naviHealth

Clinical Documentation Submission Requirements – Preservice

Preservice Authorization Requests/Reviews

The following information is required for **all naviHealth-managed patients**.

Requests for preservice authorization for all levels of care must include the necessary clinical documentation for naviHealth to make a determination. Failure to submit the required documentation may delay the processing of your request or result in a denial.

NOTE: *The requirement defined in the following paragraph is specific to Medicare Advantage.* Authorizations are typically valid for 48 hours. If the patient does not admit to post-acute care within 48 hours, you may need to provide updated information to demonstrate patient stability for transfer and/or continued medical necessity for the requested level of care; in some cases, a new authorization may be required.

Items in **bold** are the **preferred documentation**. If unavailable (e.g., no occupational therapy eval was performed), you must ensure that the necessary clinical information described is included in other documentation, such as nursing notes.

The list below represents the minimum requirements for all requests. In certain cases, we may require additional information, such as a Medication Administration Record (MAR) or results of labs, MRIs, CT scans, X-rays, etc.

SNF Preservice Authorization Requests/Reviews

The following clinical information is required for preservice authorization requests for inpatient PAC settings:

- **Hospital demographic sheet** including name/phone of POA if applicable
- **Patient's name, current location, admit date, and requested setting**
- **MD order sheet**/full name of ordering physician and NPI number
- **History and physical**
- **Nursing admission assessment**/nursing notes and CNA documentation
  - Include respiratory treatment, height, and weight
  - Ensure detailed descriptions of patient's active medical/clinical conditions requiring a skilled level of care are included, or provide additional documentation with these details
- **Physical, occupational, and speech therapy evaluations** or other clinical documentation which indicates:
  - Patient's usual living setting and available caregiver support
  - Patient's prior level of function, including assistance and DME needed and home support
- **Most recent therapy notes*** or other clinical documentation (**within the last 48 hours**) which indicates patient's current level of function and specifies level of assistance required for:
  - Bed mobility, transfers, and ambulation
  - Feeding, grooming, bathing, dressing, and toileting
  - Cognitive status, including vision/hearing impairments, behavioral health concerns, communication ability, memory and problem-solving ability
- **Most recent physician notes** or other clinical documentation (**within the last 24 hours**) which indicates:
  - Patient's current medical status
  - Stability for discharge
  - Medication orders to be continued post-discharge
- **Post-procedure or surgical notes** if procedure/surgery occurred during this admission
- **PHQ-9** (if applicable)

**For SNF – If request is for Skilled Nursing only and does not include Skilled Therapy, notes regarding current level of function are not required.*

IRF Preservice Authorization Requests/Reviews

The following clinical information is required for preservice authorization requests for inpatient PAC settings:

- **Hospital demographic sheet** including name/phone of POA if applicable
- **Patient's name, current location, admit date, and requested setting**
- **MD order sheet**/full name of ordering physician and NPI number
- **History and physical**
- **Nursing admission assessment**/nursing notes and CNA documentation
  - Include height and weight
  - Ensure detailed descriptions of patient's active medical/clinical conditions requiring a skilled level of care are included, or provide additional documentation with these details
- **Physical, occupational, and speech therapy evaluations** or other clinical documentation which indicates:
  - Patient's usual living setting and available caregiver support
  - Patient's prior level of function, including assistance and DME needed and home support
- **Most recent therapy notes** or other clinical documentation (**within the last 48 hours**) which indicates patient's current level of function and specifies level of assistance required for:
  - Bed mobility, transfers, and ambulation
  - Feeding, grooming, bathing, dressing, and toileting
  - Cognitive status, including vision/hearing impairments, behavioral health concerns, communication ability, memory and problem-solving ability
- **Most recent physician notes** or other clinical documentation (**within the last 24 hours**) which indicates:
  - Patient's current medical status
  - Stability for discharge
  - Medication orders to be continued post-discharge
- **Post-procedure or surgical notes** if procedure/surgery occurred during this admission
- **Physical medicine & rehabilitation (PM&R) consult**
  - Preadmission screening form

LTCH Preservice Authorization Requests/Reviews

The following clinical information is required for preservice authorization requests for inpatient PAC settings:

- **Hospital demographic sheet** including name/phone of POA if applicable
- **Patient's name, current location, admit date, and requested setting**
- **MD order sheet**/full name of ordering physician and NPI number
- **History and physical**
- **Nursing admission assessment**/nursing notes and CNA documentation
  - Include height and weight
  - Ensure detailed descriptions of patient's active medical/clinical conditions requiring a skilled level of care are included, or provide additional documentation with these details
- **Physical, occupational, and speech therapy evaluations** (if applicable) or other clinical documentation which indicates:
  - Patient's usual living setting and available caregiver support
  - Patient's prior level of function, including assistance and DME needed and home support
- **Most recent therapy notes** (if applicable) or other clinical documentation (**within the last 48 hours**) which indicates patient's current level of function and specifies level of assistance required for:
  - Bed mobility, transfers, and ambulation
  - Feeding, grooming, bathing, dressing, and toileting
  - Cognitive status, including vision/hearing impairments, behavioral health concerns, communication ability, memory and problem-solving ability
- **Most recent physician notes** or other clinical documentation (**within the last 24 hours**) which indicates:
  - Patient's current medical status
  - Stability for discharge
  - Medication orders to be continued post-discharge
- **Post-procedure or surgical notes** if procedure/surgery occurred during this admission
- **Vent settings and/or vent weaning** (if applicable)
- **Description and orders for wound care** (if applicable)
- **Description and orders for tube feeding** (if applicable)
- **Imaging and labs** (within the last 48 hours)
- **Vital signs** (within the last 48 hours)
- **Current medication record**