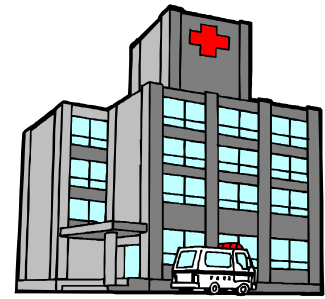


INSTITUTIONAL



**COVERED SERVICES
AND LIMITATIONS
MODULE**



**UB-92
Covered Services and Limitations Module**

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Comprehensive Outpatient Rehabilitation Facility (CORF)

A Comprehensive Outpatient Rehabilitation Facility (CORF) provides coordinated comprehensive outpatient rehabilitation services at one fixed location. A CORF must provide at least these three components of rehabilitation services to qualify for certification as a CORF:

- Physician supervision
- Physical therapy
- Social or psychological services

In addition, the CORF may provide any of the following services:

- Drugs and biologicals which cannot be self-administered
- Occupational therapy
- Speech therapy
- Orthotics and Prosthetics
- Medical supplies and equipment
- Nursing Services

The CORF may provide for one home evaluation visit to assess the home situation for continued placement of the patient in the home.

CORF services must be specific to the needs of the patient and must be directed toward the restoration of safe, functional independence. Maintenance or general conditioning is not considered appropriate in the CORF setting.

Coverage limitations for rehabilitation services, which generally apply to EqualityCare also apply to services rendered in the CORF setting.

Critical Access Hospitals (CAH)

Defined as:

- A rural public or non-profit hospital located in a State that has established a Medicare rural flexibility program.
- Is located more than a 35- mile drive from any other hospital or critical hospital.
- Is certified by the State to be a necessary provider.
- Is available for 24-hour emergency care services.
- Provides not more than 15 beds for acute inpatient care.
- Keeps patients not more than 96 hours annually.
- Is certified by the Centers for Medicare and Medicaid.

Outpatient Hospital services performed at a Critical Access Hospital are reimbursed at 70% of billed charge. Use bill type 85X with the following revenue codes:

Deleted Local Revenue Code	Revenue Code(s)	Description
683	970	General Class
	971	Laboratory
	972	Radiology/Diagnosis
	973	Radiology/Therapeutic
	974	Radiology/Nuclear Medicine
	975	Operating Room
	976	Respiratory Therapy
	977	Physical Therapy
	978	Occupational Therapy
	979	Speech Pathology
	980	General Class
	981	Emergency Room
	982	Outpatient Services
	983	Clinic
	984	Medical Social Services
	985	EKG
	986	EEG

Inpatient hospital services are reimbursed on the Level of Care methodology as outlined in the Hospital section of this module.

End Stage Renal Disease (ESRD)

ESRD Coverage

- Medicare is the primary sponsor for ESRD services. Under Medicare guidelines ESRD coverage may begin earlier, but no later than the third month after the month in which the patient begins a course of dialysis treatment.
- Medicare imposes no waiting period if the patient enters a program of home dialysis or kidney transplantation.
- EqualityCare will reimburse for services during the 90-day delay period.
- After the 90th day, EqualityCare will not reimburse for services while a Medicare eligibility determination is pending.
- If Medicare denies eligibility, then EqualityCare will be the primary sponsor if no other insurance is available.
- All ESRD claims for EqualityCare only are subject to post-payment review.
- EqualityCare requires ESRD enrollment prior to payments.

Inpatient Dialysis

EqualityCare sponsors all medically necessary services related to renal disease care according to the above guidelines. These services include inpatient renal dialysis.

Outpatient Dialysis

EqualityCare will sponsor outpatient services related to ESRD treatment under the guidelines outlined above, provided the patient is enrolled with Medicare and EqualityCare as an ESRD patient and the hospital or free-standing facility is certified as a ESRD facility. The facility is responsible for ESRD enrollment of the patient with Medicare and EqualityCare.

Home Dialysis

EqualityCare will sponsor treatment if Medicare denies coverage for a patient entered on a program of home dialysis. Personal attendants are not covered. The facility responsible for the teaching and supplies must be certified by the Wyoming Department of Health.

The hospital-based facility is responsible for the procurement, delivery and maintenance of the equipment and supplies. The facility may bill for all medically necessary services for home dialysis. Additional charges for other home supplies or equipment are non-covered and claims indicating such will be denied.

Extraordinary Care

Extraordinary care clients are clients who require skilled nursing facility extraordinary care. They have an MDS Activities of Daily Living Sum score of ten (10) or more and require special or clinically complex care as recognized under the Medicare RUG-III classification system. These conditions which have received prior authorization from the Department.

The extraordinary care resident’s cost and service requirements must clearly exceed supplies and services covered under a facility’s per diem rate. The extraordinary care fee will be paid in addition to the established EqualityCare per diem rate, but the fee shall not exceed the actual cost. The cost of this resident’s care shall not be included in the annual cost reports.

The documentation must be forwarded to CFMC along with the required supporting documentation listed on the top of the Extraordinary Care Check List. Submission of documentation does not guarantee extraordinary care status or payment. The supporting documentation will be reviewed by CFMC, who will then issue a PA Number for the resident upon approval of Extraordinary Care Status. The claim must contain the appropriate PA number and revenue code in order for the claim to be paid at the extraordinary care level.

Deleted Extraordinary Care Local Revenue Code	Extraordinary Care Rev Code as of 9/29/03	Description
678	101	All Inclusive Room and Board

The Department of Health, Aging Division has the option of final approval for any PA and may change or alter criteria based on available funding.

Questions and Concerns Contacts:

Aging Division
 Lura Crawford
 Long Term Care Program Manager
 6101 Yellowstone, Rm 259B
 Cheyenne, WY 82002
 1-307-777-5382 ph
 1-307-777-5340 fax

CFMC/QIO
 Linda Meyers
 P.O. Box 17300
 Denver, CO 80217-0300
 1-888-545-1710 ext: 3024 ph
 1-888-245-1928 fax

Federally Qualified Health Centers (FQHC)

EqualityCare will reimburse encounters to Federally Qualified Health Centers. An encounter is a face-to-face visit with an enrolled health care professional (physician, physician assistant, nurse practitioner, nurse midwife, psychologist or social worker). The place of service may only be the office, not an emergency room, home or nursing facility. Multiple encounters with one or more health professional that take place on the same day and at the same office location, constitute a **single** visit except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Reimbursement Guidelines

The encounter rate established by EqualityCare includes ALL services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes but is not limited to therapeutic and diagnostic services, all tests and supplies, and, lab and radiology incidental to a clinic visit. Do not bill any lab, radiology, tests, supplies, etc., in addition to the encounter as they are already included in the encounter rate. Services outside the clinic are billed under your fee-for-service provider number. Inpatient services are not considered FQHC services and cannot be billed using your FQHC provider number.

The EqualityCare program encourages FQHC’s to participate in the Health Check Program as outlined in the Health Check section in the Covered Services and Limitations Module. When an encounter meets the criteria for a Health Check exam or if a referral is made, use the appropriate Health Check encounter code and modifier. The Health Check encounter rate is all-inclusive. Prenatal and postnatal services rendered at the FQHC are billed as encounter services. For the Health Check Program, several preventive primary care services have been combined into one HCPCS code. You must use diagnosis code V20.2.

Deleted Local Code	Encounter	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Procedure Code Description
X5855	FQHC Encounter	520	Free-standing clinic - general classification	T1015	N/A	Clinic Visit/Encounter, All-Inclusive
X5515	FQHC Health Check Encounter	520	Free-standing clinic - general classification	99381	N/A	Preventive Medicine Evaluation and Service Management
X5515RE	FQHC Health Check Referral	520	Free-standing clinic - general classification	99381	32	Preventive Medicine Evaluation and Service Management

Modifier	Description
32	Referral

Fee for Service

Your fee for service number should also be utilized when billing for services rendered outside of the FQHC, (Nursing Home, Hospital inpatient or outpatient) using the appropriate place of service. When billing for a delivery only, procedure code 59409, 59514, 59612 or 59620 should be billed using your fee for service provider number on the CMS-1500. Global procedure codes, which include prenatal or postnatal visits, should never be used.

Home Health

Medicare certified or State Licensed Home Health agencies can provide Home Health services. These agencies may be independent or based in a hospital, nursing home, Senior Center, or Public Health agency. "EqualityCare Only" agencies must continue to meet the Conditions of Participation for Medicare but do not need to be EqualityCare certified. Wyoming "EqualityCare Only" Home Health agencies will be licensed by the Office of Health Quality. Home Health services are covered when the client is EqualityCare eligible at the time the services are rendered and is not an inpatient of a hospital or nursing facility.

Services must be:

- Intermittent
- Three or fewer visits a day for home health aide and/or skilled nursing services, where each visit does not exceed four hours
- Medically necessary
- Ordered by a physician
- Documented in a signed and dated Plan of Treatment (POT) that is reviewed and revised as medically necessary by the attending physician at least once every 60 days

Prior authorization is required for out-of-state providers only. All services, regardless of dollar amount, provided by an out-of-state provider will require PA. The PA number must be entered on the UB-92 claim form in box 63. Call ACS at 1-800-251-1268 for a PA.

Covered Services

Covered services include:

- Skilled nursing services
- Home health aide services supervised by a qualified professional
- Physical therapy services provided by a qualified licensed physical therapist
- Speech therapy provided by a qualified licensed therapist
- Occupational therapy provided by a qualified registered or certified therapist
- Medical social services provided by a qualified licensed MSW or BSW-prepared person supervised by an MSW (mental health services are provided through Mental Health Centers that are certified through the Mental Health Division)

Limitations

The following services are NOT covered:

- Homemaker services
- Respite care
- Meals on Wheels
- Services for clients who are hospital patients or residents of skilled nursing facilities
- Services for clients that are clearly inappropriate in the patient's home setting
- Services for clients that are extensive over long periods and/or are not cost effective
- Services for clients where the desired outcome could be better and faster accomplished in another setting
- Services for clients where the client must be compliant to achieve measured success and the client is not compliant

Billing Procedures

- Home Health billing must be submitted on the UB-92 claim form.
- Home Health agencies billing for rental or sale of durable medical equipment must be additionally enrolled as a medical equipment supplier. These charges must be billed on the CMS-1500 claim form with a Medical Supply provider number.
- POTs and other CMS forms must be signed, dated, and kept on file and be submitted upon request by EqualityCare. These forms must accompany PAs when submitted. Questions regarding Plans of Treatments or Utilization of Services should be addressed to the Program Manager at the Aging Division at 307-777-7366.
- Billing for services may be submitted monthly or by certification period.
- For out-of-state providers, the PA number must be in Field 63 of each UB-92 claim submitted for the prior authorized services.
- See further information in the UB-92 Billing Services Module.

Hospice

Hospice care is provided by a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A participating hospice meets the Medicare conditions of participation for hospices and has a valid EqualityCare provider agreement. Hospice is an interdisciplinary approach to caring for the psychological, social, spiritual, and physical needs of dying patients. This service is a special way of caring for a patient whose disease cannot be cured. It is, primarily, a program of care delivered in a person's home that provides, under a Plan of Care established by the hospice and the patient's attending physician, reasonable and necessary medical and support services for the management of a terminal illness.

Eligibility

Hospice care program services will be available to current EqualityCare eligible individuals of any age, who meet all the necessary program requirements which include the following documentation:

- Certified by a physician as being terminally ill
- An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course
- Completed Election Statement (Exhibit 1)

Hospice eligibility is also available through DFS for those with income no greater than 300 percent of SSI, who meet the resource limits, and elect hospice care.

Clients of hospice services are exempt from having a co-pay.

Eligible nursing facility residents may also elect to receive residential care hospice benefits if the hospice and facility have a written agreement. The hospice is to take full responsibility for the professional management of the individual's hospice care, and the nursing facility is to provide room and board to the individual. An LT101 is not necessary for nursing facility stays with hospice benefits.

In this situation, EqualityCare will pay the hospice 95-percent of the nursing facility rate for room and board in the nursing facility. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribing therapies. The hospice will be given a separate provider number to bill Nursing Facility room and board.

Forms and Processes

Reimbursement for hospice services provided to a client shall depend on ACS' receipt of a copy of the Physician's Certification Statement that the client is terminally ill and a copy of the Election Statement identifying the hospice that will provide care. Copies of each of these documents should be sent to the local DFS office as well.

- The Physician Certification Statement must be signed by a physician and include a statement that the individual's medical prognosis is life expectancy of six months or less if the terminal illness runs its normal course.
- The Election Statement must identify the following:
 - The hospice that will provide care to the individual;
 - The patient has been given a full understanding of hospice care, that with the exception of home and community-based waiver services and independent physician services, other EqualityCare services related to their terminal illness are waived for the duration of hospice care;
 - The effective date of the election of hospice care and have the signature of the client or his or her representative.

(Nursing facility resident information must be submitted by identifying the name and address of the nursing facility on the Election Statement. Patient liability will apply as it does with regular nursing facility residents.)

Hospice claims will be paid, and other medical claims related to the terminal illness (with the exceptions noted above) will not be paid, in accordance with the date of election on the signed Election Statement form. The client is not locked-in to a specific physician when they elect hospice, therefore physician claims will be paid. Reimbursement to an attending physician for direct patient care should be submitted on the CMS-1500 claim form with the appropriate CPT code.

The client will be "locked-in" to care from the hospice. Dually eligible Medicare/EqualityCare clients must elect hospice care for both Medicare and EqualityCare at the same time.

If the client revokes the election of hospice care, a copy of the Revocation Statement is to be sent to ACS. Regular EqualityCare eligibility for covered services will resume unless the client is no longer EqualityCare eligible. A copy of the Physician Certification Statement, Election Statement and Revocation Certification Statement (Exhibit 2) shall be sent, by the hospice provider, to the local DFS office. Additional copies are also kept in the client's file at the hospice for post-payment review.

Covered Services

The hospice is responsible for medical care and services related to the terminal illness provided to the client who has elected hospice care.

EqualityCare will reimburse for hospice, independent physician services and home and community-based waiver services provided to the client.

Covered hospice services include:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care
 - The total number of inpatient days for hospice clients may not exceed 20-percent of the total number of days of hospice care provided to each EqualityCare hospice clients. This restriction does not include HIV infected individuals. This will be reviewed annually on a post pay basis.
- Nursing Facility Room and Board

All services must be performed by appropriately qualified personnel.

Services provided in an inpatient setting must conform to the written Plan of Care. General inpatient hospital care may be required for procedures necessary for pain control and acute or chronic symptom management.

Limitations

Hospices must submit an approval form to the provider rendering services authorizing payment of claims for services not related to the hospice patient's terminal illness (Exhibit 3). The criteria for payment is that the pharmacy, hospitalization, or DME claim is not related to the patient's terminal illness.

Claims from providers who have not been identified by the hospice as providing services which are not related to the patient's terminal illness will be denied with the EOB message, "Client has Elected Hospice Care; Bill Hospice Provider for Services Rendered".

Reimbursement

Reimbursement is made at a predetermined rate for the level of care provided to the client by the hospice using the revenue codes listed on the following Matrix. These are the same revenue codes that Medicare uses. Remember that Medicare is primary.

NOTE: Included in the reimbursement rates are medical appliances and supplies including drugs and biologicals, home health aide and homemaker services. Physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control are also included in the rate.

Level of Care	Bill Type	Revenue Code
Routine Home Care	82X	651
Bill the routine home care rate for each day the client is under the care of the hospice and another level of care is not reimbursed. The rate is a per diem rate.		
Continuous Home Care	82X	652
Continuous home care is to be provided only during a period of crisis. Bill the continuous home care rate when continuous home care is provided. Reimbursement is for every hour or part of an hour of care furnished up to a maximum of 24 hours a day. A minimum of at least 8 hours a day must be provided. One unit equals 1 hour of service. The rate is an hourly rate.		
Inpatient Respite Care	81X	655
Respite care is reimbursed to an approved inpatient facility for a maximum of 5 consecutive days at a time including the date of admission but not counting the date of discharge. The rate is a per diem rate.		
General Inpatient Care	81X	656
Bill the general inpatient rate when general inpatient care is provided. If the client is discharged from general inpatient care as deceased, the general inpatient rate is billed for that day. If they are discharged to home, the appropriate home care rate is billed on a separate claim form. The rate is a per diem rate.		
Room and Board NF	81X	658
Bill the nursing facility room and board component when the individual is a nursing facility resident. The hospice is responsible for paying the nursing facility. Use the provider number assigned to the hospice for nursing facility resident's room and board. The rate is a per diem rate.		

EXHIBIT 1



Hospice Benefit Election Form

Name of Hospice Provider: _____

Provider Number: _____

Client Name: _____

Client Number: _____

Client Social Security Number: _____

Date of Hospice Election: _____

The patient has been given a full understanding of Hospice care, that with the exception of home and community-based waiver services and independent physician services, other EqualityCare services related to their terminal illness are waived for the duration of the election of Hospice care.

Client Signature

OR

Client Representative's Signature

NOTE: Please attach the Physician Certification Statement, signed by the physician, and include a statement that the individual's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course.

EXHIBIT 2



Hospice Benefit Revocation Form

Hospice Name: _____

Patient Name: _____

Diagnosis: _____

Admission Date: _____

Attending Physician: _____

I, _____, hereby revoke my election to Hospice Care for the remainder of the current election period.

Election Period Number	1	2	3	4
------------------------	---	---	---	---

Date Election Period Began _____

Date of Revocation _____

Number of Days Remaining _____

I understand that I am no longer covered under Hospice benefit for hospital services. If covered by Medicare/EqualityCare/Champus, I may resume regular benefits previously waived.

I understand that I may again elect to receive hospice coverage for any additional hospice election periods for which I am eligible.

Signature of Patient

Date

Signature of Witness

Date

EXHIBIT 3



Wyoming Department of Health

To: **ACS, Inc.** Date: _____

From: Hospice Name _____

Hospice Provider # _____ Phone # _____

RE: **Hospice Benefit
Approval for Charges Unrelated to Patient's Terminal Illness**

The following EqualityCare hospice benefit client has or will soon have the following medical expenses. These expenses are not relative to the terminal diagnosis and therefore, are not the financial responsibility of the hospice program. The hospice case manager has reviewed medical necessity and is authorizing payment to the provider who furnished the service.

Hospice EqualityCare Client Name: _____

ID Number: 06_____ **DOB** _____

Non Hospice Benefit Diagnosis(es): _____

(Please use valid ICD-9-CM diagnosis codes)

Physician Providing Service:	
Date of Service:	
Procedure(s) Being Performed: (Use valid CPT-4 procedure codes)	
Hospital Providing Service:	
Date(s) of Service:	
Other Providers Performing Services (Name):	
Procedure(s) Being Performed:	
Date(s) of Service:	

Additional explanation: _____

Hospice Provider Signature: _____

Printed Name: _____ **Title:** _____

Hospital Services

Provider Requirements

Swing bed services - Skilled nursing facility and intermediate care facility services furnished by a hospital with swing bed certification are not considered hospital services. Facilities providing this service must enroll separately as a swing bed provider.

Emergency hospital services - Inpatient care for emergency services provided by a hospital which is not certified for Medicare/EqualityCare participation is covered up to the point when the patient is sufficiently stabilized to move her/him to a certified hospital. The hospital will only be enrolled for the specific claim dates of service.

Certification – Pre-Admission certification and/or continued stay review is required for some admissions. Refer to the current Inpatient Utilization Management Manual.

Inpatient Monitoring Reports - Weekly reports are required for all EqualityCare patients. Refer to the current Inpatient Utilization Management Manual.

Limitations

- Abortion is not covered except to the extent required by federal law.
- Alcohol and chemical dependency inpatient rehabilitation services are not covered. Treatment for alcohol and chemical dependency is limited to detoxification and/or stabilization of acute conditions.
- Court ordered hospital services are only covered if: the service is an EqualityCare covered service; the service does not exceed EqualityCare service limitations; the admission has been certified; and the provider is enrolled at the time of service.
- Emergency detention - Services provided to a person in emergency detention are not covered.
- Hysterectomies which are not provided in conformance with federal regulations are not covered.
- Inmates - Services provided to a person who is an inmate of a public institution or an individual that is in the custody of a state, local or federal law enforcement agency are not covered.
- Organ transplants (including bone marrow) are limited to cornea transplants. Other medically necessary organ transplants (including bone marrow) are limited to clients under the age of 21 and require prior authorization.
- Outpatient hospital services are limited to a total of twelve visits per calendar year to a hospital, clinic, a hospital emergency room (for non-emergency services), and/or a physician's office for clients age 21 and older. A waiver can be requested for additional visits if necessary.
- Oxygen or other supplies that are provided to a client for use in a nursing facility are not covered.
- Physical therapy services are limited to a total of twenty visits per calendar year to a hospital, independent physical therapist or a physician's office for clients age 21 and older. A waiver can be requested if additional visits are necessary.

- Psychiatric services - Inpatient psychiatric admissions are limited to stabilization of acute conditions. Extended care psychiatric services for clients under the age of 21 may only be provided in an enrolled facility. Both of these services require pre-certification. Outpatient psychiatric services include preventive, diagnostic, therapeutic, rehabilitative and palliative services provided pursuant to an individualized treatment plan by or under the direction of a physician.
- Rehabilitation services are limited to intense rehabilitation programs following debilitation due to acute physical trauma or illness.
- Residential treatment center services are limited to EqualityCare clients under age 21.
- Sterilizations which are not provided in conformance with federal regulations are not covered.

Inpatient Prior Authorization Requirements

Hospitals are required to obtain pre-certification for the following admissions:

- Heavy Care Swing Bed - prior to admission
- Organ transplants (including bone marrow) - prior to admission
- Psychiatric - acute stabilization - within one working day
- Psychiatric - extended stay - prior to admission
- Rehabilitation - within one working day
- Residential Treatment Centers – within 7 days of admission

A pre-certification number (PCN) is required in field locator 63 on the UB claim form for the above services. Providers must call Colorado Foundation for Medical Care (CFMC) for PCN's.

Extended stay psychiatric admissions in enrolled hospitals will be assigned a length of stay and continued stay review will be required.

Refer to the CFMC Inpatient Utilization Review Management Manual for detailed requirements.

Deleted Local Revenue Codes	Revenue Code(s)	Description	PA Required
175	170-174	Nursery-Neonatal ICU	No
678	101	Negotiated Extraordinary Care, Monthly Rate	Yes
680	114 or 124	Inpatient Maintenance Psych	Yes
681	919	Inpatient Residential Treatment Center Services	Yes
682	118 or 128	Contracted Rehab Services	Yes

Inpatient Hospital Reimbursement

The level of care reimbursement system is based on a per discharge, Level of Care (LOC) methodology that recognizes differences in the costs for treating patients. Payment is based on the principal diagnosis, which can be found in box 67 on the UB-92 (the first diagnosis listed on a claim) for the patient. EqualityCare uses nine levels of care with rates based on either hospital-specific or statewide rates. Participating hospitals are reimbursed at Level of Care, plus a statewide capital reimbursement fee and a direct medical education fee (if appropriate). If your facility is not given a capital reimbursement fee or a direct medical education fee, then the LOC amount will be considered the total reimbursement. The payment levels and rate structures are as follows:

Adopted LOC Definitions		
Valid Primary Diagnosis or Revenue Code Range Rate	LOC Payment	LOC
Diagnosis Codes 640 - 669 + Surgical Procedure Code	State-Wide	21
Range of Primary Diagnosis Codes 640 - 669.99	State-Wide	20
Revenue Code 200 - 219	Hospital-Specific	22
Revenue Code 360 - 369 + Major Surgical Procedure Code * Along with major ICD-9-CM surgical procedure codes	Hospital-Specific	23
Diagnosis Code 290 - 314.90	Hospital-Specific	24
Diagnosis Code V57 - V57.99	Hospital-Specific	25
Diagnosis Code V30 - 39.99 or 764 - 765.19 and first date of service is < 29 days of age	State-Wide	26
Diagnosis Codes 773 - 773.29 or 774.00 - 774.79 and first date of service is < 29 days of age	State-Wide	27
All remaining discharges	State-Wide	28

The inpatient level of care reimbursement makes special payment provisions for the following:

- Less than one-day inpatient stays will be reviewed. Admissions determined to be appropriate will receive a per day pro-rated LOC payment.
- Transfers (the transferring hospital) will receive a per day pro-rated LOC payment for each day of care provided to the client prior to the transfer, up to the applicable LOC amount, unless the case qualifies for a high cost outlier. The transferring hospital should use a patient status of 02 or 05 to indicate a transfer.
- Transfers do not include movement of a patient from one hospital unit to another within a hospital. Also, a “discharge” from and “admission” to another unit within the hospital may not be billed as separate discharges. For example, if a patient is treated in your acute care setting and is later moved to the psychiatric unit of your hospital, you must bill for only one discharge. You should bill for only the principal diagnosis for the entire stay. Please refer to Chapter 30 - Level of Care Inpatient Hospital Reimbursement of the Rules of the Department of Health for more information.

- Transfers (the receiving hospital) will receive a per day pro-rated LOC payment for each day of care provided to the client after the transfer up to the applicable LOC amount, unless the case qualifies as a high cost outlier. The receiving hospital should use an admit source of 04 (transfer from a hospital).
- Outlier cost cases will receive a special payment. High cost outlier cases are defined as those cases for which allowable submitted charges exceed Level of Care thresholds.
- All cases involving readmission within 31 days of a previous hospital stay will suspend and will be reviewed to determine whether the readmission was necessary or avoidable. If it is determined that the readmission was not necessary, payment will be denied.
- If an outpatient hospital claim is billed for services within 24 hours of an inpatient admission, the outpatient claim will be denied. These charges should be included on the inpatient bill.

Refer to the Medicaid Rules for complete description of reimbursement methodology.

Billing Guidelines

A valid diagnosis is required. ACS, Inc. will deny a claim when a diagnosis code is not specific. If you forget to place a fourth or fifth digit on the diagnosis when applicable, your entire claim will deny.

Providers cannot submit a claim for a patient until the patient has been discharged.

The following fields **MUST** be completed on the UB-92 or your entire claim will be denied:

- Field 18 Admit hour must be complete and valid;
- Field 19 Admit type must be complete and valid;
- Field 20 Admit source must be complete and valid; and
- Field 21 Discharge hour must be complete and valid.

Since LOC is based on the principal diagnosis code, your claims will be reimbursed as a whole. Even though we will not be pricing at the line item, we will still edit validity at the line item. Line item detail will be used for future re-basing of the Level of Care reimbursement system. In effect, the whole claim may deny because of an incorrect line item.

Revenue codes 170-174, and 179 should be used for NICU Level 1 and 2 by all facilities.

Inpatient Psychiatric Services

Acute and Extended psychiatric hospitalizations require pre-certification and a pre-certification number (PCN) to be reimbursed. Instructions for these procedures are detailed in the Wyoming Inpatient Utilization Management Manual distributed by CFMC.

Acute Stabilization

EqualityCare will reimburse for acute inpatient psychiatric care for clients of all ages provided in acute care general hospitals. EqualityCare also covers acute inpatient psychiatric care for clients under 21 years of age in enrolled psychiatric hospitals.

Post-payment utilization review will ensure appropriate documentation is present to validate the inpatient psychiatric hospital admission. While acute stabilization usually requires a brief hospitalization, the hospital record must contain documentation of a physical examination, brief social history, psychiatric or psychological evaluation, treatment plan containing identifiable goals and a discharge summary. In addition there must be nursing notes written each shift.

Treatment must reflect a level of intensity sufficient to justify the inpatient level of care. Handwritten records must be legible.

Should an acute care general hospital determine that it is unable to provide the appropriate level of care for clients under age 21 who require acute psychiatric stabilization, it is expected they will transfer the client to a facility that is able to provide these services (EMTALA regs.) EqualityCare policy allows acute psychiatric stabilization for clients under age 21 to also occur in freestanding psychiatric facilities specifically enrolled to do so.

CONDITIONS REQUIRING ACUTE STABILIZATION - One or more of the conditions listed below must be described and documented as the reason for inpatient admission and must correspond with the pre-certification request.

- Suicide attempt; serious threats or gestures indicating a danger to self.
- Homicidal threats or other assaultive behavior indicating danger to others.
- Gross dysfunction; self-care failure or threats to physical health from life-threatening physical conditions resulting in an inability to care for self.
- Child exhibiting bizarre or psychotic behaviors that cannot be contained or treated in an outpatient setting.

TREATMENT REQUIREMENTS - In addition to the above documentation of acuity, the medical record must describe and document treatment of sufficient intensity to warrant hospitalization at the acute inpatient level of care.

- Evaluation and adjustment of medication under close medical supervision.
- Continuous secure setting with skilled observation and supervision.
- Documented failure of ambulatory programs with continued deterioration of emotional and/or physical condition. (Documentation of extreme agitation, not eating, physical complications, self-care failure).
- Inpatient diagnostic evaluation required to identify treatment needs, i.e., the formulation of a diagnosis.

For acute hospitalization, treatment is defined as diagnosis, evaluation, medication management, therapy or prescribed care as identified in an individualized treatment plan. The treatment plan must be prepared by a multi-disciplinary team within the hospital, and must be more extensive than observation, supervision or discharge planning. The admitting or treating physician assumes responsibility for the hospitalized client. The record must contain documentation of active treatment; such as individual, group or family therapy directed to achieve the goals outlined in the treatment plan.

Leave or pass days during an acute hospitalization will not be reimbursed. EqualityCare criteria for hospitalization at the acute level of care is not met if the patient is able to leave the hospital on pass, and the stay will be denied at the point of the pass through discharge.

Post pay review will ensure that the hospital's discharge planning has been instituted timely, is complete and of sufficient intensity that further inpatient hospitalizations may be avoided. For children and adolescents it is expected that the hospital has worked intensively with the family unit or significant others in the child's life. The client is linked to community support and services for additional treatment through the discharge planning process.

Extended Psychiatric Care for Children and Adolescents Under 21 Years of Age

To comply with the federal requirements regarding the Wyoming EPSDT program (Health Check), EqualityCare enrolls facilities to furnish extended psychiatric services to EqualityCare eligible children under age 21. Intervention with the child/adolescent remaining in his/her own home is the treatment of choice. Less restrictive and intensive out-of-home alternatives must be tried and be documented as having failed before extended psychiatric care is considered. Extended psychiatric care is not appropriate unless extensive attempts at community-based care have been tried and have not been successful. Extended psychiatric hospitalization is never the entry point into the system. The client must be referred from an acute hospitalization. Extended psychiatric care is the most intensive level of out of home care in the continuum of care.

Referrals for this service must come from the patient's primary physician during an acute hospitalization and will not be accepted from other sources.

Conditions Requiring Extended Psychiatric Care

One or more of the following conditions must be described and documented as the reason for admission.

- A DSM (latest edition) Axis I diagnosis requiring active treatment in the inpatient setting with documentation of the circumstances described above, a plan of treatment meeting EqualityCare criteria and a comprehensive discharge plan must be present.
- Serious persistence of the circumstances described in the acute admission to the extent that discharge from the current hospitalization to a lesser level of care, such as home, puts the child/adolescent at clear risk of harm to self or others.
- Serious persistence of the circumstances described above and the documented repeated failure of community based services to meet the child's/adolescent's needs for treatment.
- Further inpatient diagnostic evaluation as an extension of a current acute hospitalization is required to determine treatment needed as evidenced by the failure of efforts to evaluate on an outpatient basis.

Pre-admission review is required for all admissions to contracted extended psychiatric facilities to ensure the above referenced criteria has been met.

To request pre-admission review and a pre-certification number (PCN), the provider MUST call or fax their request to the EqualityCare Utilization Review Contractor.

All requests must be submitted within three working days prior to a planned admission or within one working day after an urgent/emergent admission.

Continued Hospitalization

One or more of the following conditions must be met to validate continued hospitalization:

- The child's/adolescent's behavior or symptoms are responding to or are likely to respond to active treatment. This must be documented in the initial or amended plans of care;
- The child/adolescent remains a danger to self or others; and/or
- Maximum hospital benefit has not been obtained and further inpatient treatment is needed.

Therapeutic leave from the hospital during an extended psychiatric hospitalization is appropriate only when documented in the treatment plan. Therapeutic leave does not negate the medical necessity of the hospitalization. EqualityCare will not reimburse for days the client is absent from the hospital.

Post-pay utilization review and on-going utilization review of extended psychiatric hospitalizations requires the same records and documentation as are required for acute psychiatric hospitalizations. Long-term hospitalizations require more thorough evaluation, assessment and treatment planning than do acute hospitalizations.

Discharge Criteria

A discharge is warranted when:

- The assessment, treatment and discharge plan have been formulated and can be implemented if the hospitalization was for the purpose of assessment and evaluation.
- The child/adolescent has received maximum benefit from hospitalization and/or treatment has been completed.
- He/she is able to appropriately control behavior and function cooperatively in a hospital environment.
- Alternative placement and follow-up care has been arranged. At the time of admission, referral sources from the community are required to have stated the goals of the extended psychiatric placement and to have formulated a discharge plan for aftercare of the child.

Emergency detention to determine if a client is dangerous to self or others or court ordered involuntary hospitalization (W.S. 25-10-109 and 25-10-110) is not a covered service reimbursable by EqualityCare.

Indian Health Services

Indian Health Services (IHS), an agency of the U.S. Public Health Services within the Department of Health and Human Services, is the principal federal health care provider for Native American people. Paramount to the goals of IHS is raising the Native Americans' health status to the highest possible level.

Indian Health Services provides comprehensive health care services, ambulatory medical care and preventative services through its service unit located at Fort Washakie on the Wind River Reservation in Wyoming.

Reimbursement Guidelines under Wyoming's EqualityCare Program

Definition: An encounter is a face-to-face visit with an enrolled health care professional. Multiple encounters with one or more professional or multiple encounters with the same health professional on the same day in a single location should be billed as one encounter unless the patient suffers illness or injury which requires additional diagnosis or treatment.

Deleted Local Code	Revenue Code	Description
X5504	779	Comprehensive Health Screenings
X5504RE	779	Comprehensive Health Screening Referrals
X5860	500	Medical Encounter (Within I.H.S. Clinic)
X5861	512	Dental Encounter (Within I.H.S. Clinic)
X5862	519	Optometric Encounter (Within I.H.S. Clinic)
X5863	259	Pharmaceutical Encounter (Within I.H.S. Clinic)
	771	VFC Administration

Billing Procedures: The following revenue codes are paid at the outpatient encounter rate published each year in the Federal Register.

- For Comprehensive Health Screenings (Health Checks), use rev code 779

Indian Health Services is encouraged to participate in the Health Check (Well Child) program for EqualityCare children under the age of twenty-one. Health Check policy is outlined in this module. When an encounter meets the standards for a Health Check exam, use the Health Check encounter code(s) to assist the EqualityCare program in tracking these services accurately. Individuals under age twenty-one are entitled to comprehensive health examinations. THIS REVENUE CODE CANNOT BE BILLED WITH ANY OTHER REVENUE CODE ON THE SAME CLAIM.

- For Comprehensive Health Screening Referrals (Health Checks), use rev code 779

When a Health Check examination indicates the need for a diagnosis/treatment of a suspected abnormality, the physician's notes must indicate this. The client should be referred for a type of service (e.g., dental care) or to a particular physician/specialist.

NOTE: Indian Health Services cannot bill multiple encounters on the same date of service. EqualityCare for Kids services cannot be billed with local codes. These services must be billed on a CMS-1500 using CPT codes and your EqualityCare for Kids provider number.

- For Medical Encounters (Within IHS Clinic), use rev code 500

All professional services (including ancillary services and supplies) must be performed by or under the direct supervision of a licensed physician or doctor of osteopathy operating within the scope of his/her practice. This includes services rendered by a nurse practitioner, physical therapist, or other covered licensed health care professional performing services consistent with their scope of practice.

- For Dental Encounters (Within IHS Clinic), use rev code 512

All professional services (including ancillary services and supplies) must be performed by or under the direct supervision of a licensed dentist operating within the scope of his/her practice.

- For Optometric Encounters (Within IHS Clinic), use rev code 519

All professional services (including ancillary services and supplies) performed by a licensed optometrist practicing within the scope of his/her practice. Routine eye examinations are not covered for client's age 21 and older. Treatment of eye diseases or eye injury continues to be covered when billed with the appropriate diagnosis code. The reason for the visit must be documented in the medical record.

- For Pharmaceutical Encounters (Within IHS Clinic), use rev code 259

All prescription drugs, over the counter drugs and medical supplies are covered by EqualityCare and are not included in the medical, dental, or optometric encounter.

- For VFC Administration, use rev code 771

All services provided during the visit are included in the encounter. Do not bill each procedure separately.

Outpatient Physical Therapy

Covered Services

EqualityCare will reimburse outpatient physical therapy services billed by a nursing facility for clients other than nursing facility residents. You must use the Uniform Billing Claim Form (UB-92) when requesting payment for outpatient physical therapy services.

Service	Claim Form	Bill Type (Field 4)	Specific Revenue Codes (Field 42)	Description	Rate per encounter or visit	Medicare Crossover
Physical Therapy	UB-92	131	420	General Class	\$65	File to Medicare - EqualityCare will pay deductible and co-insurance
			421	Visit Charge	\$65	
			422	Hourly Charge	\$65	
			424	Evaluation/ Re-evaluation	\$65	
Provider Number (Field 51) - Enter the nine-digit EqualityCare Provider Number assigned to the nursing facility for outpatient physical therapy services.						

Restorative physical therapy services can only be provided with a written order from a physician and by or under the direct supervision of a licensed physical therapist. **If services are provided by unlicensed personnel, the licensed physical therapist must be in constant attendance and on the facility's staff.** Covered physical therapy services must be specific to an active plan of treatment (POT).

Outpatient Rehabilitation physical therapy services are covered when the patient requires an intense rehabilitation program following physical debilitation due to acute physical trauma or illness. All therapy must be physically rehabilitative and provided under the following conditions:

- Prescribed during an inpatient stay and continuing on an outpatient basis; or
- As a direct result of outpatient surgery or injury.

Payment for Physical therapy services **includes all expendable medical supplies** normally used in the course of therapy. Medical supplies and equipment provided to a patient as part of the therapy services will be reimbursed through the Medical Supplies Program.

Limitations

- Services cannot be billed to EqualityCare if the client is a resident of a nursing facility, unless there is a Medicare crossover.
- Occupational and speech therapy are not covered.
- The number of physical therapy visits per calendar year is limited to twenty for clients age 21 and older unless provided by a home health agency. Outpatient physical therapy visits provided through a nursing facility will be included in the twenty-visit limit.

Returning Medications

According to the Wyoming State Board of Pharmacy Rules and the Federal Rules, it is not mandatory that medications be returned to the pharmacy once a patient has passed away. In the Wyoming State Board of Pharmacy Rules in Chapter 2 section 15 it says that it is legal to return medications to the pharmacy under certain circumstances. Wyoming EqualityCare Pharmacy Program does although require that the nursing facility return any unused medication to the pharmacy the medication was dispensed at within 30 days of a patient death. Also, if a medication has been discontinued, the unused portion should be returned to the pharmacy the medication was dispensed at, within 30 days. If the medication is not returned financial recovery could be possible.

Outpatient Services

Outpatient hospital services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services or items that are medically necessary. These services are furnished to an outpatient by a hospital enrolled in the EqualityCare program under the direction of a physician or dentist. Services provided in the emergency room of the hospital are defined as outpatient services.

Covered Services

- Medically necessary outpatient hospital services are covered pursuant to written orders by a physician and by or under the supervision of a physician.
- Patients admitted with a known diagnosis for a specific minor surgical procedure, or other treatment that is expected to keep the patient in the hospital for less than 24 hours, are considered to be an outpatient regardless of the hour of admission, whether or not a bed is used and whether or not the patient remained in the hospital past midnight.
- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes.

Limitations

- Abortion, hysterectomy, and sterilization procedures are governed by federal regulations and require specific consent forms.
- Ancillary services:
 - Durable medical equipment must be billed under the Medical Supplies program.
 - Laboratory services are limited as follows:
 - Automated profile tests must be billed with appropriate CPT procedure codes.
 - Specimen collection fee is allowed for drawing a blood sample through venipuncture. One collection fee is allowed per patient encounter regardless of the number of specimens drawn.
 - Handling fee, state fees, standing order procedures, technician call back, post mortem examinations are not covered services.
- Medical/surgical supplies used in actual treatment of an outpatient are covered. A limited supply (two day maximum) may be provided to a patient only if a prescription for the supply cannot be filled at a retail pharmacy or medical supplies provider within the two-day time frame.

NOTE: Clients who regularly present themselves to an outpatient department of a hospital for primary non-emergency services should be reported to the Program Integrity Manager at the Office of Medicaid.

- Medically necessary bone marrow transplants are limited to clients under the age of 21 and require prior authorization.
- Prescriptions for medications used in actual treatment of an outpatient are covered. A limited supply (two day maximum) may be prescribed to a patient only if a prescription for the medication cannot be filled at a retail pharmacy within the two-day time frame.

- Radiology services are limited as follows:
 - The technical component of the radiology services include administrative or supervisory services needed to produce X-ray films or other items, which are interpreted by the radiologist and should be billed by the hospital on the UB-92 claim.
 - If the radiologist uses his/her own equipment and bills for the total procedure, the hospital may not bill the technical component.
 - Routine mammography upon referral from a physician based on the following guidelines:
 - Baseline mammography between ages 35 and 40
 - Annual after age 40
- Emergency services are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
 - Placing the patient's health in serious jeopardy.
 - Serious impairment to bodily functions.
 - Serious dysfunction of any bodily organ or part.
- Observation services, which exceed 24 hours, will be reviewed for medical necessity. Hospitals are not expected to substitute outpatient observation services for medically appropriate admissions. Services must be provided in an acute care general hospital.
 - Psychiatric observation services are covered only if:
 - The client is admitted to observation by a physician
 - The client is evaluated by a multi-disciplinary team
 - An individualized treatment plan is prepared
 - A mental health professional must be available on a 24 hour basis for evaluation and initiation of treatment
 - The medical record must include discharge plan with aftercare referrals
 - Client must be under constant observation with documented checks every 15 minutes
 - Psychiatric observation does not meet the criteria established for acute psychiatric stabilization required for clients under 21 years of age, prior to an extended psychiatric admission.
- Rehabilitation services are covered when the patient requires an intense rehabilitation program following physical debilitation due to acute physical trauma or illness. Therapy is not covered for psychiatric diagnoses or birth defect diagnoses. All therapy must be physically rehabilitative.

NOTE: Ambulance and physician services must be billed using the CMS-1500 and must follow the policy defined for those programs.

Reimbursement Guidelines

EqualityCare utilizes a fee schedule for outpatient hospital services. The fee schedule payment is payment in full. All revenue codes are priced at a set fee per visit, or set fee per unit with capped maximum allowable units. Fee schedules are available for viewing and can be downloaded at <http://wyequalitycare.acs-inc.com> or upon request from ACS.

"Per visit" means all occurrences of a service provided on the same date of service during a separate visit. If more than one visit to an emergency room or clinic takes place on the same date of service, a separate claim must be submitted with time of admission and discharge entered on the claim. (The second or subsequent visits to the emergency room will be for medically necessary. Any same-day subsequent visits to the ER must have medical documentation attached.)

Therapy visits may be span billed in the 'From' 'To' fields at the claim header, but the dates of each visit should be listed separately on the line items.

Outpatient Surgery

- Outpatient surgery is paid based on the Ambulatory Surgery Center (ASC) payment group assigned to the billed HCPCS-CPT surgery code(s). Payment is an all-inclusive rate based on all services related to the surgery. Payment is the lesser of total billed charges or the ASC inclusive rate.

The ASC groups and EqualityCare group payment rates are listed below.

<u>Grouping</u>	<u>Fee</u>
1	756.29
2	806.18
3	814.03
4	1046.99
5	1075.15
6	1103.96
7	1178.66
8	2238.35
A	201.74
B	174.08
C	130.56
D	75.18
E	56.39
F	37.59
G	Surgery Only Allowed in Inpatient Setting
M	963.15
N	Non-covered surgery
U	Unlisted Procedure; Re-code with appropriate code.

- If more than one significant surgical procedure is performed during the same session, place the additional procedure on the next line using the same revenue code and enter "0" in the total charges, Field 47. Charges are not allocated among procedures. Payment for multiple surgeries will be based on 100-percent of rate for the most expensive procedure and 50-percent of the rate for other procedures. This includes bilateral procedures.
- Dental extraction/restoration can be billed with revenue code 361 and CDT codes D7111-D7250.
- An obstetric patient not admitted as an inpatient may be billed as an outpatient using appropriate CPT delivery procedure code. This service will be reimbursed at the statewide per diem rate for maternity services.

- Those surgical procedure codes that can only be done as an inpatient, are cosmetic or non-covered, or are an unlisted procedure, have an outpatient ASC indicator of G, N, or U. If you bill for one of these surgical procedures, an exception will post and the charge will be denied.
- Any outpatient surgeries which are denied as only allowed in the inpatient setting can be reconsidered.

Emergency Room/Clinic

- Emergency room (revenue codes 450 or 459) fees are based on the primary diagnosis.
- A list of emergency diagnosis codes is available upon request.
- Ancillary services will be paid **in addition to the emergency room fee.**
- If a significant surgery is performed in the emergency room, enter a HCPCS surgery code in Field 44. Otherwise, a CPT Evaluation/Management code can be reported or the field can be left blank.
- Physician services are billed on the CMS-1500 and are paid separately.
- Field 42 (Revenue Code) - Enter the appropriate three-digit revenue code necessary to identify the specific emergency room/clinic service.
- Valid Revenue Codes
- Emergency Room
- Emergency Room
- Clinic
- The twelve visits per calendar year limit for clients age 21 and older will continue to apply to non-emergency visits to the emergency room. Ancillary charges will be paid. Clients can be billed for denied visits that exceed limits.
- Only one revenue code in the 760 - 769 range will be allowed per visit.
- A co-payment of \$6.00 is also required for non-emergency visits to the emergency room. This amount will be automatically deducted from the emergency room payment.
- The limits and co-payment also apply to "clinic" visits.

Laboratory and Radiology

- Laboratory and radiology services will require a HCPCS procedure code in Field 44 in addition to the appropriate laboratory or radiology revenue code in Field 42.

LABORATORY		RADIOLOGY	
Valid Revenue Codes	Valid Procedure Codes	Valid Revenue Codes	Valid Procedure Codes
30X - 31X	Range 80000 - 89999	32X - 35X	Range 70000 - 79999; Some codes in the 90000 - 99999 range
923	P7001	40X	
	36415		
925	36600	61X	
	53670		
	Q0116		
	G0001		
	G0058 - G0060		

- Laboratory and Radiology will be paid based on the EqualityCare fee schedule.
- Radiology will be paid based on the technical component of the EqualityCare fee schedule.

NOTE: The PROFESSIONAL component must be billed on the CMS-1500.

Not Stand Alone

Certain revenue codes will NOT be reimbursed when billed separately: **250 - 259, 270 - 279, 290 - 299, 380**. Revenue codes listed as "Not Stand Alone" will not be paid in the absence of outpatient diagnostic or treatment services.

Rural Health Clinics (RHC)

EqualityCare covers medically necessary visits to a rural health clinic. A visit is a face-to-face encounter between a clinic patient and a health professional. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Reimbursement Guidelines

The encounter rate established by EqualityCare includes ALL services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes but is not limited to therapeutic and diagnostic services, all tests and supplies, and, lab and radiology incidental to a clinic visit. Do not bill any lab, radiology, tests, supplies, etc., in addition to the encounter as they are already included in the encounter rate. Services outside the clinic are billed under your fee-for-service provider number. Inpatient services are not considered RHC services and cannot be billed using your RHC provider number.

The EqualityCare program encourages RHC’s to participate in the Health Check program as outlined in the Health Check section in the Medical Services Covered Services and Limitations Module. When an encounter meets the criteria for a Health Check exam or if a referral is made, use the appropriate Health Check encounter code and modifier. The Health Check encounter rate is all-inclusive. For the Health Check Program, several preventive primary care services have been combined into one HCPCS code. You must use diagnosis code V20.2.

Deleted Local Code	Encounter	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Procedure Code Description
X5850	RHC Encounter	521	Free-standing clinic - rural health/clinic	T1015	N/A	Clinic Visit/Encounter, All-Inclusive
X5514	RHC Health Check Encounter	521	Free-standing clinic - rural health/clinic	99381	N/A	Preventive Medicine Evaluation and Service Management
X5514RE	RHC Health Check Referral	521	Free-standing clinic - rural health/clinic	99381	32	Preventive Medicine Evaluation and Service Management

Modifier	Description
32	Referral

Fee for Service

Your fee for service number should also be utilized when billing for services rendered outside of the RHC (Nursing Home, Hospital inpatient or outpatient) using the appropriate place of service. When billing for a delivery only, procedure code 59409, 59514, 59612 or 59620 should be billed using your fee for service provider number on the CMS-1500. Global procedure codes, which include prenatal or postnatal visits, should never be used.

Swing Bed Services

To enroll and participate in the EqualityCare program as a swing bed hospital, a hospital must be certified by the Medical Facilities Licensure unit of the Office of Health Quality as a swing bed facility and must meet all provider participation requirements stated. In addition, swing bed facilities are required to meet all the federal and state rules and regulations governing long term care facilities.

Covered Services

EqualityCare reimburses swing bed facilities at a per diem rate. This rate encompasses room and board charges and is all-inclusive except for physician, radiology, legend pharmacy and laboratory. Services included in the rate are described in Attachment A at the end of this section.

Evaluations That Must be Completed Prior to Nursing Facility Admissions

EqualityCare Determination of Medical Necessity (LT101) and Continued Stay Reviews

The LT101 is a functional assessment performed by a Public Health Nurse under contract to the Aging Division. It is a State requirement for the determination of medical necessity for nursing facility level of care. The Department of Family Services (DFS) will deny nursing facility eligibility to any individual who has not scored a minimum of 13 points on the LT101, and EqualityCare will deny payment for nursing facility services for that person.

The LT101 is also a condition of admission to the Long Term Care Home and Community Based Waiver Services program. An LT101 must be completed 45 days prior or 7 days after admission to a nursing home or to the LTC HCBS program.

A new LT101 is **required for an EqualityCare client:**

- Upon application for nursing facility admission. "Nursing facility" includes hospital swing bed units. It does not include Medicare-only Skilled Nursing Facilities (SNF) that do not participate in EqualityCare.
- Upon transfer to another nursing facility.
- Upon re-admission to a nursing facility after previous discharge. "Discharge" does not include temporary absence from the facility for treatment in a hospital, home visits or a trial community stay, provided such temporary absence is not longer than thirty consecutive days.
- Upon redetermination of EqualityCare eligibility following a loss of eligibility for any reason.
- Upon referral for PASRR Level II evaluation for MR or MI.
- Upon admission to a nursing home after participating in the LTC HCBS program.

Continued Stay Reviews

Nursing facility residents shall receive continued stay reviews as follows:

- During the sixth month, the twelfth month and annually after admission to the nursing facility; EXCEPTION: A determination may be made by the Public Health Nurse to discontinue annual reviews when a resident's condition is such that discharge is unlikely.
- When a resident's condition has or is expected to change substantially.

A new LT101 is required for a non-EqualityCare individual:

- Upon application for EqualityCare eligibility for nursing facility benefits.
- Upon referral for PASRR Level II evaluation for MR or MI.

A new LT101 is not required when:

- An LT101 has been performed within the previous 45 days. The PHN may issue a copy of a current LT101 (no more than 45 days old) to a nursing facility in lieu of performing another LT101, providing the PHN believes the information is still accurate and there have been no significant changes in the individual's condition or circumstances. Such a current LT101, regardless of its original purpose, will be considered valid for nursing facility admission or transfer, PASRR Level II evaluations, or EqualityCare eligibility application; it may also be considered valid for admission to the LTC HCBS Waiver.
- The individual is entering the nursing facility as private pay; however, EqualityCare will pay for a non-binding LT101 for any private pay individual and we encourage nursing facilities to make these referrals regardless of payment source. If the individual subsequently applies for EqualityCare, the LT101 will be considered valid if it is less than 45 days old at the time application is made to DFS; if more than 45 days have elapsed, a new LT101 must be performed.

Pre-Admission Screening and Resident Review (PASRR)

Federal law requires that all individuals, regardless of payment source, who apply as new admissions to EqualityCare nursing facilities on or after January 1, 1989, must be screened PRIOR TO ADMISSION for mental illness and mental retardation. Federal law further requires that any individual whose Level I screening indicates the presence or probability of MI or MR must be referred to the State Mental Health Authority or the State Mental Retardation Authority for a Level II Pre-Admission Screening (PAS) and must be determined PRIOR TO ADMISSION to be appropriate for NF placement. If the individual is appropriate for NF placement, the need for specialized services will also be determined.

If an individual seeking admission to a nursing facility has MI or MR and is found to be inappropriate for NF placement, the nursing facility may not admit the individual. If an individual already residing in a nursing facility has MI or MR and is found to be inappropriate for NF placement, the State must arrange for the resident's orderly discharge from the facility. Adverse determinations carry the right of appeal for the resident.

Individuals for whom respite care is provided under the Long Term Care HCBS Waiver or the DD HCBS Waivers are considered to be admitted to the NF and are subject to PASRR.

EqualityCare Reimbursement:

- EqualityCare will not reimburse a nursing facility for services provided to any individual who has not been screened at Level I. Payment will commence as of the Level I date or admission date, whichever is later. **No retroactive payment will be made.**
- EqualityCare will not reimburse a nursing facility for services provided to any individual with MI or MR who is admitted prior to completion of a Pre-Admission Screening (PAS). Payment will commence upon the date of determination of appropriate placement. No retroactive payment will be made. The nursing facility may be subject to withdrawal of EqualityCare certification if such a person is admitted to the facility before a PAS determination is rendered.
- EqualityCare will not reimburse a nursing facility for services provided to any individual who has previously been found to be inappropriate for nursing facility placement due to the need for specialized services. Any individual who has received such a determination must be re-evaluated and determined to be appropriate before any placement will be allowed.

PASRR Level I Screening

The purpose of the Level I screening is to identify for further screening those individuals for whom it appears that a diagnosis of mental illness or mental retardation is likely, regardless of known diagnosis. No NF may admit any individual for whom the Level I screening indicates a reason to refer the individual to Level II until the Level II evaluation is completed and a determination is rendered by the State.

Nursing Home. The Level I screening is performed by qualified staff of the nursing facility to which the individual is applying for admission. "Qualified staff" refers to personnel who, by education, professional status or administrative authority, are able to discern the possibility or probability of mental illness or mental retardation from medical records, observation of presenting evidence, or other sources.

Hospital or other. Level I screenings may also be performed by hospital discharge planners, or by qualified staff of mental institutions, ICF-MRs or community service providers when a Level II is being requested in advance of actual application for admission to a NF.

A Level I screening is required PRIOR TO ADMISSION for all **new** nursing facility admissions, regardless of payment source. "New admission" is defined as the admission of any individual who has not previously resided in any nursing facility. If the Level I results in a referral to Level II for MI or MR, the NF may not admit the resident until the Level II (PAS) is completed and the placement is determined to be appropriate.

A re-admission following a discharge, hospitalization or therapeutic home leave is not considered a "new admission" for PASRR purposes and does not require Level I screening unless a new diagnosis indicates the presence of MI or MR. An individual with MI or MR who was Level II in the past and is being re-admitted following hospitalization or therapeutic home leave is not considered a new admission.

A Level I is required upon transfer from one facility to another facility or institution if the Resident Assessment (RA) performed on admission indicates the presence or possibility of MR or MI. An inter-facility transfer is not considered a "new admission" for PASRR purposes. In the case of a transfer of a resident with MI or MR from the NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the most recent PASRR and resident assessment reports accompany the transferring resident.

Exempt hospital discharge: An exemption may be made for an individual (a) who is admitted to any NF directly from a hospital after receiving acute inpatient care at the hospital; and (b) who requires NF services for the condition for which he or she received care in the hospital; and (c) whose attending physician certified before admission to the facility that the individual is likely to require less than thirty days nursing facility services. If the individual is later found to require more than thirty days of NF care, a Level I must be initiated no later than thirty days after admission.

Routine annual Level I screenings are no longer required by EqualityCare. If the Level I does not result in a referral to Level II, it need never be performed again unless a significant change in the resident's condition indicates that a Level II evaluation is advisable.

Dementia, including Alzheimer's Disease and other dementias, is excluded from the definition of serious mental illness for PASRR purposes. An individual is considered to have dementia if he or she has a primary diagnosis of dementia as described in the DSM (current edition), or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above. A primary diagnosis of a serious mental illness supersedes a secondary diagnosis of dementia and the individual must be referred for Level II evaluation.

Also excluded from the definition of serious mental illness are those individuals experiencing anxiety or depressive reactions to a terminal or chronic debilitating condition for which admission to the Wyoming State Hospital (specialized services) would not be appropriate, but for which other mental health services may be required based on physician evaluation and recommendation. Transitory or situational depression or anxiety, or adjustment disorders related to physical illness, medication, or relocation to a nursing facility, need not be referred for a Level II. Depression of longer duration or severity, which meets the criteria for a major depressive disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), should be referred.

Mental Illness diagnoses (per DSM IV) that meet the criteria for referral include:

295.10	Schizophrenia, Disorganized type
295.20	Schizophrenia, Catatonic type
295.30	Schizophrenia, Paranoid type
295.60	Schizophrenia, Residual
295.70	Schizoaffective Disorder
295.90	Schizophrenia, Undifferentiated type
296.3	Major depressive disorder, current episode
296.4	Bipolar disorder, manic
296.5	Bipolar disorder, depressed
296.6	Bipolar disorder, mixed
296.7	Bipolar disorder, unspecified
296.8	Bipolar disorder, NOS
297.1	Delusional disorder
298.9	Psychotic disorder, NOS

Categorical determinations at Level I

Pursuant to federal guidelines, the State of Wyoming has defined certain categories of conditions that automatically constitute appropriateness for NF placement. These categorical determinations apply to individuals with a known diagnosis or presenting evidence of MI or MR and may be made at the Level I screening stage by nursing facility or hospital personnel; however, the State reserves the right to override the categorical determination and refer the individual to Level II where appropriate. Please note that a categorical determination is not an exemption from PASRR.

- *Appropriate due to terminal illness, verified in writing by a physician.* This constitutes a Level II determination of “appropriate, specialized services not required”.
- *Appropriate due to severe medical conditions.* In Wyoming, this determination may only be applied to an individual with MI or MR who is comatose, ventilator dependent, functions at the brain stem level, OR has a diagnosis such as COPD, severe Parkinson's disease, amyotrophic lateral sclerosis, congestive heart failure (CHF), cardiovascular accident (CVA), Huntington’s Disease, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end stage renal disease (ESRD), severe diabetic neuropathy or refractory anemia. The condition must result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. This constitutes a Level II determination of "appropriate, specialized services not required."

- *Convalescent care for an acute physical illness.* This determination applies only to an individual with MI or MR who has an acute physical illness which (a) required hospitalization; and (b) does not meet all the criteria for an exempt hospital discharge (defined above). This categorical determination is limited to 120 days. When it becomes apparent the individual will require NF placement longer than 120 days, the NF must refer the individual to Level II. A Level II determination must be rendered before permanent NF placement can be made.
- *Provisional placements pending further assessment in cases of delirium, where an accurate diagnosis cannot be made until the delirium clears, or for respite of caregivers.* This categorical determination is limited to fourteen days. A Level II determination must be rendered before permanent NF placement can be made.
- *Emergency placement for an individual with MI or MR for the individual's protection.* This categorical determination is limited to seven days, at which time the NF must refer the individual to Level II. A Level II determination must be rendered before permanent NF placement can be made.

NOTE: THE CODES AND MODIFIERS ARE SUBJECT TO CHANGE

CODES	MODIFIERS	DESCRIPTION
T1023		LT101
T2011	HI	PASRR LEVEL II
T2011	HP	PASRR LEVEL II PSYCHIATRIST
T2011	HE	PASRR LEVEL II - CMHC

Modifier	
HI	Multi-disciplinary team
HP	Doctoral level
HE	Mental Health Program

Attachment A

ABD Pads
Adhesive Tape
Aerosol, Other Types
Air Mattresses, Air P.R. Mattresses
Airway-Oral
Alcohol Plaster
Alcohol Sponges
Alternating Pressure Pads
Applicators, Cotton-tipped
Applicators, Swab-eez
Aquamatic K Pads (Water-Heated Pad)
Arm Slings
Asepto Syringes
Baby Powder
Bandages
Bandages-Elastic or Cohesive
Band-aids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpans, all types
Beds; manual, electric, clinitron
Bedside Tissues
Bibs
Blood Infusion Sets
Bottle, Specimen
Canes, all types
Cannula-Nasal
Catheter-Indwelling
Catheter Plugs
Catheter Trays
Catheter (Any Size)
Colostomy Bags
Combs
Commodes, all types
Composite Pads
Cotton Balls
Crutches, all types
Decubitus Ulcer Pads/Dressings
Denture cleaner/soak
Denture cups
Deodorants
Diapers
Disposal Underpads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets

Drainage Tubes
Dressing Tray
Dressing, all types
Drugs (Over the counter drugs as designated by the FDA)
Enema Supplies
Enema Unit
Equipment and Supplies for Diabetic Blood and Urine Testing
Eye Pads
Feeding Tubes
Fingernail clipping and cleaning
Flotation Mattress or Biowave Mattress
Flotation Pads and/or Turning Frames
Foot Cradle, all types
Gastric Feeding Unit, including bags
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hair Brushes
Hair Care, Basic
Hand Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Hydraulic Patient Lifts
Hypothermia Blanket
Ice Bags
Incontinency Care
Incontinency Pads and Pants
Influenza Vaccine
Infusion Arm Boards
Infusion Pumps, Enteral and Parenteral
Inhalation Therapy Supplies
Irrigation Bulbs
Irrigation Trays
I.V. Needles
I.V. Trays
Jelly, Lubricating
Lines, extra
Lotion, Soap and Oil
Massages (by facility personnel)
Mattresses, all types
Medical Social Services
Medicine Dropper
Medicine Cups
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding and feeding bags
Nebulizer and Replacement kit
Needles (various sizes)

Needles- Hypodermic, Scalp Vein
Non-Legend Nutritional Products
Nursing Services (all) regardless of level including the administration of oxygen and restorate nursing care
Nursing Supplies and Dressing
Ostomy Supplies: Adhesive, Appliance, Belts, Fact Plates, Flanges, Gaskets, irrigation sets, Night Drains, Protective Dressings, Skin Barriers, Tail Closures
Over-the-Counter Drugs
Overhead Trapeze Equipment
Oxygen, Gaseous and Liquid
Oxygen Concentrators
Oxygen Delivery Systems, Portable or Stationary
Oxygen Mask
Pads
Pitcher
Plastic Bib
Pump (Aspiration and Suction)
Pumps for Alternating Pressure Pads
Respiratory Equipment: Ambu Bags, Cannulas, Compressors, Humidifier, IPPS Machines and Circuits, Mouthpieces, Nebulizers, Suction Catheters, Suction Pumps, Tubing, etc.
Restraints
Room and Board (Semi-private or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Shampoo
Shaves
Shaving Cream
Shaving Razors
Sheepskin
Side Rails
Soap
Special Diets
Specimen Cups
Sponges
Steam Vaporizer
Sterile Pads
Sterile Saline for Irrigation
Sterile Water for Irrigation
Stomach Tubes
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including sterile sponges)
Surgical Pads
Surgical Tape
Suture Removal Kit
Suture Trays
Syringes (all sizes)
Syringes, disposable
Tape-for laboratory tests
Tape (non-allergic or butterfly)
Testing Sets and Refills (S&A)

Therapy Services
Toenail Clipping and Cleaning
Tongue Depressors
Toothbrushes
Toothpaste
Tracheostomy Sponges
Trapeze Bars
Tray Service
Underpads
Urinals, male and female
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Walkers, all types
Water Circulating Pads
Water Pitchers
Wheelchairs: Amputee, Geriatric, Heavy Duty, Hemi, Lightweight, One Arm Drive, Reclining
Rollabout, Semi-Reclining, Standard, Inc.

Reimbursement Guidelines

For any swing bed client who is not enrolled in Medicare Part A, or for whom Medicare Part A benefits have been denied, the correct bill type is 17X. For continuation of a previously paid EqualityCare claim, the correct bill type is 173. Use revenue code 100 when billing for Swing Bed Services. Use revenue code 183 for non-covered days.

Providers who bill outpatient charges for swing bed residents (including heavy care or extraordinary care clients) are subject to the following procedures:

- Laboratory and radiology charges may be billed as outpatient claims; reimbursement will be based on the outpatient fee schedule.
 - Prescription pharmacy items should be purchased from a licensed retail pharmacy that is an enrolled EqualityCare pharmacy provider. This may be the hospital pharmacy, if it is enrolled as a licensed retail pharmacy provider and bills on the Universal Pharmacy Claim form. Swing bed clients, like nursing facility residents, are not subject to pharmacy limits or co-payments. However, EqualityCare WILL NOT PAY for OTC drugs or medical supplies, as they are included in the swing bed per diem rate.
- OR**
- Pharmacy items may be billed on the UB-92 as outpatient charges ONLY in conjunction with other outpatient services and will be reimbursed at the fee schedule rate of \$10.00. Again, you may not bill EqualityCare for items included in the swing bed per diem.

Swing Bed Crossover Claims

If a nursing facility resident is eligible for both Medicare and EqualityCare and has met criteria for Medicare coverage for skilled nursing facility services, EqualityCare will pay the coinsurance and deductible for those services. Medicare covers days 1 to 20 of skilled nursing facility care as fully paid days and days 21-100 as coinsurance days as long as the individual meets Medicare criteria. Medicare coverage may cease at any time during this period if the individual no longer meets skilled nursing requirements. Direct your questions related to Medicare claims processing to the Medicare intermediary.

For any EqualityCare client who is also enrolled in Medicare Part A and Medicare benefits have been paid, the correct bill type for hospital swing bed billing is 18X (where "X" represents the third digit). Medicare is the primary payer and must be billed first. A copy of the Medicare EOMB covering the actual dates of service or a letter of denial from the Medicare fiscal intermediary for lack of a three-day hospital stay, exhaustion of benefits or non-coverage of service must be attached to the EqualityCare claim. In the case of a denial, the original denial letter may be used for successive claims for the same uninterrupted swing bed stay.



Wyoming Department of Health

Dave Freudenthal, Governor

Deborah K. Fleming, Ph.D., Director

Swing Bed Exemption Letter

Facility Name: _____ certifies that Medicare or other third party liability has been billed for this EqualityCare client.

To receive payment from Wyoming EqualityCare without an EOMB from the third party one or more of the following situations must be met and this letter must accompany a 17X UB-92 claim:

(Check one box)

1.	The client did not complete a 3 day hospital stay and is therefore not eligible for Medicare benefits. The hospital stay dates were ____/____/____ to ____/____/____. This must be reviewed if the patient returns to the hospital after any nursing facility stay, and for interim, continuing claims.
2.	This client has exhausted the Medicare and/or other insurance benefit period. The date of the Medicare and/or other insurance benefits period was/is ____/____/____ to ____/____/____.
3.	This client did complete a 3 day hospital stay. Medicare was billed for ____ days and an EOMB for that period was previously submitted. After the first claim for the first benefit period, the T19 EOB Exempt letter may be attached for succeeding claims.
4.	Medicare and/or other insurance denied payment of the swing-bed benefit. A copy of the EOMB is attached. After the first claim for the first benefit period, the T19 EOB Exempt letter may be attached to succeeding claims.

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature

Title

Date

Office of Medicaid
147 Hathaway Building • Cheyenne WY 82002
FAX (307) 777-6964 • TTY (307) 777-5648 • (307) 777-7531



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.

Facility Name
Facility Address
Contact Person
 Phone Number

From (Specify Period)
Summary of Services Provided to (Recipient Name)

Description of Service	Standard Services (specify period)			Extraordinary Services (specify period)		
	Units/or Hours (A)	Unit Price/ Hourly Rate (B)	Extended Cost (A) x (B)	Units/or Hours (C)	Unit Price/ Hourly Rate (D)	Extended Cost (C) x (D)
Staff Cost:						
Salaries - RN						
Salaries - LPN						
Salaries - Aides/Orderlies						
Other						
Other						
Sub-Total		N/A			N/A	
P/R Taxes & Benefits						
Sub-Total Staff Cost		N/A			N/A	
Billable Ancillary Services:						
Medical Supplies						
Physical Therapy						
Occupational Therapy						
Speech Therapy						
Equipment						
Other						
Sub-Total Billable Ancillary		N/A			N/A	
Other (Non-Billable) Services / Supplies:						
Other						
Sub-Total (Non-Billable) Services		N/A			N/A	
Total						
			Resident Days for Recipient from (specify period)			
			Per Diem Costs (Total Extended Costs / Days)			

Note: The terms "Billable" and "Non-Billable" refer to that service's classification under Medicare Reimbursement Principles.