Blue Cross Blue Shield Blue Care Network of Michigan

SNF/acute IPR assessment form

For Blue Cross commercial and Blue Care Network commercial
For Michigan and non-Michigan SNF/acute IPR providers

Instructions

For admissions and concurrent reviews for skilled nursing and acute inpatient rehabilitation facilities in Michigan. Complete the form and attach it to the request in the e-referral system. After the14th extension request or anytime the e-referral system is not available, fax your requests to the numbers shown below.

For non-Michigan SNFs and acute IPRs. Fax the completed 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.

IMPORTANT: Incomplete submissions or missing clinical documentation may cause delays or nonapprovals.

- For all SNF and IPR requests, also attach the hospital admission H&P, PM&R consultation and most recent PT/OT notes.
- For SNF requests for Blue Cross and Blue Shield Federal Employee Program® members, include a completed **Consent for Case Management form**, signed by the member.

Note for discharge planning:

- For BCN commercial members: For DME and P&O, contact Northwood, Inc., at 1-800-393-6432. For diabetes supplies, contact J&B Medical Supply at 1-888-896-6233.
- For Blue Cross commercial members: For information about DME and diabetes supplies, contact Provider Inquiry at 1-800-249-5103 to determine benefits.

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.

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

- You've verified the member's eligibility and benefits for skilled nursing facility and inpatient rehabilitation services 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 SNF/IPR admission or is from the last covered day.
- The member is cognitively capable and is able to actively and willingly participate in therapy.
- For SNF services, the member is receiving at least 1 hour of therapy 5 days a week.
- For IPR services, the member is receiving at least 3 hours of therapy, 5 days a week, and is able to sit for 1 hour a 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

SNF / IPR information			
Facility name		Facility NPI	Facility type: SNF / Acute inpatient rehabilitation
Name of contact person at SNF/IPR	Phone number of contact person at SNF/IPR	Fax number of contact person at SNF/IPR	
SNF/IPR street address	SNF/IPR city	SNF/IPR state	SNF/IPR ZIP code
Participates with local Blue plan: Yes No	SNF/IPR admission date	Admitting diagnosis with ICD-10 code	
Attending physician name		Attending physician phone (for non-Michigan facilities only)	
Attending physician address (for non-Michigan facilities only)			

Patient information			
Patient name	Patient date of birth	Contract number	Patient phone number

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Complications

Medical history

Name of surgical procedure	Date of surgical procedure

Admission information

Height	Weight	Estimated length of stay	Prior level of function (home)

Cognition

Cognition – A&O: x__________ or **Other:**

Vital signs

Vital signs: T P R BP

Diet

Type: NPO TPN Tube feeding

Calories / day: _________________ CCs / day: __________________

Bowel / bladder

Bowel: Continent Incontinent

Bladder: Continent Incontinent

Catheter: No Yes: Type:

Ostomy: No Yes

Post-op complications of ostomy: No Yes

Oxygen delivery

Delivery mechanism: None Type: Flow rate: Saturation:

Vent: No Yes: Saturation: Vent settings:

Suction per 24 hours

No **Yes:** **Frequency:**

Respiratory treatment

No **Yes:** **Frequency:** **Type:**

Tracheostomy

No **Yes:** **Type:**

Pain

Pain: No Yes: Location:

Medication: No Yes: Drug: Route: Dose: Frequency:

Pain scale: Before management: After management:

Significant medication changes at reassessment that affect functioning

List the changes:

IV medications

IV / PICC line: No Yes: Complete the medication information below:

Medication name	Dose	Frequency	Start date	End date

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Skin status

Skin is intact **Skin is not intact:** Complete the fields below:

#1 wound or incision: No Yes: Size L x W x D (cm):

Location and stage: Treatment (type, frequency):

#2 wound or incision: No Yes: Size L x W x D (cm):

Location and stage: Treatment (type, frequency):

Mobility: current functioning

PT / OT — Date of notes: **Focus goal:**

Bed mobility/assist needed	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind
Transfers	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind
Gait / assist needed	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind

Gait / distance **Gait / assistive device** None Type:

Stairs: Current number of stairs patient can climb: Number of stairs in home:

Stairs / assist needed	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind

Comments:

Self-care: current functioning

Occupational therapy – focus goal:

Bathing / UE	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind
Bathing / LE	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind
Dressing / UE	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind
Dressing / LE	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind
Toileting / hygiene management	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind
ADL transfers	Total assist	Max assist	Mod assist	Min assist	CGA	SBA	Mod ind	Ind

Speech therapy: current status

No speech therapy needed **Dysphagia evaluation / modified barium swallow assessment needed**

Result / aspiration risk / recommendations:

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 initiated at admission)

Note: Submit discharge summary once member has been discharged from the facility.

Discharge date (tentative): **Discharge goal:**

Discharge location: Assisted living Long-term care Foster care Home alone Home with HHC Home with family support Other:

Name of support and phone number

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

Home evaluation date:

Home – number of levels: 1 level 2 levels 3 levels Other:

Home – number of steps: At entry: At bed / bath:

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Lives with:
Supervision needs at discharge:
Equipment needs at discharge:
Discharge barriers:

Additional notes

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of Michigan

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