Medicare Skilled Nursing Facility Inpatient Review

These guidelines are based on the Medicare Benefit Policy Manual

Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance

(Rev. 261, Issued: 10-04-19)

The Medicare Benefit Policy Manual can be found here.

****Please complete all areas of this survey and fax to 1-800-416-9195.**

Ensure you complete all sections of this form as appropriate:

- Section 1 – Demographic Information
- Section 2 – Prior Level of Function
- Section 3 – Clinical Review
- Section 4 – Physical Therapy
- Section 5 – Occupational Therapy
- Section 6 – Speech Therapy
- Section 7 – Discharge Plan
- Section 8 – Protected Health Information

Date Form Completed	Admit Date to Post Acute Facility	Anticipated Discharge Date and Discharge Plan From Post-Acute Facility

SECTION 1 – DEMOGRAPHIC INFORMATION

Demographic information	Responses
Member Name	
DOB:	
Member ID#	
Reference/case number	
SNF Facility name	
Facility NPI	
Facility address, city, state, zip	
Contact name/department	
Contact phone number and fax number	
Accepting MD name and NPI	
MD phone number	
MD address, city, state, zip	

Transfer Information	Responses
Transfer from (Current setting)	
What was the date of admission in the acute care?	
Is the date of injury or illness within the last 30 days of this request?	O Yes O No
Reason for Hospital Admission	
Name/phone # of contact at transferring facility	
Diagnosis for post-acute admission (include ICD code)	
Reason for skilled stay (Does the medical complexity require frequent medical assessment, intense monitoring with a potential for rapid deterioration or debility that makes care at home unsafe?)	O Frequent Medical Assessment O Intense Monitoring with potential for rapid deterioration or debility O Home unsafe O Other: _____
****Can the member tolerate one hour of therapy 5 days a week with full participation?**	O Yes O No
Relevant Chronic or co-morbid conditions	

SECTION 2 – PRIOR LEVEL OF FUNCTION

This section for Prior Level of Function (PLOF) only.

Question:	Answer:
Does the member ambulate	O Yes O No
Does the member have gait limitations	O Yes O No Specify Limitation and Assistance Required: _____
Does patient use wheelchair	O Yes O No
Transfer level of assistance	O Independent O Modified Independence O Supervision O Contact Guard Assist O Minimal Assistance O Moderate Assistance O Maximum Assistance O Total Assistance/Dependent
Assistance with activities of daily living	O Independent O Modified Independence O Supervision O Contact Guard Assist O Minimal Assistance O Moderate Assistance O Maximum Assistance O Total Assistance/Dependent
Does member have DME at home?	O Yes O No Specify: _____
Community or other resources already in place: (meals on wheels, HHC, caregivers, etc.)	O Meals on Wheels O HCC O Caregivers O Other: _____
Baseline mental status	

Question:	Answer:
Does the member have any cognitive issues such as communication difficulty, memory deficits, perception or processing deficits?	O Yes O No Specify: _____
Does the member have any physical inability or limitations such as wound location unreachable, contractures, obesity, motor strength, comorbidity such as blindness or paralysis?	O Yes O No Specify: _____
Is the home environment not conducive to care such as no running water, no phone, no temperature control, no elevator, no access to home care agency or outpatient services, any physical or emotional abuse at home	O Yes O No Specify: _____
Home oxygen	O Yes O No Specify: _____

Home set up	Responses
# Steps to enter home:	
Stair Rails	O Yes O No Specify: _____
Bed on first or second floor	O 1st O 2nd
Bath on first or second floor	O 1st O 2nd
Availability for first floor setup	O Yes O No
Who does the member live with currently:	O Home Alone O Personal Care Home O Caregiver/Family/Significant Other O Assisted Living Facility O Long Term Residential Care O Other: _____

SECTION 3 – CLINICAL REVIEW

Clinical reviews must be submitted within 48 hours of Requested Admit Date

Question:	Answer:
Date	
Vitals	
Mental status - Able to follow commands?	O Yes O No
Abnormal Labs (if being monitored or treated):	O Yes O No Specify: _____
Will member receive IV medications: If yes name, frequency and stop date.	O Yes O No Name: _____ Frequency: _____ Stop Date: _____
Respiratory: include o2 flow, teaching needs, O2 sats, nebulizers and how often, trach (date placed, size, suctioning frequency) What is the goal: decannulation, home with trach, home oxygen, wean off oxygen, home nebs.	O Yes O No Specify: _____ Goal: _____
Oral diet: (yes/no) if yes, type	O Yes O No Type: _____
NG/Peg: (include date placed, what feeds receiving, rate, goal rate, are they tolerating)	O Yes O No Specify: _____
TPN: (yes/no) if yes stop date, rate, were they on TPN at home	O Yes O No Specify: _____
Wounds/treatment: (include stage, treatment, measurements, frequency dressing, appointment with wound specialist.)	O Yes O No Specify: _____

SECTION 4 - PHYSICAL THERAPY

Clinical reviews must be submitted within 48 hours of Requested Admit Date

Member is participating: O Yes O No

	As of Date:	Independent:	Modified Independent:	Supervision:	Contact Guard Assistance:	Minimal Assistance:	Moderate Assistance:	Maximum Assistance:	Dependent:
Bed Mobility									
Rolling Side to Side									
Supine to Sit									
Sit to Stand									
Bed to Chair									
Sitting balance static/dynamic									
Standing balance static/dynamic									
Steps with number of steps included									
Gait assistance									
Gait distance in steps/feet									
Assistive device used									

	As of Date:	Independent:	Modified Independent:	Supervision:	Contact Guard Assistance:	Minimal Assistance:	Moderate Assistance:	Maximum Assistance:	Dependent:
Wheelchair assistance									
Wheelchair distance									
Endurance									
Strength									
PT Goal: Short term and long term:									

SECTION 5 - OCCUPATIONAL THERAPY

Clinical reviews must be submitted within 48 hours of Requested Admit Date

Member is participating: O Yes O No

As of date:	As of Date	independent	modified independent	supervision	contact guard assistance	minimal assistance	moderate assistance	maximum assistance	dependent
feeding									
grooming									
Bathing UE									
Bathing LE									
Dressing UE									
Dressing LE									
Toileting/ hygiene									
Toilet/ functional transfer									
Household management									
OT Goals: Short term and long term:									

SECTION 6 - SPEECH THERAPY

Clinical reviews must be submitted within 48 hours of Requested Admit Date

Member is participating: O Yes O No

Questions:	Responses:
As of date:	
Cognition: (alert and oriented, can member follow commands)	O Alert O Oriented O Able to follow Commands
Language deficit: (yes/no) can they express needs	O Yes O No Specify: _____
Memory deficits:	O Yes O No
Safety judgement/problem solving: (are they impulsive, require a sitter)	O Yes O No Specify: _____
Swallowing deficits: (yes/no)	O Yes O No
What type of diet/liquids?	
ST Goals: Short term and long term:	Short Term Goals: _____ Long Term Goals: _____

SECTION 7 - DISCHARGE PLAN

Question:	Response:
Has Caregiver Training been completed? Any barriers to Caregiver Training?	O Yes O No Specify: _____
Anticipated disposition: (home alone, home with caregiver/family/significant other, personal care home, assisted living facility, long term residential care)	O Home Alone O Personal Care Home O Home with Caregiver/Family/Significant Other O Assisted Living Facility O Long Term Residential Care O Other: _____
Caregiver available to assist: include hours available to assist, If the answer is no, please specify.	O Yes O No Hours Available for Assistance: _____ Specify: _____
Are there any social determinates: (social connections, transportation needs, safety, financial resource strain, health literacy, housing stability, food insecurity)	O Social Connections O Safety O Transportation Needs O Financial Resource Strain O Health Literacy O Housing Stability O Food Insecurity
DME needs:	O Yes O No Specify: _____
Is a home evaluation planned/needed prior to discharge:	O Yes O No
Will the member require home health care, outpt. therapy, other -please explain:	O Yes O No Specify: _____

Question:	Response:
Community resources needed: (if yes, what)	O Yes O No Specify: _____
Next MD appointment:	
Any additional pertinent information or other discharge barriers:	

SECTION 8 – PROTECTED HEALTH INFORMATION

These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call the facility phone number listed in the demographic area above.

Providers. You are required to return, destroy, or further protect any PHI you received pertaining to a patient that you are not currently treating. You are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.