Comagine Health

Alaska Inpatient Diagnosis-Related Group (DRG) Review Assessment

Created December 2023

Please complete all sections of this form.

PATIENT NAME (first & last):_____ MEDICAID ID: _____

DATE OF BIRTH: _____ *(mm/dd/yyyy)*

I affirm that the recipient's Medicaid eligibility has been confirmed. ◉

○ Yes

○ No (Per the Alaska Medicaid Provider Manual, page 17 & 19, providers are responsible for evaluating Medicaid eligibility and third-party liability prior to submitting review requests to Comagine Health. For questions regarding eligibility or other insurance coverage, log on to the HMS, a Gainwell Technologies company provider portal at www.medicaidalaska.com or call HMS at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

Was the admission being requested, for a work-related injury? ◉

○ Yes *If yes, we are unable to process this work-related review.* Please contact the patient's employer.

○ No

1. Could this member benefit from case management services? ◉
   - ○ Yes
   - ○ No

2. Which one of the following scenarios apply to the patient admission? *(Select at least one and all that apply.)*

Acute

- ___ Was the patient in an ICU, CCU, or IMCU?
- ___ Was the patient admitted for a stroke that is confirmed by imaging (CT or MRI)?
- ___ Did the patient have intracranial hemorrhage?
- ___ Did the patient require a mechanical ventilator or requiring active titration of BiPAP?
- ___ Did the patient require IV fluids to maintain blood pressure?
- ___ Did the patient require high flow oxygen of 10 or more liters? (Via high flow nasal cannula)
- ___ Did the patient require active management of an arrhythmia with titration of IV meds?
- ___ Did the patient admit with a respiratory diagnosis and require chest tube placement or active chest tube management?
- ___ Did the patient have ongoing transfusion requirements?
- ___ Did the patient have a post-surgical ileus?
- ___ Did the patient have SBO with NGT and ongoing wall suction?
- ___ Did the patient require PRN antipsychotics?
- ___ Did the patient require IV medications for pain control?
- ___ Does the patient require titration of IV diuretics?
- ___ Did the patient require IV antibiotics with pending blood cultures?
- ___ Did the patient have neutropenic fever?
- ___ Did the patient have a post-operative infection requiring IV antibiotics?

___ Did the patient have an acute infection with failed outpatient antibiotics?
___ Did the patient admit with alcohol withdrawal syndrome and a CIWA score greater than 8?
___ Did the patient require a 1:1 sitter for decompensated acute psychiatric condition?
___ Did the patient have ongoing delirium secondary to an acute decompensated medical problem?

Inpatient Physical Rehab (IPR)

___ Did the patient admit with a stroke in the last 7 days, the patient was in stable condition, able to participate 15 hours weekly with 2 or more therapy modalities and planned to attend IPR?
___ Did the patient admit with a new traumatic brain injury in the last 30 days, able to participate in 15 hours a week of therapy and planned to attend IPR?
___ Did the patient admit with a new amputation of a hand, arm, or leg in the last 30 days, able to participate in 15 hours a week of therapy and planned to attend IPR?
___ Did the patient admit with a new spinal cord injury in the last 30 days, able to participate in 15 hours a week of therapy and planned to attend IPR?
___ Did the patient admit with a new diagnosis of Guillain-Barre syndrome in the last 30 days, able to participate in 15 hours a week of therapy and planned to attend IPR?
___ Did the patient admit with a new critical care neuropathy or myelopathy in the last 30 days, able to participate in 15 hours a week of therapy and planned to attend IPR?

Neonate

___ Was the patient a neonate born at less than 38 weeks gestation at birth?
___ Was the patient a neonate born at or near term?

OB

___ Was the patient less than 38 weeks gestation with positive fern/loss of fluids or active bleeding?
___ Was the patient admitted for preterm labor, pre-eclampsia, HELP syndrome, or intrauterine growth retardation?
___ Did the patient have post-partum fever or hemorrhage?
___ Did the patient admit for induction or active labor and had a vaginal or cesarean section delivery?
___ Did the patient admit for induction or active labor with an anticipated delivery?

Surgical

___ Was the patient admitted for a planned surgery?

Transplants

___ Was the patient admitted for a planned transplant?

Trauma

___ Was the patient involved in a major trauma (Example: fall from greater than 20 feet, motor vehicle accident, ejection from a vehicle, motorcycle accident, or pedestrian/bicyclist vs motor vehicle collision) with an injury or severe polytrauma? For Example: head, organ, or major fracture(s)
___ Did the patient sustain at least a 2nd degree burn with a minimum of 5% body surface area (BSA) with active treatment (wound care, surgery planned or on a ventilator)?
___ Did the patient sustain frostbite with active treatment orders (wound care or surgery)?

Other

___ None of the above are applicable

3. Discharge date _____ (mm/dd/yyyy)

4. Discharge disposition (select only one)
   - ◯ Discharged to Adult Foster Home
   - ◯ Discharged to Correctional Facility
   - ◯ Discharged to Foster Care or Foster Treatment Home (FTH)
   - ◯ Discharged to Group Home
   - ◯ Discharged to Residential Treatment Facility
   - ◯ Discharged to Residential Treatment Home
   - ◯ Discharged to Secure Residential Treatment Facility
   - ◯ Expired
   - ◯ Home
   - ◯ Home with In-Home Care
   - ◯ Home with Outpatient Care
   - ◯ Left Against Medical Advice (AMA)
   - ◯ Transfer to Another Acute Care Hospital
   - ◯ Transfer to Chem Dep Program
   - ◯ Transfer to Inpatient (IP) Physical Rehab
   - ◯ Transfer to IP Psych
   - ◯ Transfer to Skilled Nursing Facility (SNF)
   - ◯ Unknown

AFFIRMATION

☐ I AFFIRM that the submitted clinical documentation supports the requested stay/service(s) and are medically necessary and consistent with the recipient's current level of impairment.

☐ I ACKNOWLEDGE the services are subject to post payment review of medical necessity and completeness of documentation according to Medicaid program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules.

☐ I ACKNOWLEDGE that approval of this authorization request does not guarantee payment.