

# Frequently Asked Questions for SNFs

## Patient-Driven Payment Model

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## General Authorization Questions

### Q1. Does naviHealth authorize CMG levels much like they authorized RUG levels?

Yes. naviHealth authorizes the CMG levels for PT/OT, Speech, Nursing and Non-Therapy Ancillary (NTA) similarly to how we authorized the RUG level, based on the clinical assessments and documentation submitted by you, the provider.

It is important to point out that our proprietary decision support tool, **nH Predict**, is not designed to inform on the CMG levels authorized, but rather, to serve as a clinical guide for treatment while the patient is in your care. **nH Predict** is, and always has been, payment agnostic.

### Q2. Does naviHealth use the provider's MDS assessment to inform the CMG levels authorized?

No. naviHealth uses the supportive clinical documentation submitted by the SNF, along with a proprietary system, to evaluate the clinical needs of the patient to authorize the appropriate CMG levels. naviHealth applies prospective and concurrent utilization management functionality to look beyond the 'presence' of a particular diagnosis or clinical condition and seek to understand the clinical treatment and/or resource expenditure to ensure the provider is paid appropriately for the care and service delivered.

### Q3. The CMG levels authorized by naviHealth don't always match the CMG levels calculated on my MDS. Should I expect naviHealth to change their authorization to match my MDS?

No. Medicare Advantage Organizations (MAOs) are contracted with CMS to provide utilization management on behalf of eligible Medicare Part A

beneficiaries who have elected to participate in the MAO plan. naviHealth has been delegated by the Health Plan to deliver this service.

As part of this service, naviHealth coordinates the care of the patient prospectively and concurrently to the SNF stay. In this way, the daily rate associated with the care and service of the member is determined in near real-time. This eliminates the need for retrospective reviews and audits post-payment, which reduces the provider's exposure for 'pay backs' to the Health Plan. (See more information regarding MDS at the end of this document).

#### Q4. Does naviHealth authorize the CMG levels AND assign the HIPPS code?

Yes. CMG levels are the clinical language spoken between the naviHealth Care Coordinator and the clinicians providing service in the facility. naviHealth assigns the 2-4-character CMG level for PT/OT, Speech, Nursing and NTA. These CMG levels are finalized by day 8-10 of the patient's stay.

HIPPS code is the fiscal language spoken between the provider's billing office and the payer. A written summary of the CMG levels authorized, converted to a HIPPS code is shared. This summary is usually sent at the time the naviHealth Notice of Medicare Non-Coverage (NOMNC) is provided to the skilled facility.

#### Q5. I am worried that the claim I submit to the Health Plan will not match the level of care authorized by naviHealth. Can naviHealth assist?

Yes. Many of the Health Plans partnered with naviHealth do expect providers to bill what is authorized. To ensure a clean claim, the naviHealth Care Coordinator provides a 'naviHealth PDPM summary letter' at the time the NOMNC is issued. This letter summarizes:

- Dates of service
- The PDPM CMGs for those date

- The first four (4) characters of the corresponding HIPPS code

The final (fifth) HIPPS character is completed by the provider.

## Q6. Sometimes, the ICD-10 code on the patient's nH Predict | Outcome report does not match the billing diagnosis. Why?

The ICD-10 code on the **nH Predict | Outcome** report maps to an 'Impairment Group' and in some cases a 'Diagnostic Group.' This ensures the outputs on the report are matching your patient to "like patients." This diagnosis mapping did not change with PDPM.

You may find instances where the ICD-10 codes used on the **nH Predict | Outcome** report are different than the diagnosis codes used for PDPM, for instance the codes used for Total Hip Arthroplasties. The design of PDPM allows you to account for major surgeries independently of your primary diagnosis codes to avoid the "Return To Provider" codes. naviHealth follows the same parameters for documenting the primary PDPM ICD-10 and major surgeries.

## Pre-Service Authorizations

### Q7. Did the initial review and pre-service authorization determination process change under PDPM?

No. The determination for the SNF admission is based on medical necessity and all other CMS criteria outlined in the Medicare Benefit Policy Manual, Chapter 8. As before, only after these criteria have been met does naviHealth utilize the **nH Predict | Outcome** report to determine the clinical targets for the

SNF LOS, therapy intensity, discharge site, expectations for functional gain, and non-skilled caregiver needs.

#### Q8. Will the provider receive a PDPM CMG level prior to admission?

No. naviHealth realizes that many of the PDPM elements cannot be fully determined until after SNF admission. The PDPM CMG level is usually determined between day 8 -10 of the SNF stay after all relevant clinical data is submitted.

## Continued Stay Authorizations & CMG Level

#### Q9. Is the initial SNF authorization still for 3-5 days?

Yes. The initial pre-service authorization is generally approved for 3-5 days. naviHealth still requires PT, OT, ST and Nursing assessments within the first 48 hours of admission to the SNF – this allows naviHealth to complete our **nH Predict | Function** Assessment and deliver a SNF **nH Predict | Outcome** report to the provider.

naviHealth encourages providers to complete and submit additional discipline- specific clinical assessments that inform the CMG levels as soon as practical. naviHealth believes these assessments can be completed by day seven (7) of the member's stay.

#### Q10. Why does naviHealth expect all clinical documentation by day 7? We have until day 15 (seven days after ARD of day 8) to complete the MDS for the Medicare A-FFS patients.

naviHealth recognizes that providers have significantly more time to complete the MDS. We believe that if there is a clinical condition that warrants a care-plan and a skilled clinical intervention – it is a best practice that those clinical needs are identified, assessed and treated as early in the SNF stay as possible.

Please remember, naviHealth is not dependent upon the provider's MDS to inform the final CMG authorized.

## Q11. What documentation does naviHealth require on admission? And does that documentation determine the PDPM CMG level?

naviHealth requires PT, OT, ST, and Nursing assessments within the first 48 hours of admission to the SNF so that the nH Care Coordinator may complete our **nH Predict | Function** Assessment and deliver the patient's SNF **nH Predict | Outcome** report to the provider. This is consistent with our workflow prior to PDPM. The **nH Predict | Outcome** report is a decision support tool for the provider's care planning.

The transition to PDPM necessitated additional data submission by the SNF provider for the calculation of the CMG levels.

This includes but may not be limited to:

- PHQ-9 Assessment
- Medication Administration Record (MAR) / Treatment Administration Record (TAR)
- Discharge Planning Assessment
- Physician and Nursing Notes
- PT, OT and ST Notes

The earlier naviHealth receives this information, the sooner the PDPM CMG levels can be determined. As stated previously, naviHealth suggests all clinical assessments are completed and submitted by day seven (7). naviHealth returns the PDPM CMG level within 1-2 days.

Please see [provider resource page](#) for a complete listing of SNF clinical documentation requirements.

## Q12. Why is the provider NOT required to submit the BIMs score?

The provider may submit the BIMS Assessment score, particularly if it is completed early in the patient's stay. However, the **nH Predict | Function** Assessment scores a patient's cognitive status today much like the BIMS does in the SNF. Submitting the BIMS score may be considered redundant; therefore, it is optional.

### Q13. Once naviHealth has determined the PDPM CMG level – does that go back to the day of admission?

Yes. The PDPM CMG level informs payment from the day of admission, and as a rule, will not change during the patient's course of care.

### Q14. When might a patient's PDPM CMG level change?

A patient's PDPM CMG level may change during the course of care if any of these situations occur:

- After the CMG level/s are determined, the patient has a significant change in condition warranting the addition of, or reduction of, treatment and/or clinical resources
  - Example: Patient admits with an ankle fracture and on day 11 suffers a CVA
    - Patient may require additional clinical resources that were not originally identified because of the new diagnosis
    - naviHealth obtains supportive clinical documentation from the provider
    - naviHealth recalculates the CMG level/s of care
    - The CMG level changes effective the day of the change in clinical condition (the day of the documented CVA insult)



- Example: Patient admits with several active clinical conditions requiring care and services
  - Patient has an exceptionally long length of stay
  - Clinical conditions identified on admission have resolved and are now considered inactive
  - naviHealth re-calculates the CMG level/s of care
  - The CMG level changes effective the day the clinical conditions were determined to be inactive
- Example: Patient is away from the SNF for < 3 days (interrupted stay) and demonstrates a change in condition
  - Patient may require additional clinical resources that were not originally included in the admission CMG
  - naviHealth obtains supportive clinical documentation from the provider
  - naviHealth recalculates the CMG level/s of care
  - The CMG level changes to the date of the readmission to the SNF

### Q15. Once the CMG level is determined, is there still a need for continued stay reviews?

Yes. During the patient's stay, naviHealth continues to require documentation that demonstrates an *ongoing*, daily skilled nursing and/or rehabilitation need in the SNF care setting

### Q16. What information are SNF providers required to submit for a continued stay review?

For a SNF continued stay review, this documentation includes, but is not limited to:

- Physician notes
- Nursing notes

- Therapy notes
- Respiratory therapy notes
- Appropriate social work/discharge planning notes

This documentation assists naviHealth in determining both the continued need for skilled level of care and the monitoring of member functional improvement while in the facility. The naviHealth Care Coordinator will provide a Next Review Date for submission of weekly updates for each next continued stay review.

### Q17. What is the frequency for submission of continued stay reviews?

Providers are expected to continue to send clinical updates, as outlined above, every 5-7 days which corresponds with the Interdisciplinary Care Meeting schedule.

## Documentation Submission at Discharge

### Q18. What is required for submission when a patient is discharged from the SNF?

naviHealth continues to require documentation upon a patient's discharge from skilled services. This includes therapy discharge summaries and therapy billing/service logs. Information on individual, concurrent and group therapy is expected to be included.

These therapy utilization variables are tracked and compared to severity-adjusted targets on the **nH Predict | Pulse** report to ensure quality outcomes (functional gains, readmission, discharge to community) are not compromised.

For resources on SNF Clinical Documentation Submission Requirements please [click here](#).

## Reassessment of CMG Level

Q19. What if the SNF provider does not agree with the naviHealth CMG level/s authorized? Can a provider request a reassessment of one or more CMG levels?

Yes. The SNF may request a reassessment of the authorized CMG level/s after the final CMG levels are assigned.

The decision to change a CMG level is dependent upon the provider's submission of sufficient clinical documentation to support the change. When making a request, the provider should identify where in the submitted documentation the supportive information exists. If the information can be validated and if appropriate then, the SICC changes the CMG level back to the day of the admission. In some instances, the decision to change a CMG level may require a naviHealth Medical Director review. This decision is limited to the reassessment of the CMG level of care and is **NOT** a determination of skilled need or a denial of services.

The [Request for a Reassessment of CMG Level](#) document is an optional worksheet that may be helpful in ensuring that comprehensive clinical documentation is submitted to support the reassessment request. You may find the Request for a Reassessment of CMG Level document on the provider resource page.

Q20. What is 'sufficient documentation' to support a reassessment of a CMG level? What sources does naviHealth accept as valid?

Sufficient documentation includes, but is not limited to:

*"most recent H&P, transfer documents, physician progress notes, discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults, diagnostic reports and other sources as available."*

## Q21. Is there a timeline as to when naviHealth accepts a request to reassess a CMG level?

naviHealth expects to receive all clinical documentation and assessments by day seven (7) with a CMG determined within 1-2 days. A request to reassess CMG level/s may occur at this time.

Any requests to modify a CMG level must be communicated prior to the patient's discharge from skilled services. naviHealth recognizes that there may be exceptions to this rule, specifically when a patient has an unanticipated short length of stay.

## Q22. I submitted a request to reassess a CMG level change for an additional NTA condition and for a lower functional level, but the CMG did not change. Does this indicate that the CMG reassessment was not completed accurately or was 'denied' by naviHealth?

No. Many times, the addition of an NTA condition or a functional change will have no effect on that specific CMG.

For example: the NTA Score Range for CMG level "NC" is 6-8 points. If the original set of NTA elements added up to 6 points and the additional condition/extensive service you submitted was valued at 1 point (diabetic foot ulcer), the NTA CMG would remain at "NC" as the new value of "7" would still be within the 6-8 range.

This also may occur frequently with functional levels, as the range for the most prevalent group is quite wide (10-23) within a total range of 0-24. So, frequently the changes could be quite dramatic (functional changes from a 10 to a 20), but the CMG remains the same.

## Diagnosis and Active Clinical Conditions:

### Q23. Why is coding of the ICD-10 diagnosis so important?

ICD-10 codes determine reimbursement within all the CMGs. Capturing active and relevant ICD-10 codes accurately helps to inform the resource needs of the patient.

**Primary Admitting Diagnosis:** the correct coding of the primary admitting diagnosis affects PT, OT, Speech and Nursing CMGs, and is a factor in determining the daily rate.

**Comorbid Diagnoses:** NTA, SLP and Nursing CMGs have additional ICD-10 diagnosis factors which also serve to inform the per diem rate. These diagnoses must be active, relevant and directly impact a skilled resource need of the patient to be included.

### Q24. What is the definition of “Active Condition?” According to

CMS, the definition of “active condition” is: Physician- documented diagnoses in the last 60 days that have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the assessment period.

**‘Active Condition’ does not include** conditions that have been resolved. ‘Active Condition’ does not include conditions that have no effect on the resident’s current status, nor does it include conditions that have no impact on the resident’s plan of care during the assessment period, as these would be considered inactive diagnoses.

It is important to point out, naviHealth applies the definition of active to all clinical conditions, diagnoses and procedures of the patient, not just the conditions captured for the purpose of the NTA CMG level.

### Q25. Does naviHealth assign the primary diagnosis—or determine the primary condition of the patient?

Yes. naviHealth is responsible for determining the primary medical condition — or reason for admission to the SNF.

The primary diagnosis may change from the hospital to the SNF. If the SNF feels the primary diagnosis assigned by naviHealth should be modified, they may request a reassessment, including the proposed diagnosis, to the naviHealth Care Coordinator. If there is no alignment between the provider and the Care Coordinator, a naviHealth Medical Director determines the primary diagnosis.

## Q26. What happens if the SNF captures additional patient diagnoses that were not available in the hospital medical records?

Additional comorbidities/active diagnoses identified and documented by the SNF may result in a change in one or more of the CMG levels. We anticipate providers will request changes, most frequently to the NTA, and Nursing CMGs based on identified comorbidities of the patient. This information should be delivered to naviHealth within the first seven (7) days of the stay.

The process to request a reassessment of a CMG level is outlined previously in this document. Supporting documentation is required by naviHealth to verify presence, active status and relevance of these diagnoses or conditions; these requirements may also necessitate review by the naviHealth Medical Director. The determination by the naviHealth Medical Director is not a denial of care or services.

## Therapy Provision in PDPM

### Q27. Does naviHealth set expectations for therapy utilization (LOS and minutes) with the nH Predict?

Yes. The **nH Predict | Outcome** report is a valuable tool to Rehabilitation Providers when making determinations about intensity of therapy services.

Providers should continue to use the **nH Predict | Outcome** report to ensure patients are making the appropriate functional recovery while in their care.

## Q28. Are the therapy disciplines, minutes and number of days determined by naviHealth?

The **nH Predict | Outcome** report provides the SNF clinical teams with target therapy minutes per week, regardless of discipline. The allocation of the minutes between therapy disciplines is determined by the SNF rehab team.

As always, the delivery of therapy services (frequency, intensity and duration) is monitored on the **nH Predict | Pulse** report to ensure acceptable levels of care are delivered to each patient.

## Q29. Does naviHealth require weekly submission of therapy minutes for continuation of coverage?

Continuation of coverage is always based upon meeting the skilled care criteria outlined in Chapter 8 of the Medicare Benefit Policy Manual – Coverage of Extended Care (SNF) Services Under Hospital Insurance. Coverage does not continue if a daily skilled need is not warranted.

Currently, reporting of the minutes of OT, PT and SLP is not required on a weekly basis for the individual patient. This could change if SNF practices demonstrate a significant reduction of therapy service delivery. If practices demonstrate that patients are consistently not receiving the intensity/duration of therapy indicated by the **nH Predict | Outcome** report, further discussion and/or change of policy may be warranted.

As always, the **nH Predict | Pulse** monitors the amount of therapy delivered, by all disciplines (OT, PT and SLP), to the patients.

## Q30. How does naviHealth continue to ensure the proper utilization, intensity and mode of rehabilitation therapy?

The **nH Predict | Outcome** report is a severity-adjusted clinical treatment guide, setting skilled therapy utilization and functional outcome targets. The **nH Predict | Outcome** report continues to be the most appropriate tool to set goals and expectations for patient care, regardless of payor source or changes in payment methodology.

It is important to continue to monitor the intensity of therapy provided to each SNF patient, given potential incentives under the PDPM system to reduce OT, PT and SLP service delivery.

In addition, it is important to monitor the extent to which group and concurrent therapy is utilized. During the initial implementation of PDPM, naviHealth plans to assess how, or if, changes in group and concurrent therapy practices impact patient quality outcomes, incorporating these findings into our decision support tools going forward.

## Group and Concurrent Therapy

**Q31. Is naviHealth concerned about an overutilization of concurrent and group therapy now that PDPM allows for a combined 25 percent for each therapy discipline?**

No. naviHealth is not concerned about overutilization because we will be closely monitoring the judicious and appropriate uses of these modes of therapy and the effect upon patient outcomes.

naviHealth feels that both concurrent and group therapy are complimentary to individual therapy delivery and are an effective means of rehabilitation. It must be recognized that the overuse of these modes can have a detrimental effect on the quality outcomes.

naviHealth started collecting and tracking group and concurrent therapy use in April 2019, using the therapy billing logs submitted by the SNFs for each patient episode of care. This provides a baseline to which naviHealth can compare utilization and quality outcomes per discipline side-by-side.



naviHealth will be reporting the percentage of group and concurrent therapy at the discipline level in the **nH Predict | Pulse** report. CMS also tracks the modes of therapy, collecting the data from the new Section O on the MDS.

### Q32. Does naviHealth determine the appropriate amount of concurrent and group therapy for a patient type? If so, how/when is that communicated to providers?

No, not yet. naviHealth began collecting and recording concurrent and group therapy in April 2019. These modes will be utilized more frequently after October 1, 2019.

After October 1, 2019, targets for therapy per mode (concurrent, group or individual) are not generated on the **nH Predict | Outcome** report. Within a year or so, naviHealth feels that enough data will have been collected to enable the development of predictive targets for each therapy mode.

naviHealth views this as a future enhancement and will evaluate adding these parameters when a sufficient volume of data has been collected.

## Interrupted Stay

### Q33. How does naviHealth handle readmissions back to the hospital? What is naviHealth's expectation relative to interrupted stay vs. a readmission back to the SNF?

naviHealth follows the Interrupted Stay Policy per CMS. In summary:

If a patient is discharged from the SNF to the hospital (or other setting) and returns to the SNF **within three (3) days**, the subsequent stay is considered a continuation of the previous stay. Variable per diem schedule continues from the previous discharge.

Together, naviHealth and the SNF determine if the patient has had a clinical change which warrants a revision of the CMG levels initially authorized. Supporting documentation is required to change a CMG level and review by a naviHealth Medical Director may be necessary. The new CMG, if documentation indicates, would be effective on the day the patient returns to the SNF.

If a patient is discharged from the SNF to the hospital (or other care setting) and returns **after three (3) days**, or if the patient returns to **another SNF provider**, regardless of timing, the variable per diem resets to day one, and a naviHealth- authorized CMG level is provided.

naviHealth's current policies around prior authorization remain unchanged. When a patient is out of the facility over a midnight, a new authorization is required. Providers are advised to alert their SICC when this occurs – to secure the authorization in a timely fashion.

naviHealth expects the SNF providers to be ready, willing, and able to accept a patient back to their original SNF when the patient is deemed stable to transfer. Recovery in the original facility allows for consistency of care and a better patient experience. Likewise, it is never acceptable to delay a patient's return to the original facility once deemed stable for transfer. CMS and naviHealth are monitoring for any increase in acute days in the PDPM model.

### Q34. Is naviHealth worried that there may be more readmissions now that SNFs may be taking more complex patients?

No. There are many SNFs that currently provide high levels of medical care to sub-acute patients. These SNFs have well-trained staff who have the skill set required to provide care to the medically complex patient population. It is likely that the types of patients accepted to SNFs have not changed past October 1, 2019; rather, it is how the SNFs code the conditions of the patient that has changed.

If a SNF that was not admitting medically complex patients decided to do so due to the reimbursement changes, the facility needs to have prepared and adjusted to the demands and needs of this patient population.

## Thoughts on Restorative Nursing

Q35. When thinking about caring for the whole patient, what is naviHealth's position on Restorative Nursing Assistant (RNA) programs, functional maintenance programs, walk to dine, and/or family mobility plans?

RNA Programs and Functional Maintenance Programs (FMP) were designed to appropriately provide the patient with non-skilled, repetitive task reinforcement and execution. Implemented appropriately, these programs and assistance from family/friends can be extremely complimentary to and enhance the outcomes of skilled rehabilitation and nursing.

Properly designed RNA and FMP programs, which include skilled nursing and therapy guidance and oversight, have proven to be quite effective. naviHealth anticipates — and encourages — the proper use of such programs for non- skilled, repetitive Activities of Daily Living (ADL), mobility and eating. The early caregiver training for family and caregivers has always been a keystone of effective discharge preparation.

Q36. Will RNA programs become more robust and prevalent in the SNFs?

We hope so. It is anticipated that routine and repetitive activities may be more appropriately assigned to non-skilled personnel. Per Chapter 8 of the Medicare Benefit Policy Manual, skilled therapy is defined as "care that requires the clinical expertise of a licensed therapist." Routine, repetitive, maintenance activities were not considered skilled in RUGs and likewise will not be considered skilled in PDPM.

Given PDPM incentives, appropriate use of RNA programs is anticipated to increase in frequency and volume. The development of *well-executed programs* (e.g., Walk and Dine, Get Up and Go, etc.) with judicious allocation of services, skilled design and oversight can now become appropriate levels of care.

We must keep in mind that quality and efficiency outcomes (readmissions, lower discharge to community rates and longer LOS) cannot be compromised by the increased use of ancillary personnel.

## Guidance on MDS Completion

Q37. Does naviHealth want the provider to submit the MDS or just the clinical supportive documentation?

naviHealth is not requesting the MDS. What is most important is the clinical documentation used to inform the MDS. naviHealth uses the clinical documentation submitted to determine active and relevant conditions as well as ADL level, cognitive status and need for speech pathology services – which subsequently calculates the authorized CMG levels.

Q38. So, what your saying is, naviHealth is determining my facility's daily payment rate, not my completion of the PPS MDS?

Yes. For patients managed by naviHealth, naviHealth determines the appropriate level of reimbursement based on the clinical care and resource needs of the patient. naviHealth is not dependent upon, and does not consider, the provider completed MDS Assessment when making this determination.

Q39. This is confusing. We have always followed the PPS Assessment Schedule to inform the Health Plan as to

what level we should be paid. Are you saying we do not have to do that anymore?

Yes. Historically, SNFs may have followed the PPS assessment schedule for the MAO members in order to generate a per diem rate to submit to the Health Plan. In the naviHealth model of care, the per diem rate is determined concurrently with the member's stay based on clinical information submitted by the SNF, thus, eliminating the need for the provider to follow the PPS assessment schedule for the Medicare Advantage Member managed by naviHealth. In our model of care, utilization management criteria are applied prospectively and concurrently during the patient's stay, reducing the provider's exposure to a post-payment audit. Please keep in mind, this process is related only to care being coordinated by naviHealth – the Health Plan may have a different procedure for other members with product lines not managed by naviHealth.

**Q40. When we complete the MDS, it automatically generates a HIPPS code on my claim, which many times does not match what naviHealth authorizes. What can I do about this?**

This is because you are completing the PPS required Assessment. When the provider completes the OBRA required admission assessment, a requirement for all new admissions regardless of payer, there likely will not be CMGs calculated and therefore the claim will not be auto populated with a HIPPS code. Providers should validate this with their software vendor. Providers are encouraged to consider completing the OBRA Required instead of the PPS Admission Assessment for their naviHealth managed MAO beneficiaries.

It is important that you are identifying the member properly as NOT part of the Part A reimbursement program. The SNF may:

- Identify the Assessment as OBRA Required Admission Assessment by coding 01 on section A0310A
- Identify the Assessment as not PPS related by coding 99 on section A0310B

- Identify the member as NOT being in a Medicare covered stay by coding 0 on section A2400A

This way, the provider may advance to sections of the MDS required by the OBRA Admission Assessment and not need to be concerned about 'mis-matches' between the MDS and the naviHealth Assessment.

Regardless of the type of MDS assessment completed, the provider may enter the naviHealth authorized level of care in section Z0300 of the MDS. It is recommended the provider confirms the naviHealth authorized level of care is recorded on the claim (UB04) to ensure proper and timely claims processing.

#### Q41. If we are following the OBRA required Admission Assessment schedule and the patient is discharged prior to day 14, what should we do?

In the RAI manual, CMS is very clear about the process to follow when a patient is discharged prior to the completion of the OBRA required Admission Assessment. SNFs should follow this direction and complete the appropriate trackers, as identified by CMS. See RAI Manual Chapter 2.6 OBRA Required Assessments.

#### Q42. It's our policy to complete the PPS assessment on all MAO members in case they converted back to FFS and we were unaware. What is your advice on that?

naviHealth believes completing the OBRA Admission Assessment is a more palatable process, for reasons stated above; however, it is up to the provider to determine which assessment to complete. It is important to point out that many of the Health Plans working with naviHealth have a provider portal where eligibility can be verified. In addition, naviHealth receives an eligibility file regularly from all of our Health Plan partners, increasing our level of confidence that the payer source is accurate. If a provider chooses to follow the PPS assessment schedule, they may need to manually modify the HIPPS code on the claim to ensure the claim processes smoothly.

#### Q43. If I complete the OBRA required Admission Assessment, may I still request a CMG level change?

Yes. A provider may always request a CMG level change or an alternate primary diagnosis. This should occur at the time the final CMGs are assigned to the provider (day 8-9 of the member's stay) and should not be dependent upon the completion of the OBRA Required Assessment.

#### Q44. Does the provider need to complete section GG for naviHealth managed members?

No. Section GG is not part of the OBRA Required Admission Assessment and therefore does not need to be completed or sent to naviHealth. naviHealth identifies the 'usual functional level of the patient' based on clinical documentation submitted.

#### Q45. Is an IPA accepted for payment changes?

No. Because the provider is not required to follow the PPS Assessment Schedule for naviHealth managed MAO beneficiaries, an IPA is not necessary for payment changes. If the provider feels the member may have had a change in clinical condition that requires a CMG level change, the provider may request a reassessment to the SICC providing:

- Supporting clinical documentation
- Subsequent telephonic inquiry/discussion as indicated

This may result in a Medical Director review. Conversely, when a clinical condition identified on admission is no longer active and relevant, the SICC may recalculate the CMG level of the patient. The SICC will share any level changes with the provider.

## 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 we have hosted
- Documentation and whitepapers on PDPM
- Links to industry news and updates
- Updates to this FAQ document

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