Blue Cross Blue Shield Blue Care Network of Michigan

LTACH assessment form

For Blue Cross commercial and Blue Care Network commercial
For Michigan and non-Michigan LTACH providers

Instructions

Long-term acute care hospitals in Michigan and outside of Michigan must use this form to submit prior authorization requests. Incomplete submissions or missing clinical documentation may cause delays or nonapprovals. Before we can consider approving a request for LTACH placement:

- Three contracted SNFs must have determined that they can't provide the level of care the member requires. Two of the SNFs must be facilities that accept members who require higher levels of care such as ventilators.
- You must include the responses from the three contracted SNFs in the "Three SNFs that did not accept" section of this form.

What to submit:
Fax the completed form along with (as applicable) verification of the Medicare benefit exhaust. Also submit the hospital admission H&P, the current IV and SQ medication lists and the last two days of physician progress notes (admission only).

Fax the complete form as follows:

- UAW Retiree Medical Benefits Trust (URMBT) Blue Cross non-Medicare requests: Fax to 1-866-915-9811.
- Other Blue Cross commercial requests: Fax to 1-866-411-2573.
- BCN commercial requests: Fax to 1-866-534-9994.

NOTE: If an air ambulance is needed, prior authorization is required. Follow the instructions on the **form** to request prior authorization. Then call Alacura at 1-844-425-2287 to review the request and obtain the authorization number. Do this prior to the flight.

ATTESTATION

By submitting this form, you are attesting to the following:

- You've verified the member's eligibility and benefits and you understand that authorization is not a guarantee of payment.
- Michigan facilities must be contracted with Blue Cross or BCN; facilities outside of Michigan must participate with their local Blue plan.
- All information is from within 24 to 48 hours before the LTACH admission or is from the last covered day.

Type data into every field unless otherwise noted. Enter N/A if not applicable.

Type of request: ☐ Initial authorization ☐ Continued stay / extension of stay

Is this a Medicare benefit exhaust request? ☐ No ☐ Yes (If yes, submit verification.)

LTACH information			
LTACH facility name		LTACH NPI	
Name of contact person at LTACH	Phone number of contact person at LTACH	Fax number of contact person at LTACH	
LTACH street address	LTACH city	LTACH state	LTACH ZIP code
Participates with local Blue plan ☐ Yes ☐ No	LTACH admission date	Admitting diagnosis with ICD-10 code	
Attending physician name		Attending physician phone	
Acute care hospital contact information			
Name of contact person at acute care hospital	Phone number of contact person at acute care hospital	Fax number of contact person at acute care hospital	
Patient information			
Patient name	Patient date of birth	Contract number	Patient phone number

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Three SNFs that did not accept (Complete only for members who are not on ventilators.)		
1 – SNF name	SNF staff name	Phone
Reason for denial		
2 – SNF name	SNF staff name	Phone
Reason for denial		
3 – SNF name	SNF staff name	Phone
Reason for denial		

Current clinical information						
Height	Weight	Blood pressure	Heart rate	Respiratory rate	Temperature	Alert and oriented
Acute diagnosis			Co-morbidities			
Treatments					Medical condition stabilized ☐ Yes ☐ No	
Pertinent medical history						
Surgeries/procedures 1)					Date	
2)					Date	
Dialysis: ☐ Yes ☐ No Type: ______________ Access: ______________ Frequency: ______________						

Skin status		
Intact: ☐ Yes: Resume completing the form, starting with the "Bowel" field. ☐ No: Complete the fields below, related to wound information.		
Wound/incision location #1	Stage ☐ I ☐ II ☐ III ☐ IV ☐ Unstageable	Size: L x W x D (cm)
Description		
Treatment		Frequency
Wound/incision location #2	Stage ☐ I ☐ II ☐ III ☐ IV ☐ Unstageable	Size: L x W x D (cm)
Description		
Treatment		Frequency
Wound/incision location #3	Stage ☐ I ☐ II ☐ III ☐ IV ☐ Unstageable	Size: L x W x D (cm)
Description		
Treatment		Frequency
Wound VAC ☐ No ☐ Yes: Wound VAC provider name (BCN only) ______________		

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Wound debridement ☐ No ☐ Yes: Date ____________________

Bowel: Continent ☐ Yes ☐ No | **Bladder:** Continent ☐ Yes ☐ No | **Foley:** ☐ Yes ☐ No

Pain status

Pain ☐ Yes ☐ No	Location	Rating before medication (out of 10)

Pain medication name

Dose	Frequency	Route	Effective ☐ Yes ☐ No	Rating after medication (out of 10)

LTACH vent weaning

Oximetry	Vent ☐ Yes ☐ No	If yes, date of initial intubation

Vent rate	Setting	PEEP	FiO2

☐ CPAP ☐ BIPAP How long:	Venti mask/liters	NC/liters

Tracheostomy ☐ Yes ☐ No	Date inserted	Decannulation trial

Duration of spontaneous breathing trail (include device used, e.g. T-Bar, Oxygen)

Clinical status:	**If no, provide reason:**	
CXR stable/improving	☐ Yes ☐ No	____________________
Telemetry/cardiac rhythm	☐ Yes ☐ No	____________________
Neurologically stable past 24 hours	☐ Yes ☐ No	____________________
Continuous sedation or paralytic agent infusions	☐ Yes ☐ No ☐ N/A	____________________
NYHA Class < IV (include ejection fraction)	☐ Yes ☐ No ☐ N/A	____________________
Spontaneous breathing trail	☐ Yes ☐ No ☐ N/A	____________________

Respiratory therapies

Chest physiotherapy Frequency:	**Nebulizer treatments** Frequency:
Oxygen adjustments (based on oximetry) Frequency:	**Suctioning** Frequency:

Most current:	Hct	Hgb	Date	Stable ☐ Yes ☐ No	Blood products ☐ Yes ☐ No

Other pertinent lab results

Invasive lines

IV medication name (1)	Dose	Frequency	Ending date
IV medication name (2)	Dose	Frequency	Ending date
IV medication name (3)	Dose	Frequency	Ending date

Diet

Type: ☐ NPO ☐ TF ☐ TPN ☐ Oral	Amount of feeding	Duration

For TF – Formula: ______________________________ / Route: ☐ NG ☐ PEG ☐ J Tube ☐ Dobhoff / Corpak®

Diet

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Physical therapy

Prior level of function (include self-care)

Rehabilitation therapy: ☐ Yes ☐ No | Modality: ☐ PT ☐ OT ☐ SLP | Therapy tolerance: ☐ 1-3 hrs/day x 5 days/week

Bed mobility: ☐ Total assist ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind

Transfers: ☐ Total assist ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind

Ambulation distance | Ambulation device(s)

Ambulation assistance: ☐ Total assist ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind

Stairs: ☐ N/A #Stairs _______ ☐ Total assist ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind Device: ___________________

Occupational therapy

Bathing (upper body):	☐ Total assist	☐ Max	☐ Mod	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Bathing (lower body):	☐ Total assist	☐ Max	☐ Mod	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Dressing (upper body):	☐ Total assist	☐ Max	☐ Mod	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Dressing (lower body):	☐ Total assist	☐ Max	☐ Mod	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Toileting/Hygiene:	☐ Total assist	☐ Max	☐ Mod	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
ADL/Toileting transfers:	☐ Total assist	☐ Max	☐ Mod	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind

Speech therapy

☐ None ☐ Dysphagia evaluation | Modified barium swallow result

Risk/recommendations

Overall focus – goal of therapy

Care management

Blue Cross and BCN offer care management assistance for discharge planning.
Would you like a referral made to our Care Management department? ☐ Yes ☐ No

Discharge plans (Must be filled out on initial request)

Discharge date (tentative/actual) | Assistive devices | Resides: ☐ Alone ☐ w/Spouse ☐ w/Other

Name of support and phone number

	Name	Phone number		Name	Phone number
☐ Spouse	______________	______________	☐ Family/friend	______________	______________
☐ Child	______________	______________	☐ Home health care	______________	______________
☐ Child	______________	______________	☐ Other	______________	______________

Home description (levels, bed/bath location, steps to enter, etc.)

Discharge to home: ☐ Yes ☐ No | Alternative level of care: ☐ Rehab ☐ Adult foster home ☐ Assisted living ☐ Long term center ☐ Skilled nursing facility ☐ Other: ___________________

Additional pertinent information