Medicaid Managed Care Plans-Nursing Facility Stay Review

Instruction Sheet

Nursing Facility Stay Review Section

Complete the entire form by providing the requested information that applies. Include previous living arrangements and if it is expected that they will return to this setting. Include obstacles such as steps, railings… any hindrance to a safe discharge.

Physical Therapy Section

Include the evaluation findings and then utilize the "Update as of" section for all continued stay reviews (CSR) for each applicable area. Include any anticipated discharge needs or concerns.

Occupational Therapy Section

Include the evaluation findings and then utilize the "Update as of" section for all continued stay reviews (CSR) for each applicable area. Include any anticipated discharge needs or concerns.

Speech Therapy Section

Include the short term and long term goals sections. Include any speech, swallowing and specific discharge needs related to speech in this section.

Cognitive Status Section

Provide information to demonstrate that OAC 5101:3-3-06 ILOC Paragraph C (2) (d) is met: "due to a cognitive impairment, including but not limited to dementia, the individual requires the presence of another person, on a 24/day basis.

Wound Management Section

Include all wound care treatment and if more than 3 wounds are present, include this in the comments section of the grid.

Nursing/ADL's Section

Include any nursing updates related to ADL care by using the evaluation section for the initial presentation and the continued stay review (CSR) for each applicable area. Include documentation that supports the need for a RN/LPN skilled service.

Medication Management Section

Include all routine, IV, SQ, and specialty medications. You can use the comment section of the grid to summarize all of the routine medications and all of the specialty medications can be included in the upper grid section.

Respiratory Section:

Include all respiratory supports that are needed which could include oxygen, ventilator, respiratory medications, and include the treatment plan of care.

Discharge Needs Section:

Include ALL discharge needs and where/with and whom the discharge will occur. Include obstacles such as steps, railings… any hindrance to a safe discharge.

Contact Information:

Managed Care Plan	Web	Fax	Phone	E-mail
	**amerigroupcorp.com**	**866-495-3893**	**800-600-4441**	**Kewing1@ amerigroupcorp. com**
	**www.bchpohio.com**	**Prior auth:** **NE/SW Region**: 866-704-3069 **EC Region**: 866-535-4083 **NW Region:** 866-535-4084 **Concurrent:** **NE Region**: 866-535-4081 **SW Region**: 866-535-2895 **EC Region:** 866-709-1109 **NW Region**: 866-753-7547	**866-246-4359**	**NA**
	**www.caresource-ohio.com**	**937-531-2677**	**800-488-0134 ext: 2014**	**snf@Caresource. com**
	**www.molinahealthcare.com**	**866-449-6843**	**800-642-4168**	**NA**
	**www.unisonhealthplan.com**	**866-839-6454**	**800-366-7304**	**NA**
	**www.Ohio.Wellcare.com**	**877-431-8860**	**800-951-7719**	**Terri.ayers@ wellcare.com**
	**www.paramounthealthcare. com**	**419-887-2028**	**Sharon Alberts, RN, CCM 419-887-2220**	**sharon.alberts@ promedica.org**

Medicaid Managed Care Plans
Nursing Facility Stay Review

Please complete and fax back to [PLEASE SEE INSTRUCTION SHEET FOR INDIVIDUAL PLAN FAX]

Please indicate if this is an Initial Evaluation or Continued Stay Review:

Member Name:

Member ID#:

Date:

Facility:

Facility NPI:

Facility Reviewer:

Reviewer Contact Number:

Level of Care Requested for continued stay: (Please choose ILOC(Intermediate) or SLOC (Skilled)

Previous Level of Care assigned by AAA: (If Available)

Previous Living Arrangements:

Projected Discharge Date:

Barriers to Discharge:

PHYSICAL THERAPY

KEY: *I=independent*** S=Supervision*** MI=Modified Independent*** SBA=stand by assistance*

*ModA=Mod Assist*** MaxA=Max Assist*** CG=Contact Guard*

	Eval	*CSR*		
	Eval	**Update as of:**	**Update as of:**	**Update as of:**
Bed Mobility: Rolling				
Bed Mobility: Supine to Sit				
Transfer: Sit to Stand				
Transfer: Bed to Chair				
Transfer: Toilet				
Transfer: Tub/ Shower				
Transfer: Car				
Gait: Distance				
Assistance				
Device(s)				
Stairs				
W/C Mobility				
Safety				
Balance				

Short Term Goal:

Long Term Goal:

PT Comments/ DC plans:

OCCUPATIONAL THERAPY

	Eval		*CSR*	
	Eval	**Update as of:**	**Update as of:**	**Update as of:**
Feeding				
Grooming				
Dressing Upper Body				
Dressing Lower Body				
Bathing Upper Body				
Bathing Lower Body				
Toileting				
Homemaking Skills				

OT Comments/ D/C plans:

SPEECH THERAPY

Short Term Goal:

Long Term Goal:

ST Comments/ D/C plans/Swallowing:

COGNITIVE STATUS- *Please provide information to demonstrate that OAC 5101:3-3-06 ILOC Paragraph C (2) (d) is met: "due to a cognitive impairment, including but not limited to dementia, the individual requires the presence of another person, on a 24/day basis*

Comments:

WOUND MANAGEMENT

Wounds: Greater than 3 wounds, please comment…

	Location	**Appearance**	**Dimensions**	**Treatment**	**Frequency**
Wound #1					
Wound #2					
Wound #3					

Comments:

Nursing Section/ADL's

	Eval		*CSR*	
	Eval	**Update as of:**	**Update as of:**	**Update as of:**
Feeding				
Grooming				
Dressing Upper Body				
Dressing Lower Body				
Bathing Upper Body				
Bathing Lower Body				
Mobility				
Toileting				
Comments:				

Medication Management - *Please indicate route, frequency, start and stop date of medication.*

Name	**Dose**	**Route**	**Frequency**	**Discontinued**
Medication				
Medication				
Medication				
Medication				
Comments:				

Respiratory Status: **(Please provide information on any respiratory treatment including O2, vent settings, medication, and plan of care)**

Comments:

Discharge Plan: **(Please include where/with and whom the member plans to discharge to)**

Comments:

AUTHORIZATION STATUS:

Approved through:

Denied as of:

Reason for Denial: Member does not meet the criteria specified in OAC 5101:3-3-06 (C)(2) noted below:

_____Does not require hands-on assistance with the completion of 2 ADLs

_____Does not require hands on assistance with at least 1 ADL/ unable to self administer medication.

_____ Does not require skilled nursing services of an RN, or an LPN under the supervision of an RN, and does not require skilled rehabilitation services delivered by an appropriately trained licensed or certified health care professional.

_____The individual does not require the presence of another person, on a 24/day basis for supervision to prevent harm due

Note: If all 4 are checked, member does not meet criteria for continued NF stay.