Comagine Health
Formerly Qualis Health and HealthInsight

W.I.N.K… (What I Need to Know)

Wyoming Medicaid- Skilled Nursing Reviews

[Effective 5/13/2020]

What is Comagine Health's Website?	http://www.qualishealth.org
How can I contact Comagine Health's Care Management, Utilization Management department?	Direct Phone number (800) 783-9207 Direct Fax (800) 826-3630 Provider Portal support need, contact Lisa Layne at 888-240-0437 or Llayne@Comagine.org
What type of services or procedures require prior authorization (PA)?	The list of services or procedures requiring PA can be found on the Comagine Health website under Provider Resources, Wyoming Medicaid Prior Authorization List.
How do I submit a review through the Comagine Health provider portal?	Provider portal registration packets can be obtained from the Comagine Health website. Fax the completed packet to (800) 826-3630 or email to LLayne@comagine.org Contact Lisa for training needs to use the provider portal.
What type of document files can be submitted through the provider portal?	Word documents, PDFs and JPGs are accepted attachment formats. Image format files, TIFs, are not accepted.
When should I submit a request for skilled nursing (SN) visits?	Submit when you have all the required documentation and prior to services, following an assessment of the participant's needs and development of the nursing care plan. Prior authorizations (PA) cannot be back dated.
What HCPC codes can I submit?	Community Choices Waiver uses HCPC code S9123 (1-hour code) Comprehensive and Supports Waivers use HCPC T1002 (15 minutes unit code)
How do I submit the codes with the frequency and	Calculating the number of visits:

duration in the provider portal?	1. The list only goes to 50 for the 'time frame' when requesting services weekly. Consider using the year option. Example for one year of visits: choose year for time frame, XX for the 'units/visits requested' (calculate this total number) and 1 for time period. 2. MD orders are not required to match the request for Prior Authorization of Skilled Nursing Services. An MD may order visit amount/frequency/duration not covered by the waiver benefit. No need for physician to update orders to match service authorization as long as the order meets minimum requirements.
Does Comagine Health authorize the initial RN assessment for Waiver?	No, contact the participant's case manager for authorization of RN assessments.
What type of clinical documentation needs to be submitted for a SN review?	Both of the following are required: 1. MD signed and dated orders 2. Request for Prior Authorization of Skilled Nursing Services form
Can a nurse practitioner order SN waiver visits?	Only a MD may sign orders for skilled nursing services.
What age of participants does Comagine Health review under Skilled Nursing Waiver Services?	19 and older for the Community Choices Waiver 21 and older for the Comprehensive and Supports Waivers
How do I complete the SN PA form?	There is a 'how to guide' located at Qualishealth.org and the State of WY Medicaid website. Things to remember: 1. RN must hand sign or use a digitally authenticated signature and date on the form 2. Only RN's can sign and date the form 3. LPN/LVN's are NOT allowed to sign or be co-signed 4. No one can cosign for the RN that completed the form 5. Complete all boxes. Use N/A if needed 6. The frequency and duration of visits must match the information submitted in the portal 7. Box 16 requires frequency, duration and a narrative of participant's needs. 8. Box 18 requires specific information on a participant's plan (i.e. Assisted Living Facility, Community Living Services) 9. SN services must supplement, but no replace services

What is the difference between initial, renewal and modified SN authorizations?	Initial- a new participant. This can be at the beginning of the service plan year or as identified later in the plan year and still be an initial. Renewal- are for existing participants that currently have services in the prior year. Modification – is a change to an insisting authorization. This can occur anytime during the plan year. We will need to know what the current approved frequency and duration of visits are. Any additional PA will add to and not replace the prior PA.
Who can perform the SN visits?	A RN is required to complete the Request for Prior Authorization of Skilled Nursing Services form and perform all the Skilled Nursing services.
What information is needed in Box 16 of the Request for Prior Authorization of Skilled Nursing Services?	A narrative of a participant's specific assessed needs, nursing interventions with justification for nursing care required to address participant needs, visit frequency, visit length, and duration. Calculating frequency and duration example: 1 visit per week for one hour to assist with wound care Total = (1 x 1 x 52) = 52 visits per year. When requesting skilled nursing services, any of the following examples could be included in the narrative to assist with a clearer understanding of the justification for the services that are being requested and will allow for quicker determinations: 1. What other interventions that have been considered or have failed in the past to warrant the requested services on this request? 2. How many unscheduled/urgent/emergent care visits, urgent PCP appointments, ER visits or admissions in the past 6 months occurred? Why were they seen each time? 3. What interventions are to come from a weekly assessment? 4. If requesting medication management services, define what skilled nursing function is being completed. For example, med box prefills, what is the reason that the participant cannot complete this task on their own? Has blister or bubble pack been tried? How does a weekly visit for medication set-up facilitate and/or improve day-to-day medication compliance? Why does this service

	have to be done weekly/can it be done every two weeks or monthly? 5. If requesting Foot care, does the person have any chronic foot wounds, issues or conditions? Is there any neuropathy? Patient's BMI or height/weight (approx.)? What is the current foot assessment, nail condition, any calluses, bunions or hammer toes or ingrown nails? What is the person's ambulatory status? If diabetic, any recent changes in diabetic control or meds 6. If requesting labs, what prevents the patient from going to an outpatient lab for lab draws? Do they have a port or line? Are these scheduled or PRN lab draws? What is the frequency? 7. If requesting dressings or wound care, what are the wound details (Acute or chronic wound, Location(s), Size/dimensions, Age of the wound percentage that has healed, drainage amount and characteristics, dressing change frequency of dressing changes)? Who provides wound care on non-visit days? A picture is not required but can be very helpful 8. If requesting PICC, central line, port dressing changes, what type of dressing is used (gauze or transparent dressing)? What is the frequency and duration? 9. If education is listed as a service that indicates teaching needs, what teaching remains to be done that was not accomplished in the waiver year about to end? What new meds and/or disease processes currently require teaching? Do you have a written teaching plan? Are there any new dx in the last six months?
What can happen if all the required documentation is not received at Comagine Health?	Comagine Health will notify you via the provider portal to submit the missing information. If you are unable to submit within 6 business days, the request will be a Technical Denial. You may resubmit when you have all the required documentation and information.
What do I do if a participant needs a modification in the current plan year?	Submit both of the following: 1. MD orders are valid for up to 1 year. Orders will be renewed annually. New orders for modifications are not needed if the original order meets the needs the requirement. 2. Updated PA form with rationale for change in Box 16: • Example: The participant was recently hospitalized for heart failure. SN visits to increase to weekly

	visits from monthly for education, weight monitoring and medication adjustments for new diagnosis.
What is the second review process?	A second review is the process if you disagree with a decision (denied or reduced services). You may request a second review through the provider portal within 30 days of the decision.
What can I do after the second review process and I still disagree with the decision?	The SN provider must inform the case manager (CM) and provide the notice of denial or reduction. The case manager must notify the participant. A participant can request a reconsideration with the State of WY Medicaid. A participant may request a Fair Hearing within 30 days of the case manager's notification.
What do I do after I submit a request?	1. Watch for alerts on your dashboard 2. The provider portal can alert you when there is a change in the request. If additional information is needed, we will request the information via the portal.
How do I obtain my letter for approved services?	Letters are now a self-service process for providers. Please follow the below steps: 1. Log into the provider portal 2. In the top ribbon, click on 'MY Alerts' 3. In the left navigational panel, click on 'Correspondence' 4. A correspondence section will populate under the participants name 5. Click on the letter hyperlink to open the letter 6. Print your letter