Frequently Asked Questions for Hospitals

Patient-Driven Payment Model (PDPM)

Q1. I am a hospital discharge planner who is responsible for securing the prior authorization. What will be different in terms of what information I need to submit?

The CMS change to PDPM will likely result in SNFs requesting additional documentation from the Acute Hospitals, for traditional Medicare and Health Plan patients. Patients with properly documented medical needs and conditions may have higher per diem rates than those patients without. SNFs will be more vigilant in capturing diagnoses, services, and conditions; the hospital medical record(s) will be a key source of verified documentation. So, all hospitals can expect that the demand for additional documentation in the discharge packet will increase.

naviHealth believes we capture about 80-85% of what is necessary to authorize levels of care within the PDPM model. The remaining 10-15% may not be available until the patient transitions to and is assessed in the SNF. The type of documentation naviHealth would find valuable, if the acute care facility is in possession, would include:

- C.N.A or Nursing Tech flow sheets (capturing level of assist for ADLs)
- Depression Screen
- Detailed respiratory notes for patients receiving respiratory care

Assigning a preliminary PDPM authorization is **not** dependent upon receiving this information from the hospital but does add value if available

Q2. What will I receive from naviHealth as part of the authorization/approval?

naviHealth continues to provide the 'requestor':

- The Authorization number
- The number of days authorized (usually 3-5)
- The authorized level of care.

Instead of receiving one RUG code, the requestor will receive an authorization level for four (4) specific categories of care – PT/OT, ST, Nursing, NTA – referred to as Case Mix Groups (CMG).

- The CMS levels authorized in the hospital are considered **preliminary**
- Once the patient is admitted to the SNF, the naviHealth Care Coordinator reviews the documentation submitted by the provider to determine the final CMG levels
- The SNFs have been educated to request a change in PDPM level **after** admission to the SNF, so as to not delay the transfer of a medically-stable patient to the facility.

Q3. Are there any changes to the process if a patient re-admits back to the hospital from the SNF?

naviHealth believes that care and recovery should be consistent and that patients should return to their original SNF – so long as they are comfortable in doing so – after a rehospitalization. The original SNF has likely already completed their clinical assessments and gotten to know the patient and the family. A change to another facility could be considered disruptive and negatively impact the patient experience.

Due to CMS payment restructuring, the provider may be inclined to delay the transfer of a stable patient back to their original SNF, especially if there are facilities affiliated with the original SNF close by. naviHealth will be monitoring a SNF's timely processing of readmission referrals and their willingness to readmit patients back to their facility in a timely manner.

Q4. Is anything changing about the denial process if naviHealth denies a request?

No, the denial process remains the same. A denial determination for any case can only be determined by a naviHealth Medical Director. They will work with the naviHealth Care Coordinator to offer and execute peer-to-peers as appropriate.

Q5. Are there any changes to the provider/patient appeal process for a pre-service denial?

No, the appeal process remains the same. If a denial determination is made, naviHealth generates an Interdisciplinary Denial Notice (IDN). This letter contains the patients appeal rights and whom they should contact if they wish to initiate an appeal.

Q6. Will the authorization process take longer under PDPM and will I need to submit my authorization request sooner?

If the initial request contains all the necessary documentation for review, naviHealth does not anticipate significant delays in the authorization process. Typically, it is the "back and forth" to complete the data/document collection that delays the authorization process. Please keep in mind that clinical information about the patient cannot be more than 48 hours old, so submitting a request long before the patient is ready to transfer will likely result in requests for updates and potentially prolong the process.

How can I learn more about PDPM and the naviHealth clinical model?

Please visit the naviHealth PDPM resource page and review the materials that we have posted for you:

- Recordings and slide decks from webinars that we've hosted
- Documentation and whitepapers on PDPM
- Links to industry news and updates
- Updates to this FAQ document

We'll continue to update the page and add new resources as they become available, so please check back often.