Instructions - Prior Authorization for Skilled Nursing Request

HOME AND COMMUNITY-BASED SERVICES
WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Box 1 – Requested Service Start Date / Request Type
Enter start date for requested skilled nursing services and type of request (ie: New, Renewal, or Modification)
Box 2 – Waiver Care Plan Dates
Enter the start and end dates of the participant's waiver plan, which can be obtained from the participant's case manager.
Box 3 – Waiver Program
Select the waiver program in which the participant is enrolled.
Box 4 – Participant Information
Enter all required information.
Box 5 – Service Provider Information
Enter all required information.
Box 6 – Medications
Enter all medications the participant takes, including over-the-counter drugs. Enter dosage, frequency and route of administration. ● Enter "N" after medication(s) that are "new" orders within the last 30 days. ● Enter "C" after medication(s) that are "change" orders either in dose, frequency, or route of administration within the last 60 days. New or changed medications indicate support changes or exacerbations in the participant's condition that may warrant additional or continuing skilled nursing services.
Box 7 – Principal Diagnosis
Enter a valid ICD-10 code, including all digits, that best describes the principal reason for skilled nursing services. 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. List 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 conditions that have developed since the plan of care was established.

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 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 allergies to medications or other allergies. If there are no allergies, enter “NKA.”
Box 13A – Functional Limitations
Mark current limitations as assessed by the physician or skilled nursing provider agency. If “other” is marked, provide details below or in an addendum to the request.
Box 13B – Activities Permitted
Mark all activities allowed by the physician. If “Other” is marked, provide a narrative explanation (required) below or in an addendum to the request.
Box 14 – Mental Status
Mark the most appropriate box(es) that describe the participant’s mental status. If “Other” is marked, provide specifics here.
Box 15 – Prognosis
Mark 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 description should be comprehensive, pertinent to nature of the participant's condition and ability to respond, and should include more than words "Fair" or "Poor".
Box 18 – Residential Service Coordination
Mark "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