Exhibit 12

Physical Rehabilitation Review Worksheet
For
Pre–service Review

Providers are required to submit review requests via the Qualis Health web-based review system, iEXCHANGE. Please see section 8 of this manual for additional information

Initial Call Date: _____ Caller's Name: _____ Phone: _____

Planned Rehabilitation Admission Date: _____

Patient's Name: _____

Patient's Address: _____

_____

Birth Date: _____ Sex: _____

Medicaid ID Number: _____

Rehabilitation Facility: _____ Location: _____

Current Physician Name: _____ Physician ID #: _____ Phone #_____

Proposed Rehabilitation Physician: _____ Physician ID #: _____ Phone #_____

Phone: _____ Address: _____ City_____ State____ Zip_____

ICD–9–CM Code(s): _____

and written description _____

_____

_____

_____

_____

Relevant Surgery Codes:

_____

Severity of Illness

What is the illness/injury/surgery or exacerbation that has occurred within the last 30 days?_____

_____

What is the mobility, ADL or respiratory impairment requiring at least minimum assistance? _____

Patient's Name: _____

Severity of Illness (continued)

Is the patient clinically stable within the last 24 hours? Please provide the temperature, heart rate, respiratory rate and BP from the last 24 hours. _____

_____

Is the patient able to tolerate the comprehensive rehabilitation program of 3 hours/day or longer of skilled therapy for 5 days or greater a week? _____

_____

Is the patient able to follow visual/verbal commands?_____

_____

Does the patient desire and able to actively participate? _____

_____

Is the patient active in the community and home prior to admission with rehabilitation potential? _____

_____

Is the patient fully participating in the therapeutic evaluation and interventions prior to transfer? _____

_____

Is the admission a trial admission for 1 week or less? _____

_____

Is the prospective assessment completed by a rehabilitation professional? _____

_____

Is full participation/tolerance projected? _____

_____

What therapies are indicated? _____

_____

Is the treatment precluded in a lower level of care due to the clinical complexity? _____

Patient's Name: _____

Severity of Illness (continued)

Will the physician do an assessment/intervention 3 times/week or greater? _____

_____

Is there specialized therapeutic skills/equipment required? If so, please identify? _____

_____

Will the rehabilitation nursing services be available 24 hours/day? _____

_____

Intensity of Service

Will The Progressive Therapy Program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:_____

_____

_____ ADLs
_____ Bed mobility/Transfers
_____ Home Lifestyle modifications
_____ Positioning/Splinting
_____ Pulmonary rehabilitation
_____ ROM/Strengthening
_____ Speech language retraining
_____ Swallowing retraining
_____ Wheelchair mobility/Ambulation/Balance

If this is an admission trial of 1 week or less, the program will provide:

_____At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy

_____Full participation in evaluation/therapy

_____Rehabilitation evaluations completed with in 2 days

Identify the new medical condition that decreases the patient's participation in therapy for less than 3 hours/day for up to 3 days. _____

What medical/psychosocial management is required for this patient? _____

_____

Patient's Name: _____

Program Coordination

What is the ongoing needs assessment/procurement? _____

_____

What instruction does the patient require? _____

_____

What is identified as discharge needs, barriers, patient support systems? _____

_____

_____

_____

_____

_____

_____

Disposition Planned:

1. If Goals Achieved: _____
2. If Goals Not Achieved: _____

Physiatrist's Plan of Care and Recommendation (if applicable):

_____

_____

_____

_____

_____

_____

_____

_____

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