SNF/HHA/CORF Discharge Summary Form Instructions

This form is used to issue a Detailed Explanation of Non-coverage (DENC), OMB Approval No.0938-0910. Click here to reference the SNF/HHA/CORF Discharge Summary Form.

Section I.

- Record member's name and CarePartners of Connecticut member ID.
- Record care manager's/externally managed care manager's (CM/DCM) name, phone, and fax.
- Record member's PCP name and the Medical Group/IPA number.
- Record the names of the facility or provider as well as their phone and name of the attending physician.

Section II.

Indicate the type of service the member is being discharged from by placing an X in the appropriate check box:

- Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF).
- Record the planned date of discharge from skilled services.
- Record the date that the Notice of Medicare Non-Coverage (NOMNC) was issued to the member/representative.
- Record the name of the person who received the NOMNC.

Section III.

Verify that all elements listed in this section are documented in the member's record. The member's record must support the decision to discharge. The decision to discharge must be based on the fact that the skilled level of care is no longer medically necessary, and the member is prepared for a discharge to the next level of care.

Facilities/providers should be instructed to send the entire medical record to:

KEPRO

Fax: 833.868.4055

Note: The Medicare regulation addressing coverage requirements for skilled nursing and/or skilled rehabilitation is (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 411.15(k), and 42 CFR 409.31-35)

Section IV. No abbreviations. Use full sentences and plain nonmedical language.

1. Record the date the member was admitted, where he/she came from and why they were admitted to the current level of care (i.e., the reason the member required a skilled level of care).
2. Record the member's prior level of function (e.g., personal care, ambulation, cognitive status, and living situation: where and with whom, home care/community support services, family assistance etc.) prior to admission.
3. Record by whom the member was evaluated, including nursing, physician/NP and all licensed therapies.
4. Record the detail of the member's skilled treatment plan, including the nursing plan of care and rehab therapy plan of care, frequency of visits and specific rehabilitation treatments.
5. Record the member's therapy goals for discharge from skilled services.
6. Record the member's current status in relation to the reason for admission; include barriers to progress in reaching D/C goals and/or new D/C plan given new functional status.
7. Record where the member is being discharged and what the next level of care is.
8. Record the member's discharge plan, and any follow-up care included (e.g., VNA, physician follow-up, outpatient services).

Section V.

- Print the name of the person who completed the form.
- The person completing the form needs to provide their signature, phone # (cell or beeper).

CarePartners of Connecticut Provider Services: 888.341.1508