



Healthy Together

2011 Provider Manual

Wyoming Medicaid Health and
Utilization Management Programs



 APS Healthcare

www.WYHealthyTogether.com

INTRODUCTION

Welcome! Your Provider Manual for the Wyoming Medicaid Program offers you information about current initiatives and processes to follow for better coordination of services to our Medicaid client population. This manual is also provided to introduce you to the Wyoming Healthy Together program and other services that are provided by APS Healthcare.

In July 2004, APS Healthcare was selected by the Wyoming Department of Health, Division of Healthcare Financing's Medicaid program to provide services to the state in two contracts. The first contract includes oversight of the Medicaid PRO/QIO Behavioral Health and Medical Utilization Management (UM) program; the second contract is the Total Population Health Management program, Healthy Together. Each program is discussed in this provider manual.

APS Healthcare is accredited by URAC, an independent, non-profit organization, well-known as a leader in promoting health care quality through its accreditation and certification programs. The URAC accreditation process demonstrates a commitment to quality services and serves as a framework to improve business processes by benchmarking organizations against nationally recognized standards.

For more information on APS Healthcare's Wyoming programs and all of the utilization management forms referenced in this manual please visit <http://www.wyhealthytogether.com>.

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SECTION I: HEALTHY TOGETHER

The Healthy Together program is available to all eligible Medicaid clients. The program is a free benefit and is offered to assist clients with their healthcare needs. This is a voluntary program for clients and engagement into the program is encouraged. Clients are identified through medical, pharmaceutical, and behavioral health claims data and referrals by providers or self referrals. Clients may be referred into Healthy Together by:

- Self-referrals, by calling 1-888-545-1710
- Family and clients, by calling 1-888-545-1710
- Providers, by completing the referral form or calling 1-888-545-1710 (See referral form in Appendix A)

Components of Healthy Together

1. Health Coaching

Client support and education is provided telephonically by medical health coaches who are registered nurses with experience in the appropriate clinical areas, such as, asthma, diabetes and depression. In addition, there are licensed behavioral health staff who provide health coaching to clients with psychiatric or mental health conditions. Health coaching includes condition-specific, one-on-one telephonic support to clients in order to:

- Provide education about their chronic illness or health concerns.
- Increase their understanding on proper diet and exercise, smoking cessation and stress management.
- Offer support and resources for their medical and behavioral health needs.
- Educate them about appropriate use of the emergency room.
- Reinforce the importance of preventive and routine testing such as mammograms, pap smears, colonoscopies, and blood tests.
- Identify primary care providers when needed.
- Encourage early provider appointments during pregnancy.
- Address associated co-morbidities, such as depression, heart disease and obesity-related illnesses.

2. 24/7 Access to a Nurse

The program hosts a 24-hour/7-day a week toll-free line with access to a nurse if clients have questions about their health or the program. In discussions with their clients, nurses incorporate the use of the Healthwise Handbook—a comprehensive handbook distributed to all Medicaid households in Wyoming that contains information on preventing illnesses and caring for minor ailments at home.

3. Educational Materials

There are many clinical interventions used in the health management program. Improved outcomes are generated through interventions of printed, web-based and verbal education and support such as:

- Healthwise Handbook distributed to all Medicaid households.
- Comprehensive illness-specific educational material from a national vendor.
- Bi-annual condition-specific newsletters.
- Web-based education on health, safety and wellness topics.

Specialty Programs Within Healthy Together

1. Wellness and Prevention

Healthy Together provides a wellness and prevention program to encourage clients to stay well and to prevent complications that could lead to an illness or injury. The program includes activities with the goals of:

- Encouraging individuals to practice habits that support ongoing health and vitality.
- Improving clients' ability to be more effective in self-management of their health.

The wellness and prevention program:

- Promotes wellness and educational events, such as health fairs, blood draws, annual wellness check-ups and screenings throughout the state.
- Distributes educational materials to clients and their families that explain appropriate use of resources and when to seek medical attention.

2. Healthy Additions

The Healthy Additions program is specifically for pregnant women. Nurses with several years of maternity experience assist women with education, support, and resources to promote a healthy pregnancy and baby. The health coaches attempt to engage pregnant women into the program during their first trimester. A few of the resources available to the women through this program are:

- Educational materials specifically about what to expect during pregnancy and how to remain healthy during pregnancy.
- "Text 4 Baby" is a resource that is promoted in this program.
- 24/7 nurse support line.
- In addition, topics like Women, Infants, and Children (WIC), Pregnancy by Choice Waiver, and resources such as public health nursing are discussed.

3. Health Buddy

Health Buddy is a telehealth device that is designed to provide education, obtain clinical information, and test client knowledge on a daily basis. It supports clients in rural and urban locations and provides a communication link between providers, clients, and health coaches. The following list identifies several **National Committee for Quality Assurance** programs via the Health Buddy available for Medicaid clients based on their healthcare needs.

- Adult Asthma
- Pediatric Asthma
- Chronic Obstructive Pulmonary Disease
- Chronic Obstructive Pulmonary Disease and hypertension
- Coronary Artery Disease
- Diabetes
- Diabetes and hypertension
- Depression
- Heart failure
- Heart failure and diabetes
- Heart failures, diabetes, and hypertension
- Hypertension

Section II: Utilization Management

Introduction to Utilization Management

The goal of Utilization Management (UM) is to reduce inappropriate utilization of services while allowing the individual to obtain the services that best meet his or her healthcare needs. A benefit of APS managing both the Health Management Program (HM) and UM services is its ability to refer at-risk individuals—those who may benefit from health management, case management, counseling, or other support—who are identified within the UM process to its other programs and services.

By reviewing admissions, procedures and services, UM evaluates:

- Medical necessity of an admission, continued stay and/or course of treatment or service (“medical necessity” as defined in Chapter 1, Definitions of the Wyoming Medicaid Rules and Regulations).
- Adequacy of the discharge plan in relation to a client’s capabilities and resources.
- Efficiency of the use of healthcare services, procedures and facilities under the provisions of the Medicaid rules and regulations.

Federal regulations require Medicaid programs to review any service (admission or procedure) where it is anticipated or known that the service could either be over or underutilized, or otherwise abused, by providers or clients, or easily result in excessive, uncontrollable Medicaid costs. This is accomplished through prior authorizations for certain procedures and inpatient admissions.

Are Facilities/Providers Required to Complete the APS Prior Authorization Form if the Client has Other Insurance?

If a client has insurance with another carrier or Medicare, the facility/provider is not required to request prior authorization from APS Healthcare unless one of the following occurs:

1. The client has primary insurance with another carrier or Medicare but the benefit plan does not provide benefits for the service(s) being requested. The facility/provider is required to complete the prior authorization process for clients who do not have coverage under the primary insurance carrier or Medicare.
2. The client has primary insurance with another carrier and the benefit has been exhausted for the service being requested. The facility is required to complete the authorization process after notification that the primary insurance has maximized the benefit.

Please note that this applies only to benefits covered by Wyoming Medicaid that also require prior authorization from APS Healthcare. Medicaid is considered the payer of last resort. If no prior authorization is obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.

Prior Authorization

Prior authorization (PA) is utilization management that is conducted prior to a Medicaid client's procedure or admission. Requests for prior authorizations (PA's) are required to be submitted before the initiation of the following services:

- Transplants.*
- Weight loss surgery.
- Vagal nerve stimulator (VNS).
- Inpatient physical rehabilitation.
- Skilled nursing extraordinary care.
- Psychiatric Residential Treatment Facilities (PRTF). See page 19 for PRTF details.

*The transplant PA's are effective for one year and will need to be updated if the service is not completed during the first year.

Submission of Information for the Prior Authorization

The provider shall submit a completed prior authorization form and supporting documentation at least 3 working days before providing services. APS Healthcare may request additional information in order to complete the review. Operational hours for Wyoming Medicaid reviews are 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday, with the exception of State holidays. Information submitted for UM reviews should be submitted by fax or via the web-portal. Reviews are not performed over the telephone.

Criteria for Review

Prior authorization (PA) shall be granted if all of the following are met. The services:

- Are covered services under Wyoming Medicaid.
- Are consistent with the client's diagnosis.
- Are medically necessary based on established criteria by the rules of the Office of Healthcare Financing. The criteria used to determine medical necessity for all services requiring a PA are available on the internet at the following website:
<http://www.wyhealthytogether.com>.
- All sources of third-party liability have been exhausted.

Granting prior authorization shall constitute approval for the provider to receive Medicaid reimbursement for the approved services to be furnished, subject to the requirements of this rule and post-payment review. Prior authorization is not a guarantee of the client's eligibility or a guarantee of Medicaid payment.

Approval of Prior Authorization (PA)

Once the admission form is received from the facility, APS will review the demographic and clinical information. If the form is complete and there is supporting documentation for the need for the service/admission, the utilization management (UM) reviewer will provide a 10-digit prior authorization number to the facility/provider. All reviews are based on medical necessity.

Denial of Prior Authorization

- If a UM reviewer determines that the information provided by the provider/facility does not have adequate clinical data/medical necessity to support an approval, the review will be sent to a licensed provider for determination and peer review.
- The provider completing the peer review will attempt to contact the attending provider to review the client's treatment plan and clinical documentation prior to a denial on the service request.
- If the peer review determines that the requested service does not meet medical necessity, the review will be denied.
- Denial letters will be mailed to the provider, facility and to the client.
- The denial letter provides the instructions and timeline to submit an appeal.

Appeal Process

The provider and/or facility may request an appeal after a denial has been issued.

- After a denial determination is made, the provider may submit a letter of appeal with supporting documentation within 20 business days from the date of denial to APS Healthcare. Or, the provider may submit a revised request for prior authorization with additional clinical information.
- Once the new information is received, the review will be sent to an outside specialty provider who specializes in medical and behavioral health reviews. For example, a weight loss review would be sent to a provider who specializes in weight loss surgery.
- After the review is completed by the specialty matched provider, the denial decision will either be upheld or overturned.
- If the decision is overturned, the provider and facility will be notified that the service was approved.
- If the decision is upheld, the provider and facility will be notified that the service requested is denied. In addition, the facility and provider will be notified in the second denial letter of the reconsideration process. Either the attending physician or the hospital may ask for reconsideration of the denial by the Division pursuant to the provisions of Chapter 16 of the Wyoming Medicaid Rules and Regulations. This process is outlined in the letter sent to the provider and facility.
- A technical denial is not entitled to an appeal

The denial of a prior authorization precludes Medicaid reimbursement for the services in question.

Failure to Obtain a Timely Prior Authorization

Failure to obtain prior authorization before providing services will result in a technical denial and precludes Medicaid reimbursement for such services. Requests for prior authorization should be submitted no less than three working days in advance of services.

Acute Admissions

All Medicaid enrolled acute facilities are responsible for notifying APS Healthcare for authorization of all acute psychiatric/behavioral health admissions. Admission authorizations for acute psychiatric treatment are required to be submitted no later than one business day after admission to the hospital.

A facility must complete and submit the completed admission form and any supporting documentation within 24 hours of admission for the following inpatient hospital services:

- Acute psychiatric stabilization (including detoxification), adult.
- Acute psychiatric stabilization, child/adolescent.

If the admission meets medical necessity and is approved, the facility will receive a PA number by the end of the next working day from the decision date.

If the UM clinical evaluator is unable to determine if the admission meets medical necessity criteria, the admission request is referred to a physician reviewer. See the denial process on page 9.

Continued Stay Reviews

Continued Stay reviews for psychiatric acute admissions are required for clients in the hospital for 7 days and every 7 days beyond the admission date. The facility is required to submit a continued stay review to APS Healthcare for continued authorization until date of discharge.

Case Management Services

Case Management services are available for clients in the acute setting and will be initiated on a case by case basis.

Failure to Obtain Timely Admission Authorization

Failure to obtain admission authorization will result in a technical denial and precludes Medicaid reimbursement for such services. Requests for admission authorization should be submitted no later than 24 hours after admission.

Retroactive Eligibility

An acute facility may seek admission authorization for a client found retroactively eligible for Medicaid coverage after the date of admission for services that require admission authorization. See Retrospective Reviews on page 11 for further details.

Admission Authorization Notification

The issuance of an admission authorization notification is not a guarantee of the client's eligibility for Medicaid payment. Designated admissions are subject to continued stay and/or post-payment review pursuant to Chapter 8, Section 8, in the Wyoming Medicaid Rules and Regulations. An admission authorization may be withdrawn as a result of such reviews.

Continued Stay Reviews

Continued Stay Reviews (CSR's) are required for client admissions to facilitate the most appropriate, cost-effective and timely care for Medicaid clients. The CSR takes place during the time in which a client is confined to the facility. The purpose is to determine if the continued confinement is medically necessary and appropriate.

The following types of admissions are reviewed for continued stays:

- Inpatient physical rehabilitation.
- Skilled nursing extraordinary care.
- Acute Psychiatric care
- Psychiatric Residential Treatment Facility (PRTF), child/adolescent (see PRTF admission criteria on page 21).

Submission of Information for a Continued Stay Review (CSR)

Facilities must submit the continued stay review (CSR) form and supporting documentation to APS Healthcare. Items that are identified in the CSR form include: treatment provided, progress toward goals, and discharge plans.

A clinical reviewer will identify the date the CSR is required at the time the prior authorization is issued and will notify the facility and/or provider. Failure to complete the required continued stay review on the designated date will result in a technical denial of the remainder of the stay, or until a CSR is approved.

Issuing of Determination

The facility will be issued a determination on each CSR. The determination will either be approved or denied. Continued stay reviews will continue until services are completed. Failure to notify APS Healthcare of the continued stay will result in a technical denial.

Retrospective Reviews

A retrospective review is conducted after the date of admission for services that require prior authorization and have been provided. There are three circumstances that meet the criteria for a retrospective review:

- An individual was admitted to a facility and received services that require prior authorization and then, after the admission and services, becomes eligible for Medicaid.
- A facility provided services requiring a prior authorization and then became an Medicaid provider and received its provider enrollment number.
- A facility provided services (that require a prior authorization by Medicaid) for an individual whose primary insurance has reached its coverage maximum and Wyoming Medicaid is the secondary insurer. All appeal attempts must be exhausted. Pursuant to Chapter 35 of the Wyoming Medicaid Rules and Regulations, Medicaid will pay for services only after all sources of third-party liability have been exhausted, except as provided by 42 U.S.C. § 1396d(b) and Title V of the Social Security Act.

Procedure for Obtaining a Retrospective Review

- An attending physician or a facility cannot seek prior authorization for an individual whose application for Medicaid is pending at the time of admission.
- The facility must submit the retrospective review form and the complete medical record to APS Healthcare within thirty (30) days after the hospital receives notice of client eligibility, provider enrollment number, or confirmation from the primary insurance carrier that coverage has been maximized. Failure to request retrospective certification in a timely manner or failure to submit the complete medical record will result in a technical denial.
- The date/method of notice of eligibility and/or end of insurance benefits should be included with the request for review.

Technical Denials

A technical denial is a determination to deny admission authorization because of a provider’s failure to comply with the timeliness or other procedural requirements outlined in Chapter 8 of the Wyoming Medicaid Rules and Regulations. A technical denial is a final agency action.

Utilization Timeline Requirements

The chart below summarizes the timeline requirements for all utilization management requests. Information submitted for UM reviews should be submitted by fax or web-portal. APS Healthcare does not perform reviews over the phone.

APS Healthcare and Medicaid Notification Requirements	
Admission Certification Reviews	
Psychiatric /behavioral health services	Acute psychiatric stabilization (including detoxification) for adult: within one (1) working day of admission. Acute psychiatric stabilization for child/adolescent: within one (1) working day of admission.
Weight loss surgery	No less than three (3) working days in advance.
Extraordinary care	No less than three (3) working days in advance.
Transplants	No less than three (3) working days in advance.
Physical rehabilitation	No less than three (3) working days in advance.
Psychiatric Residential Treatment Facility (PRTF)	No less than three (3) working days in advance.
Please Note:	The facility must notify APS Healthcare within 1 day of admission for services that do not have a verified admission date. For example, a transplant may receive a prior authorization; however, the date for the transplant is not yet determined. When the client is admitted for the transplant, the facility has one business day to notify APS of the actual admission date.

Continued Stay Reviews (CSRs)	
Physical rehabilitation services	Seven (7) to thirty (30) day intervals depending on medical necessity.
Acute psychiatric care	At seven day intervals
CSRs for skilled nursing extraordinary care	At 15 days, 30 days, three (3) months, and yearly thereafter.
CSRs for Psychiatric Residential Treatment Facility (PRTF) services	Seven (7) to thirty (30) day intervals depending on medical necessity.
Retrospective Reviews	
All inpatient admissions requiring admission certification	Within 30 days after notification of eligibility for Medicaid benefits, eligibility for Medicaid provider status, or notification that primary insurance is maxed.
Appeals	
Appeals for any denial	Within 20 calendar days of the date of the denial notice.

Post-Pay Reviews

Post-pay reviews are performed at the direction of the State of Wyoming. Post payment reviews are conducted after a Wyoming Medicaid client's admission, stay, or other course of treatment or service has been completed. As defined in Chapter 8, Section 13 of the Wyoming Medicaid Rules and Regulations, the Division may conduct a post-payment review to evaluate medical necessity, level of care, quality of care, and under/over or inappropriate utilization of services.

A complete client record for specified dates of service is requested through a medical record request letter. Post-pay reviews are conducted as follows:

- Random Sample Reviews: Review of inpatient, outpatient and hospital services provided to Medicaid clients.
- Outlier Reviews: Review of care from client stays that are longer than would be expected under the level-of-care guidelines.
- Designated admissions are subject to post-pay reviews pursuant to Wyoming Medicaid Rules and Regulations, Chapter 8, Section 8. A prior authorization or admission certification may be withdrawn as a result of such reviews.

According to Wyoming Medicaid Rules and Regulations Chapter 16, providers are required to send all medical record components in a legible format. All components must be received via mail within 20 working days of the initial request. It is the responsibility of the provider to confirm that APS Healthcare has received the required documentation.

Focused Reviews

Focused reviews are performed at the direction of the State of Wyoming. The state may request the medical records from the providers. These reviews may be focused on a single provider, client or procedure, or as broad based as an entire category of service, class of client or provider type, and are in conjunction with special outcome studies. The focused review may be for any of the following: over, under and/or improper utilization of services and high-cost/high-volume services.

Provider Comments

Wyoming Medicaid is committed to assuring client and provider satisfaction with the care and services they receive. Annually, a survey is mailed to all providers of Wyoming Medicaid to determine satisfaction with the Healthy Together health management program. Providers have an opportunity to rate several aspects of the program, as well as provide comments and suggestions.

Complaint Process

APS Healthcare registers and responds to verbal and written complaints received from clients, a client's representative, practitioners, providers or other interested parties about its utilization management and health management program and services. All comments are important and are viewed as a potential opportunity for improvement. APS Healthcare will respond to all customer complaints within 2 business days.

- If a client, a client's representative, practitioner, provider or other interested parties wish to issue a formal complaint or comment based on the service they have received from APS Healthcare, please contact the APS Wyoming Clinical Manager via telephone at 1-888-545-1710, ext. 7145.
- The Clinical Manager will review and address the complaint with the appropriate person within two (2) business days of receiving the complaint. A response will be issued by the Clinical Manager within 48 hours or two (2) business days to the individual who issued the complaint/grievance, as well as to the Contract Administrator for the State of Wyoming Medicaid program.
- If the party who issued the complaint/comment does not feel as if the response was satisfactory or was not completed in a timely manner, they are encouraged to submit a written comment to the Medicaid Program Medical Care Coordinator at 6101 N. Yellowstone Rd., Suite 210, Cheyenne, WY 82002.

Section III: Inpatient Census Reports

Purpose

The purpose of the Inpatient Census Report (ICR) is to identify all Wyoming Medicaid client inpatient admissions, discharges and transfers on a weekly basis, as well as to identify those clients who are still inpatient.

Who is Required to Submit an ICR?

Medicaid participating hospitals/facilities located in Wyoming are required to submit an ICR each week. Facilities that are located outside of Wyoming are required to submit an ICR report when they have a Medicaid client in their facility.

Requirements for Submitting an ICR

Inpatient census reports must be submitted using the web-based ICR tool by 5:00 p.m. on Friday of each week. If Friday is not a working day, the ICR must be submitted by the close of business on the next working day.

To be granted user privileges for your facility, please contact APS Healthcare at (888) 545-1710.

Process for Facility Users

Facility users will use the following process for logging in and entering client information.

To log in:

1. Go to <https://wy-hospital-icr.apshealthcare.com>.
2. Enter USER ID and PASSWORD into the corresponding text boxes.
3. Click the SUBMIT button.

When a facility user logs into the application, the application will display the appropriate screen. The facility user has permission to add, edit and delete his/her own client data.

Note: LOG OFF is the only available option in the top navigation bar for the facility user.

To add client data:

1. The facility user can enter the client information in the text boxes presented on the screen.
2. After clicking SUBMIT, the data will be added to the database.
3. The records are displayed in order of date posted. The latest posted record will be displayed first.
4. Five records at a time may be displayed. Use the provided navigator to browse through other records.

To edit client data:

1. Click on the EDIT link in the last column titled, EDIT/DELETE.
2. The application will show the appropriate screen for editing.

3. After the editing is completed, click the SUBMIT button.
4. The application will return to the facility data-entry screen and the modified client data will be displayed.

Note: The CANCEL button will suspend any modifications/changes that were entered during the edit process. The application will return the user to the facility data-entry screen without any modifications/changes to the selected record.

Validations:

- Date field format should be MM/DD/YYYY.
- Admit date should be less than or equal to discharge date.
- Date posted between Friday 5:00 p.m. to the next Friday can be edited within the one-week period.
- To change the facility name, the user needs to place a request to the administrator.

Deleting client data:

Select the record to be deleted. Click on the DELETE link present on the last column titled, EDIT/DELETE. The selected record will be deleted from the database.

Section IV: Skilled Nursing Facilities ICR Process

Purpose

The purpose of the Inpatient Census Report (ICR) is to identify all Wyoming Medicaid client inpatient admissions, discharges, days in and out, and transfers on a monthly basis, as well as to identify those clients who are still inpatients.

Who is Required to Submit an ICR?

Medicaid participating Skilled Nursing Facilities located in Wyoming are required to submit an ICR each month by the 10th of the month. Facilities that are located outside of Wyoming are required to submit an ICR report when they have a Medicaid client in their facility each month by the 10th of the month. To be granted user privileges for your facility, please contact APS Healthcare at (888) 545-1710.

Requirements for Submitting an ICR

Inpatient census reports must be submitted using the web-based ICR tool by 5:00 p.m. on the 10th of each month. If the 10th is not a working day, the ICR must be submitted by the close of business on the next working day.

To be granted user privileges for your facility, please contact APS Healthcare at (888) 545-1710.

Process for Facility Users

Facility users will use the following process for logging in and entering client information.

To log in:

1. Go to <https://wy-hospital-icr.apshealthcare.com>.
2. Enter USER ID and PASSWORD into the corresponding text boxes.
3. Click the SUBMIT button.

The facility user has permission to add, edit and delete his/her own client data.

Note: LOG OFF is the only available option in the top navigation bar for the facility user.

To add client data:

1. The facility user can enter the client information in the text boxes presented on the screen.
2. After clicking SUBMIT, the data will be added to the database and will be displayed on the appropriate screen.
3. The records are displayed in order of date posted. The latest posted record will be displayed first.
4. Five records at a time may be displayed. Use the provided navigator to browse through other records.

To edit client data:

1. Click on the EDIT link in the last column titled, EDIT/DELETE.
2. The application will show the appropriate screen for editing.
3. After the editing is completed, click the SUBMIT button.

The application will return to the facility data-entry screen and the modified client data will be displayed.

Note: The CANCEL button will suspend any modifications/changes that were entered during the edit process. The application will return the user to the facility data-entry screen without any modifications/changes to the selected record.

Validations:

- Date field format should be MM/DD/YYYY.
- Admit date should be less than or equal to the discharge date.
- To change the facility name, the user needs to place a request to the administrator.

Deleting client data:

Select the record to be deleted. Click on the DELETE link present on the last column titled, EDIT/DELETE. The selected record will be deleted from the database.

SECTION V: Psychiatric Residential Treatment Facilities

Definition

Psychiatric Residential Treatment Facility (PRTF) is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents up to age 21 who have long-term mental health or psychiatric illnesses and/or serious emotional disturbance(s) that are not likely to respond to short-term interventions and have failed to respond to community based intervention(s).

PRTF's provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality, proactive treatment. In addition to diagnostic and treatment services, PRTF's should also provide instruction and support toward attainment of developmentally appropriate basic living skills/daily living activities that will enable children and adolescents to live in the community upon discharge.

The focus of a PRTF is on improvement of a client's symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; unless evidence shows family therapy would be detrimental to the client. Unless otherwise indicated, the program should facilitate family participation in the treatment planning, implementation of treatment planning, and timely, appropriate discharge planning (which includes assisting the family with varying levels of support and services to ensure a safe, stable and nurturing home environment. This is often referred to as wrap-around services. In effect, it means wrapping a child/family with support until the family reaches an adequate level of self sufficiency). Wyoming Medicaid provides wrap around services within the Children's Mental Health Waiver.

Who Should be Admitted to a PRTF?

A client may be appropriate for admission to a PRTF if he/she has a psychiatric condition that cannot be reversed with treatment in an outpatient treatment setting and the condition is characterized by severely distressing, disruptive and/or immobilizing symptoms which are persistent and pervasive.

Who Should Not be Admitted to a PRTF?

A client who is experiencing acute psychiatric behaviors is not appropriate to be admitted to a PRTF. PRTF services are not the entry point to accessing inpatient psychiatric services.

Prior Authorization for PRTF

Is Prior-Authorization required for admission to a PRTF? Yes, prior-authorization is required prior to admission to a PRTF. The facility must submit the completed admission packet to APS Healthcare 3-7 days prior to the date of the planned admission.

APS Healthcare's admission packet includes the following required information:

- The completed admission form (see Appendix D),
- Physician's order for admission,
- The psychiatric evaluation,

- The estimated length of stay,
- A viable discharge plan, and
- Any other clinical information that justifies admission.¹⁰

Facilities are allowed up to 14 days to submit the individual plan of care, which must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility.¹¹ Based on education and experience, preferably including child psychiatry, the team must be capable of:

- Assessing the client's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities.
- Assessing the potential resources of the client's family.
- Setting treatment objectives.
- Prescribing therapeutic modalities to achieve the plan's objective.

The team must include as a minimum, either,

- A Board-eligible or Board Certified psychiatrist.
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a Master's degree in clinical psychology or who has been certified by the State psychological association.

The team must also include one of the following:

- A psychiatric social worker.
- A registered nurse with specialized training or one year's experience in treating mentally ill individuals.
- An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
- A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.¹¹

The expected length of stay for WY Medicaid clients is no longer than 120 days.* Treatment plans, interventions, medication management, and discharge plans must reflect adherence to this timeline.¹²

*Exception: There may be some instances where a client requires a longer length of stay. These circumstances will be addressed on a case-by-case basis.

PRTF Admission Criteria

What are the criteria for Admission (ADM) to a PRTF? The following outlines the PRTF Admission Criteria: The client must meet all 5.

1. The client presents with a longstanding (at least 6 months) psychiatric diagnosis characterized by severely distressing, disruptive and/or immobilizing symptoms that are persistent and pervasive and which cannot be reversed with treatment in an outpatient treatment setting, or is being stepped down in intensity from an acute psychiatric facility. The diagnosis must meet the criteria for an Axis 1 as defined by the DSM-IV.

Examples would include the following:

- The presence of emotional distress.
- Regression, depression, low frustration tolerance, irritability and/or other psychiatric symptoms that interfere with the client's ability to change behavior and/or mood, form a therapeutic alliance or sustain engagement in treatment.
- Impaired reality testing.
- A condition consistent with an eating disorder diagnosis as described in the current edition of the DSM.

2. There are documented attempts to treat the client with the maximum intensity of services available at a less intensive level of care that cannot meet or has failed to meet the needs of the client within the past 6 months. The client must have failed to respond to outpatient interventions. Six months of alternative, less restrictive levels of care must have been tried and have failed, or are not psychiatrically indicated.^{7,8}

Exception: The client has had a sudden, acute onset of psychiatric illness, and a lower level of care is not psychiatrically indicated.

3. At least one of the patterns of behavior listed below must be present:
 - a. Persistent, pervasive and frequently occurring oppositional/defiant behavior.
 - b. Reckless and/or impulsive behavior, which represents a disregard for the well-being and/or safety of self/others.
 - c. Aggressiveness and/or explosive behavior.
 - d. Gestures with intent to injure self/others, which have not resulted in serious injury, without evidence that such gestures are immediately progressing to life threatening behavior.
 - e. Self-induced vomiting, use of laxatives/diuretics, strict dieting, fasting and/or vigorous exercise.
 - f. Extreme phobic/avoidant behavior.
 - g. Extreme social isolation.

- h. History of repeated life threatening injury to self /others, resulting in acute care admissions within the past 12 months. The client is not currently considered at risk to inflict life-threatening injury to self/others in the residential treatment setting.
- 4. Without intervention, there is clear evidence that the client will likely decompensate and present a risk of serious harm to self or others.
 - 5. A psychiatric evaluation by a psychiatrist that specializes in Child/Adolescent Psychiatry. Psychiatrists must be licensed and in good standing. The evaluation must take place no more than 30 days prior to PRTF Admission. ^{7,9}

What are the required items to be completed in the admission form?

(See Admission Form in Appendix)

- a. Initial diagnostic assessment.
- b. Medical, psychiatric and substance use history.
- c. Family and social assessment.
- d. Client assets and strengths.
- e. Developmental history and current developmental functioning with respect to physical, psychological and social areas, including age-appropriate adaptive functioning and social problem-solving.
- f. Psycho-educational assessment.
- g. An assessment of the need for psychological testing, neurological evaluation and speech, hearing and language evaluations.
- h. A problem list, related to the reasons why the client was admitted to this level of care.
- i. Identification of interventions for the immediate management of the problems identified in 8.
- j. The treatment objectives (desired client responses) expected to be met by the time of the first continued stay review.

Continued Stay Reviews for PRTF

What must be submitted to APS Healthcare during the first Continued Stay Review (CSR)?

The following must be submitted to APS Healthcare during the first CSR:

1. The first CSR form must be submitted to APS within 14 days of admission.
2. A psychiatric evaluation completed by the facility psychiatrist.
3. If the client is court-ordered to the facility, a copy of the court-order paperwork must accompany the submission of the CSR form.

What are the criteria for Continued Stay Review (CSR) at a PRTF?

1. The client continues to display a pattern of disturbance of thought, affect, adaptation and/or behaviors which are related to his/her psychiatric condition and requires 24 hour supervision.
2. Symptoms present at admission persist but are responding to treatment and/or a change in level of functioning occurs and/or a new problem/diagnostic aspect is discovered requiring ongoing treatment.
3. All therapies and activities outlined in the individualized treatment plan are provided within specified timeframes and reviewed by the interdisciplinary team.
 - a. The facility shall identify the interventions and treatment modalities that are being used to address each of the client's identified problem areas. The provider must indicate through documentation the progress that is being made by describing intended outcomes and actual outcomes. ^{7, 15, 16}
 - b. Interventions set to achieve objectives and goals within each reporting period must be concrete, realistic and measurable. Progress reports on all goals are required. If a goal is changed or not met, a clinical explanation as well as adjustments to the treatment plan must be documented and provided in the continued stay review. ^{7, 17}
 - c. Each client must have a designated treatment team that may include, but is not limited to: a psychiatrist, therapist, nurse, parent(s), guardian(s), family care coordinator (FCC), clients, program managers, APS Healthcare case manager, teachers, Guardian Ad Litem (GAL), Department of Family Services (DFS) representative and outdoor/recreational specialists. ^{7, 10}
 - d. The client must demonstrate an ability and capacity to respond favorably to therapeutic intervention. If the client refuses to participate in treatment, is not responding to treatment, or is decompensating over time despite therapeutic intervention, alternative facilities may be considered. Clients who exhibit the aforementioned may be sent to a peer review for discussion and/or determination. ^{7, 18}

- e. Individual Therapy must take place a minimum of one (1) hour per week, however, two sessions per week for one hour each session is recommended. ¹³

**Exception:* If a client is unable to maintain during the session for an hour at a time, sessions may be broken up throughout the week into smaller time frames so that the total weekly time for individual therapy is not less than one (1) hour.

- f. Family therapy must take place once a week for at least one (1) hour. ¹⁰

**Exception:* If a client is unable to maintain during the session for an hour at a time, sessions may be broken up throughout the week into smaller timeframes so that the total weekly time for family therapy is not less than one (1) hour.

- 4. Discharge planning is continuous and involving the client and family/guardian:
 - a. It is expected that a child/adolescent's primary psychiatric condition will be stabilized within 4 months of PRTF level of care. It is in the best interest of the client to be treated in the least restrictive environment. When a client no longer meets PRTF criteria for inpatient status, the appropriate transfer or discharge plans must immediately be implemented. This may include but is not limited to: discharge to home or to local home area which includes assistance from outpatient wrap around services, Residential Treatment Center (RTC), group home, and/or therapeutic foster home.
 - b. Discharge planning must begin at admission. Even if the discharge plan has to be updated each month, the facility and guardian(s) must know where the child/adolescent would go if they had to discharge immediately for any reason. APS Healthcare may send a request for admission or for continued stay to peer review for lack of discharge planning. ¹⁸
 - c. If a facility states a client has reached his/her maximum therapeutic benefit, or the client has plateaued in his/her treatment, then the facility must work with APS Healthcare and any other members of the treatment team to identify appropriate alternative placement. ¹⁸
 - d. A discharge summary must be sent to APS Healthcare within 30 days of discharge from a PRTF. Discharge summaries must also be sent to the client's community providers, the family care coordinator (FCC) and the school the client attends post-treatment. ⁴
 - e. Clients must discharge from a facility with both a 7-day and a 30-day follow up appointment with a mental health provider. It is the responsibility of the facility to assist the client with discharge planning and appointments. The appointment, including the date, time and provider, must be listed on the discharge summary. ⁴
 - f. Clients must discharge with prescriptions for their currently prescribed medications. Clients who are not supplied with prescriptions must be supplied with sufficient medication to sustain them until their first scheduled medication management appointment. Medications and/or prescriptions sent with the client must be listed on the discharge summary.

What items are required to be addressed for a Continued Stay at a PRTF?
(See CSR Form in Appendix)

1. The treatment team has completed the essential admission assessments and developed an interdisciplinary treatment plan.
2. An interdisciplinary treatment plan that must contain:
 - a. A list of problems related to the reason for admission.
 - b. A list of treatment modalities to address identified problems.
 - c. A description of measurable treatment objectives expected within the next review interval, which will indicate progress in achieving discharge goals.
 - d. A description of the discharge goals with an estimated discharge date.
 - e. A description of any special therapeutic assistance, if required to help the client achieve treatment objectives.
 - f. A description of the family services to be provided. It is expected that family of clients will be available to comply with family therapy for at least one full hour per week that address the following:
 - Identification of any family issues which require stabilization.
 - Identification of factors which may have created a crisis in the family and/or exacerbated the client's psychiatric condition must be provided.
 - Educating the family/primary caretakers regarding the client's condition and/or developing ways to support the client's progress in treatment.
 - Description of the changes in client and family responses required before the client can safely be discharged to the home setting.
 - A schedule for providing family services with the frequency necessary for the timely achievement of treatment objectives and discharge goals.
 - There may be occasions when family therapy is contraindicated for psychological reasons. In such instances, provisions should be made for helping the child deal with any psychological trauma caused by this situation.
 - When a return to the family/primary caretakers is not going to be possible, alternative placement and discharge planning arrangements should begin at the earliest possible date.
 - There may be occasions where the family expresses unwillingness to be involved with the child in therapy or after discharge. In such instances, each case will be dealt with on an individual basis.
3. Assessment which identifies the treatment objectives which have been achieved at this point in treatment and the discharge goals remaining to be achieved at this level of care.

4. Client Condition Summary:
 - a. The treatment objectives which have not been achieved as expected at this point in treatment.
 - b. Factors interfering with the client's ability to meet treatment objectives.
 - c. The continuing appropriateness of the current treatment objectives.
 - d. The continuing appropriateness of the modalities and interventions selected.
 - e. There is a description of measurable treatment objectives expected within the next review interval, which will indicate progress in achieving discharge goals.

5. Discharge Planning: A summary that includes an assessment of problem areas related to maintaining improvement achieved at this level of care, and arrangements for appropriate therapeutic services following discharge to assist the client in maintaining improvement achieved at this level of care. In addition, documentation must indicate active planning in identifying wrap around services in the community.

How Will the PRTF Know When the CSR is Due?

APS Healthcare will provide the PRTF a Prior Authorization (PA) number if the admission meets medical necessity. In addition, APS Healthcare will notify the facility when the next CSR form is due. The number of days approved may vary from 7- 30 days depending on the clinical presentation of the child/adolescent and also on the facilities documentation and compliance with submitting all items listed above under "What is Required for a CSR."

What is Peer Review?

If the APS utilization reviewer cannot make a medical necessity decision based on the clinical information submitted for review, the review is sent to a psychiatrist/physician reviewer. It is a URAC requirement that the APS utilization reviewer cannot deny a review based on medical necessity. A denial can only be determined by a psychiatrist or physician with current credentials and experience in behavioral health. ASP has psychiatrist reviewers and also contracts with psychiatrists and physicians as needed to complete behavioral health reviews.

Can a Residential Treatment Center (RTC) Request a PA Number for a Medicaid Client?

Medicaid cannot reimburse RTC's for room and board services. Please call ACS Provider Relations at 1-800-251-1268 if there are questions on what fees can be submitted for reimbursement.

Can a PRTF Request Therapeutic Passes?

A facility can request a therapeutic pass. APS Healthcare should be notified of all therapeutic passes prior to the planned leave of absence. Medicaid reimbursement is available for reserving beds in a PRTF for therapeutic leaves of absence of Medicaid clients less than twenty-one (21) years of age at the regular per diem rate when all of the following conditions are present:

1. A therapeutic leave of absence must be for therapeutic reasons as prescribed by the attending psychiatrist/physician and as indicated in the client's habilitation plan.

2. A physician's order for therapeutic leave must be maintained in the client's file at the facility.
3. The total length of time allotted for therapeutic leave of absence in any calendar year shall be fourteen (14) days. If the client is absent from the PRTF for more than fourteen (14) days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that client in that year.
4. In no instance will Medicaid reimburse a PRTF for reserving beds for Medicaid clients when the facility has an occupancy rate of less than ninety percent (90%). The occupancy rate is based on the total number of licensed beds. The PRTF is required to submit verification that the occupancy rate was at 90% or higher during any therapeutic leave of absence in order to obtain reimbursement for those days. If the bed rate is less than 90%, the facility should bill therapeutic leave days as non-covered days which are not eligible for reimbursement.

What is Required for Transferring a Client From one PRTF to Another PRTF?

1. A letter from the attending MD must be submitted to APS Healthcare describing the medical necessity to transfer the client from one PRTF to another PRTF.
2. The two PRTF facilities must work out arrangements for transporting the client to the new facility. The accepting facility can be referred to the ACS Travel Call Center for possible travel benefits at 800-595-0011. If a higher level of transportation is needed, for example, air flight or ambulance, the attending MD must submit a letter of medical necessity to APS Healthcare. APS Healthcare will coordinate with Medicaid to arrange the appropriate travel on a case-by-case basis.
3. The receiving facility will be required to follow the prior authorization process for a PRTF admission.
4. APS Healthcare can provide the family/guardian and/or other providers information about the PRTFs and their specialties.

Are Case Management Services Available for Medicaid Clients in PRTF's?

Yes. Case Management services are available to all WY Medicaid clients in a PRTF. Please call 1-888-545-1710 to refer a client to case management services or complete an APS referral form and fax it to APS Healthcare at 1-888- 245-1928. The referral form is attached in the Appendix section of this manual or you can obtain a referral form from the APS Healthcare website at www.wyhealthytogether.com.

What is the Role of the APS Behavioral Health Case Manager?

The role of the case manager is to assess the needs and potential needs of the client by gathering clinical information and coordinating efforts with different entities. These may include the parent/guardian, Department of Family Services (DFS) worker, guardian ad litem (GAL), facility, provider, therapist, etc. The case manager coordinates input from the different entities to facilitate appropriate support services and discharge planning. In addition, the case manager collaborates with the Children's Mental Health Waiver to ensure clients follow up services after discharge.

How Are Court Ordered Youth Cases Handled?

Youth may be court ordered to specific PRTF's in and outside of Wyoming. The admission and continued stay review process is the same for these youth. The APS case managers maintain close contact with DFS and the facility through emails and phone contact to communicate during the admission, continued stay, and discharge transition periods. APS allows DFS and facilities up to 30 transitional days for a youth who is approaching a lower level of care based on medical necessity. This allows DFS to schedule appropriate MDT or other judicial meetings. This proactive approach is to assist with seamless transitions and to prevent late notifications of transitions. In some instances, the youth may require continued residential treatment at the RTC level. In these circumstances, the funding source is transitioned to DFS. Because these youth are court ordered to a treatment program, APS Healthcare does not facilitate a discharge, rather a transition to DFS funding when the youth no longer meets medical necessity for a PRTF level of care.

What are the Expectations at the Time of Discharge from a PRTF?

It is expected that the discharge plan has been discussed and reviewed by the treatment team at the facility, APS Healthcare, the parents and/or guardians/foster parents and any other care providers such as waiver case workers. The discharge plan should be viable and well thought out for a successful discharge. The parents/guardians should be actively involved in developing the discharge plan and follow-up services. A typical discharge plan should include the following:

1. The initial follow-up appointment must be scheduled with a counselor/therapist, doctor or other provider to occur within 7 days of discharge.
2. Availability of a provider for follow-up and treatment who will continue treatment and management.
3. Medication list of prescription refills to be obtained at a local pharmacy.
4. Instructions of who and when to call if behaviors escalate or become out of control.
5. Names and phone numbers for resources available to the client/family.
6. Referral to the Children's Mental Health waiver or community mental health programs for additional support and services.

Are Facilities Required to Complete the APS Admission Form if the Client has Other Insurance?

If a client has insurance with another carrier, the facility is not required to request authorization with APS Healthcare unless one of the following occurs:

1. The client has primary insurance with another carrier, but the benefit plan does not provide benefits for the services being requested. The facility is required to complete the authorization process for clients who do not have coverage under the primary insurance carrier.
2. The client has primary insurance with another carrier and the benefit has been exhausted for the service being requested. The facility is required to complete the authorization process after notification that the primary insurance has maximized the benefit.

Section VI: Extraordinary Care

Wyoming Nursing Facility Extraordinary Care Criteria

Recipients may qualify for this benefit if they have Minimum Data Set (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:

1. Automatic Qualification:
Ventilator Dependence

2. 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.

3. Other conditions where special care or clinically complex care is required will be evaluated on a case-by-case basis by the Department.

4. Criteria are subject to change.

Provider Documentation Required

- New Requests: Completed packet (following), 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 occurs 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 at 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.

Section VII: Preadmission Screening and Resident Review (PASRR)

Introduction and Definitions

Level II PASRR Information

The information may be of use to Certified Mental Health Center staff and others interested in the determination process of whether there is a diagnosis of mental illness or mental retardation, appropriate care, related laws, and requirements.

Authorization

Preadmission Screening and Resident Reviews (PASRR's) are federally mandated screenings directed by the Medicaid Title XIX Program, Medicaid. The Mental Health and Substance Abuse Services Division (MHSASD) has final authority for mental illness (MI). Developmental Disabilities Division (DDD) has final authority for mental retardation (MR). The agent can delegate any function for which it has authority. Currently, APS Healthcare has been delegated this responsibility by both Divisions.

Purpose

The purpose is to assure appropriateness of placement and care for any person with MI or MR or any person thought to have MI or MR or who has had a change in their mental status AND who is either already in a nursing facility or who is applying for admission to a nursing facility.

Policy

All persons needing admission to a nursing facility must have a Preadmission Screening for possible mental illness (Level I). If mental illness appears to exist, the person must be referred for further evaluation (Level II).

All persons who reside in a nursing facility are subject to Resident Review if there is a substantial change in their mental status which warrants a referral for an evaluation (Level II).

Persons may not be admitted to a nursing home until the Level I screening is completed and if necessary, until the Level II evaluation is completed.

PASRR Evaluations

There are multiple levels involved with PASRR screening. PASRR Level I is performed on all clients entering into a Medicaid certified nursing facility. The link for completing the PASRR Level I is <http://wyequalitycare.acs-inc.com/index.html>. Level II evaluations are screenings for nursing facility applicants and residents who are thought to have serious MI and/or MR, to accurately assess whether an individual needs specialized services and/or nursing facility level of care. Level II screening packets are required to include:

- PASRR Level I
- Psychosocial evaluation
- Psychiatric evaluation, if on file
- LT101 less than 60 days old
- Current history and physical
- Current medications

- Progress notes
- If MR, a comprehensive medication history and IQ testing
- Informed Consent Form

Fax the completed packet to APS Healthcare, Attention: Sandra Jensen, at 1-866-858-8476, for a Level II PASRR review to be completed. Determination of Appropriateness for nursing facility placement is made by a qualified mental health clinician at APS Healthcare with coordination between MHSASD/DDD and Medicaid as necessary.

Resident Review

Nursing facilities will conduct Resident Reviews and will refer residents for a Level II evaluation when there has been a significant change in the resident's mental status. This may sometimes be identified in the routine MDS (Minimum Data Set).

The following completed forms and information must be included in the packet:

- Level I PASRR Screening from patient record
- Request for Level II PASRR Evaluation and Determination
- Previous Level II referral packet, if applicable
- Completed MDS form
- Relevant case notes/records of treatment

Minimum Data Set (MDS)

The Minimum Data Set (MDS) is part of the federally mandated process for regular clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems and significant changes in the patient's mental status. Significant mental health related changes in the MDS will trigger a Level II Resident Review.

Time Sensitive

Clients who are screened for PASRR II are often in urgent need of structured care. Completion of PASRR screenings, evaluations, determinations and related paperwork are all time sensitive; please submit all the required documentation listed above on the first submission to avoid delays in determinations. After the screening packet is complete and received by APS, a MH Clinician performs a final evaluation.

Contacts

Clarification on matters related to the Level II portion of PASRR's may be obtained by calling Sandra Jensen at APS Healthcare at 1-866-880-4080, ext. 8930. Clarifications related to billing portions of PASRR screenings may be obtained by calling ACS at 1-800-251-1268.

Helpful Links to Forms:

<http://wdh.state.wy.us/mhsa/treatment/PASRR.html>

<http://www.wyhealthytogether.com>

<http://wyequalitycare.acs-inc.com/index.html>

Responsibilities and Protocols for Level II PASRR Evaluations for Mental Illness/Mental Retardation

- I. Nursing Facilities (NF) and Hospitals
 1. Log on to the ACS web portal, <http://wyequalitycare.acs-inc.com/index.html>, and complete the Level 1 PASRR. If a Level I PASRR indicates serious mental illness or mental retardation, fax a completed packet to APS Healthcare, Attention: Sandra Jensen, at 1-866-858-8476 for a Level II PASRR review to be completed. If the Level I PASRR indicates no serious mental illness or mental retardation, it is okay to admit the client.
 2. Complete packet requirements are:
 - PASRR I
 - Psychosocial evaluation
 - Psychiatric evaluation (if on file and < 2 years old)
 - LT101 less than 60 days old
 - Current history and physical
 - Current medications
 - Progress notes
 - Informed Consent Form
 - If MR, a comprehensive medication history and IQ Testing

On the fax coversheet, you must include your name, phone number, fax number and email address.

3. Refer those persons who are in need of a psychosocial evaluation to a local community mental health center to complete it as soon as possible. Time is of the essence in gathering information and making the determination.
4. Refer those persons who are in need of a LT101 evaluation to a local public health office to complete it as soon as possible.
5. If there is a determination that NF placement is not appropriate, APS Healthcare will assist in the coordination of care in consultation with the resident and resident's family or legal representative and caregivers to:
 - a. Arrange for safe orderly discharge of the resident.
 - b. Prepare and orient the resident for such discharge.
6. File Level II Determination Summary and Notification in the patient's chart.

II. Community Health Centers

Accept a referral for the psychosocial evaluation from any nursing facility or hospital in your county. The psychosocial evaluation needs to be completed and received by the referral source within three (3) working days upon actual referral.

III. APS Healthcare Responsibilities

1. A delegated authority at APS Florida receives each referral and determines if all required documents are in the referral packet. If all documents are in the packet then referral is assigned to a reviewer. If the referral packet is incomplete then a *Notice of Missing Documentation Letter* is faxed or emailed to the referral source. If the missing documentation is not received within 2 business days then an *Administrative Closure Letter* is faxed or emailed to the referral source and mailed to client and/or guardian. If APS Florida receives the missing documentation within 2 days, the referral is then assigned to a reviewer.
2. The reviewer determines if the documents contain needed information and are representative of the client's current level of functioning. If not, additional information is requested within 2 business days by fax or emailing the referral source the *Notice of Necessary Clinical Documentation Letter*. After receiving additional information, if determination cannot be made, then outreach will be done via telephone to obtain additional information from the referring physician/provider. If yes, a determination is made; a *Determination Summary Report* is completed and uploaded into the APS Wyoming C3 Health Database. If Specialized Services (SS) are needed, a recommended plan of care is included as part of the Determination Summary Report. APS Wyoming will monitor nursing facility compliance for SS.
3. Upon approval, a delegated authority at APS will send the *Notice of Determination Letter* by first class mail to the client/legal guardian and facility. In addition, a letter will be sent to the physician and Wyoming Ombudsman via fax or email. A delegated authority also notifies ACS and APS Wyoming by *Memo* email. Final determination will be made on an annual average of 7-9 days.
4. Upon receiving the ACS *Memo* email, APS Wyoming staff will provide placement support by phone:
 - If the client is not appropriate for nursing facility placement, APS Wyoming staff will begin Care Coordination within 1 business day to assist in finding the appropriate place for the client. If the client is appropriate for nursing facility placement and the client requires SS, APS Wyoming staff will contact the admitting facility within 1 business day to verify the facility can provide the SS and discuss the importance of maintaining documentation of the SS.
 - If the client does not require SS, APS Wyoming staff will call the facility to verify that communication has occurred between the discharge planner at the hospital and the nursing facility social worker to discuss any concerns.

5. Follow-up Recommendations: If SS are recommended, APS Florida will monitor compliance with the Plan of Care recommendations and outcomes. A call will be made to the facility within 2 weeks to ensure compliance with recommendation. If SS are not initiated, the facility will be given two more weeks. A second call will be made at that time. Notifications of non-compliance will be faxed by APS to the Facilities Manager at DHCF (Office of Healthcare Financing) 307-777-6964. Documentation of SS can be requested from APS at anytime.
6. Serious Mental Illness: The determination of whether or not an individual has a serious mental illness involves reviewing the information available in the referral packet for any Diagnostic and Statistical Manual-Forth Edition-Text Revision (DSM-IV-TR) diagnoses, use of psychotropic medications, and current and past outpatient or inpatient psychiatric care. The reviewer will review for any current disturbances in orientation, affect, mood, or behavior.
7. If SS are not recommended, the process is completed. APS will track completed Level II PASRR's and will report to the State monthly.
8. Data Tracking: APS Healthcare's data system will collect and store all information and documents that are submitted. This information will include the patient's mental health diagnosis and monitoring of SS recommended for patients deemed to meet criteria for a serious mental illness and who are in need of interventions to avert or eliminate the need for acute inpatient psychiatric care. This SQL-based system tracks referrals; records outcomes including psychiatric diagnoses, the appropriateness of nursing facility placement, the need for SS; and plans of care while ensuring security and confidentiality. All data is in compliance with applicable federal and state laws (including HIPAA Privacy Rules, 45 C.F.R. Parts 160 and 164). The monitoring of SS involves confirming the initiation of the service at the nursing facility, the duration of the recommended intervention, and the outcome of the service provision. APS monitors and reports the status of SS recommendations on an annual basis. These outcomes may be reported from medical records, self-reported data or a combination of the two measures.
9. Reports: APS Healthcare provides data on the number of referrals for new admissions to nursing facilities (PAS), the number of residents requiring a Resident Review (RR) due to a significant change in their functioning, and referrals for which clinical record reviews and/or Level II evaluations are not completed due to situations such as the death of the patient, discharges/transfers from nursing facilities, those never admitted to nursing facilities, and those admitted for hospitalizations.
10. Quality Assurance: APS Healthcare maintains a policy and procedure to assure excellence in the work process and end product. The Quality Assurance process involves evaluating completed referrals using specific protocols and guidelines to determine the accuracy of determinations and appropriateness of recommendations, if applicable, and the quality of work related to the PASRR Level II evaluations. This program provides for consistent and accurate review practices for determining the appropriateness for a nursing facility placement, need for SS,

and the development of individualized plans of care when SS are deemed necessary. Inter-rater reliability statistics are utilized to monitor the consistency and validity of the determinations. Results of the Quality Analyses are utilized to determine training needs and other quality improvement activities.

IV. MHSASD Responsibilities

MHSASD has delegated their functions and responsibility as the mental health authority for the State of Wyoming to APS Healthcare for approval of the MI determination review for Level II PASRR's.

V. Disposition Based on Results of Level II Evaluation

The Level II evaluation will result in determination of appropriate or inappropriate NF placement or need for Specialized Services. "Placement" refers either to admission or continued residence. The meaning of Special Services, within the context of PASRR/MI level II evaluations, refers to psychiatric consultation, evaluation, psychotherapy, and psychotropic medication management for an acute episode of mental illness, at levels required to avert or eliminate the need for acute inpatient psychiatric care. These determinations carry the right of appeal as defined in 42 CFR Part 483.200 and chapter IV of the State Medicaid Rules:

1. Individual requires NF level of care but does not require specialized services. Placement is authorized. Mental health rehabilitation services may be recommended.
2. Individual requires NF level of care AND specialized services in the NF. (This category also includes residents who do not require NF level of care but who are considered long-term residents under the 30-month rule).
3. Individual does not require NF care and does not require specialized services. Placement is not authorized. Admission is denied. The nursing facility must arrange for orderly discharge and must prepare and orient the resident for discharge.
4. Individual does not require NF level of care but requires specialized services that cannot be provided in the NF. Placement is not authorized. Admission is denied. The nursing facility must arrange for orderly discharge and must prepare and orient the resident for discharge. The 30-month rule applies.
5. No evidence of a serious mental illness. Placement is authorized. No further screening is required.
6. No evidence of serious mental retardation. Placement is authorized. No further screening is required.
7. Individual has a primary diagnosis of dementia or a secondary diagnosis of dementia when the primary diagnosis is not a serious mental illness. Placement is authorized. No further screening is required.
8. Individual is categorically appropriate due to terminal illness or severe medical condition. Placement is authorized.
9. The evaluation was incomplete due to death or discharge.

VI. Contacts for PASRR Level II

If you need clarification regarding the PASRR Level II Process, call Sandra Jensen at 1-866-880-4080, ext. 8930, between 8-5 ET, Monday through Friday. Fax the completed PASRR Level II referral packet to 1-866-858-8476, APS Healthcare, Attention: Sandra Jensen. On the fax cover sheet, you must include your name, phone number, fax number and email address.

- VII. Helpful Links <http://www.wyhealthytogether.com>
<http://wyMedicaid.acs-inc.com/index.html>
<http://wdh.state.wy.us/mhsa/treatment/PASRR.html>
<http://wdh.state.wy.us/DDD/index.html>

**WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING
WYOMING MEDICAID PASRR**

LEVEL II INFORMED CONSENT FORM

NAME: _____

SOCIAL SECURITY #: _____

The Level II PASRR determination notices are adapted to the race, ethnicity, language, and means of communication used by the individual being evaluated.

Please fill in the following:

RACE: _____

ETHNICITY: _____

PRIMARY LANGUAGE: _____

PERFERRED METHOD OF COMMUNICATION: _____

An assessment is required for all persons applying for or receiving assistance for long term care. In order to evaluate my needs, I am giving my consent to the following:

- I agree to an assessment to identify my need for long term care, and to determine if my needs can be met in the community instead of a nursing facility.
- I authorize Wyoming Department of Health (WDH) and APS Healthcare staff to access my medical records. I understand and agree that WDH and APS may need to talk to my doctor and other health professionals. I also understand that they may need to interview family members, close friends and social services professionals about my situation.

Individual or Representative

Relationship (if representative signs) and Contact Information (address, phone, fax, email)

Date

Appeals and Hearings for PASRR Level II

A. Purpose

The purpose of this section is to ensure that individuals who were the subject of WY PASRR Level II evaluations have the right to appeal determinations in a fair and timely manner, consistent with state and federal law. APS Healthcare has established a process policy (in accordance with the Office of Healthcare Financing (DHCF), Wyoming Department of Health Appeal Hearing policy) by which any applicant or their legal representative who is dissatisfied with the outcome of a Level II PASRR can appeal the decision. A copy of this procedure is available to referral sources, the applicant or legal representative upon request.

B. Initiating the Appeal and Fair Hearing Process

The patient is provided instructions for initiating the appeals process, per the Wyoming Medicaid Rules (Rules for Medicaid Administrative Hearings), in the *Notice of Determination* letter received via mail. The appeal must be requested in writing within 30 calendar days following the date of receipt of the determination letter. As explained in the letter, the request for an appeal should be faxed to 1-866-858-8476 or mailed, addressed to:

APS Healthcare
FL PASRR/MI Clinical Manager
2728 Centerview Drive, Suite 201
Tallahassee, FL 32301
(866) 880-4080, ext. 8928

Requests for a hearing are referred to the APS Clinical Manager and are date-stamped upon receipt. From the date the appeal is received by APS, the DHCF has 20 days to review and respond to the appellant. A hearing must occur within 90 days of the PASRR II determination.

C. Reconsideration Review

When a hearing request is received, the APS Clinical Manager conducts a Reconsideration Review in which the documentation available at the time of the initial determination is reviewed for accuracy. If any errors are noted, immediate action is taken to rectify the inaccuracy. The patient or their representative is immediately notified. If the appellant is satisfied with the correction, they may choose to withdraw their request in writing to the address above.

D. Informal Conference

If no error is detected or if the appellant elects not to withdraw their request following an error correction, the APS Clinical Manager schedules a teleconference with the appellant or their representative. The patient or representative is advised the teleconference is optional and does not replace or delay the hearing process. If during the conference a satisfactory decision is made that satisfies the appellant, the request for a hearing may be withdrawn in writing to the address above.

E. Formal Hearing

All requests for a hearing are forwarded by the APS Clinical Manager to Renee Propps, Office of Healthcare Financing. The Facilities Manager will then forward all requests to the Office of Administrative Hearings (OAH) if reconsideration and/or informal teleconference do not result in resolution (within 7 business days). Only OAH can decide to reject an appeal.

APS Healthcare provides expert, telephone testimony in the event the case proceeds to a hearing. All actions to reduce or cancel benefits or services will be reviewed to determine whether or not the appeal was filed within the required 30-day time frame, thereby allowing any current benefits or services to continue until a decision can be rendered by the Hearing Officer.

The potential decisions at any stage of the Appeal and Fair Hearing process include:

- Upheld: The determining authority concurs with the adverse determination or previous appeal decision.
- Partially Overturned: The determining authority modifies the adverse determination or previous appeal decision.
- Overturned: The determining authority does not concur with the adverse determination or previous appeal decision.

The final decision is made by the DHCF following the Medicaid Rules (Rules for Medicaid Administrative Hearing) and no further administrative appeals are allowed.

Section VII: Pay for Participation Program

Overview

The Wyoming Medicaid Pay for Participation (P4P) program allows Medicaid primary care providers additional reimbursement if they complete specific screenings, provide health education for Medicaid clients with chronic illnesses, and refer them into the Healthy Together Health Management program.

How to Get Started

Call **1-888-545-1710** or **307-433-0970** to receive more information and to set up an appointment with APS Healthcare staff.

Healthy Together staff will lead the clinic, step-by-step, through implementing the P4P program:

- APS staff will work with the provider and clinic staff in using the new codes and providing additional suggestions to identify clients and streamline the referral process. APS staff will personalize a referral form for the clinic or make suggestions on how to utilize the clinics' Electronic Health Record for e-referrals.
- Education and screening forms have been developed to assist providers in using up-to-date evidence-based clinical guidelines for patient care. Free client educational tools are available to providers at www.wyhealthytogether.com.
- APS staff will help validate that practice assessments and educational materials are up-to-date with evidence-based clinical guidelines in the individual clinic's Electronic Health Record system.
- A toll-free referral number and fax line is available to refer clients with a new or established chronic illness. Each client receives a personal Health Coach who will provide telephonic case support, reinforce provider treatment plans, provide education, and encourage self-management to assist in improving patients' health outcomes.

Section IX: Appendix

Acute Inpatient Psychiatric Criteria

Acute inpatient psychiatric hospitalization is defined as the highest intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers.

All of the following are required to meet the medical necessity criteria:

1. The patient must have been diagnosed with a psychiatric illness by a licensed mental health professional.
2. Symptoms of the illness must be in accord with those described in the Diagnostic Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
3. One or more of the following must be present:
 - a. Patient presents with suicidal ideation and intention, which represents significant risk of harm, medically significant self-mutilation, and/or a recent lethal attempt to harm self, such that 24-hour/day hospitalization and observation are necessary for the patient's safety.
 - b. Patient presents with a recent history of grossly disruptive/delusional and/or violent behavior representing clear and present danger of serious harm to others.
 - c. The patient's psychiatric condition severely impairs his/her basic functional capacity as evidenced by disorganized, uncontrolled thinking/behavior that represents a genuine and proximal risk of danger to self such that 24-hour/day nursing and medical treatment is required.
 - d. Diagnosis and/or treatment is/are clearly unsafe or impossible to be provided in an ambulatory setting and can only be accomplished with 24-hour intensive nursing and medical care.

Wyoming Healthy Together Referral Form



Commit to your health.

Please complete the referral information below and fax it to **1-888-245-1928**, or you can call **1-888-545-1710**. Client information is kept confidential.

Wyoming Healthy Together Client (Patient)

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone Number(s): _____

DOB: _____

Parent or Guardian Name: _____

Medicaid Number: _____

Primary DX: _____

Reason for referral to program:

- Client needs education (disease, treatment plan)
- Reinforce medication and/or treatment compliance
- Provide links to community resources
- Assist coordination of care and/or services
- Weight Management program
- Language, literacy barrier
- Missed appointment(s)
- Maternal/Prenatal support:
EDC _____ Grav _____ Para _____
- Other: _____

Facility/Provider Information

Name: _____

Referring staff name: _____

Facility/Office: _____

Address: _____

Phone: _____

Fax: _____

Primary Care Physician: _____

Primary Mental Health Provider (if applicable):

Follow-up instructions for Healthy Together Staff

I would like clinical updates:

- Patient information (progress notes after each contact)
- When there are changes or concerns
- Other special follow-up information requested:

Wyoming Healthy Together use only

Date Received _____ Opened _____ Deferred _____ HC _____

ADMISSION CERTIFICATION

Acute Care or Psychiatric Residential Treatment Facility (PRTF) Psychiatric Services

For Wyoming Medicaid

Certification DOES NOT guarantee payment or client eligibility

Date requested:

Admission date:

Facility:

Facility UR rep:

Phone # :

Fax #:

For APS Healthcare Use Only

Date Received:

Approved: Approved YTD:

Denied:

Certified Through/LCD:

Reviewed By:

PCN :

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

Attending physician (first and last name):

Physician Address:

Physician Phone #:

Timelines for clinical information to be faxed to APS Healthcare and Authorization # to be issued:

Acute Care: You have **ONE** Working Day from the date of admission

Psychiatric Residential Treatment Facility (PRTF): You have **FOURTEEN** Calendar Days from the date of admission

PATIENT INFORMATION

Name

Medicaid ID #

Address

Phone #

DOB

Age

SS#

Sex: Male

Female

Who is patient's Legal Guardian?

Phone #

Guardian's Address

Parent's Name

Phone #

DFS Custody? Y N

Who is patient's DFS worker / Probation Office?

Phone #

Is this admission court ordered Yes No *If yes, please attach a copy of court papers.*

Client Name

Medicaid ID #

Type of admission (circle one) Voluntary / Involuntary (Title 25: Y N)

What is the requested level of care? A) Acute Psychiatric Stabilization, Adult.
B) Acute Psychiatric Stabilization, Child/Adolescent.
C) Psychiatric Residential Treatment Facility, Child/Adolescent

DSM IV code(s) (provide ALL code numbers as well as diagnosis names)

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

CLINICAL:

Precipitating Event and information / Signs & symptoms (including mental status exam): Why is patient being admitted to this facility?

Treatment History (previous providers and placements, medication trials, current providers, history of SI/ HI, attempts & self harm behaviors)

Substance use/ abuse issues:

Abuse History:

Was Abuse Reported? Yes No (explain)

Client Name

Medicaid ID #

Family/ Social History (including history of Psych & CD issues in the family):

Family therapy (include specific issues currently being addressed and dates family therapy is scheduled):

Medications ordered on Admission (dosages & frequency; for PRN meds, specify reason and how often used):

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

Patient specific treatment plan w/goals (include: level of observation, interventions, frequency of interventions)

Support System and Availability of Local Services:

Discharge Plan

1. Are wrap around services in the community being explored?
2. Where is the patient being discharged to?
3. Are outpatient services in place? If not, please explain why.
4. Does the patient have a 7 day follow-up appointment with a mental health practitioner?
5. Does the patient have a 30 days follow-up appointment with a mental health practitioner?

If patient is being transitioned to a PRTF or RTC, name of facility:

Client Name

Medicaid ID #

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

PRTF's must complete all of the following requirements for Admission.

1. Include initial diagnostic assessment:
2. Medical, psychiatric and substance abuse history:
3. Family and social assessment:
4. Client strengths and weaknesses:
5. Developmental history and current developmental functioning with respect to physical, psychological and social areas, including age appropriate adaptive functioning and social problem solving:
6. Psycho-educational assessment:
7. An assessment of the need for psychological testing, neurological evaluation and speech, hearing, and language evaluations:
8. Detailed documentation supporting why the patient was admitted to this level of care and the initial management of the problems:
9. The treatment objectives (desired client responses) expected to be met by the time of the first continued stay review:

Estimated length of stay:

Fax complete form to APS Healthcare toll-free @ 1- 888- 245-1928.

Forms can be found on-line at www.wyhealthytogether.com

CONTINUED STAY

Acute Care or Psychiatric Residential Treatment Facility (PRTF)
Psychiatric Services
For Wyoming Medicaid

Required Documentation: Treatment Plan Completed Continued Stay Form

Authorization DOES NOT guarantee payment or client eligibility

Date Requested:

Admission Date:

Facility:

Facility UR rep:

Phone # :

Fax #:

For APS Healthcare Use Only

Date Received:

Approved: Approved YTD:

Denied:

Certified Through/LCD:

Reviewed

By: PCN :

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

CSR should be received by APS Healthcare on the last covered day, from previous review, to avoid any gaps in covered days.

Primary Physician's

Name: Address:

Contact #:

Was this admission court ordered: Y N

Current Guardian name and phone #:

Therapist name and phone#:

Parent current phone#:

PATIENT INFORMATION

Name:

Medicaid ID #:

DOB:

Current DSM IV code(s) (provide ALL code numbers as well as diagnosis names; include any changes)

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

What is the clinical rationale for continued stay at the current level of care since the last review?

Interdisciplinary Treatment Plan

1. **List of problems related to the reason for admission:**

-
-
-
-
-

2. **List of treatment modalities to address identified problems – Include progress and/or difficulties observed in Group Therapy, School, and Milieu summary:**

-
-
-

3. **Provide a description of the measurable treatment objectives expected within the next review interval, which will indicate progress in achieving discharge goals:**

4. **Provide a description of any special therapeutic assistance, if required to help the patient achieve treatment objectives:**

5. **Provide an update on the treatment objectives which have been achieved at this point in treatment and the discharge goals remaining to be achieved at this level of care:**

6. **Provide a description of any incidents of time outs, seclusion, restraints, aggression, etc.:**

7. **Individual Therapy:** Please indicate dates, frequency, and summary of individual therapy:

8. **Family therapy (PRTF only)**: Please include names of those participating, goals, dates of each session and how it supports the discharge plan. (Family therapy must be at least one full hour per week):

9. **Onsite visits (PRTF only)**: Please include names of family participating in onsite visit, dates onsite is to occur, mode of transportation (if known). Family is aware that participation in therapeutic activity must occur daily while onsite to avoid jeopardizing travel reimbursement.

10. **Therapeutic passes (PRTF only)**: Please indicate all date's the patient was out of the facility overnight and note whether your bed rate was over 90% for those dates:

11. **Medications** (dosages & frequency; for Psych PRN meds, specify reason and how often used, include any meds started or discontinued with dates and reason for change):

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

12. **Discharge Planning**: documentation must include progress towards discharge plan including anticipated place of discharge, active planning in identifying wrap around services, and estimated discharge date. Is patient eligible for the Children's Mental Health Waiver services?

13. **Actual Discharge plan**: Include date, mode of transportation, provider names for medication management, specialized therapy aftercare, individual therapy dates, name and phone number of therapist. If the patient is being transferred to a lower level of care, what is the reason and name of the facility the patient being is being transitioned to?

14. **Estimated length of stay**:

Fax completed form to APS Healthcare toll-free @ 1- 888- 245-1928

Forms can be found on-line at www.wyhealthytogether.com

**PRIOR AUTHORIZATION
VAGUS NERVE STIMULATOR (VNS) FOR EPILEPSY
for Wyoming Medicaid**

Note: Prior Authorization DOES NOT guarantee payment or client eligibility

Date requested _____
Admission date _____
Hospital/Surgery Center _____
Hospital/Surgery Center Medicaid ID # _____

For APS Healthcare Use Only	
Date received	_____
Approved	_____ Denied _____
Reviewed By	_____
PA#	_____

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) & surgery codes

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medical necessity: Supporting documentation to include the following:

- Physician statement confirming diagnosis
- Detailed medical history including other diagnoses besides epilepsy
- Quality of Living Assessment (QOL)
- Other therapies tried including anti-epilepsy medication trials and surgeries
- Clear explanation of the need for VNS in patients under 12 years of age
- Clear explanation of why VNS is more appropriate than other methods of treatment for seizures that are not partial onset seizures.

Client name _____ Client Medicaid ID # _____

Physician Information: List ALL physicians who will be involved in the care of the patient.

***Neurosurgeon Name:** _____ **Phone#** _____

Provider (individual) # _____

OR

Group Practice Name: _____ Group Practice Provider ID #: _____

***Neurologist Name:** _____ **Phone#** _____

Provider (individual) # _____

OR

Group Practice Name: _____ Group Practice Provider ID #: _____

***Other Physician Name** _____ **Phone#** _____

Provider (individual) # _____

OR

Group Practice Name: _____ Group Practice Provider ID #: _____

Other contacts:

***Name** _____ **Phone#** _____

Relationship: _____

Financial Information:

Financial contact person _____ **Phone#** _____

Other Insurance? Y / N Name of Company _____ OED:

Medicare? Y / N Part A? Y / N Part B? Y / N

Medicaid is considered the payer of last resort. If no prior authorization is obtained from Medicaid and the primary insurance carrier does not reimburse, Medicaid may deny the claim due to lack of prior authorization.

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928

Forms can be found on-line at www.wyoming.apshealthcare.com

**ADMISSION CERTIFICATION
TRANSPLANT SERVICES**
for Wyoming Medicaid

Note: 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 _____
Procedure _____	
Reviewed By _____	
Auth # _____	

Attending/referring physician (first and last name) _____
 Physician Wyoming Medicaid ID # _____ Phone # _____
 Address _____

You have ONE working day from date of admission to notify APS Healthcare of admission and for an Auth # to be issued.

PATIENT INFORMATION

Name _____ Medicaid # _____
 Address _____ Phone # _____
 DOB _____ SS# _____ Sex: Male Female

Medical history: Type of transplant _____ Date of disease onset _____

Procedure description and CPT Codes(s): _____

ICD-9-CM code(s) (provide ALL code numbers, as well as diagnosis names):

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Medical necessity: *Submit information from primary transplant physician including the following:*

- | | |
|---|--|
| <input type="checkbox"/> * Diagnosis per transplant specialist evaluation | <input type="checkbox"/> * Plan of care |
| <input type="checkbox"/> * Clinical indications for procedure | <input type="checkbox"/> * Medical and/or surgical management of diagnosis including alternative therapies |
| <input type="checkbox"/> * Medical History including comorbidities | <input type="checkbox"/> * Statement of patient's ability to adhere to a disciplined medical regimen |
| Prognosis with and without transplants | |

Client Name _____ Client Medicaid ID# _____

Transplant center: Hospital name _____ Phone # _____

Address _____ Medicaid# _____

Physician Information: List ALL physicians who will be involved in the care of the transplant patient.

*Medical physician name _____ Phone# _____
Medicaid # _____

*Transplant surgeon name _____ Phone# _____
Medicaid # _____

*Assistant surgeon name _____ Phone# _____
Medicaid # _____

*Anesthesiologist name _____ Phone# _____
Medicaid # _____

*Other physician name _____ Phone# _____
Medicaid # _____

Other contacts:

*Transplant coordinator _____ Phone# _____

*Transplant nurse _____ Phone# _____

Financial Information:

Financial contact person _____ Phone# _____

Other insurance (including Medicare) precertification obtained? Y / N / Not required

Medicare? Y / N Part A? Y / N Part B? Y / N

Medicaid is considered the payer of last resort. If no precertification is obtained from Medicaid and the primary insurance carrier does not reimburse, Medicaid may deny the claim due to lack of precertification.

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928.

Forms can be found on-line at www.wyoming.apshealthcare.com

**ADMISSION CERTIFICATION
PHYSICAL REHABILITATION
for Wyoming Medicaid**

Note: 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 # _____

You have one working day from date of admission to notify APS Healthcare of admission and for an Auth # to be issued.

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. _____

Please attach current multi-disciplinary team notes.

1. Rehabilitation consult completed? Y / N Please enclose copy.
2. Reason for rehabilitation/type of injury (date) _____
3. Rehabilitation will help restore to his/her max function or independence? Y / N
4. Medically stable and able to endure active participation in at least three (3) hours of therapy per day five (5) days per week? Y / N
5. Ranchos Amigos scale of at least five (5)? Y / N List level _____
6. Will receive two (2) modalities of therapy 5-6 days per wk? Y / N
7. Requires close daily medical supervision by physicians, 24 hr. rehab nursing and/or other services? Y / N
8. Participate in interdisciplinary team meetings? Y / N Day of week and frequency _____
9. Include treatment plan based on measured goals and realistic expectations _____
10. Member will discharge home / skilled nursing facility / return to lower level of care? Y / N

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928.

CONTINUED STAY PHYSICAL
REHABILITATION for Wyoming
Medicaid

Note: 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 #	_____

PATIENT INFORMATION

Name _____ Medicaid ID # _____

ICD-9-CM code(s) (provide NEW code numbers as well as diagnosis names)

1. _____ 3. _____
2. _____ 4. _____

Please attach current multi-disciplinary team notes.

1. Patient continues to receive three (3) hours of therapy per day five (5) days a week? Y / N

2. Patient continues to receive two (2) therapy modalities per day? Y / N

List therapies _____

3. Members progress (PT, OT, ST notes, new goals) _____

4. Treatment plan reviewed and/or revised every week? Y / N

5. Anticipated discharge date and needs _____

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928.

Note: Certification DOES NOT guarantee payment or client eligibility

Date requested _____
Admission date _____
Contact person _____
Phone _____
Fax _____
Surgery center / hospital _____

For APS Healthcare Use Only	
Date received	_____
Approved	_____ Denied _____
Procedure	_____
Reviewed By	_____
PA#	_____

PROVIDER INFORMATION

Attending/referring physician (first and last name) _____
Physician provider ID # _____ Phone # _____
Address _____

PATIENT INFORMATION

Name _____ Medicaid ID # _____
Address _____ Phone # _____
DOB _____ SS# _____ Sex: Male Female

Procedure description and CPT code(s): _____

ICD-9-CM code(s) (provide ALL code numbers as well as diagnosis names):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medical necessity: Submit documentation from primary bypass physician to support policy attached:

- | | |
|---|--|
| <input type="checkbox"/> Primary diagnosis and obesity-related comorbidity(ies) | <input type="checkbox"/> Six month record of physician-supervised diet and exercise program |
| <input type="checkbox"/> Medical history include height, weight, and BMI | <input type="checkbox"/> Statement of patient's ability to adhere to a disciplined medical regimen |
| <input type="checkbox"/> Prognosis with and without gastric bypass | |

Plan of care pre and post op

Client Name _____ Client Medicaid ID # _____

Physician Information: List ALL physicians who will be involved in the care of the patient.

*Surgeon name _____ phone# _____
Medicaid Provider # _____

*Assistant surgeon name _____ phone# _____
Medicaid Provider # _____

*Other physician name _____ phone# _____
Medicaid Provider # _____

Other contacts:

*Primary care physician _____ phone# _____

*Registered dietician _____ phone# _____

*Clinical psychologist _____ phone# _____

*Physical therapist _____ phone# _____

Financial Information:

Financial contact person _____ phone# _____

Other Insurance (including Medicare) prior authorization obtained? Y / N / Not Required

Medicare? Y / N Part A? Y / N Part B? Y / N

Medicaid is considered the payer of last resort. If no prior authorization is obtained from Medicaid and the primary insurance carrier does not reimburse, Medicaid may deny the claim due to lack of prior authorization.

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
Medicaid

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	1) PASRR & Date	4) History & Physical (<1 yr old)	7) Progress notes
Documentation:	2) LT 101 less than 45 days old	5) Drug history	8) Itemized cost
	3) MDS assessment	6) Nursing Care Plan	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 YTD _____
Approved _____	Denied _____
Certified Through _____	Reviewed By _____
Auth # _____	

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

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



**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 Nursing Facility per diem rate.

REQUESTED NEGOTIATED RATE:

<u>Services under Fee Schedule:</u>	<u>Negotiated Rate per Day</u>
Ventilator Care Check box if applies: <input type="checkbox"/> \$ 435.00	\$ -

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):

_____	\$ -
_____	\$ -

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	<u>\$ -</u>

¹ Maximum coverage of 15 Kits per month.

² Maximum coverage of 10 Canisters per month.

Wyoming Healthy Together - Wyoming Medicaid Health Management Referral Form



Please complete the referral information below and fax it to **1-888-245-1928**, or you can call **1-888-545-1710**.

Client information is kept confidential.

PAY FOR PARTICIPATION (P4P)

Wyoming Healthy Together Client (Patient)

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone Number(s): _____

DOB: _____

Parent or Guardian Name: _____

Medicaid Number: _____

Primary DX: _____

Reason for referral to program:

- Client needs education (disease, treatment plan)
- Reinforce medication and/or treatment compliance
- Provide links to community resources
- Assist coordination of care and/or services
- Weight Management program
- Language, literacy barrier
- Missed appointment(s)
- Maternal/Prenatal support:
EDC _____ Grav _____ Para _____
- Other: _____

Provider Information

Name: _____

Referring staff name: _____

Office: _____

Address: _____

Phone: _____

Fax: _____

Primary Care Physician: _____

Primary Mental Health Provider (if applicable):

Follow-up instructions for Healthy Together Staff

I would like clinical updates:

- Patient information (progress notes after each contact)
- When there are changes or concerns
- Other special follow-up information requested:

Wyoming Healthy Together use only

C3#: _____ REG: _____ TLVL: _____ CC: Y - N HC: _____ RPT: Y - N EP TYPE: NEW - EXIS

DX(s): _____ | _____ | _____

Date Received: _____ Opened: _____ F/U REQ: Y - N

Section X: References and Bibliography

References

- ¹ Retrieved 11-03-10 from: <http://www.cms.gov/manuals/Downloads/bp102c02.pdf> CMS Admission requirement for Acute Psychiatric Inpatient
- ² Retrieved 10/22/2010 from: <http://www.cga.ct.gov/ph/BHPOC/BHWG-AcutePsych092205.htm>, Acute Psychiatric Inpatient Hospitalization, State of Connecticut.
- ³ Wyoming Department of Health, Wyoming Medicaid Rules, Chapter 8, Section 6, b, (i).
- ⁴ Retrieved 10/22/2010 from: http://ahca.myflorida.com/Medicaid/Quality_mc/pdfs/agency_defined_pms_1209.pdf. Medicaid HMO and PSN Performance Measure Specification Manual 12/09 Version.
- ⁵ Retrieved 10/22/2010 from: <http://www.touro.com/content/upload/AssetMgmt/PDFs/pulseDec06.pdf>. JCHAO Requirements for Discharge Summary. JCHAO IM.6.10 EP7, Dec, 2006 Issue.
- ⁶ Retrieved 11-04-10 from: <https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter07-15.pdf> CMS Psychiatric Residential Treatment Facilities Clarification
- ⁷ State of North Carolina PRTF Guidelines.
- ⁸ State of GA PRTF Guidelines: Retrieved 10/19/2010 from: http://gachildadvocate.org/vgn/images/portal/cit_1210/11/13/100251216mental%20health%20talk%20handouts.doc.
- ⁹ Retrieved Online 10/23/2010 from: www.indianamedicaid.com/ihcp/bulletins/bt200404.pdf Indiana Health Coverage Programs.
- ¹⁰ Retrieved online 11-04-10 from: <http://www.uiowa.edu/~ipro/Papers%202008/PRTF.pdf> IPRO report comparing Psychiatric Residential Treatment Facilities (PRTFs) in Iowa with those in six other states
- ¹¹ Retrieved online 11-8-10 from: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=4c648846b3bbb188e7a2e2791174811a&rgn=div8&view=text&node=42:4.0.1.1.10.4.109.5&idno=42> CFR guideline for timeline in development of treatment plan
- ¹² Retrieved online 10/19/2010 from: <http://www.cga.ct.gov/ph/BHPOC/qm/2010/qm021910.doc>: Behavioral Health Partnership Oversight Council, Quality Management, Access & Safety Subcommittee, State of Connecticut Feb, 2010.

- ¹³ Retrieved online 10/23/2010 from: okhca.org/xPolicyPart.aspx?id=547&chapter., OCHA Healthcare Policies and Rules.
- ¹⁴ <https://www.kidstarga.com/forms/docs/PRTFexplained.pdf>.
- ¹⁵ Retrieved online 10/19/2010 from: [http://www.docstoc.com/docs/2986536/Psychiatric-Residential-Treatment-Facilities-This-IPRO-report-compares-Psychiatric-Residential Health Systems of Mississippi Provider Manual for PRTF Services Criteria, Revised 2007](http://www.docstoc.com/docs/2986536/Psychiatric-Residential-Treatment-Facilities-This-IPRO-report-compares-Psychiatric-Residential-Health-Systems-of-Mississippi-Provider-Manual-for-PRTF-Services-Criteria,Revised-2007).
- ¹⁶ Retrieved online 11-4-10 from: <http://www.dphhs.mt.gov/mentalhealth/children/prtfwaivermanualfinal.pdf> DPHHS MT PRTF Guidelines, 2009.
- ¹⁷ Retrieved online 10/22/2010 from: <http://www.hsom.org/PDFs/Acute%20Care%20Manual/III.%20Criteria/III-B%20-%20Psychiatric%20Residential%20Treatment%20Criteria.pdf>. Health Systems of Mississippi Provider Manual for PRTF Services Criteria
- ¹⁸ Retrieved online 10/22/2010 from: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl. Electronic Code of Federal Regulations.
- ¹⁹ Retrieved online 10/24/2010 from: <http://www.dphhs.mt.gov/mentalhealth/children/feeschedule.pdf>.
- ²⁰ Retrieved online 10/23/2010 from: <http://ajm.sagepub.com/content/22/2/95.abstract>. American Journal of Medical Quality, Improvement of Psychiatric Ambulatory Follow-Up Care by use of Care Coordinators.
- ²¹ Retrieved online 10/24/2010 from: <http://www.behavioral.net/ME2/dirmod.asp?sid=&nm=&type=Publishing&mod=Publications%3A%3AArticle&mid=64D490AC6A7D4FE1AEB453627F1A4A32&id=025737A4D9F441209693B5718496BBC5&tier=4>. Behavioral Healthcare, Improving Aftercare Effectiveness, April, 2007. Further cited: *State of Health Care Quality* report, the National Committee for Quality Assurance (NCQA).

Bibliography

Utilization Management

Centers for Medicare and Medicaid Services, HHS.
See C.F.R. 42-456.1 through 456.406 of the Subpart D of the Federal Code.

Psychiatric Residential Treatment Facility (PRTF)

Centers for Medicare and Medicaid Services, HHS.
See 42 C.F.R. 441.151 through 441.182, 456.60, 456.160, and 456.360 of the Subpart D of the Federal code.