Wyoming
Nursing Facility
Extraordinary Care Criteria

Wyoming Department of Health

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 is 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.

Please include all costs for residents under extraordinary care negotiated rate; cost reports will be adjusted during rate setting.

WYOMING NURSING FACILITY
EXTRAORDINARY CARE
RATE REQUEST FORM

Patient Name: _____

Medicaid ID #: _____

Facility: _____

Projected Time Period: _____

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 current Nursing Facility per diem rate.

REQUESTED NEGOTIATED RATE:

Services under Fee Schedule:			Negotiated Rate per Day
Ventilator Care	Check box if applies: ☐	$ 435.00	$ -
Additional Staffing:			
Staff Time (list number of 1-1 hours required per day that are above standard care)			
RN	_____	$ 28.61	$ -
LPN	_____	$ 19.67	$ -
CNA	_____	$ 12.81	$ -

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

Equipment (list type and cost/day):

_____		$ -
_____		$ -

Medical Supplies (list items and cost/day):

_____		$ -
_____		$ -

Wound Care (list items):

Wound VAC rental	Cost/day =	_____	$ -
Wound VAC Supplies:			
Dressing Kits [1]	Cost for 15 kits =	_____ / 30	$ -
Canisters [2]	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		$ -

[1] Maximum coverage of 15 Kits per month.

[2] Maximum coverage of 10 Canisters per month.

ADMISSION CERTIFICATION

SKILLED NURSING EXTRAORDINARY CARE

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 Medicaid ID #_____

Hospital UR rep_____

Phone #_____

Fax #_____

For APS Healthcare Use Only

Date received_____

Approved_____Denied_____

Certified Through_____

Reviewed By_____

Auth #_____

Attending/referring physician (first and last name) _____

Physician Wyoming Medicaid ID #_____Phone #_____

Address_____

PATIENT INFORMATION

Name_____Medicaid 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._____

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

APS HEALTHCARE
Healthy Together

CONTINUED STAY

SKILLED NURSING EXTRAORDINARY CARE

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: <u>Certification DOES NOT guarantee payment or client eligibility</u>

Date requested_____

Admission date_____

Hospital_____

Hospital Medicaid ID# _____

Hospital UR Rep _____

Phone # _____

Fax # _____

For APS Healthcare Use Only

Date received_____

Approved_____Approved YTD_____

Denied_____

Certified Through_____

Reviewed By_____

Auth#_____

The facility has agreed to share the status of authorization with the member.

PATIENT INFORMATION

Name_____Medicaid 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._____

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