WY BMS Title 25 Provider Manual

Prepared for:

Wyoming Department of Health
122 West 25th Street, 4 West
Cheyenne, WY 82002

Prepared by:

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Version 17.0
Security: N = No Restriction

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Revision History

Revision Level	Date	Description	Change Summary
Version 0.1	5/20/2021	Initial Submission	N/A
Version 1.0	10/25/2021	First Full Submission	Revisions based on October updates from Agency
Version 1.1	03/14/2022	Second Full Submission	Updates to links behind images/graphics.
Version 2.0	04/01/2022	Third Full Submission	Revisions based on March/April updates from Agency.
Version 3.0	07/01/2022	Fourth Full Submission	Revisions based on June/July updates from Agency
Version 4.0	10/01/2022	Fifth Full Submission	Revisions based on Oct 2022 quarterly updates from Agency
Version 5.0	01/01/2023	Sixth Full Submission	Revisions based on Jan 2023 quarterly updates from Agency. Updated Note format to CNSI standardized format.
Version 6.0	04/03/2023	Seventh Full Submission	Revisions based on Apr 2023 quarterly updates from Agency.
Version 7.0	07/03/2023	Eighth Full Submission	Revisions based on July 2023 quarterly updates from Agency.
Version 8.0	10/02/2023	Ninth Full Submission	Revisions based on Oct 2023 quarterly updates from Agency.
Version 9.0	01/02/2024	Tenth Full Submission	Revisions based on Jan 2024 quarterly updates from Agency.
Version 10.0	04/01/2024	Eleventh Full Submission	Revisions based on Apr 2024 quarterly updates from the Agency.
Version 11.0	07/12/2024	Twelfth Full Submission	Revisions based on July 2024 quarterly updates from the Agency.
Version 12.0	10/01/2024	Thirteenth Full Submission	Revisions based on October 2024 quarterly updates from the Agency.
Version 13.0	01/13/2025	Fourteenth Full Submission	Revisions based on January 2025 quarterly updates from the Agency.
Version 14.0	04/01/2025	Fifteenth Full Submission	Revisions based on April 2025 quarterly updates from the Agency.

Revision Level	Date	Description	Change Summary
Version 15.0	07/01/2025	Sixteenth Full Submission	No July 2025 quarterly updates from the Agency. Updated Provider Notifications Log.
Version 16.0	10/01/2025	Seventeenth Full Submission	No October 2025 quarterly updates from the Agency. Updated Provider Notifications Log.
Version 17.0	01/01/2026	Eighteenth Full Submission	Revisions based on January 2026 quarterly updates from the Agency.

Overview

Thank you for your willingness to serve Members receiving services while under the care of the Wyoming State Hospital (WSH).

> Policies and procedure outlined in this manual are applicable ONLY in cases when the Member receiving services under a Title 25 hold is not a current Wyoming Medicaid Member.

If a Member receiving services under a Title 25 hold has active Medicaid coverage, services should be delivered and billed with all supporting documentation to Wyoming Medicaid in accordance with all policies and procedures outlined in the applicable Wyoming Medicaid Provider Manuals:

- **CMS 1500 ICD-10:** For professional services.
- **Institutional Manual ICD-10:** For all facility-based inpatient and/or outpatient services.

For information on how to obtain Prior Authorization for inpatient services provided to Medicaid Members, please call Telligen at 1-833-610-1057.

Rule References

Providers must be familiar with all current rules and regulations governing the Title 25 Program. This Provider manual is to assist Providers with billing for services rendered; it does not contain all WSH rules and regulations. Any rule or statute citations in the text are only a reference tool. They are not a summary of the entire statute or rule. In the event that the manual conflicts with a statute or rule, the statute or rule prevails. Wyoming State Hospital Rules may be located at https://rules.wyo.gov/.

Importance of Fee Schedules and Provider's Responsibility

Procedure codes listed in the following sections are subject to change at any time without prior notice. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedules on the website (*see Section 2.1* Quick Reference). Fee schedules list Medicaid covered codes, provide clarification of indicators, such as whether a code requires prior authorization and the number of days in which follow-up procedures are included. Not all codes are covered by Medicaid or are allowed for all taxonomy codes (Provider types). It is the Providers' responsibility to verify this information. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service. Providers may elect to utilize CPT or CDT codes as applicable. However, all codes pertaining to dental treatment must adhere to all state guidance and federal regulation. Providers utilizing a CPT code for Dental services will be bound to the requirements of both manuals.

Wyoming Medicaid is required to comply with the coding restrictions under the National Correct Coding Initiative (NCCI) and Providers should be familiar with the NCCI billing guidelines. NCCI information may be reviewed at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

Getting Questions Answered

This Provider manual is designed to answer most questions; however, questions may arise that require a call to a specific department such as Provider Services (*see Section 2.1* Quick Reference).

Title 25 manual, bulletins, fee schedules, forms, and other resources are available on the Medicaid website or by contacting Provider Services (*see Section 2.1* Quick Reference).

Authority

The Wyoming Department of Health, Wyoming State Hospital is the state entity designated to review and reimburse for services in accordance with Title 25 of Wyoming Statute. The Division of Healthcare Financing (DHCF), who also directly administers the Medicaid Program, has been designated as the entity to receive and process medical claims for payment of eligible services.

This manual is intended to be a guide for Providers when filing medical claims for services provided to Members under a Title 25 hold. The manual is to be read and interpreted in conjunction with State statutes and administrative procedures. This manual does not take precedence over State statutes or administrative procedures.

Table of Contents

Chapter 1 – General Information

1.1 How the Title 25 Manual is Organized

The table below provides a quick reference describing how the Title 25 Manual is organized.

Chapter	Description
Two	**Getting Help When Needed** – Telephone numbers, addresses, and web sites for help and training
Three	**Provider Responsibilities** – Obligations and rights as a Medicaid Provider. The topics covered include enrollment changes, civil rights, group practices, Provider-patient relationship, and record keeping requirements.
Four	**Common Billing Information** – Basic claim information, completing the claim form, authorization for medical necessity requirements, co-pays, prior authorizations, timely filing, consent forms, NDC, working the Medicaid Remittance Advice (RA) and completing adjustments
Five	**Third Party Liability (TPL)/Medicare** – Explains what TPL/Medicare is, how to bill it, and exceptions to it
Six	**Important Information -** This chapter contains important information such as claims review, coding, and fee schedule information.
Seven	**Critical Access Hospital and General Hospital Inpatient** – This chapter contains information regarding covered services: definitions, procedure code ranges, documentation requirements, and billing requirements and examples.
Eight	**Covered Services - Ambulance** – This chapter contains covered services and billing information for ambulance services.
Nine	**Covered Services - Non-Emergency Medical Transportation** – This chapter contains covered services and billing information for non-emergency medical transportation.
Appendices	**Appendices** – Provide key information in an at-a-glance format. This includes the last quarters Provider Notifications.

1.2 Updating the Manual

When there is a change in the Title 25 Program, the Wyoming State Hospital (WSH) will update the manuals on a quarterly (January, April, July, and October) basis and publish them to the Medicaid website.

Most of the changes come in the form of Provider bulletins (via email) and Remittance Advice (RA) banners, although others may be newsletters or Wyoming Department of Health letters (via email) from state officials. The updated Provider manuals will be posted to the website and will include all updates from the previous quarter. It is in the Provider's best interest to download an updated Provider manual and keep their email addresses up-to-date. Bulletin, RA banner, or newsletter information will be posted to the website as it is sent to Providers and will be incorporated into the Provider manuals as

appropriate to ensure the Provider has access to the most up to date information regarding Medicaid policies and procedures.

RA banner notices appear on the first page of the proprietary Wyoming Medicaid (paper) Remittance Advice (RA), which is available for download through the Provider Portal after each payment cycle in which the Provider has claims processed.

It is critical for Providers to keep their contact email address(es) up-to-date to ensure they receive all notices published by Wyoming Medicaid. It is recommended that Providers add the wyproviderservices@wymedicaid.acentra.com email address, from which notices are sent, to their address books to avoid these emails being inadvertently sent to junk or spam folders.

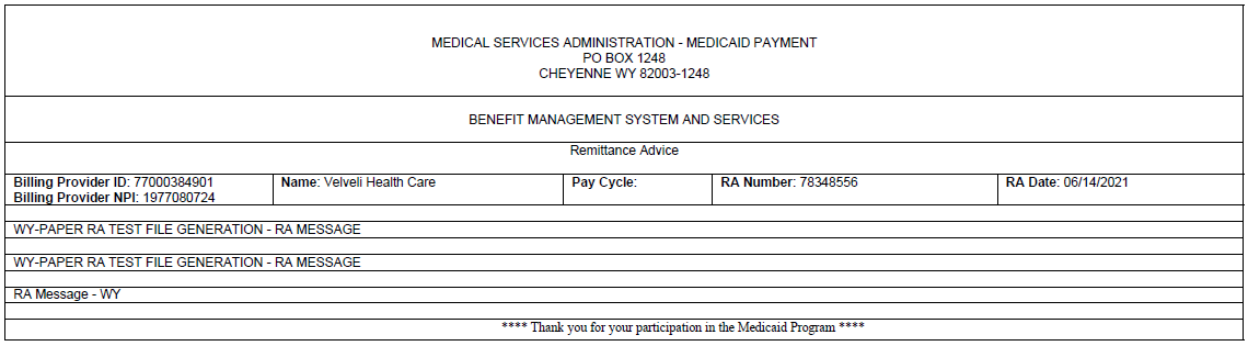
All bulletins and updates are published to the Medicaid website (*see Section 2.1* Quick Reference).

> Provider bulletins and State Letter email notifications are sent to the email addresses on-file with Medicaid.

1.2.1 Remittance Advice Banner Notices and Samples

RA banner messages are short notifications that display on the Medicaid proprietary (paper) RAs which are posted to the Provider Portal. These RAs can be retrieved from the Provider Portal by performing an RA Inquiry. These notices are targeted to specific Provider types or to all billing and pay-to Providers. This is another way for Medicaid and the Fiscal Agent to communicate to Providers. Multiple RA banners can display simultaneously, and they typically remain active for no more than 70 days. The RA banner will not be posted to the 835 electronic remittance advice.

RA Banner Sample Image:



MEDICAL SERVICES ADMINISTRATION - MEDICAID PAYMENT
PO BOX 1248
CHEYENNE WY 82003-1248

BENEFIT MANAGEMENT SYSTEM AND SERVICES

Remittance Advice

Billing Provider ID: 77000384901 **Billing Provider NPI**: 1977080724	**Name**: Velveli Health Care	**Pay Cycle**:	**RA Number**: 78348556	**RA Date**: 06/14/2021

WY-PAPER RA TEST FILE GENERATION - RA MESSAGE

WY-PAPER RA TEST FILE GENERATION - RA MESSAGE

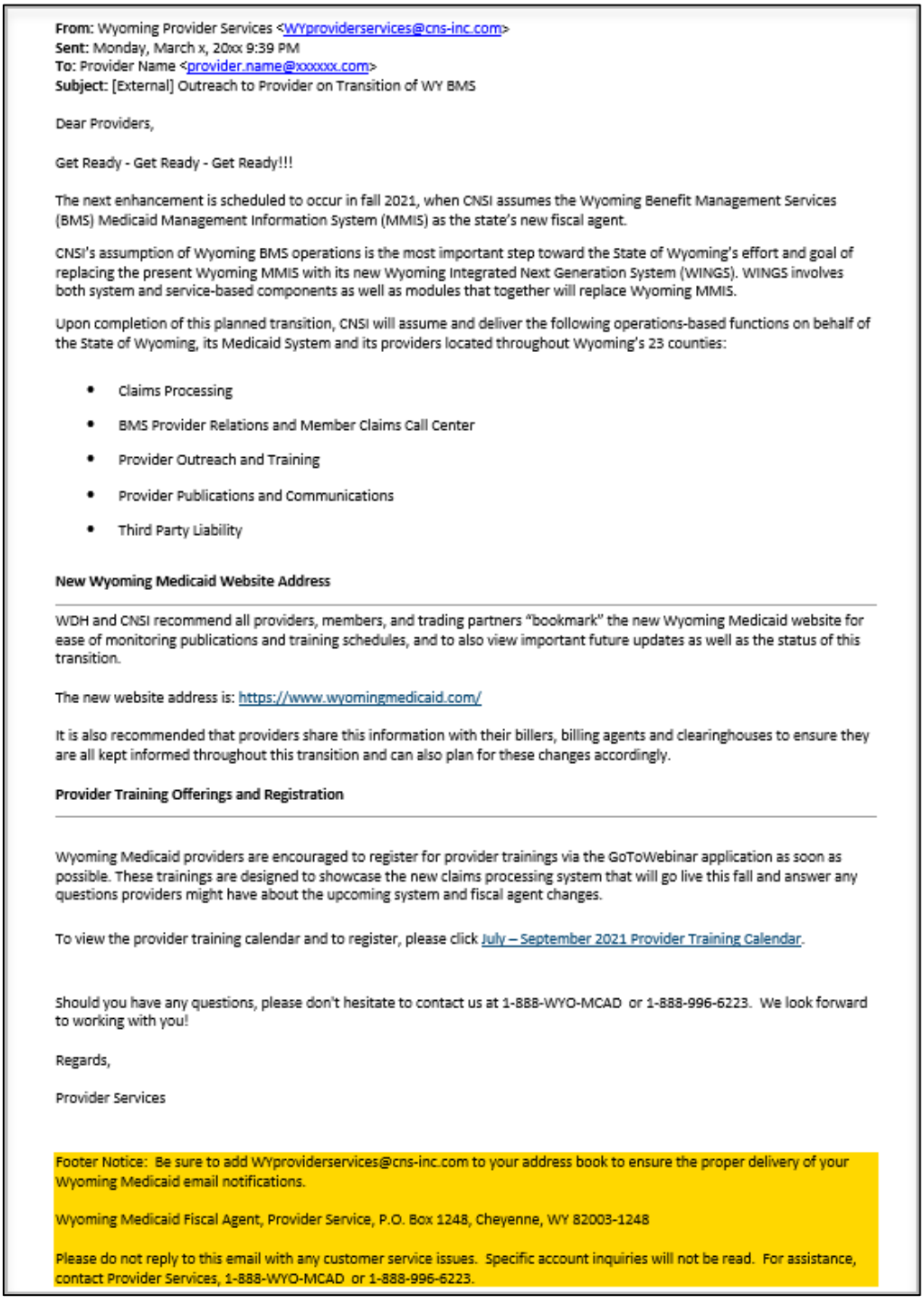
RA Message - WY

**** Thank you for your participation in the Medicaid Program ****

1.2.2 Medicaid Bulletin Notification

Medicaid deploys email bulletin notifications typically to announce information such as billing changes, new codes requiring prior authorization, reminders, up and coming initiatives, and new policy and processes.

Sample Bulletin Email Notification



From: Wyoming Provider Services <WYproviderservices@cns-inc.com>
Sent: Monday, March x, 20xx 9:39 PM
To: Provider Name <provider.name@xxxxxx.com>
Subject: [External] Outreach to Provider on Transition of WY BMS

Dear Providers,

Get Ready - Get Ready - Get Ready!!!

The next enhancement is scheduled to occur in fall 2021, when CNSI assumes the Wyoming Benefit Management Services (BMS) Medicaid Management Information System (MMIS) as the state's new fiscal agent.

CNSI's assumption of Wyoming BMS operations is the most important step toward the State of Wyoming's effort and goal of replacing the present Wyoming MMIS with its new Wyoming Integrated Next Generation System (WINGS). WINGS involves both system and service-based components as well as modules that together will replace Wyoming MMIS.

Upon completion of this planned transition, CNSI will assume and deliver the following operations-based functions on behalf of the State of Wyoming, its Medicaid System and its providers located throughout Wyoming's 23 counties:

- Claims Processing
- BMS Provider Relations and Member Claims Call Center
- Provider Outreach and Training
- Provider Publications and Communications
- Third Party Liability

New Wyoming Medicaid Website Address

WDH and CNSI recommend all providers, members, and trading partners "bookmark" the new Wyoming Medicaid website for ease of monitoring publications and training schedules, and to also view important future updates as well as the status of this transition.

The new website address is: https://www.wyomingmedicaid.com/

It is also recommended that providers share this information with their billers, billing agents and clearinghouses to ensure they are all kept informed throughout this transition and can also plan for these changes accordingly.

Provider Training Offerings and Registration

Wyoming Medicaid providers are encouraged to register for provider trainings via the GoToWebinar application as soon as possible. These trainings are designed to showcase the new claims processing system that will go live this fall and answer any questions providers might have about the upcoming system and fiscal agent changes.

To view the provider training calendar and to register, please click July – September 2021 Provider Training Calendar.

Should you have any questions, please don't hesitate to contact us at 1-888-WYO-MCAD or 1-888-996-6223. We look forward to working with you!

Regards,

Provider Services

Footer Notice: Be sure to add WYproviderservices@cns-inc.com to your address book to ensure the proper delivery of your Wyoming Medicaid email notifications.

Wyoming Medicaid Fiscal Agent, Provider Service, P.O. Box 1248, Cheyenne, WY 82003-1248

Please do not reply to this email with any customer service issues. Specific account inquiries will not be read. For assistance, contact Provider Services, 1-888-WYO-MCAD or 1-888-996-6223.

1.3 State Agency Responsibilities

The Wyoming State Hospital administers the Title 25 program for the Department of Health. They are responsible for financial management, developing policy, establishing benefit limitations, payment methodologies and fees, and performing utilization review.

1.4 Fiscal Agent Responsibilities

Acentra Health is the fiscal agent for Medicaid. They process all claims and adjustments for Title 25. They also answer Provider inquiries regarding claim status, payments, Member eligibility, and known third party insurance information.

> Neither the Wyoming State Hospital nor Acentra Health are responsible for the training of Providers' vendors, billing staff, providing procedure or diagnosis codes, or coding training. Acentra Health may assist with billing but cannot advise Providers on which codes to use.

Chapter 2 – Getting Help When Needed

2.1 Quick Reference

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Change Healthcare	Tel (877)209-1264 (Pharmacy Help Desk) Tel (877)207-1126 (PA Help Desk)	http://www.wymedicaid.org/	• Pharmacy prior authorizations (PA) • PAs for physician administered injections • Pharmacy manuals • FAQs
Claims Department Wyoming Department of Health P.O. Box 547 Cheyenne, WY 82003-0547	Fax (307)460-7408	www.wyomingmedicaid.com/	• Claim adjustment submissions • Hardcopy claims submissions • Returning Medicaid checks
Communicable Treatment Disease Program Email: CDU.treatment@wyo.gov	Tel (307)777-5800 Fax (307)777-7382 For Pharmacy Coverage Contact: ScriptGuideRX Tel (855) 357-7479	N/A	• Prescription medications • Program information

Customer Service Center (CSC)
Wyoming Department of Health
3001 E. Pershing Blvd, Suite 125
Cheyenne, WY 82001
	Tel (855)294-2127
	TTY-FLAG10 /TDD
	(855)329-5205
	(Members Only, CSC cannot speak to Providers)
	7am-6pm MST M-F
	Fax (855)329-5205
		https://www.wesystem.wyo.gov	• Member Medicaid applications
			• Member ID Card replacements
			• Member Travel Assistance
			• Members being billed by Providers
			• Eligibility questions regarding:
			  ○ Family and Children's programs
			  ○ Tuberculosis Assistance Program
			  ○ Medicare Savings Programs
			• Employed Individuals with Disabilities(EID)
			• Verification of Services

Division of Healthcare Financing (DHCF)	Tel (307)777-7531 Tel (866)571-0944	https://health.wyo.gov/healthcarefin/	• Medicaid State Rules • State Policy and Procedures

122 West 25th St, 4th Floor West Cheyenne, WY 82002	Fax (307)777-6964		• Concerns/Issues with State Contractors/Vendors
DHCF Pharmacy Program 122 West 25th St, 4th Floor West Cheyenne, WY 82002	Tel (307)777-7531 Fax (307)777-6964	N/A	• General questions
DHCF Program Integrity 122 West 25th St, 4th Floor West Cheyenne, WY 82002	Tel (855)846-2563 **NOTE:** Callers may remain anonymous when reporting	N/A	• Member or Provider Fraud, Waste and Abuse
HHS Technology Group (PRESM) Provider Enrollment Email: WYEnrollmentSvcs@HHSTechGroup.com	Tel (877)399-0121 8 am -5 pm MST M-F (call center hours)	https://wyoming.dyp.cloud Discover Your Provider	• Provider Enrollment/Re-enrollment • Provider updates • Provider enrollment questions • Email maintenance • Banking Information/W9 additions and updates
HMS (Health Management Systems) Third Party Liability (TPL) Department Wyoming Department of Health 225 East John Carpenter Freeway, Ste 500 Irving, TX 75062	Provider Services (888)996-6223 **NOTE:** Within IVR, either say Report TPL, update insurance – to be transferred to TPL. 7 am-6 pm MST M-F (call center hours) 24/7 IVR Availability	N/A	• Member accident covered by liability or casualty insurance or legal liability is being pursued • EID premiums or balances • Estate and Trust Recovery • Report Member TPL • Report a new/update insurance policy • Problems getting insurance information needed to bill • Questions or problems regarding third party coverage or payers • WHIPP program • TPL Disallowance Portal
Home and Community Based Waiver Services (HCBS)	Tel (800) 510-0280 Tel (307) 777-7531 Fax (307) 777-8685	https://health.wyo.gov/healthcarefin/hcbs/	• Community Choice Waiver (CCW) ○ Ages 65+ and other disabilities

			• Comprehensive and Supports Waivers
			  ○ Developmental and Intellectual Disabilities
			  ○ Acquired Brain Inquires

Medicare	Tel (800)633-4227	N/A	• Medicare information
Magellan Healthcare, Inc.	Tel (307)459-6162 8 am-5pm MST M-F (855)883-8740 After Hours	https://www.magellanofwyoming.com/	• Care Management Entity Services that require Prior Authorization
Provider Services Wyoming Department of Health P.O. Box 1248 Cheyenne, WY 82003-1248 Email: WYProviderOutreach@acentra.com	Tel (888)WYO-MCAD or (888)996-6223 7 am -6 pm MST M-F (call center hours) 24/7 (IVR availability) Fax (307)460-7408	www.wyomingmedicaid.com/	• Bulletin/manuals inquiries • Claim inquiries/submission problems • Member eligibility • Documentation of Medical Necessity • How to complete forms • Payment inquiries • Provider Portal assistance/training • Request Field Representative visit • Technical support for vendors, billing agents/clearinghouses • Trading Partner Registration • Training seminar questions • Timely filing inquiries • Verifying validity of procedure codes • Web Registration • Wyoming Medicaid EDI Companion Guide located on the Medicaid website
Social Security Administration (SSA)	Tel (800)772-1213	N/A	• Social Security benefits

Stop Medicaid Fraud	Tel (855)846-2563 **NOTE:** Remain anonymous when reporting	https://health.wyo.gov/healthcarefin/program-integrity/	• Information and education regarding fraud, waste, and abuse in the Wyoming Medicaid program • To report fraud, waste, and abuse •
WYhealth (Care Management) 122 W 25th St 4th Floor Cheyenne, WY 82002	Tel (888) 545-1710 Nurse Line: (OPTION 3)	https://health.wyo.gov/healthcarefin/medicaid/wyoming-medicaid-health-management/	• Diabetes Incentive Program • Educational Information about WYhealth Programs • ER Utilization Program • Medicaid Incentive Programs • Refer a Member to the Health Management Program • Referrals to Project Juno
Telligen (Utilization Management) 1776 West Lakes Pkwy West Des Moines, IA 50266	Tel (833) 610-1057	https://wymedicaid.telligen.com/	• DMEPOS Covered Services manual • Questions related to documentation or clinical criteria for DMEPOS • Preadmission Screen and Resident Review (PASRR Level II) Claims Requiring Prior Authorization (Member Eligibility - Medicaid and T26) **for:** • Acute Psych • Dental services (limited) • Severe Malocclusion • Durable Medical Equipment (DME) or Prosthetic/Orthotic Services (POS) • Extended Psych • Extraordinary heavy care • Gastric Bypass • Genetic Testing • Home Health • Psychiatric Residential Treatment Facility (PRTF) • PT/OT/ST/BH services after service threshold

			• Surgeries (limited) • Transplants • Vagus Nerve Stimulator • Vision services (limited) • Unlisted Procedures
Wyoming Department of Health Long Term Care Unit (LTC)	Tel (855)203-2936 8 am-5 pm MST M-F Fax (307)777-8399	N/A	• Nursing home program eligibility questions • Patient Contribution • Waiver Programs • Inpatient Hospital • Hospice
Wyoming Medicaid Website	N/A	www.wyomingmedicaid.com/	• Provider manuals/bulletins • Wyoming Medicaid EDI Companion Guide located on the Medicaid website • Fee schedules • Frequently asked questions (FAQs) • Forms (for example, Claim Adjustment/Void Request Form) • Contacts • What's New • Remittance Advice Retrieval • Secured Provider Portal • Trading Partner Registration • Training Tutorials • Web Registration

2.2 How to Call for Help

The fiscal agent maintains a well-trained call center that is dedicated to assisting Providers. These individuals are prepared to answer inquiries regarding Member eligibility, service limitations, third party coverage, electronic transaction questions, and Provider payment issues.

2.3 How to Get Help Online

The address for Medicaid's public website is www.wyomingmedicaid.com. This site connects Wyoming's Provider community to a variety of information, including:

- Answers to the Providers frequently asked Medicaid and Title 25 questions
- Download Forms, such as Medical Necessity, Sterilization Consent, Order vs Delivery Date Form and other forms
- Title 25 program publications, such as Provider manuals and bulletins
- Payment Exception Schedule
- Primary resource for all information related to Medicaid and Title 25
- Wyoming Medicaid Provider Portal
- Wyoming Medicaid Training Tutorials

The Provider Portal delivers the following services:

- **Data Exchange:** Upload and download of electronic HIPAA transaction files
- **Manage Provider Information**: Manage Billing Agents and Clearinghouses
- **Remittance Advice Reports:** Retrieve recent Remittance Advices
    - Wyoming Medicaid proprietary RA
        - 835 transaction
- **Domain Provider Administration:** Add, edit, and delete users within the Provider's organization
- **Electronic Claim Entry:** Direct Data Entry of dental, institutional, and medical claims
- **PASRR Level I Entry and Inquiry**
- **LT101 Inquiry**
- **Prior Authorization Inquiry:** Search any Prior Authorization to determine status
- **Member Eligibility Inquiry:** Search Wyoming Medicaid Members to determine eligibility for the current month

Chapter 3 – Provider Responsibilities

3.1 Enrollment

Title 25 payments are made only to Providers who are actively enrolled in the Medicaid Program.

To enroll as a Medicaid Provider, all Providers must complete the on-line enrollment application available on the HHS Technology Group website (*see Section 2.1* Quick Reference).

3.2 Accepting Title 25 Members

If a Member receiving services under a Title 25 (T25) hold has active Medicaid coverage, services should be delivered and billed with all supporting documentation to Wyoming Medicaid in accordance with all policies and procedures outlined in the applicable Wyoming Medicaid Provider Manuals:

- **CMS 1500 ICD-10:** For professional services.
- **Institutional Manual ICD-10:** For all facility-based inpatient and/or outpatient services.

Members receiving only T25 coverage do not require Prior Authorization (PA). Members receiving T25 coverage in addition to Wyoming Medicaid full coverage will require PA for service, as appropriate.

For information on how to submit Prior Authorization for inpatient services provided to Medicaid Members, contact Telligen (*see Section 2.1* Quick Reference).

3.2.1 Provider-Patient Relationship

The relationship established between the Member and the Provider is both a medical and a financial one. If a Member presents himself or herself as a Medicaid Member, the Provider must determine whether the Provider is willing to accept the Member as a Medicaid patient before treatment is rendered.

It is the Providers' responsibility to determine all sources of coverage for any Member. If the Member is insured by an entity other than Medicaid, and Medicaid is unaware of the insurance, the Provider must submit a Third Party Resources Information Sheet to Medicaid, attention TPL 5.2.1, Third Party Resources Information Sheet). The Provider may not discriminate based on whether a Member is insured.

Provider may not discriminate against Wyoming Medicaid Members. Providers must treat Wyoming Medicaid Members the same as any other patient in their practice. Policies must be posted or supplied in writing and enforced with all patients regardless of payment source.

3.2.2 Determining Residency for Purposes of County Liability

Pursuant to Wyoming Statute Title 25, the Member's county of residence is responsible for the payment of all services provided to a Member in the first 72 hours of the emergency detention (including all weekends and legal holidays). Services cannot be billed to the Wyoming State Hospital until after expiration of the initial 72-hour detention period unless the Member is a non-resident of the State. If

the Member is not a documented Wyoming resident, the Wyoming State Hospital will review claims for all applicable dates of service covered under the emergency detention.

A resident is defined by Wyo. Stat. § 25-10-101 (xv) as a United States citizen who has been a resident of and domiciled in Wyoming for not less than ninety (90) days and who has note claimed residency elsewhere for the purpose of obtaining medical or psychiatric services during that ninety (90) day period immediately preceding the date when services were provided. A resident also includes any alien who has resided continuously in Wyoming for at least ninety (90) days immediately prior to the date when services were provided as well as any active duty Member, the spouse or minor child of any active duty Member of the armed forces of the United States who is stationed in Wyoming.

A Member who has not been in Wyoming County for at least 90 days or doesn't otherwise meeting the definition of a resident should be considered to be a non- resident for purposes of Wyoming State Hospital payment liability.

3.2.3 Determining Primary Payer Resources (Wyo. Stat. § 25-10-112)

It is the Provider's responsibility to determine all sources of healthcare coverage for any Member.

For dates of service on or after April 1, 2017, Wyoming Medicaid is considered an allowable primary payer. All Title 25 services provided to Wyoming Medicaid Members after the expiration of the county's liability should be billed on electronically (both UB and CMS 1500 claims) with all supporting documentation to Wyoming Medicaid.

If inpatient psychiatric services are provided to a Medicaid enrolled Member, they must be prior authorized in accordance with Wyoming Medicaid policy for payment. Refer to billing requirements in the Medicaid Institutional Provider Manual located on the Medicaid website.

The Wyoming State Hospital requires all Providers to complete and submit the Title 25 Certification Form (*see Section 3.2.5.2 Title 25 Certification Form)* as evidence that all potential options for a primary payer source were identified and billed prior to submitting claims to the WSH for payment. The Title 25 Certification Form must be a fully executed attestation between the facility and the Member, to include complete Member demographic information, Member/guardian or witness signature, and an authorized signature from a facility representative. Claims submitted with an incomplete Title 25 Certification Form will not be accepted or processed.

3.2.4 Determining Eligible Dates of Service

Pursuant to Wyoming Statute § 25-10-112, the Member's county of residence is responsible for the payment of all services provided to a Member in the first 72 hours of the emergency detention (including all weekends and legal holidays). Services cannot be billed to the Wyoming State Hospital until after expiration of the initial emergency detention period unless the Member is a non-resident. If the Member is not a documented Wyoming resident, then the Wyoming State Hospital will review claims for all applicable dates of service covered under the emergency detention. If claims are received for services provided within the first 72 hours of the emergency detention, they will be returned to the Provider.

The Wyoming State Hospital calculates the expiration of county financial responsibility exactly 72 hours after the time of the initial detention, as noted in the 3-81 document. The Wyoming State Hospital will exclude all weekends and legal holidays in this calculation. For example, if a Member is detained at 8 AM on Friday morning, the 72-hour period would expire on the following Wednesday at 8 AM.

3.2.5 Submitting Required Title 25 Documentation

After determining the above information, the following Title 25 documentation must be sent via mail to the Behavioral Health Program Manager:

Samantha Robbins
Behavioral Health Program Manager
122 West 25th Street, 4 West
Cheyenne, WY 82002

- Title 25 Provider Checklist Coversheet (*see Section 3.2.5.1* Title 25 Provider Checklist Coversheet)
- Title 25 Certification form (*see Section 3.2.5.2 Title 25 Certification Form*) – **must be** completed and submitted
- Copy of the Clinician/Medical Examiner documentation supporting involuntary hold (Form 3- 81)
- Copy of the Order for Continuing Emergency Detention and/or the Order for Involuntary Hospitalization
- Copy of the Order of Dismissal – required if the patient is being discharged (Form 14- 81)
- Copy of Title 25 Discharge Date Certification
- Copy of the Explanation of Benefits, if applicable

When sending Title 25 documentation, **DO NOT** include paper claims as they will not be processed. Processing of this documentation can take 15 or more days. To determine if submitted documents have been processed, check Member eligibility by calling the Provider Services IVR or via the Provider Portal (*see Section 2.1* Quick Reference). Claims must be submitted electronically (*see Section 4.1* Electronic Billing of Wyoming State Hospital Claims) after this documentation has been reviewed and T25 eligibility has been assigned to the Member.

3.2.5.1 Title 25 Provider Checklist Coversheet

Wyoming Department of Health

Healthcare Financing Division
Wyoming Medicaid
122 W 25th Street, 4 West
Cheyenne, WY 82002
Phone (307) 777-7531 • 1-866-571-0944
Fax (307) 777-6964 • www.health.wyo.gov

Title 25 Provider Checklist Coversheet

*For all Claims submitted to the Wyoming Department of Health for payment under the Wyoming Title 25 statute

Required Documentation:

- Title 25 Provider Checklist Coversheet
- Title 25 Certification form – **must be** completed and submitted
- Copy of the Clinician or Medical Examiner documentation supporting involuntary hold (Form 3-81)
- Copy of the Order for Continuing Emergency Detention and/or the Order for Involuntary Hospitalization
- Copy of the Order of Dismissal – required if the Member is being discharged (Form 14-81)
- Copy of the Explanation of Benefits, if applicable
- WYhealth Prior Authorization Letter – for inpatient services only, approved or denied (for Medicaid Members only)

Please complete the following:

Member Date of Admit: _____

First Date of Service Billed to the Department of Health: _____

Date of Discharge: _____

Billing Instructions:

- Mail the required T25 documentation to:
  Laura Harnish
  Medicaid Benefit Quality Control Manager
  122 West 25th Street, 4 West
  Cheyenne, WY 82002

Note: Do not send paper claims with this documentation as they will not be processed.

- **Wait 15 business days** from the date the T25 documentation is placed in the mail for Medicaid to review and forward to the Fiscal Agent to add or update the Member's T25 or T26 eligibility
- **Once the 15 business days has lapsed,** submit your T25 claims electronically for Member; all T25 claims are required to be submitted electronically to WY Medicaid
  - Enter the Member's Medicaid ID on the claim
  - Remember to bill primary insurance or Medicare prior to submitting to Medicaid and enter as appropriate on the claim and/or include EOB or COB attachment
  - Include any additional supporting documentation as appropriate for medically necessary services

Effective 04/01/2025
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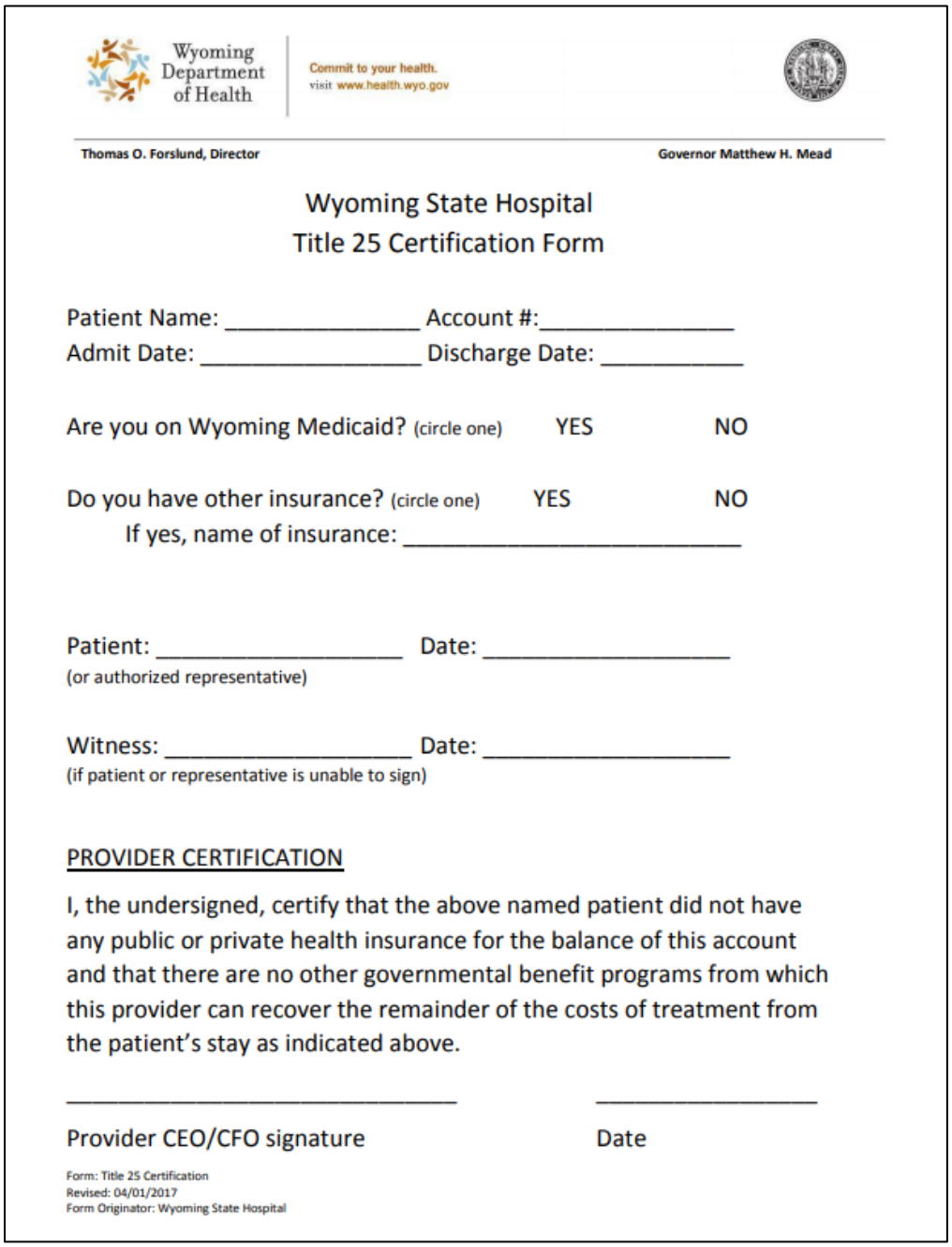
3.2.5.2 Title 25 Certification Form



Wyoming Department of Health
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Thomas O. Forslund, Director — Governor Matthew H. Mead

Wyoming State Hospital
Title 25 Certification Form

Patient Name: _____ Account #:_____
Admit Date: _____ Discharge Date: _____

Are you on Wyoming Medicaid? (circle one) YES NO

Do you have other insurance? (circle one) YES NO
If yes, name of insurance: _____

Patient: _____ Date: _____
(or authorized representative)

Witness: _____ Date: _____
(if patient or representative is unable to sign)

PROVIDER CERTIFICATION

I, the undersigned, certify that the above named patient did not have any public or private health insurance for the balance of this account and that there are no other governmental benefit programs from which this provider can recover the remainder of the costs of treatment from the patient's stay as indicated above.

_____ _____
Provider CEO/CFO signature Date

Form: Title 25 Certification
Revised: 04/01/2017
Form Originator: Wyoming State Hospital

3.3 Wyoming State Hospital Payment is Payment in Full

As a condition of receiving payment from the WSH), the Provider must accept payment as payment in full for a covered service. The Provider shall not seek any additional payment from the Member.

3.4 Record Keeping, Retention, and Access

3.4.1 Requirements

The Provider Agreement requires that the medical and financial records fully disclose the extent of services provided to Medicaid Members. The following record element requirements include, but are not limited to:

- The record must be typed or legibly written
- The record must identify the Member on each page
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record. For any drugs administered, the NDC on the product must be recorded, as well as the lot number and expiration date.
- The record must indicate the observed medical condition of the Member, the progress at each visit, any change in diagnosis or treatment, and the Member's response to treatment. Progress notes must be written for every service, including, but not limited to office, clinic, nursing home, or hospital visits billed to Medicaid.
- Total treatment minutes of the Member, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented separately, to include beginning time and ending time for services billed.

> Specific or additional documentation requirements may be listed in the covered services sections or designated policy manuals.

3.4.2 Retention of Records

The Provider must retain medical and financial records, including information regarding dates of service, diagnoses, services provided, and bills for services, for at least six (6) years from the end of the State fiscal year (July through June) in which the services were rendered. If an audit is in progress, the records must be maintained until the audit is resolved.

3.4.3 Access to Records

Under the Provider Agreement, the Provider must allow access to all records concerning services and payment to authorized personnel of Medicaid, CMS Comptroller General of the United States, State Auditor's Office (SAO), the office of the Inspector General (OIG), the Wyoming Attorney General's Office, the United States Department of Health and Human Services, and/or their designees. Records must be accessible to authorized personnel during normal business hours for the purpose of reviewing, copying,

and reproducing documents. Access to the Provider records must be granted regardless of the Providers continued participation in the program.

In addition, the Provider is required to furnish copies of claims and any other documentation upon request from Medicaid and/or their designee.

Chapter 4 – Common Billing Information

4.1 Electronic Billing of Wyoming State Hospital Claims

Providers should submit bills only upon discharge of the Member. No interim claims will be allowed.

All Title 25 claims must be submitted electronically. Claims should be submitted 15 days after submission of Required Title 25 Documentation, at the earliest.

Wyoming Medicaid requires taxonomy codes to be included on all claim submissions for billing, attending, **and** servicing and rendering Providers.

Exceptions:

- Providers who must have Out of Policy exceptions may continue to bill on paper.
- Providers who are working with WDH or Acentra Health representatives to process/special batch paper claims may continue to work with those representatives and bill on paper when necessary.

> The "Exceptions" list of items may be updated in the future to require electronic billing. A notification will be provided when those changes are made.

4.2 Basic Claim Information

The fiscal agent processes paper CMS-1500 and UB04 claims using Optical Character Recognition (OCR). OCR is the process of using a scanner to read the information on a claim and convert it into electronic format instead of being manually entered. This process improves accuracy and increases the speed at which claims are entered into the claims processing system. The quality of the claim form will affect the accuracy in which the claim is processed through OCR. The following is a list of tips to aid Providers in avoiding paper claim processing problems with OCR:

- Use an original, standard, red-dropout form (CMS-1500 [02-12] and UB 04)
- Use typewritten print; for best results use a laser printer
- Use a clean, non-proportional font
- Use black ink
- Print claim data within the defined boxes on the claim form
- Print only the information asked for on the claim form
- Use all capital letters
- Use correction tape for corrections

To avoid delays in processing of claims, or incorrect processing, it is recommended that Providers avoid the following:

- Using copies of claim forms

- Faxing claims
- Using fonts smaller than 8 point
- Resizing the form
- Entering “none,” “NA,” or “Same” if there is no information (leave the box blank)
- Mixing fonts on the same claim form
- Using italics or script fonts
- Printing slashed zeros
- Using highlighters to highlight field information
- Using stamps, labels, or stickers
- Marking out information on the form with a black marker

Claims that do not follow Title 25 Provider billing policies and procedure, or meet any of the below criteria, may be returned, unprocessed, with a letter.

- Handwritten information on the claim form
- Signature is missing or the form states "Signature on File"
- Pay-to Provider NPI or Provider ID is missing
- Claim is submitted on an obsolete paper claim format
- Claim form is illegible

When a claim is returned, the Provider may correct the claim and return it to Medicaid for processing.

> The fiscal agent and the Division of Healthcare Financing (DHCF) are prohibited by federal law from altering a claim.

Billing errors detected after a claim is submitted cannot be corrected until after WSH has made payment or notified the Provider of the denial. **Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice** (*see Section 4.10* Resubmitting Versus Adjusting Claims).

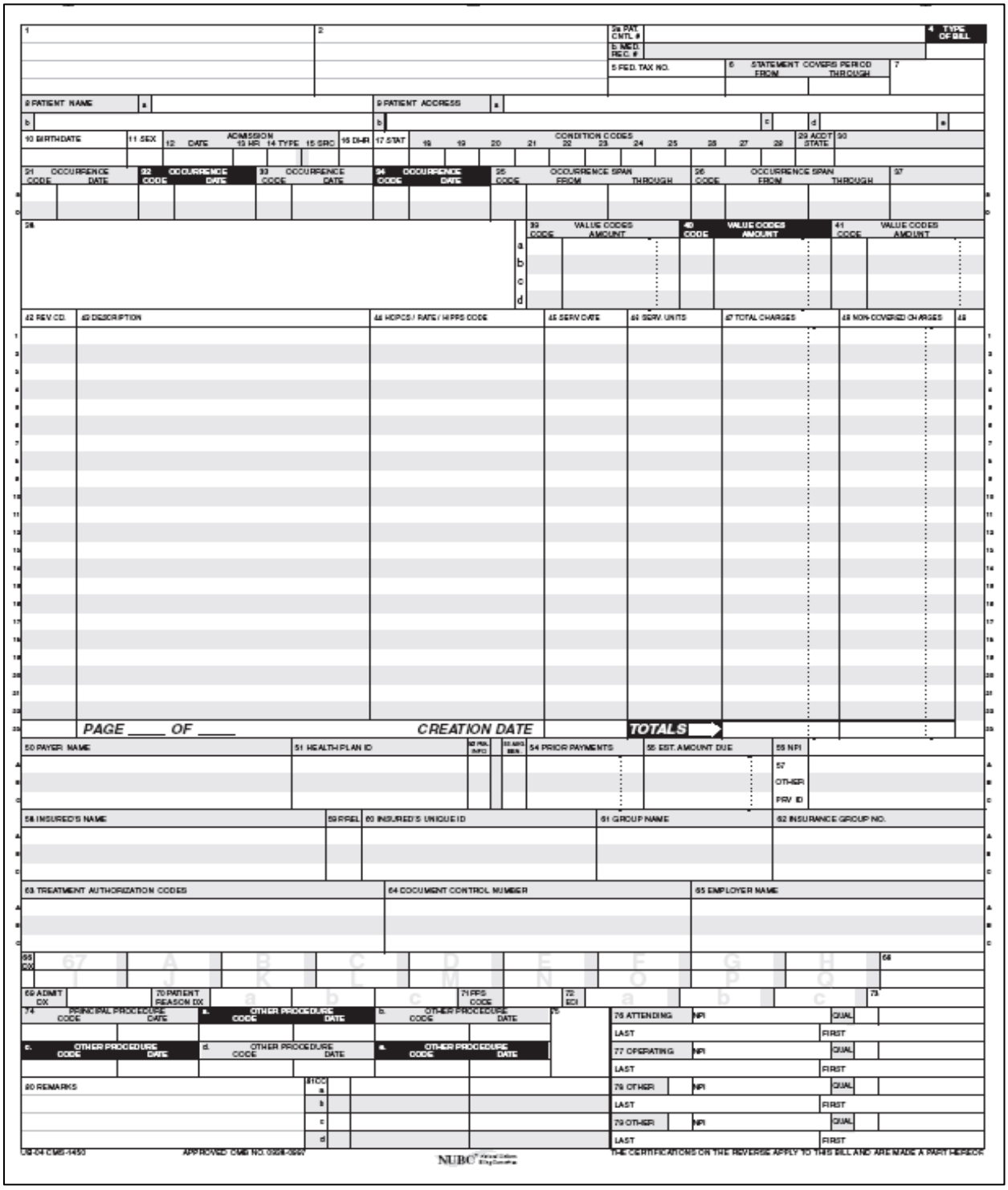
> Claims are to be submitted only after service(s) have been rendered, not before. Inpatient claims are to be submitted upon Member discharge only. No interim billing will be allowed for inpatient admissions.

4.3 Authorized Signatures

All paper claims must be signed by the Provider or the Providers’ authorized representative. Acceptable signatures may be either handwritten, a stamped facsimile, typed, computer generated, or initialed. The

signature certifies all information on the claim is true, accurate, complete, and contains no false or erroneous information. Remarks such as signature on file or facility names will not be accepted.

4.4 The UB-04 Claim Form



4.4.1 Instructions for Completing the UB-04 Claim Form

<table>
<tr><th>Field</th><th>Item Description</th><th>Required Outpatient</th><th>Required Inpatient</th><th>Action</th></tr>
<tr><td>1</td><td>Provider Name and Address and Telephone</td><td>X</td><td>X</td><td>Enter the name of the Provider submitting the bill, complete mailing address and telephone number.</td></tr>
<tr><td>2</td><td>Pay-To Name and Address</td><td>X</td><td>X</td><td>Enter the Pay-To Name and Address if different from 1.</td></tr>
<tr><td>3a</td><td>Patient Control Number</td><td>X</td><td>X</td><td>(Optional) Enter the Providers account number for the Member. Any alpha/numeric character will be accepted and referenced on the R.A. No special characters are allowed.</td></tr>
<tr><td>3b</td><td>Medical Record Number</td><td></td><td></td><td></td></tr>
<tr><td>4</td><td>Type of Bill
First Digit
1 Hospital
2 Skilled Nursing
3 Home Health
7 Clinic (ESRD,FQHC,RHC, or CORF)
8 Special Facility (Hospital, CAH)</td><td>X</td><td>X</td><td>Enter the three (3) digit code indicating the specific type of bill. The code sequence is as follows:
<table>
<tr><th>Second Digit</th><th>Third Digit</th></tr>
<tr><td>1 Inpatient</td><td>0 Non-payment/Zero Claim</td></tr>
<tr><td>2 ESRD</td><td>1 Admit through discharge Claim</td></tr>
<tr><td>3 Outpatient</td><td>2 Interim – 1st Claim</td></tr>
<tr><td>4 Other</td><td>3 Interim – Continuing claim</td></tr>
<tr><td>5 Intermediate Care Level 1</td><td>4 Interim – Last claim (thru Date is discharge date)</td></tr>
<tr><td>6 Intermediate Care Level 2</td><td>7 Adjustment or Replacement of a Prior Claim</td></tr>
<tr><td>7 Subacute Inpatient</td><td>8 Void of a Prior Claim</td></tr>
<tr><td>8 Swing bed Medicare/ Medicaid</td><td></td></tr>
</table></td></tr>
</table>

Field	Item Description	Required Outpatient	Required Inpatient	Action
5	Federal Tax Number	X	X	Refers to the unique identifier assigned by a federal or state agency.
6	Statement Covers Period From/Through Dates	X	X	For services rendered on a single day, enter that date (MMDDYY) in both the "FROM" and "THROUGH" fields. <u>Inpatient:</u> Enter the date of admission through the date of discharge. <u>Outpatient:</u> Enter the date or dates of services that are being billed on the claim. <u>Outpatient/Inpatient Combined:</u> Enter the date the Member was first seen for outpatient services through the inpatient discharge date.
7	Future Use	N/A	N/A	
8a	Patient ID	X	X	Enter Member's Medicaid number.
8b	Patient Name	X	X	Enter the Member's name as shown on the front of the Medicaid card.
9	Patient Address	X	X	Enter the full mailing address of Member.
10	Patient Birthdate	X	X	Enter Member's birthdate (MMDDYY).
11	Patient Sex	X	X	(Optional) Enter appropriate code.
12	Admission Date	X	X	Enter the date the patient was admitted as an inpatient or the date of outpatient care.
14	Type of Admission/Visit	X	X	Enter appropriate code: 1 = Emergency 2 = Urgent Care 3 = Elective (non-emergency) 4 = Newborn 5= Trauma Physician/medical professional will need to determine if the visit or service was an emergency.

Field	Item Description	Required Outpatient	Required Inpatient	Action
15	Source of Admission	X	X	Enter the Source of Admission Code
16	Discharge Hour	X	N/A	(When applicable) Enter the hour the Member was discharged.
17	Patient Discharge Status	X	X	Enter the two (2) digit code indicating the status of the patient as noted below: Code Description 01 Home or self-care 02 Other hospital 03 SNF 04 ICF 05 Other type of institution 06 Home health organization 07 Left against medical advice 09 Admitted as IP to this hosp 20 Expired 21 Law Enforcement 30 Still a patient, used for interterm billing 40 Hospice patient died at home 41 Hospice patient died at hospital 42 Hospice patient died unknown 43 Tran to Fed Hlth Care Facility 50 Discharged to hospice- home 51 Discharged to hospice- med 61 Transferred to swing bed 62 Transferred to inp rehab facility 63 Transferred to Long Term Care Hosp 64 Trans to Mcaid Nursing Facility 65 Transferred to Psych Hospital 66 Transferred to Critical Access Hospital 70 Transfer to Other

Field	Item Description	Required Outpatient	Required Inpatient	Action
18-28	Condition Codes	Situational	Situational	Enter if applicable
29	Accident State			If claim is for auto accident, enter the state the accident occurred in.
30	Future Use	N/A	N/A	
31-34	Occurrence Code and Dates	Situational	Situational	Enter if applicable.
35-36	Occurrence Span Codes and Dates	Situational	Situational	Enter if applicable.
37	Future Use	N/A	N/A	
38	Subscriber Name and Address	X	X	Enter Member's name and address.
39-41	Value Codes and Amounts	Situational	Situational	Enter if applicable
42	Revenue Codes	X	X	Enter the appropriate revenue codes.
43	Revenue Code Description	X	X	Enter appropriate revenue code descriptions.
44	HCPCS/Rates	Situational	Situational	Enter if applicable.
45	Service Date	X	X	Enter date(s) of service.
46	Units of Service	X	X	Enter the units of services rendered for each detail line. A unit of service is the number of times a procedure is performed. If only one (1) service is performed, the numeral 1 must be entered.
48	Non-Covered Charges	Situational	Situational	Enter if applicable.
49	Future Use	N/A	N/A	
50	Payer Identification (Name)	X	X	Enter name of payer.
51	Health Plan Identification Number	X	X	(Optional) Enter Health Plan ID for payer.

Field	Item Description	Required Outpatient	Required Inpatient	Action
52	Release of Info Certification	X	X	Enter Y for release on file
53	Assignment of Benefit Certification	X	X	Y marked in this box indicates Provider agrees to accept assignment under the terms of the Medicare program.
54	Prior Payments	Situational	Situational	Enter if applicable.
55	Estimated Amount Due	X	X	Enter remaining total is prior payment was made.
56	NPI	X	X	Enter Pay-To NPI.
57	Other Provider IDs	Optional	Optional	Enter legacy ID.
58	Insured's Name	X	X	Enter Member or insured's name.
59	Patient's Relation to the Insured	X	X	Enter appropriate relationship to insured.
60	Insured's Unique ID	X	X	Enter Member's Medicaid ID.
61	Insured Group Name	Situational	Situational	Enter if applicable.
62	Insured Group Name	Situational	Situational	Enter if applicable.
63	Treatment Authorization Codes	Situational	Situational	Enter if applicable.
64	Document Control Number	Situational	Situational	Enter if applicable. **NOTE:** Enter the original TCN when adjusting or voiding a previous paid claim (Type of Bill XX7 or XX8)
65	Employer Name	Situational	Situational	Enter if applicable.
66	Diagnosis/Procedure Code Qualifier	X	X	Enter appropriate qualifier.
67	Principal Diagnosis Code/ Other Diagnosis Codes	X	X	Enter all applicable diagnosis codes.
67	Present on Admission Indicator (shaded area)	X		Enter the appropriate POA indicator on each required diagnosis in the shaded area to the right of the diagnosis box
68	Future Use	N/A	N/A	

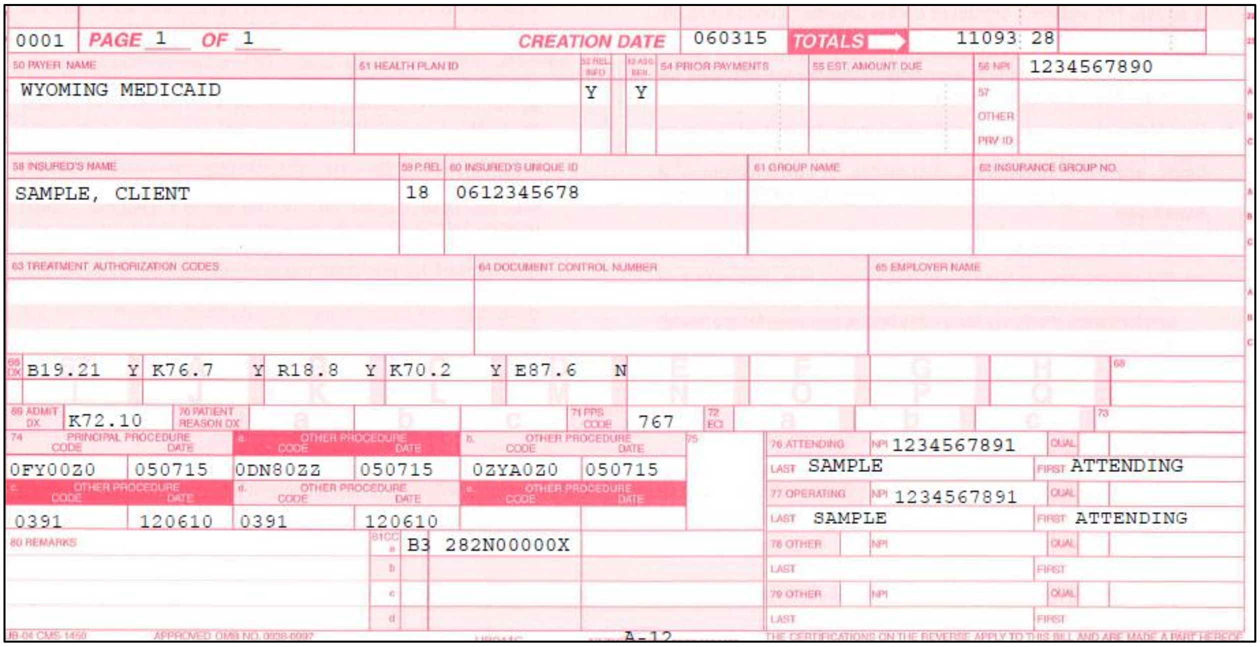
Field	Item Description	Required Outpatient	Required Inpatient	Action
69	Admitting Diagnosis Code	X	Situational	Enter if applicable.
70	Patient's Reason for Visit Code	Situational	Situational	Enter if applicable.
71	PPS Code	Situational	Situational	Enter if applicable.
72	External Cause of Injury Code	Situational	Situational	Enter if applicable.
73	Future Use	N/A	N/A	
74	Principal Procedure Code/Date	Situational	Situational	Enter if applicable.
75	Future Use	N/A	N/A	
76	Attending Name/ ID-Qualifier 1-G	X	X	Enter the Attending Physician's NPI, appropriate qualifier, last name, and first name.
77	Operating ID	Situational	Situational	Enter if applicable.
78-79	Other ID	Situational	Situational	Enter if applicable.
80	Remarks	Situational	Situational	Enter if applicable.
81	Code/Code Field Qualifiers *B3 Taxonomy	X	X	Enter B3 to indicate taxonomy and follow with the appropriate taxonomy code.

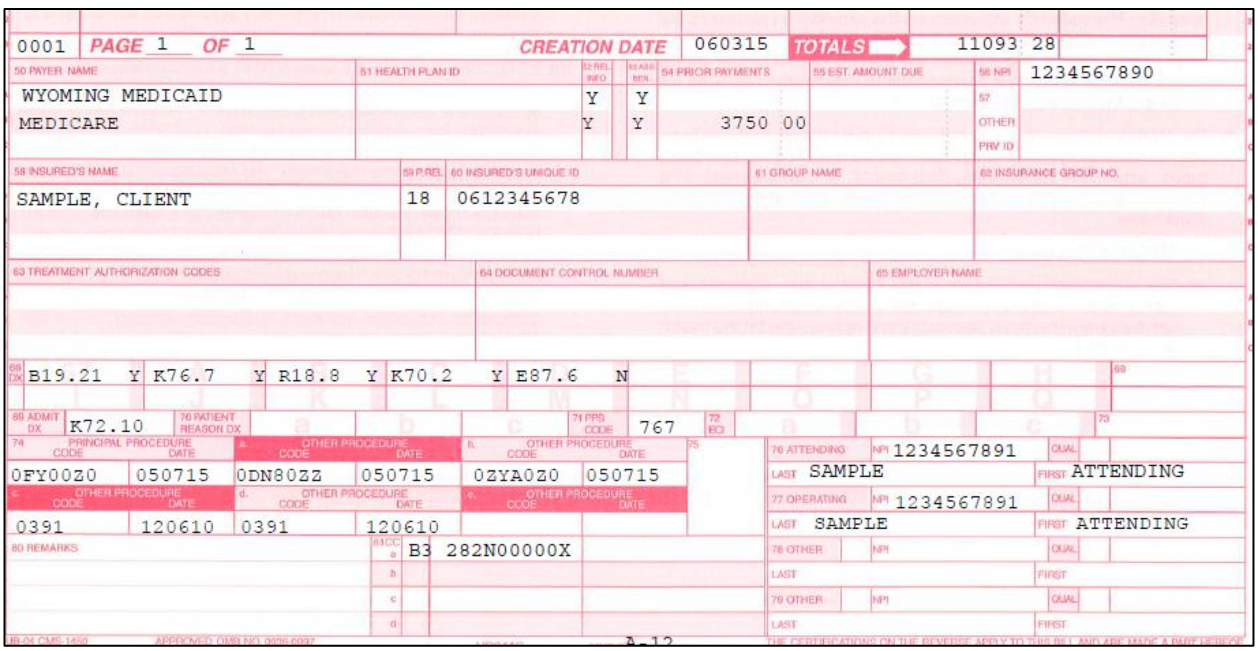
Taxonomy codes are required to be submitted on Medicaid primary claims and when billing Medicare primary and Medicaid secondary to ensure the appropriate Providers are identified. The taxonomy codes being submitted to Medicare must also be on-file with Medicaid.

4.4.2 Appropriate Bill Type and Provider Taxonomy Table

Appropriate Bill Type(s)	Pay-to Provider's Taxonomy	Taxonomy Description
11X-14X	282N00000X, 283Q00000X, 283X00000X	General and Specialty Hospitals, Medical Assistance Facilities, Long Term Hospitals, Rehabilitation Hospitals, Children's Hospitals, Psychiatric Hospitals.

Appropriate Bill Type(s)	Pay-to Provider's Taxonomy	Taxonomy Description
77X	261QF0400X	FQHC, Tribal FQHC
11X-14X,85X	282NR1301X	Critical Access Hospitals (CAH).
81X-82X	251G00000X	Hospice
83X	261QA1903X	Ambulatory Surgical Centers.
72X	261QE0700X	Hospital Based Renal Dialysis Facility, Independent Renal Dialysis Facility, Independent Special Purpose Renal Dialysis Facility, Hospital Based Satellite Renal Dialysis Facility, Hospital Based Special Purpose Renal Dialysis Facility
32X, 33X	251E00000X	Home Health Agencies.
75X	261QR0401X	CORF
71X	261QR1300X	Freestanding or Provider Based RHC
21X,23X	31400000X, 315P00000X, 283Q00000X (State Hospital Only)	SNF-ICF/ID
18X	275N00000X	Hospital Swing Bed.
11X	323P00000X	PRTF
13X, 77X	261QP0904X, 261QR0400X	Indian Health Services (IHS), National Jewish Health Asthma Day Program.


0001 PAGE 1 OF 1 CREATION DATE 060315 TOTALS 11093 28
50 PAYER NAME: WYOMING MEDICAID | 51 HEALTH PLAN ID | 52 REL INFO: Y | 53 ASG BEN: Y | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI: 1234567890 | 57 OTHER PRV ID
58 INSURED'S NAME: SAMPLE, CLIENT | 59 P.REL: 18 | 60 INSURED'S UNIQUE ID: 0612345678 | 61 GROUP NAME | 62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME
66 DX: B19.21 Y K76.7 Y R18.8 Y K70.2 Y E87.6 N
69 ADMIT DX: K72.10 | 70 PATIENT REASON DX | 71 PPS CODE: 767 | 72 ECI | 73
74 PRINCIPAL PROCEDURE CODE / DATE: 0FY00Z0 050715 | a. OTHER PROCEDURE CODE / DATE: 0DN80ZZ 050715 | b. OTHER PROCEDURE CODE / DATE: 0ZYA0Z0 050715
c. OTHER PROCEDURE CODE / DATE: 0391 120610 | d. OTHER PROCEDURE CODE / DATE: 0391 120610 | e. OTHER PROCEDURE CODE / DATE
76 ATTENDING NPI 1234567891 QUAL | LAST SAMPLE FIRST ATTENDING
77 OPERATING NPI 1234567891 QUAL | LAST SAMPLE FIRST ATTENDING
80 REMARKS | 81CC a B3 282N00000X | b | c | d
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 A-12 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.


0001 PAGE 1 OF 1 CREATION DATE 060315 TOTALS 11093 28
50 PAYER NAME: WYOMING MEDICAID | 52 REL INFO: Y | 53 ASG BEN: Y | 56 NPI: 1234567890
MEDICARE | Y | Y | 54 PRIOR PAYMENTS: 3750 00
58 INSURED'S NAME: SAMPLE, CLIENT | 59 P.REL: 18 | 60 INSURED'S UNIQUE ID: 0612345678 | 61 GROUP NAME | 62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME
66 DX: B19.21 Y K76.7 Y R18.8 Y K70.2 Y E87.6 N
69 ADMIT DX: K72.10 | 70 PATIENT REASON DX | 71 PPS CODE: 767 | 72 ECI | 73
74 PRINCIPAL PROCEDURE CODE / DATE: 0FY00Z0 050715 | a. OTHER PROCEDURE CODE / DATE: 0DN80ZZ 050715 | b. OTHER PROCEDURE CODE / DATE: 0ZYA0Z0 050715
c. OTHER PROCEDURE CODE / DATE: 0391 120610 | d. OTHER PROCEDURE CODE / DATE: 0391 120610 | e. OTHER PROCEDURE CODE / DATE
76 ATTENDING NPI 1234567891 QUAL | LAST SAMPLE FIRST ATTENDING
77 OPERATING NPI 1234567891 QUAL | LAST SAMPLE FIRST ATTENDING
80 REMARKS | 81CC a B3 282N00000X | b | c | d
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 A-12 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

4.5 Value Codes

Most frequently used value codes by Wyoming Medicaid Providers are:

4.5.1 Value Codes 80 and 81

Value code 80 is to be billed as covered days and value code 81 is to be billed as non-covered days. Value codes and accommodation units must total the number of days within the coverage period.

4.6 National Drug Code Billing Requirement

Medicaid requires Providers to include National Drug Codes (NDCs) on professional and institutional claims when certain drug-related procedure codes are billed. This policy is mandated by the Federal Deficit Reduction Act (DRA) of 2005, which requires state Medicaid programs to collect rebates from drug manufacturers when their products are administered in an office, clinic, hospital, or other outpatient setting.

The NDC is a unique 11-digit identifier assigned to a drug product by the labeler/manufacturer under Federal Drug Administration (FDA) regulations. It is comprised of three (3) segments configured in a 5-4-2 format.

- **Labeler Code:** Five-(5) digit number assigned by the FDA to uniquely identify each firm that manufactures, repacks, or distributes drug products
- **Product Code:** Four (4)-digit number that identifies the specific drug, strength, and dosage form
- **Package Code:** Two (2)-digit number that identifies the package size

4.6.1 Converting 10-Digit National Drug Codes to 11 Digits

Many NDCs are displayed on drug products using a 10-digit format. However, to meet the requirements of the new policy, NDCs must be billed to Medicaid using the 11-digit FDA standard. Converting an NDC from 10 to 11 digits requires the strategic placement of a zero (0). The following table shows two (2) common 10-digit NDC formats converted to 11 digits.

Converting 10 Digit NDCs to 11 Digits			
10 Digit Format	**Sample 10 Digit NDC**	**Required 11 Digit Format**	**Sample 10 Digit NDC Converted to 11 Digits**
9999-9999-99 (4-4-2)	0002-7597-01 Zyprexa 10mg vial	0999-9999-99 (5-4-2)	00002-7597-01

Converting 10 Digit NDCs to 11 Digits			
10 Digit Format	**Sample 10 Digit NDC**	**Required 11 Digit Format**	**Sample 10 Digit NDC Converted to 11 Digits**
99999-999-99 (5-3-2)	50242-040-62 Xolair 150mg vial	99999-0999-99 (5-4-2)	50242-0040-62

> Hyphens are used solely to illustrate the various 10 and 11-digit formats. Do not use hyphens when billing NDCs.

4.6.2 Documenting and Billing the Appropriate National Drug Codes

A drug may have multiple manufacturers, so it is vital to use the NDC of the administered drug and not another manufacturer's product, even if the chemical name is the same. It is important that Providers develop a process to capture the NDC when the drug is administered before the packaging is thrown away. It is not permissible to bill Medicaid with any NDC other than the one administered. Providers should not pre-program their billing systems to automatically utilize a certain NDC for a procedure code that does not accurately reflect the product that was administered to the Member.

Clinical documentation must record the NDC from the actual product, not just from the packaging, as these may not match. Documentation must also record the lot number and expiration date for future reference in the event of a health or safety product recall.

4.6.3 Billing Requirements

The requirement to report NDCs on professional and institutional claims is meant to supplement procedure code billing, not replace it. Providers are still required to include applicable procedure information such as date(s) of service, CPT/HCPCS code(s), modifier(s), charges, and units.

4.6.4 Submitting One National Drug Code per Procedure Code

If one (1) NDC is to be submitted for a procedure code, the procedure code, procedure quantity, and NDC must be reported. No modifier is required.

Example:

Procedure Code	Modifier	Procedure Quantity	NDC
90375	N/A	2	13533-0318-01

4.6.5 Submitting Multiple National Drug Codes per Procedure Code

If two (2) or more NDCs are to be submitted for a procedure code, the procedure code must be repeated on separate lines for each unique NDC. For example, if a Provider administers 6 mL of HyperRAB, a 5 mL vial and a 1 mL vial would be used. Although the vials have separate NDCs, the drug has one (1) procedure code, 90375. So, the procedure code would be reported twice on the claim but paired with different NDCs.

Example:

Procedure Code	Modifier	Procedure Quantity	NDC
90375	KP	1	13533-0318-01
90375	KQ	1	13533-0318-05

On the first line, the procedure code, procedure quantity, and NDC are reported with a KP modifier (first drug of a multi-drug). On the second line, the procedure code, procedure quantity, and NDC are reported with a KQ modifier (second/subsequent drug of a multi-drug).

> When reporting more than two (2) NDCs per procedure code, the KQ modifier is also used on the subsequent lines.

4.6.6 Outpatient Prospective Payment System Packaged Services (Critical Access and General Hospitals Only)

The NDC requirement does not apply to services considered packaged under Outpatient Prospective Payment System (OPPS). These services are assigned status indicator N. For a list of packaged services, consult the APC-Based Fee Schedule located on the Medicaid website (*see Section 2.1* Quick Reference).

4.6.7 UB-04 Billing Instructions

To report a procedure code with an NDC on the UB-04 claim form, enter the following NDC information into Form Locator 43 (Description):

- NDC qualifier of N4 [Required]
- NDC 11-digit numeric code [Required]

Do not enter a space between the N4 qualifier and the NDC. Do not enter hyphens or spaces within the NDC.

4.6.7.1 UB-04 One National Drug Code per Procedure Code

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636	N460574411101	90378 KP	100115	2	500.00		

4.6.7.2 UB-04 Two National Drug Codes per Procedure Code

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636	N460574411101	90378 KP	100115	2	500.00		
0636	N460574411101	90378 KQ	100115	1	250.00		

Medicaid's instructions follow the National Uniform Billing Committee's (NUBC) recommended guidelines for reporting the NDC on the UB-04 claim form. Provider claims that do not adhere to these guidelines may deny. (For placement in an electronic X12N 837 Institutional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at www.wpshealth.com/resources/files/med_a_837i_companion.pdf.

Reimbursement Methodologies

Reimbursement from the Wyoming State Hospital for covered services under Title 25 is based on a variety of payment methodologies depending on the services provided. In most cases reimbursement will mirror Medicaid' methodology and fee schedule, with the exception of the current per-diem reimbursement rate for Title 25 Members who do not have active Medicaid coverage.

Medicaid reimbursement methodologies are as below:

- Medicaid fee schedule
- By report pricing
- Billed charges
- Encounter rate
- Invoice charges
- Negotiated rates
- Per diem
- Resource Based Relative Value Scale (RBRVS)
- Outpatient Prospective Payment System (OPPS)/3M Grouper (GPCS)
- All Patients Refined Diagnosis-Related Grouping (APR DRG)

4.7 Submitting Attachments for Electronic Claims

Title 25 Documentation is submitted via mail to the Medicaid Benefits Quality Control Manager and is not required to be attached to claims. However, claims may still require attached documentation; such as, primary payer EOBs, invoices, or any additional supporting documentation as appropriate for medically necessary services.

The fiscal agent created a process that allows Providers to submit electronic attachments for electronic claims when they indicate a claim requires supporting documentation, this triggers the "Attachment Indicator" to be set to "Y". Providers can attach documents to previously submitted claims that are in the BMS and they can attach documents to a claim at the time of direct data entry (DDE) into the BMS.

Uploading attachments to a claim that is in the BMS via the Provider Portal:

- These claims are in the BMS and revolve for 30-days waiting for an attachment. Typically, these claims have been submitted electronically by a billing agent or clearinghouse, but they could have been entered directly into the BMS.
- Claims pend and revolve in the BMS when the attachment indicator on the electronic claim was marked at the time of the claim submission. For more information on the attachment indicator, consult the Provider software vendor or clearinghouse, or the X12N 837 Institutional Electronic Data Interchange Technical Report Type 3 (TR3). Access the TR3 at www.wpshealth.com/resources/files/med_a_837i_companion.pdf.

Important attachment information:

- Providers may not attach a document to many claims/TCNs at one time
- Attachment(s) must be added per claim/TCN
- Multiple attachments can be added or uploaded to one claim/TCN
- Attachment(s) size limit is 50 MBs when attaching documents at the time of keying a direct data entry claim into the BMS via the Provider Portal
    - This limit does not apply when uploading attachments to the claim/TCN that has been previously submitted and is already in the BMS
- When completing direct data entry of a claim, Providers have the option of uploading the supporting documentation at the time of the claim submission or not.
    - If Providers choose to mail or email the documentation, the Providers can print the system generated attachment coversheet (*see Section 4.7.1.1* Sample of Systematically Generated Provider Portal Attachment Coversheet) for that specific claim or download and complete the Attachment Coversheet (*see Section 4.7.1.2* Attachment Coversheet and Instructions) from the website. Submitting paper attachments is not the preferred method as Wyoming Medicaid is moving away from paper attachments.
    - Providers can access previously submitted claims via the Provider Portal by completing a "Claim Inquiry" within the Provider Portal. No attachment coversheet is required as the Provider will upload their attachments directly to the TCN that is in the BMS.
- If the attachment is not received within 30 days of the electronic claim submission, the claim will deny, and it will be necessary for the Provider to resubmit it with the proper attachment.

Resources:

- *Chapter 8* – Covered Services – Ambulance
- Provider Publications and Trainings posted to the Medicaid website (*see Section 2.1* Quick Reference)
    - Select Provider, select Provider Publications and Trainings, then select Provider Training, Tutorials and Workshops
    - Select the appropriate claim type tutorial (Dental, Institutional, or Professional) for the step-by-step instructions to upload or attach a document at the time of entering the claim (direct data entry) into the BMS via the Provider Portal
    - Select 'Electronic Attachments' tutorial when uploading or attaching documents directly to a TCN/claim within the BMS via the Provider Portal

4.7.1 Attachment Coversheets

There a two (2) Attachment Coversheets:

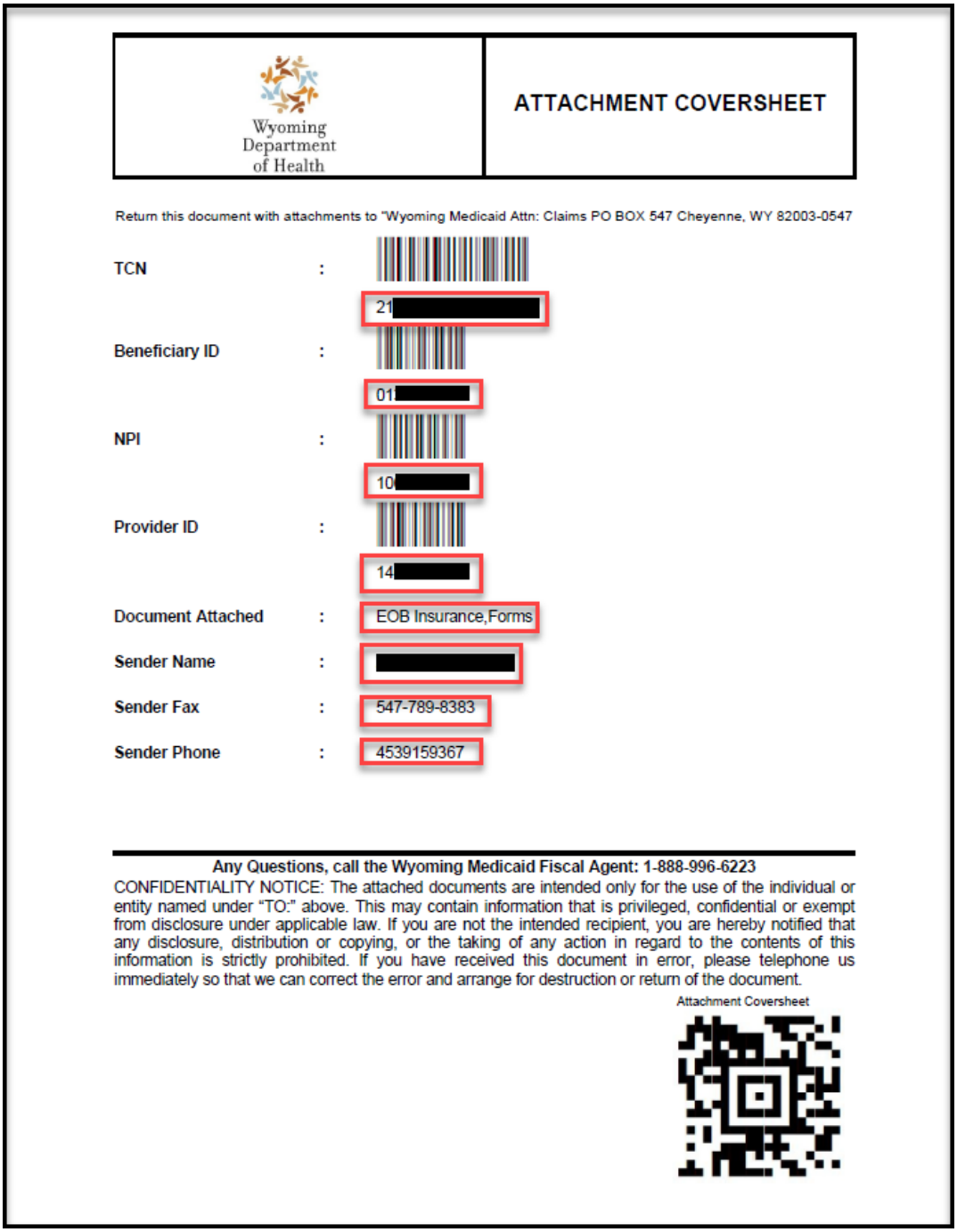
- Attachment Coversheet systematically generated and printed from the Provider Portal (*see Section 4.7.1.1* Sample of Systematically Generated Provider Portal Attachment Coversheet)
    - This coversheet can be printed at the time of direct data entry of the claim or from completing a 'Claim Inquiry' process within the Provider Portal
    - The advantage of submitting this system generated form is all the fields are auto populated, it is barcoded, and the form has a QR code to ensure proper routing and matching up to the claim/TCN in the BMS
- Attachment Cover Sheet downloaded from the website (*see Section 4.7.1.2* Attachment Coversheet and Instructions)
    - This coversheet can be downloaded and must be filled in by the Provider
    - The data entered on the form must match the claim exactly in DOS, Member information, pay-to provider NPI, and so on. The complete instructions are provided with the *4.7.1.2* Attachment Coversheet and Instructions.

Mail or fax (25 pages maximum) the attachment coversheets with the supporting documents to the Claims Department (*see Section 2.1* Quick Reference). Coversheets can also be emailed to the Provider Services email address, WYProviderOutreach@acentra.com, made to the Attention: Claims Department

- All emails must come secured and cannot exceed 25 pages

> All steps must be followed; otherwise, the fiscal agent cannot join the electronic claim and paper attachment and the claim will deny. Also, if the paper attachment is not received within 30 days of the electronic claim submission, the claim will deny, and it will be necessary to resubmit it with the proper attachment.

4.7.1.1 Sample of Systematically Generated Provider Portal Attachment Coversheet



Wyoming Department of Health

ATTACHMENT COVERSHEET

Return this document with attachments to "Wyoming Medicaid Attn: Claims PO BOX 547 Cheyenne, WY 82003-0547

TCN	:	21[redacted]
Beneficiary ID	:	01[redacted]
NPI	:	10[redacted]
Provider ID	:	14[redacted]
Document Attached	:	EOB Insurance,Forms
Sender Name	:	[redacted]
Sender Fax	:	547-789-8383
Sender Phone	:	4539159367

Any Questions, call the Wyoming Medicaid Fiscal Agent: 1-888-996-6223

CONFIDENTIALITY NOTICE: The attached documents are intended only for the use of the individual or entity named under "TO:" above. This may contain information that is privileged, confidential or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, distribution or copying, or the taking of any action in regard to the contents of this information is strictly prohibited. If you have received this document in error, please telephone us immediately so that we can correct the error and arrange for destruction or return of the document.

Attachment Coversheet

4.7.1.2 Attachment Coversheet and Instructions

Wyoming Department of Health

Completing the Attachment Cover Sheet

An asterisk (*) denotes a required field.
Complete all applicable fields.

Title	Action
Pay to Provider Name*	Enter the name of the Pay to (Group) Provider.
Pay to NPI*	Enter the 10-digit NPI or Provider Number for the Pay to (Group) Provider.
Member Name*	Enter the Member's full name.
Medicaid ID*	Enter the Member's 10-digit Wyoming Medicaid ID number.
Claim From Date of Service*	Enter the first date of service on the claim in mm/dd/yyyy format.
Claim To Date of Service*	Enter the last date of service on the claim in mm/dd/yyyy format.
Transaction Control Number (TCN)*	Enter the 17-digit Transaction Control Number (TCN) for the electronic claim
Attachment Type*	Select the attachment type that was indicated on the electronic claim.

This cover sheet can be uploaded electronically via the Web Portal.

Return the completed cover sheet with attachments to:
Wyoming Medicaid Fiscal Agent
Attn: Claims Department
P.O. Box 547
Cheyenne, WY 82003-0547

Wyoming Department of Health

Attachment Cover Sheet

Use this cover sheet when electronically submitting a claim that requires attachments. The supporting documents (for example, EOB or medical records) must be attached to this cover sheet. If documents are received without this cover sheet, then the request **CANNOT** be processed, and the documents will be shredded.

- All information entered on this cover sheet must match the data entered in the 837 claim transaction exactly, including the Attachment Type.
- The Attachment Transmission Code in the 837 claim transaction must be set to 'BM' (By Mail) to indicate the attachment is being sent separately.

Pay to Provider Name _____ **Pay-To NPI/ Provider Number** _____

Member Name _____ **Member ID** _____

Claim From Date of Service _____ **Claim To Date of Service** _____ **Transaction Control Number (TCN)** _____

Attachment Type

- ☐ AS: Admission Summary
- ☐ B2: Prescription
- ☐ B3: Physician Order
- ☐ B4: Referral Order
- ☐ CT: Certification
- ☐ CK: Consent Form(s)
- ☐ DA: Dental Models
- ☐ DG: Diagnostic Report
- ☐ DS: Discharge Summary
- ☐ EB: Explanation of Benefits
- ☐ MT: Models
- ☐ NN: Nursing Notes
- ☐ OB: Operative Notes
- ☐ OZ: Support Date for Claim
- ☐ PN: Physical Therapy Notes
- ☐ PO: Prosthetics or Orthotic Certification
- ☐ PZ: Physical Therapy Certification
- ☐ RB: Radiology Films
- ☐ RR: Radiology Reports
- ☐ RT: Report of Tests and Analysis Report

This cover sheet can be uploaded electronically via the Web Portal.

Return the completed cover sheet with attachments to:

Wyoming Medicaid Fiscal Agent
Attn: Claims Department
P.O. Box 547
Cheyenne, WY 82003-0547

WYBMS-Attachment Coversheet

4.8 Remittance Advice

After claims have been processed weekly, Medicaid posts a Medicaid proprietary (paper) Remittance Advice (RA) to the Provider Portal that each Provider can retrieve. This RA is not the 835 HIPAA payment file. The Agency will not mail paper remittance advices.

The RA plays an important communication role between Providers and Medicaid. It explains the outcome of claims submitted for payment. Aside from providing a record of transactions, the RA assists Providers in resolving potential errors. Any Provider currently receiving paper checks should begin the process with the State Auditor's Office to move to electronic funds transfer. Any new Providers requesting paper checks shall only be granted in temporary, extenuating circumstances.

4.8.1 Remittance Advice Organization

The RA is organized in the following manner:

- **Cover Page:** This first page is important and should not be overlooked as it may include an RA Banner message from Wyoming Medicaid (*see Section 1.2.1* Remittance Advice Banner Notices and Samples).
- **Summary Page:** This second page includes key financial and provider-related information.
- **Detail Pages:** The next pages are the claim detail pages which list the Members information, TCNs, rendering NPIs, dates of services, procedure and revenue codes, modifiers, PPS/DRG/APC pricing, quantity, billed amount, (Medicaid) approved amounts/check applied amounts, TPL and Medicare amounts, Member responsible amount, PPA, and reason and remark codes, and (Medicaid) error codes.

  The detail pages are separated by paid, credited, and denied statuses
- **Glossary Pages:** The last pages list the (Medicaid) error code and error description with the associated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) for the denied lines and claims.

4.8.2 Remittance Advice General Information and Definitions

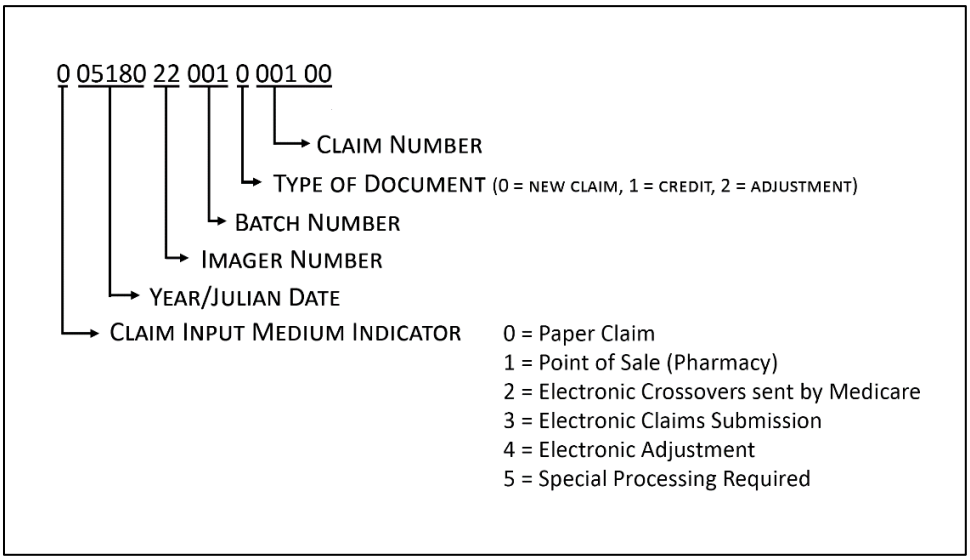
- Remittance Advices are generated for each Billing Provider.
- In the TCN, Original TCN, and Recovery Check number column:
  - When a check is received from the provider the check number(s) will display directly under the TCN(s).
- In the Beneficiary Name, Beneficiary ID, Patient Account #, and Gross Adj ID column:
  - The last name, first name, and MI is populated from the Member eligibility file and is reported only once per claim.
- Gross Adjustments (GA) are reported on the Summary page.

- If multiple TCNs are reported for the same beneficiary on the same RA, the sort order for the report is oldest to newest based on the Date of Service.
- If a TCN is reported with an unknown beneficiary name, the record will show at the beginning of the Provider's RA (but after GAs) ahead of named beneficiaries.
- In the Rendering Provider ID/NPI/Name column:
    - Both the Rendering Provider ID and NPI will display, along with the Rendering Provider Name.
- In the Billed Amount Column:
    - The sum of all line charges is reported on the header line (it is the actual unadjusted amount).
    - The service line reports the individual charge from each line.
    - The billed amount is the amount the Provider billed.
- In the Approved Amount and Check Applied Amount column:
    - The sum of all line approved amounts is reported at the invoice header.
    - The service line reports the line approved amount.
    - For adjustments, the reversal claim prints the TCN of the history claim being adjusted. It shows the total amount reversed (credited) from the original claim.
    - Below the approved Adjustment Header, the net adjustment amount for the claim will be printed.
    - The check applied amount(s) will display, and the associated check number(s) will appear in the TCN/Original TCN/Recovery Check# column.
- Error Code: This column will display the Medicaid specific error codes for header and lines.
    - Error codes may indicate the following:
        - Denial, or
        - Pay and Report: Informational
- Remark and Reason Codes are Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs) from the standard HIPAA code set that appear on the 835.
- Zero payments are considered paid claims and are reported as usual.
- The Billing Provider information is populated from the HHS Provider Enrollment file.
- The RA is not posted to the Provider Portal until warrant data is available, which is typically on Fridays.
- When multiple Modifiers are associated to a record – the first two (2) modifiers received will be printed, separated by a forward slash (/). Additional modifiers are not included on the RA.

- The tooth number is not included on the RA.

4.8.3 Transaction Control Number

- A unique Transaction Control Number (TCN) is assigned to each claim. TCNs allow each claim to be tracked throughout the Medicaid claims processing system. The digits and groups of digits in the TCN have specific meanings, as explained below:
- TCN definition prior to 10/18/2021:



- TCN definition after 10/18/2021:

Field	Field Description	Length	Value
1st Digit	Input Medium Indicator	1	1 – Paper Claim without Attachment(s) 2 – Direct Data Entry (DDE) Claim – via Provider Portal 3 – Electronic Claim – HIPAA Compliant Transaction 4 – Adjusted Claims – Provider adjustments or BMS mass or gross adjustments 8 – Paper Claim with Attachment(s)
2nd Digit	TCN Category	1	1 – Assigned to Institutional, Professional and Dental Claims 2 – Assigned to Crossover Claims – Received via Medicare Intermediary
3rd to 7th Digit	Batch Date	5	YYDDD – Year + 3-digit Julian Date

8th Digit	Adjustment Indicator	1	0 – Original Paper Claim 1 – Original Electronic HIPAA Claim 7 – Replacement (Adjustment) Claim 8 – Void Claim
9th to 14th Digit	Sequence Number	6	Sequence Number starting with 000001 at the beginning of each Julian Date.
15th to 17th Digit	Line Number	3	Line Number will begin with 001 for every new claim. The header will have the line number as 000.

4.8.4 Locating the Medicaid Paper Remittance Advice within the Provider Portal

Follow these steps to locate the Medicaid Paper Remittance Advices (RA) on the portal:

1. Log in to the secure Provider Portal.
2. Select the **Provider Access** profile.
3. Select the **Archived Documents** from the My Inbox drop-down list.
4. Select **Paper RA** from the **Document Type** drop-down list.
5. Select **Paper RA** from **Document Name** drop-down list.
6. Select **Go**. Paper RAs display.
7. Select the document name link to open the RA.

4.8.5 Remittance Advice Glossary

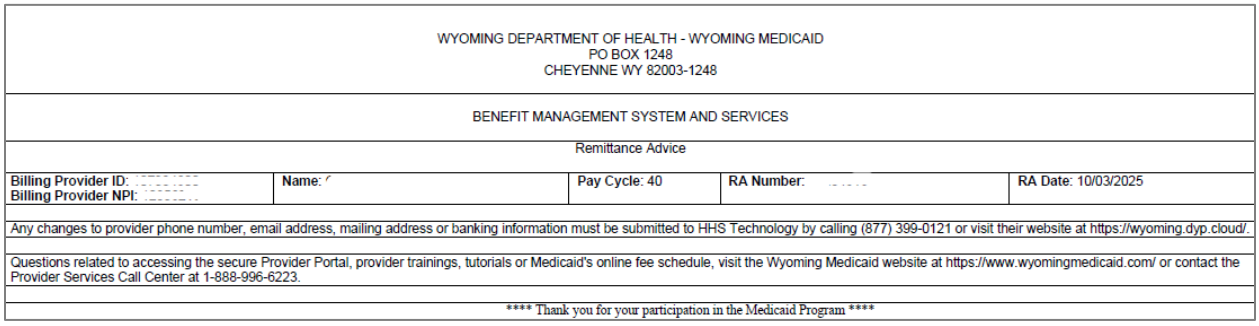
Field Name	Field Description
Billing Provider ID	Billing provider Medicaid-specific ID.
Billing Provider NPI	Billing provider National Provider Identification Number.
Name	Name of Billing Provider.
Pay Cycle	Pay cycle for the Remittance Advice according to the Remittance Advice Schedule.
RA Number	Remittance Advice Identification Number.
RA Date	Date the Remittance Advice was created.
Financial Adjustments	Shows financial adjustments for the Remittance Advice.
Adjustment Type	Type of adjustment applied to the claim.

Field Name	Field Description
Previous Balance	Previous balance for the provider.
Adjustment Amount	Provider adjustment amount (positive or negative).
Remaining Balance	Provider remaining balance after adjustments to claims are applied to the Remittance Advice.
Checks Received	Checks received by the provider to satisfy a credit balance.
Count	Count of checks received from the provider.
Amount	Total check amount of all checks received for credit balance.
Claims Summary	Claims summary count.
Status	Status of claims: Paid/Credited /Denied/Gross Adjustment.
Count	Count for each claim status.
Total Billed Amount	Total billed amount for each claim status.
Total Approved Amount	Total approved amount for each claim status.
Paid	Number of Paid claims.
Credited	Number of Credited claims.
Denied	Number of Denied claims.
Gross Adjustment	Number of Gross Adjustments.
Payment Summary	Shows Provider payment summary.
Total Payment Approved Amount	Total Claims payment amount including any checks applied. This includes all paid claims from and claim status.
Balance Owed Deduction	Previous Balance deducted up to the total payment amount.
Warrant/EFT Amount	Total Medicaid EFT paid amount.
Warrant/EFT #	Warrant or Electronic Fund Transfer number.
Warrant/EFT Date	Warrant or Electronic Fund Transfer date.
Beneficiary Name/Beneficiary ID/Patient Account #/Gross Adj ID	Beneficiary Name/Beneficiary ID/Patient Account #/Gross Adj ID.

Field Name	Field Description
TCN/ Original TCN/Recovery Check #	All TCN (claim) numbers that apply to the Remittance Advice.
Rendering Provider ID/NPI/Name	Rendering provider information including Provider ID, NPI, and Name.
Invoice Date/Service Date(s)	Invoice Date (for Gross Adjustments), Service Dates.
Revenue/Procedure/Modifier	Revenue Code(s), Procedure Code(s), and Modifier(s) as applicable.
PPS/DRG/APC	Perspective Payment System (PPS); Diagnosis Related Grouping (DRG) - For Inpatient; Ambulatory Payment Classification (APC) - For Outpatient. For institutional claims only.
Qty	Number of units billed.
Billed Amount	The billed amount on the claim. The service line reports the individual billed amount from each line.
Approved Amount/Check Applied Amount	Approved Amount on the claim. The service line reports the line approved amount. Credited claim status shows the total amount reversed (credited) from the original claim. Check applied amount for recovered claims.
TPL and Medicare Amount	TPL/Other Payer Insurance Amount. The total the primary insurance paid.
Member Responsible Amount	Indicative of co-pay for plans that require this be paid for select plans.
PPA	Patient Pay Amount (Patient Contribution). Applied to Nursing Home claims. Also, can be identified as Resident Liability (RL) or Share of Cost (SOC).
Error Code	Indicates denied or pay and report Medicaid-specific codes.
Status Totals	The total status amounts included on the Remittance Advice, including claims, TPL, member responsibility, PPA, and each claim status.
Claim Adjustment Reason Codes (CARC) Details	Claim Adjustment Reason Codes Details.
Remittance Advice Remark Codes (RARC) Details	Remittance Advice Remark Codes Details.
Error Code Details	Medicaid-specific error code details with associated CARC and RARC.

4.8.6 Sample Remittance Advice and How to Read the Remittance Advice

4.8.6.1 Sample Cover Page (First Page)



WYOMING DEPARTMENT OF HEALTH - WYOMING MEDICAID
PO BOX 1248
CHEYENNE WY 82003-1248

BENEFIT MANAGEMENT SYSTEM AND SERVICES

Remittance Advice

Billing Provider ID: [redacted] **Billing Provider NPI:** [redacted]	**Name:** [redacted]	**Pay Cycle:** 40	**RA Number:** [redacted]	**RA Date:** 10/03/2025

Any changes to provider phone number, email address, mailing address or banking information must be submitted to HHS Technology by calling (877) 399-0121 or visit their website at https://wyoming.dyp.cloud/.

Questions related to accessing the secure Provider Portal, provider trainings, tutorials or Medicaid's online fee schedule, visit the Wyoming Medicaid website at https://www.wyomingmedicaid.com/ or contact the Provider Services Call Center at 1-888-996-6223.

**** Thank you for your participation in the Medicaid Program ****

Interpreting the Cover Page:

Cover Page Field Name	Notes
Billing Provider ID	Billing Medicaid Number.
Billing Provider NPI	Billing National Provider Identification Number.
Name	Name of Billing Provider.
Pay Cycle	Pay cycle for the Remittance Advice Report established according to the Remittance Advice Schedule.
RA Number	Remittance Advice Identification Number (system generated for each Billing Provider).
RA Date	Date the Remittance Advice was Created.
Banner Message	Wyoming Medicaid message.

4.8.6.2 Sample Summary Page

Billing Provider ID: Billing Provider NPI:	Name:	Pay Cycle: 1	RA Number:	RA Date: 12/20/2024

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance
Balance Owed by Tax ID	$166.95		$166.95

CHECK RECEIVED INFORMATION ONLY

Check Received	2	$9,208.35

CLAIM SUMMARY

Status	Count	Total Billed Amount	Total Approved Amount
Paid	37	$227,900.58	$44,254.47
Credited	4	-$210,403.43	-$19,735.20
Denied	5	$11,698.33	$0.00
Gross Adjustment	0	$0.00	$0.00

PAYMENT SUMMARY

Total Payment Approved Amount: $24,519.27 Balance Owed Deduction Amount: -$166.95 Warrant\EFT Amount: $24,519.27

Warrant/EFT #: Warrant/EFT Date: 12/19/2024

Interpreting the Summary Page:

Summary Page Field Name	Field Description
Billing Provider ID	Billing Provider Number.
Billing Provider NPI	Billing National Provider Identification Number.
Name	Name of Billing Provider.
Pay Cycle	Pay cycle for the Remittance Advice Report established according to the Remittance Advice Schedule.
RA Number	Remittance Advice Identification Number (system-generated for each Billing Provider).
RA Date	Date the Remittance Advice was Created.
FINANCIAL ADJUSTMENTS	Shows Financial Adjustments for the Remittance Advice.
Adjustment Type	Type of Adjustment.
Previous Balance	Previous Provider balance.
Adjustment Amount	Provider adjustment amount (+ or -).
Remaining Balance	Provider remaining balance.
CHECK RECEIVED INFORMATION ONLY	Shows Check Information for the Remittance Advice.

Summary Page Field Name	Field Description
Check Received	• Count of checks received from the provider • Total check amount of all checks received
CLAIM SUMMARY	Claims Summary Count.
Status	Claim Statuses: • Paid • Credited (Adjustment or Void) • Denied • Gross Adjustment
Count	Count for each claim status.
Total Billed Amount	Total billed amount for each claim status.
Total Approved Amount	Total approved amount for each claim status.
PAYMENT SUMMARY	Shows Provider payment summary.
Total Payment Approved Amount	Total Claims payment amount including any checks applied. This includes all paid claims from and claim status.
Balance Owed Deduction Amount	Previous Balance deducted up to the total payment amount.
Warrant/EFT Amount	Total Medicaid EFT paid amount.
Warrant/EFT #	Warrant or Electronic Fund Transfer number.
Warrant/EFT Date	Warrant or Electronic Fund Transfer Date.

4.8.6.3 Sample Detail Pages

4.8.6.3.1 Sample Detail – Paid Claims Status

Billing Provider ID: Billing Provider NPI:		Name:		Pay Cycle: 1			RA Number:		RA Date: 12/20/2024			
Beneficiary Name Beneficiary ID Patient Account # Gross Adj ID	TCN Original TCN Recovery Check#	Rendering Provider ID/NPI /Name	Invoice Date Service Date(s)	Revenue Procedure Modifier	PPS DRG APC	Qty	Billed Amount	Approved Amount Check Applied Amount	TPL and Medicare Amount	Member Responsible Amount	PPA	Error Code
Status: Paid												
0600 560	3124339		12/04/2024 08/04/2024-08/08/2024	0UB70ZZ, 10D00Z1	D-539		$22,398.23	$9,656.55		$0.00	$0.00	5183, 7173
0800 5607	3124347 3124256		12/12/2024 08/06/2024-08/22/2024	02HV33Z, 04L23DZ, 0B9F8ZX, 0B9J8ZX, 0BH17EZ, 0DB68ZX, 0DJ08ZZ, 5A12012, 5A1945Z, XW0G886	D-241		$162,932.30	$19,693.29		$0.00	$0.00	
					Status Total	130 8	$227,900.58	$44,254.47	$0.00	$0.00	$0.00	

The Paid Claim Status section will conclude with Status Totals.

> In the above example, the first claim is paid and posting the error codes 5183 and 7173 – which are informational, "pay and report" error codes, not causing the claim or a line to be denied.

4.8.6.3.2 Sample Detail – Credited Claims Status

Billing Provider ID: Billing Provider NPI:		Name:		Pay Cycle: 1			RA Number:		RA Date: 12/20/2024			
Beneficiary Name Beneficiary ID Patient Account # Gross Adj ID	TCN Original TCN Recovery Check#	Rendering Provider ID/NPI /Name	Invoice Date Service Date(s)	Revenue Procedure Modifier	PPS DRG APC	Qty	Billed Amount	Approved Amount Check Applied Amount	TPL and Medicare Amount	Member Responsible Amount	PPA	Error Code
Status: Credited												
0800 5596	4124347 3124256		12/12/2024 08/06/2024-08/22/2024	02HV33Z, 04L23DZ, 0B9F8ZX, 0B9J8ZX, 0BH17EZ, 0DB68ZX, 0DJ08ZZ, 5A12012, 5A1945Z, XW0G886	D-241		-$163,178.30	-$19,693.29		$0.00	$0.00	
0000 5528	4124348 4123075 9800, 4798 ←		12/13/2024 01/30/2023-02/08/2023	0JH63XZ, 5A09357, 5A1D70Z, 5A1D90Z	D-720		-$46,705.78	-$9,183.53 $4.25, ← $9,179.28 ←	$14,981.22	$0.00	$0.00	
0600 5520	4124348 00 3123082 9800, 4798 ←		12/13/2024 11/17/2022-11/17/2022					$20.57, ← $4.25 ←	$88.65	$0.00	$0.00	
	4124348 01		11/17/2022-11/17/2022	80053	A-000 00	-1	-$0.19	-$3.65		$0.00		
	4124348 02		11/17/2022-11/17/2022	80175	A-000 00	-1	-$0.40	$0.00		$0.00		
	4124348 03		11/17/2022-11/17/2022	80177	A-000 00	-1	-$0.31	-$0.60		$0.00		
	4124348 04		11/17/2022-11/17/2022	82728	A-000 00	-1	-$0.26	-$4.22		$0.00		
	4124348 05		11/17/2022-11/17/2022	83540	A-000 00	-1	-$0.08	-$3.85		$0.00		
	4124348 06		11/17/2022-11/17/2022	83550	A-000 00	-1	-$0.10	-$5.69		$0.00		
	4124348 07		11/17/2022-11/17/2022	84443	A-000 00	-1	-$0.31	-$4.85		$0.00		
	4124348 08		11/17/2022-11/17/2022	85025	A-000 00	-1	-$0.16	-$1.96		$0.00		
					Status Total	-9	-$210,403.43	-$19,735.20	$15,069.87	$0.00	$0.00	

> In the example above the two check numbers appear in the TCN/Original/Recovery Check# field and the check applied amounts

appear in the Approved Amount/Check Applied Amount field. The sum of the check amounts will equal the check received amount on the Summary page.

The Credited Claims Status section will conclude with Status Totals.

4.8.6.3.3 Sample Detail – Denied Claims Status

Billing Provider ID: Billing Provider NPI:		Name:		Pay Cycle: 1			RA Number:			RA Date: 12/20/2024		
Beneficiary Name Beneficiary ID Patient Account # Gross Adj ID	TCN Original TCN Recovery Check#	Rendering Provider ID/NPI /Name	Invoice Date Service Date(s)	Revenue Procedure Modifier	PPS DRG APC	Qty	Billed Amount	Approved Amount Check Applied Amount	TPL and Medicare Amount	Member Responsible Amount	PPA	Error Code
Status: Denied												
0600 56080	3124353 00		12/18/2024 11/15/2024-11/15/2024							$0.00	$0.00	
	3124353 01		11/15/2024-11/15/2024	36415	A-000 00	0	$25.00	$0.00		$0.00		1716
	3124353 02		11/15/2024-11/15/2024	80053	A-000 00	0	$98.00	$0.00		$0.00		1716
	3124353 03		11/15/2024-11/15/2024	84443	A-000 00	0	$155.00	$0.00		$0.00		1716
	3124353 04		11/15/2024-11/15/2024	85027	A-000 00	0	$64.00	$0.00		$0.00		1716
	3124353 05		11/15/2024-11/15/2024	71046	A-055 21	0	$185.00	$0.00		$0.00		1716
	3124353 06		11/15/2024-11/15/2024	99285-25	A-050 25	0	$1,107.00	$0.00		$0.00		1716
	3124353 07		11/15/2024-11/15/2024	93005	A-057 33	0	$176.00	$0.00		$0.00		1716
					Status Total	0	$11,698.33	$0.00	$5,554.89	$0.00	$0.00	

Error Code details with associated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) are located after the Detail pages in the Glossary pages.

The Denied Claims Status section will conclude with Status Totals.

4.8.6.3.4 Interpreting the Detail Pages

Detail Page Field Name	Notes
Beneficiary Name/Beneficiary ID/Patient Account # Gross Adj ID	Beneficiary Name, Beneficiary ID, Patient Account Number, Gross Adjustment Identification Number. (Fields, as applicable, display with no gaps).
Original TCN/TCN/Type of Bill	Original Transaction Control Number (for the newly adjusted and void Transaction Control Numbers), Transaction Control Number, Type of Bill.
Rendering Provider ID/NPI/Name	Rendering Provider Identification, National Provider Identification, Name when present. Provider Identification is included when a Provider National Provider Identification is not present (atypical Provider enrollment).
Invoice Date/Service Date(s)	Invoice Date (for Gross Adjustments), Service Dates.

Detail Page Field Name	Notes
Revenue Procedure/Modifier	Revenue, Procedure Code, Modifier as applicable.
PPS/DRG/APC	For Institutional claims only: • Perspective Payment System (PPS). • Diagnosis Related Grouping (DRG) - For Inpatient. • Ambulatory Payment Classification (APC) - For Outpatient. • For all others: blank.
Qty	Number of units billed.
Billed Amount	The amount a Provider billed on the claim (the unadjusted amount). The service line reports the individual billed amount from each line.
Approved Amount/Check Applied Amount	Approved Amount on the claim. The service line reports the line approved amount. Credited claim status shows the total amount reversed (credited) from the original claim. Check applied amount for recovered claims.
TPL and Medicare Amount	TPL/Other Payer Insurance Amount. This is the total the primary insurance paid.
Member Responsible Amount	Indicative of co-pay for plans that require this be paid for select plans.
PPA	Patient Pay Amount (Patient Contribution). Applied to Nursing Home claims. Also, can be identified as Resident Liability (RL) or Share of Cost (SOC).
Error Code	This is indicating denied or pay and report Medicaid specific codes.
Status Totals	The total status amounts for each Claim Status (Paid, Credited, or Denied) section, included on the Remittance Advice including quantity, approved and check applied amounts, TPL and Medicare amounts, member responsibility amounts, and PPA.

4.8.6.4 Sample Glossary

GLOSSARY

Error Code

Error Code	Error Description	Claim Adjustment Reason Codes (CARC)	Remittance Advice Remark Codes (RARC)
1037	HISTORY TCN MISSING OR NOT FOUND	16	M47
1144	PROCEDURE OR REVENUE CODE NOT COVERED NATIONALLY ON DATE OF SERVICE	96	N56
1146	BENEFICIARY GENDER NOT VALID FOR SERVICE CODE	7	
1192	UNABLE TO DETERMINE THE BENEFIT PLAN	31	
1202	PAYMENT REFLECTS MAXIMUM MEDICAID ALLOWANCE FOR OI PAYMENT	23	
1225	EXACT DUPLICATE OF A PAID CLAIM IN SYSTEM HISTORY	18	N522
1408	PARENT TCN/CLAIM NOT FOUND	16	M47
1409	INVALID PARENT TCN/CLAIM	16	M47
1716	MEMBER ON A LIMITED PLAN, NOT ELIGIBLE FOR MEDICAID SERVICES	31	

Claim Adjustment Reason Codes (CARC)

Claim Adjustment Reason Codes (CARC)	Claim Adjustment Reason Codes (CARC) Description
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
7	The procedure/revenue code is inconsistent with the patient s gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
31	Patient cannot be identified as our insured.

Remittance Advice Remark Codes (RARC)

Remittance Advice Remark Codes (RARC)	Remittance Advice Remark Codes (RARC) Description
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
M135	Missing/incomplete/invalid plan of treatment.
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.
N152	Missing/incomplete/invalid replacement claim information.
M44	Missing/incomplete/invalid condition code.
M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).

4.8.7 When a Member Has Other Insurance

If the Member has other insurance coverage reflected in Medicaid records, payment may be denied unless Providers report the coverage on the claim. Medicaid is always the payer of last resort. For exceptions and additional information regarding Third Party Liability, *see Chapter 5* – Third Party Liability. Providers may verify other carrier information via the Provider Portal(*see Section 2.1* Quick Reference). The Third Party Resources Information Sheet (*see Section 5.2.1* Third Party Resources Information Sheet) should be used for reporting new insurance coverage or changes in insurance coverage on a Member's policy.

4.9 Resubmitting versus Adjusting Claims

Resubmitting and adjusting claims are important steps in correcting any billing problems. Knowing when to resubmit a claim versus adjusting it is important.

Action	Description	Timely Filing Limitation
VOID	**Claim has paid;** however, the Provider would like to completely cancel the claim as if it was never billed.	May be completed any time after the claim has been paid.
ADJUST	**Claim has paid, even if paid $0.00;** however, the Provider would like to make a correction or change to this paid claim. **Claim has paid with denied line(s):** For UB (Inpatient/Outpatient) claims, the Provider **mus**t adjust the partially paid claim.	Must be completed within six (6) months (180 days) after the claim has paid UNLESS the result will be a lower payment being made to the Provider, then no time limit.
RESUBMIT	**Claim has denied entirely:** The Provider may resubmit on a new claim.	One (1) year (365 days) from the date of service.

4.9.1 How Long do Providers Have to Resubmit or Adjust a Claim?

The deadlines for resubmitting and adjusting claims are different:

- Providers may resubmit any claim within 12 months (365 days) of the date of service
- Providers may adjust any paid claim within 6 months (180 days) of the date of payment

Adjustment requests for over-payments are accepted indefinitely. However, the Provider Agreement requires Providers to notify Medicaid within 30 days of learning of an over-payment. When Medicaid discovers an over-payment during a claims review, the Provider may be notified in writing. In most cases, the over-payment will be deducted from future payments. Refund checks are not encouraged. Refund checks are not reflected on the Remittance Advice. However, deductions from future payments are reflected on the Remittance Advice, providing a hardcopy record of the repayment.

4.9.2 Resubmitting a Claim

Resubmitting is when a Provider submits a claim to Medicaid that was previously submitted for payment but was either returned unprocessed or denied. Electronically submitted claims may reject for X12 submission errors. Claims may be returned to Providers before processing because key information such as an authorized signature or required attachment is missing or unreadable.

How to Resubmit:

- Review and verify the Error Codes on the RA/835 transactions and make all corrections and resubmit the claim
    - Contact Provider Services for assistance (see *Section* 2.1 Quick Reference) on claim denials

- **Claims must be submitted with all required attachments with each new submission**
- If the claim was denied because Medicaid has record of other insurance coverage, enter the missing insurance payment on the claim or submit insurance denial information when resubmitting the claim to Medicaid

4.9.2.1 When to Resubmit to Medicaid

- **Claim Denied:** Providers may resubmit to Medicaid when the entire claim has been denied, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Error Codes on the RA/835 transactions, make the appropriate corrections, and resubmit the claim.
- **Paid Claim with One (1) or More Line(s) Denied:**
  - For Professional, Waiver, and Dental claims, the **Providers may resubmit the individually denied lines as a new claim or adjust the partially paid claim.**
  - **For UB (Inpatient/Outpatient) claims, the Provider must adjust the partially paid claim.**
- **Claim Returned Unprocessed:** When Medicaid is unable to process a claim it will be rejected or returned to the Provider for corrections and to resubmit

4.9.3 Adjusting or Voiding Paid Claims

When a Provider identifies an error on a paid claim, the Provider must either adjust or void the claim electronically (preferred) or submit an Adjustment/Void Request Form (*see Section 4.9.3.4* Adjustment/Void Request Form*)* or submit an electronic claim adjustment or void. If the incorrect payment was the result of a keying error (paper claim submission), by the fiscal agent contact Provider Services to have the claim corrected (*see Section 2.1* Quick Reference).

Denied claims cannot be adjusted.

When adjustments are made to previously paid claims, Medicaid reverses the original payment and processes a replacement claim. The result of the adjustment appears on the RA/835 transaction as two (2) transactions. The reversal of the original payment will appear as a credit (negative) transaction. The replacement claim will appear as a debit (positive) transaction and may or may not appear on the same RA/835 transaction as the credit transaction.

> All items on a paid claim can be corrected with an adjustment EXCEPT the pay-to Provider number. In this case, the original claim will need to be voided and the corrected claim submitted.

4.9.3.1 When to Request an Adjustment

- When a claim was overpaid or underpaid.

- When a claim was paid, but the information on the claim was incorrect (such as Member ID, date of service, procedure code, diagnoses, units, and so on)
- When Medicaid pays a claim and the Provider subsequently receives payment from a third-party payer, the Provider must adjust the paid claim to reflect the TPL amount paid.
    - If an adjustment is submitted stating that TPL paid on the claim, but the TPL paid amount is not indicated on the adjustment or an EOB is not sent in with the claim, Medicaid will list the TPL amount as either the billed or reimbursement amount from the adjusted claim (whichever is greater). It will be up to the Provider to adjust again, with the corrected information.
    - Attach a corrected claim showing the insurance payment and attach a copy of the insurance EOB.
    - For the complete policy regarding Third Party Liability, *see Chapter 5* – Third Party Liability.

An adjustment cannot be completed when the mistake is the pay-to Provider number or NPI.

4.9.3.2 When to Request a Void

Request a void when a claim was billed in error (such as incorrect Provider number, services not rendered, and so on).

4.9.3.3 How to Request an Adjustment or Void

To adjust or void a paid claim, Providers are encouraged to complete claim adjustments and voids electronically but may complete use the Adjustment/Void Request Form (*see Section 4.9.3.4* Adjustment/Void Request Form). The requirements for adjusting/voiding a claim are as follows:

- An adjustment/void can only be processed if the claim has been paid by Medicaid
- Medicaid must receive individual claim adjustment requests within 6 months (180 days) of the claim payment date
- A separate Adjustment/Void Request Form must be completed for each claim
- If the Provider is correcting more than one (1) error per claim, use only one (1) Adjustment/Void Request Form
    - Correct all items that should be corrected and attach this corrected claim to the Adjustment/Void form
    - Indicate "Corrected Claim" as the reason for adjustment

4.9.3.4 Adjustment/Void Request Form

Wyoming Department of Health

Adjustment/Void Request Form

PART A – Request Type

☐ 1a CLAIM ADJUSTMENT

Attach a copy of the claim with corrections made in **BLUE INK**.

DO NOT USE HIGHLIGHTER

Complete both Section B and Section C.

If attaching a check, make check payable to Division of Healthcare Financing (DHCF).

☐ 1b VOID CLAIM

Attach a copy of the claim or Remittance Advice.

☐ 2 CANCELLATION OF THE ENTIRE REMITTANCE ADVICE

Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances.

Complete Section C only.

Attach Remittance Advice.

If manual check, attach the check from DHCF.
If EFT, make payable to DHCF for the entire remit amount.

PART B – Claim Information

If you selected either 1a or 1b, complete all of the following fields to facilitate processing. If you selected 2, skip this section.

Transaction Control Number (TCN) _____ Payment Date _____

Provider Name _____ NPI/Provider Number _____

Member ID _____ Prior Authorization Number _____

Date of Service	Proc Code/ Revenue Code	Charges	Service Line of Claim	Units	Other

Reasons for Adjustment or Void *(Check one or more.)*

☐ Billed in error ☐ Billed incorrect units ☐ Billed incorrect procedure code(s)

☐ Billed incorrect amount ☐ Receipt of TPL or Medicare Payment ☐ Other: _____

PART C – Signature and Date

Provider Signature _____ Date _____

INTERNAL USE ONLY BELOW THIS LINE

Adjusted By _____ Date _____

Mail completed form and attachments to:
Wyoming Medicaid Fiscal Agent
Attn: Claims Department
P.O. Box 547
Cheyenne, WY 82003-0547

WYBMS-Adjustment/Void form

If a Provider wants to void an entire RA, contact Provider Services (*see Section 2.1* Quick Reference).

4.9.3.5 How to Complete the Adjustment/Void Request Form

Section	Field #	Field Name	Action
A	1a	Claim Adjustment	Mark this box if any adjustments need to be made to a claim. Attach a copy of the claim, with corrections made in BLUE ink (do not use red ink or highlighter) or attach the RA. Remember to attach all supporting documentation required to process the claim, such as EOB, EOMB, consent forms, invoice, and so on Both Section B and C must be completed.
	1b	Void Claim	Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the RA. Sections B and C must be completed.
	2	Cancellation of the Entire Remittance Advice	Mark this box **only** when every claim on the RA is incorrect. Attach the RA. Complete only Section C
B	1	17-digit TCN	Enter the 17-digit transaction control number(TCN) assigned to each claim from the RA
	2	Payment Date	Enter the Payment Date
	4	Provider Name	Enter the Provider name.
	3	NPI/Provider Number	Enter Provider's ten (10)-digit NPI number or nine (9)-digit Medicaid Provider ID
	5	Member ID	Enter the Member's ten (10)-digit Medicaid ID number
	6	Member Name	Enter the Member's first and last name.
	7	Prior Authorization Number	Enter the ten (10)-digit PA number, if applicable.
	8	Reasons for Adjustment or Void	Either choose the appropriate option and indicate the correction in the table as well as within the attached

			claim form, or for more than one change, enter "See Corrected Claim"
C		Provider Signature and Date	Signature of the Provider or the Providers' authorized representative and the date.

4.9.3.6 Adjusting or Voiding a Claim Electronically via an 837 Transaction

Wyoming Medicaid prefers claim adjustments and voids on paid claims to be submitted electronically, *see Chapter 8* of the *WY BMS Institutional Provider Manual*, the Wyoming Medicaid EDI Companion Guide, or the Provider Publications and Trainings all posted to the Medicaid website (*see Section 2.1* Quick Reference) for the specific tutorial.

4.10 Timely Filing

The Division of Healthcare Financing adheres strictly to its timely filing policy. The Provider must submit a clean claim to the WSH within 12 months (365 days) of the date of service. A clean claim is an error free, correctly completed claim, with all required attachments that will process and approve to pay within the 12-month (365 days) time period. Submit claims immediately after providing services so that, when a claim is denied, there is time to correct any errors and resubmit. Claims are to be submitted only after the service(s) have been rendered, and not before. For deliverable items (such as dentures, DME, glasses, hearing aids, and so on) the date of service must be the date of delivery, not the order date.

4.10.1 Exceptions to the Twelve Month (365 days) Limit

Exceptions to the 12-month (365 days) claim submission limit may be made under certain circumstances. The chart below shows when an exception may be made, the time limit for each exception, and how to request an exception.

Exceptions Beyond the Control of the Provider	
When the Situation is:	**The Time Limit is:**
Medicare Crossover	A claim must be submitted within 12 months (365 days) of the date of service **or** within 6 months (180 days) from the payment date on the Explanation of Medicare Benefits (EOMB), **whichever is later.**
Member is determined to be eligible on appeal, reconsideration, or court decision (retroactive eligibility)	Claims must be submitted within 6 months (180 days) of the date of the determination of retroactive eligibility. The Member must provide a copy of the dated letter to the Provider to document retroactive eligibility. If a claim exceeds timely filing, and the Provider elects to accept the Member as a Medicaid Member and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be an SSI award notice or a notice from WDH.

Exceptions Beyond the Control of the Provider	
When the Situation is:	**The Time Limit is:**
Member is determined to be eligible due to agency corrective actions (retroactive eligibility)	Claims must be submitted within 6 months (180 days) of the date of the determination of retroactive eligibility. The Member must provide a copy of the dated letter to the Provider to document retroactive eligibility. If a claim exceeds timely filing, and the Provider elects to accept the Member as a Medicaid Member and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing.
Provider finds their records to be inconsistent with filed claims, regarding rendered services. This includes dates of service, procedure/revenue codes, tooth codes, modifiers, admission or discharge dates/times, treating or referring Providers or any other item which makes the records/claims non-supportive of each other.	Although there is no specific time limit for correcting errors, the corrected claim must be submitted in a timely manner from when the error was discovered. If the claim exceeds timely filing, the claim must be sent with a cover letter requesting an exception to timely filing citing this policy.

4.10.2 Appeal of Timely Filing

A Provider may appeal (*see Section 2.3.2 How to Appeal* of the *Institutional Provider Manual* located on the Medicaid website) a denial for timely filing **only** under the following circumstances:

- The claim was originally filed within 12 months (365 days) of the date of service and is on file with Wyoming Medicaid, **and**
- The Provider made at least one (1) attempt to resubmit the corrected claim within 12 months (365 days) of the date of service, **and**
- The Provider must document in their appeal letter all claims information and what corrections they made to the claim (all claims history, including TCNs) as well as all contact with or assistance received from Provider Services (dates, times, call reference number, who was spoken with, and so on), **or**
- A Medicaid computer or policy problem beyond the Provider's control that prevented the Provider from finalizing the claim within 12 months (365 days) of the date of service

Any appeal that does not meet the above criteria will be denied. Timely filing will not be waived when a claim is denied due to Provider billing errors or involving third party liability.

Appeals for claims that denied appropriately will be automatically denied. The appeals process is not an apt means to resubmit denied

claims nor to submit supporting documentation. Doing so will result in denials and time lost to correct claims appropriately.

4.11 Billing Tips to Avoid Timely Filing Denials

- File claims soon after services are rendered
- Carefully review the Wyoming Medicaid Error Codes on the Remittance Advice/835 transaction (work RAs/835s weekly)
- Resubmit the entire claim or denied line only after all corrections have been made
- Contact Provider Services (*see Section 2.1* Quick Reference):
  - With any questions regarding billing or denials
  - When payment has not been received within 30 days of submission, verify the status of the claim
  - When there are multiple denials on a claim, request a review of the denials prior to resubmission

Once a Provider has agreed to accept a patient as a Medicaid Member, any loss of Medicaid reimbursement due to Provider failure to meet timely filing deadlines is the responsibility of the Provider.

Chapter 5 – Third Party Liability

5.1 Definition of a Third Party Liability

5.1.1 Third Party Liability

Third Party Liability (TPL) is defined as the right of the department to recover, on behalf of a Member, from a third-party payer, the costs of Medicaid services furnished to the Member.

In simple terms, TPL is often referred to as other insurance, other health insurance, medical coverage, or other insurance coverage. Other insurance is considered a third-party resource for the Member. Third-party resources may include but are not limited to:

- Health insurance (including Medicare)
- Indian Health Services
- Veteran's Administration
- Medicaid (Wyoming or another state)
- County of Residence

5.1.2 Third Party Payer

Third Party Payer is defined as a person, entity, agency, insurer, or government program that may be liable to pay, or that pays pursuant to a Member's right of recovery arising from an illness, injury, or disability for which Medicaid funds were paid or are obligated to be paid on behalf of the Member. Third party payers include, but are not limited to:

- Medicare
- Medicare Replacement (Advantage or Risk Plans)
- Medicare Supplemental Insurance
- Insurance Companies
- Other
    - County of Residence
    - Medicaid (Wyoming or another state)
    - Indian Health Services
    - Veteran's Administration
    - Tricare

> When attaching an EOMB to a paper claim adjustment request and the TPL is Medicare Replacement or Medicare Supplement, hand-

write the applicable type of Medicare coverage on the EOMB (such as Medicare Replacement, Medicare Supplement).

The WSH is always the payer of last resort. It is a secondary payer to all other payment sources and programs and should be billed only after payment or denial has been received from such carriers.

5.1.3 Medicare

Medicare is administered by the Centers for Medicare and Medicaid Services (CMS) and is the federal health insurance program for individuals age 65 and older, certain disabled individuals, individuals with End Stage Renal Disease (ESRD) and amyotrophic lateral sclerosis (ALS). Medicare entitlement is determined by the **Social Security Administration**. Medicare is primary to Medicaid. Services covered by Medicare must be provided by a Medicare-enrolled Provider and billed to Medicare first.

Medicare Part A and Part B claims automatically cross over to Medicaid. If claims are not automatically crossing over, Providers need to troubleshoot by verifying the following:

- Were taxonomy codes included on the claim for the billing, rendering, or attending providers?
- If the billing taxonomy code was included on the claim, does Wyoming Medicaid have this taxonomy code listed on the provider's file either as a primary or secondary taxonomy code?
- Verify the member's Medicare eligibility dates to the dates of service on the claim.

5.1.3.1 Medicare Part A

Part A (Hospital Insurance): Helps cover:

- Inpatient Care in Hospitals
- Skilled Nursing Facility Care
- Hospice Care
- Home Health Care

To avoid Medicaid claim denials, Providers must bill using the appropriate Medicare coverage type based on the services provided, such as, Part A is appropriate for inpatient hospital services, Part A **is not correct** for outpatient services.

5.1.3.2 Medicare Part B

Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers

- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventative services (like screenings, shots, or vaccines, and yearly "Wellness" visits)

> To avoid Medicaid claim denials, Providers must bill using the appropriate Medicare coverage type based on the services provided, such as, Part A is appropriate for inpatient hospital services, Part A **is not correct** for outpatient services.

5.1.3.3 Medicare Part C (Advantage or Replacement Plans)

Medicare Replacement Plans are also known as Medicare Advantage Plans or Medicare Part C and are treated the same as any other Medicare claim. Many private companies have Medicare replacement policies. A Medicare Advantage Plan will provide Part A and Part B coverage. Advantage plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Part D, prescription drug coverage.

- Providers must verify whether a policy is a Medicare replacement policy, when attaching an explanation of benefits (EOB) to a claim, providers must write on the EOB the type of policy.
- Medicare replacement policy claims are billed as any other Medicare claim.
- The "Claim Filing Indicator" or "Primary Payer Responsibility" on tertiary claims must be Medicare Part A or B, dependent upon the services provided, not commercial insurance.
    - Dental providers are to use the "Claim Filing Indicator" of Medicare Part B.

> Medicare Replacement claims do not automatically crossover to Medicaid.

5.1.3.4 Medicare Part D

Part D (Drug coverage): Helps cover the cost of prescription drugs (including many recommended shots or vaccines).

5.1.4 Medicare Supplement Plans

Medicare Supplement Plans are additional coverage to Medicare provided by private health insurance companies.

- Providers must verify whether a policy is a Medicare replacement or supplement policy, when attaching an explanation of benefits (EOB) to a claim, Providers must write the type of policy on the EOB.

- Medicare supplement policy claims are billed as commercial insurance or TPL on the claim.
    - The "Claim Filing Indicator" or "Primary Payer Responsibility" on tertiary claims must be Commercial Insurance, not Medicare Part A or B.

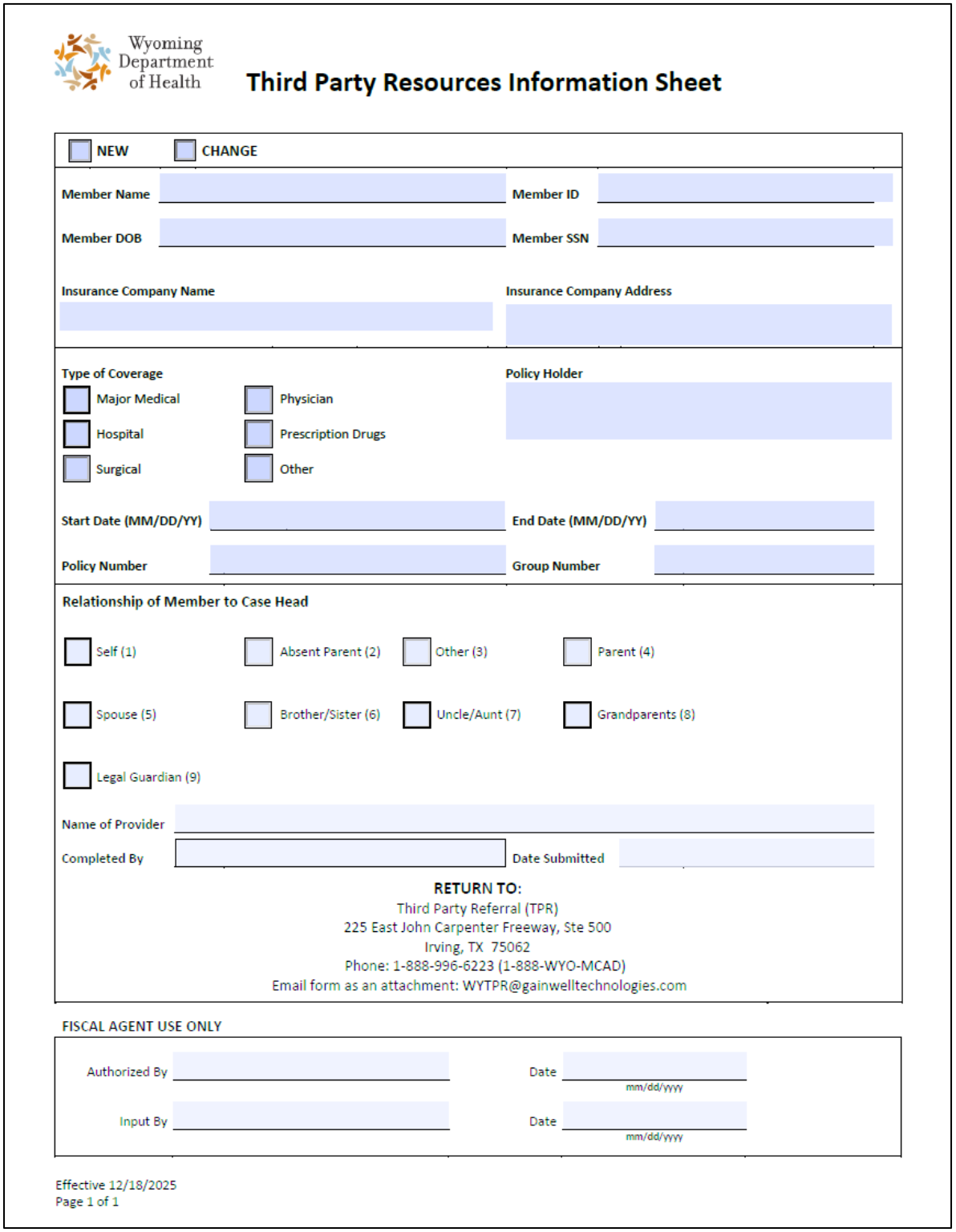
5.2 Provider's Responsibilities

Providers have an obligation to investigate and report the existence of other third-party liability information. The WSH uses the Title 25 Certification Form (located on the Medicaid website) as documentation that Providers have complied with all applicable statutes, rules, and guidelines for identifying and seeking payment from responsible primary payers (*see Section 3.2.5* Submitting Required Title 25 Documentation). Providers play an integral and vital role as they have direct contact with the Member. The contribution Providers make to the WSH in the TPL arena is significant. Their cooperation is essential to the functioning of the Title 25 Program and to ensuring prompt payment.

At the time of Member intake, the Provider must obtain primary payer information from the Member. Providers can bill the client for copays and deductibles in the first 72 hours. At the same time, the Provider should also ascertain if additional insurance resources exist and document findings on the Title 25 Certification Form. When a TPL/Medicare has been reported to the Provider, these resources must be identified on the claim for claims to be processed properly. Other insurance information may be reported to Medicaid using the Third Party Resources Information Sheet (see *Section 5.2.1* Third Party Resources Information Sheet). Claims should not be submitted prior to billing TPL/Medicare.

Member TPL policies are updated on a weekly basis in the BMS (Benefit Management System). Insurance policies that are verified (not submitted) by Wednesday of each week will be reflected in the Member's file within the BMS the following Monday.

5.2.1 Third Party Resources Information Sheet



Wyoming Department of Health

Third Party Resources Information Sheet

☐ NEW ☐ CHANGE

Member Name _____ Member ID _____

Member DOB _____ Member SSN _____

Insurance Company Name _____ Insurance Company Address _____

Type of Coverage

☐ Major Medical ☐ Physician

☐ Hospital ☐ Prescription Drugs

☐ Surgical ☐ Other

Policy Holder _____

Start Date (MM/DD/YY) _____ End Date (MM/DD/YY) _____

Policy Number _____ Group Number _____

Relationship of Member to Case Head

☐ Self (1) ☐ Absent Parent (2) ☐ Other (3) ☐ Parent (4)

☐ Spouse (5) ☐ Brother/Sister (6) ☐ Uncle/Aunt (7) ☐ Grandparents (8)

☐ Legal Guardian (9)

Name of Provider _____

Completed By _____ Date Submitted _____

RETURN TO:
Third Party Referral (TPR)
225 East John Carpenter Freeway, Ste 500
Irving, TX 75062
Phone: 1-888-996-6223 (1-888-WYO-MCAD)
Email form as an attachment: WYTPR@gainwelltechnologies.com

FISCAL AGENT USE ONLY

Authorized By _____ Date _____ mm/dd/yyyy

Input By _____ Date _____ mm/dd/yyyy

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Medicaid maintains a reference file of known commercial health insurance as well as a file for Medicare Part A and Part B entitlement information. Both files are used to deny claims that do not show proof of

payment or denial by the commercial health insurer or by Medicare. Providers must use the same procedures for locating third party payers for Medicaid Members as for their non-Medicaid Members.

Providers may not refuse to furnish services to a Medicaid Member because of a third party's potential liability for payment for the service (S.S.A. §1902(a)(25)(D)) (*see Section 3.2* Accepting Title 25 Members).

5.2.2 Provider is Not Enrolled with Third Party Liability Carrier

The WSH ***will not accept*** a letter with a claim indicating that a Provider does not participate with a specific health insurance company. The Provider must work with the insurance company and/or Member to have the claim submitted to the carrier.

Providers cannot refuse to accept Medicaid Members who have other insurance if their office does not bill other insurance. However, a Provider may limit the number of Medicaid Members they are willing to admit into their practice. The Provider may not discriminate in establishing a limit. If a Provider chooses to opt-out of participation with a health insurance or governmental insurance, Medicaid will not pay for services covered by, but not billed to, the health insurance or governmental insurance.

5.2.3 Medicare Opt-Out

Providers may choose to opt-out of Medicare. However, the WSH will not pay for services covered by, but not billed to, Medicare because the Provider has chosen not to enroll in Medicare. The Provider must enroll with Medicare if Medicare will cover the services in order to receive payment from Medicaid.

> In situations where the Provider is reimbursed for services and Medicaid later discovers a source of TPL, Medicaid will seek reimbursement from the TPL source. If a Provider discovers a TPL source after receiving Medicaid payment, they must complete an adjustment to their claim within 30 days of receipt of payment from the TPL source.

5.2.4 Third Party Disallowance

When TPL commercial health insurance/Medicare Part A and Part B/Worker's Compensation coverage is identified by Wyoming Medicaid retrospectively, Wyoming Medicaid may seek recoupment from the Provider of service of any paid claims that should have been the responsibility of a primary payer through the third-party disallowance process. A letter will be delivered to the Provider of service identifying the liable third-party coverage accompanied by a list of claims that need to be billed to the liable third party. Providers will be given 60 days from the date of the letter to bill their claims to the liable third party and receive reimbursement. At the close of the 60-day period, Wyoming Medicaid will automatically recoup the original payment it made on the claims.

Providers are instructed not to attempt to adjust their claims during the 60-day period as the claims will be locked. At the conclusion of the 60-day period, claims will be automatically adjusted by the BMS. Additionally, Providers are instructed not to submit a manual refund payment (cash, check, money order, and so on) so as to avoid duplication of the automated adjustment process.

Providers are encouraged to work directly with Wyoming Medicaid's vendor, Health Management Systems (HMS), to access the online TPL Disallowance Portal (*see Chapter 8* of the *WY BMS Institutional Provider Manual* located on the Medicaid website) and to obtain assistance throughout the disallowance process (*see Section 2.1* Quick Reference).

5.2.5 Third Party Liability Credit Balance Audits

Wyoming Medicaid leverages the services of its vendor, Health Management Systems (HMS), to conduct periodic credit balance audits to ensure all overpayments due to Wyoming Medicaid are processed appropriately (*see Section 2.1* Quick Reference). If selected for a credit balance audit, the Provider of service of will receive a notification from HMS advising them of the audit and the audit process. An assigned HMS credit balance auditor will contact the Provider of service to schedule the audit and answer any questions the Provider may have regarding the process.

Providers are instructed not to attempt to adjust their claims during the credit balance audit process. At the conclusion of the audit, claims will be automatically adjusted in the BMS. Additionally, Providers are instructed not to submit a manual refund payment (such as cash, check, or money order) so as to avoid duplication of the automated adjustment process.

Providers are encouraged to work directly with Wyoming Medicaid's vendor, Health Management Systems (HMS), to obtain assistance throughout the credit balance process (*see Section 2.1* Quick Reference).

5.3 Billing Requirements

Providers should bill TPL/Medicare and receive payment to the fullest extent possible before billing the WSH. The Provider must follow the rules of the primary insurance plan (such as obtaining prior authorization, obtaining medical necessity, obtaining a referral, or staying in-network) or the related Title 25 claim will be denied. Follow specific plan coverage rules and policies. The CMS does not allow state dollars to be spent if a Member with access to other insurance does not cooperate or follow the applicable rules of their other insurance plan.

The WSH will not pay for and will recover payments made for services that could have been covered by the TPL/Medicare if the applicable rules of that plan had been followed. It is important that Providers maintain adequate records of the third-party recovery efforts for a period of time not less than six (6) years after the end of the state fiscal year. These records, like all other Medicaid records, are subject to audit/post-payment review by Health and Human Services, the Centers for Medicare and Medicaid Services (CMS), the state Medicaid agency, or any designee.

Medicaid requires Providers to submit claims with taxonomies to reach a unique Provider. To avoid crossover claim denials, Providers must include taxonomies when submitting claims to Medicare.

> Providers are required to complete the prior authorization process in instances where the Member has other insurance with another carrier.
>
> **Exception**: For Members eligible only for the QMB benefit plan, Providers do not need to complete the Medicaid prior authorization request process.

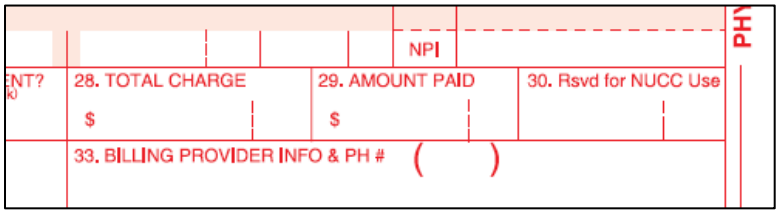
If prior authorization is not obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.

Once payment/denial is received by TPL/Medicare, the claim may then be billed to Medicaid as a secondary claim. If payment is received from the other payer, the Provider should compare the amount received with Medicaid's maximum allowable fee for the same claim.

> Although the Explanation of Benefits (EOB) or Coordination of Benefits (COB) are not required to be attached to the claim, Providers are encouraged to attach the EOB or COB to the claim.

- If payment is less than Medicaid's allowed amount for the same claim, indicate the payment in the appropriate field on the claim form
    - **CMS-1500/837P – Other Insurance (TPL) and Medicare Part B Information:**
        - **Field 11: Insured's Policy, Group, or FECA Number**
        - **Field 11a: Insured's Date of Birth**
        - **Field 11 b: Other Claim ID (situational)**
        - **Field 11c: Insurance Plan Name or Program Name**
            - **Commercial Insurance Policy Name**
            - **Medicare Part B (including Medicare Advantage Plans)**
        - **Field 11d: Is there another Health Benefit Plan?**
            - **Situational: Mark "X" in the correct box**
            - **If marked "Yes", complete Fields 9, 9a, and 9 d (Tertiary)**

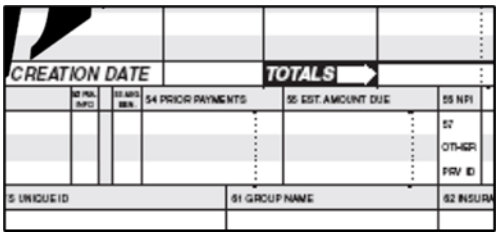
- **Field 29: Amount Paid**
  - **Enter total amount the other payers (Medicare or other insurance) paid on the covered services only.**



CMS-1500 (Professional) claims will apply Other Insurance (TPL) and Medicare (including Medicare Advantage Plans) at the line level.

- **Claim Adjustment Reason Codes (CARC) must be entered on the service lines with the appropriate Claim Adjustment Group Code (www.x12.org/codes)**

- **UB-04/837I – Inpatient and Outpatient Claim Types Other Insurance (TPL) and Medicare Information:**
  - **Field 50 Payer Identification: Enter name of payer (Medicare or commercial insurance name)**
    - **Field 50 A: Payer Identification - Primary**
    - **Field 50 B: Payer Identification - Secondary**
    - **Field 50 C: Payer Identification - Tertiary**
  - **Field 51 Health Plan Identification Number**
    - **Field 51 A: Health Plan Identification Number – Primary**
    - **Field 51 B: Health Plan Identification Number – Secondary**
    - **Field 51 C: Health Plan Identification Number – Tertiary**
  - **Field 54 Prior Payments: Enter amount paid by the payer to the Provider**
    - **Field 54 A: Payer Paid Amount – Primary**
    - **Field 54 B: Payer Paid Amount – Secondary**
    - **Field 54 C: Payer Paid Amount – Tertiary**



- **Field 55 Estimated Amount Due: Enter remaining total as prior payment was made**
  - **Field 55 A: Remaining Total Amount – Primary**
  - **Field 55 B: Remaining Total Amount – Secondary**
  - **Field 55 C: Remaining Total Amount – Tertiary**
- **Fields 58 - 62: Enter Insured's name, patient's relationship to insured, insured's unique ID, and insured group names**
- Field 64 Treatment Authorization Codes: Enter **only** Medicaid's prior authorization number, when applicable

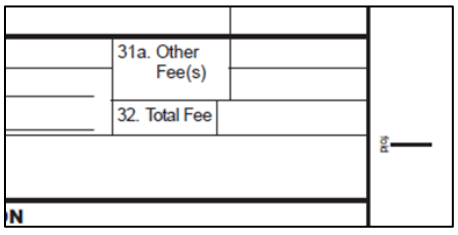
Inpatient claims will apply Other Insurance (TPL) and Medicare at the header level of the claim.

- Claim Adjustment Reason Codes (CARC) must be entered at the header with the appropriate Claim Adjustment Group Code (www.x12.org/codes)

Outpatient claims will apply Other Insurance (TPL) and Medicare at the service lines of the claim.

- Claim Adjustment Reason Codes (CARC) must be entered on the service lines with the appropriate Claim Adjustment Group Code (www.x12.org/codes)
- Claim types that submit encounter claims (RHC, FQHC, IHS, ESRD) will apply TPL and Medicare to the detail lines or service lines, and **not** to the encounter line.

- **Dental/837D – Other Insurance (TPL) and Medicare (including Medicare Advantage Plans) Information:**
  - **Other Coverage section**
    - Field 4: Dental
    - Fields 5 - 11: Complete with other dental policy information (TPL or Medicare) only
    - Field 31a - Other Fees: Enter the amount paid by the other insurance (TPL) or Medicare



Dental claims will apply Other Insurance (TPL) and Medicare Part B (including Medicare Advantage Plans) at the line level.

- **Claim Adjustment Reason Codes (CARC) must be entered on the service lines with the appropriate Claim Adjustment Group Code (www.x12.org/codes).**

- If the TPL payer paid less than 67% of the calculated Medicaid allowed amount, include the appropriate claim reason codes on the claims. Attaching the explanation of benefits (EOB) to the electronic claim is encouraged (see 4.7 Submitting Attachments for Electronic Claims).

> Medicaid will accept refunds from a Provider at any time. Timely filing will not apply to adjustments where money is owed to Medicaid (see *Section 4.10* Timely Filing).

- If a denial is obtained from the third party payer/Medicare that a service is not covered, attach the denial to the claim (see 4.7 Submitting Attachments for Electronic Claims). The denial will be accepted for one (1) calendar year or benefit plan year, as appropriate, but will still need to be attached with each claim.
    - If verbal denial is obtained from a third-party payer, type a letter of explanation on official office letterhead. The letter must include:
    - Date of verbal denial
    - Payer's name and contact person's name and phone number
    - Date of Service
    - Member's name and Medicaid ID number
    - Reason for denial

- If the third-party payer/Medicare sends a request to the Provider for additional information, the Provider must respond. If the Provider complies with the request for additional information and, after ninety (90) days from the date of the original claim, the Provider has not received payment or denial, the Provider may submit the claim to the WSH with the Previous Attempts to Bill Services Letter (*see Section 5.3.1.1* Previous Attempts to Bill Services Letter). A claim submitted to a third-party payer will be considered "denied" if the claim is submitted and no response is received within the 90 days of being properly submitted. If a claim is later paid after originally being denied, and payment was already received from the WSH or the county, payment must be returned to the payer

> Waivers of timely filing will not be granted due to unresponsive third-party payers.

- In situations involving litigation or other extended delays in obtaining benefits from other sources, Medicaid should be billed as soon as possible to avoid timely filing. If the Provider believes there may be casualty insurance, contact the TPL Unit (*see Section 2.1* Quick Reference). TPL will investigate the responsibility of the other party. Medicaid does not require Providers to bill a third party when liability has not been established. However, the Provider

cannot bill the casualty carrier and Medicaid at the same time. The Provider must choose to bill Medicaid or the casualty carrier (estate). Medicaid will seek recovery of payments from liable third parties. If Providers bill the casualty carrier (estate) and Medicaid, this may result in duplicate payments.

- **Notify the TPL Department for requests for information**. Release of information by Providers for casualty related third party resources not known to the State may be identified through requests for medical reports, records, and bills received by Providers from attorneys, insurance companies, and other third parties. Contact the TPL Department (*see Section 2.1* Quick Reference) prior to responding to such requests.
- If the Member received reimbursement from the primary insurance, the Provider must pursue payment from the patient. If there are any further Medicaid benefits allowed after the other insurance payment, the Provider may still submit a claim for those benefits. The Provider, on submission, must supply all necessary documentation of the other insurance payment. Medicaid will not pay the Provider the amount paid by the other insurance.
- **Providers may not charge Medicaid Members, or any other financially responsible relative or representative of that individual any amount in excess of the Medicaid paid amount. Medicaid payment is payment in full. There is no balance billing.**

> When attaching an EOMB to a claim and the TPL is Medicare Replacement or Medicare Supplement, hand-write the applicable type of Medicare coverage on the EOMB (such as Medicare Replacement or Medicare Supplement).

5.3.1 How Third Party Liability is Applied

The amount paid to Providers by primary insurance payers is often less than the original amount billed, for the following reasons:

- Reductions resulting from a contractual agreement between the payer and the Provider (contractual write-off); and,
- Reductions reflecting patient responsibility (copay, coinsurance, deductible, and so on). The WSH will pay no more than the remaining patient responsibility (PR) after payment by the primary insurance.
- The WSH will reimburse the Provider for the patient liability up to the allowable amount. A Provider must include the contract write-off amount and the amount paid by the other insurance as the third-party liability payment.
- **CMS-1500 (Professional) claims will apply Other Insurance (TPL) and Medicare (including Medicare Advantage Plans) at the line level.**

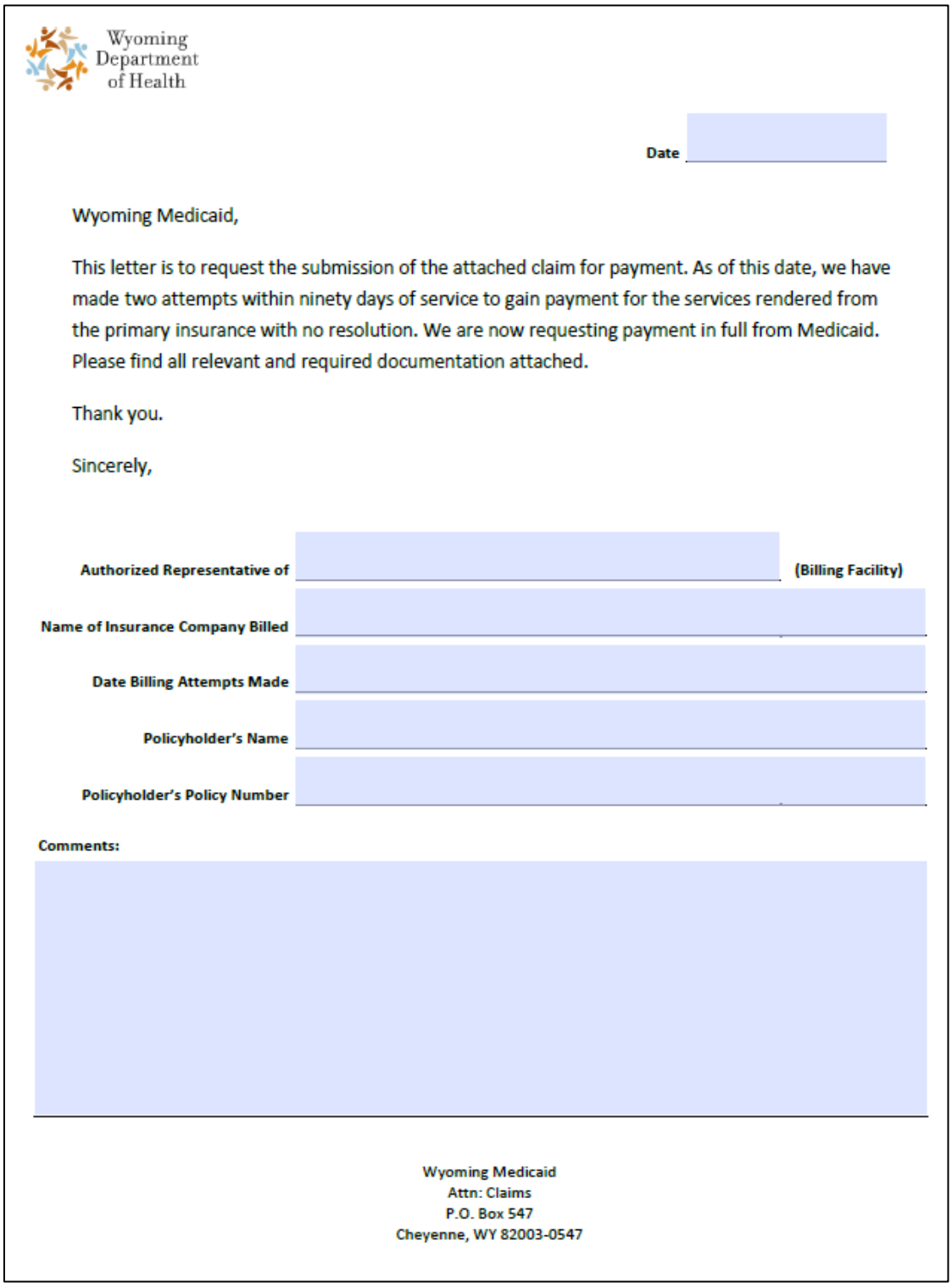
- **Claim Adjustment Reason Codes (CARC) must be entered on the service lines with the appropriate Claim Adjustment Group Code (**www.x12.org/codes**)**

- UB-04 Inpatient claims will apply Other Insurance (TPL) and Medicare at the header level of the claim.
  - Claim Adjustment Reason Codes (CARC) must be entered at the header with the appropriate Claim Adjustment Group Code (www.x12.org/codes)
- UB-04 Outpatient claims will apply Other Insurance (TPL) and Medicare at the service lines of the claim.
  - Claim Adjustment Reason Codes (CARC) must be entered on the service lines with the appropriate Claim Adjustment Group Code (www.x12.org/codes)
  - Claim types that submit encounter claims (RHC, FQHC, IHS, ESRD) will apply TPL and Medicare to the detail lines or service lines, and **not** to the encounter line.

If the payer does not respond to the first attempt to bill with a written or electronic response to the claim within sixty (60) days, resubmit the claims to the TPL. Wait an additional thirty (30) days for the third-party payer to respond to the second billing. If after ninety (90) days from the initial claim submission the insurance still has not responded, bill the WSH with the Previous Attempts to Bill Services Letter.

Waivers of timely filing will not be granted due to unresponsive third-party payers.

5.3.1.1 Previous Attempts to Bill Services Letter



Wyoming Department of Health

Date _____

Wyoming Medicaid,

This letter is to request the submission of the attached claim for payment. As of this date, we have made two attempts within ninety days of service to gain payment for the services rendered from the primary insurance with no resolution. We are now requesting payment in full from Medicaid. Please find all relevant and required documentation attached.

Thank you.

Sincerely,

Authorized Representative of _____ **(Billing Facility)**

Name of Insurance Company Billed _____

Date Billing Attempts Made _____

Policyholder's Name _____

Policyholder's Policy Number _____

Comments:

Wyoming Medicaid
Attn: Claims
P.O. Box 547
Cheyenne, WY 82003-0547

Do not submit this form for Medicare or automobile/casualty insurance.

5.3.2 Acceptable Proof of Payment or Denial

Documentation of proper payment or denial of TPL/Medicare must correspond with the Member's/beneficiary's name, date of service, charges, and TPL/Medicare payment referenced on the Title 25 claim. If there is a reason why the charges do not match (such as other insurance requires another code to be billed, institutional and professional charges are on the same EOB, third party payer is Medicare Advantage plan, replacement plan or supplement plan) this information must be written on the attachment.

5.3.3 Coordination of Benefits

Coordination of Benefits (COB) is the process of determining which source of coverage is the primary payer in a particular situation. COB information must be complete, indicate the payer, payment date and the payment amount.

If a Member has other applicable insurance, Providers who bill electronic and web claims will need to submit the claim COB information provided by the other insurance company for all affected services. For claims submitted through the Medicaid website, see the Web Portal Tutorials on billing secondary claims.

For Members with three insurances, tertiary claims can be submitted through the Provider Portal, with both EOBs attached to the claim.

5.3.4 Blanket Denials and Non-Covered Services

When a service is not covered by a Member's primary insurance plan, a blanket denial letter should be requested from the TPL/Medicare. The insurance carrier should then issue, on company letterhead, a document stating the service is not covered by the insurance plan. The Provider can also provide proof from a benefits booklet from the other insurance, as it shows that the service is not covered or the Provider may use benefits information from the carrier's website. Providers should retain this statement in the Member's file to be used as proof of denial for **one calendar year or benefit plan year**, as appropriate. The non-covered status must be reviewed and a new letter obtained at the end of **one calendar year or benefit plan year**, as appropriate.

If a Member specific denial letter or EOB is received, the Provider may use that denial or EOB as valid documentation for the denied services for that Member for one calendar year or benefit plan year, as appropriate. The EOB must clearly state the services are not covered. The Provider must still follow the rules of the primary insurance prior to filing the claim to Medicaid.

If the service or equipment is not covered under the Member's plan, or the insurance company does not cover the service or equipment, then Medicaid will process the claim as being primary.

- TPL/Other Insurance Electronic Billing Requirements:
    - Indicate claim requires supporting documentation – triggers attachment indicator as Y.

- Submit claim to Medicaid as secondary – enter appropriate Payer ID (list is available on the TPL and Medicare Payer IDs web page on the WY Medicaid website).
- Enter TPL paid amount $0.00.
- At the line enter full billed dollar amount and enter Claim Adjustment Reason Code (CARC) code 204.

- Attach either the blanket denial letter on the primary payer's letterhead or the primary insurance Explanation of Benefits (EOB).

5.3.5 Third Party Liability and Copays

A Member with commercial health insurance primary to Wyoming Medicaid is required to pay the Wyoming Medicaid copay. Submit the claim to Wyoming Medicaid in the usual manner, reporting the insurance payment on the claim with the balance due. If the Wyoming Medicaid allowable covers all or part of the balance billed, Wyoming Medicaid will pay up to the maximum Wyoming Medicaid allowable amount, minus any applicable Wyoming Medicaid copay. Wyoming Medicaid will deduct the copay from its payment amount to the Provider and report it as the copay amount on the Provider's RA. Remember, Wyoming Medicaid is only responsible for the Member's liability amount or patient responsibility amount up to its maximum allowable amount.

Submit claims to Wyoming Medicaid only if the TPL payer indicates a patient responsibility. If the TPL does not attribute charges to patient responsibility or non-covered services, Wyoming Medicaid will not pay.

5.3.6 Primary Insurance Recoup after Medicaid Payment

In the instance where primary insurance recovers payment after the timely filing threshold, and to bill Wyoming Medicaid as primary, the Provider will need to submit an appeal for timely filing. The appeal must include proof from the primary insurance company that money was taken back as well as the reasoning. The appeal must be submitted within 90 days of recovered payment or notification from the primary insurance for it to be reviewed and processed appropriately.

5.4 Medicare Pricing

Wyoming Medicaid changed how reimbursement is calculated for Medicare crossover claims. This change applies to all service Providers.

- Part B crossovers are processed and paid at the line level (line by line)
- Part A inpatient crossovers, claims are processed at the header level

- Part B *outpatient* crossovers, claims are priced at the line level (line by line) totaled, and then priced at the header level

5.4.1 Medicaid Covered Services

For services covered under the Wyoming Medicaid State Plan, the new payment methodology will consider what Medicaid would have paid, had it been the sole payer. Medicaid's payment responsibility for a claim will be the lesser of the Medicare coinsurance and deductible, or the difference between the Medicare payment and Medicaid allowed charge(s).

Example:

- Procedure Code 99239
- Medicaid Allowable - $97.67
- Medicare Paid - $83.13
- Medicare assigned Coinsurance and Deductible - $21.21
    - First payment method option: (Medicaid Allowable) $97.67 – (Medicare Payment) $83.13 = $14.54
    - Second payment method option: Coinsurance and deductible = $21.21
    - Medicaid will pay the lesser of the Medicaid payment methodology or the coinsurance and deductible
    - This procedure code would pay $14.54 since it is less than $21.21

If the method for Medicaid covered services results in a Medicaid payment of $0.00 and the claim contains lines billed for physician-administered pharmaceuticals, the line will pay out at $0.01.

5.4.2 Medicaid Non-Covered Services

For specific Medicare services which are not otherwise covered by Wyoming Medicaid State plan, Medicaid will use a special rate or method to calculate the amount Medicaid would have paid for the service. This method is Medicare allowed amount, divided by 2, minus the Medicare paid amount.

Example:

- Procedure Code: E0784 – (Not covered as a rental – no allowed amount has been established for Medicaid)
- Medicaid Allowable – Not assigned
- Medicare Allowable - $311.58
- Medicare Paid – $102.45

- Assigned Coinsurance and Deductible - $209.13
    - First payment method option: (Medicare Allowable) 311.58 ÷ 2 = $155.79 – (Medicare Paid Amount) $102.45 = (Calculated Medicaid allowable) $53.34 Second payment method option: Coinsurance and deductible = $209.13
    - Medicaid will pay the lesser of the Medicaid payment methodology or the coinsurance and deductible
    - This procedure code would pay $53.34 since it is less than $209.13

> If the method for Medicaid non-covered services results in a Medicaid payment of $0.00 and the claim contains lines billed for physician-administered pharmaceuticals, the line will pay out at $0.01.

5.4.3 Coinsurance and Deductible

For Members on the QMB plan, CMS guidelines indicate that coinsurance and deductible amounts (Medicare cost sharing) remaining after Medicare pays cannot be billed to the Member under any circumstances, regardless of whether the Provider billed Medicaid or not.

For Members on other plans who are dual eligible, coinsurance and deductible amounts remaining after Medicare payment cannot be billed to the Member if the claim was billed to Wyoming Medicaid, regardless of payment amount (including claims that Medicaid pays at $0.00).

If the claim is not billed to Wyoming Medicaid, and the Provider agrees in writing prior to providing the service not to accept the Member as a Medicaid Member and advises the Member of their financial responsibility, and the Member is not on a QMB plan, then the Member can be billed for the coinsurance and deductible under Medicare guidelines.

Chapter 6 – Important Information

6.1 Claims Review

The WSH is committed to paying claims as quickly as possible. Claims are processed using an automated claims adjudication system. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims that it cannot detect. For this reason, payment of a claim does not mean the service was correctly billed or the payment made to the Provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the WSH later discovers the service was incorrectly billed or paid, or the claim was erroneous in some other way, the WSH is required to recover any overpayment, regardless of whether the incorrect payment was the result of WSH, fiscal agent, Provider error or other cause.

6.2 Coding

****IMPORTANT**

Standard use of medical coding conventions is required when billing the WSH. The following suggestions may help reduce coding errors and unnecessary claim denials:

- **Inpatient services – for inpatient days, use revenue code 0919 with the appropriate inpatient bill type**
- **Outpatient/ER/Observation services – claims should be completed in accordance with routine outpatient claim coding and the appropriate outpatient/ER/Observation bill type**
- **Professional services – should be billed on the CMS 1500 claim form in accordance with standard CPT/HCPCS coding guidelines**
- Use current CPT-4, HCPCS Level II, and ICD-10-CM coding books.
- For claims that have dates of service spanning across the ICD-10 implementation date (10/1/15):
    - **Outpatient claims –** use diagnosis codes based on the FIRST (1st) date of service
    - **Inpatient claims:** use diagnosis codes based on the LAST date of service
- Use the current version of the NUBC Official UB Data Specifications Manual.
- Always read the complete description and guidelines in the coding books.
- Relying on short descriptions can result in inappropriate billing.
- Attend coding classes offered by certified coding specialists.
- Use the correct unit of measurement. In general, the WSH follows the definitions in the CPT-4 and HCPCS Level II coding books. One (1) unit may equal “one (1) visit” or “15 minutes”. Always check the long version of the code description.
- Effective April 1, 2011, the National Correct Coding Initiative (NCCI) methodologies were incorporated into Medicaid’s claim processing system comply with federal requirements. The methodologies apply to both CPT Level I and HCPCS Level II codes.

Wyoming Medicaid is required to comply with the coding restrictions under the National Correct Coding Initiative (NCCI) and Providers should be familiar with the NCCI billing guidelines. NCCI information can be reviewed at:

http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Coding denials cannot be billed to the Member but can be reconsidered per Wyoming Medicaid Rules, Chapter 16. For the complete appeal process, *see Section 2.3.2 How to Appeal* of the *Institutional Provider Manual* located on the Medicaid website.

6.3 Importance of Fee Schedules

For eligible Title 25 Members, the maximum allowable per diem reimbursement rate for inpatient services provided is $610 per day. This rate is an all-inclusive rate for the facility. **For billing of all eligible inpatient days, use revenue code 0919 for payment of the per diem.**

All outpatient, ER, and observation services will be priced and reimbursed according to Medicaid's OPPS methodology.

All professional services for eligible dates of service will be paid according to the Medicaid fee schedule rate in place on the claim date of service. Fee schedules list Medicaid covered codes, provide clarification of indicators such as whether a code requires prior authorization and the number of days in which follow-up procedures are included. Not all codes are covered by Medicaid or are allowed for all taxonomy codes (Provider types). It is the Provider's responsibility to verify this information. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service. The WSH complies with the coding restrictions under the National Correct Coding Initiative (NCCI) and Providers should be familiar with the NCCI billing guidelines. NCCI information can be reviewed at:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/indes.html.

Chapter 7 – Critical Access Hospital and General Hospital Inpatient

7.1 General Coverage Principles and Definitions

The WSH reimburses for inpatient psychiatric and medical hospital services when they are directly related to an emergency detention or involuntary hospitalization.

7.1.1 Critical Access Hospital

A hospital that meets the following CMS criteria:

- Is located in a state that has established with CMS a Medicare rural hospital flexibility program; and
- Has been designated by the state as a Critical Access Hospital (CAH); and
- Is currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the ten (10) year period from November 29, 1989 to November 29, 1999; or is a health clinic or health center that was downsized from a hospital
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary road available, the mileage criterion is 15-miles)
- Maintains no more than 25 inpatient beds
- Maintains an annual average length of stay of 96 hours per patient for acute inpatient care
- Complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services seven (7) days per week.

7.1.2 General Acute Care Hospital

This is a hospital that is certified with CMS as a hospital but not a Critical Access Hospital, to provide inpatient and outpatient services.

7.1.3 Psychiatric Hospital

These are hospitals which specialize in the treatment of serious mental illnesses and have been certified by Medicare as a Psychiatric Hospital.

7.1.4 Inpatient Services

Inpatient Services are those services for which the Title 25 Member was determined to be mentally ill and admitted as an inpatient to the hospital facility, regardless of the length of stay.

- Inpatient hospital services are covered pursuant to written orders by a physician or staff under the supervision of a physician or other appropriate practitioner.

- Services are considered inpatient services when the patient is admitted as an inpatient to the facility, regardless of the hour of admission, whether or not a bed is used and whether or not the patient remained in the hospital past midnight.

7.1.5 Acute Psychiatric Admissions Requirement

Inpatient psychiatric admission requirements for the stabilization of acute conditions are covered when the following medical necessity is met:

- The Member must have been diagnosed with a psychiatric illness by a licensed mental health professional.
- Symptoms of the illness must be in accord with those described in the Diagnostic Statistical Manual of Mental Disorders, Edition V (DSM-V).
- Evidence of the following must be present:
    - **"Mentally ill" (Wyo. Stat. § 25-10-101 (ix)):** means a physical, emotional, mental or behavioral disorder which causes a person to be dangerous to themselves or others and which requires treatment, but does not include addiction to drugs or alcohol, drug or alcohol intoxication or developmental disabilities, except when one (1) or more of those conditions co-occurs as a secondary diagnosis with a mental illness.
    - **"Dangerous to themselves or others" (Wyo. Stat. § 25-10-101 (ii)):** means that, as a result of mental illness, a person:
        - Evidences a substantial probability of physical harm to themselves as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm; or
        - Evidences a substantial probability of physical harm to other individuals as manifested by a recent overt homicidal act, attempt or threat or other violent act, attempt or threat which places others in reasonable fear of serious physical harm to them; or
        - Evidences behavior manifested by recent acts or omissions that, due to mental illness, they are unable to satisfy basic needs for nourishment, essential medical care, shelter or safety so that a substantial probability exists that death, serious physical injury, serious physical debilitation, serious mental debilitation, destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition or serious physical disease will imminently ensue, unless the individual receives prompt and adequate treatment for this mental illness. No person, however, shall be deemed to be unable to satisfy their needs for nourishment, essential medical care, shelter, or safety if they are able to satisfy those needs with the supervision and assistance of others who are willing and available.

7.2 Inpatient Billing Guidelines

7.2.1 Outpatient Services Followed by Inpatient Services

When a Member is initially seen in an outpatient setting and later admitted as an inpatient of the same facility within 24 hours of the outpatient services, the services must be combined and billed as one (1) claim. The outpatient services will be considered part of the inpatient stay and will not be reimbursed separately.

- Coverage period (FL 6) for the claim must be the date the WSH became liable for payment through the discharge date (if the entire admission was involuntary). If at any time during the inpatient stay, the Member transitions from involuntary to voluntary, the WSH will not pay for voluntary days.
    - Services cannot be billed until after expiration of the initial 72-hour detention period unless the Member is a non-resident of the State.
    - The Wyoming State Hospital calculates the expiration of county financial responsibility exactly 72 hours after the time of the initial detention. The Wyoming State Hospital will exclude all weekends and legal holidays in this calculation. For example, if a Member is detained at 8:00am on Friday morning, the 72-hour period would expire on the following Wednesday at 8:00am.
- The admit date (FL 12) must be the date the Member was admitted to inpatient services.
- All outpatient services should be included on the claim, using the correct dates of service.
- The outpatient services will be considered in the per diem reimbursement calculations.

Value codes and your accommodation units must total the number of days within the coverage period.

- According to the NUBC Official UB Data Specifications Manual and Medicare guidance, the "admission date" and "from" dates are not required to match however, when the number in FLs 18-41 is added to the number of days represented in the covered days, the sum must equal the total number of days reflected in the statement covers period field. (FL 6). Use of value code 81 (non-covered days) to account for outpatient days will satisfy this requirement.

7.2.2 Claim Coding

****IMPORTANT**

- Valid diagnosis codes are required. All diagnosis codes will be validated against the current ICD coding book for the dates of service on the claim.

> Diagnosis codes must be valid for the date of discharge on the claim. Claims processing is based on codes and policy effective for the date of discharge.

- All inpatient claims must have a complete and valid admit hour, admit type, admit source, and discharge hour.
- Inpatient claims field 18-21 (Admit hour, admit type, admit source, and discharge hour) must be complete and valid.
- As the per diem is based on the days of service, the claim will be reimbursed as a whole; however, each line item will be edited for validity. Any error on a line item may cause the whole claim to deny.
- **For billing of all eligible inpatient days, use revenue code 0919 for payment of the per diem.**
- **Inpatient services – for inpatient days, use revenue code 0919 with the appropriate inpatient bill type**
- **Outpatient/ER/Observation services – claims should be completed in accordance with routine outpatient claim coding (procedure and revenue codes) and the appropriate outpatient/ER/Observation bill type**
- **Professional services – should be billed on the CMS 1500 claim form in accordance with standard CPT/HCPCS coding guidelines**

7.3 Billing Examples

7.3.1 Standard Claims

Example 1 – Members with no Medicaid eligibility (T25 eligible only), AND no approved PA, AND age 22-64:

Coverage Period	Revenue Code	Discharged
7/4/2020 – 8/27/2020	0919 – 54 Units	Yes

Example 2 – Members with Medicaid eligibility AND an approved PA (Medicaid and T26 eligible) AND 21 and under, or 65 and over:

Coverage Period	Revenue Code	PA Effective Dates	Discharged
8/31/2020 – 10/3/2020	0124 – 33 Units	8/31/2020 – 10/8/2020	Yes

7.3.2 Medicare Crossover Claims

When Medicare only covers part of the Member's stay:

Coverage Period	Revenue Code	PA Effective Dates	Discharged
8/19/2020 – 9/11/2020	0919 – 17 Units	8/31/2020 – 10/8/2020	Yes

Services not covered by Medicare should be billed using the following steps:

8. Bill to Medicare as normal.
9. Receive denial from Medicaid.
10. Bill to Medicaid as a straight Medicaid claim with the Medicare paid dates entered as non-covered using Value Code 81.
    a. DO NOT include Medicare payment amounts on the claim.
    b. Attach the Medicare EOB to the claim as documentation.
11. Receive denial from Medicaid.
12. Appeal the denial with an explanation that Medicare did not cover the entire stay and that only the remaining portion is being billed.

7.3.3 Claims Requiring Prior Authorization (Member Eligibility - Medicaid and T26)

Services that require prior authorization (PA) must be billed with an approved PA number on the claim. However, the PA effective dates must match the coverage period of the claim. If the effective dates on the PA do not match, contact Telligen (*see Section 2.1* Quick Reference) for questions and corrections.

Example 1:

PA Information

PA Effective Dates	PA Approved Dates	PA Denied Dates
1/8/2020 – 1/16/2020	1/8/2020 – 1/14/2020	1/15/2020

Claim Information

Coverage Period	Discharged	Non-Covered Days	Revenue Code
1/8/2020 – 1/16/2020	Transferred 1/16/2020	1 – 1/15/2020	0124 – 7 units

Chapter 8 – Covered Services – Ambulance

8.1 Ambulance Overview

The Wyoming State Hospital will reimburse for certain Title 25 transportation expenses incurred in order to transfer or discharge patients to another location. Before arranging patient transportation and submitting claims to the Wyoming State Hospital, a Provider must first contact the Wyoming State Hospital to arrange for Member transportation using the Wyoming State Hospital's transportation resources. If transportation cannot be provided, it is the Provider's responsibility to arrange for the transportation of the Member, as necessary and appropriate. Providers should call the Wyoming State Hospital at 307-789-3464 and ask for the Security Manager or the Admissions Coordinator.

After confirming that transportation is not able to be provided by the Wyoming State Hospital, the Provider may enroll (HHS Technology Group, Provider Enrollment vendor, *see Section 2.1* Quick Reference) as a Provider (if not already) and submit claims for reimbursement of transportation expenses, as outlined in this manual, for reimbursement of transportation expenses. Claims will be paid per department rules and at the corresponding Medicaid rates.

This applies to Title 25 Members who are not enrolled and active in another Wyoming Medicaid Benefit Plan.

8.2 Ambulance Services

Procedure Code Range: **A0380-A0436**

Ambulance Providers are independent ambulances or hospital-based ambulances.

Medicaid covers ambulance transports, with medical intervention, by ground to the nearest **appropriate facility.**

An **appropriate facility** is considered an institution generally equipped to provide the required treatment for the illness or injury involved.

Each ambulance service provided to a Member (transport) **must be medically necessary** for all ages to be covered by Medicaid.

Ambulance Services must be billed using the CMS-1500 claim form and must follow the policy defined below for those programs. Refer to CMS-1500 Provider Manual located on the Medicaid website.

Medicare crossover claims must be billed using the UB-04/Institutional claim form.

8.3 Covered Services

****IMPORTANT**

8.3.1 Emergency Transportation

Medicaid covers emergency transportation by either Basic Life Support or Advanced Life Support ambulance under the following conditions:

- A medical emergency exists in that the use of any other method of transportation could endanger the health of the patient; and
- The patient is transported to the nearest facility capable of meeting the patient's medical needs; and
- The destination is an acute care hospital or psychiatric hospital where the patient is admitted as inpatient or outpatient.

For purposes of this section, a medical emergency is considered to exist under any of the following circumstances:

- Restraints are required to transport the patient (often when a psychiatric diagnosis is made); or
- The Member is considered a threat to themselves or others.

8.3.2 Non-Emergency Transportation

Non-emergency transportation is covered when any other mode of transportation would endanger the health or life of a Member and at least one (1) of the following criteria is met:

- The Member is determined to be an immediate danger to themselves or others at the time of transport and is being transported from a hospital or one psychiatric facility to another.
- Trip report documentation must support the danger explicitly and must be attested to by a licensed clinical counsellor, physician, or psychiatrist. Transfer documents must be signed by a licensed clinic counselor or mental health professional, physician, or psychiatrist and indicate why the client must be transported by ambulance. A signature of transfer by a discharge planner or nurse will not be accepted.
- **If a Member is stabilized and can be transported safely by another mode of transport, an ambulance is not covered under Medicaid (flight risk or suicidal ideation in itself would not be covered).**

  Example: A trip report indicates the Reason for Transport is "suicidal ideation", but the Certificate of Transport signed by a valid physician indicates "danger to self or others" the trip would be covered but may result in denials for conflicting documentation.

- Facility to facility transportation to obtain medically necessary care unavailable at the originating facility by ambulance if it would endanger the health or life of the Member to be transported by any other method

8.3.3 Definition of Service Levels

Basic Life Support Services – Non-Emergency: Basic Life Support non-emergency services must meet one (1) of the criteria listed under Non-Emergency Transportation and the definition of Basic Life Support Services.

Advanced Life Support Services: Advanced Life Support (ALS), means treatment rendered by highly skilled personnel, including procedures such as cardiac monitoring and defibrillation, advanced airway management, intravenous therapy and/or the administration of certain medications.

Advanced Life Support Level 1 – Emergency (ALS1-emergency): This level of service is transportation by ground ambulance with provision for medically necessary supplies, oxygen, and at least one (1) ALS intervention. The ambulance and its crew must meet certification standards for ALS care. An ALS intervention refers to the provision of care outside the scope of an EMT-basic and must be medically necessary (for example, medically necessary EKG monitoring, drug administration, and so on) An ALS assessment does not necessarily result in a determination that the Member requires an ALS level of service.

Advanced Life Support Level 1 – Non-Emergent (ALS1 non-emergent): This level of service is the same as ALS1-emergency but in non-emergent circumstances.

Advanced Life Support Level 2 (ALS2): Covered for the provision of medically necessary supplies and services including:

- At least three (3) separate administrations of one (1) or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids)

8.4 Disposable Supplies

Medicaid covers disposable and non-reusable supplies such as gauze and dressings, defibrillation supplies, and IV drug therapy disposable supplies. When medically necessary, each service is allowed to be billed up to five (5) units.

8.5 Oxygen and Oxygen Supplies

Medicaid covers oxygen and related disposable supplies only when the Member's condition at the time of transport requires oxygen. Medicaid does not cover oxygen when it is provided only on the basis of protocol.

8.6 Mileage

Although mileage may be billed in addition to the base rate for ground transport, it is only paid for loaded miles (Member on board) from pickup to destination.

Loaded mileage is covered in addition to the base rate for all air transports.

Mileage must be medically necessary, which means that mileage should equal the shortest route to the nearest appropriate facility. Exceptions may occur such as road construction or weather.

When billing for mileage, one (1) unit is equal to one (1) statute (map) mile for both air and ground transport. Mileage must be rounded to the nearest mile.

Rounding Rules:

- 1.49 miles or less will be rounded down to one (1) unit or mile
- 1.5 miles and above will be rounded up to the next mile, for two (2) units or miles

Example: Mileage on WATRS report 20.6 miles, round up to 21 miles or units for billing.

8.7 Non-Covered Services

Medicaid does not reimburse for the following ambulance services:

- Transportation to receive services that are not covered services
- No-load trips and unloaded mileage (when no patient is aboard the ambulance), including transportation of life-support equipment in response to an emergency call
- Transportation of a Member who is pronounced dead before an ambulance is called
- When a Member is pronounced dead after an ambulance is called but before transport
- Transportation of a family member or friend to visit a Member or consult with the Member's physician or other Provider of medical services
- Transportation to pick up pharmaceuticals
- Air ambulance services to transport a Member from a hospital capable of treating the Member to another hospital because the Member or family prefers a specific hospital or practitioner
- Transportation of a Member in response to detention ordered by a court or law enforcement agency (if within the first 72 hours)
- Transportation based on a physician's standing orders
- Stand-by time
- Special attendants
- Specialty Care Transport (SCT)
- Paramedic Intercept (PI)

- When a Member has been stabilized and can be transported by another mode of transportation
- When a Member can be transported by a mode other than ambulance without endangering the Member's health, regardless of whether other transportation is available
- If a Member is an inpatient at a hospital, Medicaid does not pay separately for round trip ambulance transport for an outpatient service (for example, x-ray or other procedure) at a different hospital. This type of transport is included in the Medicaid payment to the hospital for the inpatient stay.
- Transports related to Emergency/Involuntary Detainment/Title 25 unless a Title 25 Member has been placed on the Title 25 program or is Medicaid eligible.

8.8 Multiple Member Transportation

When more than one (1) Member is transported during the same trip, Medicaid will cover one (1) base rate and one (1) mileage charge per transport, not per Member. Medicaid will reimburse for each Member's supplies and oxygen.

8.9 Usual and Customary Charge

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that would be billed to other payers for that service.

8.10 Billing Requirements

The following are the procedure codes accepted for ambulance services:

Procedure Code	Description
GROUND*/Advanced Life Support (ALS)*	
A0390	ALS mileage (per mile)
A0398	ALS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0433	Advanced life support, level 2 (ALS 2)

Wyoming Medicaid does not require a separate trip report provided the request for service has been entered appropriately into the Wyoming Ambulance Trip Reporting System https://health.wyo.gov/publichealth/ems/ems-program-2/watrs/, and marked appropriately for Wyoming Medicaid to review.

For Wyoming Medicaid to be able to view the report, EMS Providers or billing agents must select either the "Primary Method of Payment" or "Insurance Company Name" as Wyoming Medicaid. Both of these data elements are in the Billing section of WATRS. Failure to select the proper data element will prohibit Wyoming Medicaid staff from being able to review the entered information, and claims will be denied for not having a Trip Report.

Wyoming Medicaid will no longer accept paper trip reports for any billed claim and will only review the data entered into WATRS. Please see the Rules and Regulations for Wyoming Emergency Medical Services W.S. 33-36-101 through -115 Chapter 4, Section 4 for reporting requirements.

The WATRS reporting requirements apply if:

- The call originates in Wyoming (for example, Wyoming – Any destination)
- If the ambulance itself starts in Wyoming, goes somewhere out of state and comes back to Wyoming. (for example, Wyoming - Denver - Wyoming)
- If the ambulance itself starts in Wyoming, goes somewhere out of state and ends out of state. (for example, Wyoming - Denver - Salt Lake)
- If the ambulance itself starts in a state other than Wyoming but comes into Wyoming and drops off a patient in Wyoming and is licensed in the state of Wyoming. (for example, Utah - Wyoming)

> A Provider must attest that all information on the WATRS Trip Report is true, accurate, and, complete to the best of their knowledge. Not signing the attestation will result in non-payment of claims.

Exceptions to submitting a trip report via WATRS:

- Transports that do not touch ground in Wyoming at any point
- An out-of-state ambulance service that only transports a patient from out of state to a Wyoming destination and is not required to be licensed in the state of Wyoming (Provider has license in another state)

If submitting a paper trip report, the claim should be submitted through the usual electronic billing method, and the claim should indicate that an attachment will be coming and by what method: electronic or mail (*see Section 4.8* Submitting Attachments for Electronic Claims).

The paper trip report must include the following:

- Documentation in the narrative to support the level of service billed (ALS/BLS, Emergent/ Non-Emergent, and if air transport rotary/fixed wing)

- Documentation in the narrative to support the medical necessity of the transport
- Documentation in the narrative of the use and medical necessity of any supplies
- Documentation in the narrative of the use and medical necessity of any oxygen
- Documentation of the patient loaded miles (must match the number of units billed on the claim)

8.11 Community Emergency Medical Services

Community Emergency Medical Services (CEMS) provided by CEMS programs and their employed EMTs and Paramedics will be covered.

Employed EMTs and Paramedics must have completed the required training programs and have been endorsed as CEMS Providers by the Office of Emergency Medical Services

8.11.1 Enrollment

Providers must enroll with Wyoming Medicaid as a CEMS Provider group to receive reimbursement, even if the Provider is currently enrolled and active with Wyoming Medicaid as an ambulance Provider. Providers will need to enroll under the Provider type of Emergency Medical Technician (EMT) for the pay-to/group (Ambulance Agency) and then also enroll each endorsed EMT and Paramedic as Members of this group.

8.11.1.1 Community Emergency Medical Services Group Enrollment

When completing the group enrollment, in the Taxonomy Category, select “Transportation Services” from the drop-down, and select Taxonomy Description "146N00000X - Emergency Medical Technician (EMT)".

8.11.1.2 Emergency Medical Technician or Paramedic Individual or Treating Enrollment

When completing the enrollment for individual Emergency Medical Technicians (EMT) and Paramedics, in the Taxonomy Category, select “Transportation Services” from the drop-down list and select Taxonomy Description “146N00000X - Emergency Medical Technician (EMT)" ***or*** "146L00000X - Paramedic" as appropriate.

For each enrollment, the Ambulance Business, EMT, or Paramedic license with the CEMS endorsement is required with the supplemental documents.

8.11.2 Covered Services

8.11.2.1 Community Emergency Medical Services – Technician

Wyoming Medicaid will reimburse for services provided in a "treat and release" or "treat and refer" situation in response to a call for service. Covered services include:

- Appropriately treating and releasing Members, rather than providing transportation to a hospital or emergency department
- Treating and transporting Members to appropriate destinations other than a hospital or an emergency department
- Treatment and referral to a primary care or urgent care facility
- Assessment of the Member and reporting to a primary care Provider to determine an appropriate course of action

A trip report must be entered into WATRS for these services if:

- The call originates in Wyoming and ends in Wyoming
- If the ambulance itself starts in Wyoming, goes somewhere out of state and comes back to Wyoming
- If the ambulance itself starts in Wyoming, goes somewhere out of state and ends out of state
- If the ambulance itself starts in a state other than Wyoming, but comes into Wyoming and drops off a patient in Wyoming

8.11.2.2 Community Emergency Medical Services – Clinician

Wyoming Medicaid will reimburse for services provided as part of a plan of care established with the directing physician and must be:

- Within the scope of practice for the license held by the Community Emergency Medical Services – Clinician (CEMS-C) Provider
- Provided under the direct written or verbal order of a physician
- Coordinated with care received by the Member from other community Providers in order to prevent duplication of services
- Identified in a written, well documented plan of care, which may include:
    - Health assessments
    - Chronic disease monitoring and education
    - Medication compliance
    - Immunizations and vaccinations

- Laboratory specimen collection
- Hospital discharge follow-up care
- Minor medical procedures

There is no WATRS documentation requirement for CEMS-C services as WATRS does not contain the ability for a Provider to report care provided outside of a call for service. Documentation of services provided, physician's orders, and the plan of care shall be kept in the Member's comprehensive medical record maintained by the ambulance agency and supplied to the Department upon request.

8.11.3 Billing Requirements

CEMS Services	
Procedure Code	**Description**
A0998	CEMS-T Services – Ambulance Response & Treatment, No Transport
99600	CEMS-C Services – Unlisted Home Visit Service or Procedure

Chapter 9 – Covered Services – Non-Emergency Medical Transportation

9.1 Non-Emergency Medical Transportation Overview

The Wyoming State Hospital will reimburse for certain Title 25 transportation expenses incurred to transfer or discharge Members to another location. Before arranging Member transportation and submitting claims to the Wyoming State Hospital, a Provider must first contact the Wyoming State Hospital to arrange for Member transportation using the Wyoming State Hospital's transportation resources. If transportation cannot be provided, it is the Provider's responsibility to arrange for the transportation of the Member, as necessary and appropriate. Providers should call the Wyoming State Hospital at 307-789-3464 and ask for the Security Manager or the Admissions Coordinator.

After confirming that transportation is not able to be provided by the Wyoming State Hospital, the Provider may enroll (HHS Technology Group, Provider Enrollment vendor, *see Section 2.1* Quick Reference) as a Provider (if not already) and submit claims for reimbursement of transportation expenses, as outlined in this manual, for reimbursement of transportation expenses. Claims will be paid per department rules and at the corresponding Medicaid rates.

This applies to Title 25 Members who are not enrolled and active in another Wyoming Medicaid Benefit Plan.

9.2 Non-Emergency Medical Transportation

WSH provides non-emergency medical transportation (NEMT) services to Members who need assistance traveling to and from medical appointments to enrolled Providers to obtain covered services.

WSH enrolls taxi providers (344600000X) and non-taxi ride providers (347C00000X) to provide covered services.

9.3 Covered Services

9.3.1 Taxi and Non-Taxi Rides

- Covered for adults and children
- Member must initiate the ride by contacting the Customer Service Center and select the travel request option.
- The Member will contact Ride Provider once the ride is approved
- If the ride is approved a Prior Authorization (PA) number will be generated for the Provider. The Provider will retrieve the PA number from the Provider Portal and enter it on the claim (*see Section 6.13.2 Prior Authorization Status Inquiry* of the *CMS-1500 Provider Manual* located on the Medicaid website).

9.4 Billing Information

9.4.1 Taxi Rides

Procedure Codes: **A0100, S0215**

- Taxi Provider must receive prior authorization for the taxi ride
- Bill procedure code A0100 – Base Rate – 1 unit for each one-way trip
- Bill procedure code S0215 – mileage for each mile or part of a mile
- Mileage is always rounded up. Example: 5.2 miles would be billed as 6 miles
- Bill with the PA number associated with the ride
- Mileage without the Member on board is not eligible for billing
- Wait time is not a covered service
- No show or late Members are not a covered service; however, they should be reported to Provider Services (*see Section 2.1* Quick Reference)
- All rides billed are subject to post payment review and as such records should be kept with detail including:
    - Prior Authorization
    - Prior Authorization number
    - Member information
    - Date and time of pick-up
    - Pick up address
    - Destination address
    - Total mileage
    - Total charge

> Providers cannot span bill for dates. All services (rides) with different dates of service must be billed on separate lines.

9.4.2 Non-Taxi Rides

Procedure Codes: **A0110, A0080**

- Ride Provider must receive prior authorization for the ride
- Bill with the PA number associated with the ride
- Bill procedure code A0110 – Base Rate – 1 unit for each one-way trip

- Bill procedure code A0080 – mileage for each mile or part of a mile above 15 miles
    - Mileage is always rounded up
        - Example – A trip of 23.2 miles would be billed with code A0110 as the base rate (1 unit) and A0080 for the mileage (9 units: 23.2 miles - 15 base miles = 8.2 miles, round up to 9 miles = 9 units)

> The first 15 miles are INCLUDED with the base rate and are not billed.

- Mileage without the Member on board is not eligible for billing
- Wait time is not a covered service
- No show or late Members are not a covered service; however, they should be reported to Provider Services (*see Section 2.1* Quick Reference)
- All rides billed are subject to post payment review and as such records should be kept with detail including:
    - Prior Authorization
    - Prior Authorization number
    - Member information
    - Date and time of pick up
    - Pick up address
    - Destination address
    - Total mileage
    - Total charge

> Providers cannot span bill for dates. All services (rides) with different dates of service must be billed on separate lines.

Appendices

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Appendix A – Change Control Table

Table 1 provides detailed changes made to this version of the WY BMS Title 25.

Table 1. Change Control Table

Effective Date	Changes
01/01/2026	**Chapter 1 – General Information** 1.2 Updating the Manual: Updated the email address for WY Provider Services.
	Chapter 2 – Getting Help When Needed 2.1 Quick Reference: Updated email address for Communicable Treatment Disease Program. Updated postal address for HMS. Removed MCH/CSH row. Removed link to IVR Navigation Tips from Provider Services.
	Chapter 3 – Provider Responsibilities 3.2.5 Submitting Required Title 25 Documentation: Replaced contact from Justin Browning to Samantha Robbins, Behavioral Health Program Manager. Added bullet for "Copy of Title 25 Discharge Date Certification."
	Chapter 4 – Common Billing Information 4.8.1 Remittance Advice Organization: Updated detail for Summary Page, Detail Pages, and Glossary Page. 4.8.2 Remittance Advice General Information and Definitions: Removed reference to PPS column. Added reference to Recovery Check Number column. Removed statement about original TCN being reported once per invoice. Updated location where Gross Adjustment report are reported. Added reference to Check Applied Amount column. Removed reference to approved amount being the Medicaid allowed amount or paid amount. Removed reference to Category column. 4.8.5 Remittance Advice Glossary: New Section. 4.8.6 Sample Remittance Advice and How to Read the Remittance Advice: Removed "s" from "Advices" in section title. 4.8.6.1 Sample Cover Page (First Page): Replaced image of sample cover page. Added Banner Message to table of Cover Page Field Names. 4.8.6.2 Sample Summary Page: Updated section title to Sample Summary Page. Replaced image of sample summary page. Changed table intro to Interpreting the Summary Page and changed the Notes column of the table to the Field Description column. Updated Field Descriptions table. 4.8.6.3 Sample Detail Pages: Updated section title to Sample Detail Pages. Replaced screenshot and note. 4.8.6.3.1 Sample Detail – Paid Claims Status: NEW Section. 4.8.6.3.2 Sample Detail – Credited Claims Status: NEW Section.

Effective Date	Changes
	4.8.6.3.3 **Sample Detail – Denied Claims Status**: NEW Section. 4.8.6.3.4 Interpreting the Detail Pages: NEW Section. 4.8.6.4 Sample Remittance Advice (Detail Page) with a Denied Claim: REMOVED Section. 4.8.6.4 Sample Glossary: NEW Section. 4.8.6.5 Sample Error Code Details with Associated Claim Adjustment Reason Codes and Remittance Advice Remark Codes: REMOVED Section. 4.8.6.6 Sample Remittance Advice (Summary and Detail Pages) with a Void Claim: REMOVED Section. 4.8.6.7 Sample Remittance Advice (Summary and Detail Pages) with a Paid and Denied Claim: REMOVED Section. 4.8.6.8 Sample Remittance Advice (Detail Page) with an Adjustment and Void Claim: REMOVED Section. 4.9.3 Adjusting or Voiding Paid Claims: Under When to Request an Adjustment, removed "if the payment is less than 67% of the calculated Medicaid allowed amount" from statement to attach a corrected claim showing insurance payment and attach a copy of the insurance EOB.
	Chapter 5 – Third Party Liability 5.2.1 Third Party Resources Information Sheet: Replaced screenshot with updated form.
	Appendix B – Provider Notifications Log: Updated.

Appendix B – Provider Notifications Log

Provider Notifications Log
No bulletins were published to be included in this quarterly release. Therefore, there are no bulletin assemblies included within the Provider Manual during this update.