

## Preservice Authorization Requests/Reviews

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

Requests for preservice authorization or review for inpatient Long-Term Care Hospital (LTCH) 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.

## Preservice Authorization Requests & BPCI-A/ACO Reviews

The following clinical information is required for preservice authorization requests or reviews 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

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**Preservice Authorization Requests/Reviews (continued)**

- **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**

## Long-Term Care Hospital Documentation

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The following sections outline the documentation required for naviHealth-managed patients throughout the patient's recovery journey. Please submit clinical documentation from the EMR and/or patient's chart. We **cannot** accept forms or summaries that have not been signed by a licensed clinician or are not part of the patient's medical record.

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

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### Admission Review – Health Plan, BPCI-A, ACO

Please submit the following information upon admission:

- **Demographic sheet** including attending physician
  - **Discharge planning assessment**/case management or social work notes – if available
  - **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, within 48 hours of admission) including:
    - Patient's usual living setting and available caregiver support
    - Patient's prior level of function, including assistance and DME needed and home support
    - Patient's current level of function for bed mobility, transfers, and ambulation
    - Patient's current level of function for feeding, grooming, bathing, dressing, and toileting
    - Patient's cognitive status, including vision/hearing impairments, behavioral health concerns, communication ability, memory and problem-solving ability
  - **Most recent therapy notes** (if applicable, within the last 48 hours)
  - **Most recent physician notes** (within the last 24 hours)
  - **Labs, vital signs, medication orders** (past 2 days)
  - **Vent settings and/or vent weaning** (if applicable)
  - **Description and orders for wound care** (if applicable)
  - **Description and orders for tube feeding** (if applicable)
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## Long-Term Care Hospital Documentation (continued)

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### Interim Reviews – Health Plan, BPCI-A, ACO

Your Care Coordinator will provide a Next Review Date for submission of weekly updates.

- **Demographic sheet** or ensure at least two patient identifiers are included on submitted clinical
  - **Case management or social work notes**/any updates to discharge plan
  - **Physician and nursing notes** since last update including:
    - Specific details for ongoing active management of IV meds, wounds, enteral feedings, abnormal lab values, med adjustments, etc.
    - Caregiver training status
    - Physician orders
  - **Physical, occupational, and speech therapy notes since last update** (if applicable; most recent should be **within 24 hours of Next Review Date**) including:
    - Patient's current level of function for bed mobility, transfers, and ambulation
    - Patient's current level of function for feeding, grooming, bathing, dressing, and toileting
    - Patient's cognitive status, including vision/hearing impairments, behavioral health concerns, communication ability, memory and problem-solving ability
    - Caregiver training status
  - **Most recent therapy notes** (if applicable, within the last 48 hours)
  - **Most recent physician notes** (within the last 24 hours)
  - **Labs, vital signs, medication orders** (past 2 days)
  - **Vent settings and/or vent weaning** (if applicable)
  - **Description and orders for wound care** (if applicable)
  - **Description and orders for tube feeding** (if applicable)
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### Discharge Reviews – Health Plan, BPCI-A, ACO

The following must be submitted for records closure within 72 hours of patient discharge:

- **Patient's discharge instructions** (preferably **within 24 hours of discharge**).
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### Hospital Readmissions – Health Plan, BPCI-A, ACO

Notify your Care Coordinator as soon as possible of any readmissions, including date and time of readmission, and reason. Consult your Care Coordinator for guidance.

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