Wyoming Nursing Facility
Extraordinary Care Criteria

Recipients who have an MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

Conditions considered under extraordinary client criteria include:

- Automatic Qualification:
  - Ventilator Dependence

- The following qualifying diagnoses must have additional criteria met:
  - Cerebral Palsy (ICD 9 343)
  - Morbid Obesity (ICD 9 278.01)
  - Multiple Sclerosis (ICD 9 340)
  - Quadriplegia (ICD 9 344.00, 344.01, 344.02, 344.03, 344.04, or 344.09)

  - Must have **one** of the following:
    - Ventilator dependence
    - Tracheostomy
    - Coma
    - Seizures
    - Disease process involving five (5) or more functional areas of visual, motor, sensory, cognitive, coordination and/or bowel and bladder (Multiple Sclerosis only)
    - Spastic Quadriplegia (Cerebral Palsy only)

  **AND**

  - Must have **three** of the following:
    - Skin care could include Stage 3 or 4 ulcer/ turning every two hours
    - Foley incontinence care could include urinary tract infections/ diarrhea/ constipation/ bowel and bladder training
    - Tube feedings/aphasia could include dehydration/ weight loss/ aspiration pneumonia
- Physical therapy could include wound care/range of motion exercises.
- Special equipment used only by this resident that is clearly above and beyond what is covered in the per diem rate.
- Other conditions where special care or clinically complex care are required will be evaluated on a case by case basis by the Department.
- Criteria are subject to change.

**Provider Documentation Required:**

- New Requests- Completed packet (following) and required documentation and cost review
- Continued Stay Review - completed Continued Stay form and required documentation
- Annual Cost review for extraordinary care client rates will be done in conjunction with October 1 rate effective date reviews.

Continued stay reviews - utilization review at 15 days, 30 days, 90 days and yearly thereafter. If medical evaluation shows difference or change in services needed; notify APS at 1-888-545-1710.

If client has a change in services needed, provider can submit new cost information for consideration of rate adjustment. Incremental revenue of negotiated rate is offset against applicable cost report. Notify Myers & Stauffer of change for modification to reimbursement. 1-800-336-7721.

***Change in Policy beginning 10/01/09:*** Please include all costs for residents under extraordinary care negotiated rate; cost reports will be adjusted during rate setting.
Patient Name: 

Medicaid ID #: 

Facility: 

Projected Time Period: 

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Per Wyoming Medicaid Rules, Chapter 7, Section 22 (a), the negotiated rate determined is to cover the cost of medically necessary services and supplies that are not included in the Nursing Facility per diem rate.

**REQUESTED NEGOTIATED RATE:**

<table>
<thead>
<tr>
<th>Services under Fee Schedule:</th>
<th>Negotiated Rate per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator Care</td>
<td>$435.00 $ -</td>
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</tbody>
</table>

Additional Staffing:

Staff Time (list number of 1-1 hours required per day that are above standard care):

- **RN** $27.28 $-  
- **LPN** $18.76 $-  
- **CNA** $12.22 $-

**Additional Services required (Invoices must accompany request to be considered):**

**Equipment (list type and cost/day):**

| Cost/day = | $ - |

| Medical Supplies (list items and cost/day): | $ - |

| Cost/day = | $ - |

**Wound Care (list items):**

- **Wound VAC rental** Cost/day = $ -  
- **Wound VAC Supplies:**

  - **Dressing Kits**
    - Cost for 15 kits = $ / 30 $ -  
  - **Canisters**
    - Cost for 10 canisters = $ / 30 $ -  
  - **Other (specify)** Cost/day = $ -  
  - **Other (specify)** Cost/day = $ -

Sub-total Negotiated Rate $ -  

Current Nursing Facility Per Diem Rate $ -  

Net Extraordinary Care Rate $ -  

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1. Maximum coverage of 15 Kits per month.  
2. Maximum coverage of 10 Canisters per month.
CONTINUED STAY
SKILLED NURSING EXTRAORDINARY CARE
For Wyoming EqualityCare

Extraordinary Recipients: MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

Note: Certification DOES NOT guarantee payment or client eligibility

Date requested__________________________
Admission date__________________________
Hospital_____________________________
Hospital EqualityCare ID #________________
Hospital UR rep________________________
Phone #________________________________
Fax #_________________________________

For APS Healthcare Use Only
Date received_________________________
Approved_________ Denied_________
Certified Through_____________________
Reviewed By__________________________
PCN#_______________________________

PATIENT INFORMATION

Name_________________________________ EqualityCare ID #________________________

Please include current: 1) MDS assessment 2) Progress notes 3) Nursing Care Plan 4) MD orders

Ventilator Dependent? Y / N

New ICD-9-CM code(s) (provide ALL code numbers as well as diagnosis names)
1.____________________________________ 4.____________________________________
2.____________________________________ 5.____________________________________
3.____________________________________ 6.____________________________________

HCPCS code(s) (provide ALL code numbers as well as diagnosis names)
1.____________________________________ 4.____________________________________
2.____________________________________ 5.____________________________________
3.____________________________________ 6.____________________________________

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928
Forms can be found on-line at www.wyoming.apshealthcare.com
ADMISSION CERTIFICATION
SKILLED NURSING EXTRAORDINARY CARE
For Wyoming EqualityCare

Extraordinary Recipients: MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

Required Documentation:
1) PASRR & Date
2) LT 101 less than 45 days old
3) MDS assessment
4) History & Physical (<1 yr old)
5) Drug history
6) Nursing Care Plan
7) Progress notes
8) Itemized cost
9) MD statement w/Dx
& expected LOS

Ventilator Dependent? Y / N

Note: Preadmission certification DOES NOT guarantee payment or client eligibility

Date requested__________________________
Admission date__________________________
Hospital ________________________________
Hospital EqualityCare ID #________________
Hospital UR rep __________________________
Phone # _________________________________
Fax # _________________________________

Attending/referring physician (first and last name) ________________________________
Physician Wyoming EqualityCare ID # ___________ Phone # __________________
Address ________________________________

PATIENT INFORMATION

Name ____________________________ EqualityCare ID # __________________
Address _______________________________ Phone # __________________
DOB __________________ SS# ____________ Sex: Male Female

ICD-9-CM code(s) (provide ALL code numbers as well as diagnosis names)
1. __________________ 4. __________________
2. __________________ 5. __________________
3. __________________ 6. __________________

HCPCS code(s) (provide ALL code numbers as well as diagnosis names)
1. __________________ 4. __________________
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