compass Health

FAX TRANSMITTAL SHEET

TO: MEDICAL

FROM:

DATE: Tuesday, May 23, 2023

FAX NUMBER:

COMMENTS: ACUTE INPATIENT REHAB REQUEST

Number of pages including this cover sheet: 31
If there are problems receiving this transmittal please call:

MOLINA HEALTHCARE | Molina Complete Care

Request for Prior Authorization

Molina Complete Care is your partner in providing care.

In order to efficiently process your authorization request, fields marked with * must be completed.

Member Information:

*Full Name: Acevedo, Marylou Karin Height Weight

Address:

Telephone #: (434)464-4793 *DOB: 10 / 20 / 1998 *Medicaid #: 976001231038

Emergency/Legal Guardian Contact Person: Telephone #:

Request Type: *Physical Health* ☑ *Behavioral Health* ☐

☐ Out of Network - If Out of Network, reimbursement will be at DMAS Medicaid Rates - Accept: Yes ☐ No ☐

☐ Standard/Routine

☐ Concurrent

☑ Expedited

☐ Retrospective* For inpatient medical/behavioral related to inability to verify insurance coverage timely (up to 5 days postdischarge)

Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Request outside of this definition should be submitted as one of the other options.

Inpatient Services	Outpatient Services	Additional Services
☐ Surgical Procedure	☐ Surgical Procedure	☐ Skilled Home Care Services
☐ Hospitalization	☐ Infusion Therapy	☐ Private Duty Nursing
☐ SNF	☐ OT/PT/ST	☐ DME Purchase
☐ Custodial NF	☐ Personal Care	☐ DME Rental
☐ LTACH	☐ Respite Services	☐ J-Codes *(Authorized up to 6 months at a time.)*
☐ Hospice (inpatient)	☐ Hospice (outpatient)	☐ Other
☑ Inpatient Rehabilitation	☐ Other	
☐ Long Stay Hospital		
☐ TDO/ECO		

*Requested Diagnosis Code: K85.10, R00.0, K83.1

*Requested CPT/HCPCS Code:

*Requested Number of Visits: 7 *DOS From: 05 / 25 / 2023 to 06 / 01 / 2023

*Frequency of Service: *(Detailed)*

Indicate the # of units, visits, or hours being requested daily, weekly or monthly as pertained to service requested. (i.e.:3 visits/week; 8 hrs/day).

J Code					
Drug Name/ Strength					
Dose					
Route					
Frequency					
Total Doses					

PLEASE SEND CLINICAL NOTES AND ALL SUPPORTING DOCUMENTATION WITH THIS REQUEST FORM

Requesting Provider:

*Name: Jeffcott

*Provider ID #:

TIN/NPI #: 1295949410

Telephone #: (123) 123-1234

*Fax #: (123) 123-1234

*Contact Name/Phone #:

Servicing Provider/Facility:

*Name: Vanthoff, Scott

*Provider ID that claim will be billed with:

TIN/NPI #: 1487242855

Telephone #: (123) 123-1234

*Fax #: (123)123-1234

*Contact Name/Phone #: TEMPLE MACK

*Address to mail letter:

Submitted By: TEMPLE MACK (Please Print) Date: 05 / 23 / 2023

Utilization Management Department Phone: **CCC Plus**: 1-800-424-4524 or **Medallion 4.0**: 1-800-424-4518

UM CCC Plus Fax: 1-866-210-1523 or **UM Medallion 4.0 Fax:** 1-855-769-2116

Physician-Administered/HCPCS Utilization Management Department Fax: 1-844-278-5731

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Ann Tuzson, PT
Physical Therapist
Physical Therapy

Progress Notes
Signed

Date of Service: 05/22/23 1424

Signed

Physical Therapy Treatment Note

Treatment Units: 45 minutes (3 units)

Assessment: Patient very motivated to work with PT and OT. Patient gives excellent effort. Patient could benefit from 3 hours of therapy per day. Patient has long history of spinal stenosis (13 years) which limits R LE strength. Patient is weak throughout but UEs stronger than LEs. Recommend working on sliding board transfers to w/c. Biggest limitation to mobility and standing is muscular weakness. Will follow for PT. Patient and mother did report a fall or near fall when patient was sitting edge of bed - patient tends to lean back at edge of bed as a result.
PT frequency and duration: follow 4-5x/week

PT discharge recommendations: acute rehab

Subjective: Patient eager to work with PT and OT.

General Appearance: Saline lock. Foley.

Precautions: Fall risk

Communication: WFL

ROM:
ROM: WFL

Strength
Strength:

Strength: LLE grossly 2/3, R LE grossly 2/2-, UEs grossly 2.**Balance**
Unsupported sitting: with UE support, moderate assist and maximal assist (patient requires max A to regain balance when COM moves outside BOS)

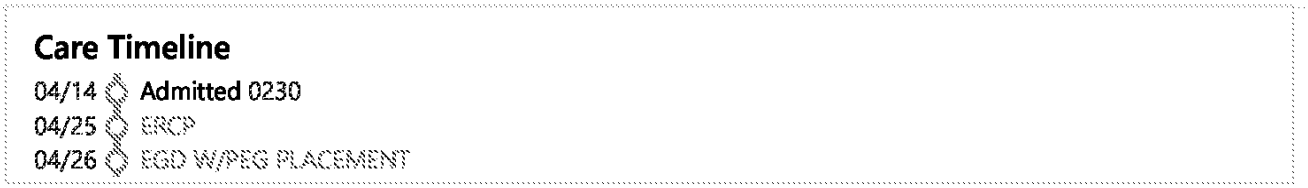
Functional Mobility
Rolling: maximal assist and dependent or 2 person
Supine to sit: maximal assist and dependent or 2 person
Sit to supine: maximal assist and dependent or 2 person
Sit to stand: maximal assist and dependent or 2 person
Stand to sit: maximal assist and dependent or 2 person
Location at end of session: in bed with bed alarm on
Communicated with: RN and OT

Activity Limitations
Impairments: strength and balance
Functional limitations: bed mobility, transfer, gait, home activities and community activities
Interventions: patient instruction/education, assistive technology/equipment, functional training and therapeutic exercise

Activity Orders (From admission, onward)
Start Ordered
05/02/23 1928 Inpatient Activity Order Progressive Mobility Protocol
UNTIL DISCONTINUED
Question: Type of Activity Answer: Progressive Mobility Protocol
05/02/23 1928
04/25/23 0000 Rest at home for the remainder of the day; you may be unusually tired today. (Outpatient with General Anesthesia)
04/25/23 1524
04/25/23 0000 Do not drive any vehicle or operate any machinery for the remainder of the day. (Outpatient with General Anesthesia)
04/25/23 1524

Goals
Goal(s) formulated with: patient/family
Patient will roll: minimal assist, with verbal cues and with rail
Goal status: ongoing
Patient will go supine to sit: moderate assist, with verbal cues, with rail and with HOB elevated
Goal status: ongoing
Patient will go sit to supine: moderate assist, with verbal cues, with HOB elevated and with rail
Goal status: ongoing
Patient will sit edge of bed: supervision/contact guard, with verbal cues and for 10 minutes
Goal status: ongoing

Ann Tuzson, PT 2551
5/22/2023



05/02 ERCP
Transferred to 4 WEST ICU 2050
05/06 Transferred out of 4 WEST ICU 1805
05/17 ERCP

Printed by MACK, TEMPLE [MACKT]

Progress Notes Date of Service: 05/22/23 1417

Occupational Therapist
Occupational Therapy

Signed

Signed

Occupational Therapy Treatment

Name:
MRN:

Treatment Time:
30 minutes (2 units)

HPI: "with multiple congenital anomalies including congenital spinal stenosis w/ severe spinal stenosis w/ cord compression from cervicomedullary junction to T4 s/p C2-C4 laminectomy, cleft palate, and tracheoesophageal fistula s/p repair in infancy, HFrEF who **presents as transfer for post-procedure pancreatitis.** ERCP 4/25 notable for duodenal edema & distal CBD stricture with subsequent placement of a 7 Fr x 7 cm CBD stent. Given ongoing pancreatitis, PEG-J placed 4/26. He was progressing w/ TF, but developed E coli bacteremia from infected WOPN now s/p cystogastrostomy & limited necrosectomy 5/2. A dorsal PD stent and 2 pigtail stents (placed through Axios LAMS) were placed, & J arm was replaced. Ecoli bacteremia (zosyn resistant) & infected WOPN (including candida) now treated w/ CTX/metro/fluc."

Activity Orders/Precautions:
Chair/bed alarm
High fall risk

Activity Orders (From admission, onward)

Start		Ordered
05/02/23 1928	**Inpatient Activity Order Progressive Mobility Protocol** UNTIL DISCONTINUED Question: Type of Activity Answer: Progressive Mobility Protocol	05/02/23 1928
04/25/23 0000	**Rest at home for the remainder of the day; you may be unusually tired today. (Outpatient with General Anesthesia)**	04/25/23 1524
04/25/23 0000	**Do not drive any vehicle or operate any machinery for the remainder of the day. (Outpatient with General Anesthesia)**	04/25/23 1524

Subjective: "I'll try whatever you say." "Thank you so much" "Yeah, let's try it again"

Occupational Performance

General Appearance: Patient received supine in bed. See flowsheet for details. Mother bedside.

Integument:
Systemic edema, worse at distal BLEs/feet and RUE. BLEs and RUE elevated on pillows at start of session

Functional Cognition:

Level of Alertness: alert
Attention: sustained attention impaired
Follows Commands: Multi-step, verbal cues
Problem Solving: diminished

Psychosocial Behavior:
psychosocial behavior: actively participates
attentive to therapist
Very pleasant
Highly motivated

Extremity Range of Motion and Strength:
RUE limited by edema, demonstrating grossly 3-/5 strength at shoulder, 3+/5 distally
LUE AROM/Strength at least 3+/5
BLE weakness, worse on right; see PT notes for LE details.
Pt provided with theraball this session for hand strengthening and RUE edema reduction

Balance:
Static Sitting: with bilateral upper extremity support while seated edge of bed and initially required minimal assistance with progression to brief periods of standby assistance after performing some balance training activities at edge of bed. Tends to lean posteriorly
Dynamic Sitting: Moderate Assistance with bilateral upper extremity support while seated edge of bed while being assisted to scoot hips to edge

Functional Mobility/Transfers:
Rolling: Maximum Assistance to left and right with bed rail and verbal cueing, log roll technique utilized, pt unable to bend either knee up without assistance
Supine to sit: Maximum Assistance, 2 person assistance
Sit to supine: Maximum Assistance, 2 person assistance
Sit to stand: Attempted x 2 trials in Sara stedy. Pt unable to clear buttocks from bed despite bed elevated and 2 person assistance but gave a great effort.
*Patient sat edge of bed with great tolerance for ~15 minutes for balance training and light ADL performance

ADLs/IADLs:
Lower body dressing: Total Assistance for donning/doffing socks
Toileting: Total Assistance (patient also with condom catheter)

Compression (prior session):
Patient sized for and donned with double layer tubigrip (size F) for BLEs distal to knees for edema reduction

AM-PAC Score:

Raw Score:	10	CMS 0-100% Score:	74.70%
Standardized Score:	2.96	CMS Modifier:	CL

A Raw score of ≤ 18 at evaluation: consider inpatient rehabilitation at discharge. MDC is a raw score change of 6.

Jette D et al. **AM-PAC "6 clicks" Functional Assessment Scores Predict Acute Care Hospital Discharge Destination** Physical Therapy, 2014: 94; 1252-61
Jette D et al. **Validity of the AM-PA "6-Clicks" Inpatient Daily Activity and Basic Mobility Short Forms** Physical Therapy, 2014: 94; 379-91

Vital Signs:
Patient asymptomatic during session

Pain:

Pain did not interfere with session

Interventions and Education Provided

Patient was seen today for ADL Training, Compensatory Strategy, and Functional Mobility/Transfers
- Explained the role and goals of occupational therapy, including evaluation, course of treatment, and discharge planning.
- Educated on therapy disposition recommendations and appropriate follow-up therapy options at discharge.
- Educated patient/caregiver in edema management and reduction strategies.
- Instructed in appropriate antigravity UE exercise program. Discussed progression of exercises and frequency to be performed. Theraball provided for hand strengthening

Patient and Caregiver will require further education prior to discharge.
Patient left in bed-chair position with call bell within reach. Bed alarm activated. RN informed about session.

Equipment Provided During Hospitalization:
none

Impairments:
Musculoskeletal, Skin Integrity, Psychosocial, Balance, Sensory
Sensory: Pain
Musculoskeletal: Range of Motion (Joint Mobility), Strength, Endurance, Coordination

Performance Deficits:
ADLs, IADLs, Leisure/Play
General ADLs: Bathing and Showering, Toileting and Toileting Hygiene, Dressing, Feeding, Functional Mobility, Personal Device Care, Grooming and Personal Hygiene
General IADLs: Health Management and Maintenance, Home Establishment and Management, Community Mobility, Meal Preparation, Safety and Emergency Maintenance, Shopping

Assessment and Plan of Care

Assessment:
Patient seen for ongoing OT treatment. He performed basic ADLs, bed mobility and edge of bed sitting balance with excellence tolerance this date and demonstrated good functional progress. He is limited primarily by overall deconditioning/weakness, edema, decreased activity tolerance, and balance deficits. He is highly motivated to participate and is an excellent rehab candidate given his independent prior level of function, motivation, and great family support. Recommend PM&R consult to assist with rehab placement.
Recommend patient discharge to acute rehab. Acute OT will follow to maximize functional abilities.

Treatment Goals:

ONGOING unless MET 05/22/23 :
Patient will independently remove hospital gown after lace has been unfastened, while in supported sitting.
Patient will wipe face with mod A following set-up, while in supported sitting.
Patient will drink from a cup with a straw using hands in a bimanual fashion, with mod-max A
Patient will feed self finger food with mod A (proximally), while in supported sitting
Patient will perform bed mobility with moderate assistance

Expected Frequency:
4-5x/week

Planned interventions:
ADL Training, Compensatory Strategy, Functional Mobility/Transfers

Discharge Recommendations:
Acute Rehab

Equipment Recommended for Discharge:
To be determined by facility

OT Recommendations for Nursing Staff:
Recommend bedpan/urinal for toileting, Chair position in bed or Stryker chair for all meals, assist as needed

Team Communication:
RN, PT, Family (mom)

Allison Titus, OTR/L
PIC# 4378

5/22/2023, 14:17
On-call OT PIC 9315

Admission (Current) on 4/14/2023

Care Timeline

04/14 Admitted 0230
04/25 ERCP
04/26 EGD W/PEG PLACEMENT
05/02 ERCP
Transferred to 4 WEST ICU 2050
05/06 Transferred out of 4 WEST ICU 1805
05/17 ERCP

Physician
Internal Medicine

Progress Notes
Signed

Date of Service: 05/22/23 1200

Signed

DEPARTMENT OF MEDICINE
General Medicine Service - Progress Note

Date: 5/22/2023

Name:
Admit date: 4/14/2023

Principal reason for admission: sepsis 2/2 necrotizing pancreatitis

SUBJECTIVE

Patient complaints/ events Past 24 Hours:
- fullness significantly improved since TF held ON. Eating breakfast

OBJECTIVE

Vitals

Most Recent	24 Hour Min/Max
Temp: 37 °C (98.6 °F)	Temp Min: 36.9 °C (98.4 °F) Max: 37.2 °C (99 °F)
Heart Rate: 105	Pulse Min: 105 Max: 113
BP: (!) 104/57	BP Min: 104/57 Max: 114/66
Resp: 19	Resp Min: 18 Max: 20
SpO2: 98 %	SpO2 Min: 96 % Max: 98 %

I have reviewed the patient's vital signs and nursing notes.

GEN: 50 y.o. lying comfortably in bed
CV: RRR w/o murmurs, rubs, or gallops
PULM: Clear without increased work of breathing
MSK: 2+ LE edema
SKIN: Warm and dry
NEURO: Alert, interactive, able to answer questions appropriately

I have reviewed the patient's current/relevant laboratory, radiographic, and microbiological studies today.

Reviewed in eDH. Remarkable for the following:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.

Recent Labs

	05/20/23 0619	05/22/23 1205
NA	132*	130*
K	4.4	4.6
CL	97*	97*
CO2	27	24
BUN	8	7*

CREATININE	0.3*	0.4*
CALCIUM	8.1*	8.5

Recent Labs

	05/20/23 0619	05/22/23 1205
AST	45*	53*
ALT	44	44
ALKPHOS	801*	868*
BILITOT	1.3*	1.6*

No results for input(s): INR, PTT in the last 72 hours.

5/17 ERCP:

Impression:

- Persistent significant duodenal edema and deformity from adjacent pancreatitis.
- Inspection of WOPN cavity revealed little residual solid material and viable cavity walls.
- Removal of migrated biliary stent (required standard gastroscope advancement to the jejunum)
- Cholangiogram demonstrated a diffuse biliary stricture through the pancreatic head, likely flow limiting.
- Successful limited biliary sphincterotomy and 4mm balloon dilation.
- Balloon clearance of debris / sludge from the biliary tree.
- Placement of a 10mm x 8 cm fully covered viabil bile duct stent.
- No pancreatic duct injections and no wire passes were made.

5/15 CT A/P:

Impression

1. Persistent intrahepatic and extrahepatic biliary ductal dilation with interval migration of biliary stent, now located in the jejunum. Pancreatic duct stent has also migrated with pigtail in the distal duodenum.
2. Gastrostomy tube bumper now appears to be partially located in the anterior abdominal wall soft tissues (Buried bumper syndrome).
3. Sequelae of necrotizing pancreatitis with similar size of multiple peripancreatic necrotic collections. Small volume ascites.
4. Severe narrowing of the portosplenic confluence without discrete thrombus.

Rohit Sukumar, M.D.
Resident Physician, Radiology

Rachita Khot, MD
Attending Physician, Abdominal Imaging

5/12 ECG without significant QT prolongation per personal review

5/11 CXR:

Impression

Left basilar subsegmental atelectasis with small left pleural effusion.

Kristen Reeder, M.D.

Resident Physician, Radiology

Michael B. Sneider, M.D.
Thoracic Imaging, Attending Physician

5/9 CT A/P:

Impression

1. Evolving sequela of necrotizing pancreatitis with interval cystgastrostomy placement and evacuation of large retroperitoneal walled off necrosis. Overall, volume of peripancreatic/retroperitoneal collections has significantly decreased in size. Few residual peripancreatic collections (walled off necrosis) described above, the largest is seen anterior to the duodenum and measures 8.5 x 2.7 x 6 cm.
2. Stable moderate intrahepatic biliary ductal dilation and slightly decreased diameter of the common bile duct, now measuring 1.6 cm (previously 2.2 cm). CBD stent remains in unchanged configuration.
3. Small volume ascites, slightly increased from prior.

Meghan R Clark, M.D.
Resident Physician, Radiology

5/7 XR tube study -

Impression

Percutaneous gastrostomy tube with jejunal extension terminating beyond the ligament of Treitz.

A.J. Pesch, MD
Attending Physician, Abdominal Imaging

ASSESSMENT & PLAN

including congenital spinal stenosis w/ severe spinal stenosis w/ cord compression from cervicomedullary junction to T4 s/p C2-C4 laminectomy, cleft palate, and tracheoesophageal fistula s/p repair in infancy, HFrEF with prolonged hospitalization for acute pancreatitis c/b E.coli bacteremia iso necrotizing pancreatitis s/p necrosectomy.

 # Elevated liver enzymes: 5/15 CT showing migrating biliary stents. s/p 5/17 ERCP exchanging biliary stent and dilation. Tbili and ALP downtrending
- GI following, trend LFTs

 # Sepsis secondary to infected WOPN 2/2 E.coli, lactobacillus, and candida albicans
 # Necrotizing pancreatitis
 # Septic shock, resolved
Patient remains afebrile. No signs of recurrent infectious process with 5/15 CT. No c/f infection at this time. Still in hospital at time of ID follow up. Getting repeat CT and re-engaging ID to see if abx still needed.
- ID reconsulted, will give formal recs after repeat CT today (5/22). Originally recommended switch to PO amoxicillin 1 g TID, metronidazole, cipro, fluc upon discharge. f/u CT scan at 2 weeks from 5/9 scan. f/u w/ ID clinic in 2-3 weeks
- cont ampicillin and ciprofloxacin
- continue metronidazole for 2 week course post 5/2 procedure (last 5/16)
- cont fluconazole to 600 mg daily - 2 week course from initiation (last 5/20)
- GI following
- PPI

- EKG last checked on 05/12/2023 to monitor QTc.
- trend LFTs

 # Mild protein calorie malnutrition
 # G-J tube
Patient's fullness and diarrhea have improved since holding TF. J arm is still clogged with unknown cause. Working to get a calorie count today with regular diet to see if meeting needs. If goes well, can potentiall removed PEG.
- RD consulted
- continue holding nocturnal TF 85 ml/hr rate tonight (6p to 9a). low fat formula at increased rate
- advancing diet as tolerated - added creon given diarrhea and other evidence of pancreatic insufficiency -
- G tube to clamp
- replete electrolytes QOD for inpatient monitoring
- If gastric content output >500 into Foley bag, will require infusion back through J arm (as long as pH >5) to prevent severe metabolic alkalosis
- appreciate nutrition recs
- at discharge: Schedule GI Nutrition with his GI Clinic follow up appointment - if he will be seen here. If not, would recommend nutrition follow up by Continuum RD.

 # Hyperglycemia and hypertriglyceridemia 2/2 acute pancreatitis - improved
A1c 6.1 on admission. Sugars well controlled
- hold NPH 21 U BID while holding TF
- SSI changed to meal times and bedtime

 # HFrEF, Decompensated
 # Non-obstructive CAD
- Continue PTA aspirin and rosuvastatin
- GDMT:
- BB: Restarted metoprolol 5/4
- ARNi: Restarted sacubitril-valsartan 5/5
- MRA: Restarted spironolactone
- SGLT2i: Restarted dapagliflozin 5/5
- strict I/Os, daily weights (standing preferred)
- LE edema increased today, giving 40 mg IV Lasix

 # Chronic macrocytic anemia
History of macrocytic anemia, Hb declining during admission iso acute illness. Transiently concern for GI bleed, EGD on 05/02 r/o. Received 1 pRBC.
- CTM CBC

 # Obesity, class 3
- BMI: 45.0 (5/10/23)
- Monitoring to prevent development of pressure ulcers

 # GERD
- pantoprazole 40 mg po BID

 # Risk Assessment:
The Patient is considered High Risk Due to Need for Close Monitoring due to High Risk of Decompensation

 # Disposition: severely deconditioned. PT/OT following. Recommend acute rehab. Care plan to be discussed with nursing, pharmacy, and case management on interdisciplinary rounds on Monday. Still does not have insurance authorization or an accepting facility.
- consulting PMR for reevaluation

DAILY CHECKLIST

Nutrition plan reviewed? Clears - jejunal feeds
VTE prophylaxis ordered? Heparin (any form)
Delirium: high risk
Central line/PICC access needed? No
Foley catheter needed? No
Telemetry indicated? no

O. Julian Ahsan, MS4
PIC 6450

I have seen and examined the patient on 5/22/23. I was present with Julian Ahsan while the E/M service was performed. I have performed (or re-performed) the physical exam and/or medical decision making documented by the student. I agree with and have verified that the student documentation is accurate. I have reviewed the provider's history, exam, assessment and management plans. I concur with or have edited all elements of the provider's note.

Joseph Kerley
Hospital Medicine
PIC #8546

Admission (Current) on 4/14/2023

Care Timeline

04/14 Admitted 0230
04/25 ERCP
04/26 EGD W/PEG PLACEMENT
05/02 ERCP
Transferred to 4 WEST ICU 2050
05/06 Transferred out of 4 WEST ICU 1805
05/17 ERCP

Lindsay, Steaven Dewayn

MRN: 0693795

Angel Morvant, MD
Physician
Internal Medicine

H&P
Addendum

Date of Service: 04/14/23 0242

DEPARTMENT OF MEDICINE
General Medicine Service - History and Physical Exam
Date: 4/14/2023
Patient Name: Steaven Dewayn Lindsay
MRN: 0693795
Age/Sex: 50 y.o. / male
Team: Hospitalist Night 2
PCP: Kim Rexrode

HISTORY

Chief Complaint: abdominal pain

Reason for Admission: Post-procedure pancreatitis

HPI: Steaven Dewayn Lindsay is a 50 y.o. male with multiple congenital anomalies including congenital spinal stenosis w/ severe spinal stenosis w/ cord compression from cervicomedullary junction to T4 s/p C2-C4 laminectomy, cleft palate, and tracheoesophageal fistula s/p repair in infancy, HFrEF (now 45-50%) who presents as transfer for post-procedure pancreatitis.

UVA chart and OSH records reviewed and summarized below.

He underwent EGD on 2/6/23 for evaluation of bloating and dysphagia which showed erosive gastropathy and a submucosal nodule in the duodenum with normal gastric/duodenal biopsies. He underwent EUS on 3/30/23 which noted a duodenal submucosal lesion w/ biopsy showing reactive changes. He underwent EGD w/ EMR on 4/13/23 during which the 10 mm submucosal nodule was removed.

He was doing well post-procedurally until he arrived home. Then he developed acute sharp pain in the center of his abdomen that radiated to the left side. He took some Tylenol but this didn't help and he started vomiting. He called GI and was instructed to go to the local ED (Bath County). There, he was treated with pain meds, anti-emetics, and fluids. A CT abd/pelvis was obtained and consistent with acute pancreatitis. Lipase was 6915. Given recent procedure yesterday, he was accepted for transfer for further management at UVA.

At the time of evaluation, he reports his pain is much improved after getting pain medications at the OSH. He has ongoing nausea which may have worsened some on the ride here. He reports some subjective fevers at the OSH as well. Otherwise no new symptoms.

Family Contact:
Extended Emergency Contact Information
Primary Emergency Contact: Lindsay,Sharon
Address: RT 2 BOX 628
HOT SPRINGS, VA 24445
Home Phone: 540-839-5460
Work Phone: 540-839-7286
Mobile Phone: 540-968-2726
Relation: Mother

Solid Tumor and/or Metastatic Cancer Not present.

Encephalopathy/Other Neurological Conditions Not present.
Weight Loss Not present.

Past Medical History:

Diagnosis	Date
• Blood pressure elevated without history of HTN	
• Cleft palate	
• Congenital anomaly of esophagus	
• GERD (gastroesophageal reflux disease)	

Past Surgical History:

Procedure	Laterality	Date
• CLEFT PALATE REPAIR		
• ESOPHAGUS SURGERY *artificial esophagus*		
• PR CATH PLACEMENT & NJX CORONARY ART ANGIO IMG S&I *Coronary Angiography performed by Kanwar Paul Singh, MD at UVHE CARDIAC CATH AND EP LABS*	N/A	3/30/2022
• PR EGD INTRMURAL NEEDLE ASPIR/BIOP ALTERED ANATOMY *UPPER EUS performed by Vanessa Shami, MD at UVHE ENDOSCOPY/BRONCHOSCOPY SUITE*	N/A	3/30/2023
• PR L HRT CATH W/NJX L VENTRICULOGRAPHY IMG S&I *LEFT HEART CATH W/WO VENTRICULOGRAPHY performed by Kanwar Paul Singh, MD at UVHE CARDIAC CATH AND EP LABS*	N/A	3/30/2022
• SPINE SURGERY *C spine surgery at UVA*		11/2011
• UPPER GI, EGD, FLEXIBLE, TRANSORAL, DIAGNOSTIC ENDOSCOPY *GI UPPER ENDOSCOPY (EGD) performed by Amy Doran, MD at UVHE ENDOSCOPY/BRONCHOSCOPY SUITE*	N/A	2/6/2023
• UPPER GI, EGD, FLEXIBLE, TRANSORAL, DIAGNOSTIC ENDOSCOPY *GI UPPER ENDOSCOPY (EGD) performed by Vanessa Shami, MD at UVHE ENDOSCOPY/BRONCHOSCOPY SUITE*	N/A	3/30/2023

Social History

Tobacco Use

- Smoking status: Former
  - Years: 1.00
  - Types: Cigarettes
- Smokeless tobacco: Never
- Tobacco comments:
  quit 11 years ago

Vaping Use

- Vaping Use: Never used

Substance Use Topics

- Alcohol use: Not Currently
- Drug use: Never

Family History

Problem	Relation	Age of Onset
• Diabetes	Father	
• High Blood Pressure	Father	
• Heart Disease	Father	
• Stroke	Father	

Lindsay, Steaven Dewayn (MRN 0693795)

- Colon Cancer — Maternal Grandmother

I have reviewed the past medical history, surgical history, family history, social history, medications and allergies and they are up to date and correctly populated.

Prior to Admission Medications:

Outpatient Medications Marked as Taking for the 4/14/23 encounter (Hospital Encounter)

Medication	Sig	Dispense	Refill
• Acetaminophen 500 MG CAPS	Take 2 capsules by mouth every 6 hours as needed. Indications: Pain		
• aspirin 81 MG chewable tablet	Take 1 tablet by mouth daily.	90 tablet	3
• Chlorpheniramine Maleate (ALLERGY PO)	Take by mouth.		
• dapagliflozin (FARXIGA) 10 MG TABS tablet	Take 1 tablet by mouth daily. (Patient taking differently: Take 10 mg by mouth every evening.)	90 tablet	3
• docusate sodium (COLACE) 100 MG capsule	Take 100 mg by mouth daily as needed for constipation.		
• MELATONIN PO	Take 10 mg by mouth nightly.		
• metoprolol succinate ER (TOPROL-XL) 100 MG 24 hr tablet	Take 1 tablet by mouth daily.	90 tablet	3
• Multiple Vitamin (MULTIVITAMIN ADULT) TABS	Take 1 tablet by mouth daily.		
• omeprazole (PRILOSEC) 20 MG capsule	Take 2 capsules by mouth every morning (before breakfast).	30 capsule	0
• rosuvastatin (CRESTOR) 40 MG tablet	Take 1 tablet by mouth daily.	90 tablet	3
• sacubitril-valsartan (ENTRESTO) 24-26 MG TABS tablet	Take 1 tablet by mouth 2 times daily.	180 tablet	3
• spironolactone (ALDACTONE) 25 MG tablet	Take 1 tablet by mouth daily.	90 tablet	3

REVIEW OF SYSTEMS:

14 systems reviewed, pertinent ROS noted in HPI and all other systems negative.

PHYSICAL EXAM

Visit Vitals

BP (!) 142/83 (BP Location: Left arm, Patient Position: Supine)

Pulse	100
Resp	18
SpO2	96%

I have reviewed the nursing notes and vital signs.

Cachexia present? No

CONSTITUTIONAL: Appears comfortable, in NAD.
HEENT: Anicteric sclera. MMM
NECK: No JVD present.
CARDIO: RRR. Normal S1, S2. No m/r/g.
PULM: CTAB. No rales, wheezes, or rhonci. Normal respiratory effort. No respiratory distress.
GI: Bowel sounds present. Soft, mildly distended. Moderate TTP in epigastric region and center of abdomen. No rebound/guarding.
MSK: No LE edema. Non TTP. ROM grossly intact.
SKIN: Warm, well-perfused, and dry. No rashes appreciated on exposed skin.
HEME: No petechiae or ecchymoses on exposed skin.
NEURO: Awake and alert, interactive. Oriented to person, place, time, situation. Face symmetric. Moves all limbs spontaneously without gross deficit.
PSYCH: Normal mood and affect.

DIAGNOSTIC STUDIES

I have reviewed the patient's current/relevant laboratory, radiographic, and microbiological studies today.

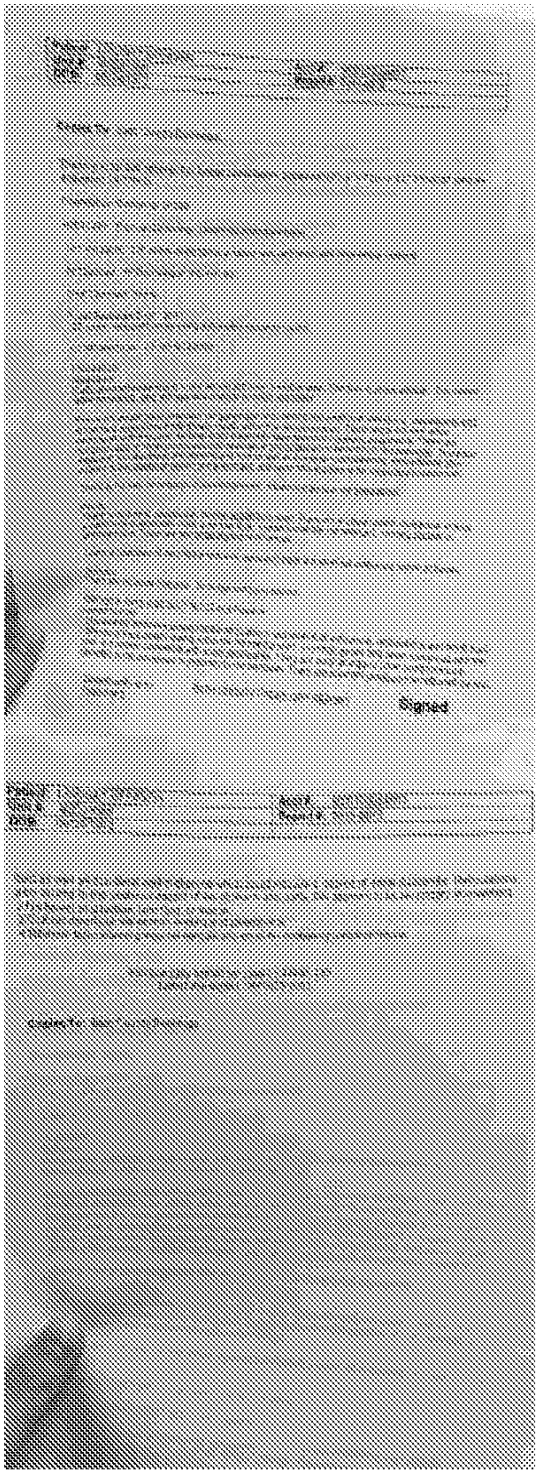
Significant Findings, Abnormalities or Trends:

Labs:
UVA labs pending

OSH labs:
WBC 16.3 w/ neutrophil predominance, Hgb 16.2, Hct 47.6, Plt 259
Na 136, K 4.3, Cl 101, CO2 27, BUN 10, Cr 0.9, Glu 185, Mg 1.5
T.bili 0.5, Alk phos 46, ALT 42, AST 28
LA 1.9
Amylase 459
Lipase 6915

Micro:
OSH SARS-CoV-2 negative

Radiology:
OSH CT abd/pelvis w/ contrast (scanned in media tab)



ASSESSMENT & PLAN

Steaven Dewayn Lindsay is a 50 y.o. male with multiple congenital anomalies including congenital spinal stenosis w/ severe spinal stenosis w/ cord compression from cervicomedullary junction to T4 s/p C2-C4 laminectomy, cleft palate, and tracheoesophageal fistula s/p repair in infancy, HFrEF (now 45-50%) who presents as transfer for post-procedure pancreatitis.

Acute pancreatitis in the setting of recent EGD w/ EMR of duodenal nodule

Developed acute epigastric and central abdominal pain after EGD w/ EMR of duodenal nodule on 4/13/23. OSH labs w/ lipase 6915 and CT abd/pelvis c/w acute pancreatitis w/o significant complication. Transferred for further management.
- LR at 125 cc/hr
- Scheduled acetaminophen and PRN hydromorphone for pain
- NPO
- Pantoprazole in place of PTA omeprazole
- PRN ondansetron for nausea

HFrEF (previously 35-40%, now 45-50%)
Non-obstructive CAD
- Continue PTA aspirin anad rosuvastatin
- Continue PTA metoprolol succinate
- PTA Entresto, spironolactone, and dapagliflozin ordered but held pending labs

ADMISSION CHECKLIST

Aspiration precautions indicated? No
Risk of Encephalopathy: high risk
VTE prophylaxis ordered? Heparin Prophylaxis (any form) and SCD/Compression Device
Telemetry indicated? No
For General Medicine admissions (GM-3rd Floor or GM-5C teams), please answer:
Would you be surprised if this patient were to die within the next 12 months? Yes

Angel Morvant, MD
Hospitalist, Internal Medicine
PIC 2493

Admission (Current) on 4/14/2023

Care Timeline

04/14 Admitted 0230
04/25 ERCP
04/26 EGD W/PEG PLACEMENT
05/02 ERCP
Transferred to 4 WEST ICU 2050
05/06 Transferred out of 4 WEST ICU 1805
05/17 ERCP

ENCOMPASS HEALTH

Name: Lindsay, Steaven
Date of Birth: 09/24/1972
Sex: Male
Phone: (540)839-5460
Next of Kin: Sharon Lindsay
Phone: 5409682726
MRN: 86664

ID: 5624576
Referring Hospital: UVA
Room #: UVHE 3WES / 0693795
Referral Credit: Meadows, Jennifer
Case Manager: Becky Monteith
Referring Physician:
Patient Number: 798561

Pre-Screen Admission Form

Basic

Demographics

MRN: 86664

Patient Number: 798561

Name: Steaven Lindsay

Address

PO BOX 58
Street Verified
WARM SPRING, VA 24484

Home Phone: (540)839-5460

Cell Phone: 540-292-0895

email: s_lindsay04@yahoo.com

Date of Birth: 09/24/1972

Age: 50

SSN: *********

Sex: Male

US Citizen: Yes

Marital Status: SINGLE

Veteran: No

Religion: UNKNOWN

Do you need or want an interpreter to communicate with a doctor or health care staff: No

What is your preferred language: ENGLISH

Hispanic, Latino, or Spanish Origin: No

Race: White

Race: White

Primary Contact First Name: Sharon

Last Name: Lindsay

Home Phone: 5409682726

Relationship: PARENT

Secondary Contact First Name: Cheryll

Last Name: Milton

Home Phone: 5409680075

Relationship: RELATIVE

Health Care Proxy: No

Organ Donor: No

Currently Hospice: No

ESRD: No

Dialysis: No

Durable Medical POA: No

DNR Code Status: No

Hospital Stay in Last Sixty Days: No

Core Program/RIC: SPINAL CORD NON TRAM

Type of Admit: Initial Rehab

Referring Info

Referring Facility: UVA

Referral Credit: Meadows, Jennifer

Inpatient Rehabilitation Hospital: UVA

Inpatient Rehabilitation Hospital ID: 03011300

Location/Room #: UVHE 3WES / 0693795

Referral Date: 05/23/2023

Onset Date: 04/14/2023

Case Manager: Becky Monteith

Referral Source Driver: UVA Medical Center

Volume Vehicle: Hospital

Awareness: DIS PLANNER/SOCIAL WORKER

Physician

Primary Care: Kimberly rexrode *

Referring: JOSEPH KERLEY

* Selected by patient to receive notifications

Physician Comments: Bath physicians group

Insurance

Primary Insurance

Name: MOLINA COMPLETE CARE

Policy Holder: self

ID: 908530973

Pre-Cert Required: Yes

Secondary Insurance

Medicare Advantage Replacement Policy: No

Injury Due to Accident: No

MVA: No

Accident Other: No

Medical

Social History

Lives Family: Yes

Home Levels: 1

Number of Steps to Enter: 7 with rails

Number of Steps Within: 1 step down into kitchen

Disabled: Yes

Cultural / Educational Issues: No

OP / HH / SNF Services immediately preceding hospitalization: No

Assistive Device None: Yes

DC Caregiver: mom

Support System: intact

Anticipated DC Destination: home with services

Hospitalization History

Primary Acute Diagnosis: SPINAL CORD INJURY

Secondary Acute Diagnosis: OTHER

Other Diagnosis: cervical cord atrophy with signal abnormality from C2 - C4, mild regression syndrome, congenitally narrow spinal canal, and fatty filum terminalis

Other Diagnosis: HFrEF, Decompensated, Non-obstructive CAD

Other Diagnosis: Sepsis 2/2 infected WOPN 2/2 E.coli, lactobacillus, candida albicans Necrotizing pancreatitis

Other Diagnosis: Elevated liver enzymes

Other Diagnosis: Hyperglycemia and hypertriglyceridemia 2/2 acute pancreatitis

Description of Onset / Current Surgical Procedures: Steaven Lindsay is a 50 y/o male with pmh of congenital spinal stenosis w/ severe spinal stenosis w/ cord compression from cervicomedullary junction to T4 s/p C2-C4 laminectomy and additional congenital anomalies, requiring EGD with EUS for submucosal nodule in the duodenum which was complicated by post procedure pancreatitis and pancreatic fluid collection that developed into necrotizing pancreatitis, further c/b sepsis s/p cystgastrostomy (5/2) with fluid growth of E coli and polymicrobial growth- plan to continue on ampicillin, ciprofloxacin, metronidazole, and fluconazole. His hospital course has been additionally complicated by: Elevated liver enzymes- s/p 5/17 ERCP exchanging biliary stent and dilation- trending LFTs, Hyperglycemia and hypertriglyceridemia- continue NPH and SSI, Chronic macrocytic anemia- s/p 1U PRBCs this admission- stable, and hx of Non-obstructive CAD - continue with home meds, noted LE edema s/p IV lasix. Noted dysphagia this admission with need for PEG-J placement, improved swallow with SLP assist, able to upgrade to regular diet. J-arm removal 5/23, with hold on PEG feeds d/t adequate PO intake at this time. PEG remains in the event it is needed again in near future. Team feels patient is medically stable and ready for discharge.
**PLOF: Independent at baseline for ambulation with no use of AD unless he was in a crowd, then he would utilize a cane. Independent with all ADLs. Stayed active by walking outside and completing yardwork. Also coached little league sports for his nephews' teams. Noted RLE and RUE weakness baseline d/t congenital spinal abnormalities, but no falls at home.
**CLOF: Max-Total A Bed mobility, Max-Total A OOB transfers with STEDY, ambulation not yet attempted, Total A toileting 2/2 condom cath, Total A LB dressing. LB strength 2/3. Significant deconditioning d/t bed bound status impacting function.
**Medical Management: Anticipate that in order for this patient to approach his previously high baseline, he requires a minimum of 3 hours of physical therapy by skilled PT and OT clinicians, 5 days a week to address deficits related to decreased mobility and transfer training. OT is required to provide education for the patient to restore his self-care/ADL abilities, home safety/functional transfer training, and energy conservation strategies. Due to the complexity of the patient's nursing, medical management, and rehabilitation needs, he will require the IDT approach of an IRF with PMR oversight of: vitals management, lab oversight iso elevated LFTS, frequent nursing checks/turns to prevent ulcer formations, and medication management. A lower level of care cannot provide the total IDT approach needed to return this patient safely home and avoid readmission.

Active Medical Issues and Treatments: cervical cord atrophy with signal abnormality from C2 - C4, findings of mild regression syndrome, congenitally narrow spinal canal, and fatty filum terminalis, HFrEF, Decompensated, Non-obstructive CAD , Sepsis 2/2 infected WOPN 2/2 E.coli, lactobacillus, candida albicans Necrotizing pancreatitis, Elevated liver enzymes, Hyperglycemia and hypertriglyceridemia 2/2 acute pancreatitis

Medical History

Medical History

GERD: Yes

Other Medical History: True

Blood pressure elevated without history of HTN

Cleft palate

Congenital anomaly of esophagus

congenital spinal stenosis w/ severe spinal stenosis w/ cord compression from cervicomedullary junction to T4

HFrEF 45-50%

Medical Comments: tracheoesophageal fistula

Surgical History

Does the patient have any surgical history: Yes

Did the patient have surgery in the last 100 days prior to this admission?: Yes

Recent Surgery Type: EGD w/ EMR submucosal nodule removal

Recent Surgery Date: 4/13/2023

Did the surgery carry some degree of risk to the patient's life or the potential for severe disability?: No

Laminectomy: Yes

Spinal Surgery: Yes

Other Surgical History: Yes

cleft palate repair

cath placement

upper GI EGD

Comorbidities

Morbid Obesity: Yes

Septicemia: Yes

Other Comorbidities: Yes

Elevated liver enzymes

Chronic macrocytic anemia

reduced EF 45-50%

Baseline Data, Diagnostics & Labs

Vitals

05/23/2023

Temp: 98.2

Blood Pressure: 119/59

Pulse: 104

Resp: 16

05/22/2023

Temp: 98.6

Blood Pressure: 104/57

Pulse: 105

Resp: 15

Diagnostics

Allergies / Reactions: Oranges, tomatoes

Height (in): 62

Height (cm): 157.48

Current Weight (lb): 229

Current Weight (kg): 103.87

BMI: 41.88

Chest X-Ray: XR CHEST SINGLE VW 5/11:"
Left basilar subsegmental atelectasis with small left pleural effusion."

XR CHEST SINGLE VW 5/2:"1. Left retrocardiac opacity favored to represent atelectasis in the setting of ipsilateral effusion.
2. Prominence of the pulmonary vasculature with mild interval increase in perihilar predominant interstitial opacities consistent with findings of mild pulmonary edema. Small bilateral pleural effusions.
3. Relatively low-lying ET tube. Consider retraction of 1 cm"

MRI: MRI L SPINE WO CONTRAST 5/1:"CERVICAL SPINE:
1. No evidence of acute cervical spine osseous or ligamentous injury.
2. Again seen multilevel cervical thoracic segmentation anomalies status post C2-C4 laminectomies. Unchanged cervical cord atrophy with signal abnormality from C2 - C4.
3. Multilevel neural foraminal stenoses as above.

LUMBAR SPINE:
1. Partially visualized right psoas muscle hemorrhage which is queried as a cause patient's right lower extremity weakness.
2. No evidence of acute lumbar spine osseous or ligamentous injury.
3. Again seen findings of mild regression syndrome, congenitally narrow spinal canal, and fatty filum terminalis. Mild multilevel neural foraminal stenoses as above."

MRI ABDOMEN W WO CONTRAST MRCP 4/14:"1. Exam significantly limited by motion artifact. Within these limitations, findings of severe acute interstitial pancreatitis. No discrete organized fluid collection. No definite evidence of ductal disruption, however evaluation is limited due to motion artifact and susceptibility artifact from metallic clips in the duodenum."

CT: CT ABDOMEN PELVIS W CONTRAST 5/22:"
1. Sequelae of necrotizing pancreatitis with similar size of multiple peripancreatic necrotic collections. Mildly increased peripancreatic stranding, which may be secondary to recent ERCP.

2. Interval decrease in biliary ductal dilation status post new stent placement within the common bile duct. Additional stents and cystogastrostomy are in unchanged position, including migrated pancreatic duct stent.

3. Unchanged narrowing of the portosplenic confluence. The splenic vein is poorly opacified without definite evidence of thrombus.

4. Gastrojejunostomy tube with malpositioned J-arm coiled in the stomach.

5. Small volume ascites. Bilateral pleural effusions, left greater than right."

ECHO: Echocardiogram Transthoracic 4/18:"
Left Ventricle: Normal cavity size and wall thickness. Ejection fraction is 50 - 55%. Left ventricular systolic function is moderately decreased. Abnormal septal motion consistent with left bundle branch block.
Right Ventricle: Normal cavity size and ejection fraction."

Doppler: US UPPER EXTREMITY - DOPPLER DVT - RT 4/25:"
1. No evidence of right upper extremity deep venous thrombosis.
2. No evidence of right upper extremity superficial venous thrombosis.
3. Small hypoechoic sub-centimeter foci in the area of as of the subcutaneous bruising, may represent tiny hematomas versus nonpathologically enlarged lymph nodes."

Other: XR ABDOMEN 2 VIEWS 5/7:"Percutaneous gastrostomy tube with jejunal extension terminating beyond the ligament of Treitz.
"

Labs

05/23/2023

NA: 132

K: 4.2

Cl: 98

Glucose: 142

Bun: 8

CREAT: .4

Albumin: 2.4

Calcium: 8.5

05/22/2023

NA: 130

K: 4.6

Cl: 97

Glucose: 186

Bun: 7

CREAT: .4

Albumin: 2.4

05/20/2023

NA: 132

K: 4.4

Cl: 97

Glucose: 228

Bun: 8

CREAT: .3

Albumin: 2.2

Calcium: 8.1

Infection Control

Infection Control

Blood Culture

Date: 05/02/2023

Results: Escherichia coli

Wound Culture

Date: 05/14/2023

Results: Pancreatic Fluid: 1 Colony Candida albicans, 3+ Escherichia coli, 1+ Lactobacillus species

COVID-19

Have received/plan to receive the COVID-19 Vaccine: Yes

1st Dose COVID-19 Product: Moderna

1st Dose COVID-19 Date: 03/31/2021

2nd Dose COVID-19 Product: Moderna

2nd Dose COVID-19 Date: 04/28/2021

COVID Comments: 12/6/2021 Booster

Infectious Disease Risk Screening

Factors/Symptoms

Chills: No

Fever: No

Fatigue: No

Headache: No

Runny or Stuffy Nose: No

Sore Throat: No

Shortness of Breath: No

New or Worsening Cough: No

Vomiting: No

Diarrhea: No

Muscle Pain: No

Recent Exposure to Communicable Disease: No

Illness with Generalized Rash: No

Recent Seizures: No

Isolation: No

Respiratory

Oxygen: No

Home 02: No

Wound Care

Wounds or Incisions: Yes

Wound Description: Wound: Buttocks

Pharmacy / Medications

Additional Medications: Please see MAR

Diet

Diet Type: Diet

Restrictions

Heart Healthy (2ga Na): Yes

Modifiers

Texture [for food]

Level 7 - Regular: Yes

Liquid Consistency

Level 0 - Thin: Yes

Allergies and Restrictions

Food Allergies: Yes

Food Allergies/Preferences: tomatoes- intolerance, oranges

Tube Feeding

Tube Feeding : Yes

Insertion Date: 04/26/2023

Tube Feeding J: Yes

Tube Feeding PEG: Yes

Product: NA

Rate: NA

TPN/PP: No

Dentures

Diet Other Comment: Vivonex RTF at 85 mL/hr from 18:00 hours until 09:00 hours (until 1250 ml infused) + 2 packs Prosource TF daily (HELD)
Resume tube feeds if PO intake is inadequate.

Nursing

History of Falls: Yes

Date of Last Fall: 05/01/2023

Two or more falls in the last year: No

Fall with injury in the last year: No

Pain Issues: Yes

Pain Location: chronic neck

Bladder/Bowel Management

Bladder Continent: Yes

Bowel Continent: Yes

Comprehension / Communication

Follows Simple Commands

Prior: Intact

Current: Intact

Follows Complex Commands

Prior: Intact

Current: Intact

Hearing

Prior: Intact

Current: Intact

Vision

Prior: Intact

Current: Intact

Verbal Communication

Prior: Intact

Current: Intact

Auditory Comprehension

Prior: Intact

Current: Intact

Orientation: A & O x4

Therapy Precautions & Restrictions

Weight Bearing Status FWB: Yes

Therapy Device Used: No

Functions And Goals

Prior Level of Function

Ambulation: Independent

ADL's: Independent

Prior Cognitive Status Independent: Yes

Prior Physical Level of Activity: Active

Home Equipment: Walker, rollator, bedside, shower chair, pedal bike, walk in shower.

Current Level of Function

Bed Mobility: Maximal Assistance

Maximal Assistance Comments: Rolling; Supine <> sit

Bed Mobility: Dependent

Dependent Comments: Rolling; Supine <> sit

Transfers: Maximal Assistance

Maximal Assistance Comments: Sit <> stand

Transfers: Dependent

Dependent Comments: Sit <> stand

Ambulation: Dependent

Dependent Comments: Not tested

Basic ADL's: Dependent

Dependent Comments: Toileting- condom cather

Dressing: Dependent

Dependent Comments: LB dressing

Balance:

Static Sitting: Poor

Dynamic Sitting: Poor

Static Standing: Poor

Dynamic Standing: Poor

Strength:

RUE: 3+/5

RLE: 2-3/5

LUE: 3+/5

LLE: 2/5

Comments: Distal extremity edema

Goals

Patient/Family Goals: Increase independence with transfers, ambulation and ADLs.

This patient is expected to make measurable improvement that will be of practical value to the patient related to the following goals:

Patient Will:

Improve Strength and Endurance

Improve Balance

Improve Safety and Awareness and Reduce Fall Risk

Ambulate 20 Feet with/without Assistive Device and CGA

Be CGA in Toilet Transfers

Be Min Assist in Bathing and Dressing Activities

Resume Normal Bowel and Bladder Function

Data Collector Signature

Data Collector Signature: Labelle, Lauren OTA

Data Collector Signature Date/Time: 05/23/2023 15:21:01 EDT

Summary

Designated Clinician Screener Conclusions

According to the Medicare Benefits Policy Manual, section 110.2, this patient meets medical necessity criteria for IRF admission as described below:

1. This patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines:

Physical Therapy

Occupational Therapy

2. This patient requires an intensive rehabilitation program generally consisting of at least: 3 hours a day, 5 days a week

3. Expected Level of Improvement/Goals: This patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program.

Goals for this patient include the following:

Pt is reasonably expected to make significant functional gains in order to return home at highest level of independence.

Potential Risks for Clinical Complications:

Fall Risk

Skin Breakdown

DVT

Hyper/Hypoglycemic Episode

4. This patient requires physician supervision by a rehabilitation physician defined as a licensed physician with training and experience in inpatient rehabilitation.

Active Medical Issues and Treatments: cervical cord atrophy with signal abnormality from C2 - C4, findings of mild regression syndrome, congenitally narrow spinal canal, and fatty filum terminalis, HFrEF, Decompensated, Non-obstructive CAD , Sepsis 2/2 infected WOPN 2/2 E.coli, lactobacillus, candida albicans Necrotizing pancreatitis, Elevated liver enzymes, Hyperglycemia and hypertriglyceridemia 2/2 acute pancreatitis

5. This patient requires an intensive and coordinated interdisciplinary approach to providing rehabilitation.

Anticipated Length of Stay: 14-20 Days

Discharge Destination: HOME WITH SERVICES

Anticipated Post Discharge Treatment Needs

Home Health

Occupational Therapy

Physical Therapy

Conclusions:

Patient Meets Guidelines for Admission

Referral Source Notified: Yes

Patient/Family Contacted: Yes

Designated Clinician Screener Signature: Labelle, Lauren OTA

Designated Clinician Screener Signature Date/Time: 05/23/2023 15:21:34 EDT

Physician Section

Upon review of information from the designated screener, I have concluded this patient should be admitted to an inpatient rehabilitation hospital for medically necessary care.

Physician Signature: _____

Physician Signature Date/Time: _____