SKILLED COVERAGE CHECKLIST

I have confirmed that there are needs for daily skilled nursing care or therapy that requires a licensed therapist or nurse that cannot be administered at a lower level of care.*	☐ **Yes** ☐ **No**

REFERRING CASE MANAGER

Name: _____

Phone number: _____

Fax number: _____

Case manager signature and date: _____

***This must be "Yes" to move forward with the fast pass process. If "No", attach detailed clinical documentation to support medical necessity for the request.**

FAX REQUEST TO HEALTH ALLIANCE AT (217) 902-9712.
ONE REQUEST PER FAX.

MEMBER DETAILS (complete all fields)

Member name: _____

Member number and DOB: _____

SKILLED NURSING FACILITY DETAILS

Accepting facility: _____

Contact person: _____

Phone number: _____ Fax number: _____

DISCHARGE PLANNING

Is the member/family agreeable to skilled nursing facility admission?

_____

What is the alternate discharge plan in the event SNF admission is denied?

_____

_____

One or more of the following sections must have all items in a given qualifying level of care applicable for the member's needs marked "yes" to be approved. If the criteria cannot be met, attach detailed clinical documentation to support medical necessity for the request.

SKILLED THERAPY - notes must be CURRENT/NO OLDER THAN 24 HOURS	
Can the member medically tolerate daily skilled therapy?	☐ Yes ☐ No
Does the member have the cognitive ability to participate in a skilled therapy program?	☐ Yes ☐ No
Does the member have the motivation to participate with a therapy program with no refusals?	☐ Yes ☐ No
Is the member's current level of function significantly different from their prior level of function?	☐ Yes ☐ No
Is the member unable to ambulate greater than 40 feet (if this was not the baseline level of function)?	☐ Yes ☐ No
Does the member require at least minimal, moderate or maximum assist to complete sit to stand and/or transfer from surface to surface?	☐ Yes ☐ No

COMPLEX WOUND CARE	
Does the wound require a complex dressing change (medicated dressings/packing/etc.) MORE OFTEN than once per day?	☐ Yes ☐ No
Is the wound being treated WITHOUT the use of a wound vac?	☐ Yes ☐ No

INTRAVENOUS THERAPY	
Is the IV therapy scheduled MORE OFTEN than once in a 24-hour period?	☐ Yes ☐ No
Will the IV therapy be administered WITHOUT the use of a CADD pump at the extended care facility?	☐ Yes ☐ No

NEW OSTOMY, G-TUBE, TRACH	
Does the member have a new ostomy/g-tube or trach?	☐ Yes ☐ No
Is there training needed for the member/caregiver for care of the new ostomy?	☐ Yes ☐ No

PROGNOSIS/TREATMENT OPTIONS/CHOICES	
Does the member have an expectation of material improvement in overall condition WITHOUT a plan for palliative care or Hospice services?	☐ Yes ☐ No