Blue Cross Blue Shield Blue Care Network of Michigan
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Provider alert
Medicare Plus Blue℠ and BCN Advantage℠
Categories: Authorizations/referrals, Billing/claims/coding
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Reminder: Assessments and clinical documentation to submit for services received by Medicare Advantage members in SNFs

For Medicare Plus Blue and BCN Advantage members, skilled nursing facilities must submit certain items to naviHealth within specific time frames.

PT, OT, ST and nursing assessments

SNFs must submit physical therapy, occupational therapy, speech therapy and nursing assessments to naviHealth within 48 hours of a member's admission to a skilled nursing facility.

naviHealth uses these assessments to:

- Complete the nH Predict functional assessment
- Create and deliver the nH Predict outcome report to the member and the SNF in a timely manner

Clinical documentation and assessments for calculating CMG levels

By day seven of a member's stay, SNFs must submit the following items to naviHealth so they can calculate the case mix group, or CMG, level:

- PHQ-9 assessment
- Medication Administration Record, or MAR / Treatment Administration Record, or TAR
- Discharge planning assessment
- Physician and nursing notes
- Physical, occupational and speech therapy notes

naviHealth will calculate the CMG level within two days of receiving clinical documentation and assessments. They'll use the CMG level to generate patient-driven payment model, or PDPM, codes, which are used for billing.

Requirements for reassessments of CMG levels

After naviHealth has calculated the CMG level, SNFs can submit requests to reassess CMG levels. **Be sure to request the reassessment prior to discharging the member from skilled services.** Send the clinical documentation required for the reassessment to naviHealth as soon as possible.

Clinical documentation for the reassessment of CMG levels includes — but isn't limited to — information from the most recent history and physical, transfer documents, physician progress notes, discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and diagnostic reports.

naviHealth will use the clinical documentation to determine whether to change the CMG level. The provider must identify where the supporting documentation appears within the clinical documentation. If naviHealth determines that the CMG level should change, they'll change it retroactive to the day of admission.

You can use the *Request for a Reassessment of the CMG Level* worksheet to ensure that you submit comprehensive clinical documentation to support the request. You can find this worksheet:

- By requesting it from your assigned naviHealth Care Coordinator.
- Through the naviHealth resource website for Blue Cross and BCN at https://partners.navihealth.com/partner/bcbsm*. If you haven't already registered for this website, see the "How do I access naviHealth documents related to this program?" section of the Post-acute care services: Frequently asked questions for providers document to learn how.

Note: The decision to change a CMG level may require review of the request by a naviHealth medical director.

Additional information

If you have questions about the information in this provider alert, contact your naviHealth Care Coordinator or your naviHealth Provider Relations Manager.

You can find more information in the Post-acute care services: Frequently asked questions for providers document. We're updating this document to include the information in this provider alert.

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