THE OHIO STATE UNIVERSITY
HEALTH PLAN

# CONTINUED STAY FOR SNF, ECF OR LTACH AUTHORIZATION FORM



**Instructions:** Please print all requested information and submit this form to OSU Health Plan via email at**:** **UtilizationManagement.OSUHealthPlan@osumc.edu** or fax to: **614-292-2667.** Contact your OSU Health Plan UM Case Manager at 614-292-4700 should you have questions or require assistance in completing the entire form.

**PATIENT INFORMATION:** PRINT all information requested below

First Name_____Last Name_____DOB____/____/____
Insurance ID #_____Diagnosis_____ICD-10_____; _____

Admission Date_____Review Date_____Current Auth.#_____

**FACILITY INFORMATION:** PRINT all information requested below:

Facility Name_____Phone (_____)_____-_____
Contact Name_____Phone (_____)_____-_____ext._____
Fax Number (_____)_____-_____Email Address_____

**CLINICAL REPORT:** PLEASE ATTACH INITIAL PT, OT, AND SLP EVALUATIONS WITH **FIRST** CONTINUED STAY REVIEW. INCLUDE CURRENT LIST OF MEDICATIONS, INCLUDING ANY IV/IM MEDICATIONS, A LIST OF TREATMENTS, AND PHYSICIAN PROGRESS NOTES WITH **EACH** UPDATE.

Height_____Current weight_____Vital signs_____

Code status_____Health Care POA Name_____Phone_____

NUTRITION: PO diet_____Tube feeds via_____Formula/Amt _____

___Bolus___times per day OR via pump_____hours per day. TPN____ hours per day_____

RESPIRATORY: Pulse ox readings_____Oxygen via_____@_____liters/min CPAP BIPAP Trach-

size_____type_____Suction frequency/amounts_____

Ventilator settings:_____Weaning plan/progress_____

_____

DIABETES MANAGEMENT (IFAPPLICABLE) Blood sugar range_____Frequency of BGM_____

Is patient independent in BGM?_____Teaching needed?_____

WOUNDS/PRESSURE ULCERS: PLEASE ATTACH INITIAL ASSESSMENT, MEASUREMENTS, CURRENT TREATMENT / PREVENTION PLANS.

HEMODIALYSIS: Facility name_____Location_____Days_____

Venous access via AV fistula_____Port_____PERITONEAL DIALYSIS_____Frequency_____

Was patient seen in Hospital ED or hospitalized since last clinicalreport? No___Yes___If yes, please explain_____

_____

Any falls or injuries since lastclinical report?_____

Physician appointments since last report?_____

Upcoming appointments?_____

****PLEASE NOTE: OSU HEALTH PLAN REQUIRES PRIOR AUTHORIZATION AND USE OF OUR IN NETWORK AMBULANCE PROVIDERS IF THE HEALTH PLAN WILL BE REIMBURSING FOR AMBULANCE OR WHEELCHAIR TRANSPORTING SERVICE.**

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**PHYSICAL THERAPY-Fill out form even if evaluations are attached.**

Please indicate the level of function: **I**=Independent; **MI**=Modified Independent; **D**=Dependent; **Min**=Min. Assist; **Mod**=Mod. Assist; **Max**=Max Assist; **Total**=Total Assist; **CGA**=Contact Guard Assist; **S**=Supervision.

| Function | PLOF | Goal | Initial evaluation date _____ | Date | Date |
|---|---|---|---|---|---|
| Bed Mobility | | | | | |
| Transfers | | | | | |
| Ambulation | | | | | |
| Distance | | | | | |
| Assistive Device | | | | | |
| Stairs | | | | | |
| ROM-UE<br>ROM-LE | | | | | |
| Wt. Bearing | | | | | |
| Strength | | | | | |
| Balance | | | | | |
| Endurance | | | | | |

Has patient refused to participate in therapy since last clinical update? Yes No

COMMENTS_____

_____

Current amount of therapy_____minutes/day &_____times/week.

# CONTINUED STAY FOR SNF, ECF OR LTACH AUTHORIZATION FORM



**OCCUPATIONAL THERAPY-Fill out form even if evaluations are attached.**

Please indicate the level of function: **I**=Independent; **MI**=Modified Independent; **D**=Dependent; **Min**=Min. Assist; **Mod**=Mod. Assist; **Max**=Max Assist; **Total**=Total Assist; **CGA**=Contact Guard Assist; **S**=Supervision.

| Function | PLOF | Goal | Initial evaluation date _____ | Date | Date |
|---|---|---|---|---|---|
| Grooming | | | | | |
| UB-Bathing | | | | | |
| UB-Dressing | | | | | |
| Toileting transfer | | | | | |
| Toileting hygiene | | | | | |
| Homemaking skills | | | | | |
| Strength-upper body | | | | | |
| Balance | | | | | |
| Endurance | | | | | |

Has patient refused to participate in therapy since last clinical update? Yes No

Comments_____

_____

_____

_____

_____

Current amount of therapy_____minutes/day &_____times/week.

**SPEECH THERAPY-Fill out form even if evaluations are attached.**

| Function | PLOF | Goal | Initial evaluation date _____ | Date | Date |
|---|---|---|---|---|---|
| Dysphagia/ Swallowing | | | | | |
| Diet restrictions | | | | | |
| Articulation | | | | | |
| Aphasia | | | | | |
| Dysphasia | | | | | |
| Cognitive abilities | | | | | |
| Memory | | | | | |
| Problem solving | | | | | |
| Safety Awareness | | | | | |

Has patient refused to participate in therapy since last clinical update? Yes No

Was MBS evaluation done? ___Yes ___No

Date_____Results_____

_____

Comments_____

_____

_____

Current amount of therapy_____minutes/day &_____times/week

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# CONTINUED STAY FOR SNF, ECF OR LTACH AUTHORIZATION FORM



**DISCHARGE PLANNING/TRANSITION OF CARE-**Standards of care require discharge planning from the day of admission. Please complete this form and submit with the initial continued stay request. If there are changes or updates during the course of care, include the information with each subsequent report. Indicate no changes/date at the bottom of the page.

Facility Discharge Planner name_____Title_____

Direct phone number (_____)_____-_____Email address _____

Date/time of care conference(s)_____

**Anticipated discharge date**_____DC to_____own home_____other address _____

_____Phone_____

If planning transition to another facility, please list type/address/phone_____

_____

Does patient live alone?_____Is patient competent to make decisions?_____

Behavior concerns_____

Financial concerns_____

Caregiver(s) Name(s)_____Phone_____Relationship_____
Name(s)_____Phone_____Relationship_____
Name(s)_____Phone_____Relationship_____

Home environment: Is therapy planning a home assessment? If yes-date/time_____

Type of home___single level___multilevel; Steps to enter_____Steps in home_____Ramp(s) needed?_____

Bed/Bath on what level_____Barriers/Concerns_____

Community Referrals: Home delivered meals; Home health aide; Homemaker; ERS; Transportation; Adult protective services. Please list type, name and phonenumbers _____

_____

Is patient a Veteran?_____Services_____

Home Care: RN PT OT SLP MSW (**CIRCLE ALL THAT APPLY**) ****Please note Home health aide is not a covered benefit under the Health Plan. In network home care providers must be used. A current list can be found on our website** https://osuhealthplan.com/find-a-provider-search/#. **or by calling customer service at 614-292-4700.**

Agency name_____Phone_____

DME ordered_____

_____

DME Company Name_____Phone_____

****Must be an in network DME provider and prior authorization is not required for medically necessary items costing less than $2,000.**

Comments_____

_____

No change/Date_____No change/Date_____No change/Date_____No change/Date_____No change/Date_____

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Please note: The turnaround time for OSUHP authorization process is one business day.

Patient Name_____

Authorization # _____

**TO BE COMPLETED BY OSU HEALTH PLAN**

Level of Care: ☐ ECF/SNF 1 ☐ SNF 2 ☐ SNF 3 ☐ SNF 4 ☐ LTAC

☐ Approved for dates_____ Next Review Date _____

☐ Denied – Reason _____

Comments _____

_____

_____

_____

_____

Case Manager Name_____,RN Telephone Number (614) _____

Email Address _____