naviHealth

Submitting Pre-service Authorization Requests using CarePort Care Management

Effective June 1, 2019, **all pre-service authorization requests** for care in a Skilled Nursing Facility, Inpatient Acute Rehab Center or Long-Term Acute Care Hospital require a medical necessity review by naviHealth. Providers may continue to use Care Management (CM) – previously known as AllScripts – as an acceptable medium to submit the requests for Blue Cross® Blue Shield® of Michigan and Blue Care Network members with BCN Advantage℠ or Medicare Plus Blue℠ PPO coverage.

Please note: the acute care facility is expected to secure the preservice authorization prior to transitioning the member to an inpatient post-acute care setting.

What's Changing

As of June 1, 2019, the BCBSM – Evicore Medicare Plus Blue SNF, IRF, LTACH PAC Authorization Form is no longer required. Instead, the **naviHealth Authorization Initiation Form** should be used for all pre-service authorization requests. Work is underway to incorporate the naviHealth Authorization Initiation Form directly into the CM application, eliminating the need to attach. You will be notified as soon as this work is complete.

Discharge Planner/Case Manager: please use the following checklist to ensure all appropriate clinical information is submitted for medical necessity review:

- ❑ Hospital Face Sheet
- ❑ History & Physical Document
- ❑ Therapy Evaluations (within previous 48 hours) including:
  - ❑ Prior Living Situation
  - ❑ Current Cognitive Status
  - ❑ Prior Level of Function
- ❑ Therapy Notes (within previous 24-48 hours)
- ❑ Physician Notes (within previous 24 hours)
- ❑ Physician Orders Sheet / Medication List
- ❑ Post-procedure Notes
- ❑ Nursing Admission Assessment

Using CM to Complete a Pre-service Authorization Request

1. Create insurance payor referral in CM
2. Complete and file attach/PrintAttach the **naviHealth Authorization Initiation Form**
3. Ensure all requested Clinical and Therapy information is included with the request
4. Go to '**Choose recipients**', select Provider Group "**Insurance Payor – naviHealth**" and click "**Find**"
   - The listing of '**naviHealth – BCBS Michigan**' will auto-populate
   - Ensure to "**unmask**" the referral before sending
5. naviHealth responses, via electronic communication within the CM application:
   - **Referral Received** to acknowledge receipt of the request
   - **An approval** (with authorization ID number, number of days authorized, start date, next review date and RUG level)
   - **A request for additional clinical information** – stating specifically what is required.
   - **An offer for a peer to peer review** if there is a potential denial. The provider is expected to respond promptly to the peer to peer review offer, so as not to result in a delay in processing the authorization request. Targeted peer to peer completion is 4 hours.
   - **A denial** – either because member does not meet medical necessity criteria (this will be followed up with a phone call from naviHealth) OR if the member is not being managed by naviHealth.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association. naviHealth is an independent company that contracts with Blue Cross and BCN to manage post-acute care authorizations for Medicare Advantage members.

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