WYO MEDICAID
DIVISION OF HEALTHCARE FINANCING

HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

REQUEST FOR PRIOR AUTHORIZATION OF SKILLED NURSING SERVICES: FORM INSTRUCTIONS

BOX 1 – Requested Service Start Date / Request Type
Start date for requested skilled nursing services and type of request (ie: New, Renewal, or Modification)
BOX 2 – Waiver Care Plan Dates
These are the dates for the waiver care plan start and end. This date will remain the same for the 12 month plan period. Obtain these dates from the participant's waiver case manager.
BOX 3 – Waiver Program
Identify the Home and Community Based Services (HCBS) waiver program in which the participant is enrolled.
BOX 4 – Participant Information
Required information: Wyoming Medicaid ID, Participant Name, Address, Date of Birth, Sex
BOX 5 – Service Provider Information
Required information: Wyoming Medicaid Provider ID (10 digits), Provider Agency Name, Address, Telephone number, Name of RN completing this form
BOX 6 – Medications
Enter all medications, including over-the-counter drugs. Enter dosage, frequency and route of administration. Enter an "N" after the medication(s) that are "new" orders for the current waiver care plan period. Enter a "C" after the medication(s) that are "change" orders either in dose, frequency or route of administration for the current waiver care plan period. New or changed medications indicate and support changes or exacerbations in the recipient's condition that may warrant additional or continuing skilled nursing services. Note: N = new medication within last 30 days; C = changed medication (dosage, frequency, or route of administration) within last 60 days.
BOX 7 – Principal Diagnosis
Enter a valid ICD-10 code which best describes the principal reason for skilled nursing services. The code is the full ICD-10-CM diagnosis code including all digits.

Wyoming Department of Health, Division of Healthcare Financing
6101 Yellowstone Road, Suite 210
Cheyenne, Wyoming 82002
Phone: (307) 777-7531
Fax: (307) 777-6964

If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

Enter the date of onset or exacerbation.

Indicate if the diagnosis is a new onset ("O") or an exacerbation ("E") of a pre-existing or chronic condition by placing an "O" or an "E" after the diagnosis.

BOX 8 – Other Pertinent Diagnoses

Enter all pertinent diagnoses relevant to the care rendered. Place in order of seriousness to justify the discipline and services being rendered.

Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently.

Enter the date of onset, if it is a new diagnosis, or the most recent exacerbation of a previous diagnosis.

BOX 9 – DME and Supplies

List supplies and equipment needed for care.

BOX 10 – Safety Measures

Enter the physician's instructions for safety measures or those identified by the skilled nursing provider agency.

BOX 11 – Nutritional Requirements

Enter the physician's orders for the diet including:

- Therapeutic diets;
- Specific dietary requirements; and
- Fluid restrictions or requirements.
- Total parenteral nutrition (TPN) can be listed in this Box or under medications.

BOX 12 – Allergies

Enter medicine allergies or other allergies or "NKA."

BOX 13A – Functional Limitations

Check current limitations as assessed by the physician or skilled nursing provider agency. If "other" is checked, provide details below or in an addendum to the request.

BOX 13B – Activities Permitted

Check all activities allowed by physician. If "Other" is checked, a narrative explanation is required below or in an addendum to the request.

BOX 14 – Mental Status

Check the most appropriate box(es) that describe the participant's mental status. If "Other" is checked, specify here.

BOX 15 – Prognosis
Check the box that specifies the most appropriate prognosis for the participant.
BOX 16 – Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
List the frequency and duration of visits for each discipline. List all the services and treatments to be provided by each discipline. Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks or months.
BOX 17 – Goals/Rehabilitation/Potential Discharge Plans
Enter a description of achievable goals and the participant's ability to meet these goals. If applicable, address discharge plans, including plans for care after discharge. Describe the expected health outcomes and the participant's ability to achieve goals and estimate of time needed to achieve them. This information should be pertinent to nature of the participant's condition and ability to respond and include more than words "Fair" or "Poor".
BOX 18 – Residential Service Coordination
Check "Yes" or "No". If yes, specify living situation (i.e.: Assisted Living Facility, Community Living Services) and describe the plan for the coordination of the services provided by the residential service provider and the skilled nursing services included in this request. Skilled nursing services must supplement, but not replace, the services offered in the residential setting.
BOX 19 – Registered Nurse (RN) Signature and Date
Signature of RN completing request
BOX 20 – Attestation
By signing in Box 19, the RN attests to the statement in Box 20.
BOX 21 – ANTI-FRAUD STATEMENT