



COMMUNITY-BASED SERVICES UNIT

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

COMMUNITY CHOICES WAIVER PROGRAM PROGRAM BULLETIN

Bulletin Ref: CCW-2019-02

To: All Community Choices Waiver Program Stakeholders

From: Tyler Deines, Community-Based Services Administrator

Date: March 29, 2019

Subject: Skilled Nursing Prior Authorization and Service Coordination Procedures

Purpose:

To provide direction to case managers and service providers on the prior authorization and service coordination procedures for skilled nursing services available under the Community Choices Waiver (CCW) program. This bulletin is provided as notice of revision to the CCW Policy & Procedures Manual (rev. 03/2018).

Background:

The CCW program is administered by the Community-Based Services Unit (CBSU) and provides eligible individuals access to an array of Medicaid home and community-based services (HCBS) as an alternative to care provided in a nursing facility. Skilled nursing services are a covered benefit of the CCW program and are designed to supplement, but not replace, the home health services available through the Medicaid State Plan.

The Wyoming Department of Health, Division of Healthcare Financing has contracted with Comagine Health (formerly Qualis Health, Inc.) to conduct prior authorization reviews of skilled nursing services provided under the HCBS waiver programs. Prior authorization reviews facilitate coordination and minimize the duplication of Medicaid benefits to ensure the most effective use of public resources. A registered nurse from Comagine Health will conduct a peer review of all requests for skilled nursing services to ensure those services are authorized:

- Within the scope and limitations of the skilled nursing services benefit;
- According to the assessed needs of the CCW program participant;
- Consistent with the practice of nursing as defined by the Wyoming Nurse Practice Act; and
- In such a manner that does not duplicate other services provided under the CCW program or the Medicaid State Plan.

Policy Change:

The following revisions to the CCW Policy and Procedures Manual (rev. 03/2018) are effective immediately upon release of this bulletin:

On pages 15 and 16: "A Case Manager must be able to: . . .

- Maintain individual participant records and ensure complete documentation is appropriately uploaded to the EMWS. This shall include, but is not limited to: . . .
 - Physician's Orders (Required for Skilled Nursing) ~~must be completed by a physician~~
 - ◆ ~~Orders must be written on a prescription pad. or Form CMS-485 "Home Health Certification".~~
 - ◆ Orders must include:
 - ▶ A request for nursing assessment and treatment
 - ▶ The principal diagnosis and reason for skilled nursing
 - ▶ Other pertinent diagnoses, if applicable
 - ▶ ~~The duration of skilled nursing (number of months up to one year)~~
 - ▶ ~~The frequency of skilled nursing visits (number per week/month)~~
 - ▶ ~~Disclaimer to indicate the orders are specifically for the CCW only~~
 - ▶ Physician's signature
 - ▶ Must be uploaded to the EMWS before skilled nursing can be added to the plan.
 - ◆ Orders shall be valid for up to one (1) year
 - ◆ A new order must be obtained and uploaded to the EMWS prior to the service plan renewal
 - ◆ ~~Services provided can only happen while the order is valid~~
 - ◆ ~~New orders must be obtained and provided to the case manager to upload in EMWS for any modifications to the plan~~
 - ◆ ~~New orders must be obtained and uploaded to continue services prior to expiration of the previous orders~~
 - Request for Prior Authorization of Skilled Nursing Services forms
 - Skilled Nursing Prior Authorization Approval Letters
 - ◆ Prior authorization approval letters shall be valid for up to one (1) year
 - ◆ A new prior authorization approval letter must be obtained and uploaded to the EMWS prior to the annual service plan renewal
 - Skilled Nursing Prior Authorization Denial Letters"

On page 25: "Responsibilities:

- Work with the case manager and Prior Authorization Review Contractor to ensure appropriate and necessary services are included in the participant's person-centered plan
- Ensure current physician's orders are in place to support provision of Skilled Nursing services as required. Orders must include:
 - A request for skilled nursing assessment and treatment
 - The principal diagnosis and reason for skilled nursing
 - Other pertinent diagnoses, if applicable
 - ~~The duration of skilled nursing (number of months up to one year)~~
 - ~~The frequency of skilled nursing visits (number per week/month)~~
 - ~~Disclaimer to indicate the orders are specifically for the CCW only~~
 - Physician's signature

- Orders shall be valid for up to one (1) year
- The physician's orders must be provided to the case manager for upload in the EMWS before the skilled nursing assessment visit can be added to the plan.
- Conduct a comprehensive assessment of the participant's skilled nursing needs and complete the Request for Prior Authorization of Skilled Nursing Services form.
- Submit the Request for Prior Authorization of Skilled Nursing Services form and any other pertinent documentation to the Prior Authorization Review Contractor for approval
- Upon approval by the Prior Authorization Review Contractor, prior authorization approval letter must be provided to the case manager for upload in the EMWS before skilled nursing can be added to the plan.
- Skilled nursing services must be delivered as specified in the participant's person-centered plan and as approved by the Prior Authorization Review Contractor
 - Prior authorization approval letters shall be valid for up to one (1) year
 - A new prior authorization approval letter must be obtained and provided to the case manager before any modification to the amount, scope, frequency, or duration of skilled nursing services
 - A new prior authorization approval letter must be obtained and uploaded to the EMWS prior to the annual service plan renewal
 - ~~○ Services provided can only happen while the order is valid~~
 - ~~○ New orders must be obtained and provided to the case manager to upload in EMWS for any modifications to the plan~~
 - ~~○ New orders must be obtained and uploaded to continue services prior to expiration of the previous orders"~~

On page 60: Add to the Community Choices Waiver Program Rate Schedule:

T1001 Skilled Nursing Assessment:
\$84.50 per assessment"

Procedure or Information:

Case managers and skilled nursing service providers shall use the following process for obtaining prior authorization of skilled nursing services to be included in the participant's person-centered plan.

1. The case manager identifies a potential need for long-term skilled nursing services by reviewing the most current LT101 assessment or through discussion with the participant and/or their designee.
 - a. Short-term skilled nursing services to address acute needs must be referred to an approved home health agency for potential Medicaid State Plan coverage.
2. The participant selects a skilled nursing provider agency, and the choice is documented on the Choice of Provider (CPVDR) form.
3. The case manager makes a referral to the provider agency using the Provider Duty Sheet (PDS) and requests an initial nursing assessment visit.

4. The provider agency contacts the participant's primary care physician's (PCP) office to obtain orders for skilled nursing assessment and treatment.
5. The provider agency provides the physician's orders to the case manager for upload into the Electronic Medicaid Waiver System (EMWS).
6. The case manager adds one unit of service for Skilled Nursing Assessment (T1001) to the participant's person-centered plan.
7. A registered nurse from the provider agency conducts a comprehensive nursing assessment and completes the Request for Prior Authorization Request of Skilled Nursing Services form.
8. The provider agency submits the Prior Authorization Request of Skilled Nursing Services form along with any other pertinent documentation to Comagine Health for review.
9. Comagine Health conducts a peer review and provides a notice of approval or denial¹ to the provider agency. Approval letters specify the frequency and duration of the service(s) to be provided.
10. The provider agency submits a copy of the prior authorization approval or denial letter to the case manager.
 - a. If prior authorization is denied, the case manager must provide a letter to the participant with notice of the denial and information on the participant's opportunity to request a fair hearing in accordance with Chapter 4 of the Rules and Regulations for Medicaid.
11. The case manager adds approved services to the participant's person-centered plan and uploads the prior authorization approval letter to the EMWS.
12. The provider delivers skilled nursing services as specified in the participant's person-centered plan.

¹ Denials are issued when the requested services do not fall within the scope and limitations of the skilled nursing services benefit, are not supported by the assessed needs of the participant, are inconsistent with the practice of nursing as defined by the Wyoming Nurse Practice Act, and/or duplicate other services provided under the CCW program or the Medicaid State Plan.

Comagine Health may issue a technical denial when insufficient or incomplete information is submitted by the provider agency. The provider agency will have an opportunity to submit requested additional information or clarification for the review process to continue. This is not a final denial decision and should not be provided to the case manager. If the provider fails to satisfy the documentation requirements or respond to a technical denial, the request may be denied.