Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

LTACH assessment form

For Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠

For Michigan and non-Michigan LTACH providers

Important! Before completing this form, verify that the member's Blue Cross Blue Shield of Michigan or Blue Care Network benefits are active and that the proposed services and the desired number of inpatient days are available based on the level of care.

Instructions

Complete this form and submit it along with the supporting clinical documentation when requesting prior authorization for admissions to and extensions of stays at long-term acute care hospitals, or LTACHs.

What to submit

Submit 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).

How to submit

- **For LTACHs in Michigan**. Complete this form and attach it along with the supporting clinical documentation to the request in the e-referral system. After the fourteenth extension request or anytime the e-referral system is not available, fax your requests to the numbers shown below.
- **For non-Michigan LTACHs that have access to Availity®.** You can fax these requests to the numbers below or submit them using the e-referral system, which you can access through Availity as follows:
  1. Log in to Availity.
  2. Enter the member's contract number from their ID card. Be sure to include the alpha prefix. Availity will determine the member's plan and take you to the Pre-Service Review for Out-of-Area and Local Members screen.
  3. Click *e-referral*, under the Authorization Vendors heading
- **For non-Michigan LTACHs that don't have access to Availity.** Fax the completed form along with the supporting clinical documentation 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.
  - Medicare Plus Blue and BCN Advantage: Fax to 1-866-796-3713.

Important information

- 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.

  Note: This requirement applies only to Blue Cross commercial and BCN commercial requests, for members who aren't on ventilators. It doesn't apply to Medicare Plus Blue and BCN Advantage requests.
- If non-emergency air ambulance transport is needed, prior authorization is required. To request prior authorization, follow the instructions in the document titled **Non-emergency air ambulance prior authorization program: Overview for Michigan and non-Michigan providers**. 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.)

Information about the LTACH where member is being admitted			
LTACH facility name		LTACH NPI	
Last name of contact person at LTACH		First 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 (mm/dd/yyyy)	Admitting diagnosis with ICD-10 code	
Attending physician name		Attending physician phone	

Information about the transferring facility (as applicable)	
Facility name:	Facility NPI:

Acute care hospital contact information	
Last name of contact person at acute care hospital	First 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 last name		Patient first name	
Patient DOB (mm/dd/yyyy)	Patient phone number	9-digit subscriber ID (No alpha prefix)	3-character alpha prefix

Three SNFs that did not accept (Complete only for Blue Cross commercial and BCN commercial 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 (mm/dd/yyyy)	
2)					Date (mm/dd/yyyy)	
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) _____

Wound debridement ☐ No ☐ Yes: Date (mm/dd/yyyy) _____

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 (mm/dd/yyyy)
Vent rate	Setting	PEEP	FiO2

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

Tracheostomy ☐ Yes ☐ No	Date inserted (mm/dd/yyyy)	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 (mm/dd/yyyy)	Stable ☐ Yes ☐ No	Blood products ☐ Yes ☐ No

Other pertinent lab results

Invasive lines

IV medication name (1)	Dose	Frequency	Ending date (mm/dd/yyyy)
IV medication name (2)	Dose	Frequency	Ending date (mm/dd/yyyy)
IV medication name (3)	Dose	Frequency	Ending date (mm/dd/yyyy)

Diet

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

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

Diet

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 ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind

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

Ambulation distance	Ambulation device(s)

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

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

Occupational therapy

Bathing (upper body):	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Bathing (lower body):	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Dressing (upper body):	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Dressing (lower body):	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Toileting/Hygiene:	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
ADL/Toileting transfers:	☐ Total assist	☐ Max	☐ 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 (tentative/actual) date (mm/dd/yyyy)

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 ☐ Assisted living ☐ Skilled nursing facility ☐ Adult foster home ☐ Long term center ☐ Other: _____

Additional pertinent information

Availity is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.