**INPATIENT REHABILITATION**

**Initial Request**

**Required Service Authorization Information**

1. Provider contact name:
2. Provider contact number:
3. Out of state providers, located close to the proximity of the VA State line and who are enrolled with Virginia Medicaid as a provider class type 085 (Out of State Rehab Hospital) need to determine and document evidence that one of the following items are met at the time the service authorization request is submitted to the service authorization contractor:

 Services provided out of state for circumstances other than these specified reasons shall not be covered.

A. The medical services must be needed because of a medical emergency;

B. Medical services must be needed and the member's health would be endangered if he were required to travel to his state of residence;

C. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

D. It is the general practice for members in a particular locality to use medical resources in another state.

See the applicable provider class instructions above when requesting one of these services.

Services provided out of state for circumstances other than these specified reasons shall not be covered. Please refer to 12VAC30-10-120 and 42 CFR 431.52**.**

1. Is this a pre-admission (pre-auth) review (patient has not arrived at your facility) or an admission review (patient is already in your facility) or a retro review (the member has retro eligibility):
2. Patient diagnosis :
3. Date of injury/illness/surgery/exacerbation: Include admit date to acute care (if greater than 30 days from admission to rehab facility please provide the date of change in plan of care, treatment, exacerbation within the last 30 days and describe):
4. Please list baseline level of function AND new impairments with functional activity limitation and the level of assistance needed for each impairment (provide FIM scores, if available):

8. Has patient been medically stable for at least 24 hours prior to rehab admission: yes/no

 A. For pediatric patients please note:

Vital signs stable for last 24 hours: yes/no

Neurological stability last 24 hours: yes/no

No active bleeding and laboratory values stable for last 24 hours: yes/no

1. Can the patient sit supported for at least one hour per day: yes / no (If no, please describe limitations.)
2. Can the patient follow verbal/visual commands: yes / no. If no, please describe limitations:
3. Does the patient have the desire or ability to actively participate in therapy: yes/no:
4. Is the patient able to tolerate a comprehensive rehab program of at least 3 hours/day, 5 days/week of therapy: yes/no AND Will this amount of therapy be provided: yes/no
5. Was the patient active in the home and community prior to admission: yes/no
6. Is/Was the patient fully participating in therapy prior to transfer to rehab facility: yes/no
7. Does the patient have potential to benefit from intensive rehabilitation: yes/no
8. Please list the therapies that will be provided:
9. Can This Service Be Provided At a Lower Level of Care: Yes / No
10. Does the patient need the following AND will these be provided in the rehab facility:
11. Medical practitioner assessment at least 3 times/week: yes/no.
12. Specialized therapeutic skills or equipment: yes/no; and
13. Rehab nursing services available 24 hours/day: yes/no
14. Please Describe Any Other Pertinent Information Related To This Service Authorization Request or expand on any of the above questions:
15. Is/Was the Preadmission Assessment completed by a licensed/certified clinician and does the rehab practitioner agree with the findings: yes/no.

**If this is a preadmission request stop here; if this is an admission/retro request continue with # 21.**

1. Was there an evaluation with full rehab team participation and plan of care documented within 72 hours with therapeutic interventions initiated: yes/no
2. Please document Plan of Care to include time limited goals, expectations and input from the patient and/or family whenever possible, projected functional outcomes, and an expected discharge plan, inclusive of a discharge destination.
3. Please note treatment goals :
4. Please note the medical and/or psychosocial management that will be provided: (example...medications, nutrition, wound/skin care, etc.)
5. Has discharge planning been initiated: yes/no. What discharge needs have been identified at this time?
6. Was the Post admission evaluation completed by the rehab medical practitioner within 24 hours: yes/no