WY BMS Dental Provider Manual

Prepared for:

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

Wyoming Department of Health

Prepared by:

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Acentra HEALTH

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Security: N = No Restriction

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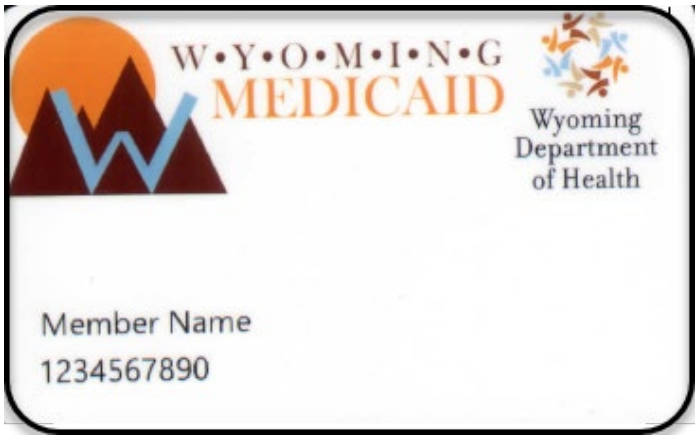
Revision History

Revision Level	Date	Description	Change Summary
Version 0.1	5/12/2021	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 Jul 2023 quarterly updates from Agency.
Version 8.0	10/02/2023	Ninth 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 the Agency.
Version 10.0	04/01/2024	Eleventh Full Submission	Revisions based on Apr 2024 quarterly updates from the Agency.



Overview

Thank you for your willingness to serve Members of the Medicaid Program and other medical assistance programs administered by the Division of Healthcare Financing. This manual supersedes all prior versions.

Rule References

Providers must be familiar with all current rules and regulations governing the Medicaid Program. Provider manuals are to assist Providers with billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are only a reference tool. They are not a summary of the entire rule. In the event that the manual conflicts with a rule, the rule prevails. Wyoming State 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, CDT, 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

The Provider manuals are 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).

Medicaid manuals, bulletins, fee schedules, forms, and other resources are available on the Medicaid website or by contacting Provider Services.

Authority

The Wyoming Department of Health is the single state agency appointed as required in the Code of Federal Regulations (CFR) to comply with the Social Security Act to administer the Medicaid Program in Wyoming. The Division of Healthcare Financing (DHCF) directly administers the Medicaid Program in accordance with the Social Security Act, the Wyoming Medical Assistance and Services Act, (W.S. 42-4-101 et seq.), and the Wyoming Administrative Procedure Act (W.S. 16-3-101 et seq.). Medicaid is the name chosen by the Wyoming Department of Health for its Medicaid Program.

This manual is intended to be a guide for Providers when filing medical claims with Medicaid. The manual is to be read and interpreted in conjunction with Federal regulations, State statutes, administrative procedures, and Federally approved State Plan and approved amendments. This manual does not take precedence over Federal regulation, State statutes or administrative procedures.

Table of Contents

Chapter 1 – General Information

1.1 How the Dental Manual is Organized

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

Chapter	Description
Two	**Getting Help When Needed** – Quick Reference guide, telephone numbers and 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	**Utilization Review** – Fraud and abuse definitions, the review process, and rights and responsibilities.
Five	**Member Eligibility** – How to verify eligibility when a Member presents their Medicaid card
Six	**Common Billing Information** – Basic claim information, completing the claim form, authorization for medical necessity requirements, co-pays, prior authorizations, timely filing, consent forms, working the Medicaid remittance advice (RA) and completing adjustments
Seven	**Third Party Liability (TPL)/Medicare** – Explains what TPL/Medicare is, how to bill it and exceptions to it.
Eight	**Electronic Data Interchange (EDI) and Provider Portal** – Explains the advantages of exchanging documents electronically and details the features of the Provider Portal, explains the web registration process, and directs trading Providers to the Wyoming Medicaid EDI Companion Guide located on the Medicaid website.
Nine	**Important Information –** This chapter covers important billing information such as coding, definitions of supervision and face-to-face visit requirements.
Ten	**Dental Covered Services** – This chapter provides information such as: definitions, procedure code ranges, documentation requirements, covered and non-covered services, and billing examples.
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 Medicaid Program, Medicaid 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 critical for Providers 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.

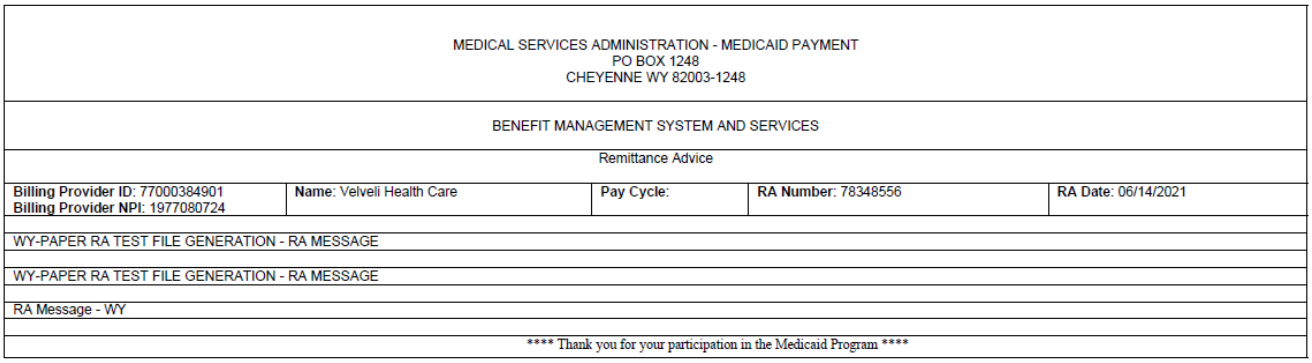
It is critical for Providers to keep their contact email address(es) up-to-date to ensure they receive all notices published by Wyoming Medicaid. It is recommended that Providers add the WYProviderServices@cns-inc.com email address, from which notices are sent, to their address books to avoid these emails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

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

1.2.1 Remittance Advice Banner Notices 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/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 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 Sample

Medicaid bulletin email notifications typically 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 Division of Healthcare Financing administers the Medicaid 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, with the exception of pharmacy. They also answer Provider inquiries regarding claim status, payments, Member eligibility, known third party insurance information and Provider training visits to train and assist the Provider office staff on Medicaid billing procedures or to resolve claims payment issues.

> Wyoming Medicaid is not responsible for the training of Providers' billing staff, providing procedure or diagnosis codes, or coding training.

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 5615 High Point Drive, #100 Irving, TX 75038	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

Maternal & Child Health (MCH) /Children Special Health (CSH) Public Health Division 122 West 25th Street 3rd Floor West Cheyenne, WY 82002	Tel (307)777-7941 Tel (800)438-5795 Fax (307)777-7215	N/A	• High Risk Maternal • Newborn intensive care • Program information
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 (IVR Navigation Tips located on the Medicaid website) Email: WYProviderOutreach@cns-inc.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) Prior Authorization **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 Write for Help

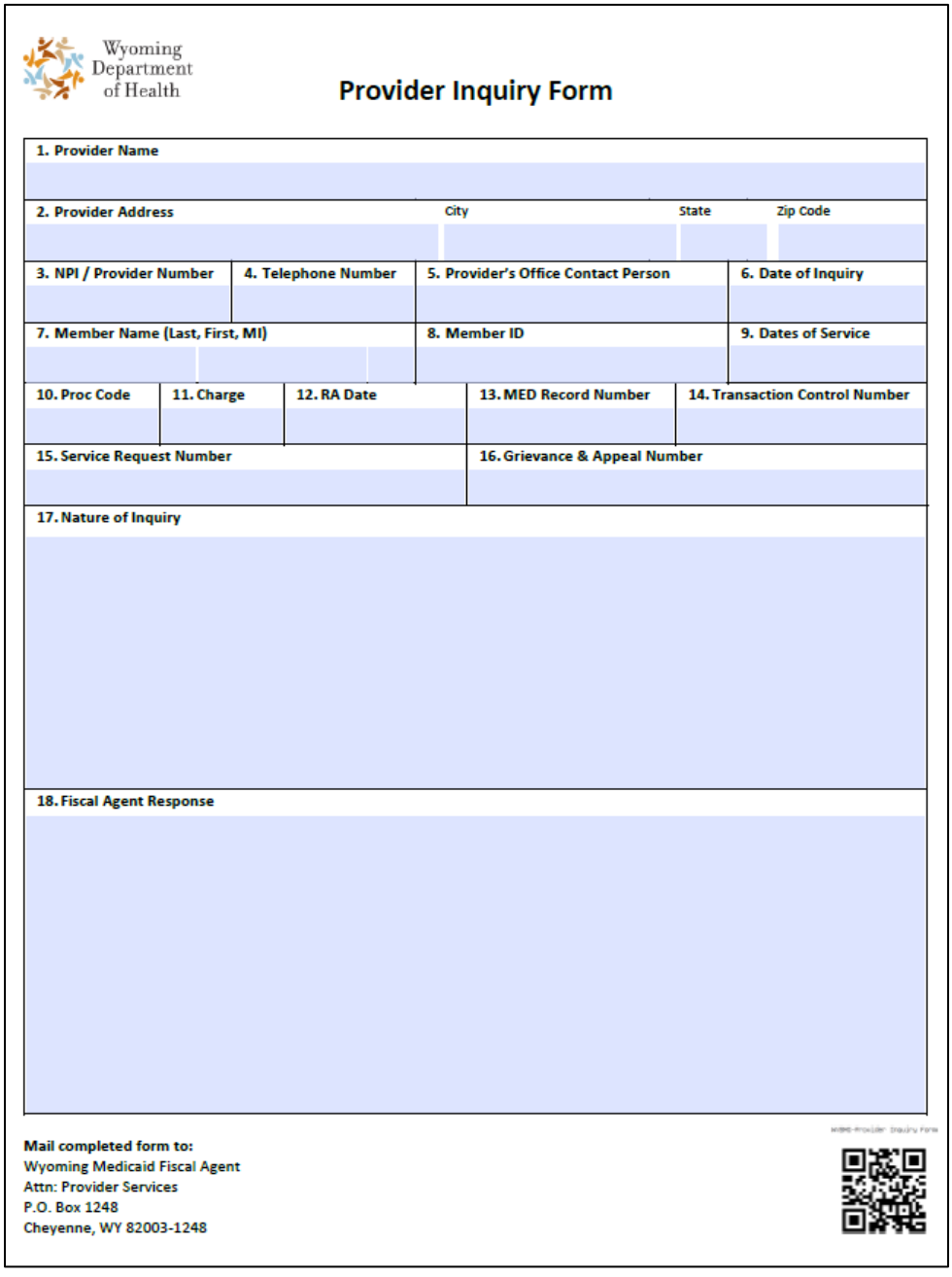
In many cases, writing for help provides the Provider with more detailed information about the Provider claims or Members. In addition, written responses may be kept as permanent records.

Reasons to write vs. calling:

- **Appeals –** Include the First Level Appeal and Grievance Request Form (see *Section 2.3.2.1*), the claim that is believed to have been denied or paid erroneously, all documentation previously submitted with the claim, an explanation for request, and documentation supporting the request.
- **Written documentation of answers –** Include all documentation to support the Provider request.
- **Rate change requests –** Include request and any documentation supporting the Provider request.
- **Requesting a service to be covered by Wyoming Medicaid –** Include request and any documentation supporting the Provider request

To expedite the handling of written inquiries, we recommend Providers use a Provider Inquiry Form (see *Section 2.3.1* Provider Inquiry Form). Providers may copy the form in this manual. Provider Services will respond to the Provider inquiry within ten (10) business days of receipt.

2.3.1 Provider Inquiry Form



Wyoming Department of Health

Provider Inquiry Form

1. Provider Name				
2. Provider Address		**City**	**State**	**Zip Code**
3. NPI / Provider Number	**4. Telephone Number**	**5. Provider's Office Contact Person**	**6. Date of Inquiry**	
7. Member Name (Last, First, MI)		**8. Member ID**	**9. Dates of Service**	
10. Proc Code	**11. Charge**	**12. RA Date**	**13. MED Record Number**	**14. Transaction Control Number**
15. Service Request Number		**16. Grievance & Appeal Number**		
17. Nature of Inquiry				
18. Fiscal Agent Response				

Mail completed form to:
Wyoming Medicaid Fiscal Agent
Attn: Provider Services
P.O. Box 1248
Cheyenne, WY 82003-1248

This form is located on the Wyoming Medicaid website.

2.3.2 How to Appeal

For timely filing appeals and instances where Third Party Liability is applied after Medicaid payment, the Provider must submit the appeal in writing to Provider Services (*see Section 2.1* Quick Reference) or via the Grievance and Appeal process on the Provider Portal, and needs to include the following:

- The First Level Appeal and Grievance Request Form (*see Section 2.3.2.1*)
- Documentation of previous claim submission (TCNs, documentation of the corrections made to the subsequent claims)
- Documentation of contact with Provider Services
- An explanation of the problem
- A clean copy of the claim, along with any required attachments and required information on the attachments. A clean claim is an error free, correctly completed claim, with all required attachments that will process and pay.

The grievance and appeal quick reference guide (QRG), *Entering and Monitoring Grievance and Appeals via the Provider Portal*, is available on the "Provider Training, Tutorials and Workshops" page on the Medicaid website.

For claims denied in error within timely filing, the Provider must submit the appeal in writing to Provider Services (*see Section 2.1* Quick Reference) These should include the following.

- The First Level Appeal and Grievance Request Form (see *Section 2.3.2.1*)
- An explanation of the problem and any desired supplementary documentation
- Documentation of previous claim submission (TCNs, documentation of the corrections made to the subsequent claims)
- Documentation of contact with Provider Services
- A clean copy of the claim, along with any required attachments and required information on the attachments. A clean claim is an error free, correctly completed claim, with all required attachments that will process and pay.

> Appeals for claims that denied appropriately or submission of attachments for denied claims 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.

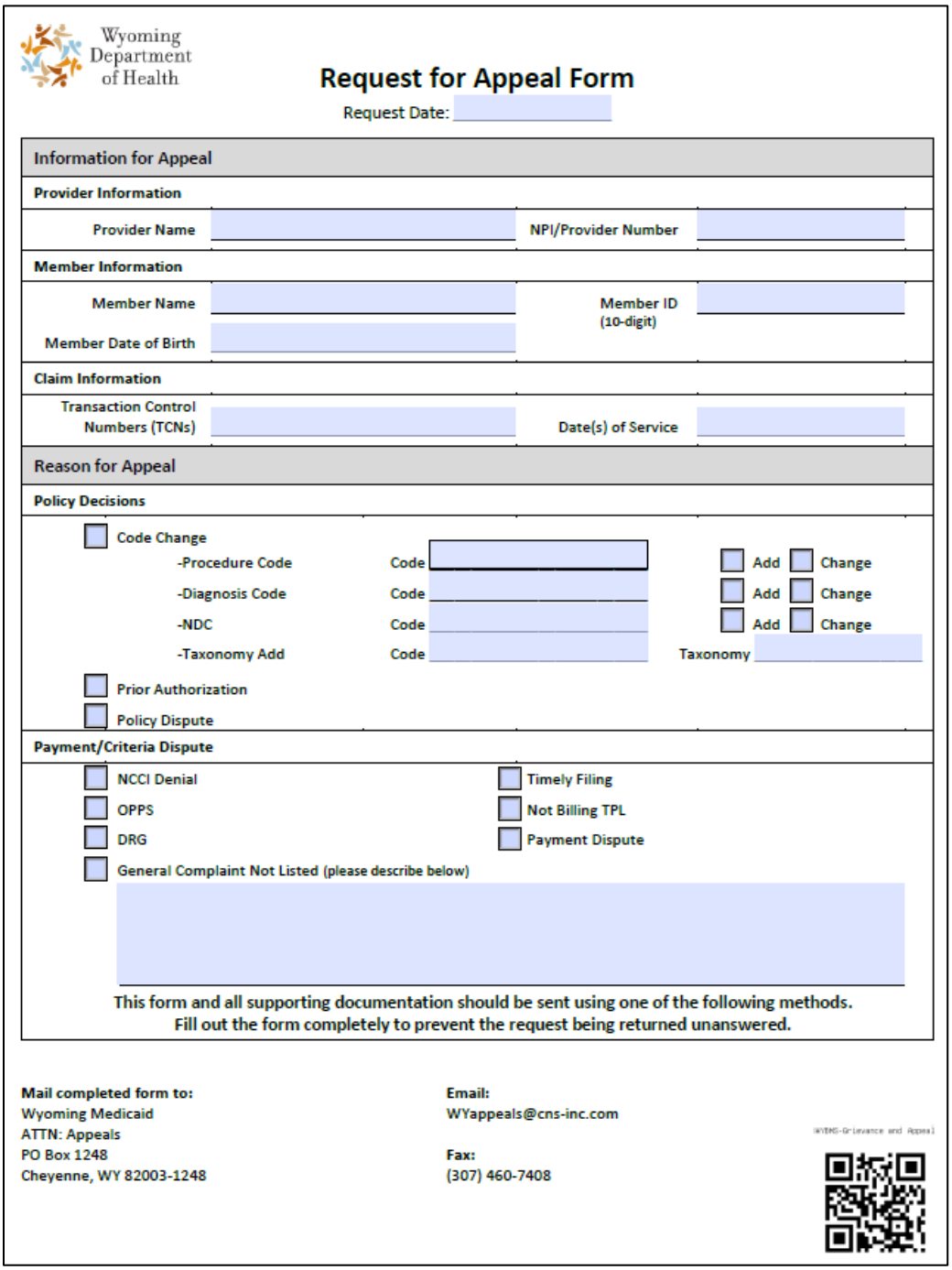
Appeals for changes to CPT, Diagnosis, and/or NDC Codes will also be sent to Provider Services for review. These requests should include ALL of the following.

- The First Level Appeal and Grievance Request Form (see *Section 2.3.2.1* First Level Appeal and Grievance Request Form)

- An explanation of the problem
- Any desired supplementary documentation
- Documentation of contact with Provider Services

If a Provider wishes to dispute an appeal decision or request second level review, follow the above processes with the Second Level Appeal and Grievance Request Form (see *Section 2.3.2.2* Second Level Appeal and Grievance Request Form) in place of the First Level Appeal and Grievance Request Form (see *Section 2.3.2.1* First Level Appeal and Grievance Request Form).

2.3.2.1 First Level Appeal and Grievance Request Form



Wyoming Department of Health

Request for Appeal Form

Request Date: _____

Information for Appeal

Provider Information

Provider Name _____ NPI/Provider Number _____

Member Information

Member Name _____ Member ID (10-digit) _____

Member Date of Birth _____

Claim Information

Transaction Control Numbers (TCNs) _____ Date(s) of Service _____

Reason for Appeal

Policy Decisions

☐ Code Change

-Procedure Code Code _____ ☐ Add ☐ Change

-Diagnosis Code Code _____ ☐ Add ☐ Change

-NDC Code _____ ☐ Add ☐ Change

-Taxonomy Add Code _____ Taxonomy _____

☐ Prior Authorization

☐ Policy Dispute

Payment/Criteria Dispute

☐ NCCI Denial ☐ Timely Filing

☐ OPPS ☐ Not Billing TPL

☐ DRG ☐ Payment Dispute

☐ General Complaint Not Listed (please describe below)

This form and all supporting documentation should be sent using one of the following methods.
Fill out the form completely to prevent the request being returned unanswered.

Mail completed form to:
Wyoming Medicaid
ATTN: Appeals
PO Box 1248
Cheyenne, WY 82003-1248

Email:
WYappeals@cns-inc.com

Fax:
(307) 460-7408

WYBMS-Grievance and Appeal

This form is located on the Wyoming Medicaid website.

2.3.2.2 Second Level Appeal and Grievance Request Form

Wyoming Department of Health

Appeal/Grievance

2nd Level Request Form

Received Date: _____ **Ref #:** _____ **Review Type:** ☐ Appeal ☐ Grievance

Review Category:

☐ Procedure Code	☐ Dx Code	☐ Taxonomy Add
☐ NCCI Denial	☐ OPPS	☐ Claim Denied per Policy
☐ PA	☐ Timely Filing	☐ Not Billing TPL
☐ Adjustment	☐ Payment Dispute	☐ General Complaint
☐ DRG		

Review Requested of:

Sending Department: ☐ Medical Policy ☐ Provider Services ☐ Claims ☐ TPL

Explanation:

Included in request:

☐ Letter from Complainant	☐ Research Documentation
☐ Medical Records	☐ Original Request
☐ Claims Attachments	☐ Original PA Request
☐ Claims History Query	☐ PA Supporting Information
☐ Call Log	☐ Other Correspondence

Mail completed form to:
Wyoming Medicaid ATTN:
Appeals
PO Box 1248
Cheyenne, WY 82003-1248

Email:
WYappeals@cns-inc.com

Fax:
(307) 460-7408

Effective 05/05/2022
Page 1 of 1

This form is located on the Wyoming Medicaid website.

2.4 How to Get a Provider Training Visit

Provider Services Field Representatives are available to train or address questions the Provider's office staff may have on Medicaid billing procedure or to resolve claims payment issues.

Provider Services Field Representatives are available to assist Providers with help in their location, by phone, or webinar with Wyoming Medicaid billing questions and issues. Generally, to assist a Provider with claims specific questions, it is best for the Field Representative to communicate via phone or webinar, as they will then have access to the systems and tools needed to review claims and policy information. Provider Training visits may be conducted when larger groups are interested in training related to Wyoming Medicaid billing. When conducted with an individual Provider's office, a Provider Training visits generally consists of a review of a Provider's claims statistics, including top reasons for denial and denial rates, and a review of important Medicaid training and resource information. Provider Training Workshops may be held during the summer months to review this information in a larger group format.

Due to the rural and frontier nature, and weather, in Wyoming visits are generally conducted during the warmer months only. For immediate assistance, a Provider should always contact Provider Services (*see Section 2.1* Quick Reference).

2.5 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 questions
- Download Forms, such as Medical Necessity, Sterilization Consent, Order vs Delivery Date Form and other forms
- Medicaid publications, such as Provider manuals and bulletins
- Payment Exception Schedule
- Primary resource for all information related to Medicaid
- 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.

2.6 Training Seminars and Presentations

The fiscal agent and the Division of Healthcare Financing may sponsor periodic training seminars at selected in-state and out-of-state locations. Providers will receive advance notice of seminars by the Medicaid bulletin email notifications, Provider bulletins or Remittance Advice (RA) banners. Provider may also check the Medicaid website for any recent seminar information.

Chapter 3 – Provider Responsibilities

3.1 Enrollment and Re-Enrollment

Medicaid payment is made only to Providers who are actively enrolled in the Medicaid Program. Providers are required to complete an enrollment application, undergo a screening process and sign a Provider Agreement at least every five (5) years. In addition, certain Provider types are required to pay an application fee and submit proof of licensure and/or certification. These requirements apply to both in state and out-of-state Providers.

Due to the screening requirements of enrollments, backdating enrollments must be handled through an appeal process. If the Provider is requesting an effective date prior to the completion of the enrollment, a letter of appeal must be submitted with proof of enrollment with Medicare or another State's Medicaid that covers the requested effective date to present.

All Providers have been assigned one (1) of three (3) categorical risk levels under the Affordable Care Act (ACA) and are required to be screened as follows:

Categorical Risk Level	Screening Requirements
LIMITED **Includes:** • Physician and non-physician practitioners, (includes nurse practitioners, CRNAs, occupational therapists, speech/language pathologist audiologists) and medical groups or clinics • Ambulatory surgical centers • Competitive Acquisition Program/Part B Vendors: • End-stage renal disease facilities • Federally Qualified Health Center (FQHC) • Histocompatibility laboratories • Hospitals, including critical access hospitals, VA hospitals, and other federally-owned hospital facilities • Health programs operated by an Indian Health program • Mammography screening centers • Mass immunization roster billers • Organ procurement organizations • Pharmacy newly enrolling or revalidating via the CMS-855B application	Verifies Provider or supplier meets all applicable Federal regulations and State requirements for the Provider or supplier type prior to making an enrollment determination Conducts license verifications, including licensure verification across State lines for physicians or non-physician practitioners and Providers and suppliers that obtain or maintain Medicare billing privileges, as a result of State licensure, including State licensure in States other than where the Provider or supplier is enrolling Conducts database checks on a pre- and post-enrollment basis to ensure that Providers and suppliers continue to meet the enrollment criteria for their Provider/supplier type.

Categorical Risk Level	Screening Requirements
• Radiation therapy centers • Religious non-medical health care institutions • Rural health clinics • Skilled nursing facilities	
MODERATE **Includes**: • Ambulance service suppliers • Community mental health centers (CMHC) • Comprehensive outpatient rehabilitation facilities (CORF) • Hospice organizations • Independent Clinical Laboratories • Independent diagnostic testing facilities • Physical therapists enrolling as individuals or as group practices • Portable X-ray suppliers • Revalidating home health agencies • Revalidating DMEPOS suppliers	Performs the "limited" screening requirements listed above Conducts an on-site visit
MODERATE **Includes**: • Ambulance service suppliers • Community mental health centers (CMHC) • Comprehensive outpatient rehabilitation facilities (CORF) • Hospice organizations • Independent Clinical Laboratories • Independent diagnostic testing facilities • Physical therapists enrolling as individuals or as group practices • Portable X-ray suppliers • Revalidating home health agencies • Revalidating DMEPOS suppliers	Performs the "limited" screening requirements listed above Conducts an on-site visit

Categorical Risk Level	Screening Requirements
HIGH **Includes**: • Prospective (newly enrolling) home health agencies • Prospective (newly enrolling) DMEPOS suppliers • Prosthetic/orthotic (newly enrolling) suppliers Individual practitioners suspected of identity theft, placed on previous payment suspension, previously excluded by the OIG, and/or previously had billing privileges denied or revoked within the last ten (10) years	Performs the "limited" and "moderate" screening requirements listed above. Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a five (5) percent or greater direct or indirect ownership interest in the Provider or supplier. Conducts a fingerprint-based criminal history record check of the FBI's Integrated Automated Fingerprint Identification System on all individuals who maintain a five (5 percent or greater direct or indirect ownership interest in the Provider or supplier Categorical Risk Adjustment: CMS adjusts the screening level from limited or moderate to high if any of the following occur: • Exclusion from Medicare by the OIG • Had billing privileges revoked by a Medicare contractor within the previous ten (10) years and is attempting to establish additional Medicare billing privilege by — ○ Enrolling as a new Provider or supplier ○ Billing privileges for a new practice location • Has been terminated or is otherwise precluded from billing Medicaid • Has been excluded from any Federal health care program • Has been subject to a final adverse action as defined in §424.502 within the previous ten (10) years

The ACA has imposed an application fee on the following institutional Providers:

- In-state only
  - Institutional Providers
  - PRTFs
  - Substance Abuse Centers (SAC)
  - Wyoming Medicaid-only nursing facilities
  - Community Mental Health Centers (CMHC)
  - Wyoming Medicaid-only home health agencies (both newly enrolling and re-enrolling)

Providers that are enrolled in Medicare, Medicaid in other states, and CHIP are only required to pay one (1) enrollment fee. Verification of the payment must be included with the enrollment application.

The application fee is required for the following:

- New enrollments
- Enrollments for new locations
- Re-enrollments
- Medicaid requested re-enrollments (as the result of inactive enrollment statuses)

The application fee is non-refundable and is adjusted annually based on the Consumer Price Index (CPI) for all urban consumers.

After a Provider's enrollment application has been approved, a welcome letter will be sent.

If an application is not approved, a notice including the reasons for the decision will be sent to the Provider. No medical Provider is declared ineligible to participate in the Medicaid Program without prior notice.

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

3.1.1 Wyoming Department of Health Healthcare Provider and Pharmacy Agreement

Wyoming Department of Health Provider Participation Agreement
(All Medicaid, CHIP, Communicable Disease Treatment (Ryan White) Program, Breast and Cervical Cancer Screening, Colorectal Screening, Title 25 Involuntary Detention, and Children's Special Health Provider applicants must complete)

Healthcare Provider and Pharmacy Agreement

STATE OF WYOMING
DEPARTMENT OF HEALTH
V1.2c as Revised 4/2021, PRESM, HHS Technology Group (HTG)

1. **Parties.** The parties to this Healthcare Provider and Pharmacy Agreement (Agreement) are the (Provider), whose name and address are delineated on page six (6) of this Agreement, and the Wyoming Department of Health (WDH), whose address is Herschler Building, 122 West 25th Street, 4 West, Cheyenne, WY 82002.

2. **Purpose of Agreement.** The purpose of this Agreement is to ensure that the Provider, who furnishes services to clients of WDH medical benefit programs, bills and receives payment for such services in accordance with applicable law. WDH medical benefit programs include the following: Medicaid, Kid Care Children's Health Insurance Program (CHIP), Communicable Disease Treatment (Ryan White) Program, Breast and Cervical Cancer Screening, Colorectal Screening, Title 25 Involuntary Detention, and Children's Special Health (individually Program or collectively the Programs).

3. **Term of Agreement.** This Agreement is effective when all federal and state required verifications have produced acceptable results and all parties have executed it. This Agreement shall remain in effect for no longer than five (5) years from the date of final execution. Termination of this Agreement shall be pursuant to Section 7. P. of this Agreement.

4. **Payment.** WDH through its Programs, agree to pay the Provider for services provided to eligible clients in accordance with applicable program rules and federal and state statutes and regulations. No payment shall be made before the State or its Agent verifies that all enrollment steps have been completed including provider agreement, additional screening, and financial enrollment forms. No payment shall be made before the last required signature is affixed to this Agreement. However, pursuant to federal and state regulations, in some instances an agreement may be made retroactively effective to cover eligible dates of service.

5. **Responsibilities of the Provider.** The Provider shall:

   A. Comply with state and federal law, as well as WDH Rules and policies applicable to each Program for which Provider submits a claim for payment.

   B. For the Wyoming Medicaid and CHIP Programs specifically, and in addition to requirements in Section 5A above, comply with the Social Security Act (42 U.S.C. § 1396, *et seq.*); the Wyoming Medical Assistance and Services Act (Wyo. Stat. § 42-4-101, *et seq.*); the regulations of the Centers for Medicare & Medicaid Services (CMS); the United States Department of Health and Human Services (HHS) (42 C.F.R. Chapter IV Subchapter C); and Section 6032 of the Deficit Reduction Act of 2005 (Employee Education About False Claims Recovery).

   C. Comply with licensing and certification standards as contained in Wyoming statutes, regulations and rules, or applicable licensing and certification standards in the state where a service is provided.

   D. Comply with the Wyoming Medicaid and CHIP Provider Manuals, as revised or updated quarterly, and all Program bulletins which are integrated into the manuals. These Provider manuals provide additional guidance and requirements for the respective Programs identified in Section 2 above.

   E. Ensure that the charges submitted for services or items provided to eligible WDH clients shall not exceed the charges for comparable services or items provided to persons not eligible for these Programs.

   F. Not submit claims for payment prior to provision of qualifying services. If providing administrative assistance such as managing payments to providers of self-directed care participants, the Provider shall not accept claims prior to services being performed.

   G. Bill all third-party payers as defined in applicable WDH Rules and policies before submitting claims to WDH or its fiscal agent.

H. Accept as payment in full the amounts paid in accordance with Wyoming statutes and WDH Rules and policies, and the Provider shall not seek additional payment from any source prohibited by law, including the client or any member of his or her family.

I. Not require prepayment by clients who present proper proof of program eligibility, with the exception of services requiring co-payment as defined in WDH Rules or policies. This provision shall not apply to any service or item not covered by the Program, if the client agrees in writing in advance to pay for such service or item.

J. File all claims in accordance with applicable federal and state laws and regulations and in accordance with WDH Rules and policies.

K. Cooperate with the applicable Program to recover any payment made under this Agreement which is later determined by the Program to have been in excess of that permitted by federal or state laws, regardless of whether the Provider or the Program caused the excess payment. The Provider further agrees to notify the Program in writing within thirty (30) days after learning of any excess payment.

L. Retain all records necessary to fully disclose the extent of services or items provided to clients and all records necessary to document the claims submitted for program reimbursement for such services or items. All such medical and financial records shall be retained by the Provider for six (6) years beyond the end of the fiscal year in which payment for services was rendered, except that if any litigation, claim, audit or other action involving the records initiated before the expiration of the sixth (6th) year, the records shall be retained until the completion of the action. Failure to maintain records for claims may result in an audit and, in addition, will be considered under the False Claims Act, other state laws, federal laws, or regulations, and are subject to prosecution.

Upon request, the Provider shall make on-site access to and copies of client records and information for claims paid for by WDH available to the Program, or its authorized representatives, including CMS, HHS, other Federal agencies, the Comptroller General of the United States, the Attorney General of the State of Wyoming, the Wyoming Medicaid Fraud Control Unit (MFCU), or any of their duly authorized representatives, or any federal/state contractors such as the Unified Program Integrity Contractor (UPIC), Medicaid Integrity Contractor (MIC), and Recovery Audit Contractor (RAC).

M. Safeguard the use and disclosure of information concerning applications for or clients of the Programs in accordance with applicable federal and state statutes and regulations.

N. Submit, within thirty-five (35) days after the date on the request by the Programs, MFCU, or HHS, full and complete information as to ownership, business transactions and criminal activity in accordance with 42 C.F.R. § 455.105. Provider agrees to all other required disclosures and timelines as set forth in 42 C.F.R. §§ 455.100 through 455.106.

O. Provide the Programs with advance notice in accordance with WDH Rules, of any change or proposed change in: name; ownership; licensure; certification, or registration status; type of service or area of specialty; additions, deletions or replacement in group membership; mailing addresses; and participation in the Program. A change in the Provider's ownership or organization shall not relieve the Provider of its obligations under this Agreement, and all terms and conditions of this Agreement shall apply to the new ownership or organization.

For Providers enrolling as pharmacies, written disclosure of contact information for the entity legally responsible for debt at the time of sale or transfer of a pharmacy is required at least thirty (30) days in advance of the sale or transfer. Ensuring this information is updated with WDH shall be the responsibility of the entity legally responsible for said debt. Legal documentation of the provisions of the sale must be included with the written disclosure.

P. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices and Health Maintenance Organization (HMOs) specified in 42 C.F.R. § 489, Subpart I, and in 42 C.F.R. § 417.436(d).

Q. Comply with and maintain all documents for any Plans of Care that are required by WDH.

R. If Provider is submitting a claim under the Communicable Disease Treatment (Ryan White) Program, the Provider shall comply with the following additional terms and conditions:

i. Requirements in WDH Rules and the Communicable Disease Treatment (Ryan White) Program policy manual.

ii. Upon submission of the first claim for Communicable Disease Treatment (Ryan White) Program payment, renew the Provider's acceptance of the Communicable Disease Treatment (Ryan White) Program Special Provisions.

iii. For all patients testing positive for a rapid or confirmatory HIV laboratory test, provide immediate counseling and connection with a WDH Treatment Program Case Manager for possible enrollment into Communicable Disease Treatment (Ryan White) Program services.

iv. HIV care physicians will provide evaluation, medication management, and a comprehensive treatment plan including as needed, indirect consultation for care management or treatment plan questions.

v. HIV care physicians will assure that high quality medical care is based on healthcare outcomes in accordance with Title XXVI of the Public Health Service Act, the Health Resources and Services Administration (HRSA), and Ryan White HIV AIDS Program (RWHAP) policy clarification notice #15-02 as found at https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters.

vi. Serve HIV patients per the HHS Clinical Guidelines as found at https://hab.hrsa.gov/clinical-quality-management/clinical-care-guidelines-and-resources.

vii. Primary Infectious Disease practices, or Providers serving as the primary HIV care provider, will develop a quality management plan to assure that HHS Clinical Guidelines are being measured and corrective action plans are designed to improve measurements.

viii. Providers serving HIV positive patients will develop a method for maintaining open communication between HIV Case Manager and the Provider's office. Case management notes regarding clinical care of the patient should be maintained in the Provider's charting system.

ix. Document as required, the patient's consent to referral and, if applicable, release of the patient's protected health information.

x. Allow WDH staff or its appointee access to medical charts for auditing clinical measures per HHS Clinical Guidelines.

xi. Allow WDH staff or its appointee access to financial records so that WDH can verify compliance with HRSA rules and regulations regarding program income. Clinics may be required to submit quarterly reports dependent on level of Ryan White patient load as a sub-recipient of Federal funds.

xii. Participate in WDH offered provider and clinic staff training as outlined in the Communicable Disease Treatment (Ryan White) provider manual.

xiii. Maintain a program to provide cultural competency training for all staff.

xiv. Retrieve on a regular basis and maintain a program to assure that HHS Clinical Guidelines are practiced as established at https://hab.hrsa.gov/clinical-quality-management/clinical-care-guidelines-and-resources.

6. **Special Provisions.** The Provider explicitly understands that:

A. Reimbursement from WDH through its Programs is from state and federal funds and that any falsification of claims, statements, or documents, or any concealment of material fact is a violation of state and federal laws, and any person who falsifies or conceals a material fact may be subject to criminal prosecution.

B. The Provider is responsible for all service claims submitted to WDH through its Programs seeking reimbursement for services provided to a client, regardless of whether the claim is submitted by the Provider's employee, sub-contractor, vendor, or business agent.

C. The Provider's participation in the Programs pursuant to this Agreement may be sanctioned or terminated for failure to comply with its terms and with WDH Rules. By signing this Agreement, Provider acknowledges that in the event of a dispute under this Agreement, the Provider is required to seek administrative relief pursuant to WDH Rules as a condition precedent to any other remedy.

D. Should Provider commence a proceeding in bankruptcy during the term of this Agreement, any pending claims for payments under this Agreement prior to commencing the bankruptcy proceeding will be subject to suspension, offset, and recoupment actions.

E. Should either federal or state law require Provider re-enrollment, Provider understands and agrees that additional information, including but not limited to all license renewals, may be requested and must be provided in order to process any re-enrollment application. Failure by Provider to give any and all requested information may result in denial of re-enrollment and suspension of any future payments.

F. Providers enrolling as a psychiatric residential treatment facility agrees to participate in periodic quality assurance reviews conducted pursuant to WDH Rules and policies.

G. Providers understand and agree that there may be an application fee required for WDH to process enrollment or re-enrollment per Section 6401 (a) of the Affordable Care Act (ACA).

H. **Certification of Information Contained in Provider Application.** The Provider has read the provider application, and the information provided electronically on the provider application is true, correct and complete. If the Provider becomes aware of any information in their electronic application that is not true, correct, or complete, the Provider agrees to notify the WDH of this fact immediately. Omission, misrepresentation, or falsification of any information contained in the Provider Application may be punishable by criminal, civil, or other administrative actions including revocation of WDH provider billing numbers, recovery of funds, fines, penalties, damages, or imprisonment under State or Federal law.

I. **Authorization to verify information in Provider Application**. WDH will verify information provided by the Provider in their electronic application. The Provider agrees to notify WDH of any changes impacting the Provider Application sixty (60) days prior to the effective date of the change consistent with Wyoming Rules 048.0037.3 (WDH 048, Chapter 3 Section 4(f)). The Provider understands that a change in the incorporation of their organization, ownership change, or their status as an individual or group biller will require a new enrollment.

J. **Ability to Legally Participate.** The Provider attests that no individual practitioner, owner, director, officer, employee, or subcontractor is subject to sanctions, barred, suspended, or excluded by any Federal program including the Medicare program, other state Medicaid programs, or WDH.

K. **Termination due to inactivity**. If the Provider does not submit claims for a total of fifteen (15) consecutive months, WDH may inactivate and terminate the assigned provider number and the provider will need to submit a new enrollment application. WDH may choose to not inactivate a provider during a public health emergency or declared disaster, or may grant an appeal to termination for inactivity.

L. **Overpayments.** Any existing or future overpayment to the Provider by WDH shall be recouped by WDH Programs.

M. **Use of Provider billing number assigned by WDH.** The Provider agrees that the billing number assigned by WDH will only be used by the provider who provided the service or to whom benefits were reassigned under current Federal or WDH health care program regulations may be used when billing WDH for other service. In no instance shall Provider use another provider's WDH billing number or allow its WDH billing number to be used inappropriately.

N. **Presentment of False Claims**. The Provider will not knowingly present or cause to be presented a false or fraudulent claim for payment by any WDH Program, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

7. **General Provisions.**

A. **Applicable Law, Rules of Construction, and Venue.** The construction, interpretation, and enforcement of this Agreement shall be governed by the laws of the State of Wyoming, without regard to conflicts of law principles. The terms "hereof," "hereunder," "herein," and words of similar import, are intended to refer to this Agreement as a whole and not to any particular provision or part. The Courts of the State of Wyoming shall have jurisdiction over this Agreement and the parties. The venue shall be the First Judicial District, Laramie County, Wyoming.

If the enrolling Provider is a Federal or Federally Recognized Tribal Entity (Tribe), the parties agree that this Agreement shall be governed and interpreted according to federal laws and regulations, and any other applicable laws and regulations. In the event a dispute arises under this Agreement, jurisdiction will be in a court of competent jurisdiction.

B. **Assignment Prohibited and Provider Agreement Not Used as Collateral.** Neither party shall assign or otherwise transfer any of the rights or delegate any of the duties set forth in the Agreement without the prior written consent of the other party. The Provider shall not use this Agreement, or any portion thereof, for collateral for any financial obligation.

C. **Assumption of Risk.** The Provider shall be responsible for any medical or service claim submitted by the Provider and denied because of the Provider's failure to comply with State or Federal requirements. The Program shall notify the Provider of any State or Federal determination of noncompliance.

D. **Audit and Access to Records.** Medicaid, other WDH programs, MFCU, HHS, and any of their representatives shall have access to any books, documents, papers, and records of the Provider which are pertinent to this Agreement. The

Provider shall, immediately upon receiving written instruction from the Program, provide to any independent auditor or accountant, all books, documents, papers, and records of the Provider which are pertinent to this Agreement. The Provider shall cooperate fully with any such independent auditor or accountant during the entire course of any audit authorized by Medicaid, other WDH programs, the MFCU, or HHS.

E. **Availability of Funds.** Each payment obligation of WDH is conditioned upon the availability of funds which are appropriated or allocated for the payment of this obligation. If funds are not allocated and available for continued performance of services by the Provider, the Agreement may be terminated by WDH at the end of the period for which the funds are available, or WDH may suspend payments to the Provider. WDH shall notify the Provider at the earliest possible time of the services which will or may be affected by a shortage of funds. At the earliest possible time means at least sixty (60) days in advance. No penalty shall accrue to WDH in the event this provision is exercised, and WDH shall not be obligated or liable for any future payments due or for any damages as a result of termination under this section.

F. **Compliance with Laws.** The Provider shall keep informed of and comply with all applicable Federal, State and local laws and regulations in the performance of this Agreement.

G. **Entirety of Provider Agreement.** This Agreement, consisting of six (6) pages, represents the entire and integrated Agreement between the parties and supersedes all prior negotiations, representations, and agreements, whether written or oral.

H. **Indemnification.** The Provider shall release, indemnify, and hold harmless the State of Wyoming, WDH, and their officers, agents, and employees from any and all claims, suits, liabilities, court awards, damages, costs, attorneys' fees, and expenses arising out of Provider's failure to perform any of Provider's duties and obligations hereunder or in connection with the negligent performance of Provider's duties or obligations, including, but not limited to, any claims, suits, liabilities, court awards, damages, costs, attorneys' fees, and expenses arising out of Provider's negligence or other tortious conduct.

Notwithstanding the foregoing paragraph, if the Provider is a State or Federal agency, governmental entity, Tribe, or political subdivision, each party to this Agreement shall be responsible for any liability arising from its own conduct. Neither party agrees to insure, defend, or indemnify the other.

I. **Independent Contractor.** The Provider shall function as an independent contractor for the purposes of this Agreement, and shall not be considered an employee of the State of Wyoming for any purpose. The Provider shall be free from direction or control over the details of the performance of services under this Agreement. The Provider shall assume sole responsibility for any debts or liabilities that may be incurred by the Provider in fulfilling the terms of this Agreement, and shall be solely responsible for the payment of all Federal, State and local taxes which may accrue because of this Agreement. Nothing in this Agreement shall be interpreted as authorizing the Provider or its agents or employees to act as an agent or representative for or on behalf of the State of Wyoming, WDH or its Programs, or to incur any obligation of any kind on behalf of the State of Wyoming, WDH, or its Programs. The Provider agrees that no health or hospitalization benefits, workers' compensation, unemployment insurance or similar benefits available to State of Wyoming employees will inure to the benefit of the Provider or the Provider's agents or employees as a result of this Agreement. If the Provider is providing services to self-directed care participants, the Provider understands and agrees that under no circumstances is the State of Wyoming a joint employer.

J. **Kickbacks.**

i. The Provider certifies and warrants that no gratuities, kickbacks or contingency fees were paid in connection with this Agreement, nor were any fees, commissions, gifts, or other considerations made contingent upon the signing of this Agreement.

ii. No staff member of the Provider shall engage in any contract or activity which would constitute a conflict of interest as related to this Agreement.

K. **Nondiscrimination and Americans with Disabilities Act.** The Provider shall comply with the Civil Rights Act of 1964, the Wyoming Fair Employment Practices Act (Wyo. Stat. § 27-9-105, *et seq.*), the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101, *et seq.*, and the Age Discrimination Act of 1975 and any properly promulgated rules and regulations thereto and shall not discriminate against any individual on the grounds of age, sex, color, race, religion, national origin, or disability in connection with the performance under this Agreement.

Nothing in this paragraph will obligate the Tribe to comply with any law which by its terms does not apply to Tribes, or which has been held by a court of competent jurisdiction not to apply to Tribes, nor will it prevent Provider from providing Native American hiring preference.

L. **Notices.** All notices arising out of, or from the provisions of this Agreement, shall be in writing and given to the parties at the address provided under this Agreement, either by regular mail, or delivery in person, or as specified in applicable rule.

M. **Sovereign and Governmental Immunity.** Pursuant to Wyo. Stat. § 1-39-104(a), the State of Wyoming, WDH, and the Programs expressly reserve sovereign immunity by entering into this Agreement and specifically retain all immunities and defenses available to them as sovereigns. If Provider is a State or Federal agency, governmental entity, Tribe, or political subdivision, Provider expressly reserves its sovereign or governmental immunity, as applicable. The parties acknowledge that the State of Wyoming has sovereign immunity and only the Wyoming Legislature has the power to waive sovereign immunity. Designations of venue, choice of law, enforcement actions, and similar provisions shall not be construed as a waiver of sovereign immunity. The parties agree that any ambiguity in this Agreement shall not be strictly construed, either against or for either party, except that any ambiguity as to sovereign immunity shall be construed in favor of sovereign immunity.

N. **Suspension and Debarment, or Exclusion.** By signing this Agreement, the Provider certifies that he/she is not suspended, debarred, or voluntarily or otherwise excluded from Federal financial or non-financial assistance. Further, the Provider agrees to notify the Program by certified mail should the Provider or any of its employees, agents or contractors become debarred, suspended, or voluntarily or otherwise excluded during the term of this Agreement.

O. **Taxes.** The Provider shall pay all taxes and other such amounts required by federal, state and local law, including but not limited to, federal and social security taxes, workers' compensation, unemployment insurance and sales taxes.

P. **Termination of Agreement.** This Agreement may be terminated, without cause, by either party upon thirty (30) days written notice. This Agreement may be terminated immediately for cause if the Provider fails to perform in accordance with, or comply with, the terms of this Agreement. Provider understands and agrees that should Provider be excluded from participation in other States' Medicaid programs or be excluded or terminated by the federal government in Medicare, Medicaid or other federal health care programs, that the State of Wyoming is required to impose similar sanctions including but not limited to termination of this Agreement. In addition, should re-enrollment be required for purposes of credentialing or otherwise, such re-enrollment will be denied if the aforementioned sanctions have been imposed. The term of this Agreement may be extended by WDH during a public health emergency or designated disaster.

Q. **Waiver.** The waiver of any breach of any term or condition of this Agreement shall not be deemed a waiver of any prior or subsequent breach. Failure to object to a breach shall not constitute a waiver.

8. **Signatures.** By signing below, the Provider certifies that he/she has read, understood, and agreed to the terms and conditions of all six (6) pages of this Agreement and that the information furnished is true, accurate, and complete. This Agreement shall be deemed fully and properly executed on the date the Provider signs it.

Printed Name of Individual Practitioner or Organization			
Street	**City**	**State**	**Zip Code**
Electronic Signature of Individual Practitioner or Legally Authorized Representative		**Title**	**Date stamp (Date, Time)**

3.1.2 Ordering, Referring, and Prescribing, and Attending Providers

Wyoming Medicaid requires that ordering, referring, or prescribing (ORP) Providers be documented on claims. All ORP Provider and attending Provider must be enrolled with Wyoming Medicaid. This applies to all in state and out-of-state Providers, even if they do not submit claims to Wyoming Medicaid, except on Medicare crossover claims.

Providers who are enrolled as an ORP ONLY will not term due to 12 months of inactivity (no paid claims on file). If they are enrolled as a treating Provider but only being used as an ORP Provider, these Providers will term due to 12 months of inactivity (no paid claims on file).

Taxonomies That May Order, Refer, or Prescribe (ORP)	
Taxonomy	**Taxonomy Description**
All 20s	Physicians (MD, DO, interns, residents, and fellows)
101Y00000X	Provisional Professional Counselor (PPC) or Certified Mental Health Worker
101YA0400X	Licensed Addictions Therapist (LAT), Provisional Licensed Addictions Therapist (PLAT), or Certified Addictions Practitioner (CAP)
101YP2500X	Licensed Professional Counselor
103G00000X	Neuropsychologist
103TC0700X	Clinical Psychologist
1041C0700X	Licensed Clinical Social Worker (LCSW), Certified Social Worker (CSW), or Masters of Social Worker (MSW) with Provisional License (PCSW)
106H00000X	Licensed Marriage and Family Therapist (LMFT) or Provisional Marriage and Family Therapist (PMFT)
111N00000X	Chiropractic
1223s	Dentists
152W00000X	Optometrists
175T00000X	Peer Specialist
176B00000X	Midwife
213E00000X	Podiatrist
225100000X	Physical Therapists
225X00000X	Occupational Therapists

Taxonomies That May Order, Refer, or Prescribe (ORP)	
Taxonomy	**Taxonomy Description**
231H00000X	Audiologist
363A00000X	Physician Assistants (PA)
363Ls	Nurse Practitioners
364SP0808X	Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health
367A00000X	Midwife, Certified Nurse

Taxonomies Always Required to Include a Referring, Attending, Prescribing or Ordering (RAPO) NPI on Claims	
Taxonomy	**Taxonomy Description**
332S00000X	Hearing Aid Equipment
332B00000X	Durable Medical Equipment (DME) & Supplies
335E00000X	Prosthetic/Orthotic Supplier
291U00000X	Clinical Medical Laboratory
261QA1903X	Ambulatory Surgical Center (ASC)
261QE0700X	End-Stage Renal Disease (ESRD) Treatment
261QF0400X	Federally Qualified Health Center (FQHC)
261QR0208X	Radiology, Mobile
261QR0401X	Comprehensive Outpatient Rehabilitation Facility (CORF)
261QR1300X	Rural Health Clinic (RHC)
225X00000X	Occupational Therapist
225100000X	Physical Therapist
235Z00000X	Speech Therapist
251E00000X	Home Health
251G00000X	Hospice Care, Community Based
261Q00000X	Development Centers (Clinics/Centers)

Taxonomies Always Required to Include a Referring, Attending, Prescribing or Ordering (RAPO) NPI on Claims	
Taxonomy	**Taxonomy Description**
261QP0904X	Public Health, Federal/Health Programs Operated by IHS
275N00000X	Medicare Defined Swing Bed Unit
282N00000X	General Acute Care Hospital
282NR1301X	Critical Access Hospital (CAH)
283Q00000X	Psychiatric Hospital
283X00000X	Rehabilitation Hospital
314000000X	Skilled Nursing Facility
323P00000X	Psychiatric Residential Treatment Facility
111N00000X	Chiropractors
231H00000X	Audiologist
133V00000X	Dietitians

3.1.3 Enrollment Termination

3.1.3.1 License and Certification

Seventy-five (75) days prior to licensure or certification expiration, Medicaid sends all Providers a letter requesting a copy of their current license or other certifications. If these documents are not submitted by the expiration date of the license or other certificate, the Provider will be terminated as of the expiration date as a Medicaid Provider. Once the updated license or certification is received, the Provider will be reactivated and a re-enrollment will not be required unless the Provider remains termed for license more than one (1) year, which the Provider will then be termed due to inactivity.

3.1.3.2 Contact Information

If any information listed on the original enrollment application subsequently changes, **Providers must notify Medicaid in writing 30 days prior to the effective date of the change.** Changes that would require notifying Medicaid include, but are not limited to, the following:

- Current licensing information
- Facility or name changes
- New ownership information

- New telephone or fax numbers
- Physical, correspondence, or payment address change
- New email addresses
- Tax Identification Number

It is critical that Providers maintain accurate contact information, including email addresses, for the distribution of notifications to Providers. Wyoming Medicaid policy updates and changes are distributed by email, and occasionally by postal mail. Providers are obligated to read, know, and follow all policy changes. Individuals who receive notification on behalf of an enrolled Provider are responsible for ensuring they are distributed to the appropriate personnel in the organization, office, billing office, and so on.

If any of the above contact information is found to be inaccurate (mail is returned, emails bounce, phone calls are unable to be placed, physical site verification fails, or so on) the Provider will be placed on a claims hold. Claims will be held for 30 days pending an update of the information. A letter will be sent to the Provider, unless both the physical and correspondence addresses have had mail returned, notifying them of the hold and describing options to update contact information. The letter will document the information currently on file with Wyoming Medicaid and allow the Provider to make updates/changes as needed. If a claim is held for this reason for more than 30 days, it will then be denied that the Provider will have to resubmit once the correct information is updated. If the information is updated within the 30 days, the claim(s) will be released to complete normal processing.

Please contact HHS Technology Group by phone (*see Section 2.1* Quick Reference) or by email, at WYEnrollmentSvcs@HHSTechGroup.com to update this information or if you have any questions.

3.1.3.3 Inactivity

Providers who do not submit a claim within **fifteen (15) months may** be terminated due to inactivity and a new enrollment will be required.

3.1.3.4 Re-Enrollment

Providers are required to complete an enrollment application, undergo a screening process, and sign a Provider Agreement at least every five (5) years. Prior to any re-enrollment termination, Providers will be notified by HHS Technology Group in advance that a re-enrollment is required to remain active. If a re-enrollment is completed and approved prior to the set termination date, the Provider will remain active with no lapse in their enrollment period.

3.1.4 Discontinuing Participation in the Medicaid Program

The Provider may discontinue participation in the Medicaid Program at any time. Thirty (30) days written notice of voluntary termination is requested.

Notices should be address to HHS Technology Group, Provider Enrollment (*see Section 2.1* Quick Reference).

3.2 Accepting Medicaid Members

3.2.1 Compliance Requirements

All Providers of care and suppliers of services participating in the Medicaid Program must comply with the requirements of Title VI of the Civil Rights Act of 1964, which requires that services be furnished to Members without regard to race, color, or national origin.

Section 504 of the Rehabilitation Act provides that no individual with a disability shall, solely by reason of the handicap:

- Be excluded from participation;
- Be denied the benefits; or
- Be subjected to discrimination under any program or activity receiving federal assistance.

Each Medicaid Provider, as a condition of participation, is responsible for making provision(s) for such individuals with a disability in their program activities.

As an agent of the Federal government in the distribution of funds, the Division of Healthcare Financing is responsible for monitoring the compliance of individual Provider and, in the event a discrimination complaint is lodged, is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

3.2.2 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.

Providers must verify eligibility each month as programs and plans are re-determined on a varying basis, and a Member eligible one (1) month may not necessarily be eligible the next month.

Presumptive Eligibility may begin or end mid-month.

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 (see *Section 7.2.1* Third Party Resources Information Sheet) to Medicaid. The Provider may not discriminate based on whether or not 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.**

When and what must be billed to a Medicaid Member.

Once this agreement has been reached, all Wyoming Medicaid covered services the Provider renders to an eligible Member are billed to Medicaid.

	Member is Covered by a FULL COVERAGE Medicaid Program and the Provider accepts the Member as a Medicaid Member	**Member is Covered by a LIMITED COVERAGE Medicaid Program and the Provider accepts the Member as a Medicaid Member**	**FULL COVERAGE or LIMITED COVERAGE Medicaid Program and the Provider does not accept the Member as a Medicaid Member**	**Member is not covered by Medicaid (not a Medicaid Member)**
Service is covered by Medicaid	Provider can bill the Member only for any applicable copay	Provider can bill the Member if the category of service is not covered by the Member's limited plan	Provider can bill the Member if written notification has been given to the Member that they are not being accepted as a Medicaid Member	Provider may bill Member
Service is covered by Medicaid, but Member has exceeded their service limitations	Provider can bill the Member OR Provider can request authorization of medical necessity/prior authorization and bill Medicaid	Provider can bill the Member OR Provider can request authorization of medical necessity/prior authorization and bill Medicaid	Provider can bill the Member if written notification has been given to the Member that they are not being accepted as a Medicaid Member	Provider can bill Member
Service is not covered by Medicaid	Provider can bill the Member only if a specific financial agreement has been made in writing	Provider can bill the Member if the Category of service is not covered by the Member's limited plan. If the Category of service is covered, the Provider can only bill the Member if a specific financial agreement has been made in writing	Provider can bill the Member if written notification has been given to the Member that they are not being accepted as a Medicaid Member	Provider can bill Member

Full Coverage Plan: Plan covers the full range of medical, dental, hospital, and pharmacy services and may cover additional nursing home or waiver services.

Limited Coverage Plan: Plan with services limited to a specific category or type of coverage.

Specific Financial Agreement: Specific written agreement between a Provider and a Member, outlining the specific services and financial charges for a specific date of service, with the Member agreeing to the financial responsibility for the charges

3.2.2.1 Accepting a Member as Medicaid after Billing the Member

If the Provider collected money from the Member for services rendered during the eligibility period and decides later to accept the Member as a Medicaid Member, and receive payment from Medicaid:

- Prior to submitting the claim to Medicaid, the Provider must refund the entire amount previously collected from the Member to him or her for the services rendered; and
- The 12-month (365 days) timely filing deadline will not be waived (see *Section 6.14* Timely Filing).

In cases of retroactive eligibility when a Provider agrees to bill Medicaid for services provided during the retroactive eligibility period:

- Prior to billing Medicaid, the Provider must refund the entire amount previously collected from the Member to him or her for the services rendered; and
- The 12-month (365 days) timely filing deadline will be waived (see *Section 6.14* Timely Filing).

> Medicaid will not pay for services rendered to the Members until eligibility has been determined for the month services were rendered.

The Provider may, at a subsequent date, decide not to further treat the Member as a Medicaid patient. If this occurs, the Provider must advise the Member of this fact in writing before rendering treatment.

3.2.2.2 Mutual Agreements between the Provider and Member

Medicaid covers only those services that are medically necessary and cost-efficient. It is the Providers' responsibility to be knowledgeable regarding covered services, limitations, and exclusions of the Medicaid Program. Therefore, if the Provider, without mutual written agreement of the Member, delivers services and is subsequently denied Medicaid payment because the services were not covered, or the services were covered but not medically necessary and/or cost-efficient, the Provider may not obtain payment from the Member.

If the Provider and the Member mutually agree in writing to services which are not covered (or are covered but are not medically necessary and/or cost-efficient), and the Provider informs the Member of their financial responsibility prior to rending service, then the Provider may bill the Member for the services rendered.

3.2.3 Missed Appointments

Appointments missed by Medicaid Members **cannot** be billed to Medicaid. However, if a Provider's policy is to bill **all** patients for missed appointments, then the Provider may bill Medicaid Members directly.

Any policy must be equally applied to all Members and a Provider may not impose separate charges on Medicaid Members, regardless of payment source. Policy must be publicly posted or provided in writing to all patients.

Medicaid only pays Providers for services they render (such as services as identified in 1905 (a) of the Social Security Act). They must accept that payment as full reimbursement for their services in accordance with 42 CFR 447.15. Missed appointments are not a distinct, reimbursable Medicaid service. Rather, they are considered part of a Providers' overall cost of doing business. The Medicaid reimbursement rates set by the State of designed to cover the cost of doing business.

> For Members who miss dental appointments, Wyoming Medicaid has a tracking process as detailed in *Section 10.1* No Show Appointments and Broken Appointments.

3.3 Medicare Covered Services

Claims for services rendered to Members eligible for both Medicare and Medicaid which are furnished by an out-of-state Provider must be filed with the Medicare intermediary or carrier in the state in which the Provider is located.

Questions concerning a Member's Medicare eligibility should be directed to the Social Security Administration (*see Section 2.1* Quick Reference).

3.4 Medical Necessity

The Medicaid Program is designed to assist eligible Members in obtaining medical care within the guidelines specified by policy. Medicaid will pay only for medical services that are medically necessary and are sponsored under program directives. Medically necessary means the service is required to:

- Diagnose
- Treat
- Cure
- Prevent an illness which has been diagnosed or is reasonably suspected to:
    - Relieve pain
    - Improve and preserve health
    - Be essential for life

Additionally, the service must be:

- Consistent with the diagnosis and treatment of the patient's condition
- In accordance with standards of good medical practice
- Required to meet the medical needs of the patient and undertaken for reasons other than the convenience of the patient or their physician
- Performed in the least costly setting required by the patient's condition

Documentation, which substantiates that the Member's condition meets the coverage criteria, must be on file with the Provider.

All claims are subject to both pre-payment and post-payment review for medical necessity by Medicaid. Should a review determine that services do not meet all the criteria listed above, payment will be denied or, if the claim has already been paid, action will be taken to recoup the payment for those services.

3.5 Medicaid Payment is Payment in Full

As a condition of becoming a Medicaid Provider, the Provider must accept payment from Medicaid as payment in full for a covered service.

The Provider may never bill a Medicaid Member:

- When the Provider bills Medicaid for a covered service, and Medicaid denied the Providers claim due to billing errors such as wrong procedure and diagnosis codes, lack of prior authorization, invalid consent forms, missing attachments, or an incorrectly filled out claim form.
- When Medicare or another third-party payer has paid up to or exceeded what Medicaid would have paid.
- For the difference in the Providers' charges and the amount Medicaid has paid (balance billing).

The Provider may bill a Medicaid Member:

- If the Provider has not billed Medicaid, the service provided is not covered by Medicaid, and, prior to providing services, the Provider informed the Member in writing that the service is non-covered and he/she is responsible for the charges, and the Member agreed in writing to pay for such services before they were furnished.
- If a Provider does not accept a patient as a Medicaid Member (because they cannot produce a Medicaid ID card or because they did not inform the Provider they are eligible).
- If the Member is not Medicaid eligible at the time the Provider provides the services or is on a plan that does not cover those particular services. Refer to the table above for guidance (see *Section 3.2.2* Provider-Patient Relationship).
- If the Member has reached the threshold on physical therapy, occupational therapy, speech therapy, behavioral health services, chiropractic services with dates of service prior to

06/01/2021, dietitian services with dates of service prior to 01/01/2021, prescriptions, and/or office/outpatient hospital visits and has been notified that the services are not medically necessary in writing by the Provider

> The Provider may contact Provider Services or access the Provider Portal to receive service thresholds when completing a Member eligibility verification for a Member (*see Section 2.1* Quick Reference).

- If the Provider is an out-of-state Provider and are not enrolled and have no intention of enrolling.

3.6 Medicaid ID Card

It is each Provider's responsibility to verify the person receiving services is the same person listed on the card. If necessary, Providers should request additional materials to confirm identification. It is illegal for anyone other than the person named on the Medicaid ID Card to obtain or attempt to obtain services by using the card. Providers who suspect misuse of a card should report the occurrence to the Program Integrity Unit (*see Section 2.1* Quick Reference).

3.7 Verification of Member Age

Because certain services have age restrictions, such as services covered only for Members under the age of 21, and informed consent for sterilizations, Providers should verify a Member's age before a service is rendered.

Routine services may be covered through the month of the Member's 21st birthday.

3.8 Verification Options

One (1) Medicaid ID Card is issued to each Member. Their eligibility information is updated every month. The presentation of a card is not verification of eligibility. It is each Provider's responsibility to ensure that their patient is eligible for the services rendered. A Member may state that they are covered by Medicaid, but not have any proof of eligibility. This can occur if the Member is newly eligible or if their card was lost. Providers have several options when checking patient eligibility.

3.8.1 Free Services

The following is a list of free services offered by Medicaid for verifying Member eligibility:

- Contact Provider Services to speak with a Customer Service Representative.
- Email/Fax a list of identifying information to Provider Services for verification. Send a list of beneficiaries for verification and receive a response within ten (10) business days.
- Call the Interactive Voice Response (IVR) System. IVR is available 24 hours a day seven (7) days a week. (*see Section 2.1* Quick Reference)

- Use the Ask Medicaid feature within the Provider Portal on the Medicaid website (*see Section 2.1* Quick Reference).
- Use the Member Eligibility Inquiry via the Provider Portal on the Medicaid website (*see Section 2.1* Quick Reference) – Search Wyoming Medicaid Members to determine eligibility for the current month.
    - Primary Insurance information will not be available through this function.

3.8.2 Fee for Service

Several independent vendors offer web-based applications that electronically check the eligibility of Medicaid Members. These vendors typically charge a monthly subscription and/or transaction fee.

3.9 Freedom of Choice

Any eligible non-restricted Member may select any Provider of health services in Wyoming who participates in the Medicaid Program, unless Medicaid specifically restricts their choice through Provider lock-in or an approved Freedom of Choice waiver. However, payments can be made only to health service providers who are enrolled in the Medicaid Program.

3.10 Out-of-State Service Limitations

Medicaid covers services rendered to Medicaid Members when Providers participating in the Medicaid Program administer the services. If services are available in Wyoming within a reasonable distance from the Member's home, the Member must not utilize an out-of-state Provider.

Medicaid has designated the Wyoming Medical Service Area (WMSA) to be Wyoming and selected border cities in adjacent states. WMSA cities include:

Colorado	Montana	South Dakota	Idaho	Nebraska	Utah
Craig	Billings	Deadwood	Montpelier	Kimball	Salt Lake City
	Bozeman	Custer	Pocatello	Scottsbluff	Ogden
		Rapid City	Idaho Falls		
		Spearfish			
		Belle Fourche			

The cities of Greeley, Fort Collins, and Denver, Colorado are excluded from the WMSA and are not considered border cities.

Medicaid compensates out-of-state Provider within the WMSA when:

- The service is not available locally and the border city is closer for the Wyoming resident than a major city in Wyoming; and
- The out-of-state Provider in the selected border city is enrolled in Medicaid.

Medicaid compensates Provider outside the WMSA only under the following conditions:

- **Emergency Care:** When a Member is traveling, and an emergency arises due to accident or illness.
- **Other Care:** When a Member is referred by a Wyoming physician to a Provider outside the WMSA for services not available within the WMSA.
    - The referral must be documented in the Provider's records. Prior authorization is **not** required unless the specific service is identified as requiring prior authorization (*see Section 6.8* Prior Authorization).
- Children in out-of-state placement.

If the Provider is an out-of-state, non-enrolled Provider and renders services to a Medicaid Member, the Provider may choose to enroll in the Medicaid Program and submit the claim according to Medicaid billing instructions or bill the Member.

Out-of-state Providers furnishing services within the state on a routine or extended basis must meet all the certification requirements of the State of Wyoming. The Provider must enroll in Medicaid prior to furnishing services.

3.11 Record Keeping, Retention, and Access

3.11.1 Requirements

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

- 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.

3.11.2 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.

3.11.3 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.

3.11.4 Audits

Medicaid has the authority to conduct routine audits to monitor compliance with program requirements.

Audits may include, but are not limited to:

- Examination of records;
- Interviews of Providers, their associates, and employees;
- Interviews of Members;
- Verification of the professional credentials of Providers, their associates, and their employees;
- Examination of any equipment, stock, materials, or other items used in or for the treatment of Members;

- Examination of prescriptions written for Members;
- Determination of whether the healthcare provided was medically necessary;
- Random sampling of claims submitted by and payments made to Providers;
- Audit of facility financial records for reimbursement; and/or
- Actual records review may be extrapolated and applied to all services billed by the Provider.

The Provider must grant the State and its representatives' access during regular business hours to examine medical and financial records related to healthcare billed to the program. Medicaid notifies the Provider before examining such records.

Medicaid reserves the right to make unscheduled visits (such as when the Member's health may be endangered, when criminal/fraudulent activities are suspected, and so on).

Medicaid is authorized to examine all Provider records in that:

- All eligible Members have granted Medicaid access to all personal medical records developed while receiving Medicaid benefits
- All Providers who have, at any time, participated in the Medicaid Program, by signing the Provider Agreement, have authorized the State and their designated agents to access the Provider's financial and medical records
- Provider's refusal to grant the State and its representatives' access to examine records or to provide copies of records when requested may result in:
    - Immediate suspension of all Medicaid payments
    - All Medicaid payments made to the Provider during the six (6) year record retention period for which records supporting such payments are not produced, shall be repaid to the Division of Healthcare Financing after written requests for such repayment is made
    - Suspension of all Medicaid payments furnished after the requested date of service
    - Reimbursement will not be reinstated until adequate records are produced or are being maintained
    - Prosecution under applicable State and Federal Laws.

3.12 Tamper Resistant RX Pads

On May 25, 2007, Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law.

The above law requires that ALL written, non-electronic prescriptions for Medicaid outpatient drugs must be executed on tamper-resistant pads in order for them to be reimbursable by the federal government. All prescriptions paid for by Medicaid must meet the following requirement to help insure against tampering:

Written Prescriptions: As of October 1, 2008, prescriptions must contain all three (3) of the following characteristics:

1. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement, all written prescriptions must contain:
    - Some type of "void" or illegal pantograph that appears if the prescription is copied.
    - May also contain any of the features listed within category one, recommendations provided by the National Council for Prescription Drug Programs (NCPDP) or that meets the standards set forth in this category.
2. One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. This requirement applies only to prescriptions written for controlled substances. In order to meet this requirement all written prescriptions must contain:
    - Quantity check-off boxes PLUS numeric form of quantity values OR alpha AND numeric forms of refill value.
    - Refill Indicator (circle or check number of refills or "NR") PLUS numeric form of refill values OR alpha AND numeric forms of refill values.
    - May also contain any of the features listed within category two, recommendations provided by the NCPDP, or that meets the standards set forth in this category.
3. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all written prescriptions must contain:
    - Security features and descriptions listed on the FRONT of the prescription blank.
    - May also contain any of the features listed within category three (3), recommendations provided by the NCPDP, or that meets the standards set forth in this category.

Computer Printed Prescriptions: As of October 1, 2008, prescriptions must contain all three (3) of the following characteristics:

1. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement all prescriber's computer-generated prescriptions must contain:
    - Same as Written Prescription for this category
2. One (1) or more industry-recognized features designed to prevent the erasure or modification of information printed on the prescription by the prescriber. In order to meet this requirement all computer-generated prescriptions must contain:
    - Same as Written Prescription for this category

3. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all prescriber's computer-generated prescriptions must contain:
    - Security features and descriptions listed on the **FRONT** or **BACK** of the prescription blank.
    - May also contain any of the features listed within category three (3), recommendations provided by the NCPDP, or that meets the standards set forth in this category.

In addition to the guidance outlined above, the tamper-resistant requirement does not apply when a prescription is communicated by the prescriber to the pharmacy electronically, verbally, or by fax; when a managed care entity pays for the prescription; or in most situations when drugs are provided in designated institutional and clinical settings. The guidance also allows emergency fills with a non-compliant written prescription as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours.

Audits of pharmacies will be performed by the Wyoming Department of Health to ensure that the above requirement is being followed. If the Provider has any questions about these audits or this regulation, please contact the Pharmacy Program Manager at (307) 777-7531.

Chapter 4 – Utilization Review

4.1 Utilization Review

The Division of Healthcare Financing (DHCF) has established a Program Integrity Unit whose duties include, but are not limited to:

- Review of claims submitted for payment (pre and post payment reviews)
- Reviews of medical records and documents related to covered services
- Audit of medical records and Member interviews
- Review of Member Verification of Services responses
- Operation of the Surveillance/Utilization Review (SUR) process
- Provider screening and monitoring
- Program compliance and enforcement

4.2 Complaint Referral

The Program Integrity Unit reviews complaints regarding inappropriate use of services from Providers and Members. No action is taken without a complete investigation.

To report fraud, waste, and abuse, please complete the Wyoming Medicaid Fraud, Waste, & Abuse Confidential Complaint Form located on the Program Integrity website.

https://health.wyo.gov/healthcarefin/program-integrity/

4.3 Release of Medical Records

Every effort is made to ensure the confidentiality of records in accordance with Federal Regulations and Wyoming Medicaid Rules. Medical records must be released to the agency or its designee. The signed Provider Agreement allows the Division of Healthcare Financing, or its designated agents, access to all medical and financial records. In addition, each Member agrees to the release of medical records to the Division of Healthcare Financing when the accept Medicaid benefits.

The Division of Healthcare Financing will not reimburse for the copying of medical records when the Division or its designated agents requests records.

4.4 Member Lock-In

In designated circumstances, it may be necessary to restrict certain services or “lock-in” a Member to a certain physician, hospice, pharmacy, or other Provider. If a lock-in restriction applies to a Member, the lock-in information is provided on the Provider Portal when completing a Member eligibility verification (*see Section 2.1* Quick Reference).

A participating Medicaid Provider who is not designated as the Member's primary practitioner may provide and be reimbursed for services rendered to lock-in Members only under the following circumstances:

- In a medical emergency where a delay in treatment may cause death or result in lasting injury or harm to the Member
- As a physician covering for the designated physician or on referral from the designated primary physician

In cases where lock-in restrictions are indicated, it is the responsibility of each Provider to determine whether they may bill for services provided to a lock-in Member. Contact Provider Services in circumstances where coverage of a lock-in Member is unclear (*see Section 2.1* Quick Reference).

4.5 Pharmacy Lock-In

The Medicaid Pharmacy Lock-In Program limits certain Medicaid Members from receiving prescription services from multiple prescribers and utilizing multiple pharmacies within a designated time period.

When a pharmacy is chosen to be a Member's designated Lock-In Provider, notification is sent to that pharmacy with all important Member identifying information. If a Lock-In Member attempts to fill a prescription at a pharmacy other than their Lock-In pharmacy, the claim will be denied with an electronic response of “NON-MATCHED PHARMACY NUMBER-Pharmacy Lock-In.”

Pharmacies have the right to refuse Lock-In Provider status for any Member. The Member may be counseled to contact the Medicaid Pharmacy Case Manager at (307) 777-8773, to obtain a new Provider designation form to complete.

Expectations of a Medicaid designated Lock-In pharmacy:

- Medicaid pharmacy Providers should be aware of the Pharmacy Lock-In Program and the criteria for Member lock-in status as stated above. The entire pharmacy staff should be notified of current Lock-In Members.
- Review and monitor all drug interactions, allergies duplicate therapy, and seeking of medications from multiple prescribers. Be aware that the Member is locked-in when “refill too soon” or “therapeutic duplication” edits occur. Cash payment for controlled substances should serve as an alert and require further review.
    - Gather additional information, which may include, but is not limited to, asking the Member for more information and/or contacting the prescriber. Document the finding and outcomes. The Wyoming Board of Pharmacy will be contacted when early refills and cash payment are allowed without appropriate clinical care and documentation.

When doctor shopping for controlled substances is suspected, please contact the Medicaid Pharmacy Case Manager at (307) 777-8773. The Wyoming Online Prescription Database (WORx) is online with 24/7 access for practitioners and pharmacists. The WORx program is managed by the Wyoming Board of Pharmacy at https://worxpdmp.com/ and can be used to view Member profiles with all scheduled II

through IV prescriptions the Member has received. The Wyoming Board of Pharmacy may be reached at (307) 634-9636 to answer questions about WORx.

EMERGENCY LOCK-IN PRESCRIPTIONS

If the dispensing pharmacist feels that in their professional judgment, a prescription should be filled and they are not the Lock-In Provider, they may submit a hand-billed claim to Change Healthcare for review (*see Section 2.1* Quick Reference). Overrides may be approved for true emergencies (auto accidents, sudden illness, and so on).

Any Wyoming Medicaid Member suspected of controlled substance abuse, diversion, or doctor shopping should be referred to the Medicaid Pharmacy Case Manager.

- Pharmacy Case Manager (307) 777-8773 or
- Fax referrals to (307) 777-6964
    - Referral forms may be found on the Pharmacy website (*see Section 2.1* Quick Reference).

For more information regarding the Pharmacy Lock-In Program, refer to the Medicaid Pharmacy Provider Manual (*see Section 2.1* Quick Reference).

4.6 Hospice Lock-In

Members requesting coverage of hospice services under Wyoming Medicaid are locked-in to the hospice for all care related to their terminal illness. All services and supplies must be billed to the hospice Provider, and the hospice Provider will bill Wyoming Medicaid for covered services. For more information regarding the hospice program, refer to the Institutional Provider Manual on the Medicaid website (*see Section 2.1* Quick Reference).

4.7 Fraud and Abuse

The Medicaid Program operates under the anti-fraud provisions of Section 1909 of the Social Security Act, as amended, and employs utilization management, surveillance, and utilization review. The Program Integrity Unit's function is to perform pre- and post-payment review of services funded by Medicaid. Surveillance is defined as the process of monitoring for services and controlling improper or illegal utilization of the program. While the surveillance function addresses administrative concerns, utilization review addresses medical concerns. Utilization review may be defined as monitoring and controlling the quality and appropriateness of medical services delivered to Medicaid Members. Medicaid may utilize the services of a Professional Review Organization (PRO) to assist in these functions.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, documents, or concealment of material facts may be prosecuted as a felony in either Federal or State court. The program has processes in place for referral to the Medicaid Fraud Control Unit (MFCU) when suspicion of fraud and abuse arise.

Medicaid has the responsibility, under Federal Regulations and Medicaid Rules, to refer all cases of credible allegations of fraud and abuse to the MFCU. In accordance with §42 CFR Part 455, and Medicaid Rules, the following definitions of fraud and abuse are used:

Fraud	"An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."
Abuse	"Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid Program."

4.8 Provider Responsibilities

The Provider is responsible for reading and adhering to applicable State and Federal regulations and the requirements set forth in this manual. The Provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The Provider certifies by their signature or the signature of their authorized agent on each claim or invoice for payment that all information provided to Medicaid is true, accurate, and complete. Although claims may be prepared and submitted by an employee, billing agent, or other authorized person, Providers are responsible for ensuring the completeness and accuracy of all claims submitted to Medicaid.

4.9 Referral of Suspected Fraud and Abuse

If a Provider becomes aware of possible fraudulent or program abusive conduct/activity by another Provider, or eligible Member, the Provider should notify the Program Integrity Unit in writing.

To report fraud, waste, and abuse, please complete the Wyoming Medicaid Fraud, Waste, & Abuse Confidential Complaint Form located on the Program Integrity website.

https://health.wyo.gov/healthcarefin/program-integrity/

4.10 Sanctions

The Division of Healthcare Financing (DHCF) may invoke administrative sanctions against a Medicaid Provider when a credible allegation of fraud, abuse, waste, and/or non-compliance with Provider Agreement and/or Medicaid Rules exists, or who is under sanction by another regulatory entity (such as Medicare, licensing boards, OIC, or other Medicaid designated agents).

Providers who have had sanctions levied against them may be subject to prohibitions or additional requirements as defined by Medicaid Rules (*see Section 2.1* Quick Reference).

4.11 Adverse Actions

Provider and Members have the right to request an administrative hearing regarding an adverse action, after reconsideration, taken by the Division of Healthcare Financing. This process is defined in Wyoming Medicaid Rule, Chapter 4, entitled “Medicaid Administrative Hearings.”

Chapter 5 – Member Eligibility

5.1 What is Medicaid?

Medicaid is a health coverage program jointly funded by the Federal government and the State of Wyoming. The program is designed to help pay for medically necessary healthcare services for children, pregnant women, family Modified Adjusted Gross Income (MAGI) adults, and the aged, blind, or disabled.

5.2 Who is Eligible?

Eligibility is generally based on family income and sometimes resources and/or healthcare needs. Federal statutes define more than 50 groups of individuals that may qualify for Medicaid coverage. There are four (4) broad categories of Medicaid eligibility in Wyoming:

- Children
- Pregnant women
- Family MAGI Adults
- Aged, Blind, or Disabled

> Incarcerated persons are automatically ineligible for Wyoming Medicaid. If a Member becomes incarcerated while on Medicaid, all benefits will be suspended, and Providers should pursue alternate payment sources.

5.2.1 Children

- Newborns are automatically eligible if the mother is Medicaid eligible at the time of birth.
- Low Income Children are eligible if family income is at or below 133% of the federal poverty level (FPL) or 154% of the FPL, dependent on the age of the child.
- Presumptive Eligibility (PE) for Children allows temporary coverage for a child who meets eligibility criteria for the full Children's Medicaid program.
    - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.
- Foster Care Children in Department of Family Services (DFS) custody, including some who enter subsidized adoption or who age out of foster care until they are age 26.
- PE for Former Foster Youth allows temporary coverage for a person who meets eligibility criteria for the full Former Foster Youth Medicaid.

- PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.

5.2.2 Pregnant Women

- Pregnant Women are eligible if family income is at or below 154% of the FPL. Women with income less than or equal to the MAGI conversion of the 1996 Family Care Standard must cooperate with child support to be eligible.
- Presumptive Eligibility (PE) for Pregnant Women allows temporary outpatient coverage for a pregnant woman who meets eligibility criteria for the full Pregnant Woman Medicaid program.
  - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.

5.2.3 Family MAGI Adult

- Family MAGI Adults (caretaker relatives with a dependent child) are eligible if family income is at or below the MAGI conversion of the 1996 Family Care Standard.
- PE for Caretaker Relatives allows temporary coverage for the parent or caretaker relative of a Medicaid eligible child who meets eligibility criteria for the full Family MAGI Medicaid program.
  - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.

5.2.4 Aged, Blind, or Disabled

5.2.4.1 Supplemental Security Income and Supplemental Security Income-Related

- **SSI:** A person receiving Supplemental Security Income (SSI) automatically qualifies for Medicaid.
- **SS- Related:** A person no longer receiving SSI payment may be eligible using SSI criteria.

5.2.4.2 Institution

All categories are income eligible up to 300% of the SSI Standard.

- Nursing Home
- Inpatient Hospital Care
- Hospice
- ICF ID – Wyoming Life Resource Center

- INPAT-PSYCH – WY State Hospital – Members are 65 years and older.

5.2.4.3 Home and Community Based Waiver

All waiver groups are income eligible when income is less than or equal to 300% of the SSI Standard.

- Acquired Brain Injury
- Community Choices
- Children's Mental Health
- Comprehensive
- Support

5.2.5 Other

5.2.5.1 Special Groups

- **Breast and Cervical Cancer (BCC) Treatment Program:** Uninsured women diagnosed with breast or cervical cancer are income eligible at or below 250% of the FPL.
- Presumptive Eligibility (PE) for BCC allows temporary coverage for a woman who meets eligibility criteria for the full BCC Medicaid program.
    - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.
- **Tuberculosis (TB) Program:** Individuals diagnosed with tuberculosis are eligible based on the SSI Standard.
- **Kid Care CHIP:** To be eligible for this program the following criteria must be met.
    - A United States citizen, a lawful qualified non-citizen (refugee or asylum) or a lawful, permanent alien who has lived in the United States for at least 5 consecutive years;
    - A Wyoming resident;
    - **Less than 19 years of age (not past the month of their 19th birthday);**
    - Not eligible for or already enrolled in Medicaid;
    - Not currently covered by health insurance nor has had health insurance during the last 30 days, except as provided for under *Section 4.7* Fraud and Abuse;
    - Not eligible to receive health insurance benefits under Wyoming's state employee benefit plan;
    - Not residing in a public correctional institution.
    - Financially eligible based on a MAGI income eligibility determination.

5.2.5.2 Employed Individuals with Disabilities

Employed Individuals with Disabilities (EID) are income eligible when income is less than or equal to 300% of SSI using unearned income and must pay a premium calculated using total gross income.

5.2.5.3 Medicare Savings Programs

- Qualified Medicare Beneficiaries (QMBs) are income eligible at or below 100% of the FPL. Benefits include payment of Medicare premiums, deductibles, and cost sharing.
- Specified Low Income Beneficiaries (SLMBs) are income eligible at or below 135% of the FPL. Benefits include payment of Medicare premiums only.
- Qualified Disabled Working Individuals (QDWIs) are income eligible at or below 200% of the FPL. Benefits include payment of Medicare Part A premiums only.

5.2.5.4 Non-Citizens with Medical Emergencies (Emergency Benefit Plan)

A non-citizen who meets all eligibility factors under a Medicaid group except for citizenship and social security number is eligible for emergency services. With the Emergency Service group, coverage includes those situations which have been defined as well as labor and delivery of a newborn. This does not include dental services.

5.3 Maternal and Child Health

Maternal and Child Health (MCH) provides services for high-risk pregnant women, high-risk newborns, and children with special healthcare needs through the Children's Special Health (CSH) program. The purpose is to identify eligible Members, assure diagnostic and treatment services are available, provide payment for authorized specialty care for those eligible, and provide care coordination services. CSH does not cover acute or emergency care.

- A Member may be eligible only for an MCH program or may be dually eligible for an MCH program or other Medicaid programs. Care coordination for both MCH only and dually eligible Members is provided through the Public Health Nurse (PHN).
- MCH has a dollar cap and limits on some services for those Members who are eligible for MCH only.
- Contact MCH for the following information:
    - The nearest PHN
    - Questions related to eligibility determinations
    - Questions related to the type of services authorized by MCH (*see Section 2.1* Quick Reference)

Providers must be enrolled with Medicaid and MCH to receive payment for MCH services. Claims for both programs are submitted to and processed by the fiscal agent for Wyoming Medicaid (*see Section*

2.1 Quick Reference). Providers are asked to submit the medical record to CSH in a timely manner to assure coordination of referrals and services.

5.4 Eligibility Determination

5.4.1 Applying for Medicaid

- Persons applying for Medicaid or Kid Care CHIP may complete the Streamlined Application. The application may be mailed to the Wyoming Department of Health (WDH). Applicants may also apply online at https://www.wesystem@wyo.gov or by contacting the Customer Service Center (*see Section 2.1* Quick Reference).
- Presumptive Eligibility (PE) applicants may also apply through a qualified Provider or qualified hospital for the PE programs.

5.4.2 Determination

Eligibility determination is conducted by the Wyoming Department of Health Customer Service Center (CSC) or the Long Term Care (LTC) Unit centrally located in Cheyenne, WY (*see Section 2.1* Quick Reference).

Persons who want to apply for programs offered through the Department of Family Services (DFS), such as Supplemental Nutrition Assistance Program (SNAP) or Child Care need to apply in person at their local DFS office. Persons applying for Supplemental Security Income (SSI) need to contact the Social Security Administrations (SSA) (*see Section 2.1* Quick Reference).

Medicaid assumes no financial responsibility for services rendered prior to the effective date of a Member's eligibility as determined by the WDH or the SSA. However, the effective date of eligibility as determined by the WDH may be retroactive up to 90 days prior to the month in which the application is filed, as long as the Member meets eligibility criteria during each month of the retroactive period. If the SSA deems the Member eligible, the period of original entitlement could precede the application date beyond the 90-day retroactive eligibility period and/or the 12 month (365 days) timely filing deadline for Medicaid claims (see *Section 6.14* Timely Filing). This situation could arise for the following reasons:

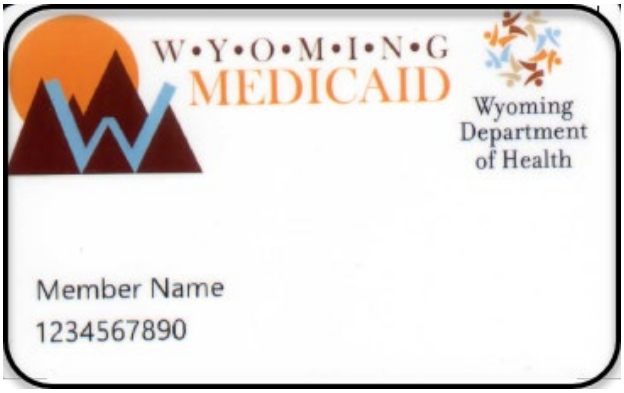
- Administrative Law Judge decisions or reversals
- Delays encountered in processing applications or receiving necessary Member information concerning income or resources

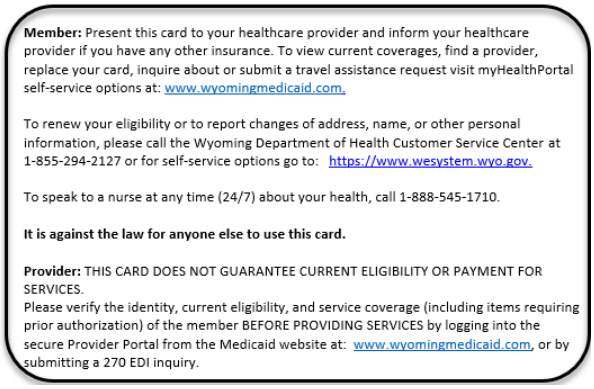
5.5 Member Identification Cards

A Medicaid ID Card is mailed to Members upon enrollment in the Medicaid Program or other health programs such as the Communicable Treatment Disease Program (CTDP) and Children's Special Health (CSH). Not all programs receive a Medicaid ID Card, to confirm if a plan generates a card or not, refer to the "card" indicator on the Medicaid and State Benefit Plan Guide.

If a Member has been on Medicaid previously and has reapplied, they will not receive a new Medicaid card. Members who would like a new card may contact the Customer Service Center (*see Section 2.1* Quick Reference) or print an ID card from the Member Portal, myHealthPortal

Sample Medicaid ID card:





> Kid Care CHIP Members will also use this card.

5.6 Other Types of Eligibility Identification

5.6.1 Medicaid Approval Notice

In some cases, a Provider may be presented with a copy of Medicaid Approval Notice in lieu of the Member's Medicaid ID Card. Provider should always verify eligibility before rendering service(s) to a Member who presents a Medicaid Approval Notice.

> Refer to “Verification Options” (*see Section 3.8* Verification Options) on ways to verify a Member's eligibility.

Chapter 6 – Common Billing Information

6.1 Electronic Billing

All original claims submitted to Wyoming Medicaid are required to be filed electronically. Wyoming Medicaid's Fiscal Agent, Acentra Health will not accept paper claims for any Medicaid services.

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

Exceptions:

- Providers who have a Letter of Agreement (LOA) with the Wyoming Department of Health (WDH) will submit paper claims per the LOA. To minimize errors, organize the documents in the following order:
  - Top Page: LOA
  - Next Page: Paper Claim
  - Last Pages: Supporting Documentation
- Providers who must have Out of Policy exceptions done for certain nursing home Durable Medical Equipment (DME) items 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. This includes providers who submit a blanket denial letter for members with Cigna coverage that is primary to Medicaid.

> 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.

6.2 Basic Paper Claim Information

The 2012 ADA Claim Form is the only dental claim form that will be accepted. Claims that do not follow Medicaid Provider policies and procedures will be returned unprocessed with a letter. When a claim is returned because of billing errors or missing attachments, 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.

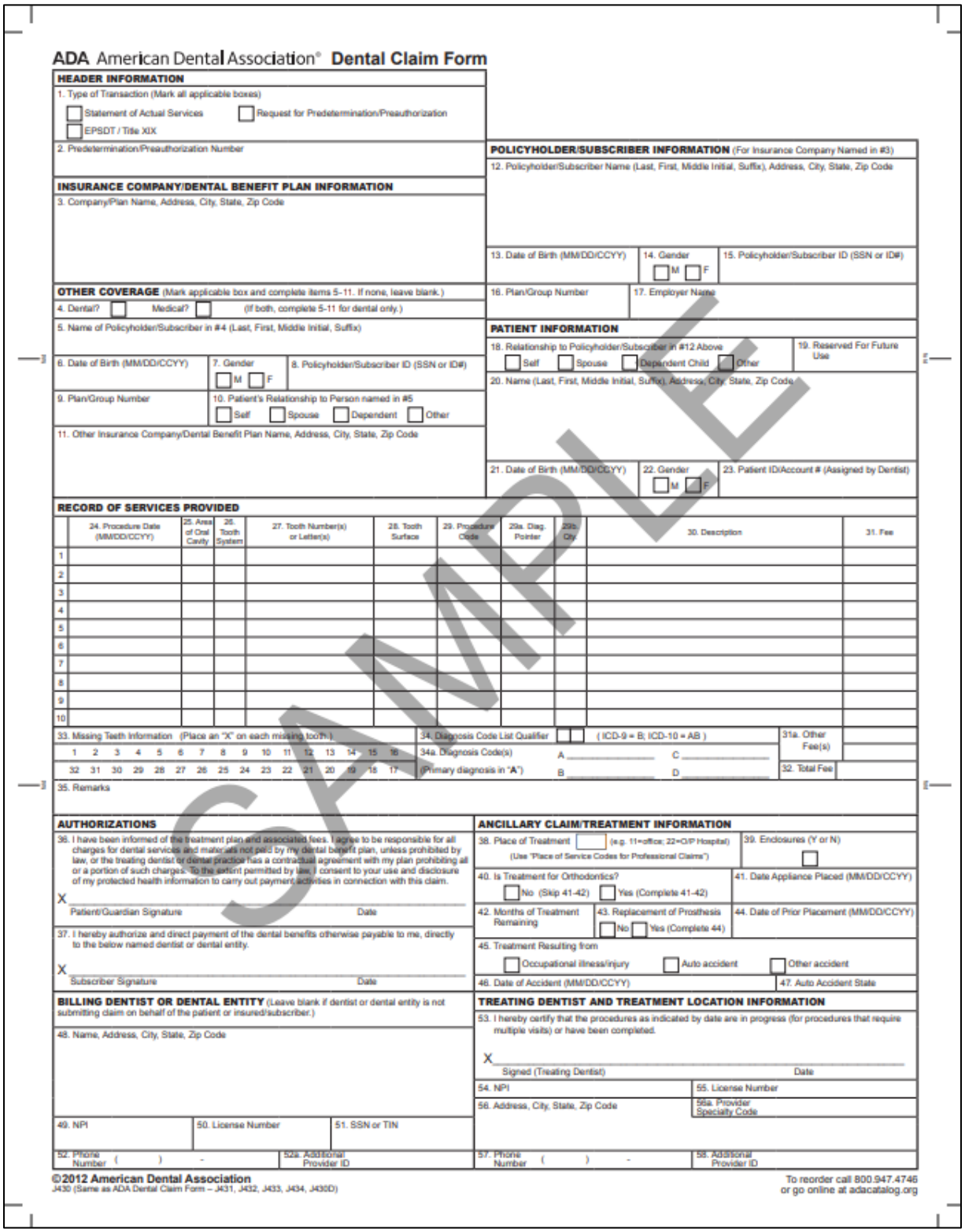
Billing errors detected after a claim is submitted cannot be corrected until after Medicaid has made payment or notified the Provider of the denial. **Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice** (*see Section 6.12* Resubmitting Versus Adjusting Claims).

> Claims are to be submitted only after service(s) have been rendered, 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.

6.3 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.

6.4 The Dental Claim Form



ADA American Dental Association® **Dental Claim Form**

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at adacatalog.org

6.4.1 Instructions for Completing the Dental Claim Form

Claim Item	Title	Required	Action
1	Type of transaction	X	Mark "Statement of Actual Services."
2	Predetermination/ Prior Authorization	X	(When applicable) Enter Prior Authorization number here.
3	Insurance Company/ Dental Benefit Plan		
4	Other dental or medical coverage	X	(When applicable) Mark appropriate box. If no, skip to box 18. If yes, complete boxes 5-11.
5	Subscriber name	X	(When applicable) Enter policyholder's name.
6	Date of birth	X	(When applicable) Enter policyholder's date of birth.
7	Gender	X	(When applicable) Enter policyholder's gender.
8	Subscriber identifier	X	(When applicable) Enter policyholder's social security number or policy number.
9	Plan/Group number	X	(When applicable) Enter policyholder's plan/group number.
10	Relationship to primary subscriber	X	(When applicable) Mark appropriate box.
11	Other carrier name and address	X	(When applicable) Enter carrier name and address.
12	Policyholder/ Subscriber Information	X	(When applicable) Enter the primary subscriber's name, address, city, state, and zip code.
13	Date of Birth	X	(When applicable) Enter the primary subscriber's date of birth (MMDDCCYY).
14	Gender	X	(When applicable) Enter the primary subscriber's gender.
15	Subscriber Identifier	X	(When applicable) Enter the primary subscriber's SSN or ID#.
16	Plan/Group Number	X	(When applicable) Enter the primary subscriber's plan/group number.
17	Employer Name	X	(When applicable) Enter the primary subscriber's employer name.

Claim Item	Title	Required	Action
18	Patient information-relationship to primary subscriber	X	Mark applicable box.
19	Reserved for Future Use		No entry required.
20	Name and address of patient	X	Enter name and address of patient.
21	Patient date of birth	X	Enter patient's date of birth.
22	Gender		No entry required.
23	Patient ID/account number	X	Enter the patients 10-digit Member ID number.
24	Procedure Date	X	Enter date services were rendered.
25	Area of oral cavity		(When applicable) Enter quadrant or arch: • UR- Upper Right • UL – Upper Left • LL- Lower Left, • LR – Lower Right • UA – Upper Arch • LA – Lower Arch
26	Tooth system		No entry required.
27	Tooth numbers (s) or letter(s)	X	(When applicable) Enter tooth number (s) or letter (s). For supernumerary teeth – add an S after the tooth code (for example, supernumerary tooth A becomes AS) (15+50=65).
28	Tooth surface	X	(When applicable) Enter tooth surface: • B – Buccal surface • D – Distal surface • F – Facial surface • I – Incisal surface • L – Lingual surface • M – Mesial surface • O – Occlusal surface

Claim Item	Title	Required	Action
29	Procedure code	X	Enter appropriate CDT –code.
29a	Diagnosis Pointer		No entry required.
29b	Qty		Enter the units of service.
30	Description		No entry required.
31	Fee	X	Enter usual and customary charges for the procedure.
31a	Other Fees	X	(When applicable) Enter the amount paid by another dental plan. Do not enter prior Medicaid payments. This box is reserved for third party coverage only. If this amount is more than 67% of the calculated Medicaid allowed amount, Providers do not need to attach an EOB.
32	Total fee	X	Add together all of the fees listed in item 31 and enter the total amount in this field.
33	Missing teeth information		No entry required.
34	Diagnosis List Qualifier		No entry required.
34a	Diagnosis Codes		No entry required.
35	Remarks		No entry required – Notes in this box will not be reviewed by Medicaid.
36	Patient/Guardian Signature	X	No entry required.
37	Subscriber signature		No entry required.
38	Place of treatment	X	Office=11; Hospital=21; Other=99
39	Number of enclosures		No entry required.
40	Is treatment for orthodontics		No entry required.
41	Date appliance placed		No entry required.
42	Months of treatment remaining		No entry required.
43	Replacement of prosthesis		No entry required.

Claim Item	Title	Required	Action
44	Date prior placement		No entry required.
45	Treatment resulting		No entry required.
46	Date of accident		No entry required.
47	Auto accident state		No entry required.
48	Name, address, city, state, zip of billing dentist or dental entity	X	Enter the name, address, city, state, and zip code of the billing dentist or dental entity.
49	NPI	X	(When applicable) Enter Group/Pay-To NPI number.
50	License number		No entry required.
51	SSN or TIN		No entry required.
52	Phone number		No entry required.
52a	Additional Provider ID		No entry required.
53	Treating dentist signature	X	Sign and date the claim. All claims must be signed and dated. Providers have the choice of using a handwritten signature, a facsimile signature, a typed signature, initials, or an authorized signature. However, Providers are responsible for ensuring that the signature on the claim is that of authorized individual. Providers are responsible for all claims billed using their Medicaid Provider number.
54	Treating dentist's NPI number	X	If a group practice, enter the treating Provider's NPI number.
55	License number		No entry required.
56	Address, city, state, zip code	X	Enter the address, city, state, and zip code of treatment location.
56a	Provider specialty code	X	Enter taxonomy code.
57	Phone number		No entry required.
58	Additional Provider ID		No entry required.

6.5 Reimbursement Methodologies

Medicaid reimbursement for covered services is based on a variety of payment methodologies depending on the service provided.

- Medicaid fee schedule
- By report pricing
- Billed charges
- Invoice charges
- Negotiated rates

6.5.1 Invoice Charges

- The invoice must be dated within 12 months (365 days) prior to the date of service being billed.
    - If the invoice is older, a letter must be included with the claim explaining the age of the invoice (such as product purchased in large quantity previously and is still in stock).
- All discounts will be taken on the invoice.
- The discounted pricing or codes cannot be marked out.
- A packing slip, price quote, purchase order, or delivery ticket may be used only if the Provider no longer has access to the invoice, is unable to obtain a replacement from the supplier or manufacturer, and a letter with explanation is included.
- Items must be clearly marked (such as how many calories are in a can of formula, items in a case, milligrams, ounces).

6.6 Usual and Customary Charges

Charges for services submitted to Medicaid must be made in accordance with an individual Provider's usual and customary charges to the general public unless:

- The Provider has entered into an agreement with the Medicaid Program to provide services at a negotiated rate; or
- The Provider has been directed by the Medicaid Program to submit charges at a Medicaid-specified rate.

6.7 Co-Payment Schedule

Description	Exceptions

There is no co-pay for Kid Care CHIP Plans B or C when the service is for routine care.	Co-payment requirements do not apply to:
	• Children defined as:
	  ○ Medicaid eligibility for children is under 21
	  ○ Kid Care CHIP eligibility for children is under 19
	EXCEPTION: Co-Pays Apply to the children's KIDC Benefit Plan (Kid Care CHIP Plans B & C)
	• Nursing Facility Residents
	• Pregnant Women
	• Family planning services
	• Emergency services
	• Hospice services
	• Medicare Crossovers
	• Members of a Federally recognized tribe

To clarify, children on the KIDB Benefit Plan (Kid Care CHIP Plan A) do not have co-pays. Children on the KIDC benefit plan (Kid Care CHIP Plan B or C) have co-pays.

Co-payments are applicable per procedure code, and some claims may have more than one co-payment amount.

6.8 Prior Authorization

Medicaid requires Prior Authorization (PA) on selected services and equipment. **Approval of a PA is never a guarantee of payment.** A Provider should not render services until a Member's eligibility has been verified and a PA has been approved (if a PA is required). Services rendered without obtaining a PA (when a PA is required) may not be reimbursed.

Selected services and equipment requiring prior authorization include, but are not limited to the following – use in conjunction with the Dental and Medicaid Fee Schedules to verify what needs PA:

Services Requiring PA	PA Vendor
Cone Beam CT Capture and Interpretation	Telligen (833) 610-1057
Specialized Denture Services	
Implant Services and Fixed Prosthesis (Bridges)	
Oral and Maxillofacial Surgery	
Orthodontics/Severe Malocclusion Program	

> Services requiring PA are outlined in *Chapter 11* – Covered Services.

6.8.1 Requesting Prior Authorization

Providers must request a PA from Telligen (*see Section 2.1* Quick Reference). Dental prior authorizations must be submitted electronically via Telligen's portal. Prior

Authorizations will not be issued after a procedure is complete. The Provider must obtain a PA prior to rendering services.

> Modifications or issues concerning PAs originally issued by the previous fiscal agent, Conduent, should be directed to the Utilization Management Coordinator, Amy Buxton, at amy.buxton@wyo.gov.

6.8.2 Prior Authorization Status Inquiry

The BMS will receive approved and denied PAs (278 transactions) from Telligen. PAs in a pending status will not be sent to the BMS.

Providers are able to inquiry and view PA statuses on the Provider Portal by completing a Prior Authorization Inquiry. Statuses include approved, denied, or used. A PA may have both approved and denied lines. For lines that are approved, the corresponding item may be purchased, delivered, or services may be rendered.

The complete 10-digit PA number must be entered in box 2 of the ADA Dental Claim Form. For placement in an electronic X12N 837 Dental Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3).

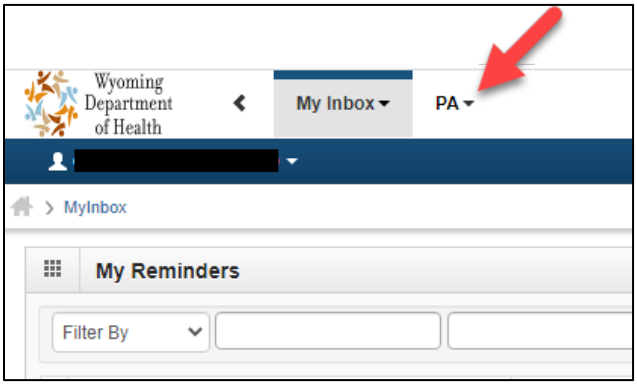
> Used PAs will be viewable on the Provider Portal.

To complete a Prior Authorization (PA) Inquiry via the Provider Portal:

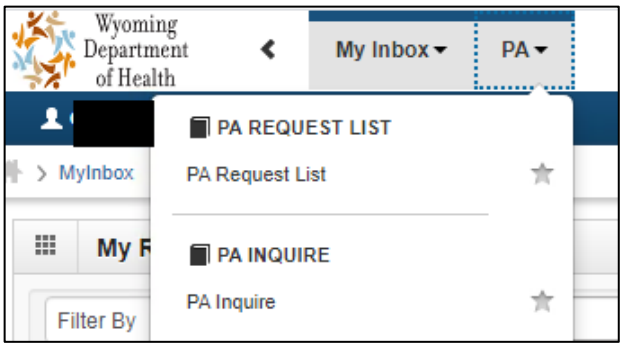
1. Log in to the Medicaid Portal (*see Section 2.1* Quick Reference).

> The Provider or user must have the Prior Authorization Access, Provider Profile to inquire on prior authorizations.

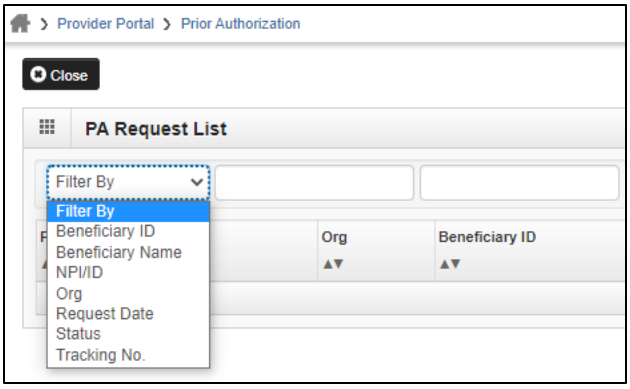
2. Once the user is logged into to the Provider Portal and selects Prior Authorization Access from the Provider Profile drop-down list, **PA** appears next to "My Inbox".



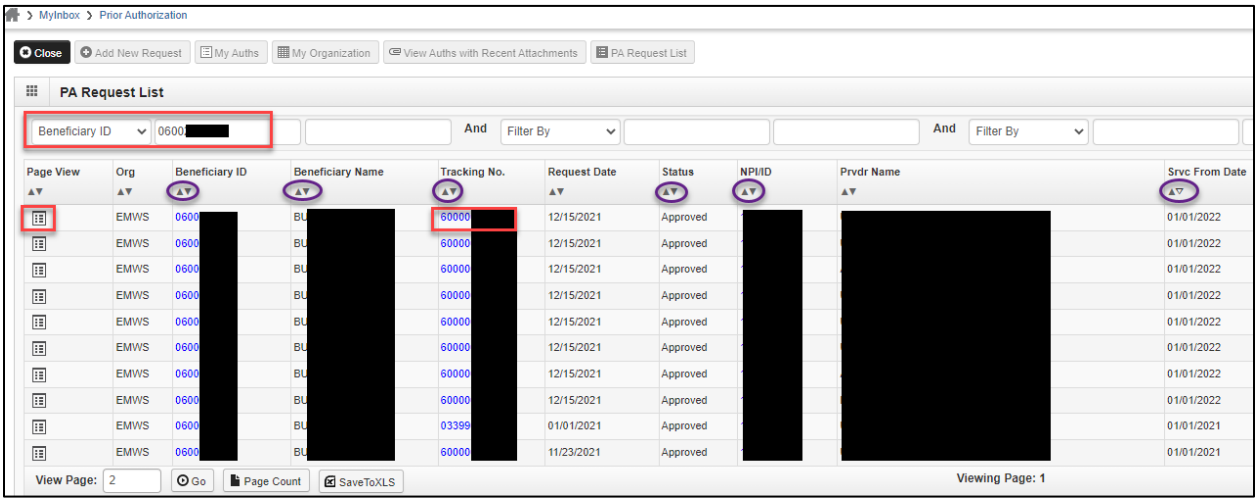
3. From the **PA** drop-down list, select **PA Request List** (do not have PA number) or **PA Inquire** (have PA number).



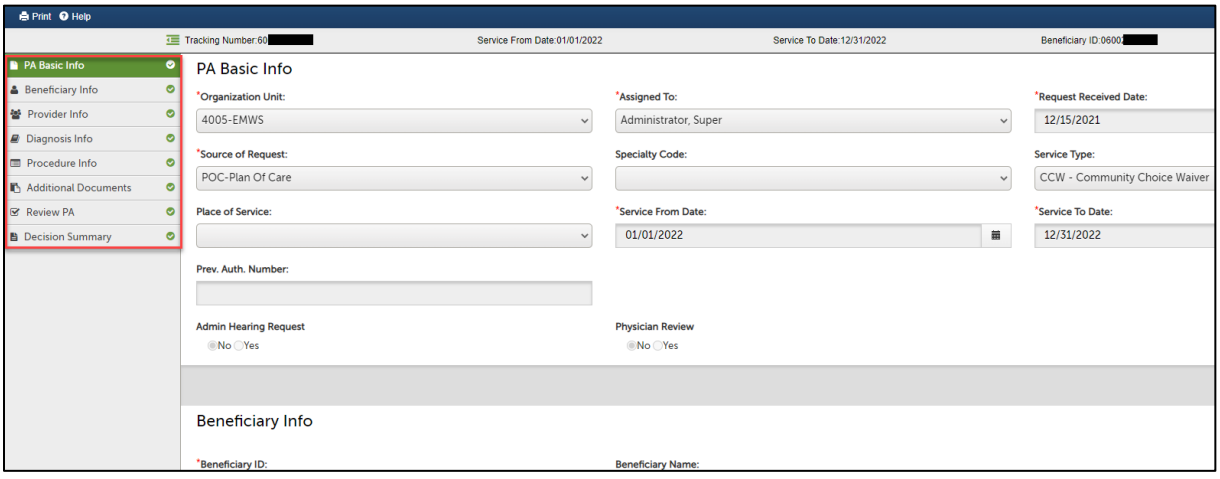
> Providers inquiring on PAs may select PA Request List and filter (search) in various ways, such as PA Tracking No., Beneficiary (Member) ID, Beneficiary (Member) Name, Status.



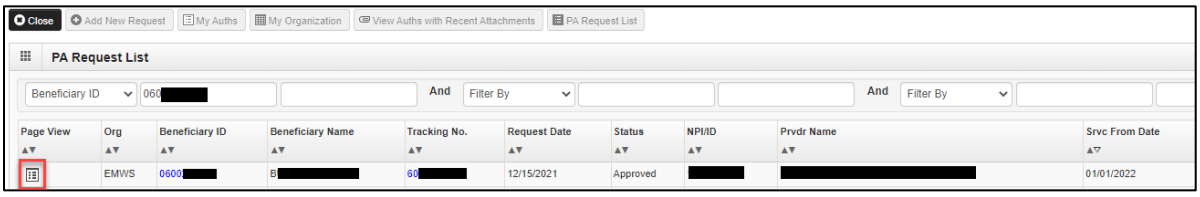
Example of a search by the Beneficiary (Member) ID- Select **Beneficiary ID** in the first drop-down list, then enter the 10-digit Medicaid Member ID number and select **Go**. Below is partial information that is displayed.



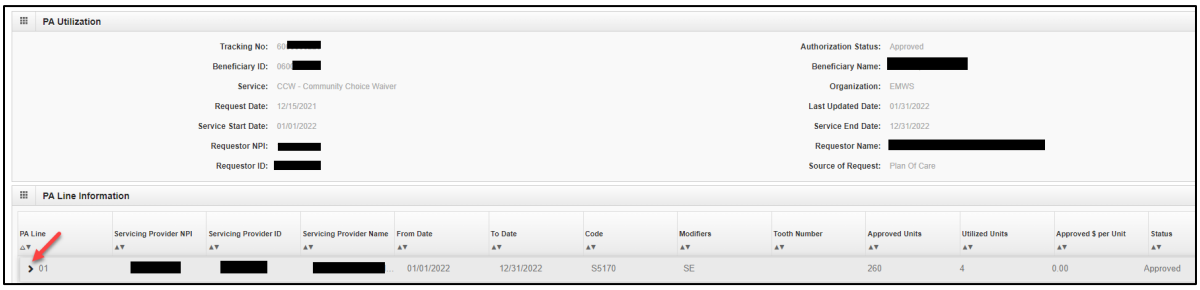
4. Select the PA Tracking Number in blue to go to the PA. Providers can navigate the PA by scrolling up and down or using the navigation on the left to go directly to a specific area.



Or select the **Page View** icon to view the PA information, including the approved units, utilized units and the claims associated with this PA.



5. Select the **greater than (>)** icon next to the line number to view the claims (TCNs) submitted with this PA number.



6. Providers may print the PA or view only.

6.9 Billing of Deliverables

All dental procedures that involve delivering an item to the Member can only be billed to Medicaid on the date the item is delivered to the Member. This includes crowns, bridges, removable appliances, and partial and complete dentures. The Provider is responsible for billing these procedures only on the seat/delivery date.

Wyoming Medicaid will allow a Provider to bill using the prep date only if one of the following conditions is present:

- Member is not eligible on the delivery date but was eligible on the prep date
- Member does not return to the office for the delivery of the product

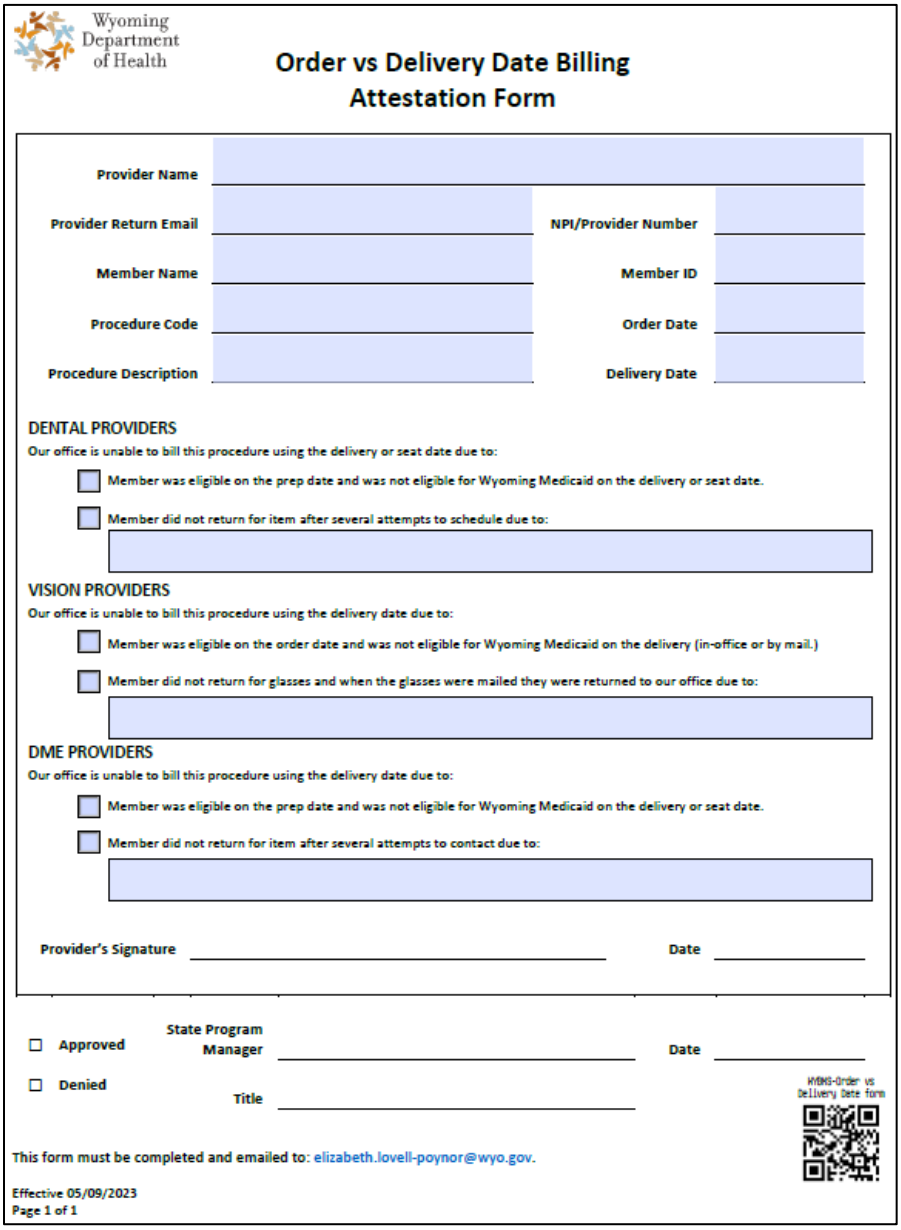
A Provider may use the order date as the date of service only if they have obtained a signed exception form from the State. To obtain this authorization, follow the steps below.

- Print the “Order vs Delivery Date Exception Form,” (*see Section 6.9.1* Order vs Delivery Date Exception Form).
- Complete the form and fax or mail it to the address at the bottom of the form

- Once the form is signed by the State, it will be returned to the Provider and must be a part of the Member's permanent clinical record
- The Provider may then bill the claim using the order date as the date of service

> If an audit of clinic records is performed, and it is found that the Provider billed on the order date but does not have s signed Order vs Delivery Date Exception Form for the Member and the DOS, the money paid will be recovered.

6.9.1 Order vs Delivery Date Exception Form



Wyoming Department of Health

Order vs Delivery Date Billing Attestation Form

Provider Name

Provider Return Email | NPI/Provider Number

Member Name | Member ID

Procedure Code | Order Date

Procedure Description | Delivery Date

DENTAL PROVIDERS

Our office is unable to bill this procedure using the delivery or seat date due to:

- ☐ Member was eligible on the prep date and was not eligible for Wyoming Medicaid on the delivery or seat date.
- ☐ Member did not return for item after several attempts to schedule due to:

VISION PROVIDERS

Our office is unable to bill this procedure using the delivery date due to:

- ☐ Member was eligible on the order date and was not eligible for Wyoming Medicaid on the delivery (in-office or by mail.)
- ☐ Member did not return for glasses and when the glasses were mailed they were returned to our office due to:

DME PROVIDERS

Our office is unable to bill this procedure using the delivery date due to:

- ☐ Member was eligible on the prep date and was not eligible for Wyoming Medicaid on the delivery or seat date.
- ☐ Member did not return for item after several attempts to contact due to:

Provider's Signature | Date

☐ Approved

☐ Denied

State Program Manager | Date

Title

WDH-Order vs Delivery Date form

This form must be completed and emailed to: elizabeth.lovell-poynor@wyo.gov.

Effective 05/09/2023
Page 1 of 1

This form is located on the Wyoming Medicaid website.

6.10 Submitting Attachments for Electronic Claims

When a claim requires supporting documentation (such as sterilization consent form, op notes, EOB, or EOMB). Providers may either upload their documents electronically or complete one of the attachment coversheets to mail or email their documents.

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 6.10.1.1* Sample of Systematically Generated Provider Portal Attachment Coversheet) for that specific claim or download and complete the Attachment Coversheet (*see section 6.10.1.2* 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 – Electronic Data Interchange
- 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

6.10.1 Attachment Cover Sheets

There a two (2) Attachment Coversheets:

- Attachment Coversheet systematically generated and printed from the Provider Portal (*see Section 6.10.1.1* 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 6.10.1.2* 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 form (*see Section 6.10.1.2* Attachment Coversheet and Instructions)

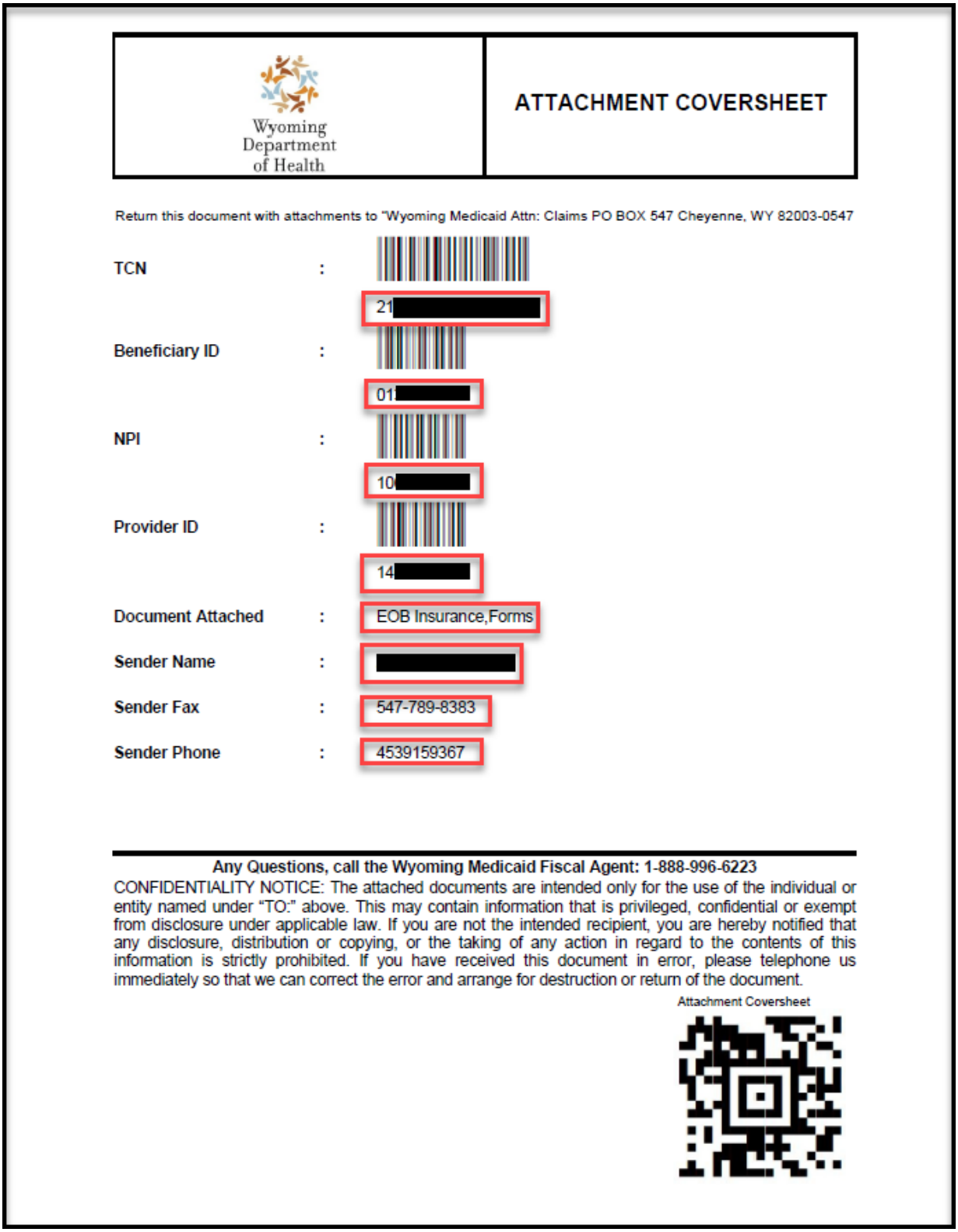
Mail or fax (25 pages maximum) the attachment coversheets with the supporting documents to the Claims Department (*see Section 2.1* Quick Reference). Coversheets can also be emailed to the Provider Services email address, WYProviderOutreach@cns-inc.com, made to the Attention: Claims Department

- 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.

6.10.1.1 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

6.10.1.2 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

6.11 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.

6.11.1 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* RA Banner Notices Samples).
- **Summary Page:** This second page provides a summary of paid, denied, credited, gross adjusted, total billed, and total paid.
- **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, DRG/APC, quantity, billed amount, (Medicaid) approved amounts, TPL amounts, Member responsible amount, category, and reason and remark codes
- **Glossary Pages:** The last pages list the Error Code details with associated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) and for the denied lines and claims.

6.11.2 Remittance Advice General Information and Definitions

- Remittance Advices are generated for each Billing Provider.
- In Prospective Payment System (PPS) column:
  - For Outpatient, report APC Pay Status Code (at each line).
  - For Inpatient, report DRG.
  - For all other Providers, this is blank.
- In the Original TCN, TCN, Type of Bill column:
  - Type of Bill is only reported for Institutional Claims.
- The original TCN is reported once per invoice, it is not repeated on each service line.

- In the Gross Adj ID, Beneficiary Name, Beneficiary ID, Patient Account #, and Medical Record # 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 at the beginning of the Provider's RA and after the first or cover 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 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. The Category Column will contain 'C' for Credited.
    - Below the approved Adjustment Header, the net adjustment amount for the claim will be printed and the category will be 'P' for Paid.
    - The approved amount is the Medicaid allowed amount or paid amount
- In the Category Column:
    - Reversal prints in the Category Column next to the history claim being adjusted.
    - Individual lines, other than the suspended lines will report as credit (C), paid (P), denied (D), or gross adjustment (GA) in this column.
    - The header line, if not "Suspended", will report as credit (C), paid (P), denied (D), or gross adjustment (GA) in this column.

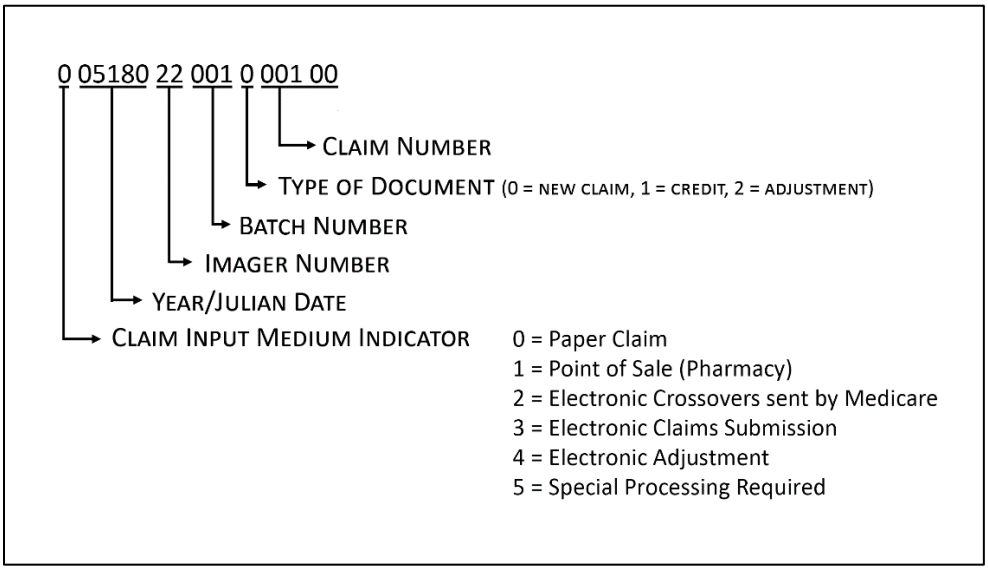
- The status of the Header is “D” if all service lines are denied.

- 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 and Paper RA.
- 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.
- 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.
- 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.

6.11.3 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.

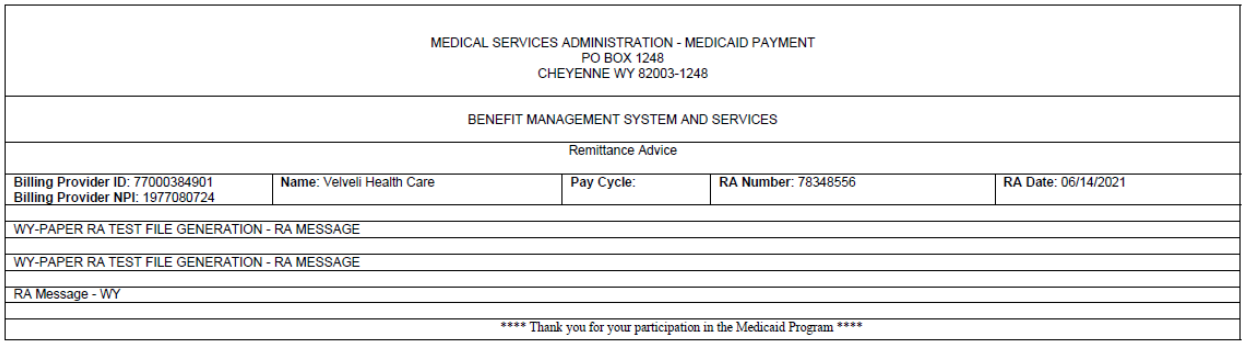
6.11.4 Locating the Medicaid Paper Remittance Advice within the Provider Portal

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.

6.11.5 Sample Remittance Advices and How to Read the Remittance Advice

6.11.5.1 Sample Cover Page (First Page)



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

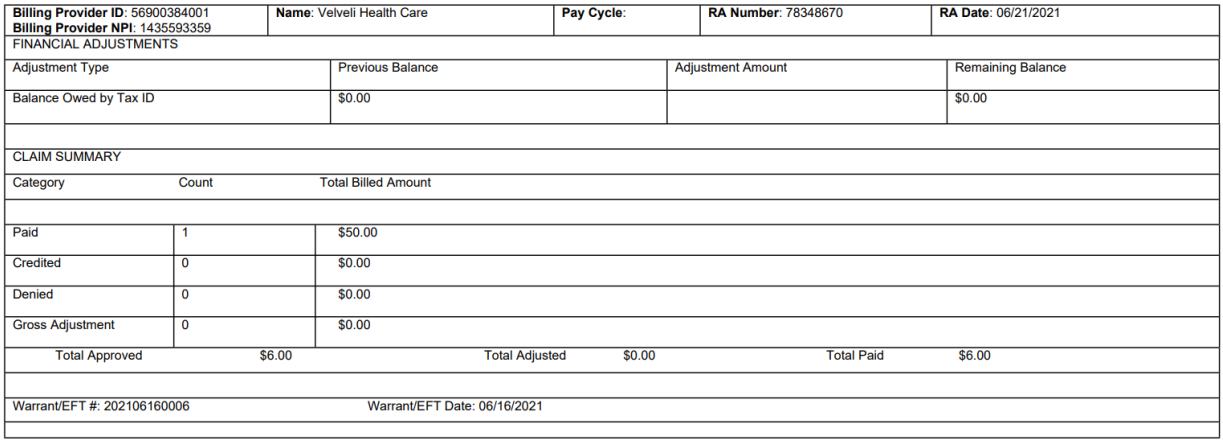
RA Message - WY

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

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.

6.11.5.2 Sample Remittance Advice Summary Page with a Paid Claim



Billing Provider ID: 56900384001 **Billing Provider NPI**: 1435593359	**Name**: Velveli Health Care	**Pay Cycle**:	**RA Number**: 78348670	**RA Date**: 06/21/2021

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance
Balance Owed by Tax ID	$0.00		$0.00

CLAIM SUMMARY

Category	Count	Total Billed Amount
Paid	1	$50.00
Credited	0	$0.00
Denied	0	$0.00
Gross Adjustment	0	$0.00

Total Approved $6.00 Total Adjusted $0.00 Total Paid $6.00

Warrant/EFT #: 202106160006 Warrant/EFT Date: 06/16/2021

Interpreting the Summary and Detail Pages:

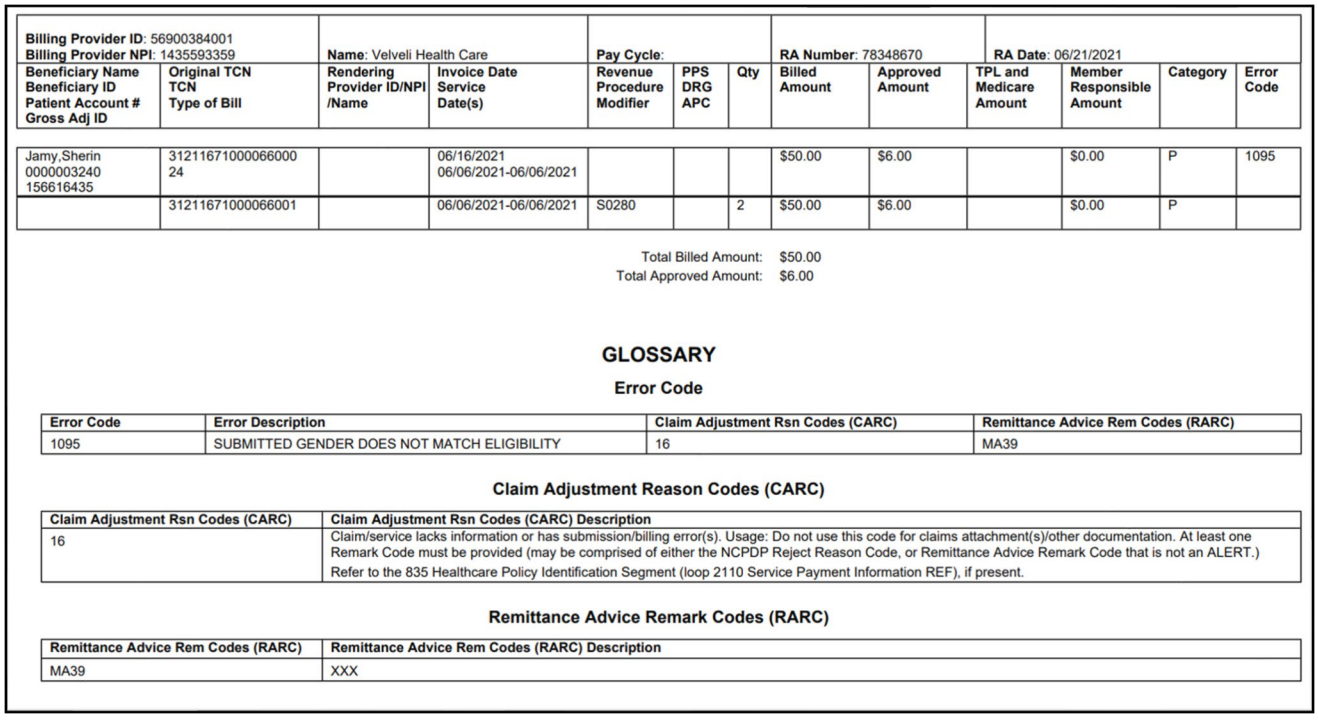
Summary Page Field Name	Notes
Billing Provider ID	Billing Provider Number.
Billing Provider NPI	Billing National Provider Identification Number.
Name	Name of Billing Provider.
Pay Cycle	Pay cycle for the Remittance Advice Report established according to the Remittance Advice Schedule.
RA Number	Remittance 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.
CLAIM SUMMARY	Claims Summary Count.
Category	Claim Categories: • Paid • Credited (Adjustment or Void)

Summary Page Field Name	Notes
	• Denied • Gross Adjustment
Count	Count for each claim category.
Total Billed Amount	Total billed amount for each claim category.
Paid	Number of Paid claims.
Credited	Number of Credited claims.
Denied	Number of Denied claims.
Gross Adjustment	Number of Gross Adjustments.
Payment AP/AR Netting	Amount displays as applicable.
Total Approved	Total approved claims amount for the Billing Provider.
Total Adjusted	Sum of the financial adjustment amounts (+ or -).
Total Paid	Sum of total approved and adjusted (Medicaid Paid Amount).
Warrant/EFT #	Warrant or Electronic Fund Transfer number.
Warrant/EFT Date	Warrant or Electronic Fund Transfer Date.

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.
Revenue Procedure/Modifier	Revenue, Procedure Code, Modifier as applicable.
PPS/DRG/APC	• For Inpatient: DRG. • For Outpatient: APC - Pay Status.

Detail Page Field Name	Notes
	• For all others: blank.
Qty	Quantity (Billed Units).
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	Approved amount on the claim. The service line reports the line approved amount. For Credited claim category, displays the total amount reversed (credited) from the original claim.
TPL and Medicare Amount	TPL and Other Payer Insurance Amount.
Member Responsible Amount	Member Responsible Amount (Patient Contribution).
Category	Category indicating Status of Claim: P= Paid, C= Credited, D= Denied.

6.11.5.3 Sample Remittance Advice (Detail Page) with a Paid Claim



Billing Provider ID: 56900384001
Billing Provider NPI: 1435593359
Name: Velveli Health Care
Pay Cycle:
RA Number: 78348670
RA Date: 06/21/2021

Beneficiary Name / Beneficiary ID / Patient Account # / Gross Adj ID	Original TCN / TCN / Type of Bill	Rendering Provider ID/NPI /Name	Invoice Date / Service Date(s)	Revenue / Procedure / Modifier	PPS / DRG / APC	Qty	Billed Amount	Approved Amount	TPL and Medicare Amount	Member Responsible Amount	Category	Error Code
Jamy,Sherin 0000003240 156616435	31211671000066000 24		06/16/2021 06/06/2021-06/06/2021				$50.00	$6.00		$0.00	P	1095
	31211671000066001		06/06/2021-06/06/2021	S0280		2	$50.00	$6.00		$0.00	P	

Total Billed Amount: $50.00
Total Approved Amount: $6.00

GLOSSARY

Error Code

Error Code	Error Description	Claim Adjustment Rsn Codes (CARC)	Remittance Advice Rem Codes (RARC)
1095	SUBMITTED GENDER DOES NOT MATCH ELIGIBILITY	16	MA39

Claim Adjustment Reason Codes (CARC)

Claim Adjustment Rsn Codes (CARC)	Claim Adjustment Rsn Codes (CARC) Description
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.

Remittance Advice Remark Codes (RARC)

Remittance Advice Rem Codes (RARC)	Remittance Advice Rem Codes (RARC) Description
MA39	XXX

In the above example, the claim is paid (P) and posting the error code 1095 – which is informational, a "pay and report" error code, not causing the claim or a line to be denied.

6.11.5.4 Sample Remittance Advice (Detail Page) with a Denied Claim

Billing Provider ID: 999999999
Billing Provider NPI: 1234567890
Name: Test LLC
Pay Cycle: 19
RA Number: 23232323
RA Date: 05/06/2022

Beneficiary Name / Beneficiary ID / Patient Account # / Gross Adj ID	Original TCN / TCN / Type of Bill	Rendering Provider ID/NPI /Name	Invoice Date / Service Date(s)	Revenue / Procedure / Modifier	PPS / DRG / APC	Qty	Billed Amount	Approved Amount	TPL and Medicare Amount	Member Responsible Amount	Category	Error Code
Test1,Test2 000001234 FUSD0000	55555555555555000 02	999999999 1114080660 John Doe	04/28/2022 01/06/2022-01/06/2022				$99.21	$0.00		$0.00	D	1001
	55555555555555001		01/06/2022-01/06/2022	90837		0	$99.21	$0.00	$0.00	$0.00	D	1002
Test1,Test2 000001234 FUSD0000	44444444444444000 02	999999999 1114080660 John Doe	04/28/2022 01/12/2022-01/12/2022				$99.21	$0.00		$0.00	D	1001
	44444444444444001		01/12/2022-01/12/2022	90837		0	$99.21	$0.00	$0.00	$0.00	D	1002

Total Billed Amount: $910.92
Total Approved Amount: $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.

GLOSSARY

Error Code

Error Code	Error Description	Claim Adjustment Reason Codes (CARC)	Remittance Advice Remark Codes (RARC)
1001	Timely Filing Missing	25	M455
1002	Invalid Billing Provider	45	

Claim Adjustment Reason Codes (CARC)

Claim Adjustment Reason Codes (CARC)	Claim Adjustment Reason Codes (CARC) Description
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability).
25	Payment denied. Your Stop loss deductible has not been met.

Remittance Advice Remark Codes (RARC)

Remittance Advice Remark Codes (RARC)	Remittance Advice Remark Codes (RARC) Description
M455	Missing Physician Order.

6.11.5.5 Sample Error Code Details with Associated Claim Adjustment Reason Codes and Remittance Advice Remark Codes

GLOSSARY

Error Code

Error Code	Error Description	Claim Adjustment Reason Codes (CARC)	Remittance Advice Remark Codes (RARC)
1001	Timely Filing Missing	25	M455
1002	Invalid Billing Provider	45	

Claim Adjustment Reason Codes (CARC)

Claim Adjustment Reason Codes (CARC)	Claim Adjustment Reason Codes (CARC) Description
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability).
25	Payment denied. Your Stop loss deductible has not been met.

Remittance Advice Remark Codes (RARC)

Remittance Advice Remark Codes (RARC)	Remittance Advice Remark Codes (RARC) Description
M455	Missing Physician Order.

6.11.5.6 Sample Remittance Advice (Summary and Detail Pages) with a Void Claim

- The original TCN is listed in the field above the new void TCN

Billing Provider ID: 56900384001 **Billing Provider NPI**: 1435593359	**Name**: Velveli Health Care	**Pay Cycle**:	**RA Number**: 0	**RA Date**: 06/21/2021

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance
Balance Owed by Tax ID	-$6.00		$0.00

CLAIM SUMMARY

Category	Count	Total Billed Amount
Paid	0	$0.00
Credited	1	-$50.00
Denied	0	$0.00
Gross Adjustment	0	$0.00

Total Approved $0.00 Total Adjusted $0.00 Total Paid $0.00

Warrant/EFT #: Warrant/EFT Date: 06/21/2021

Billing Provider ID: 56900384001 Billing Provider NPI: 1435593359		Name: Velveli Health Care		Pay Cycle:			RA Number: 0		RA Date: 06/21/2021			
Beneficiary Name Beneficiary ID Patient Account # Gross Adj ID	**Original TCN TCN Type of Bill**	**Rendering Provider ID/NPI /Name**	**Invoice Date Service Date(s)**	**Revenue Procedure Modifier**	**PPS DRG APC**	**Qty**	**Billed Amount**	**Approved Amount**	**TPL and Medicare Amount**	**Member Responsible Amount**	**Category**	**Error Code**
Jamy,Sherin 0000003240 156616435	41211678000123000 24		06/16/2021 06/06/2021-06/06/2021				-$50.00	-$6.00		$0.00	C	1095
	41211678000123001		06/06/2021-06/06/2021	S0280		-2	$50.00	-$6.00		$0.00	C	

Total Billed Amount: -$50.00
Total Approved Amount: -$6.00

GLOSSARY

Error Code

Error Code	Error Description	Claim Adjustment Rsn Codes (CARC)	Remittance Advice Rem Codes (RARC)
1095	SUBMITTED GENDER DOES NOT MATCH ELIGIBILITY	16	MA39

Claim Adjustment Reason Codes (CARC)

Claim Adjustment Rsn Codes (CARC)	Claim Adjustment Rsn Codes (CARC) Description
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.

Remittance Advice Remark Codes (RARC)

Remittance Advice Rem Codes (RARC)	Remittance Advice Rem Codes (RARC) Description
MA39	XXX

6.11.5.7 Sample Remittance Advice (Summary and Detail Pages) with a Paid and Denied Claim

Billing Provider ID: 49934000301 Billing Provider NPI: 1005268960	Name: Velveli Health Care	Pay Cycle:	RA Number: 78348641	RA Date: 06/21/2021

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance
Balance Owed by Tax ID	$0.00		$0.00

CLAIM SUMMARY

Category	Count	Total Billed Amount
Paid	1	$3,500.00
Credited	0	$0.00
Denied	1	$3,500.00
Gross Adjustment	0	$0.00

Total Approved $3,500.00 Total Adjusted $0.00 Total Paid $3,500.00

Warrant/EFT #: 202106160001 Warrant/EFT Date: 06/16/2021

Billing Provider ID: 4993000301 Billing Provider NPI: 1005268960		Name: Velveli Health Care		Pay Cycle:			RA Number: 78348641			RA Date: 06/21/2021		
Beneficiary Name Beneficiary ID Patient Account # Gross Adj ID	**Original TCN TCN Type of Bill**	**Rendering Provider ID/NPI /Name**	**Invoice Date Service Date(s)**	**Revenue Procedure Modifier**	**PPS DRG APC**	**Qty**	**Billed Amount**	**Approved Amount**	**TPL and Medicare Amount**	**Member Responsible Amount**	**Category**	**Error Code**
Thomas,Roy 0000003184 156616435	31211661000175000 24		06/15/2021 01/30/2021-01/30/2021				$3,500.00	$3,500.00		$0.00	P	
	31211661000175001	202039930 1576193357 Velveli Health Care Velveli Health Care	01/30/2021-01/30/2021	00882		1	$3,500.00	$3,500.00		$0.00	P	
Thomas,Roy 0000003184 156616435	31211661000172000 24		06/15/2021 05/29/2021-05/29/2021				$3,500.00	$0.00		$0.00	D	
	31211661000172001		05/29/2021-05/29/2021	00882		0	$3,500.00	$0.00		$0.00	D	1232

Total Billed Amount: $7,000.00
Total Approved Amount: $3,500.00

GLOSSARY

Error Code

Error Code	Error Description	Claim Adjustment Rsn Codes (CARC)	Remittance Advice Rem Codes (RARC)
1232	DATE OF DEATH IS BEFORE THE DATE OF SERVICE OR DATE OF BIRTH IS AFTER THE DATE OF SERVICE	13	

Claim Adjustment Reason Codes (CARC)

Claim Adjustment Rsn Codes (CARC)	Claim Adjustment Rsn Codes (CARC) Description
13	The date of death precedes the date of service.

6.11.5.8 Sample Remittance Advice (Detail Page) with an Adjustment and Void Claim

- The original TCNs are listed in the fields above the new adjusted and void TCNs

Billing Provider ID: 55300349901 Billing Provider NPI: 1241854003	Name: Velveli Health Care	Pay Cycle:	RA Number: 78348669	RA Date: 06/21/2021

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance
AP/AR Netting		$20.00	
Balance Owed by Tax ID	$0.00		$0.00

CLAIM SUMMARY

Category	Count	Total Billed Amount
Paid	2	$134.92
Credited	1	-$500.00
Denied	1	$100.00
Gross Adjustment	0	$0.00

AP/AR Netting $20.00

Total Approved $54.92 Total Adjusted $20.00 Total Paid $34.92

Warrant/EFT #: 202106160005 Warrant/EFT Date: 06/16/2021

Billing Provider ID: 55300349901 Billing Provider NPI: 1241854003		Name: Velveli Health Care		Pay Cycle:			RA Number: 78348669		RA Date: 06/21/2021			
Beneficiary Name Beneficiary ID Patient Account # Gross Adj ID	**Original TCN TCN Type of Bill**	**Rendering Provider ID/NPI /Name**	**Invoice Date Service Date(s)**	**Revenue Procedure Modifier**	**PPS DRG APC**	**Qty**	**Billed Amount**	**Approved Amount**	**TPL and Medicare Amount**	**Member Responsible Amount**	**Category**	**Error Code**
Sifa,Abu 0000003400 156616435	31211677000071000 12		06/16/2021 02/21/2021-02/21/2021				$34.92	$34.92		$0.00	P	
	31211677000071001	610013991 1515707077 Joan Health Care Joan Health Care	02/21/2021-02/21/2021	99341		1	$34.92	$34.92		$0.00	P	1825
Sifa,Abu 0000003400 156616435	31211677000073000 12		06/16/2021 02/21/2021-02/21/2021				$100.00	$0.00		$0.00	D	1014,1409
	31211677000073001		02/21/2021-02/21/2021	99341		0	$100.00	$0.00		$0.00	D	1825
Sifa,Abu 0000003400 156616435	31211671000074000 12		06/16/2021 02/22/2021-02/22/2021				$100.00	$54.92		$0.00	P	
	31211671000074001		02/22/2021-02/22/2021	99341		1	$100.00	$54.92		$0.00	P	1825
Abu 0000003400 156616435	41211678000072000 12		06/16/2021 02/21/2021-02/21/2021				-$500.00	-$54.92		$0.00	C	
	41211678000072001		02/21/2021-02/21/2021	99341		-1	$500.00	-$54.92		$0.00	C	

Total Billed Amount: -$265.08
Total Approved Amount: $34.92

GLOSSARY

Error Code

Error Code	Error Description	Claim Adjustment Rsn Codes (CARC)	Remittance Advice Rem Codes (RARC)
1014	CLAIM WAS ALREADY ADJUSTED	B13	N10
1409	INVALID PARENT TCN/CLAIM AT HEADER	16	M47
1825	CLAIM BEING REVIEWED FOR INCAR BENEFIT PLAN WITH ACTIVE MEDICARE	22	N598

Claim Adjustment Reason Codes (CARC)

Claim Adjustment Rsn Codes (CARC)	Claim Adjustment Rsn Codes (CARC) Description
22	This care may be covered by another payer per coordination of benefits.

WY_1384

Claim Adjustment Rsn Codes (CARC)	Claim Adjustment Rsn Codes (CARC) Description
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
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.

Remittance Advice Remark Codes (RARC)

Remittance Advice Rem Codes (RARC)	Remittance Advice Rem Codes (RARC) Description
N598	Health care policy coverage is primary.
N10	XXX
M47	XXX

Providers may obtain RAs from the Provider Portal, see *Chapter 8* – Electronic Data Interchange or go to the Provider Publications and Trainings posted on the Medicaid website and download the Quick Reference Guide for the steps (*see Section 2.1* Quick Reference).

6.11.6 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 7* – 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 7.2.1* Third Party Resources Information Sheet) should be used for reporting new insurance coverage or changes in insurance coverage on a Member's policy.

6.12 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):** • Provider may choose to adjust this paid claim or resubmit only the denied line(s) as a new 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.

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

The deadlines for resubmitting and adjusting claims are different:

- Provider may resubmit any denied claim or line within 12 months (365 days) of the date of service.
- Provider may adjust any paid claim within six (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.

6.12.2 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 Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) 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.

6.12.2.1 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 Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) on the RA/835 transaction, make the appropriate corrections, and resubmit the claim.
- **Paid Claim with One (1) or More Line(s) Denied:** For dental claims, the Provider may resubmit the individually denied lines as a new claim or 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.

6.12.3 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 6.12.3.4* Adjustment/Void Request Form). 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.

6.12.3.1 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 if the payment is less than 67% of the calculated Medicaid allowed amount.
    - For the complete policy regarding Third Party Liability, *see Chapter 7* – Third Party Liability.

> Replace An adjustment cannot be completed when the mistake is the pay-to Provider number or NPI.text with imported note text.

6.12.3.2 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).

6.12.3.3 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 the Adjustment/Void Request Form (*see Section 6.12.3.4* 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 six (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 :

  a. Correct all items that should be corrected and attach this corrected claim to the Adjustment/Void form.

  b. Indicate "**Corrected Claim"** as the reason for adjustment.

6.12.3.4 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). This form is located on the Wyoming Medicaid website.

6.12.3.5 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"

Section	Field #	Field Name	Action
C		Provider Signature and Date	Signature of the Provider or the Providers' authorized representative and the date.

6.12.3.6 Adjusting a Claim Electronically via an 837 Transaction

Wyoming Medicaid prefers claim adjustments and voids on paid claims to be submitted electronically, refer to *Chapter 8* – Electronic Data Interchange, or refer to the Wyoming Medicaid EDI Companion Guide or Provider Publications and Trainings posted to the Medicaid website (*see Section 2.1* Quick Reference) for the specific tutorial.

6.13 Credit Balances

A credit balance occurs when a Provider's credits (take backs) exceed their debits (payouts), which results in the Provider owing Medicaid money.

Credit balances may be resolved in two (2) ways:

1. Working off the credit balance: By taking no action, remaining credit balances will be deducted from future claim payments. The deductions appear as credits on the Provider's RA(s)/835 transaction(s) until the balance owed to Medicaid has been paid.
2. Sending a check, payable to the "Division of Healthcare Financing," for the amount owed. This method is typically required for Providers who no longer submit claims to Medicaid or if the balance is not paid within 30 days. A notice is typically sent from Medicaid to the Provider requesting the credit balance to be paid. The Provider is asked to attach the notice, a check, and a letter explaining that the money is to pay off a credit balance. Include the Provider number to ensure the money is applied correctly.

> When a Provider number with Wyoming Medicaid changes, but the Provider's tax-ID remains the same, the credit balance will be moved automatically from the old Medicaid Provider number to the new one and will be reflected on RAs/835 transactions.

6.14 Timely Filing

The Division of Healthcare Financing adheres strictly to its timely filing policy. The Provider must submit a clean claim to Medicaid 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 (*see Section 6.9* Billing of Deliverables).

6.14.1 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 six (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 with in six (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.
Member is determined to be eligible due to agency corrective actions (retroactive eligibility)	Claims must be submitted within six (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.

6.14.2 Appeal of Timely Filing

A Provider may appeal (*see Section 2.3.2* How to Appeal) 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 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 results in denials and time lost to correct claims appropriately.

6.15 Important Information Regarding Retroactive Eligibility Decisions

The Member is responsible for notifying the Provider of the retroactive eligibility determination and supplying a copy of the notice.

A Provider is responsible for billing Medicaid only if:

- They agreed to accept the patient as a Medicaid Member pending Medicaid eligibility; or
- After being informed of retroactive eligibility, they elect to bill Medicaid for services previously provided under a private agreement. In this case, any money paid by the Member for the services being billed to Medicaid would need to be refunded prior to a claim being submitted to Medicaid.

> The Provider determines at the time they are notified of the Member's eligibility if they are choosing to accept the Member as a Medicaid Member. If the Provider does not accept the Member, they remain private pay.

In the event of retroactive eligibility, claims must be submitted within six (6) months (180 days) of the date of determination of retroactive eligibility.

> Inpatient Hospital Certification: A hospital may seek admission certification for a Member found retroactively eligible for Medicaid benefits after the date of admission for services that require

admission certification. The hospital must request admission certification within 30 days after the hospital receives notice of eligibility. To obtain certification, contact Telligen (*see Section 2.1* Quick Reference).

6.16 Member Fails to Notify Provider of Eligibility

If a Member fails to notify a Provider of Medicaid eligibility, and is billed as a private-pay patient, the Member is responsible for the bill unless the Provider agrees to submit a claim to Medicaid. In this case:

- Any money paid by the Member for the service being billed to Wyoming Medicaid must be refunded prior to billing Medicaid;
- The Member can no longer be billed for the service; and
- Timely filing criterion is in effect.

The Provider determines at the time they are notified of the Member's eligibility if they are choosing to accept the Member as a Medicaid Member. If the Provider does not accept the Member, they remain private pay.

6.17 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 7 – Third Party Liability

7.1 Definition of a Third Party Liability

7.1.1 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)
- Vision coverage
- Dental coverage
- Casualty coverage resulting from an accidental injury or personal injury
- Payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more Members.

7.1.2 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
    - Disability Insurance
    - Workers' Compensation
    - Spouse or parent who is obligated by law or by court order to pay all or part of such costs (absent parent)
    - Member's estate
    - Title 25

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).

Medicaid is 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.

7.1.3 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, and 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.

7.1.3.1 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.

7.1.3.2 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.

7.1.3.3 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.

7.1.3.4 Medicare Part D

Part D (Drug coverage)

Helps cover the cost of prescription drugs (including many recommended shots or vaccines).

7.1.4 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 on the EOB the type of policy.
- 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.

7.1.5 Disability Insurance Payments

If the disability insurance carrier pays for health care items and services, the payments must be assigned to Wyoming Medicaid. The Member may choose to receive a cash benefit. If the payments from the disability insurance carrier are related to a medical event that required submission of claims for payment, the reimbursement from the disability carrier is considered a third-party payment. If the disability policy does not meet any of these, payments made to the Wyoming Medicaid Member may be treated as income for Medicaid eligibility purposes.

7.1.6 Long-Term Care Insurance

When a long-term care (LTC) insurance policy exists, it must be treated as TPL and be cost avoided. The Provider must either collect the LTC policy money from the Member or have the policy assigned to the Provider. However, if the Provider is a nursing facility and the LTC payment is sent to the Member, the monies are considered income. The funds will be included in calculation of the Member's patient contribution to the nursing facility.

7.1.7 Exceptions

The only exceptions to this policy are referenced below:

- **Children's Special Health (CSH):** Medical claims are sent to Wyoming Medicaid's MMIS fiscal agent
- **Indian Health Services (IHS):** 100% federally funded program
- **Ryan White Foundation:** 100% federally funded program
- Wyoming Division of Victim Services/Wyoming Crime Victim Compensation Program
- Policyholder is an absent parent
  - Upon billing Medicaid, Providers are required to certify if a third party has been billed prior to submission. The Provider must also certify that they have waited 30 days from the date of service before billing Medicaid and has not received payment from the third party
- Services are for preventative pediatric care (Early and Periodic Screening, Diagnosis, and Treatment [EPSDT]), prenatal care.
- Wyoming Medicaid will deny claims for prenatal services for Wyoming Medicaid Members with health insurance coverage other than Wyoming Medicaid. If the Provider of service(s) does not bill the liable third party, the claim will be denied. Providers will receive claim denial information on their remittance advices along with the claims billing addresses for the liable third parties. Providers will be required to bill the liable third parties.

> Inpatient labor and delivery services and post-partum care must be cost avoided or billed to the primary health insurance.

- The probable existence of third-party liability cannot be established at the time the claim is filed.
- Home and community based (HCBS) waiver services, as most insurance companies do not cover these types of services

> It may be in the Provider's best interest to bill the primary insurance themselves, as they may receive higher reimbursement from the primary carrier.

7.2 Provider's Responsibilities

Providers have an obligation to investigate and report the existence of other third-party liability information. Providers play an integral and vital role as they have direct contact with the Member. The contribution Providers make to Medicaid in the TPL arena is significant. Their cooperation is essential to the functioning of the Medicaid Program and to ensuring prompt payment.

At the time of Member intake, the Provider must obtain Medicaid billing information from the Member. At the same time, the Provider should also ascertain if additional insurance resources exist. 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 7.2.1* 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.

7.2.1 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)
5615 High Point Drive
Irving, TX 75038
Phone: 1-888-996-6223 (1-888-WYO-MCAD)
Email form as an attachment: WYTPR@hms.com

FISCAL AGENT USE ONLY

Authorized By _____ Date _____ mm/dd/yyyy

Input By _____ Date _____ mm/dd/yyyy

This form is located on the Medicaid website.

Medicaid maintains a Member reference file of verified commercial health insurance and Medicare Part A and Part B entitlement information. This file is 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 patients.

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 Medicaid Members).

7.2.2 Provider is Not Enrolled with Third Party Liability Carrier

Medicaid 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.

7.2.3 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* – Electronic Data Interchange) and to obtain assistance throughout the disallowance process (*see Section 2.1* Quick Reference).

7.2.4 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 (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 obtain assistance throughout the credit balance process (*see Section 2.1* Quick Reference).

7.3 Billing Requirements

Providers should bill TPL/Medicare and receive payment to the fullest extent possible before billing Medicaid. 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 Medicaid claim will be denied. Follow specific plan coverage rules and policies. CMS does not allow federal 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.

Medicaid 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 the Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS), the state Medicaid agency, or any designee.

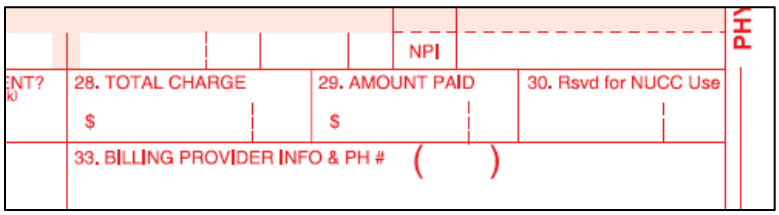
> Providers are required to complete the prior authorization process in instances where the member has other insurance with another carrier.

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.**



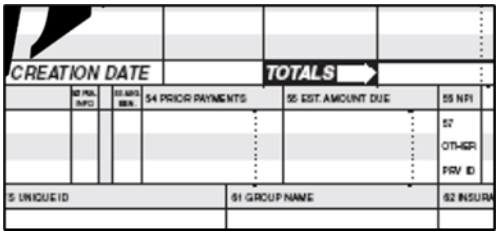
CMS-1500 (Professional) claims will apply Other Insurance (TPL) and Medicare (including Medicare Advantage Plans) at the line level.

- **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.

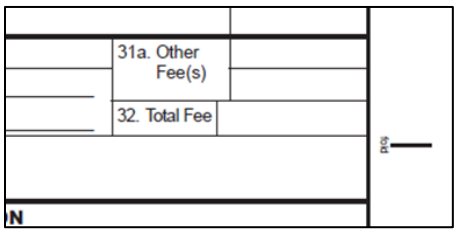
- Claim Adjustment Reason Codes (CARC) must be entered at the header with the appropriate Claim Adjustment Group Code (www.x12.org/codes)

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, included the appropriate claim reason codes on the claims. Attaching the explanation of benefits (EOB) to the electronic claim is encouraged (*see Section 6.10* Submitting Attachments for Electronic Claims).
- If payment is received from the other payer after Medicaid already paid the claim, Medicaid's payment must be refunded for either the amount of the Medicaid payment or the amount of the insurance payment, whichever is less. A copy of the EOB from the other payer must be included with the refund showing the reimbursement amount.

> 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 6.14* 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 Section 6.10* 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 Medicaid with the Previous Attempts to Bill Services Letter.

> 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 TPL Department (*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, Medicare Supplement).

7.3.1 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). Wyoming Medicaid will pay no more than the remaining patient responsibility (PR) after payment by the primary insurance.
- Wyoming Medicaid will reimburse the Provider for the patient liability up to the Medicaid Allowable Amount. For preferred Provider agreements or preferred patient care agreements, do not bill Medicaid for the difference between the payment received from the third party based on such agreement and the Providers billed charges.
- **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.
- **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 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 Medicaid with the Previous Attempts to Bill Services Letter (*see Section 7.3.1.1* Previous Attempts to Bill Services Letter).

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

7.3.1.1 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. This form is located on the Medicaid website.

7.3.2 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 Medicaid 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.

7.3.3 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 Provider 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.

7.3.4 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).

7.3.5 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.

7.3.6 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.

7.4 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

7.4.1 Medicaid Covered Services

For services covered under the Wyoming Medicaid State Plan, the 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.

7.4.2 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.

7.4.3 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 8 – Electronic Data Interchange

8.1 What is Electronic Data Interchange?

In its simplest form, Electronic Data Interchange (EDI) is the electronic exchange of information between two (2) business concerns (trading partners), in a specific, predetermined format. The exchange occurs in basic units called transactions, which typically relate to standard business documents, such as healthcare claims or remittance advices.

8.2 Benefits

Several immediate advantages can be realized by exchanging documents electronically:

- **Speed:** Information moving between computers moves more rapidly, and with little or no human intervention. Sending an electronic message across the country takes minutes or less. Mailing the same document will usually take a minimum of one (1) day.
- **Accuracy:** Information that passes directly between computers without having to be re-entered eliminates the chance of data entry errors.
- **Reduction in Labor Costs:** In a paper-based system, labor costs are higher due to data entry, document storage and retrieval, document matching, and so on As stated above, EDI only requires the data to be keyed once, thus lowering labor costs.

8.3 Standard Transaction Formats

In October 2000, under the authority of the Health Insurance Portability and Accountability Act (HIPAA), the Department of Health and Human Services (DHHS) adopted a series of standard EDI transaction formats developed by the Accredited Standards Committee (ASC) X12N. These HIPAA-compliant formats cover a wide range of business needs in the healthcare industry from eligibility verification to claims submission. The specific transaction formats adopted by DHHS are listed below.

- X12N 270/271 Eligibility Benefit Inquiry and Response (Real-time allowed for Switch Vendors only)
- X12N 276/277 Claims Status Request and Response (Switch Vendors only)
- X12N 277CA Health Care Claim Acknowledgement
- X12N 278 Request for Prior Authorization and Response (Vendors only)
- X12N 835 Claim Payment/Remittance Advice
- X12N 837 Dental, Professional and Institutional Claims
- X12N 999 Functional Acknowledgement
- X12N TA1 Interchange Acknowledgement

As there is no business need, Medicaid does not currently accept nor generate X12N 820 and X12N 834 transactions.

8.4 Wyoming Specific HIPAA 5010 Electronic Specifications

Wyoming Medicaid specific HIPAA 5010 electronic specifications are located in the Wyoming Medicaid EDI Companion Guide located on the Medicaid Website (*see Section 2.1* Quick Reference).

This guide is intended for trading partner use in conjunction with the ASC X12N Standards for Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.

8.5 Sending and Receiving Transactions

Medicaid has established a variety of methods for Providers to send and receive EDI transactions. The following table outlines the Provider Portal requirements for other options refer to the Wyoming Medicaid EDI Companion Guide (SFTP).

EDI Options				
Method	**Computer Requirements**	**Access Cost**	**Transactions Supported**	**Contact Information**
Web Portal The Medicaid Provider Portal provides an interactive, web-based interface for entering individual transactions and a separate data exchange facility for uploading and downloading batch transactions.	Compatible Web Browsers and Versions • Google Chrome - Version 90.0.4430.212 (Official Build) (64-bit) • Firefox - Version 88.0.1 • Microsoft Edge - Version 90.0.818.6 (Official Build) (64-bit)	Free	X12N 270/271 Eligibility Benefit Inquiry and Response (Real-time allowed for Switch Vendors only) X12N 276/277 Claims Status Request and Response (Switch Vendors only) X12N 277CA Health Care Claim Acknowledgement X12N 278 Request for Prior Authorization and Response (Vendors only) X12N 835 Claim Payment/Remittance Advice X12N 837 Dental, Professional and Institutional Claims X12N 999 – Functional Acknowledgement X12N TA1 Interchange Acknowledgement	Provider Services Telephone: (888)WYO-MCAD or (888)996-6223 7-6 pm MST M-F Website: www.wyomingmedicaid.com

EDI Options				
Method	**Computer Requirements**	**Access Cost**	**Transactions Supported**	**Contact Information**
			NOTE: Only the 837 transactions can be entered interactively.	

8.6 Provider Portal

The BMS or Provider Portal requires the following:

- The use of "Pop-Ups" depending on the browser take one of the following actions:
  - Update the browser to allow pop-ups
  - Turn off the browser pop-up blocker
  - Enable pop-up blockers within the browser
- Entries required to be in capital letters, enable 'Caps Lock'

8.6.1 Provider Portal Features

- Ask Medicaid
- Claim Adjustments/Voids
- Claims Status Inquiry
- Claims Submission
- Electronic Claim Attachment
- Eligibility Inquiry
- Grievance and Appeal Submission and Monitoring
- LT101 Inquiry
- Manage EDI Information
- Manage Provider/Billing Agents & Clearinghouses
- Manage SFTP User Account
- PASRR Level I Inquiry/Entry with print capability
- Prior Authorization (PA) Inquiry
- Remittance Advice (RA) List
- Medicaid Proprietary (paper) RA
- Upload Files

- View Provider Information

> Many of the Provider Portal features have training tutorials or guides available on the Medicaid website, go to the Provider Publications and Trainings (*see Section 2.1* Quick Reference) for the step-by-step instructions.

8.6.2 Provider (Users)

The Wyoming Benefit Management System (BMS) developed and implemented by Acentra Health is the Providers source of information for Wyoming Medicaid as well as providing access to the secure Provider Portal. Through the Provider Portal Providers are able to submit claims electronically, verify Member eligibility, inquire on prior authorizations, retrieve remittance advices, upload attachments to claims, enter PASRR Level I screenings, manage billing agents/clearinghouses, establish an administrator, create new users, reset passwords and more.

8.6.2.1 Key Points and Terminology

- Providers can have one (1) or more domains (Provider IDs)
- Provider Domains are created based on how the Provider is enrolled with Wyoming Medicaid (PRESM), such as individual and group Providers, hospitals, facilities, and so on
- The first individual to register for the Provider Portal will be the Provider Domain Administrator for that Provider's organization and will have the ability to do the following:
    - Set up new user accounts and
    - Assign and maintain domains and profiles (security access levels) for new users
    - Users can be given multiple profiles
- Users can view and perform actions within the Provider Portal based on the selected Domain and user profile(s)
- Users can view and perform actions for different domains by switching the domain, in cases of multiple Provider enrollments
- New billing and pay-to Providers are required to complete the Web Registration process to gain access to the Provider Portal
    - Users will register for Single Sign On (SSO) registration
    - Users will register for Provider Domain
    - User can be given multiple profiles

8.6.2.2 Provider Portal Access and Web Registration

To access the web portal secure features, new billing and pay-to Providers must complete the one-time Web Registration process for the BMS Provider Portal. New billing and pay-to Providers will be received by the BMS nightly from the Provider Enrollment (PRESM) vendor, HHS Technology Group. The USER completing the Provider's web registration will automatically be assigned the 'Provider Domain Administrator (Provider user)' role.

- Provider Domain Administrator's will initially create their personal user ID through Okta Single Sign-On (SSO) registration process.
- Then will be required to set up an additional security feature, multi-factor authentication (MFA), to protect Provider and Member data. A detailed instruction guide on how to complete any or all three MFAs has been created for users and is available on the following web pages:
    - Provider Home
    - Provider Publications and Training > Provider Training, Tutorials and Workshops > Provider Tutorials > WY BMS Multifactor Authentication User Guide
- Upon successfully establishing their Okta account and MFA, the system directs users to begin the Provider registration process.
- Providers receive two unique Web Registration letters, both of which are required to complete the registration process:
    - **Welcome Letter:** contains legacy Provider ID (9-digit Medicaid ID), and "Temporary ID" for registration
    - **Security Letter:** contains legacy Provider ID (9-digit Medicaid ID), and "Temporary Key" needed for registration
- Four (4) elements are required to successfully complete the one-time web registration process:
    - Medicaid or Legacy Provider ID
    - Welcome Letter with Temporary ID
    - Security Letter with Temporary Key
    - **Tax ID (SSN/EIN):** this is the Tax ID that is on file with HHS and where Medicaid payments are delivered to the pay-to Provider
        - Providers are required to enter the Tax ID as an additional authentication step
- Once the Provider Domain Administrator completes the web registration, they can add new users and other administrators
    - Administrators can manage access rights through "profiles" within the Provider Portal

Visit the Medicaid website (*see Section 2.1* Quick Reference) for the Provider Web Registration Tutorial and the Multiple Provider Web

Registration for step-by-step instructions for completing the registration process.

8.6.2.3 Provider Profile Names and Access Rights (Provider User)

Provider Profile Name	Access Rights
Provider Domain Administrator	Allows **Provider User** to perform: • User Account Maintenance for accounts under a Provider, including Associating Security Profiles and Approving New User Accounts • Upload files **NOTE:** Providers are encouraged to have more than one (1) Domain Administrator to account for unforeseen circumstances.
Prior Authorization (PA) Access	Allows the **Provider User** to perform: • View & Inquire on PAs
Eligibility Inquiry	Allows the **Provider User** to perform: • Inquire on Member eligibility • Inquire on LT101 • Enter and inquire on PASRR Level I
Provider Access	Allows the **Provider User** to perform: • View the Provider Information • Manage EDI Information – contact information • Manage SFTP User Account – create user and password reset • Manage Mode of Claims Submission Associate Billing Agents and Clearinghouses (BA/CH) • Submit HIPAA batch transactions (270, 276, 837) - must have a SFTP account • Retrieve acknowledgement responses (999, TA1, 271, 277, 277CA) • Online Batch Claims Submission (837) • Retrieve HIPAA batch responses (835) • Grievance and Appeal Submission and Monitoring • View and download Medicaid Paper RA via My Inbox and Archived Documents
Claims Access	Allows the **Provider User** to perform: • Claims inquiry (837 D, I, P) • Claims inquiry on pharmacy claims • On-line claims entry or direct data entry (DDE)

Provider Profile Name	Access Rights
	• Claim adjustment/void • Resubmit denied/voided claims • View and download remittance advice (RA List)
Claim Inquiry Only	Allows the **Provider User** to perform: • Claims inquiry (837 D, I, P) • Claims inquiry on pharmacy claims

8.6.3 Billing Agent and Clearinghouse

Through the Wyoming Medicaid website new billing agents and clearinghouses must enroll to access the Provider Portal. Within the Provider Portal, Billing Agent and Clearinghouses (BA/CH) are able to establish a Provider Domain Administrator, set up new users, manage their information, view associated Providers, perform online batch submissions, retrieve HIPAA batch responses and acknowledgements, and establish and manage one SFTP account.

To access the web portal secure features, BA/CHs must complete the one-time enrollment for the BMS Provider Portal. The **user completing** the BA/CH web registration will automatically be assigned the 'Provider Domain Administrator (BA/CH user)' role.

Within the BMS BA/CHs are considered 'Providers' and will be assigned a BMS Provider ID number which will be a nine (9) digit number beginning with the number '5'. This Provider ID will also be the BA/CH's trading partner ID (TPID), this is only the case for 'new' BA/CH. Also, use this Provider ID when calling into Provider Services for assistance (*see Section 2.1* Quick Reference).

> A BA/CH is an entity performing EDI transactions on behalf of another or multiple Providers.

8.6.3.1 Key Points and Terminology

- New BA/CHs, enrolling September 18, 2021 and after will be assigned a 9-digit Provider ID which will also be their Trading Partner ID (TPID).
  - This Provider ID will begin with the number five "5"
  - Enter the 9-digit Provider ID when accessing the Provider Services IVR (*see Section 2.1* Quick Reference).
- BA/CHs previously enrolled prior to September 18, 2021 will be converted and will be assigned a 9-digit Provider ID beginning with the number "5".
  - These BA/CHs will CONTINUE to use their Legacy TPID when submitting electronic transactions

- This newly assigned 9-digit Provider ID must be used when accessing the Provider Services IVR (*see Section 2.1* Quick Reference)

- The first individual to register as a BA/CH will be the Provider Domain Administrator (BA/CH user) for that organization and will have the ability to do the following:
  - Set up new user accounts and
  - Assign and maintain domains and profiles (security access levels) for new users
  - Users can be given multiple profiles
- Users can view and perform actions within the Provider Portal based on the selected Domain and user profile(s)
- Users can view and perform actions for different domains by switching the domain, in cases of multiple enrollments
- BA/CH will register for Single Sign On (SSO) registration, one time only.

8.6.3.2 Billing Agent and Clearinghouse New Enrollment

To access the web portal secure features, new BA/CH Providers must enroll. The USER completing the BA/CH Provider's enrollment/web registration will automatically be assigned the 'Provider Administrator (BA/CH user)' role.

- BA/CH Provider Domain Administrators initially create their personal user ID through Okta Single Sign-On (SSO) registration process.
- Then complete the new enrollment steps on the Medicaid Website, (www.wyomingmedicaid.com) and select **BA/CH Enrollment** from the **Provider** drop-down list.
- After enrolling and signing the Trading Partner Agreement (TPA), BA/CHs are redirected to the Provider Portal where they select the BMS Domain and create a profile.
- Testing is recommended for new BA/CHs, refer to the Wyoming Medicaid EDI Companion Guide located on the Medicaid website for instructions.

> Visit the Medicaid website for the Billing Agent/Clearinghouse Tutorial for step-by-step instructions for completing the enrollment process.

8.6.3.3 Billing Agent and Clearinghouse Profile Names and Access Rights (Billing Agent and Clearinghouse User)

BA/CH Profile Name	Access Rights
Provider Domain Administrator	Allows the **BA/CH user** to perform: • User account maintenance for accounts under a Provider, including Associating Security Profiles and Approving New User Accounts
Provider Access	Allows the **BA/CH user** to perform: • Manage Provider (BA/CH) information • View Associated Providers • Manage SFTP User Account • On-line batch claims submission (837 D, I, P)) • Submit HIPAA batch transactions (270, 276, 837) • Retrieve HIPAA batch responses (835) • Retrieve acknowledgements and responses (999, TA1, 271, 277, 277CA)

8.6.4 Third Party Liability Disallowance Portal

The HMS TPL Disallowance Portal is a secure web-based application that functions as the primary point-of-contact throughout the claim identification and recovery process. Providers can access and update contact and claim information utilizing a broad scope of self-service options.

In this portal Providers will be able to communicate with HMS via email and chat functions and have real-time ability to review, acknowledge, report, and upload documentation.

Providers will not automatically have access to the HMS TPL Disallowance Portal, letters will be delivered to Provider of services when Wyoming Medicaid is seeking recoupment of any paid claims that should have been the responsibility of a primary payer through the third-party disallowance process ((*see Section 7.2.3* Third Party Disallowance).

> Many of the Provider Portal features have training tutorials or guides available on the Medicaid website, go to the Provider Publications and Trainings (*see Section 2.1* Quick Reference) for the step-by-step instructions.

8.7 Additional Information Sources

For more information regarding EDI, please refer to the following websites:

- Centers for Medicare and Medicaid Services: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html. This is the official HIPAA website of the Centers for Medicare & Medicaid service.
- Washington Publishing Co.: http://www.wpc-edi.com/hipaa/HIPAA_40.asp. This website is the official source of the implementation guides for each of the ASC X12 N transactions.

> This site is currently unavailable due to a ransomware attack. An alternative source is https://www.wpshealth.com/index.shtml.

- Workgroup for Electronic Data Interchange: http://www.wedi.org/. This industry group promotes electronic transactions in the healthcare industry.
- Designated standard maintenance organizations: http://www.hipaa-dsmo.org/. This website explains how changes are made to the transaction standards.

Chapter 9 – Important Information

9.1 Claims Review

Medicaid is committed to paying claims as quickly as possible. Claims are electronically processed using an automated claims adjudication system and are not usually reviewed prior to payment to determine whether the services provided were appropriately billed. 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 Medicaid later discovers the service was incorrectly billed or paid, or the claim was erroneous in some other way, Medicaid is required by federal regulations to recover any overpayment, regardless of whether the incorrect payment was the result of Medicaid, fiscal agent, Provider error or other cause.

9.2 Coding

Standard use of dental coding conventions is required when billing dental services. Provider Services, or the Division of Healthcare Financing cannot suggest specific codes to be used in billing services. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use Current Dental Terminology (CDT) coding book
- 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.
- Coding denials cannot be billed to the Member, but can be reconsidered per Wyoming Medicaid Rules, Chapter 16. For the complete process on completing an appeal and completing the Request For Appeal Form (*see Section 2.3.2* How to Appeal).

9.3 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 and Dental fee schedules on the website or contact Provider Services (*see Section 2.1* Quick Reference). Fee schedules list Medicaid covered codes, limitations, and provide clarification of indicators such as whether a code requires prior authorization. Not all codes are covered by Medicaid. It is the Provider's responsibility to verify this information.

9.4 By Report or Manually Priced Codes

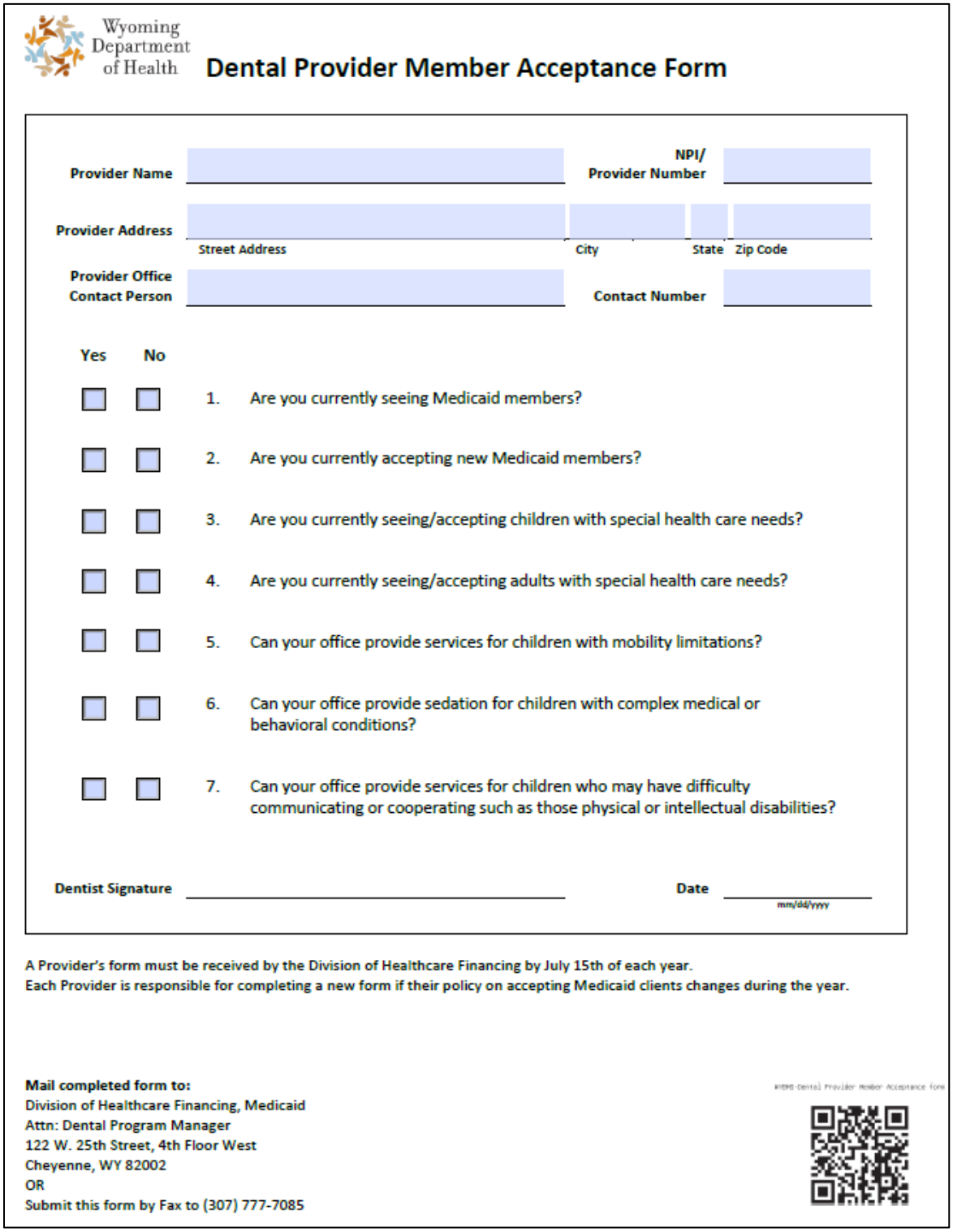
Certain dental codes are manually priced or by report. By report dental codes are noted on the fee schedule by MP and will be paid at 70% of billed charge for dates of service prior to 01/01/2021. For 01/01/2021 and forward dates of service, by report dental codes will be paid at 68.25%. Retrospective reviews may reveal inappropriate codes being billed or paid. After review by the Division of Healthcare

Financing and the Department of Oral Health, if it is determined that the billing was inappropriate, federal regulations require that Medicaid recover any overpayment. Documentation should always support billing.

9.5 Dental Provider Member Acceptance Form Requirement

Each quarter the Division of Healthcare Financing must collect data from the Medicaid dental Providers regarding accepting Medicaid Members into their practice. In order to comply with this requirement, a Provider must complete the Dental Provider Member Acceptance Form (*see Section 10.5.1* Dental Provider Member Acceptance Form). This form relays the required information to the Division. All dental Providers will be required to complete this form as a new enrolled Provider and annually. Dental Providers will only be required to complete this form quarterly if there have been changes to their office policies on accepting Medicaid Members. If no changes have occurred, the dental Provider will only need to complete this form annually in July.

9.5.1 Dental Provider Member Acceptance Form



Wyoming Department of Health

Dental Provider Member Acceptance Form

Provider Name _____ **NPI/ Provider Number** _____

Provider Address _____ _____ _____ _____
Street Address City State Zip Code

Provider Office Contact Person _____ **Contact Number** _____

Yes	No		
☐	☐	1.	Are you currently seeing Medicaid members?
☐	☐	2.	Are you currently accepting new Medicaid members?
☐	☐	3.	Are you currently seeing/accepting children with special health care needs?
☐	☐	4.	Are you currently seeing/accepting adults with special health care needs?
☐	☐	5.	Can your office provide services for children with mobility limitations?
☐	☐	6.	Can your office provide sedation for children with complex medical or behavioral conditions?
☐	☐	7.	Can your office provide services for children who may have difficulty communicating or cooperating such as those physical or intellectual disabilities?

Dentist Signature _____ **Date** _____
mm/dd/yyyy

A Provider's form must be received by the Division of Healthcare Financing by July 15th of each year.
Each Provider is responsible for completing a new form if their policy on accepting Medicaid clients changes during the year.

Mail completed form to:
Division of Healthcare Financing, Medicaid
Attn: Dental Program Manager
122 W. 25th Street, 4th Floor West
Cheyenne, WY 82002
OR
Submit this form by Fax to (307) 777-7085

BMS-Dental Provider Member Acceptance Form

This form is located on the Medicaid website.

9.6 Supernumerary Teeth

- For Alphabetic tooth codes, add an S after the tooth code (for example, supernumerary tooth A becomes AS)
- For Numeric tooth codes, add 50 to the tooth codes value (for example, supernumerary tooth 15 becomes 15+50 = 65)

9.7 Dental Services Performed in an Indian Health Services or Tribal Clinic

For information on services performed in an Indian Health Services (IHS) or Tribal Clinic refer to the latest Tribal Provider Manual posted on the Medicaid website (*see Section 2.1* Quick Reference)

Chapter 10 – Covered Services

10.1 No Show Appointments and Broken Appointments

Dental Code Range: D0000

Appointments canceled or missed by Medicaid Members cannot be billed to Medicaid. Medicaid recognizes the concern of missed/broken appointments and for tracking purposes only has created code D0000. Providers will not be reimbursed for this code. When submitting a claim to Medicaid for missed/broken appointments an amount of $0.00 should be entered in box 31 (fee) of the claim form. This line will show as a denial on the Remittance Advice. If a Provider's policy is to bill all patients for missed appointments/broken appointments, the Provider may bill Medicaid Members.

10.2 Examinations

10.2.1 Examinations for Children (Ages 0-20)

Dental Code Range: D0120-D0180

- **D0120:** Routine periodic oral evaluation, **reimbursable** once every six 6 months.
- **D0140:** Limited oral evaluation, **reimbursable** twice every 12 months.
- **D0145:** Oral evaluation for patients 0-3 years of age – **reimbursable** once every six 6 months but not in addition to D0120 or D0150.
- **D0150:** Comprehensive oral evaluation, **reimbursable** once every 12 months, and may replace a D0120.
- **D0160 and D0170:** Detailed and extensive oral evaluations, **reimbursable** as needed.
- **D0180:** Comprehensive periodontal evaluations are **reimbursable** once every 12 months, ages 19-20 years. Not to be billed with any other exam codes (D0120-D0170).
- **D0412:** Blood Glucose Test is a covered service for Member of any age once every six 6 months.

10.2.2 Examinations for Adults

Dental Code Range: D0120-D0191

- D0120: Routine periodic oral evaluation, reimbursable once every six 6 months.
- **D0140:** Limited oral evaluation, **reimbursable** twice every 12 months.
- D0150: Comprehensive oral evaluation, reimbursable once every 12 months, and may replace a D0120.
- **D0412:** If the Provider and/or Member would like all of the 3rd molars removed at time of surgery, only teeth that are documented to be symptomatic should be billed to Medicaid.

10.3 Radiographs and Diagnostic Imaging

Dental Code Range: D0210-D0330

Diagnostic radiological procedures, performed in accordance with current American Dental Association (ADA) guidelines, are to be limited to those instances in which a dentist anticipates that the information is likely to contribute materially to the proper diagnosis, treatment, and prevention of disease. **Routine use of periapical radiographs for primary anterior teeth is not considered appropriate unless there is clearly documented medical need.**

- **D0210 –** Intraoral complete series*:
  - **Reimbursable** every five (5) years for Members of any age **for dates of service 06/30/2021 and earlier**.
  - **Reimbursable** every three (3) years for Members of any age **for dates of service 07/01/2021 and forward.**
- **D0330 –** Panoramic film*:

  Reimbursable every five (5) years for Members five (5) years and older **for dates of service 06/30/2021 and earlier.**

  Reimbursable every three (3) years for Members six (6) years and older **for dates of service 07/01/2021 and forward**.
  - **D0270, D0272, or D0274 –** Bitewing X-rays – **reimbursable** once every year for Members of any age.
- **D0220:** Intraoral first film
- **D0230:** Each additional film after the first (as needed).

  A maximum of seven (7) periapicals are allowed per visit.
- **D0367 –** Cone Beam CT Capture and Interpretation with Field of view of Both Jaws: **reimbursable** when Providers are performing an implant, exposure of un-erupted tooth for the purpose of orthodontic bonding, jaw surgery **for Members age 0-20**, or a request has been made by a Cleft Palate team for diagnostic purposes related to a Member's cleft palate/lip treatment. A Prior Authorization will be required for this code (*see Section 6.8.1* Requesting Prior Authorization).

  When making referrals, the referring dentist should send the dentist/specialist a copy of the current radiographs to prevent unnecessary duplication of services, expenditure and radiation exposure. Medicaid will only reimburse one (1) Provider per date of service for radiographs.

10.4 Preventive Dental Care

10.4.1 Preventative Dental Care for Children

Dental Code Range: D1110 - D1354

- **D1110:** Prophylaxis-Adult (ages 12 - 20) **reimbursable** every six (6) months
- **D1120:** Prophylaxis-Child (ages 0-11) **reimbursable** every six (6) months
- **D1206 –** Topical application of fluoride varnish (office procedure): **reimbursable** every six (6) months, for ages 0-20
- **D1208 –** Topical application of fluoride (office procedure): **reimbursable** every six (6) months, for ages 0-20.
- **D1310:** Nutritional Counseling **reimbursable** every six (6) months for ages 0-3.
- **D1330:** Oral Hygiene Instruction **reimbursable** one (1) time for any Member age 4-20 for different treating Providers.
- **D1351:** The application of sealants for permanent molar teeth and primary second (2nd) molars. Sealants are allowed once per tooth per 18 months. Medicaid will not pay for a sealant and a filling on the same tooth on the same date of service.
- **Allowed Tooth Numbers:** 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32, A, J, K and T
- **D1352:** Preventive resin restoration in a moderate to high caries risk patient: permanent tooth is allowed once per tooth per 18 months. Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin, includes placement of a sealant in any radiating non-carious fissures or pits. D1351 sealant should not be billed on the same tooth on the same date of service. When there are separate restorations on each surface, D1352 may be billed multiple times per tooth and requires a tooth number along with quadrant. Records must clearly indicate each restoration is treatment for a separate surface of decay and not one continuous restoration.
- **D1354:** Interim Caries Arresting Medicament (Silver Diamine Fluoride) is allowed once per tooth per 18 months. D1351, D1352, or any other restorative procedure (D2000-D2999) cannot be billed on the same tooth on the same date of service. Records must indicate tooth number and surface applied to. When billing, a tooth number is required but not a surface. Wyoming Medicaid will perform post-payment review of this code monthly to review for high utilization and appropriateness. Clinical records must support billing for each tooth and outcomes of the treatment at follow-up visits.

10.4.2 Preventative Dental Care for Adults

Dental Code Range: D1110

- **D1110:** Prophylaxis, **reimbursable** once every six (6) months.

> When an adult Member (21 years and older) is scheduled for a D1110, but the Member is in need of a D4341, scaling and root planing, these procedures are the financial responsibility of the Member. Providers may bill the Member for this service as long as the Member is informed, in writing, prior to the procedure that they are financially responsible.

10.5 Periodontal Treatment

10.5.1 Periodontal Treatment for Children

Dental Code Range: D4210-D4999

Scaling, root planing and curettage can be billed once per quadrant and are considered one (1) procedure regardless of the number of visits it takes to complete. Periodontal treatment is allowed once in a 24month period when indicated with a diagnosis of periodontitis. This includes scaling and root planing or a full mouth debridement. D4910, Periodontal Maintenance is reimbursable every three (3) months for Members who have had scaling and root planing. Clear evidence of bone loss must be present on the current radiographs to support the diagnosis of periodontitis. There must be current six (6) point periodontal charting inclusive of a periodontal prognosis. Gingivectomies can be billed once per quadrant, per lifetime. Minor scaling procedures will be considered part of a prophylaxis.

- **D4346:** Scaling in presence of generalized moderate or severe gingival inflammation- full mouth, after oral evaluation. This procedure is allowed once every 24 months, AND the Member cannot have had D4341, D4342, or D4355 within the last 12 months. This procedure is intended to treat gingival inflammation.
- **D4355:** Full mouth debridement is allowed once every 24 months, AND the Member cannot have had D1110 or D4346 within the last 12 months. This procedure is intended to debride the mouth so that further examination can be done to determine stage of periodontal disease.

10.5.2 Periodontal Treatment for Adults

Dental Code Range: D4346 and D4355

Scaling and full mouth debridement are the only covered periodontal treatment services covered for adult Members (ages 21 and older).

10.6 Prosthetics Removable

10.6.1 Prosthetics Removable for Children

Dental Code Range: D5110-D5899

There are no limits on the fabrication of denture and/or partial services for Members under the age of 21 years old.

- **D5110-D5140:** Complete dentures (including routine post-delivery care) placed immediately must be of structure and quality to be considered the final prosthesis.
- **D5211-D5281:** Partial dentures (including routine post-delivery care)
- **D5410-D5422:** Denture/partial adjustments
    - For dates of service prior January 1, 2021 this service is limited to two (2) per 12-month period.
    - For dates of service January 1, 2021 and forward this service is limited to two (2) per arch per 12-month period.
- **D5510-D5721:** Other services include the repair of a broken denture base, repair or replacement of broken clasps, replacement of teeth.
- **D5730-D5761:** Denture/partial relines,
    - For dates of service prior to January 1, 2021 this service is limited to two (2) per 12-month period
    - For dates of service January 1, 2021 and forward this service is limited to once every three (3) years.
- **D5810-D5821:** Interim complete/partial dentures
- **D5850-D5851:** Tissue conditioning, this service is limited to once per lifetime, per arch.
- **D5860-D5866:** Specialized denture services require Prior Authorization (PA) (*see Section 6.8.1* Requesting Prior Authorization).

> In the event a Member is not satisfied with the denture/partial, the Member must return to the Provider who made the appliance to allow the Provider the opportunity to work with the Member to fit it properly. If a Member has returned to the Provider more than three (3) times and is still not able to wear the appliance, a Member may contact Provider Services for guidance on how to proceed with the dispute. A Member should not proceed to a different Provider to have adjustments done.

Contact Provider Services (*see Section 2.1* Quick Reference) for denture benefit availability.

10.6.2 Prosthetics Removable for Adults

Dental Code Range: D5410-D5761

Relines and repairs to existing removable appliances are covered.

- **D5410-D5422:** Denture/partial adjustments,
  - For dates of service prior January 1, 2021 this service is limited to two (2) per 12-month period.
  - For dates of service January 1, 2021 and forward this service is limited to two (2) per arch per 12-month period
- **D5511-D5671:** Other services include the repair of a broken denture base, repair or replacement of broken clasps, replacement of teeth.
- **D5730-D5761:** Denture/partial relines
  - For dates of service prior January 1, 2021 this service is limited to two (2) per 12-month period.
  - For dates of service January 1, 2021 and forward this service is limited to once every three (3) years.

In the event a Member is not satisfied with the denture/partial, the Member must return to the Provider who made the appliance to allow the Provider the opportunity to work with the Member to fit it properly. If a Member has returned to the Provider more than three (3) times and is still not able to wear the appliance, a Member may contact Provider Services for guidance on how to proceed with the dispute. **A Member should not proceed to a different Provider to have adjustments done.**

Contact Provider Services (*see Section 2.1* Quick Reference) for denture benefit availability.

10.7 Extractions

10.7.1 Extractions for Children

Dental Code Range: D7111-D7250

- Extractions are reimbursable for those teeth that demonstrate radiographically, pathologic, pulpal involvement, periapical infection, periodontally involved teeth of the class IV category, and large carious lesions that the eligible Member wants extracted even though they have been informed of alternate treatment remedies. Current radiographs and other clinical documentation of teeth that are extracted must be maintained in the patient record.

- Incision and drainage are reimbursable when an emergency extraction cannot be performed due to health reasons or in the case of gingival infections, peri coronal or lateral abscess due to periodontal pathology.

10.7.2 Extractions for Adults

Dental Code Range: D7111-D7250, D7410, D7411, D7510

- Extractions are reimbursable for those teeth that demonstrate radiographically, pathologic, pulpal involvement, periapical infection, periodontally involved teeth of the class IV category, and large carious lesions that **the eligible Member wants extracted even though they have been informed of alternate treatment remedies.** Current radiographs and other clinical documentation of teeth that are extracted must be maintained in the patient record.
- **D7510-** Incision and drainage is reimbursable when an emergency extraction cannot be performed due to health reasons or in the case of gingival infection, pericoronal or lateral abscess due to periodontal pathology.

10.8 Oral and Maxillofacial Surgery

Oral surgery procedures that are not covered using a CDT procedure code should be billed using a CPT code on a CMS-1500 Claim Form. It is the Provider's responsibility to check covered medical services prior to rendering services. For use of the CPT codes refer to the CMS-1500 Provider Manual located on the Medicaid website and obtain Prior Authorizations as required.

10.8.1 Oral and Maxillofacial Surgery for Children

Dental Code Range: D7111-D7999

Reimbursement of oral surgical procedures includes routine preoperative and postoperative care, sutures, suture and/or wire removal, and local anesthetics.

Impacted third molars or supernumerary teeth are covered only when they are symptomatic; that is, causing pain, infected, preventing proper alignment of permanent teeth or proper development of the arch. Reimbursement for prophylactic extractions of third molars is not a covered service.

Orthognathic surgery is only covered when required to complete treatment for severe malocclusion. The Member must be approved for orthodontic treatment through the Medicaid Severe Malocclusion program to be considered for corrective jaw surgery. The following oral surgery codes require an approval prior to performing the services, from Medicaid, in the form of a Prior Authorization (PA): D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, and D7950. Prior Authorizations will not be issued after a procedure is completed. Providers must obtain a PA prior to rendering services and at the time of the Severe Malocclusion request (*see Section 6.8.1* Requesting Prior Authorization). Requests for Oral and Maxillofacial surgery must include the Consideration for Oral Surgery Form, found on the Telligen website, PA vendor (*see Section 2.1* Quick Reference). If the Provider and/or Member would like

all of the 3rd molars removed at time of surgery, only teeth that are documented to be symptomatic should be billed to Medicaid.

10.8.2 Oral and Maxillofacial Surgery for Adults

Dental Code Range: D7111-D7140, D7210-D7241, D7250, D7410-D7411, D7510

Reimbursement of oral surgery procedures includes routine preoperative and post-operative care, sutures, suture and/or wire removal, and local anesthetics.

Impacted third molars or supernumerary teeth are covered only when they are symptomatic; that is, causing pain, infected, preventing proper alignment of permanent teeth or proper development of the arch. Reimbursement for prophylactic extractions of third molars is not a covered service. If the Provider and/or Member would like all of the 3rd molars removed at time of surgery, only teeth that are documented to be symptomatic should be billed to Medicaid.

10.9 Anesthesia

Dental Code Range: D9222-D9223, D9239-D9243, and D9248

- **D9222-D9223, D9239-D9243,** and **D9248** are reimbursable. Dentists may only administer parenteral sedation and general anesthesia if they meet the requirements of the Wyoming State Board of Dental Examiners or the licensing board in the state they practice, and it is within their scope of practice.
- Sedation and general anesthesia shall not be billed routinely, but limited to those patients requiring dental care who would not be expected to tolerate treatment or become unmanageable in the usual office setting due to medical, emotional, or developmental limitations, and/or extent of treatments needs that are documented.
- The administration of intravenous (IV) or intramuscular (IM) sedation is subject to the same requirements as general anesthesia.

10.10 Dental Services Performed in Federally Qualified Health Centers, Indian Health Services, or Rural Health Clinics

Dental services that are performed in Federally Qualified Health Centers, Indian Health Services, or Rural Health Clinics (FQHC/IHS/RHC) must be billed on the most current ADA claim form/837D. Dental services will receive an encounter rate that is established by Wyoming Medicaid and includes **all services** provided during the encounter and is considered to be an all-inclusive rate. On Medicaid primary encounter claims, the encounter claim will always be reimbursed at the encounter rate and will not be reduced when the submitted charges are less.

10.10.1 Dental (Other Than Orthodontics) Claims

- **D9999:** Must be billed as line one as the encounter rate
- Additional detail lines must be billed with appropriate covered CDT codes showing each service provided and billed with a zero (0) dollar amount.
- All charges for the same visit must be submitted on one (1) claim.

Example:

Child is seen for an exam, X-ray, and prophy. Bill as follows:

Line	Procedure Code	Date	Amount	NPI
1	D9999	1/5/21	Fee encounter rate	Treating Provider NPI
2	D1120	1/5/21	$0.00	Treating Provider NPI
3	D0240	1/5/21	$0.00	Treating Provider NPI
4	D1120	1/5/21	$0.00	Treating Provider NPI

If any codes on the claim deny due to being non-covered, the entire claim will deny. The Provider is responsible for checking eligibility and frequency limitations and only billing Medicaid for covered dental services for that Member.

Refer to the Dental Fee Schedule located on the Medicaid website for age limitation.

Services provided outside the clinic, including inpatient services, should be billed under the clinic's fee-for service Provider number.

Multiple encounters with one (1) or more health professional that take place on the same day at the same office location constitute a single visit except when the patient, after the first encounter, suffers illness or injury requiring a distinctly separate diagnosis or treatment.

10.11 Services Covered for Children Only

10.11.1 Restorative Treatment

Dental Code Range: D2140-D2394 and D2510-D2664

Restorative treatment is limited to those services essential to restore and maintain adequate dental health. Pins and special preparations are reimbursed separately from the restoration. Temporary restorations are reimbursable only as a result of palliative or emergency treatment. When more than one (1) surface is involved, and one (1) continuous filling is used, select the appropriate code from the

range of D2140-D2394. When there are separate fillings on each surface, the one (1) surface codes (D2140 and D2391) are to be used. Records must clearly indicate each filling is treatment for a separate surface of decay.

Inlays and Onlays are a covered service but paid at the same rate as amalgam and composite fillings.

> D2140-D2394 and D2510-D2664 are allowed once per tooth, per surface, every 18 months.

10.11.2 Crowns

Dental Code Range: D2710-D2934

- **D2929-D2933:** Prefabricated metal or tooth colored (plastic/composite/stainless/zirconia) materials for the fabrication of an **interim** crown on a primary or permanent tooth to protect until exfoliation or a permanent crown can be placed. Treatment of severely decayed primary posterior teeth is reimbursable for those teeth that are not near exfoliation
- **D2710-D2794:** The dentist may place a permanent crown when determined appropriate for Members between the ages of 14-20 **or** ages zero (0) to 13 if the permanent tooth has had a root canal therapy. Primary molars, with no permanent tooth but visible by X-ray, may have permanent crowns placed if decay or marked attrition is present.

  > For Members ages zero (0) to13, a prior authorization (see *Section* 6.8. Prior Authorization) is required.

- **D2910-D2920:** Re-cementation of crowns, inlays, or onlays is covered as needed.

10.11.3 Labial Veneers

Dental Code Range: D2961-D2962

Labial veneers may be used instead of full crowns for anterior permanent teeth that are severely fractured or carious, having continuous loss of fillings. Only CDT codes D2961 or D2962 will be reimbursed. Documentation to justify the need for services must be included in the patient's record.

10.11.4 Endodontics

Dental Code Range: D3110-D3330

The fee for endodontic treatment will include all necessary radiographs during treatment, including preoperative and postoperative radiographs. Root canal therapy for permanent teeth includes, extirpation, treatment, filling of root canals and all necessary radiographs, including a post-treatment radiograph. Emergency endodontic procedures, such as open tooth to drain, may be performed prior to root canal therapy. Endodontic treatment will only be reimbursed for situations where adequate bone viability can be documented. A radiograph demonstrating the completed endodontic treatment is

required to be a part of the clinical procedure and must be included in the patient's permanent clinical record. Pulpal therapy for primary teeth is reimbursable for those teeth only not near exfoliation.

> A pulpotomy is not to be billed in conjunction with root canal therapy when performed on the same date or as an emergency endodontic procedure. Additionally, a Provider may not bill for a pulpotomy and a root canal therapy on the same tooth. The Provider may only bill for the pulpotomy or the root canal therapy.

10.11.5 Apicoectomy

Dental Code Range: D3410-D3426

Preoperative and postoperative radiographs are required as part of the clinical record for apicoectomies. A retrograde filling may be placed when necessary and billed separately.

10.11.6 Implant Services and Fixed Prosthesis

Dental Code Range: D6010-D6199 and D6205-D6999

The Member must be between the ages of 17-20 and be eligible for Medicaid for permanent tooth replacement to be considered. Temporary replacement of a lost tooth may be provided to a Member to maintain space prior to the age of 17 by using the appropriate code.

The tooth/teeth to be replaced must be documented and must have been lost due to one (1) of the following.

- Be congenitally missing
- Loss due to trauma
- Loss due to abnormal pathology not related to periodontal disease or carious lesions

The requesting dentist is responsible for determining if the Member is an appropriate candidate for an implant or bridge based on completion of growth and neighboring teeth. Documentation of bone density, bone height and completion of skeletal growth must be in the patient record.

Fixed bridges and cast partials are covered only for the replacement of permanent teeth. A fixed bridge is not a reimbursable service when done in conjunction with a removable appliance in the same arch.

- When a Provider is requesting an implant the length of treatment must be considered based on the Member's age. Typically, when a Member turns 19 years old, eligibility ends and restorative treatment for the previously placed implant will not be a covered service. Prior authorizations (PAs) are only valid for Member's who are eligible for Medicaid benefits at the time of service (*see Section 6.8.1* Requesting Prior Authorization).

> If the tooth or teeth to be replaced were not lost due to the above conditions, Wyoming Medicaid will not pay for an implant or fixed

bridge. The requesting dentist must also consider the condition of neighboring teeth when requesting prior authorization. If the neighboring teeth are free of decay or large restorations, an implant can be indicated. If the neighboring teeth are in need of restorations, a fixed bridge should be indicated.

The Member must be free of gingivitis and/or periodontal disease and must have proven adequate home care. The request will not be approved without a documented home care status included. The Member must also be tobacco free; if the Member is currently using tobacco products, they must be referred to the Wyoming Quit line (800)784-8669 and display abstinence for six (6) months.

Replacement of a missing tooth will only be reimbursed once per lifetime. If Wyoming Medicaid has paid for any type of permanent tooth replacement to replace the tooth/teeth, then an implant or fixed bridge will not be approved.

All implant codes and fixed prosthesis require an approval, prior to performing the services, in the form of a Prior Authorization (PA). Prior Authorizations (*see Section 6.8.1* Requesting Prior Authorization) will not be issued after a procedure is complete. The Provider must obtain a PA prior to rendering services. Prior Authorizations must also include a Tooth Replacement (Implant) Request Form, refer to the Telligen website, PA vendor (*see Section 2.1* Quick Reference).

10.11.7 Biopsy of Oral Tissue – Soft

Dental Code Range: D7286

Removal of oral soft tissue lesions is allowed as needed to restore oral cavity to normal function and/or to check for pathology.

10.11.8 Occlusal Orthotic Device

Dental Code Range: D7880 (By Report), D9944, and D9945

- **D7880:** An occlusal splint may be provided to a Member if the Member has been diagnosed with Temporomandibular Joint Dysfunction (TMJ). A report of TMJ diagnosis and complete treatment plan including any physical therapy, and/or drugs used to treat symptoms must be submitted with the claim. This must be billed on the delivery date.
- **D9944:** Occlusal guard-hard, full arch. This must be billed on the delivery date.
- **D9945:** Occlusal guard-soft, full arch. This must be billed on the delivery date.

10.11.9 Nitrous Oxide or Analgesia

Dental Code Range: D9230

Nitrous Oxide is a covered benefit for any Member age 0-19. Nitrous will only be reimbursed in conjunction with extractions or restorative procedures. Supporting documentation of why the Member required the use of nitrous must be part of the patient's record and be available upon request. **It is the Provider's responsibility to verify the Member's eligibility prior to services rendered. When checking eligibility, the Provider must verify that the Member is under the age of 20 years old.**

10.11.10 Behavior Management

Dental Code Range: D9920

Behavior Management is a covered benefit for Members under ten (10) years old and/or disabled Members under 21 with a recognized mental or physical disability, such as Autism, Down Syndrome, or Paralysis, **who exhibit behavior(s) that require additional time for a procedure to be completed; supporting documentation must be a part of the patient's record and a report of specific behavior that warranted behavior management must be attached to the claim form.** This procedure is reimbursable at one (1) unit per visit and a maximum of three (3) units per 12 months.

10.11.11 Hospital Calls – Ambulatory Surgical Centers or Hospital Outpatient

- Medicaid covers only those services that are medically necessary and cost-efficient. It is the Provider's responsibility to be knowledgeable regarding covered services, limitations, and exclusions of the Medicaid Program. Therefore, if Providers, without getting mutual agreement of the Member, deliver services and are subsequently denied Medicaid payment because services were not covered or the services were covered but not medically necessary or cost-efficient, Providers may not obtain payment from the Member.
- If the Provider and the Member mutually agree in writing to services, which are not covered (or are covered but not medically necessary or cost-efficient), and the Provider informs the Member of their financial responsibility prior to rendering service, then, the Provider may bill the Member for the services rendered.
- Medicaid will cover dental services in an outpatient or hospital setting if it has been determined that it is medically necessary and the Member cannot tolerate dental services in-office for one (1) of the following reasons:
    - The Provider has attempted the procedure and the Member was uncooperative and the Member or staff were put at risk for injury.
    - For Members under the age of five (5) who have demonstrated uncooperative behavior during routine visits and performing restorative dentistry in-office would be dangerous for the Member or staff.

- Members who have documented developmental delays and have demonstrated uncooperative behavior in an office setting. A diagnosis of a developmental or physical delay is not an automatic reason to schedule a Member for a hospital dental call.
- Members who have been unresponsive to treatment in the office (such as local anesthesia not effective, IV sedation not achieved).
- The Member is considered medically compromised and an in-office attempt may be dangerous for the Member. Documentation from the Member's physician stating the condition or conditions that compromise the Member must be a part of the Member's records and available to Medicaid if requested.

> Each of the above situations ***must be documented clearly*** in the Member's clinical records to adequately demonstrate medical necessity.

- Additionally, the service must be:
  - Consistent with the diagnosis and treatment of the patient's condition.
  - In accordance with standards of good medical and dental practice.
  - Required to meet the dental needs of the patient and undertaken for reasons other than the convenience of the patient or their dentist.
  - Performed in the least costly setting required by the patient's condition.
- **D9420:** Hospital or Ambulatory Surgical call may be billed out by the dentist along with dental procedures that are performed in the facility on the ADA Claim Form.

10.11.12 Other Drugs and Medications

Dental Code Range: D9630

D9630 can be billed for Members if there is a documented need for additional medications. Antibiotics, antimicrobials and fluoride gels or rinses are the only medications that will be considered. This code should not be billed for pre-med prophylactic antibiotics given in office. Wyoming Medicaid will only cover D9630 for Members who need medications to treat the following diagnosed conditions:

- Rampant caries
- Cervical decay
- Gingivitis or Periodontitis
- Severe sensitivity

The report of specific drugs given in the office and for the treatment of what condition must be attached to the claim form. The following must be present on the report:

- Member name

- Date of service
- Diagnosed condition
- Medication given
- Doctor or hygienist signature

10.11.13 Space Maintenance

Dental Code Range: D1510, D1516, D1517, D1575, D1551-D1553

- **D1510, D1516, D1517 and D1575:** Space maintainers must be billed using a quadrant in box 25 (area of oral cavity) of the claim form. Use UA, UR, UL, LA, LR or LL to indicate which area of the oral cavity the space maintainer was placed.
- **D1551:** Re-cementation of bilateral space maintainer, maxillary, is covered as needed
- **D1552:** Re-cementation of bilateral space maintainer, mandibular, is covered as needed
- **D1553:** Re-cementation of unilateral space maintainer, per quadrant, is covered as needed

10.11.14 Tobacco Counseling

Dental Code Range: D1320

This code is **reimbursable** once (1) per 12-month period.

10.11.15 Orthodontics

Dental Code Range: D8000-D8999

Medicaid eligible Members under the age of 19 may receive treatment for severe malocclusion. Medicaid only reimburses codes D8000-D8999 to enrolled orthodontists who have obtained a Prior Authorization (PA) for treatment in the Wyoming Severe Malocclusion Program (SMP) prior to treatment (*see Section 6.8.1* Requesting Prior Authorization).

Severe malocclusion is defined as malocclusion that is detrimental to the child's physical well-being, such as the ability to chew food in a compatible manner for digestion and/or breathing, or for correction of speech pathology.

10.11.15.1 Referral to the Severe Malocclusion Program

When a Member is provided services at their general dentist for a check-up appointment, and the Member appears to meet the set criteria of the Severe Malocclusion Program, the Member may be referred to an enrolled orthodontist. It is up to the Provider to know the criteria for the Severe Malocclusion Program and only refer appropriate Members to participating orthodontists.

- If the Member does not appear to meet the Severe Malocclusion Program, there is a parent handout available on the website to assist in explaining why the Member does not meet the criteria. (*see Section 2.1* Quick Reference)
- No referral form is needed for ages 12-18 for D8660.
- Orthodontists may also provide consultations to walk in Members ages 12-18 with no referral.
- If a Provider finds it medically necessary for a child under the age of 12 to be part of the Severe Malocclusion Program, a SMP Under 12 Form found on the Telligen website, should be included with the request (*see Section 2.1* Quick Reference). A PA will be required for these Members for the consultation (D8660) (*see Section 6.8.1* Requesting Prior Authorization).
    - The form must be filled out completely and the child should not be provided services by the orthodontist until a PA is issued.

10.11.15.2 Submitting Records for Approval or Denial

The orthodontist will need to do the following prior to rendering services to a new Member for consultation (D8660):

- Verify Member eligibility prior to rendering services to the Member.
- Verify age appropriateness.
- Verify the code or service has not been billed previously (one [1] lifetime benefit).
- The orthodontist may collect records on a new Member. The records should include the Severe Malocclusion Request Form, Dental Insurance Attestation Form, color photos, X-rays of the Member, and any additional required forms. All forms are available on the Telligen website (*see Section 2.1* Quick Reference). Each case will be reviewed, and based on qualifying criteria, will be forwarded to the State Orthodontic Consultant for review; ***or***
- The case will be administratively denied and the denial status will be available to the Provider on the Provider Portal.

Orthodontic cases will be forwarded to the State Dental Consultant if they meet at least one (1) of the following criteria;

- Cleft palate deformities with a recommendation from the Cleft Palate Team.
- **Impacted anterior teeth:** Considered when it is demonstrated that the tooth or teeth is or are impacted (soft or hard); not indicated for extraction and treatment planned to be brought into occlusion. Arch space must be available for correction.
- **Deep Impinging Overbite:** Considered when the lower incisors are destroying the soft tissue of the palate and there is tissue laceration and/or clinical attachment loss.
    - Color Photographic documentation will be required.

- **Anterior Cross bite:** Considered when clinical attachment loss and recession of the gingival margin are present.
    - Color Photographic documentation will be required.
- **Severe Traumatic Deviation:**
    - Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology.
    - Congenitally missing teeth are not considered a Severe Traumatic Deviation. Missing teeth should be indicated on Part 2 (Diagnostic Information) of the Severe Malocclusion Request Form, refer to the PA vendor.
    - A narrative should be written on Part 2 (Diagnostic Information) of the Severe Malocclusion Request Form explaining what the deviation is.
- A minimum HLD index score of 30 is required to qualify for the program. All cases will be reviewed by the Orthodontic Consultant and the Medicaid Program Manager and if special circumstances apply, a lower score may be approved.

Cases that are forwarded on to the Orthodontic Consultant will be sent with all attached X-rays, color photos, and required forms from the orthodontist.

- After the consultant reviews the case, they will document their recommendation and return the entire case back to the Medicaid Program.
- If the case is approved, WYhealth will issue a Prior Authorization (PA) to the Provider, for treatment to be started.
- If denied, the PA status will reflect the denial and any additional comments from the consultant.

Cases that are recommended for surgical intervention in conjunction with orthodontic treatment will require a consultation with an oral surgeon prior to approval/denial of orthodontic treatment and/or orthognathic surgery.

- An Oral Surgeon Consultation Form, available on the Telligen website (*see Section 2.1* Quick Reference), will be included with this letter to the orthodontist.
- The referring orthodontist should send this form along with any X-rays with the Member to the oral surgeon.
- The oral surgeon will be responsible for completing this form and returning it to Telligen, PA vendor (see *Section* 6.8. Prior Authorization).
- Telligen will add this to the Member's request and submit the case to the orthodontic consultant for consideration.
- If qualified, any requests submitted for the orthodontist and the oral surgeon will be approved for their portions of the treatment.

- If denied, the PA status will reflect the denial and any additional comments from the denying agency.

> A PA is only valid if the Member is eligible for Medicaid on the date of service.

Cases that are submitted to the program as transfers from other states may be evaluated and approved with the intent of completing treatment that was already started. The requesting orthodontist should indicate on their request how much time is expected to complete the treatment. When approved, the State Orthodontic Consultant will also evaluate the length of time needed to complete the case. A PA will be issued for the D8670 and the number of units determined to complete the case will be approved. If the Member does not have orthodontic bands/brackets on one of the arches, D8080/D8090 may be authorized for a partial payment, if the requesting orthodontist anticipates banding this arch.

An orthodontist may request reconsideration of a denied application.

- The orthodontist must write a request letter stating the reason for the request. Any additional supporting documentation should be sent to Telligen for re-consideration.
- Telligen will forward this on to the program manager and orthodontic consultant for re-consideration. The request will only be sent back to the orthodontic consultant if the orthodontist has provided new evidence supporting the request.
- Requests for reconsideration that do not have any new information to support the request will be denied by Telligen.
- If reconsideration is approved, the PA status will reflect the approval and any additional comments from the approving agency.
- The Provider must also indicate on their claim form in box 30, that the Member has entered the retention phase.

The following codes will be reimbursed to enrolled orthodontists who have obtained a PA for the Member:

- **D8660:** Pre-Orthodontic Consultation, once per lifetime per Member
  - A PA is only required for this code for children under the age of 12 if the Provider finds it medically necessary for a child to be part of the Severe Malocclusion Program early for Interceptive treatment.
- **D8080:** Comprehensive Orthodontic Treatment (ages 12-14), once per lifetime per Member.
- **D8090:** Comprehensive Orthodontic Treatment (ages 15-18), once per lifetime per Member.
- **D8670:** Periodic Orthodontic Treatment, maximum of eight (8) payments; Maximum of one (1) payment per three (3) month period.
- **D8680:** Orthodontic Retention and Removal, this may be authorized for Members who have moved here from another state and are unable to or do not plan to continue treatment.

- **D8010-D8030: Limited Orthodontic Treatment:**
    - This will only be authorized for Members who are ages 6-11 and meet the limited treatment criteria (see *Section* 11.11.15.4. Wyoming Medicaid Interceptive Criteria).
- **D8703:** Maxillary replacement of Lost/Broken Retainer, once per lifetime per Member.
- **D8704:** Mandibular replacement of Lost/Broken Retainer, once per lifetime per Member.
- **D8999:** Final Balance Payment
    - This code to be billed for Member's who lose eligibility during treatment. A Prior Authorization is required.

10.11.15.3 Billing Instructions for Severe Malocclusion Program

The Severe Malocclusion Program (SMP) will issue a Prior Authorization (PA) to each Provider for each Member. The PA will authorize the specific treatment for the Member. The Provider is only permitted to bill for services authorized within the PA. It is the responsibility of the Provider to check Member eligibility for each date of service. To check eligibility, call Provider Services or verify on the Provider Portal (*see Section 2.1* Quick Reference). Include the TPL amounts on the claim refer to *Section 6.4.1* Instructions for Completing the Dental Claim Form *and Chapter 7* –Third Party Liability for additional information.

- **D8660:** Pre–orthodontic treatment visit. This code will be paid once per lifetime per Member unless the Member has been placed on a hold by the State to monitor growth or oral hygiene progress. The State can issue a PA for a second consultation at a time determined appropriate by the State Orthodontic Consultant and program manager.
    - PA is only required for this code for children under the age of 12 if the Provider finds it medically necessary for a child to be part of the Severe Malocclusion Program or if the Member is having a second consultation.
    - The Provider may not bill any other services with this visit. The fee indicated includes exam, records, all photos, diagnostic casts, and X-rays.
    - Providers who offer this service as part of a free consultation to all their patients should not bill Medicaid for this service. If a Member is screened with no records for application consideration and the Member returns on a second visit to have records taken, the Provider can bill for this service at that visit.
- **D8080 (age 12-14) or D8090 (age 15-20):** Comprehensive orthodontic treatment. The Provider may not bill any other services with this visit. The fee indicated includes exam, banding, retention, and all photos during the treatment phase. This code will only be paid once per lifetime per Member.
    - If the Member has a primary insurance, the D8080 or D8090 must be billed to the primary insurance before billing Medicaid. A primary EOB must be attached when submitting the claim.

- If the primary insurance does not cover orthodontic services, the EOB that states orthodontics are not covered must be attached to all claims submitted throughout treatment (*see Section 6.10* Submitting Attachments for Electronic Claims).
- If the primary insurance covers orthodontic treatment, the primary insurance must be billed before each claim can be submitted (including D8670, quarterly payments) and the EOB must be attached to all claims submitted. When the maximum benefit from the primary insurance is met, attach a copy of the final EOB to each subsequent claim.
- Providers must bill Medicaid for their full treatment amount for D8080 or D8090.

- **D8670:** Periodic orthodontic treatment visit (as part of the PA) reimburses per quarter (maximum of four (4) quarters per year for not more than 24 months).
  - When billing for periodic treatment visits, the claim should contain the actual date of service for each time the Member was seen during the quarter. These dates of service should be on separate lines of the claim with the fee for each line showing $0.00. The last line should have the last date of service for the quarter with the fee of $300.00. The Member must be seen within the quarter for the Provider to bill this code. The Provider will be paid the quarterly payment as long as the Member is seen within the quarter and the Provider has not exceeded eight (8) payments in the authorized treatment time period (typically 24 months).
  - Due to the federal government's match to this program, tracking of each time a Member is seen in the office for orthodontic adjustments is required to be reported.
  - Once orthodontic bands are removed and the retention phase has begun, the Provider may continue to bill D8670 (quarterly payments) until the total amount of the PA has been paid. Once the total has been paid to the Provider, the Provider may no longer bill for any orthodontic services without a new PA.
    - When bands are removed and the retention phase begins, the Member must be seen at least once per quarter in order for the Provider to bill the D8670 (quarterly payments).
  - When the Member enters retention, the Provider is responsible for sending in a final photo of the Member to Telligen to be included in the Member's State records.
    - Billing Example:

      Member comes to Provider's office for periodic treatment visits on 1/2/21, 2/2/21, and 3/2/21. The Provider should bill as follows:

      Line 1: 1/2/2021 D8670 $0.00

      Line 2: 2/2/2021 D8670 $0.00

      Line 3: 3/2/2021 D8670 $300.00

- **D8999:** If the Member becomes ineligible for Medicaid at any time during treatment, the Provider will be paid the balance of the original Prior Authorization (PA). Providers must request this payment by submitting a final claim. The final claim must contain the following:
    - Date of service must be the last day the Member was seen during the last month of eligibility.

      Example:

      Member was seen 1/2/21, 2/2/21, 2/19/21 and 3/2/21. Member's eligibility ended 2/28/21. The final date of service should be 2/19/21.
    - Procedure code must be D8999, Orthodontic Treatment. Indicate in box 30 (Description), "PA balance for Orthodontic Treatment".
    - A separate PA number for this code will be required to bill.
    - Fee must be the total balance due from the original Prior Authorization (PA).
- **D8680:** Orthodontic Retention and Removal (removal of appliances and/or bands and construction and placement of retainers) reimburses $600.00. **This code is to be billed by Providers who are accepting orthodontic Members from other states who will not be continuing treatment.** This code will only be paid once per lifetime per Member.
- **D8703:** Maxillary replacement of lost or broken retainer reimburses $150.00.
- **D8704:** Mandibular replacement of lost or broken retainer reimburses $150.00.

> When billing either D8703 or D8704, indicate in box 25 (area of oral cavity) on the claim form, UA for upper retainer or LA for lower retainer. These codes will only be paid once per lifetime per Member.

- **D8010 - D8030:** Limited orthodontic treatment for transitional dentition (6-11 years). The Provider may not bill any other services with this visit and the fee indicated includes exam, banding, retention, all photos, and follow-up visits. This code will be paid once per lifetime.

10.11.15.4 Wyoming Medicaid Interceptive Criteria

- Interceptive orthodontic treatment may be approved for ages 6-11 and will only be billable by enrolled orthodontists.
- Interceptive orthodontic treatment may be authorized for mixed dentitions where early intervention could result in avoiding a future crippling malocclusion or reducing the need for complex comprehensive appliance therapy.
- The goal of the interceptive treatment is to reduce the severity of the malformation/malocclusion, mitigate its cause, and to prevent subsequent occlusal conditions that could cause a worsening malocclusion.

- Interceptive treatment will be evaluated on a case-by-case basis and may be authorized by the program only if there is clear evidence of immediate need for treatment based on the established criteria.
- A Member with a pre-qualifying condition may not display sufficient need to have the orthodontic service approved immediately. The State Orthodontic Consultant will review each case for timing and will discuss the plan with the requesting orthodontist if there is need. It is imperative that the treatment request form provide adequate documentation of immediate need and treatment planning.
- It will be the Provider's responsibility to inform the parent/guardian that if interceptive treatment is approved their child may not be eligible for full comprehensive treatment later, depending on the severity of their condition.
- The Provider has full responsibility for maintaining documentation to justify the services provided and billed to Medicaid.
- Cases that are denied can be resubmitted at appropriate intervals as determined by the Member's orthodontist and the State Orthodontic Consultant.
- Space maintenance appliances (D1510, D1515) are billable separately from D8010 - D8030 Limited Orthodontic Treatment if necessary, prior to Interceptive Treatment.
- Diagnostic Criteria for Limited Orthodontic Treatment (D8010 - D8030) is as follows:
    - Cleft and other craniofacial anomalies.
    - Overjet of more than 10mm.
    - Anterior crossbite-class III mandibular prognathism or reverse overjet.
    - Anterior openbite greater than 3mm.
    - Impeded eruption of teeth due to crowding, displacement, presence of supernumerary teeth, retained primary teeth, (and) any pathologic cause, or impacted anterior teeth.
- HLD (Handicapping Labio-Lingual Deviation) index scoring will be collected for documentation purposes, but will not be part of the qualifying criteria for this program.

10.11.16 Orthodontic Services Performed in Federally Qualified Health Centers, Indian Health Services, or Rural Health Clinics

Dental services that are performed in Federally Qualified Health Centers, Indian Health Services, or Rural Health Clinics (FQHC/IHS/RHC) must be billed on the most current ADA claim form/837D. Dental services will receive an encounter rate that is established by Wyoming Medicaid and includes ALL services provided during the encounter and is considered to be an all-inclusive rate. On Medicaid primary encounter claims the encounter claim will always be reimbursed at the encounter rate and will not be reduced when the submitted charges are less.

10.11.16.1 Dental Orthodontic Services

Dental Code Range: D8000-D8999

Providers must obtain a prior authorization (PA) before beginning any orthodontic treatment (*see Section 11.11.15* Orthodontics). Providers will only be allowed to bill for procedure codes that are listed on their PA.

Wyoming Medicaid has a set rate of $1200 for an approved interceptive case and $3600 for an approved Comprehensive case. Facilities will be paid their full encounter rate during each quarterly billing cycle, up to these established maximums. When claims paid reaches these set amounts, the Provider is expected to continue orthodontic treatment until complete, but no further payments will be made to the Provider.

- **D8999:** Must be billed online one with the encounter rate
    - Prior Authorization required (*see Section 6.8.1* Requesting Prior Authorization)
- Additional detail lines must be billed with appropriate covered CDT codes showing each service provided and billed with a zero ($0.00) dollar amount.
- All charges for the same visit must be submitted on one (1) claim.
- Prior authorization (PA) numbers must be on all claims for the Member's orthodontic visits.
- Provider may bill Medicaid for the initial banding and then quarterly (including all of the dates the child was seen for orthodontic adjustments during the quarter). The facility will not bill each time the child is in the facility for orthodontic treatment, only once per quarter.
- Actual dates of service must be included on the quarterly claim.
- No other dental codes may be billed on an orthodontic claim. Only codes in the D8000-D8999 range can be on the claim.

Example:

Child is banded on 1/5/2021 and returns on 2/12/2021, 3/20/2021 and 4/30/2021 for adjustments. Bill as follows

Claim number 1:

Line	Procedure Code	Date	Amount	NPI
1	D8999	1/5/2021	Fee encounter rate	Treating Provider NPI
2	D8080	1/5/2021	$0.00	Treating Provider NPI

Claim number 2:

Line	Procedure Code	Date	Amount	NPI
1	D8999	1/5/2021	Fee encounter rate	Treating Provider NPI
2	D8080	1/5/2021	$0.00	Treating Provider NPI

(This claim will not be submitted until the last date of service on the quarter, 4/30/2021)

> If any codes on the claim deny due to being non-covered, the entire claim will deny. The Provider is responsible for checking eligibility and frequency limitations and only billing Medicaid for covered dental services for the Member. To check eligibility, contact Provider Services or verify on the Provider Portal (*see Section 2.1* Quick Reference). Include the TPL amounts on the claim, *see Section 6.4.1*. Instructions for Completing the Dental Claim Form and *Chapter 7* –Third Party Liability for additional information.

10.11.16.2 End of Treatment

At the conclusion of orthodontic treatment, the Provider must provide the Member with retainers. The removal and retention visits are not reimbursable in addition to the PA amount. The established PA amount includes these procedures.

10.11.16.3 Discontinued Treatment

If the Member discontinues treatment (does not return, removes their own braces, or requests removal early), the Provider stops billing Wyoming Medicaid. No further payments can be made to the Provider if services have discontinued. Wyoming Medicaid can only pay claims for actual dates of service the Provider saw the Member in the facility. This also applies to the Provider removing appliances early for non-compliance.

10.11.16.4 Resuming Treatment

If the Member returns at a later date to resume treatment and the PA is not expired, the facility may resume treatment but can only be reimbursed for the remaining amount on the PA.

10.11.17 Health Check – Early Periodic Screening, Diagnosis, and Treatment

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program was enacted by Congress mandating states provide eligible children under the age of 21 with well-child screening, diagnostic and medically necessary treatment services through their Medicaid programs. Services provided under EPSDT include periodic screening to include dental, vision and hearing, as well as any medically

necessary treatment. As part of the requirements for providing EPSDT services under the federal Medicaid program the state is required to publish a periodicity schedule which meets reasonable standards of dental care. The periodicity instructions and table that the state has chosen are listed below. The EPSDT program in Wyoming is referred to as Health Check.

10.11.17.1 Suggested Procedures for Health Check Dental Services

- Birth to 12 months
    - **Clinical Oral Examination:** First examination at the eruption of the first tooth and no later than 12 months. Repeat every six (6) months or as indicated by the child's risk status or susceptibility to disease. Includes pathology and injuries. A Provider must request, in writing, authorization to see a child more often than every six (6) months based on risk status and medical necessity.
    - **Assess Oral Growth And Development:** By clinical examination.
    - **Caries Risk Assessment:** Must be repeated regularly and frequently to maximize effectiveness.
    - **Radiographic Assessment:** As allowed by the child's cooperation and frequency limitations.
    - **Prophylaxis & Topical Fluoride:** Must be repeated regularly and frequently to maximize effectiveness and as allowed by the child's cooperation and frequency limitations.
    - **Fluoride Supplementation:** Considered when systemic fluoride exposure is suboptimal. Up to at least 16 years.
    - **Anticipatory Guidance and Counseling:** Appropriate discussion and counseling should be an integral part of each visit for care.
    - **Oral Hygiene Counseling:** Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
    - **Dietary Counseling:** At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
    - **Injury Prevention Counseling:** Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouth guards.
    - **Counseling For Nonnutritive Habits:** At first, discuss the need for additional sucking; digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
- 12 to 24 months
    - Repeat birth - 12-month procedures every six (6) months or as indicated.
- Two (2) to six (6) years

- Repeat birth - 12-month procedures every six (6) months.
- **Assessment And Treatment Of Developing Malocclusion:** Discuss possible future malocclusions with parent and refer if early interceptive treatment is medically necessary.
- **Assessment For Pit And Fissure Sealants:** For caries-susceptible first primary molars and permanent molars with deep pits and fissures; placed as soon as possible after eruption.

- Six (6) to 12 years
  - Repeat two (2) - six (6) year procedures every six (6) months.
  - **Substance Abuse Counseling:** As appropriate or needed.
  - **Counseling For Intraoral/Perioral Piercing:** as needed.
- 12 years and older
  - Repeat six (6) - 12-year procedures every six (6) months.
  - **Assessment and/or Removal of Third Molars:** as needed.
  - Transition to adult dental care

Appendices

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Appendix A – Change Control Table

Table 1 provides detailed changes made to this version of the WY BMS Dental Provider Manual.

Table 1. Change Control Table

Effective Date	Changes
04/01/2024	**Chapter 10 Covered Services** Section 10.1 No Show Appointments and Broken Appointments: Updated Broken Appointment Procedure Code from D9986 to D0000.
	Appendices Appendix B –Provider Notifications Log: Updated table.

Appendix B – Provider Notifications Log

Provider Notifications Log			
Active Dates	**Notification Type**	**Title**	**Audience**
March 2024	Email, Provider Bulletin, and What's New	Partial Units and Claims DDE Warning Message	All Providers
January 2024	Email, Provider Bulletin	Wyoming Medicaid's 2024 Payment Exception Calendar	All Providers

Wyoming Medicaid
Dental Provider Bulletin
April 2024, Quarter 1

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Partial Units and Claims DDE Warning Message

Attention All Providers

Claims submitted to Wyoming Medicaid, on or after March 9, 2024, may be denied or paid with denied lines when submitted with partial units (e.g., 3.5 units).

New Claim Edit and Associated Claim Adjustment Reason Code (CARC)/Remittance Advice Remark Code (RARC):

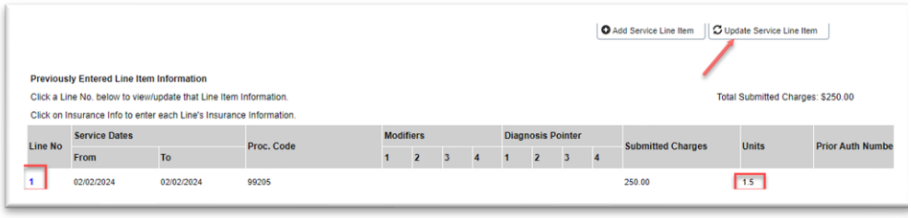
- Edit 7212 – Unit(s) of service is partial and not valid.
- CO-16 – Claim/service lacks information or has submission/billing error(s).
- M53 – Missing/incomplete/invalid days or units of service.

Provider Portal – Direct Data Entry (DDE) Claim Submission:

For DDE claim entry, if partial units are entered in the "Units/Quantity" field in the "Basic Line Item Information" when "Add Service Line Item" is selected, a warning message will display at the top of the page but will **not** prevent the claim from being submitted.

Once the error appears, the provider may "edit" and "update the service line item" by clicking on the line number which will display the line details, then the units can be updated to a whole number.

Warning: Partial Unit(s) of Service were entered, please recheck the value



Deployment Information
Deployment Date: March 22, 2024
Audiences: All Providers

Wyoming Medicaid's 2024 Payment Exception Calendar

Attention All Billing Providers:

The Wyoming Medicaid Payment Exception Schedule for 2024 has been posted to Payment Exceptions web page of the Wyoming Medicaid website.

The payment exception schedule documents the changes to the normal weekly payment schedule.

The normal weekly payment schedule, is as follows:

- Medicaid payment runs on Wednesdays, the State Auditor's Office (SAO) runs payment on Thursdays, and EFT (electronic fund transfers) and check mail dates occur on Fridays.
- Paper Remittance Advices (RAs) and 835s are delivered on Fridays.

Note: The EFT date is the date the SAO transmits the payment to banks (financial institutions), and they have up to three (3) business days to post to accounts.

Deployment Information
Deployment Date: January 15, 2024
Audiences: All Providers