Washington State Health Care Authority

Long Term Acute Care (LTAC) Authorization/Update Request

REFERENCE / AUTH NUMBER
TODAY'S DATE

☐ Proposed admit ☐ Admission info ☐ Extension request ☐ Readmission ☐ Notice of discharge

Please attach clinical documentation necessary to determine medical necessity. At discharge, forward discharge summary.

☐ Kindred ☐ Northern Idaho ☐ Regional ☐ Vibra	TELEPHONE NUMBER		FAX NUMBER
CLIENT NAME	PROVIDERONE ID	BIRTH DATE	MEDICARE EXHAUST DATE
DATE ADMITTED TO LTAC	LENGTH OF STAY REQUESTED FROM TO	ESTIMATED TOTAL LOS	LTAC CASE MANAGER

Anticipated discharge plan: ☐ Home ☐ SNF ☐ AFH ☐ Hospital ☐ Other:

LTAC-related diagnoses		
	ICD 9 Dx:	DESCRIPTION:
	ICD 9 Dx:	DESCRIPTION:
	ICD 9 Dx:	DESCRIPTION:
	ICD 9 Dx:	DESCRIPTION:

IDENTIFY THE QUALIFYING CONDITIONS BASED ON WAC CRITERIA (WAC 182.550.2570)

LEVEL I SERVICES:

Client requires eight (8) or more hours of direct skilled nursing care per day AND the client's medical needs cannot be met at a lower level of care due to clinical complexity. Level 1 services include one of the following:

☐ Ventilator weaning care, or

☐ Care for a client who has:

- Wounds that require on-site wound care specialty service and daily assessment and/or interventions; AND
- At least one comorbid condition (such as chronic renal failure requiring hemodialysis).

LEVEL II SERVICES:

Client requires four (4) or more hours of direct skilled nursing care per day AND the client's medical needs cannot be met at a lower level of care due to clinical complexity. Level 2 services include one of the following:

☐ Ventilator care for a client who is ventilator dependent and is not weanable, AND has complex medical needs; or

☐ Care for a client who:

- Has a tracheostomy;
- Requires frequent respiratory therapy services for complex airway management AND has the potential for decannulation; AND
- Has at least one comorbid condition (such as quadriplegia).

OTHER:

☐ **Client does not meet above WAC criteria. Provide clinical information to justify medical necessity of LTAC-level care.**

Ventilator patients	Discharge/Transfer Information
Currently on Vent: ☐ Yes ☐ No Last Day on Vent: Decannulated: ☐ Yes, date: ☐ No	Discharge Date: Disposition: **FAX THE DISCHARGE SUMMARY TO LTAC Program Manager**

Did you contact Home and Community Services (HCS) for assistance discharging this patient?

Name of DSHS Case Manager (Social Worker or Nurse), if known:

Is/was patient difficult-to-place? ☐ No ☐ Bariatric ☐ Behavioral ☐ High respiratory needs

☐ High medical needs ☐ Other, explain

Call the LTAC Program Manager at 360-725-5144 for general questions.
1-800-562-3022 for authorization questions

Fax: 1-866-668-1214 for prior authorization requests

A typed and completed *General Authorization for Information* form (13-835) must be the first page of your request.