Ambition: Post-Acute Care Management for Blue Medicare Members
Frequently Asked Questions for Providers
Effective February 2, 2015
(FINAL: 12/18/14)

Key Messages

• As of February 2, 2015, naviHealth will manage pre-service authorizations for post-acute care services in a skilled nursing facility, as well as discharge planning and care management for our Blue MedicareSM (Medicare Advantage) members in skilled nursing facilities.

• With a combination of concierge-like services, proven processes, and data-driven technology, naviHealth uses a targeted patient and provider engagement model to predict and evaluate the most appropriate post-acute care option based on the patient’s unique needs.

• naviHealth works with facilities, providers, patients and families to ensure that the right amount of care is delivered at the right time and in the most appropriate post-acute care (PAC) setting for Medicare members. Evidence-based protocols optimize care, resulting in reduced hospital readmissions, increased patient satisfaction, and improved patient outcomes.

• naviHealth’s decade of experience managing post-acute care (serves more than 1.8 million Medicare Advantage members in 16 states) will help Blue Cross and Blue Shield of North Carolina (BCBSNC) improve on measurable functional outcomes our Blue Medicare members in a skilled nursing facility (SNF) setting.

About naviHealth and Their Role

Who is naviHealth?
naviHealth is a post-acute care manager working with health care organizations, to lower post-acute care costs by empowering the patient, improving care coordination, and using a proven data and technology-driven approach to better assist patients and their families through the entire continuum of post-acute care.

What does naviHealth do?
naviHealth uses a team-based approach that operates as connective support between the patient, providers and the patient’s health plan. Work begins in the hospital prior to discharge, where naviHealth personnel will educate patients and family about available post-acute care options, as well as help patients set and achieve reasonable goals.
Why is BCBSNC contracting with naviHealth to provide management of post-acute care for Blue Medicare members?
Post-acute care spending currently represents 23 percent of all Medicare expenditures and, on average, more than 40,000 Medicare beneficiaries are discharged from hospitals across the country every day. Many leave the hospital without a plan or guide for what’s next, which can lead to large variations in post-acute care utilization, spending and outcomes. BCBSNC believes there is a significant opportunity to improve the member experience and outcomes while improving network efficiency and reducing costs – and this new service will help to do that.

What does BCBSNC hope to achieve with this program?
Through this new relationship with naviHealth, BCBSNC hopes to achieve improved member experiences and increased member satisfaction through a patient-focused approach to post-acute care, a more coordinated and data-driven approach to managing patient care, and a reduction in the number of avoidable hospital readmissions. All of this will help us in our mission to make health care more affordable.

Won’t this arrangement just encourage naviHealth to push to reduce patient stays, regardless of patient needs?
No. naviHealth has a documented track record of both reducing costs and improving patient health outcomes, including reduced readmission rates.

How does naviHealth work with providers and patients to arrange appropriate post-acute care?
Local naviHealth clinical personnel will work directly with the patient, family, skilled nursing facilities and hospital discharge planners to help our Blue Medicare members navigate the next level of care, whether it is to their home or to another post-acute setting like a skilled nursing facility.

How do acute-care hospitals and skilled nursing facilities contact naviHealth?
Here are naviHealth’s phone and fax numbers:
- naviHealth Call Center Toll-Free Number: 1-844-801-3686
- naviHealth Fax Number/Prior Auth Requests: 1-855-847-7242 (Hospitals)
- naviHealth Fax Number/Concurrent Review: 1-844-206-7051 (SNFs)
- naviHealth Fax Number/Administrative: 1-844-331-4502

Submitting information for one patient per fax will allow for a more streamlined review process.

What are naviHealth’s hours of operation?
You can contact naviHealth from 8 a.m. to 5 p.m. EST Monday through Friday, except for national holidays. For after hours/weekend/holiday requests, providers should continue to make independent care decisions, based on the best interest of the member and contact naviHealth within one business day for review and authorization determination.

**What technology does naviHealth use to make patient assessments?**

naviHealth’s recommendations and assessments are based upon similar patients in their proprietary LiveSafe decision-support technology and database, which incorporates more than 750,000 patient outcomes. This technology allows naviHealth to personalize the patient’s care plan to include the optimal PAC setting, expected length of stay in post-acute care (PAC) setting, anticipated therapy intensity, and projected functional improvement for the patient.

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**Authorization Process From Hospital to Skilled Nursing Facility and Continued SNF Care**

**How is naviHealth notified of a hospital admission?**

naviHealth will receive an electronic census and diagnostic information from BCBSNC on a daily basis for Blue Medicare members.

**What is naviHealth’s role during discharge planning?**

If a patient needs to be admitted to a SNF, the naviHealth clinical coordinator will conduct a function-based patient assessment to help guide the patient’s post-acute recovery process. The naviHealth team member serves as a valuable adjunct to the SNF team, as a liaison to BCBSNC, and helps support the member and the family during the PAC recovery process.

**When should providers contact naviHealth for a skilled nursing facility authorization?**

Authorizations must be generated BEFORE a patient is admitted to a skilled nursing facility. If a transfer happens after normal business hours, the SNF must notify naviHealth within 24 hours or the next business day.

**Will naviHealth be on-site at hospitals or skilled nursing facilities?**

Yes, naviHealth may be on-site at some participating hospitals, depending on the Blue Medicare member volume at the facility and service intensity. The purpose of naviHealth being on-site is to interact with case managers/discharge planners to better facilitate the care provided to our members. For SNF providers with a high volume of Blue Medicare members, it is likely a naviHealth care coordinator will be on site on a regular basis. Facilities will also be supported telephonically if volume and/or geographical location prohibit efficient on-site presence.

**Can facilities request an on-site naviHealth care coordinator?**

naviHealth will strategically place on-site care coordinators where volume and opportunity allow. Providers will initially see the majority of on-site care coordination in the SNF.
Will the naviHealth care coordinator be available to have conversations with patients and/or their families?
Yes, naviHealth care coordinators will discuss current course of care and/or the expectations with the patient and/or family regarding the next level of care, where and when appropriate.

Who is responsible for obtaining prior authorization for admission to a skilled nursing facility?
The skilled nursing facility is responsible for obtaining prior authorization, although the prior authorization should be a collaboration between the hospital, skilled nursing facility, and naviHealth. The earlier in the process that the naviHealth care coordinator can start the assessment, the better service they can offer to the member, family and provider.

Which services will naviHealth authorize?
naviHealth authorizes care delivered at a skilled nursing facility, including the initial admission and continued stay requests. They also issue the notification for the last covered day for the skilled nursing facility to deliver care. naviHealth only manages these Medicare Part A benefits for Blue Medicare members.

Which services will naviHealth not authorize?
BCBSNC will retain responsibility to authorize all other post-acute care services for its Blue Medicare members, including ambulance services, acute inpatient rehabilitation, and long-term acute-care admissions, durable medical equipment, home health agency services, and other at-home services. Requests related to Medicare Part B services should be directed to BCBSNC.

What is the expected turnaround time naviHealth anticipates on authorization requests?
Authorizations that are requested with complete and accurate clinical / administrative information should be completed within 24-48 hours from receipt and validation. naviHealth is committed to a rapid and accurate process, and providers are encouraged to work with naviHealth to submit clinical information regarding a SNF admission as early in the process as possible.

If an urgent decision is needed regarding a SNF admission, what is the process for urgent review?
The clinical information should be submitted to naviHealth and marked as “urgent.” These cases will be reviewed for clinical urgency, and if they meet the CMS definition of “Expeditied,” they will be reviewed first.

What happens if a request for a SNF admission is sent to BCBSNC instead of naviHealth?
Providers should submit all SNF requests to naviHealth. In the event a request is submitted to BCBSNC in error, the request will be forwarded to naviHealth for review and processing. The provider does not need to resubmit the request to naviHealth.

How is the final decision determined if there is a variance between naviHealth and the skilled nursing facility regarding a member’s plan of care?
Medical decisions are based on collaboration between naviHealth and the skilled nursing facility on a case-by-case basis. naviHealth will send any cases where agreement cannot be reached to a naviHealth medical director for final determination.

When a Blue Medicare member in a skilled nursing facility has a change of condition or there is a need for a readmission, who should be contacted?
All changes of conditions should be reported to the member’s medical provider by the skilled nursing facility. Members who readmit into a SNF should follow the existing process for acute-care admissions. If this change in medical condition warrants a change in member status, naviHealth should be contacted.

How many days are usually authorized on an initial SNF admission?
Initial authorizations are typically three days. This allows the SNF to appropriately assess the member for therapy/medical needs and interventions following the patient transition. Following the initial authorization, additional authorizations will be based on the naviHealth LiveSafe assessment, unique needs of the member, and will be driven by updated clinical information. The length of authorization will take into consideration the need to have the Notice of Medicare Noncoverage (NOMNC) issued timely.

Who is responsible for issuing the NOMNC to the member?
The facility will continue to issue the NOMNC to the member upon determination of last covered skilled day. New to the process is the requirement that the SNF must fax a copy of the completed NOMNC to naviHealth at 1-844-331-4502.

What about patients already in a SNF as of February 2, 2015? Will naviHealth manage post-acute care for these patients as of February 2, 2015?
No. For those patients already in a SNF prior to February 2, 2015, authorization requests (e.g. concurrent reviews, requests for additional days, etc.) will continue to be managed by BCBSNC. This includes managing the QIO appeals for members who were admitted prior to February 2, 2015. naviHealth will begin authorizing services for any patient with a new SNF admission on or after February 2, 2015.
What if an authorization was already submitted to BCBSNC for an admission to a SNF to begin on or after February 2, 2015? Will a new authorization need to be submitted from naviHealth?

No, naviHealth will honor authorizations that were approved by BCBSNC prior to the member’s admission to a SNF on February 2, 2015. You do not need to submit another authorization request. For those patients placed in a SNF on after February 2, 2015, authorization requests (e.g. concurrent reviews, requests for additional days, etc.) will be managed by naviHealth.

Once the patient is discharged from the SNF, what information needs to be sent to naviHealth?

In addition to receiving a copy of the Notice of Medicare Noncoverage (NOMNC), naviHealth requires billing logs and the therapy discharge assessment conducted at the end of the patient stay. This information helps naviHealth create a complete patient record and allows them to include this information on the SNF dashboard that is presented to the SNF community. Please fax this information to the attention of naviHealth at 1-844-331-4502.

Authorization Process From Nonhospital Setting to Skilled Nursing Facility

What are naviHealth’s requirements regarding admissions from the emergency room, home, etc?

If a member is in the emergency department during business hours, the standard prior authorization process as outlined in the previous section needs to be followed. If it is after hours and all parties agree that transition is appropriate, the facility should do what is in the best interest of the member. The skilled nursing facility is required to update naviHealth of the transfer by the next business day.

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

Do admissions to a skilled nursing facility from the patient’s home or a doctor’s office require prior authorization?

Yes. Prior authorization must be obtained from naviHealth.

Is prior authorization required if a member transitions from being a long-term care patient to requiring a skilled level of care?

Yes. Prior authorization must be obtained from naviHealth.

Authorization Process for Therapy Services/Home Health/Medical IV Therapy
Is therapy evaluation required by naviHealth for every hospital admission?
For those Blue Medicare members you believe will require placement in a skilled nursing facility, naviHealth strongly encourages a therapy evaluation as soon as possible while the patient is in the acute care setting.

Do skilled nursing facilities need to call naviHealth for prior authorization for outpatient/Medicare Part B therapies?
No, prior authorization for outpatient therapies will continue to be handled by BCBSNC.

Does naviHealth provide prior authorization for home health visits?
No, prior authorization for home health visits will continue to be handled by BCBSNC.

What are the criteria for an authorization if a patient has medical needs only (e.g. IV therapy)?
Clinical information should support the need for skilled care at the requested level of care. Frequency/duration/dosage of IV medications, tube feedings, wound care measurements, etc. should be included along with appropriate labs, physician notes, etc.

Who handles discharge planning needs (for example, durable medical equipment) for the patient when they’re ready to go home from the skilled nursing facility?
BCBSNC will continue to handle any post-discharge needs from a SNF for the patient. The provider will continue to order and arrange delivery for all medically necessary DME.

If naviHealth recommends that a patient be released from a SNF earlier than a provider or the facility recommends, what does naviHealth do to ensure the patient and family are equipped to properly care for the patient?
naviHealth care coordinators will work with the facilities to identify barriers to discharge and post-discharge needs. If the member is going to be discharged from the SNF and needs to continue to require a service that naviHealth is not delegated to manage (i.e., DME, home health, etc.), the SNF should work to ensure those services are set up in advance, just as they do today.

Does naviHealth ever recommend that a patient be released from the hospital directly to home care instead of a SNF?
Yes, if this is what is clinically appropriate for the member based on the member’s needs. If the outcomes prediction solution tool predicts the same or better functional and medical recovery for the patient in the home setting as compared to a SNF, the naviHealth care coordinator will present this option to the patient and family for their consideration, so an informed decision can be made.
What is the process for denials and appeals?
A denial of post-acute care services will be issued by naviHealth, similar to the approval of services. naviHealth generates the notification of denial for coverage to both the provider and patient. naviHealth offers a peer-to-peer clinical conversation with the naviHealth medical director, if requested. To initiate a peer-to-peer discussion regarding a denial, the provider should call the naviHealth Customer Service number (1-844-801-3686) during regular hours of operation.

Any pre-service appeal of the denial of services rendered by naviHealth will be handled by BCBSNC, just as appeals are currently handled today. BCBSNC will continue to handle all provider appeals when the patient is not yet admitted to a SNF or when the member is still inpatient, just as they do today.

Will concurrent review still be required with naviHealth?
Yes. Navihealth will inform organizations when concurrent review is required based on the initial number of days certified by naviHealth. The SNF must provide the information to naviHealth within 24 hours of the review date.

Will the process for Quality Improvement Organization (QIO) requests change for a fast-track appeal?
The member will continue to call Kepro (the QIO) to start the fast-track appeals process. Kepro will notify naviHealth of the request so they can process the QIO. The delegation of the SNF level-of-care reviews does not change the CMS requirements for the fast-track appeals process.

What happens when QIO appeals are overturned? Does naviHealth or BCBSNC call the facility about the outcome?
If a member appeal is overturned by the QIO, the QIO will return the decision to naviHealth and to the provider. naviHealth will then notify the provider of the next review date or the last covered day.

Reimbursement Methodology and RUG Process

If a skilled nursing facility does not provide clinical information in a timely manner, will it impact the payments (e.g. will days be denied for services rendered)?
Yes. Skilled nursing facilities are required to cooperate with concurrent (continued stay) review activities, which include providing naviHealth (on behalf of BCBSNC) with timely clinical information within 24 hours of the last certified (authorized) day.

Failure to provide this information means naviHealth will not be able to perform timely initial or concurrent review of the admission. BCBSNC will not reimburse the SNF for covered services incurred prior to the performance of the initial or concurrent review of the admission. The
facility shall not bill, charge, or collect a deposit from, seek remuneration or compensation from the BCBSNC member, or any person acting on the member’s behalf, for covered services incurred prior to the initial or concurrent review.

Is anything changing with the Resource Utilization Group (RUG) process?
The RUG level is assigned by naviHealth as part of the authorization process and is 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 Blue Medicare members.

How does naviHealth assign the RUG level on SNF authorizations?
Upon authorization for a skilled nursing facility stay at a facility where reimbursement is based on RUG rates, naviHealth will authorize a preliminary RUG level based on clinical information provided in the acute setting. The RUG level may be adjusted once the member is evaluated by the SNF’s rehabilitation services. If the member has nursing-only needs, naviHealth will notify the SNF, which will be responsible for determining the appropriate nursing RUG.

How does naviHealth’s LiveSafe tool determine the 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, as well as hinder the member’s overall functional improvement. Conversely, overutilization of therapy services has been shown to produce unnecessary fatigue in the elderly population and a more rapid gain in functional mobility has not been demonstrated.

The determination of the intensity of approved therapy is based on the naviHealth LiveSafe tool, which houses more than 750,000 actual member records. Serving as an evidence-based proactive tool, LiveSafe 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.

What will happen to the RUG level if there is a significant clinical change in the middle of the patient’s stay in the SNF?
If there is a significant clinical change in the patient’s status, the SNF should contact the naviHealth care coordinator with additional information that will allow the RUG level to be re-evaluated. If the change in condition is significant enough to alter the RUG level, the new RUG level will be effective as of the date of the change.

What is the process if naviHealth authorizes one RUG level or level of care, but the provider disagrees with the authorization and would like to request an alternate RUG?
naviHealth’s goal is to make the best determination based on individual need and informed by a strong evidence base. If a SNF feels that a different RUG level or level of care is appropriate for a member, the facility should contact naviHealth via their onsite care coordinator or toll-free number. The supporting clinical information should be supplied to document the request, which will be further reviewed by the naviHealth team. Clinical scenarios that do not appear to need an adjusted RUG level or level of care will be reviewed by a naviHealth medical director. naviHealth will communicate the review decision to the facility.

**How will the approved RUG level be communicated to the SNFs?**
SNFs will receive the approved RUG level when the initial authorization is provided to the SNF.

**Will naviHealth also be assigning the assessment indicators?**
naviHealth will be providing the RUG level, which should be reported as the first three digits of the Health Insurance Prospective Payment System ((HIPPS) code. The provider should report “60” as the assessment indicator for members receiving therapy. For members receiving nursing/medical care only, SNFs will continue to follow the same process they use today to report HIPPS codes on the claim.

**Benefits for Blue Medicare Providers**

**How will acute and post-acute facilities be impacted?**
Central to naviHealth’s approach is an on-site care coordinator to provide guidance to members and their caregivers while collaborating with the facility’s care team. When possible and where appropriate, the naviHealth care coordinators may be on-site at acute hospitals and skilled nursing facilities.

**How does naviHealth and BCBSNC envision the hospital and skilled nursing facility working together?**
In order to ensure seamless member transitions from the hospital into a skilled nursing facility, we encourage collaborative discharge planning between the two entities. This includes exchanging appropriate medical records, having clear physician orders, and ensuring the prior authorization is in place with naviHealth before the member transitions into a skilled nursing facility following hospitalization.

**How frequently will naviHealth share performance metrics information with SNFs?**
naviHealth is able to provide performance information related to the SNF’s overall efficiency, length of stay and therapy intensity, as well as efficacy, functional improvement, and discharge to community and readmission rates. The frequency will depend on the volume of admissions for the facility. Typically, once naviHealth has at least 20-25 completed records in their system,
these results and information can be shared with the provider of care via their BCBSNC Network Management representative.

**Will BCBSNC share the results with hospitals?**
Yes, BCBSNC will share the information with hospitals, as it can help augment their reviews of post-acute care providers like SNFs that they use in their specific area or region.

**Will this SNF process change have any impact on the Blue Medicare provider network?**
While the provider may see changes to their daily operations relative to the naviHealth model, the Blue Medicare provider network will not change. naviHealth will have personnel in the NC market who will work directly with hospitals and SNFs to ensure a smooth transition of post-acute care management for this patient population to naviHealth.

**Have physicians been educated about naviHealth and its role?**
Yes. BCBSNC published a provider news article about naviHealth and its role with managing post-acute care for our Blue Medicare members on its provider Web portal in mid-November and began targeted outreach to administrators and case management leaders with large NC hospital systems in December. Skilled nursing facility administrators, case managers, rehab directors, etc. will be invited to attend regional town halls introducing naviHealth in early 2015. BCBSNC strongly recommends provider attendance at these meetings.

### Benefits for Blue Medicare Members

**What is the benefit to Blue Medicare members? Will they notice any difference?**
We expect the transition to be seamless for our members, but to produce significant benefit to them. Given the stress of major illness or injury, it’s important that our members receive medical services at the appropriate level of care and return home as soon as possible. Most members and their families find the naviHealth care coordinators to be valuable guides during this challenging time in their lives.

**How much will this process change potentially save Blue Medicare members?**
This program is designed to optimize our members’ recovery journey through post-acute care. As a result, Blue Medicare members could reduce their direct out-of-pocket costs as a result of optimizing care decisions. Any member cost reduction achieved will be a result of lessening the incidence of inappropriate admissions, driving length of stay to the appropriate level, and reducing readmissions.

**Does BCBSNC’s relationship with naviHealth change the member’s benefit plan or premiums?**
No. There is no change to Blue Medicare member benefit plans, and there is no additional...
charge to the member. They will continue to be eligible for 100 days of skilled level of care based on medical necessity and eligible benefit periods.

What can a member expect his or her experience to be?
A “high-tech, high-touch” member experience. The “high-tech” refers to the decision-support tools and technology that the naviHealth care coordinators use to guide members through their recovery process. And the “high-touch” aspect refers to the personalized attention our members will receive from the naviHealth care coordinators to help them and their care-givers understand and efficiently manage their condition.

What protections are in place for members whose personal information is shared with naviHealth staff? Does HIPAA come into play?
Our member’s confidentiality is always at the forefront of what we do and how we do it. naviHealth is a delegated entity that complies with all CMS rules and regulations related to PHI.