

Wyoming Medicaid – Tired of Holding for the Next Available Representative?

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The changes outlined below are being implemented to allow providers to view the same error codes the call center representatives see. These are Medicaid specific which should reduce the need to call on every claim denial. The Member Eligibility enhancements give providers the capability to search on codes, claim history, and limits, just to mention a few.

In addition to this bulletin, the Wyoming Medicaid Field Representatives will be offering provider workshops the last week of September through the second week of October 2022. The workshops' focus will be on a complete review of these three enhancements which will give providers more resources within the secure Provider Portal to troubleshoot and avoid claim denials.

There will also be updates to both the '[Retrieving Paper RA](#)' Quick Reference Guide (QRG) and the '[Member Eligibility, Code Review/Service Limits, Historical Claim Searches](#)' QRG, formerly called "Provider Member Eligibility Search." QRGs are located on the [Provider Training, Tutorials and Workshops web page](#).

If providers need assistance with these changes or have questions about how to register for a provider workshop, please contact the Provider Services Call Center (1-888-WYO-MCAD or 1-888-996-6223).

Enhancement – Error Codes will display on Provider Portal

Effective September 5, 2022, the provider view of claims in the secure Provider Portal will include Medicaid-specific error codes. This will assist providers in determining claim or line denial reasons.

To see these error codes in claims on the secure Provider Portal, providers will need to sign into the [Wyoming Medicaid Provider Portal](#), select 'Claims Access' as the profile, then select the Claim dropdown menu, and then select 'Claim Inquiry.'

Note: Providers can search for claims by TCN or other filter options.

First, select the TCN hyperlink of the claim that is to be viewed.

The screenshot shows the 'Inquire Claims' interface. At the top, there is a search bar with 'TCN' selected as the filter type and '21221141000002009' entered in the search field. Below the search bar, there are options for 'With Status', 'In', 'Claim', and 'Last 6 Months'. A table of search results is displayed below, with the first row highlighted. A red arrow points to the TCN value in the first row of the table.

TCN	From Date	To Date	Submitted Charges	Claim Status	Approved Amount	Pay Cycle Date
AT	AT	AT	AT	AT	AT	AT
21221141000002009	04/01/2022	04/01/2022	540.00	Denied	50.00	

After selecting the TCN hyperlink, the claim will open and providers will be able to view the Medicaid error codes and their corresponding description, along with the Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that are currently available.

Next, select the notebook icon to view line item information

Select this icon to expand or collapse this section

TCN	Error Code	Error Description	Reason Code	Remark Code
1121102100000073	1000	HEADER SERVICE FROM DATE INVALID	16 - Claims/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 935 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52 - XXX
1121102100000073	1003	SERVICE LINE TO DATE MISSING	16 - Claims/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 935 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59 - XXX

There will be provider workshops coming soon that will offer additional details on claim inquiry searches using the 'Filter By' options, how to download claim search results, and more.

Enhancement – Paper Remittance Advice (RA) Enhancement

Effective September 9, 2022, providers will experience an enhancement to paper Remittance Advices (RAs). This paper RA enhancement allows providers to see Medicaid-specific error codes. CARCs and RARCs that are currently visible will continue to display on all RAs.

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	5555555555555000 02	999999999 1114080660 John Doe	04/28/2022 01/06/2022-01/06/2022				\$99.21	\$0.00		\$0.00	D	1001
	5555555555555001		01/06/2022-01/06/2022	90837		0	\$99.21	\$0.00	\$0.00	\$0.00	D	1002
Test1_Test2 000001234 FUSD0000	4444444444444000 02	999999999 1114080660 John Doe	04/28/2022 01/12/2022-01/12/2022				\$99.21	\$0.00		\$0.00	D	1001
	4444444444444001		01/12/2022-01/12/2022	90837		0	\$99.21	\$0.00	\$0.00	\$0.00	D	1002

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.

Member Eligibility Enhancement

Effective September 5, 2022, Member Eligibility Search screens have been expanded to provide information without having to visit several places. It is designed to save you time when planning services for a member. With this new eligibility enhancement, there will be fields where you can specify the procedure and diagnosis codes you plan to use. The result will have details as to whether or not those codes are valid and if a Prior Authorization (PA) is required for the member for the service you plan.

Utilization for such things as vision and dental will also display so you know if the member has utilized those services. This will give accurate information to help determine what is available to the member before you see them. For example:

- The member calls to schedule an eye exam
- A Search is complete on the Enhanced Eligibility page
- The result shows that the member had an eye exam 6 months ago conducted by a different Vision provider
- Medical necessity needs to be assessed prior to the appointment so you know what can be billed to Wyoming Medicaid.

Inquiry Detail page

To submit an Eligibility Inquiry on a specific Member, complete one of the following criteria sets and click 'Submit'.

- Member ID/Card Number or
- Last Name, First Name and Date Of Birth or
- Last Name, First Name and SSN or
- SSN and Date Of Birth

Additional Search Options (Use if needed with one of the Search Options above to obtain a unique member match):

- Gender
- Zip Code
- Case Number
- Diagnosis Code(s)
- Procedure/Revenue Code

MEMBER ELIGIBILITY INQUIRY

Search By Service Type(s):

Servicing Provider NPI/Provider ID: 90000300 *

Filter By: Member ID

SSN: AAA-GG-SSSS

Last Name: First Name:

Date of Birth: MM/DD/YYYY Zip Code:

Gender: --SELECT--

MA Case Number:

Inquiry Start Date: 08/30/2022 * Inquiry End Date: 08/30/2022 *

Diagnosis Code(s): 1: 2: 3: 4:

Procedure/Revenue Code:

View of what Providers will see when they enter info in the Eligibility Search

Info: Allowed Units mentioned below are the service usage threshold per calendar year before an Authorization of Medical Necessity is required.

Disclaimer: Eligibility shown does not guarantee payment of services.

Inquiry Date Range: 08/30/2022 - 08/30/2022 Commercial / Other: N

Gender:

Date Of Birth:

Case Number:

Case Phone: Ext:

Case Email:

County Of Residence:

Citizenship: Yes

Diagnosis Code 1:

Diagnosis Code 2:

Diagnosis Code 3:

Diagnosis Code 4:

Procedure/Revenue Code: V2103

Lock-In Provider Restriction: N

Indicators: Y

Phone:

Diagnosis Code 1 Covered:

Diagnosis Code 2 Covered:

Diagnosis Code 3 Covered:

Diagnosis Code 4 Covered:

Procedure/Revenue Code Covered: Yes

Non Covered Service Types

The result from the inquiry shows a “Yes” for the Procedure Code. Clicking on the “Yes” will take you to additional information.

Disclaimer: Eligibility shown does not guarantee payment of services.

Procedure/Revenue Code: V2103 Description: SpheroCylindr 4.00d/12-2.00d

AgeRange: 0 to 20 years Gender: Both

Category: HCPCS/CPT

Limit

Limit Code ▲▼	Limit Desc ▲▼	Period Type ▲▼	Time Period Value ▲▼	Anchor Date ▲▼	PA Override ▲▼	Allowed units ▲▼	Used Units ▲▼	Balance Units ▲▼
2P365D3	ONE PR OF LENSES PER 365 DAYS	DAY	365	First Date Of Service	No	2	2	0

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Indicators

Claim Type ▲▼	Modifier ▲▼	Indicator Name ▲▼	Indicator Value ▲▼	Start Date ▲▼	End Date ▲▼
0-All		PROC_REFER_IND	N-No	01/01/2021	12/31/2999
0-All		Prior Authorization	N-No	01/01/2021	12/31/2999
0-All		Procedure Status Indicator	03-Status Indicator 03	01/01/2021	12/31/2999
0-All		Procedure Tooth Requirement Indicator	N-TOOTH CODE NOT REQUIRED	01/01/2021	12/31/2999
0-All		QUADRANT NMBR RQURD INDCTR	N-No	01/01/2021	12/31/2999
0-All		TOOTH_SURF_CD	N-No	01/01/2021	12/31/2999
0-All		Trauma Code	N-No	01/01/2021	12/31/2999

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The procedure code shows that this member is allowed 2 units per 365 days and that they have already used their units for the current 365-day period.

Note: The disclaimer is at the top of each page. Eligibility shown does not always result in a payment of services.