APS HEALTHCARE
Healthy Together

ADMISSION CERTIFICATION

SKILLED NURSING EXTRAORDINARY CARE

for Wyoming EqualityCare

equalitycare

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

Required Documentation:

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

Ventilator Dependent? Y / N

Note: Preadmission certification DOES NOT guarantee payment or client eligibility

Date requested____________________

Admission date____________________

Hospital____________________

Hospital EqualityCare ID #____________________

Hospital UR rep____________________

Phone #____________________

Fax #____________________

For APS Healthcare Use Only

Date received____________________

Approved__________ Denied__________

Certified Through____________________

Reviewed By____________________

Auth #____________________

Attending/referring physician (first and last name) ____________________

Physician Wyoming EqualityCare ID # ____________________ Phone #____________________

Address____________________

PATIENT INFORMATION

Name ____________________ EqualityCare ID #____________________

Address ____________________ Phone # ____________________

DOB____________________ SS#____________________ Sex: Male Female

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

1.____________________ 4.____________________

2.____________________ 5.____________________

3.____________________ 6.____________________

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

1.____________________ 4.____________________

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 Criteria

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

Conditions considered under extraordinary client criteria include:

✓ Automatic Qualification:

- Ventilator Dependence

✓ The following qualifying diagnoses must have additional criteria met:

- Cerebral Palsy (ICD 9 343)
- Morbid Obesity (ICD 9 278.01)
- Multiple Sclerosis (ICD 9 340)
- Quadriplegia (ICD 9 344.00, 344.01, 344.02, 344.03, 344.04, or 344.09)

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

    AND

  - Must have three of the following:
    - Skin care could include Stage 3 or 4 ulcer/ turning every two hours
    - Foley incontinence care could include urinary tract infections/ diarrhea/constipation/bowel and bladder training
    - Tube feedings/aphasia could include dehydration/weight loss/aspiration pneumonia

   - Physical therapy could include wound care/range of motion exercises.
   - Special equipment used only by this resident that is clearly above and beyond what is covered in the per diem rate.

- Other conditions where special care or clinically complex care are required will be evaluated on a case by case basis by the Department.
- Criteria are subject to change

Provider Documentation Required:

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

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

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

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

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:

Services under Fee Schedule:				Negotiated Rate per Day
Ventilator Care	Check box if applies: ☐	$	435.00	$ -

Additional Staffing:

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

				Negotiated Rate per Day
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):

Item		Amount		
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.

Version: 10/2009