



ADMISSION CERTIFICATION
SKILLED NURSING EXTRAORDINARY CARE

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

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

Note: Preadmission certification DOES NOT guarantee payment or client eligibility

Date requested
Admission date
Hospital
Hospital Medicaid ID #
Hospital UR rep
Phone #
Fax #

For APS Healthcare Use Only
Date received
Approved Denied
Certified Through
Reviewed By
Auth #

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

PATIENT INFORMATION

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

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

- 1. 4.
2. 5.
3. 6.

HCPCS code(s) (provide ALL code numbers as well as diagnosis names)

- 1. 4.
2. 5.
3. 6.

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928
Forms can be found on-line at www.wyoming.apshealthcare.com

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>	Check box if applies: <input type="checkbox"/>	\$	435.00	Negotiated Rate per Day
Ventilator Care	<input type="checkbox"/>			\$ -
Additional Staffing:				
Staff Time (list number of 1-1 hours required per day that is 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 item):

Wound VAC rental	Cost/day =	_____	\$ _____
Wound VAC Supplies:			
Dressing Kits ¹	Cost for 15 Kits =	_____ / 30	\$ _____
Canisters ²	Cost for 10 canisters =	_____ / 30	\$ _____
Other (specify) _____	Cost/day =	_____	\$ _____
Other (specify) _____	Cost/day =	_____	\$ _____

Sub-total Negotiated Rate	\$ _____
Current Nursing Facility Per Diem Rate	\$ _____
Net Extraordinary Care Rate	\$ _____

¹ Maximum coverage of 15 Kits per month.
² Maximum coverage of 10 Canisters per month.