  - 2 Person - Minimum Assist
  - 1 Person - Moderate Assist
  - 2 Person - Moderate Assist
  - 1 Person - Maximum Assist
  - 2 Person - Maximum Assist
  - Dependent
  - Not Tested

***Patient can Transfer into the Tub/Shower Independently:***

- N
- Y

- Modified Independent
- Supervision/Standby Assist
- Contact Guard
- 1 Person - Minimum Assist
- 2 Person - Minimum Assist
- 1 Person - Moderate Assist
- 2 Person - Moderate Assist
- 1 Person – Maximum Assist

- 2 Person – Maximum Assist
- Dependent
- Not Tested

**Patient Use Adaptive Equipment to Bathe:**

- N
- Y

- Tub Seat/Bench
- Hand Held Shower
- Other

**Patient can Feed Self Independently:**

- N
- Y

- Modified Independent
- Supervision/Standby Assist
- Contact Guard
- 1 Person - Minimum Assist
- 2 Person - Minimum Assist
- 1 Person - Moderate Assist
- 2 Person - Moderate Assist
- 1 Person - Maximum Assist
- 2 Person - Maximum Assist
- Dependent
- Not Tested

**Patient uses adaptive equipment to eat:**

- N
- Y

- Modified Plate
- Modified Cup
- Modified Utensils
- Other

**Patient Has Difficulty Responding to Interview Questions:**

- N
- Y

- A little
- A lot
- Unable

**Patient Has Difficulty Reading a Menu or Other Simple Literature:**

- N
- Y

- A little
- A lot
- Unable

**Patient Has Difficulty Carrying on a Conversation in a Small Group:**

- N
- Y
  - A little
  - A lot
  - Unable

***Patient Has Difficulty Remembering Where Put Items:***

- N
- Y
  - A Little
  - A lot
  - Unable

***Patient Has Difficulty Remembering to Take Medication on Time or Not At All:***

- N
- Y
  - A little
  - A lot
  - Unable

***Patient Has Difficulty Retelling a Recent Story or Event to Others:***

- N
- Y
  - A little
  - A lot
  - Unable

***Patient Has Difficulty Planning an Activity Several Days in Advance:***

- N
- Y
  - A Little
  - A lot
  - Unable

***Patient Has Difficulty filling Out a Short Form (bank slip) accurately:***

- N
- Y
  - A little
  - A lot
  - Unable

***Patient Has Difficulty Keeping Documents Organized:***

- N
- Y
  - A Little
  - A lot
  - Unable



**Current Medical Needs**

**Medical**

**Incontinence:**

N

Y

Bladder:

N

Y

New Condition:

N

Y

Management Plan

Catheter removal Date

Retraining

Toileting Plan

Teaching Required

Patient

Spouse

Family Member

Other

Other

Bowel:

N

Y

New Condition:

N

Y

Management Plan

Rectal Tube

Retraining

Toileting Plan

Teaching required:

Patient

Spouse

Family member

**Ventilator:**

N

Y

New Condition:

N

Y

Suctioning Required:

N

Y

Frequency:

Plan to Wean:

- N
- Y

Plan:

**Restricted Weight Bearing:**

- N
- Y

Lower Extremity:

- N
- Y
  - Right
  - Left
  - NWB
  - TDWB
  - PWB

Upper Extremity:

- N
- Y
  - Right
  - Left
  - NWB
  - TDWB
  - PWB

**Intra venous:**

- N
- Y

IV Fluids:

start date: (mm/dd/yyyy) (Calendar insert)  
stop date: (mm/dd/yyyy) (Calendar insert)in

IV Abx

start date: (mm/dd/yyyy) (Calendar insert)  
stop date: (mm/dd/yyyy) (calendar insert)

Other:

start date: (mm/dd/yyyy) (calendar insert)  
stop date: (mm/dd/yyyy) (calendar insert)

Teaching required

- N
- Y
  - Patient
  - Spouse
  - Family member

Other

**Dialysis:**

N

Y

New Condition:

N

Y

Hemo

Schedule:

Setting:

Transportation Required:

N

Y

Peritoneal:

Teaching required

N

Y

Patient

Spouse

Family member

Other

**Feeding Tube:**

N

Y

New Condition:

N

Y

Continuous

Bolus

Type:

NG - Tube

G - Tube

J - Tube

Other

Residual:

N

Y

Frequency: (drop down)

1 x day

2 x day

3+ x day

Amount:

Wean:

N

Y

Plan:

Teaching required:

- N
- Y

- Patient
- Spouse
- Family member
- Other

**Severe Obesity:**

- N
- Y

Height:

Weight:

BMI:

**Dysphagia:**

- N
- Y

New Condition:

- N
- Y

Alternative Diet required:

- N
- Y

Texture:

- N
- Y

- Regular
- Ground
- Puree
- NPO

Liquids:

- N
- Y

- Thin
- Nectar Thick
- Honey Thick
- Pudding Thick

Teaching required

- N
- Y

- Patient
- Spouse
- Family member

Other

**Oxygen:**

N

Y

Newly Required:

N

Y

L/minute (drop down)

1

2

3+

Weaning Potential:

N

Y

Plan:

Teaching required

N

Y

Patient

Spouse

Family member

Other

**Infection Control /Precautions:**

N

Y

Isolation

Negative Pressure

Respiratory

Contact

Teaching required

N

Y

Patient

Spouse

Family member

Other

**Wound Care:**

N

Y

Pressure:

Location:

Measurements:

Condition:

- Drainage
- Necrosis
- Slough
- Odor

Treatment:   
Frequency of treatment:

- Stage:
- II
  - III
  - IV
  - Resolving

Surgical

Location:   
Measurements:   
Treatment:   
Frequency of treatment:   
Condition:

Vascular:

Location:   
Measurements:   
Treatment:   
Frequency of treatment:   
Condition:

Other

Location:   
Measurements:   
Treatment:   
Frequency of treatment:   
Condition:

Teaching Required

- N
  - Y
- Patient
  - Spouse
  - Family member
  - Other

***Pain Management:***

- N
- Y

Location:   
Intensity:

- 0
- 1
- 2

- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Intervention:   
Medication:   
Dose:   
Frequency:

- Teaching required
- N
  - Y
- Patient
  - Spouse
  - Family member
  - Other

**Medication Management Teaching/Training:**

*(Identify ONLY NEW or COMPLEX medication management needs. A comprehensive list of member's medication regime may be included, if necessary, in "Other Pertinent Medical Information")*

- N
- Y

Medication Name:   
Mode:   
Dosage:   
Frequency:   
Duration:

- Trainee:
- Patient
  - Spouse
  - Family member
  - Other

Methodology:

**Other Pertinent Rehab Information:**

**Other Pertinent Medical Information:**

**Helpful Hint:** Use this box to document members who are being referred for post-acute care for a condition NOT identified as New, to list specific meds including IV antibiotics and specific treatments not otherwise listed such as wound vac treatment OR if there was insufficient room in any identified area, or if there is any other information to share about the case.

**Other Pertinent Social Information:**

**Helpful Hint:** Use this box to document the initial discharge plan as well as any changes to the discharge plan. Also, any psycho-social issues including but not limited to: depression, mental health disorder, environmental, or familial challenges to the discharge, up to 4,000 characters.

**Discharge Only:**

*(Required only when a member discharges from PAC setting)*

PT:

Start Date: (mm/dd/yyyy) (calendar insert)  
End Date: (mm/dd/yyyy) (calendar insert)  
Total Visits:  
Total Minutes:

OT:

Start Date: (mm/dd/yyyy) (calendar insert)  
End Date: (mm/dd/yyyy) (calendar insert)  
Total Visits:  
Total Minutes:

ST:

Start Date: (mm/dd/yyyy) (calendar insert)  
End Date: (mm/dd/yyyy) (calendar insert)  
Total Visits:  
Total Minutes:



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