



Post-Acute Facility Continued Stay Review Form
For PACE Program Members ONLY

For Family Care (LTC) members call 1-866-937-2783 and ask to speak to the member's Interdisciplinary Team Staff (IDTS) about authorization requirements. CCI UM does not review or authorize any services for the LTC program.

Please complete this form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, phone: 262-207-9393, please call UM with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	DOB:	Medicare #:
		Medicaid #:
Provider Name/Clinic:		
Tax ID:	NPI #:	
Clinical Review:	Phone Number:	Fax Number:
Contact/Title:		
DATE OF REVIEW:		

Skilled Nursing Services: Frequency: _____ Detailed, current notes regarding the services: -Ventilator Settings and RT notes -Wound Care Notes (Dimension, Treatment Orders -IV Antibiotic Information (Dose, Frequency, Stop Date)	Update Enter Here:
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Physical Therapy: Frequency:					
Transfers:	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other _____
Ambulation: _____ (feet using device) _____	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other _____
Gait (describe):			Balance (describe):		
Stairs: <input type="checkbox"/> Yes <input type="checkbox"/> NO _____ # of stairs					

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Occupational Therapy: Frequency: _____					
ADL's Upper Body	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other_____
ADL's Lower Body	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other_____
Toileting:	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other_____
Bed Mobility:	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other_____

Speech Therapy:	
Frequency:	Diet:
Progress:	

SNF Medicare A Discharge Plan:	
Projected SNF MED A discharge/LCD date:	Barriers to discharge:
Weekly Update/Progress towards established plan of care goals:	

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