



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.

Special Care/Clinically Complex:

Yes No

1. **Quadriplegia** (ICD 9 344.00, 344.01, 344.02, 344.03, 344.04, and 344.09) with ADL Sum 10 +

AND

- Ventilator dependent (automatically qualify); and/or
- Tracheostomy; and/or
- Coma;

PLUS

Three (3) or more of the following:

- Skin care could include
 - Stage 3 or 4 pressure 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

Special Care/Clinically Complex (Cont):

Yes No

2. **Multiple Sclerosis** (ICD-9 340) with ADL Sum 10 +

AND

- Ventilator Dependent (automatically qualify); and/or
- Tracheostomy; and/or
- Coma; and/or
- Seizures; and/or
- Disease process involving **five** (5) or more functional areas of visual, motor, sensory, cognitive, coordination and/or balance, and/or bowel and bladder

PLUS

Three (3) or more of the following:

- Skin care could include
- Stage 3 or 4 pressure 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

Special Care/Clinically Complex (Cont):

Yes No

3. **Cerebral Palsy** (ICD-9 343) with ADL Sum 10 +

AND

- Ventilator dependent (automatically qualify); and/or
- Tracheostomy; and/or
- Seizures; and/or
- Spastic quadriplegia; and /or
- Coma;

PLUS

Three (3) or more of the following:

- Skin care could include
 - Stage 3 or 4 pressure 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

Special Care/Clinically Complex (Cont):

Yes No

4. **Ventilator dependent** recipient with MDS Activities of Daily Living Sum score of ten (10) or more and requires special care or clinically complex care as recognized under the Medicare RUG III classification system.

AND MAY INCLUDE

- Special equipment used only by this resident that is clearly above and beyond what is covered in the per diem rate

5. **Morbid Obesity** (ICD -9 278.01) with MDS Activities of Daily Living Sum score of ten (10) or more and requires special care or clinically complex care as recognized under the Medicare RUG III classification system.

PLUS

Three (3) or more of the following:

- Skin care could include
- Stage 3 or 4 pressure 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

Extraordinary Recipients:

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.

Required documentation:

1. PASRR Date: _____
2. LT 101 less than 45 days
3. MDS assessment
4. History and Physical (<1 yr old)
5. Drug history
6. Nursing Care Plan
7. Progress notes
8. Itemized cost
9. Doctors statement with Dx's and prognosis (includes expected length of treatment)

For CFMC use only	
Date received: _____	
Approved: _____	Denied: _____
Certified Through: _____	
Reviewed By: _____	
PCN: _____	

Name: _____ **DOB:** _____

Medicaid ID #: _____ **SS #:** _____

Admitting Facility Name: _____ **Contact person:** _____

Address: _____
_____ **Phone:** _____

Discharging Facility Name: _____ **Contact person:** _____

Address: _____
_____ **Phone:** _____

Requesting Date: _____ **Admit Date:** _____

Ventilator Dependent: _____

ICD 9 Diagnosis Codes	
1. (____) _____	7. (____) _____
2. (____) _____	8. (____) _____
3. (____) _____	9. (____) _____
4. (____) _____	10. (____) _____
5. (____) _____	11. (____) _____
6. (____) _____	12. (____) _____

HCPCS Codes**	
1. (____) _____	5. (____) _____
2. (____) _____	6. (____) _____
3. (____) _____	7. (____) _____
4. (____) _____	8. (____) _____

** Include DME providers name and address.

WYOMING NURSING FACILITY EXTRAORDINARY CARE RATE REQUEST FORM

Patient Name: _____
 Medicaid ID #: _____
 Facility: _____
 Projected Time Period Extraordinary Rate
 will be needed: _____

Per Wyoming Medicaid Rules, Chapter 7, Section 22 (a)(ii), the following documentation must be submitted to the Department:

- (A) Treatment Plan (*reason for request*)
- (B) A proposed reimbursement rate, including all relevant financial records and all medical records which document the medical necessity for services provided to an extraordinary recipient.

PROPOSED REIMBURSEMENT RATE:

	Extraordinary Services- 30 day period		
Description of Service	Units/or Hours	Unit Price/ Hourly rate	Extended Cost
Staff Cost:			
Salaries - RN	_____	_____	_____
Salaries - LPN	_____	_____	_____
Salaries - Aides/Orderlies	_____	_____	_____
Other	_____	_____	_____
Other	_____	_____	_____
Sub-Total	_____	N/A	_____
P/R Taxes & Benefits	_____	_____	_____
Sub-Total Staff Cost	_____	N/A	_____
Billable Ancillary Services:			
Medical Supplies	_____	_____	_____
Physical Therapy	_____	_____	_____
Occupational Therapy	_____	_____	_____
Speech Therapy	_____	_____	_____
Equipment	_____	_____	_____
Other:	_____	_____	_____
Sub-Total Billable Ancillary	_____	N/A	_____
Other (Non-Billable) Services / Supplies:			
Other:	_____	_____	_____
Sub-Total (Non-Billable) Services	_____	N/A	_____
Total	_____		_____
Resident days			30
Per Diem Costs (<i>Total cost / days</i>)			_____
Nursing Facility Per Diem Rate			_____
Extraordinary per diem rate plus nursing facility per diem rate:			_____