

IDAHO SPECIAL RATE REQUEST FORM – SKILLED NURSING FACILITY

To: **Central Office Bureau of Long-Term Care**

Date Request Sent: _____

Patient Name: _____

Medicaid ID #: _____

DOB: _____

Facility: _____

Provider #: _____

Per IDAPA 16.03.10.270, a special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions in these rules. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than thirty (30) days.

- Initial Renewal/Extension Discontinue

Type and Reason for Request and Documentation Please attach documentation indicated with request.

- Equipment and Non-Therapy Supplies: Purchase Rental: Type and cost/day _____ \$ _____
 Attach vendor invoice with HCPCS code
 Provide description of equipment/non-therapy supplies and documentation to support request not addressed in content of care (IDAPA 16.03.10.225 and 290)
- Ventilator or Tracheostomy
 Documentation to support additional direct care staff required to meet the exceptional resident's needs
 Unlicensed: # of Hours _____ Licensed (RN LPN): # of Hours _____
 Equipment and/or Supplies – provide detail description and invoice including HCPCS codes

Time period for special rate request: _____ Start Date: _____ End Date: _____

A special rate request must be based on an identified condition that will continue for a period greater than thirty (30) days.

Facility Representative Name: _____ Phone/Fax: _____

Signature Facility Representative: _____ Date: _____

Please Fax completed form to: Division of Medicaid, Bureau of Long-Term Care 1- 877-483-0279.

Idaho Special Rate Request Form – Skilled Nursing Facility Completion Instructions

- Special Rate requests must be submitted to the Central Office Bureau of Long-Term Care on the current Idaho Special Rate request Form – Skilled Nursing Facility (revised October 2012).
- In order to process the request, **all of the following fields must be complete:** Date Request Sent, Patient Name, Medicaid ID #, Facility Name, Provider #, Signature, Date, Printed Name and Phone.
- Submit special rate requests promptly to prevent denial due to untimely submission. Special rate requests are only approved the date received by the Central Office Bureau of Long-Term Care.

Type of Special Rate Requested

- Indicate whether the special rate is an initial, renewal/extension or discontinue request.
- Check the type and reason of special rate requested.

Time period for special rate request

- The “Start” and “End” dates must be filled in.
- A special rate request must be based on an identified condition that will continue for a period greater than thirty (30) days.
- Requests received without the required documentation will be returned.

Equipment and Non-Therapy Supplies:

- Equipment and non-therapy supplies not addressed in IDAPA 16.03.10.225 or adequately addressed in the current RUG system, as determined by the Department, are reimbursed in accordance with IDAPA 16.03.09.755 Durable Medical Equipment: Provider Reimbursement as an add-on amount.
- Attach invoice with HCPCs codes.
- If the requested item is a purchase and approved, the facility is reimbursed over a 10-month period. Purchase arrangements must be made between the facility and the vendor. Product service agreements cannot be included in the special rate request.

Ventilator and Tracheostomy Care:

- In the case of residents who are ventilator dependent and who receive tracheostomy care, the special add-on amount to the facility’s rate for approved residents receiving this care, is determined by combining the following two (2) components:
 - (1) Calculation of a staffing add-on for the cost, if any, for additional direct care staff required in meeting the exceptional needs of these residents. The hourly add-on rate is equal to the current WAHR CNA wage rate plus a benefits allowance based on annual cost report data, then weighted to remove the CNA minimum daily staffing time adjusted for the appropriate skill level of care staff (IDAPA 16.03.10.270.c.i.)
 - (2) Calculation of an add-on for equipment and non-therapy supplies following the provisions in Subsection 270.06.a. of this rule (IDAPA 16.03.10.270.c.ii)
- Attach invoice with HCPCs codes.

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- Facilities must submit a new Idaho Nursing Facility Special Rate Request Form and appropriate documentation to extend or reduce an existing special rate. If the patient expires, is discharged or no longer requires the special rate item, please complete form with the revised end date.
- If you have any questions or need assistance in completing a request, please contact Central Office Bureau of Long-Term Care Alternative Care Coordinator at (208) 364-1891.