Clinical Documentation Submission Requirements – Skilled Nursing Facility (SNF)

Preservice Authorization Requests/Reviews

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

Requests for preservice authorization for inpatient PAC settings 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.

Items in **bold** are **required documentation**.

Preservice Authorization Requests:

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

Commonly found in Physician History & Physical (H&P):

- **Patient's acute presentation and diagnosis**

Commonly found in Most Recent Physician Progress Note(s):

- **Patient's current medical status demonstrating stability**
- **Patient's ongoing skilled medical need(s)**

Commonly found in PT/OT/ST Therapy Evaluation(s):

- **Patient's usual living setting***
- **Patient's prior level of function***

Commonly found in Most Recent Therapy Progress Note(s)

- **Patient's current mobility, transfers & ambulation***
- **Patient's current ADL status, e.g. bathing/dressing***
- **Patient's current cognitive status***

Applies when therapy is indicated

NOTE: *The requirements outlined on this page are 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.

Clinical Documentation Submission Requirements – Skilled Nursing Facility (SNF)

Skilled Nursing Facility Documentation

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 **required 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.

Please ensure ALL clinical documentation submitted includes at least two patient identifiers.

Admission Review:

Please submit the following information within the first 48-hours of admission:

- **Demographic Sheet** including attending physician
- **Acute Hospital Discharge Summary**
- **Nursing Admission Assessment**/nursing notes and CNA documentation
  - Include respiratory treatment, restorative nursing, 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** including patient's:
  - Usual living setting and available caregiver support
  - Prior level of function, including assistance and DME needed and home support
  - Current level of function for bed mobility, transfers, and ambulation
  - Current level of function for feeding, grooming, bathing, dressing, and toileting
  - Cognitive status, including vision/hearing impairments, behavioral health concerns, communication, memory and problem-solving ability

Continued on next page

Clinical Documentation Submission Requirements – Skilled Nursing Facility (SNF)

Skilled Nursing Facility Documentation (Continued)

Interim Reviews:

Your Care Coordinator will provide a Next Review Date for submission of weekly updates. **First Interim Review – PDPM:** The following information is required for PDPM CMG calculation and should be submitted by day seven (7) of the patient's stay.

- **PHQ-9 Assessment**: **ONLY** submit once during a patient's stay
- **Medication Administration Record (MAR)/Treatment Administration Record (TAR)**

- **All Interim Reviews:**
  - **Discharge Planning Assessment/** Case management or social work notes
  - **Physician and Nursing Notes** since last update including:
    - Specific details for ongoing medical necessity and active management of IV meds, wounds, enteral feedings, abnormal lab values, med adjustments, etc.
    - Caregiver training status
    - Physician orders if any updates
  - **Physical, Occupational, and Speech Therapy Notes*** since last update (most recent should be within 24 hours of Next Review Date) including patient's:
    - Current level of function for bed mobility, transfers, and ambulation
    - Current level of function for feeding, grooming, bathing, dressing, and toileting
    - Cognitive status, including vision/hearing impairments, behavioral health concerns, communication, memory and problem-solving ability
    - Caregiver training status

NOMNCs:

For Health Plan **ONLY**. Required for Medicare Advantage patients. If a NOMNC has been issued, submit a copy of the signed, valid NOMNC to naviHealth on the day of issuance.

Discharge Reviews – Health Plan:

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

- **Patient's Discharge Instructions** (preferably within 24 hours of discharge).
- **Therapy Discharge Summaries** (if applicable)
- **Therapy Service/Billing Logs** (if applicable) including minutes and visits recorded for entire stay

Hospital Readmissions:

Notify your Care Coordinator as soon as possible of any readmissions, including date and time of readmission, reason, and expected return to SNF. Medicare Advantage patients out of the facility past midnight require a new authorization. Consult your Care Coordinator for guidance.