WY BMS Institutional Provider Manual

Prepared for:

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

Prepared by:

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2277 Research Boulevard
Rockville, MD 20850

10/01/2024
Version 12.0
Security: N = No Restriction

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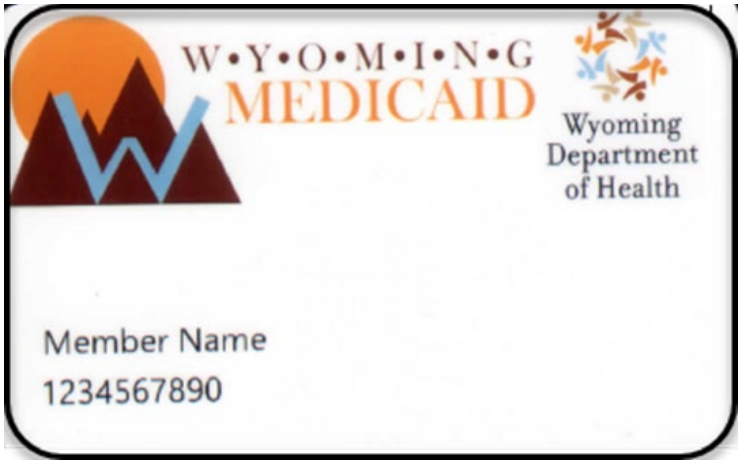
Revision History

Revision Level	Date	Description	Change Summary
Version 0.1	4/28/2021	Initial Submission	N/A
Version 1.0	10/25/2021	First Full Submission	Revisions based on October updates from Agency
Version 1.1	03/14/2022	Second Full Submission	Updates to links behind images/graphics.
Version 2.0	04/01/2022	Third Full Submission	Revisions based on March/April updates from Agency.
Version 3.0	07/01/2022	Fourth Full Submission	Revisions based on June/July updates from Agency
Version 4.0	10/01/2022	Fifth Full Submission	Revisions based on Oct 2022 quarterly updates from Agency
Version 5.0	01/01/2023	Sixth Full Submission	Revisions based on Jan 2023 quarterly updates from Agency. Updated Note format to CNSI standardized format.
Version 6.0	04/03/2023	Seventh Full Submission	Revisions based on Apr 2023 quarterly updates from Agency.
Version 7.0	07/03/2023	Eighth Full Submission	Revisions based on July 2023 quarterly updates from Agency.
Version 8.0	10/02/2023	Ninth Full Submission	Revisions based on Oct 2023 quarterly updates from Agency.
Version 9.0	01/02/2024	Tenth Full Submission	Revisions based on Jan 2024 quarterly updates from the Agency.
Version 10.0	04/01/2024	Eleventh Full Submission	Revisions based on Apr 2024 quarterly updates from the Agency.
Version 11.0	07/12/2024	Twelfth Full Submission	Revisions based on July 2024 quarterly updates from the Agency.
Version 12.0	10/01/2024	Thirteenth Full Submission	Revisions based on Oct 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 Schedule and Provider's Responsibility

Procedure codes listed in the following Sections are subject to change at any time without prior notice. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedules on the website (*see Section 2.1* Quick Reference). Fee schedules list Medicaid covered codes, provide clarification of indicators, such as whether a code requires prior authorization and the number of days in which follow-up procedures are included. Not all codes are covered by Medicaid or are allowed for all taxonomy codes (Provider types). It is the Providers' responsibility to verify this information. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service. Providers may elect to utilize current procedural technology (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 Institutional Manual is Organized

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

Chapter	Description
Two	**Getting Help When Needed –** Telephone numbers, addresses, and web sites for help and training
Three	**Provider Responsibilities –** Obligations and rights as a Medicaid Provider. The topics covered include enrollment changes, civil rights, group practices, Provider-patient relationship, and record keeping requirements.
Four	**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, NDC, 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 partners to the Wyoming Medicaid EDI Companion Guide located on the Medicaid website.
Nine	**Important Information –** This chapter contains important information such as claims review, coding, and fee schedule information.
Ten through Twenty	**Institutional UB-04 Covered Services –** These chapters contain information regarding covered services: definitions, procedure code ranges, documentation requirements, and billing requirements and 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.

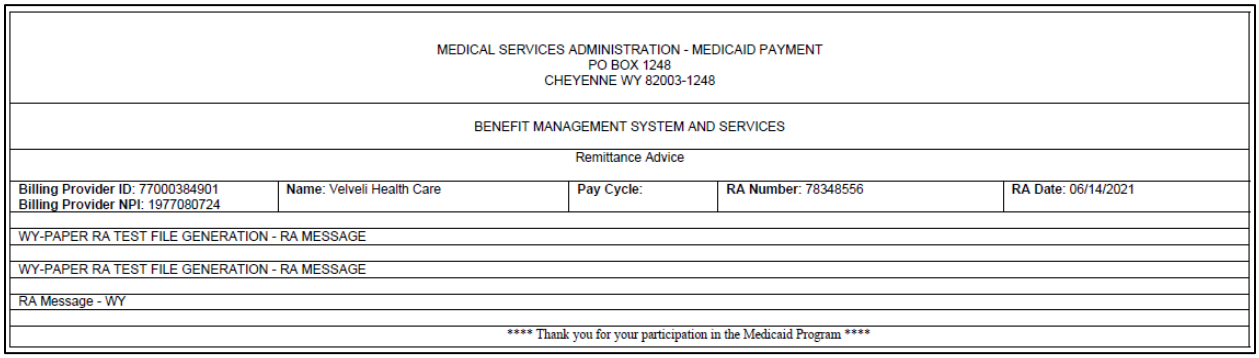
It is critical for Providers to keep their contact email addresses up-to-date to ensure they receive all notices published by Wyoming Medicaid. It is recommended that Providers add the WYProviderServices@cns-inc.com email address, from which notices are sent, to their address books to avoid these emails 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 RA Banner Notices and Samples

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

RA Banner Sample Image:



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

BENEFIT MANAGEMENT SYSTEM AND SERVICES

Remittance Advice

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

WY-PAPER RA TEST FILE GENERATION - RA MESSAGE

WY-PAPER RA TEST FILE GENERATION - RA MESSAGE

RA Message - WY

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

1.2.2 Medicaid Bulletin Notification

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

Sample Bulletin Email Notification

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

Dear Providers,

Get Ready - Get Ready - Get Ready!!!

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

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

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

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

New Wyoming Medicaid Website Address

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

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

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

Provider Training Offerings and Registration

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

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

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

Regards,

Provider Services

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

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

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

1.3 State Agency Responsibilities

The 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 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' vendors, 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

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
			• Employed Individuals with Disabilities(EID) • Verification of Services
Division of Healthcare Financing (DHCF) 122 West 25th St, 4th Floor West Cheyenne, WY 82002	Tel (307)777-7531 Tel (866)571-0944 Fax (307)777-6964	https://health.wyo.gov/healthcarefin/	• Medicaid State Rules • State Policy and Procedures • 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 (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)	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

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
	24/7 IVR Availability		• 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	Tel (888)WYO-MCAD or (888)996-6223 7 am -6 pm MST M-F (call center hours)	www.wyomingmedicaid.com/	• Bulletin/manuals inquiries • Claim inquiries/submission problems • Member eligibility

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Cheyenne, WY 82003-1248 (IVR Navigation Tips) Email: WYProviderOutreach@cns-inc.com	24/7 (IVR availability) Fax (307)460-7408		• 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

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
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

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
			• 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.

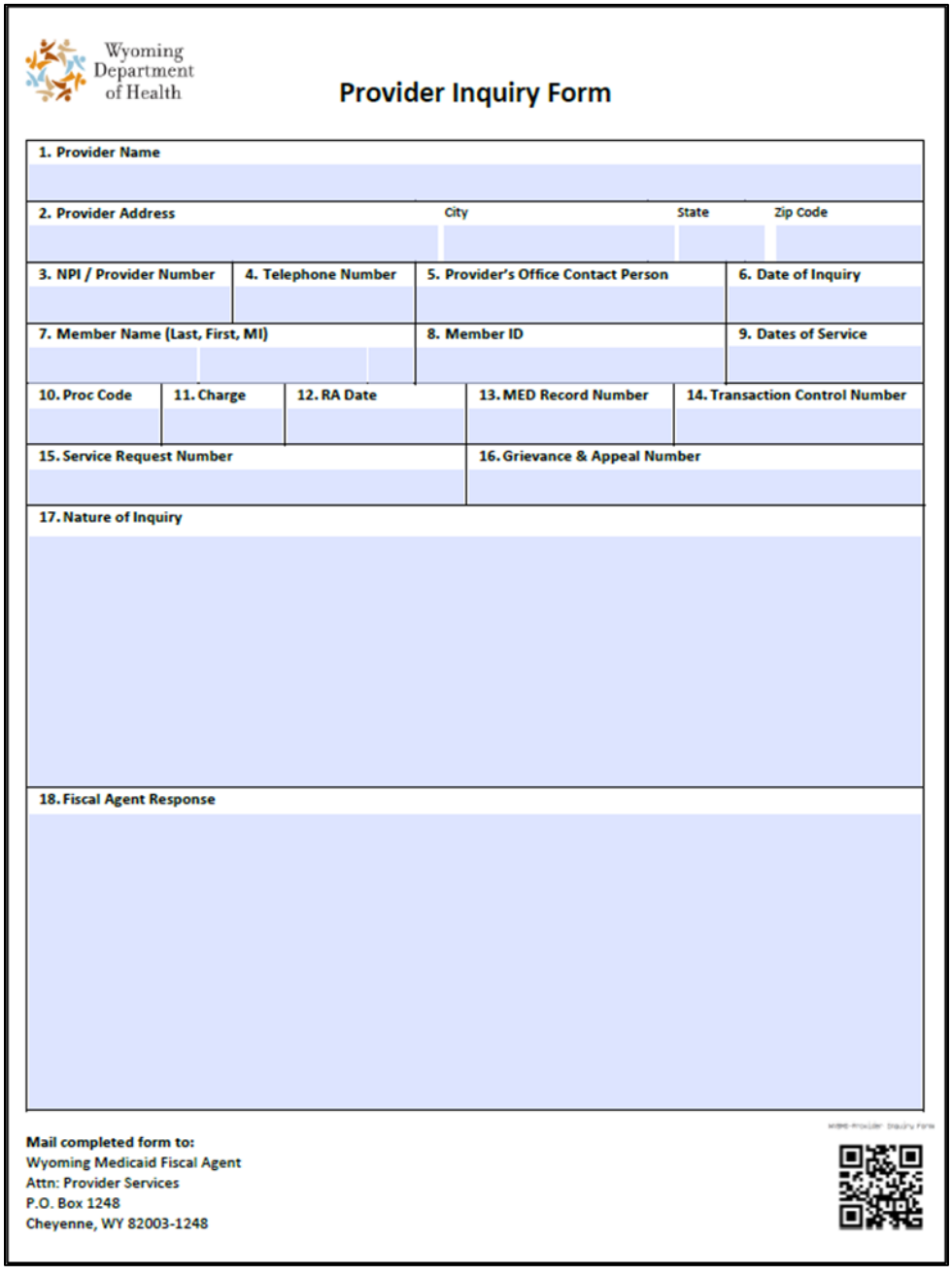
Reasons to write vs. calling:

- **Appeals:** Include the First Level Appeal and Grievance Request Form (*see Section 2.3.2.1* First Level Appeal and Grievance Request Form), 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). Provider Services will respond to the Provider inquiry within ten 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 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* First Level Appeal and Grievance Request Form)
- Documentation of previous claim submissions (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* First Level Appeal and Grievance Request Form)
- An explanation of the problem and any desired supplementary documentation
- Documentation of previous claim submissions (TCN(s), 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.

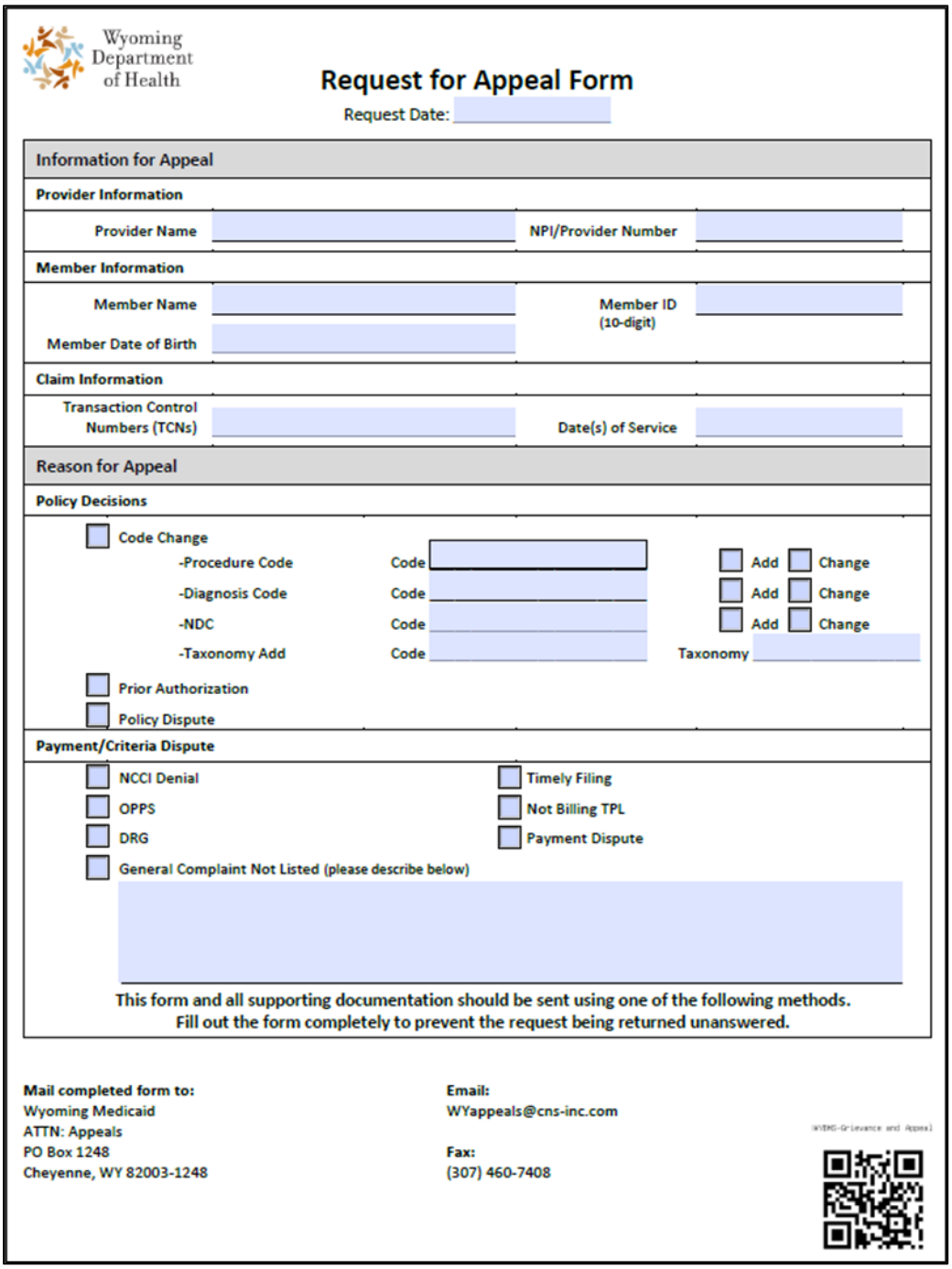
Appeals for claims that denied appropriately or submission of attachments for denied claims will be automatically denied. The appeals process is not an apt means to resubmit denied claims nor to submit supporting documentation. Doing so will result in denials and time lost to correct claims appropriately.

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

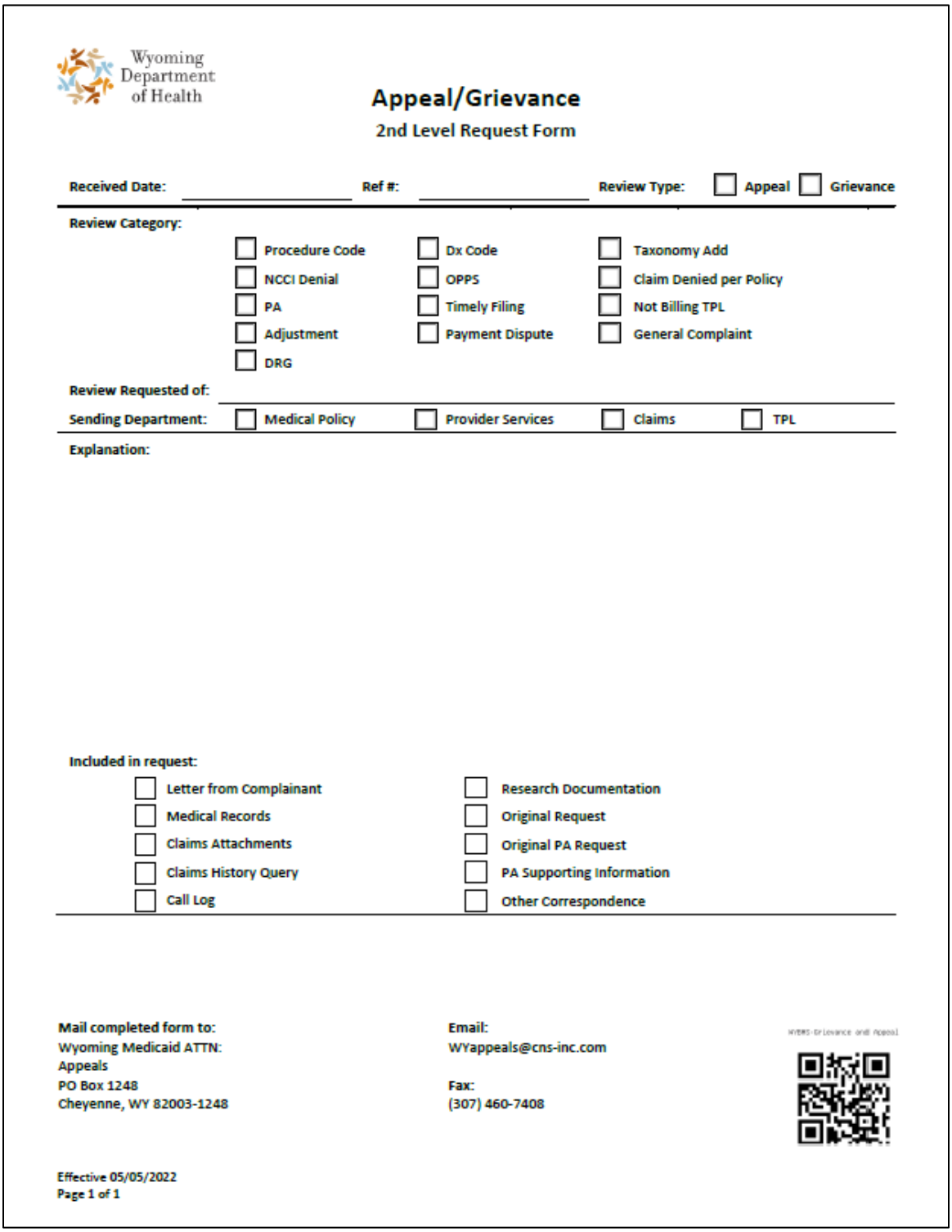
Email:
WYappeals@cns-inc.com

Fax:
(307) 460-7408

WYDH-Grievance and Appeal

This form is located on the 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 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 visit generally consists of a review of the 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 of, 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 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 (paper) 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 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 or certification. These requirements apply to both in state and out-of-state Providers.

Due to the screening requirements of enrollment, 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 centers (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
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 —

Categorical Risk Level	Screening Requirements
	○ 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 on-line 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 or 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 for 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 within 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, and 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 to Medicaid, attention TPL (*see Section 7.2.1* Third Party Resources Information Sheet). The Provider may not discriminate based on whether a Member is insured.

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

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 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 Medicare and Medicaid Dual Eligible Members

Dual eligible Members are those Members who have both Medicare and Medicaid. For Members on the QMB plan, CMS guidelines indicate that coinsurance and deductible amounts 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.

3.2.2.2 Provider Taxonomy Requirements When Billing Medicare for Dually Eligible Members

Wyoming Medicaid requires taxonomy codes to be included on all Medicare primary claim submissions for billing, attending, and servicing or rendering Providers. Medicaid requires these taxonomies to get to a unique Provider.

Medicaid receives Medicare claim Coordination of Benefits Agreement (COBA) files daily and when the Benefit Management System (BMS) is unable to identify the unique billing provider, the claims are denied and will not appear on the Provider's Remittance Advice (RA) or 835s. Providers are not aware of the claims crossing over and denying. Providers will not be able to locate them within the Provider Portal either.

The Wyoming Medicaid Provider manuals are posted on and accessible from the Wyoming Medicaid website. Refer to *Section 6.5* Medicare Crossovers, more specifically *Section 6.5.2* Billing Information.

- If a payment is not received from Medicaid after 45 days of the Medicare payment, submit a claim to Medicaid and include the Coordination of Benefits (COB) information in the electronic claim.

> The line items on the claim being submitted to Medicaid must be the same as the claim submitted to Medicare, except when Medicare denies, then the claim must conform to Medicaid policy.

- Providers must enter the industry standard X12 Claim Adjustment Reason Codes (CARC) along with the Claim Adjustment Group Codes from the Explanation of Medical Benefits (EOMB) when submitting the claim from a clearinghouse or direct data entry (DDE) within the Provider Portal.
- Providers may enter Remittance Advice Remark Codes (RARC) when submitting a HIPAA compliant electronic claims transaction (837).

Billing Provider and Credentialing Staff Action Steps

1. Review and verify that all Provider NPIs on the claim have an associated taxonomy.
2. When submitting taxonomies on the Medicare claims *and they are not automatically crossing to Medicaid*, verify that Medicaid has these taxonomies on file as well.
    a. To verify and update information, billing providers may access their provider enrollment file by logging into the Provider Portal and submitting a "Change of Circumstance", if applicable, with HHS Tech Group, the Provider Enrollment vendor.
        - Training materials are listed under "Info for Providers" on the DYP, HHS Tech Group website.
        - Questions regarding enrollment or change of circumstances that are not addressed in the training materials may be directed to:
            - Email address: WYEnrollmentSvcs@HHSTechGroup.com or
            - Phone number: 1-877-399-0121
    b. Allow one to two (1 to 2) business days for updates (change of circumstances) to appear in the Wyoming Medicaid Provider Portal prior to submitting claims.
3. When all enrollment information is accurate, verify your software is transmitting taxonomies for all Providers (billing, attending, and rendering) when submitting claims to Medicare.

3.2.2.3 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 6.19* 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 6.19* 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.

3.2.2.4 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 the covered services, limitations, and exclusions of the Medicaid Program. Therefore, if the Provider, without mutual written agreement of the Member, delivers services and are 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 rendering 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. Policies 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 are designed to cover the cost of doing business.

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 that they are 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 (*see Section 3.2.2* Provider-Patient Relationship for guidance).
- 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 (*see Section 6.9* Service Thresholds) 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 threshold information 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. There is a limit of three (3) verifications per call but no limit on the number of calls.
- 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).
- 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.

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 of the certification requirements of the State of Wyoming. The Provider must enroll in Medicaid prior to furnishing services.

- Medicaid Rule, Section 7. Out-of-State Providers

- A service furnished by an enrolled provider located outside Wyoming is Medicaid reimbursable if:
  - The services are needed because of a medical emergency;
  - The client is located outside of Wyoming and the client's health would be endangered if required to return to the state;
  - The Department determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
  - It is general practice for clients in a particular locality in Wyoming to use medical resources in another state;
  - The client is referred to a provider outside Wyoming when prior authorized and comparable services are not available within the state;
  - The out-of-state provider is closer to the client's residence than a provider of comparable services within Wyoming; or
  - The client is less than 22 years of age; and
    - Is a foster child and in the custody of the Wyoming Department of Family Services who resides with a foster family out of state and whose Medicaid coverage cannot otherwise be transferred to the receiving state; or
    - Has been placed in an out-of-state institution

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 record element requirements include, but are not limited to:

- The record must be typed or legibly written
- The record must identify the Member on each page
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record. For any drugs administered, the NDC on the product must be recorded, as well as the lot number and expiration date.

- The record must indicate the observed medical condition of the Member, the progress at each visit, any change in diagnosis or treatment, and the Member's response to treatment. Progress notes must be written for every service, including but not limited to, office, clinic, nursing home, or hospital visits billed to Medicaid.
- Total treatment minutes of the Member, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented separately, to include beginning time and ending time for services billed.

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

3.11.2 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
- 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 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:

4. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. 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.
5. 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. 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.
6. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. 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. 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. 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. 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 if 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)
- Review 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 receives and reviews complaints regarding fraud, waste and abuse 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 they 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 inquiry (*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 *Chapter 16* – Hospice.

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 the 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 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 SSI Related

- **Supplemental Security Income (SSI):** A person receiving SSI automatically qualifies for Medicaid
- **SSI 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
- Hospital
- 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 resident 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 3.7* Verification of Member Age;
    - 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 6.19* Timely Filing). This situation could arise for the following reasons:

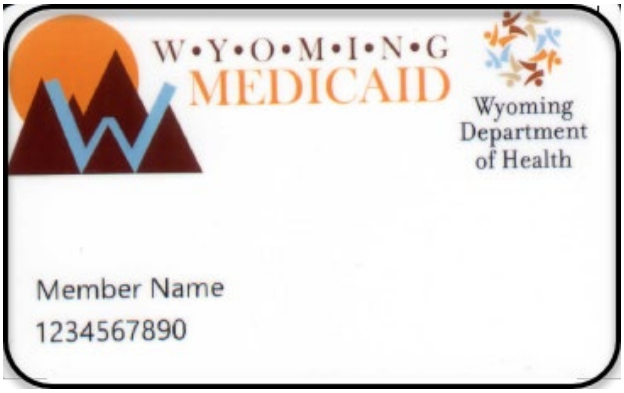
- Administrative Law Judge decisions or reversals
- Delays encountered in processing applications or receiving necessary Member information concerning income or resources

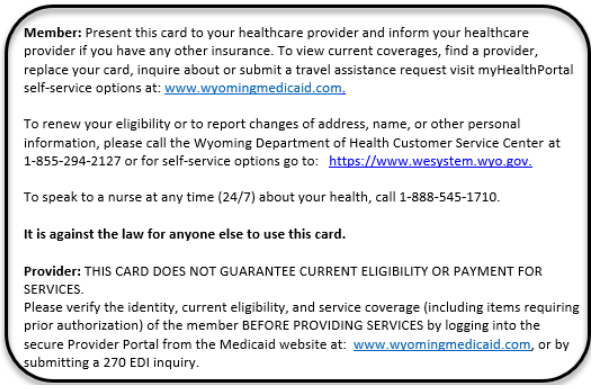
5.5 Member Identification Cards

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 located on the Medicaid website.

If a Member has been on Medicaid previously and have reapplied, they will not receive a new Medicaid card. Member 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 *Section 3.8 Verification Options* for 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 service.

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 Member 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 Claim Information

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

- Use an original, standard, red-dropout form (CMS-1500 (02-12) and UB04)
- Use typewritten print; for best results use a laser printer
- Use a clean, non-proportional font
- Use black ink

- Print claim data within the defined boxes on the claim form
- Print only the information asked for on the claim form
- Use all capital letters
- Use correction tape for corrections

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

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

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

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

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

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

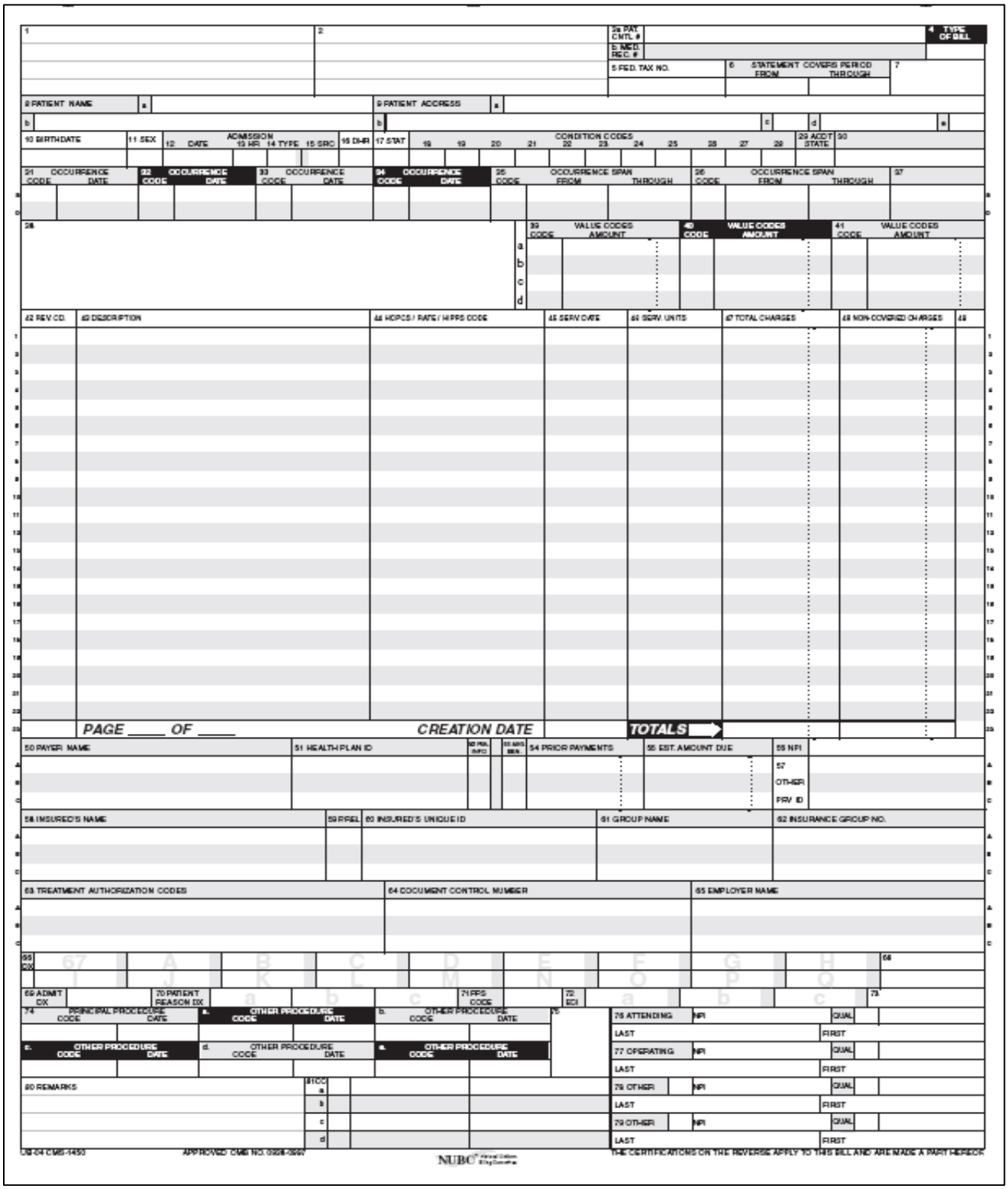
Billing errors detected after a claim is submitted cannot be corrected until after Medicaid has made payment or notified the Provider of the denial. Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice (*see Section 6.17* Resubmitting Versus Adjusting 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 UB-04 Claim Form



6.4.1 Instructions for Completing the UB-04 Claim Form

Field	Item Description	Required Outpatient	Required Inpatient	Action
1	Provider Name and Address and Telephone	X	X	Enter the name of the Provider submitting the bill, complete mailing address and telephone number.
2	Pay-To Name and Address	X	X	Enter the Pay-To Name and Address if different from 1.
3a	Patient Control Number	X	X	Enter the Providers account number for the Member. Any alpha/numeric character will be accepted and referenced on the R.A. No special characters are allowed.
3b	Medical Record Number	N/A	N/A	N/A
4	Type of Bill First Digit 1 Hospital 2 Skilled Nursing 3 Home Health 7 Clinic (ESRD, FQHC, RHC, HIS, or CORF) 8 Special Facility (Hospital, CAH)	X	X	Enter the three (3) digit code indicating the specific type of bill. The code sequence is as follows: <u>Second Digit</u> 1 Inpatient 2 ESRD 3 Outpatient 4 Other 5 Intermediate Care Level 1 6 Intermediate Care Level 2 7 Subacute Inpatient 8 Swing Bed Medicare/Medicaid <u>Third Digit</u> 0 Non-payment/Zero Claim 1 Admit through discharge Claim 2 Interim – 1st Claim 3 Interim – Continuing claim 4 Interim – Last claim (thru Date is discharge date) 7 Adjustment or Replacement of a Prior Claim 8 Void of a Prior Claim
5	Federal Tax Number	X	X	Refers to the unique identifier assigned by a federal or state agency.
6	Statement Covers Period From/Through Dates	X	X	For services rendered on a single day, enter that date (MMDDYY) in both the “FROM” and “THROUGH” fields. <u>Inpatient:</u>

Field	Item Description	Required Outpatient	Required Inpatient	Action
				Enter the date of admission through the date of discharge. <u>Outpatient:</u> Enter the date or dates of services that are being billed on the claim. <u>Outpatient/Inpatient Combined:</u> Enter the date the Member was first seen for outpatient services through the inpatient discharge date.
7	Future Use	N/A	N/A	N/A
8a	Patient ID	X	X	Enter Member's Medicaid number.
8b	Patient Name	X	X	Enter the Member's name as shown on the front of the Medicaid card.
9	Patient Address	X	X	Enter the full mailing address of Member.
10	Patient Birthdate	X	X	Enter Member's birthdate (MMDDYY).
11	Patient Sex	X	X	(Optional) Enter appropriate code.
12	Admission Date	X	X	Enter the date the patient was admitted as an inpatient or the date of outpatient care.
14	Type of Admission/Visit	X	X	Enter appropriate code: 1 = Emergency 2 = Urgent Care 3 = Elective (non-emergency) 4 = Newborn 5= Trauma Physician/medical professional will need to determine if the visit or service was an emergency.
15	Source of Admission	X	X	Enter the Source of Admission Code
16	Discharge Hour	X	N/A	(When applicable) Enter the hour the Member was discharged.
17	Patient Discharge Status	X	X	Enter the two (2) digit code indicating the status of the patient as noted below:

Field	Item Description	Required Outpatient	Required Inpatient	Action	
				Code	Description
				01	Home or self-care
				02	Other hospital
				03	SNF
				04	ICF
				05	Other type of institution
				06	Home health organization
				07	Left against medical advice
				09	Admitted as IP to this hosp
				20	Expired
				21	Law Enforcement
				30	Still a patient, used for interterm billing
				40	Hospice patient died at home
				41	Hospice patient died at hospital
				42	Hospice patient died unknown
				43	Tran to Fed Hlth Care Facility
				50	Discharged to hospice- home
				51	Discharged to hospice- med

Field	Item Description	Required Outpatient	Required Inpatient	Action	
				61	Transferred to swing bed
				62	Transferred to inp rehab facility
				63	Transferred to Long Term Care Hosp
				64	Trans to Mcaid Nursing Facility
				65	Transferred to Psych Hospital
				66	Transferred to Critical Access Hospital
				70	Transfer to Other
18-28	Condition Codes	Situational	Situational	Enter if applicable	
29	Accident State	N/A	N/A	If claim is for auto accident, enter the state the accident occurred in.	
30	Future Use	N/A	N/A	N/A	
31-34	Occurrence Code and Dates	Situational	Situational	Enter if applicable.	
35-36	Occurrence Span Codes and Dates	Situational	Situational	Enter if applicable.	
37	Future Use	N/A	N/A	N/A	
38	Subscriber Name and Address	X	X	Enter Member's name and address.	
39-41	Value Codes and Amounts	Situational	Situational	Enter if applicable	
42	Revenue Codes	X	X	Enter the appropriate revenue codes.	
43	Revenue Code Description	X	X	Enter appropriate revenue code descriptions.	

Field	Item Description	Required Outpatient	Required Inpatient	Action
44	HCPCS/Rates	Situational	Situational	Enter if applicable.
45	Service Date	X	X	Enter date(s) of service.
46	Units of Service	X	X	Enter the units of services rendered for each detail line. A unit of service is the number of times a procedure is performed. If only one (1) service is performed, the numeral 1 must be entered.
48	Non-Covered Charges	Situational	Situational	Enter if applicable.
49	Future Use	N/A	N/A	N/A
50	Payer Identification (Name)	X	X	Enter name of payer.
51	Health Plan Identification Number	X	X	(Optional) Enter Health Plan ID for payer.
52	Release of Info Certification	X	X	Enter Y for release on file
53	Assignment of Benefit Certification	X	X	Y marked in this box indicates Provider agrees to accept assignment under the terms of the Medicare program.
54	Prior Payments	Situational	Situational	Enter if applicable.
55	Estimated Amount Due	X	X	Enter remaining total is prior payment was made.
56	NPI	X	X	Enter Pay-To NPI.
57	Other Provider IDs	Optional	Optional	Enter legacy ID.
58	Insured's Name	X	X	Enter Member or insured's name.
59	Patient's Relation to the Insured	X	X	Enter appropriate relationship to insured.
60	Insured's Unique ID	X	X	Enter Member's Medicaid ID.
61	Insured Group Name	Situational	Situational	Enter if applicable.
62	Insured Group Name	Situational	Situational	Enter if applicable.

Field	Item Description	Required Outpatient	Required Inpatient	Action
63	Treatment Authorization Codes	Situational	Situational	Enter if applicable.
64	Document Control Number	Situational	Situational	Enter if applicable. **NOTE:** Enter the original TCN when adjusting or voiding a previous paid claim (Type of Bill XX7 or XX8)
65	Employer Name	Situational	Situational	Enter if applicable.
66	Diagnosis/Procedure Code Qualifier	X	X	Enter appropriate qualifier.
67	Principal Diagnosis Code/Other Diagnosis Codes	X	X	Enter all applicable diagnosis codes.
67	Present on Admission Indicator (shaded area)	X		Enter the appropriate POA indicator on each required diagnosis in the shaded area to the right of the diagnosis box
68	Future Use	N/A	N/A	N/A
69	Admitting Diagnosis Code	X	Situational	Enter if applicable.
70	Patient's Reason for Visit Code	Situational	Situational	Enter if applicable.
71	PPS Code	Situational	Situational	Enter if applicable.
72	External Cause of Injury Code	Situational	Situational	Enter if applicable.
73	Future Use	N/A	N/A	N/A
74	Principal Procedure Code/Date	Situational	Situational	Enter if applicable.
75	Future Use	N/A	N/A	N/A
76	Attending Name/ID-Qualifier 1-G	X	X	Enter the Attending Physician's NPI, appropriate qualifier, last name, and first name.
77	Operating ID	Situational	Situational	Enter if applicable.
78-79	Other ID	Situational	Situational	Enter if applicable.

Field	Item Description	Required Outpatient	Required Inpatient	Action
80	Remarks	Situational	Situational	Enter if applicable.
81	Code/Code Field Qualifiers *B3 Taxonomy	X	X	Enter B3 to indicate taxonomy and follow with the appropriate taxonomy code.

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

6.4.2 Appropriate Bill Type and Provider Taxonomy Table

Appropriate Bill Type(s)	Pay-to Provider's Taxonomy	Taxonomy Description
11X-14X	282N00000X, 283Q00000X, 283X00000X	General and Specialty Hospitals, Medical Assistance Facilities, Long Term Hospitals, Rehabilitation Hospitals, Children's Hospitals, Psychiatric Hospitals.
77X	261QF0400X	FQHC, Tribal FQHC
11X-14X, 85X	282NR1301X	Critical Access Hospitals (CAH).
81X-82X	251G00000X	Hospice
83X	261QA1903X	Ambulatory Surgical Centers.
72X	261QE0700X	Hospital Based Renal Dialysis Facility, Independent Renal Dialysis Facility, Independent Special Purpose Renal Dialysis Facility, Hospital Based Satellite Renal Dialysis Facility, Hospital Based Special Purpose Renal Dialysis Facility
32X, 33X	251E00000X	Home Health Agencies.
75X	261QR0401X	CORF
71X	261QR1300X	Freestanding or Provider Based RHC
21X, 23X	31400000X, 315P00000X, 283Q00000X (State Hospital Only)	SNF-ICF/ID
18X	275N00000X	Hospital Swing Bed.

Appropriate Bill Type(s)	Pay-to Provider's Taxonomy	Taxonomy Description
11X	323P00000X	PRTF
13X, 77X	261QP0904X, 261QR0400X	Indian Health Services (IHS), National Jewish Health Asthma Day Program.

6.5 Medicare Crossovers

Medicaid processes claims for Medicare and Medicaid services when provided to a Medicaid eligible Member.

6.5.1 General Information

- Dually eligible Members are Members that are eligible for Medicare and Medicaid
- Providers may verify Medicare and Medicaid eligibility via the Provider Portal (*see Section 2.1* Quick Reference).
- Providers must accept assignment of claims for dually eligible Members
- Be sure Wyoming Medicaid has record of all applicable NPIs and taxonomies under which the Provider is submitting to Medicare to facilitate the electronic crossover process
- Medicaid reimburses the lesser of the assigned coinsurance and deductible amounts or the difference between the Medicaid allowable and the Medicare paid amount for dually eligible Members as indicated on the Medicare (Explanation of Medicare Benefits) EOMB
    - Wyoming Medicaid's payment is payment in full. The Member is not responsible for any amount left over, even if assigned to coinsurance or deductible by Medicare.

6.5.2 Billing Information

- Medicare is primary to Medicaid and must be billed first. Direct Medicare claims processing questions to the Medicare carrier.
- When posting the Medicare payment, the EOMB may state that the claim has been forwarded to Medicaid. **No further action is required, it has automatically been submitted.**
- Medicare transmits electronic claims to Medicaid daily. Medicare transmits all lines on a claim with any Medicare paid claim – If one (1) line pays, and three (3) others are denied by Medicare, all four (4) lines will be transmitted to Wyoming Medicaid.
- The time limit for filing Medicare crossover claims to Medicaid is 12 months (365 days) from the date of service or 6 months (180 days) from the date of the Medicare payment, whichever is later

- **If payment is not received from Medicaid after 45 days of the Medicare payment, submit a claim to Medicaid and include the COB (Coordination of Benefits) information in the electronic claim.** The line items on the claim being submitted to Medicaid must be exactly the same as the claim submitted to Medicare, except when Medicare denies, then the claim must conform to Medicaid policy.
    - Providers must enter the industry standard X12 Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) along with the Claim Adjustment Group Codes (x12.org/codes) from the EOMB when submitting the claim via a clearinghouse or direct data entry via the Provider Portal
- If a paper claim adjustment is being submitted, the EOMB must be attached and the Medicare amount paid entered on the claim. If the Medicare policy is a **replacement/advantage or supplement**, this information must be noted (it can be hand written) on the EOMB.

> Do not resubmit a claim for coinsurance or deductible amounts unless the Provider has waited 45 days from Medicare's payment date. A Provider's claims may be returned if submitted without waiting the 45 days after the Medicare payment date.

6.6 Provider Preventable Conditions

The following conditions are Health Care-Acquired Conditions (HCACs) and will be denied in any Medicaid inpatient hospital setting:

- Foreign object retained after surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma; including fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor Glycemic control including: Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity
- Surgical site infections following:
    - Coronary artery bypass graft (CABG) – Mediastinitis

- Bariatric Surgery; including Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures; including Spine, Neck, Shoulder, Elbow

- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following Total Knee Replacement or Hip Replacement with pediatric and obstetric exceptions
- Iatrogenic Pneumothorax with Venous Catheterization
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

The following are Outpatient Provider Preventable Conditions (OPPC) and will be denied in any health care setting:

- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

6.6.1 Providers Included in the Provider Preventable Condition Review

Under Medicaid, the State must deny payments in any inpatient hospital setting for the identified PPCs. This includes Medicare's inpatient prospective payment system (IPPS) hospitals, as well as other inpatient hospital settings that may be IPPS exempt under Medicare. This also includes facilities that States identify as inpatient hospital settings in their Medicaid plans, critical access hospitals (CAHs) that operate as inpatient hospitals and psychiatric hospitals.

6.6.2 Present on Admission Indicator

Wyoming Medicaid requires Present on Admission (POA) indicators on all inpatient hospital for all hospital types participating in Wyoming Medicaid. Wyoming Medicaid has adopted Medicare's list of exempt ICD-10 diagnosis codes. The list of diagnosis codes exempt from the POA requirement can be found at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

Wyoming's Health Care-Acquired Condition Inpatient Payment Adjustment Process:

1. At the end of each quarter, identify inpatient claims from the prior quarter for non-exempt hospitals with non-principle diagnosis codes falling into one (1) of the 11 Hospital-Acquired Condition (HAC) categories.
2. Request POA indicator information from the hospitals for each of the claims identified in Step 1. *Effective January 1, 2012: review POA indicators submitted on the claim instead of requesting information from hospitals.*

3. Review POA indicator information submitted by the hospitals, and based on the indicator, take the following actions:

POA Indicator	Definition	Action
Y	Diagnosis was present at time of inpatient admission	Claim is not a HAC. Drop from HAC adjustment consideration.
N	Diagnosis was not present at time of inpatient admission.	Claim is a HAC. Request adjusted claim from the hospital (see *Step 4*).
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	Request medical records related to the claim to determine appropriateness of the "U" indicator assignment (*see Step 6*).
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Claim cannot be confirmed as a HAC. Drop from HAC adjustment consideration.
Blank	Exempt from POA reporting. **NOTE:** The number "1" is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for diagnosis codes exempt from POA reporting.	Diagnosis code is not subject to HAC payment policy. Drop claim from adjustment consideration.

4. For all claims with a POA indicator of "N," request that the hospital submit an adjusted claim which identifies all charges associated with the HAC as "non-covered" and all charges not associated with the HAC as "covered."
5. Determine the APR DRG assignment and outlier payment for each of the adjusted claims received in Step 4. If the total payment is less than what was originally paid for the claim, then request a refund from the hospital for the difference. The fiscal agent for Wyoming Medicaid will maintain a listing of these claims, including the submitted charges and payment, and the adjusted charges and payment.
6. Request medical records for all claims identified in Step 3 with a POA indicator of "U" and for a sample of claims with a POA indicator of "Y" (no more than five (5) from each hospital).
    a. For claims with a POA indicator of "Y," review medical record documentation to validate the accuracy of the assignment of the "Y" indicator by verifying that the condition was present on admission. If the review determines that the indicator should be "N", then proceed to Steps 4 and 5. Further, based on the results of the review, Wyoming Medicaid may request additional claims.
    b. For claims with a POA indicator of "U", review the medical record to determine whether the use of the "U" indicator is appropriate. If the review determines that the indicator should be

"N," then proceed to Steps 4 and 5. If the review determines that the indicator should be "Y," then the claim is not a HAC. Drop from the HAC adjustment consideration.

c. Wyoming Medicaid will monitor the results and increase or decrease the sample size in each subsequent quarter, as necessary. Wyoming Medicaid may also drop hospitals from future sampling, depending on the results of the first year of reviews.

> CMS site list: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

6.7 Value Codes

Most frequently used value codes by Wyoming Medicaid Providers:

Value code 54

- Must be populated on Inpatient and Inpatient crossover claims
- Must be populated when:
  - Newborn is less than or equal to 29 days old
- Inpatient/Inpatient crossover claims will be denied if:
  - If value code 54 is submitted with value of 0 or less
  - Or value code 54 is submitted with value of 10,000 greater
  - Or value code 54 is submitted multiple times on a claim

Value Code 80 and 81

Value code 80 is to be billed as covered days and value code 81 is to be billed as non-covered days.

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

> For the complete nursing facility value code billing requirements refer to Chapter 18 – Skilled Nursing Facility and Swing Bed Services.

6.8 National Drug Code Billing Requirement

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

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

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

6.8.1 Converting 10-Digit National Drug Codes to 11 Digits

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

Converting 10-Digit NDCs to 11 Digits			
10 Digit Format	**Sample 10-Digit NDC**	**Required 11-Digit Format**	**Sample 10-Digit NDC Converted to 11 Digits**
9999-9999-99 (4-4-2)	0002-7597-01 Zyprexa 10mg vial	0999-9999-99 (5-4-2)	00002-7597-01
99999-999-99 (5-3-2)	50242-040-62 Xolair 150mg vial	99999-0999-99 (5-4-2)	50242-0040-62

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

6.8.2 Documenting and Billing the Appropriate National Drug Code

A drug may have multiple manufacturers, so it is vital to use the NDC of the administered drug and not another manufacturer's product, even if the chemical name is the same. It is important that Providers develop a process to capture the NDC when the drug is administered, before the packaging is thrown away. It is not permissible to bill Medicaid with any NDC other than the one administered. Providers

should not pre-program their billing systems to automatically utilize a certain NDC for a procedure code that does not accurately reflect the product that was administered to the Member.

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

6.8.3 Billing Requirements

The requirement to report NDCs on professional and institutional claims is meant to supplement procedure code billing, not replace it. Providers are still required to include applicable procedure information such as dates of service, CPT or HCPCS codes, modifiers, charges, and units.

6.8.4 Submitting One National Drug Code per Procedure Code

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

Example:

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

6.8.5 Submitting Multiple National Drug Codes per Procedure Code

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

Example:

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

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

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

6.8.6 Outpatient Prospective Payment System Packaged Services (Critical Access and General Hospitals only)

The NDC requirement does not apply to services considered packaged under OPPS. For a list of packaged services, consult the APC-Based Fee Schedule located on the Medicaid website (*see Section 2.1* Quick Reference).

6.8.7 UB-04 Billing Instructions

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

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

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

6.8.7.1 UB-04 One National Drug Code per Procedure Code

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

6.8.7.2 UB-04 Two National Drug Codes per Procedure Code

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

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

6.9 Service Thresholds Per Calendar Year

6.9.1 Under Age 21

Medicaid Members under 21 years of age are subject to thresholds each calendar year for:

- Physical therapy visits

- Occupational therapy visits
- Speech therapy visits
- Chiropractic visits for dates of service prior to 06/01/2021
- Dietitian visits for dates of service prior to 01/01/2021
- Emergency dental visits
- Behavioral health visits for dates of service 01/01/2021 and forward

6.9.2 Ages 21 and Older

Medicaid Members 21 years of age and older are subject to thresholds each calendar year for:

- Office/outpatient hospital visits
- Physical therapy visits
- Occupational therapy visits
- Speech therapy visits
- Chiropractic visits for dates of service prior to 06/01/2021
- Dietitian visits for dates of service prior to 01/01/2021
- Emergency dental visits
- Behavioral health visits

OFFICE AND OUTPATIENT HOSPITAL VISITS		
Codes	**Service Threshold**	**Does not apply to:**
Procedure Codes: 99281-99285 99201-99215 **Revenue Codes:** 0450-0459 0510-0519	12 combined visits per calendar year	• Members Under Age 21 • Emergency Visits • Family Planning Services • Medicare Paid Crossovers

Ancillary services (for example, lab, X-ray, and so on) provided during an office/outpatient hospital visit that exceeded the threshold will still be reimbursed.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, BEHAVIORAL HEALTH VISITS, CHIROPRACTIC VISITS AND DIETITIAN		
Codes	**Service Threshold**	**Does not apply to:**
Procedure codes: 90785; 90791; 90792; 90832-90834; 90836-90838; 90845-90849; 90853; 90857;92507-92508; 92526; 92609; 96105-96146; 97010-97039; 97110-97150; 97151-97158; 97161-97546; 97802-97804; 98940-98942; (all modalities on same date of service count as 1 visit) **HCPCS Level II codes:** G9012; H0004; H0038; H0046, H2010; H2014; H2017; H2019; S9480, T1017 (all modalities on same date of service count as 1 visit) **Revenue codes:** 0421-0449 (each unit counts as 1 visit)	20 physical therapy visits per calendar year 20 occupational therapy visits per calendar year 30 speech therapy visits per calendar year Behavioral Health Visits: • 2020 dates of service and prior - threshold of 30 visits per calendar year applies to Members 21 and over only • 2021 dates of service and forward - threshold applies to all Members Chiropractic Visits: • 05/31/2021 dates of service and prior - 20 chiropractic visits per calendar year • 06/01/2021 dates of service and forward – Chiropractic services are not covered Dietitian Visits: • 2020 dates of service and prior - 20 dietitian visits per calendar year • 2021 dates of service and forward - no threshold on visits	• Medicare Paid Crossovers • Inpatient and ER behavioral health services

6.9.3 Office and Outpatient Hospital Visits Once Threshold is Met

Procedure Code Range: **99281–99285, 99201–99215**

Revenue Code Ranges: **0450–0459 & 0510–0519**

Once the threshold for a calendar year has been reached, the process will be as follows:

- When a claim is submitted for the 13th office or outpatient hospital visit, the Member will be enrolled into a care management program with WYhealth to help manage their medical conditions and healthcare needs
- Both the Member and any Providers who have billed office or outpatient hospital visits for the Member in that calendar year will receive a letter informing them the Member has exceeded the 12-visit threshold and the Member has been enrolled in the care management program

- Wyoming Medicaid will use the Member's participation in the care management program to determine the medical necessity for services provided, and will continue to process additional claims for office or outpatient hospital visits according to Medicaid guidelines
- As long as the Member continues to participate in the care management program, no further action is required by the Provider for claims to process as normal
- Should the Member choose **not** to participate in the program, the Member and the Provider will receive another letter informing them that office visit and outpatient hospital visit claims will need to be reviewed for medical necessity before being processed for payment
    - The review of medical necessity may include review of diagnosis codes on the claim, a call from the UM Coordinator to the Provider's office, or a written request for medical records regarding the visit.
    - Providers may choose to bill the Member so long as they have informed the Member, in writing, prior to rendering service(s) that:
        - The service is not medically necessary, OR
        - They will not be providing medical records to help Medicaid determine the medical necessity of the visit, OR
        - They will not be billing Medicaid
- The Member can begin or resume participation in the care management program at any point after meeting the threshold to reinstate claims processing without additional verification of medical necessity by the Provider

> Claims that are for Members under the age of 21 that are coded as emergencies, family planning, or where Medicare has paid as primary are not subject to this process and do not count towards this threshold.

6.9.4 Prior Authorization Once Thresholds are Met

Once the threshold has been reached for a calendar year, or once the Provider is aware the threshold will be met and the Member is nearing the threshold, a Prior Authorization may be requested for the following services (*see Section 6.13* Prior Authorization):

- Physical therapy visits
- Occupational therapy visits
- Speech therapy visits
- Behavioral health visits (see *Chapter 13 – Covered Services – Behavioral Health* of the *CMS-1500 Provider Manual* located on the Medicaid website)

> If the Member is seen by different treating Providers on the same day, it will be counted individually as a visit. For example, the pay-to-Provider is the same for both treating Providers. The Member has appointments with Provider A for individual counseling at 1PM on 4/1/2021 and Provider B for group therapy at 2PM on 4/1/2021, it will count as two 2 visits.

Requests can be made by:

- Physicians
- Nurse practitioner
- Physical, occupational, or speech therapists
- Psychiatrists
- Psychologist
- Licensed mental health professionals (such as, licensed professional counselor, licensed marriage and family therapist, licensed certified social workers and licensed addiction therapists)
- Community mental health centers
- Substance abuse treatment centers
- Board Certified Behavior Analysts

6.10 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
- Encounter rate
- Invoice charges
- Negotiated rates
- Per diem
- Resource Based Relative Value Scale (RBRVS)
- Outpatient Prospective Payment System (OPPS)/3M Grouper (GPCS)
- All Patients Refined Diagnosis-Related Grouping (APR DRG)

6.10.1 Invoice Charges

For manually priced items an invoice, which provides proof of purchase and actual cost(s) for equipment and/or supplies, is required. The lowest price on the invoice, including Provider discounts, will be used.

For dates of service 12/31/2020 and prior, manually priced items for Durable Medical Equipment (DME) are priced at lowest invoice cost, plus shipping, plus 15%.

For dates of service 01/01/2021 forward manually priced items for DME are priced at lowest invoice cost, plus shipping, plus 12.13%.

To receive the cost of shipping the manufacturer must be the one to break down the shipping/handling on the invoice. If the manufacturer does not include a shipping/handling breakdown on the invoice, and there is more than one (1) item, it cannot be included in the cost of the item.

> If more than one (1) piece of DME can meet the Member's needs, coverage is only available for the most cost-effective piece of equipment.

- 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
- Effective July 1, 2024, if any part of an invoice is missing or marked out, the claim or claim line will be denied.
- A packing slip, price quote, purchase order, delivery ticket, and so on may be used **only** if the Provider no longer has access to the invoice, is unable to obtain a replacement from the supplier/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, and so on)

6.11 Co-Payment Schedule

$3.65 Co-Payment Schedule		
Procedure and Revenue Code(s)	**Description**	**Exceptions**
T1015 and 0521 Revenue Code	Rural Health Clinic encounters	Co-payment requirements do not apply to: • Children defined as: ○ Medicaid eligibility for children is under 21
T1015 and 0520 Revenue Code	Federally Qualified Health Center encounters	

$3.65 Co-Payment Schedule		
Procedure and Revenue Code(s)	**Description**	**Exceptions**
0450-0459 and 0510-0519	Outpatient hospital visits (non –emergency)	○ Kid Care CHIP eligibility 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 • Inpatient Hospital stays • Members of a Federally recognized tribe

To clarify, Members on the KIDB Benefit Plan (Kid Care CHIP Plan A) do not have co-pays. Members 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.

Emergency services are identified by the Type of Admission/Visit indicator.

Type of Admission/Visit Indicator Number	Description
1	Emergency
2	Urgent Care
3	Elective (non-emergent)
4	Newborn
5	Trauma

6.12 How to Bill for Newborns

When a mother is eligible for Medicaid, at the time the baby is born, the newborn is automatically eligible for Medicaid for one (1) year. However, the WDH Customer Service Center (*see Section 2.1* Quick Reference) must be notified of the newborn's name, gender, date of birth, and the mom's name and

Medicaid number for the newborn's Medicaid ID Card to be issued. This information can be faxed, emailed, or mailed to the WDH Customer Service Center on letterhead from the hospital where the baby was born or reported by the parent of the baby. **The Provider will need to have the newborn's Member ID to bill newborn claims.**

6.13 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.

Submitting Requests for Prior Authorization

- **Do not send requests with codes that do not require a prior authorization to Telligen. To determine if a code requires a prior authorization and a modifier, refer to the** Wyoming Medicaid Fee Schedules (https://www.wyomingmedicaid.com/portal/fee-schedules)**.**

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

Agency Name	Phone and Email	Services Requiring PA
Home and Community Based Services (HCBS)	Contact case manager Case manager will contact the Division of Healthcare Financing (DHCF)	• Community Choice Waiver (CCW) • Comprehensive and Supports Waivers (Developmental Disability (DD) Waivers)
Change Healthcare	(877) 207-1126	• Pharmacy Prior Authorizations (PA) • PAs for physician administered injections: ○ Belimuab Injections ○ Botox, Dysport, and Myobloc Injections ○ Ilaris/Cankinumab ○ Ocrevus/Ocrelizumab ○ Pralatrexate ○ Reslizumab (CINQAIR) IV Infusion Treatment ○ Synvisc & Hylagen Injections ○ Tysabri IV Infusion Treatment

Clubhouse Services	Wdh-clubhouse@wyo.gov	• Mental health clubhouse services
Magellan Healthcare	Tel (307)459-6162 8-5pm MST M-F (855) 883-8740 (after hours) http://www.magellanofwyoming.com/	Care Management Entity (CME) services that include: • Family Care Coordination • Family Peer Support Partner • Youth Peer Support Partner • Youth and Family Training & Support • Respite services
DHCF Utilization Management Coordinator	Email Amy Buxton Amy.buxton@wyo.gov	• Personal Care Services, Home Health (*see Section 15.2.3* Billing Requirements)
Magellan Healthcare	Tel (307) 459-6162 8-5pm MST M-F (855) 883-8740 (after hours) http://www.magellanofwyoming.com/	Care Management Entity (CME) services that include: • Family Care Coordination • Family Peer Support Partner • Youth Peer Support Partner • Youth and Family Training & Support • Respite services
Telligen (Utilization Management)	(833) 610-1057	• Acute Psych • Binaural Hearing Aids • Cochlear Implant – 1x/5yrs • Dental Implants & fixed bridges • Severe Malocclusion • Specialized Denture Services • Oral & Maxillofacial Surgeries • Durable Medical Equipment (DME) • Extended Psych • Extraordinary Care • Gastric Bypass • Genetic Testing

		• Home Health • MedaCube • Prosthetic and Orthotic Supplies (POS) • PRTF – Psychiatric Residential Treatment Facility • PT/OT/ST/BH once threshold has been met • Surgeries (within range 10000-99999) that requires prior authorization • Transplants • Vagus Nerve Stimulator • Vision – Lenses, Contacts, & Scleral Shells • Unlisted Codes

6.13.1 Requesting an Emergency Prior Authorization

Contact the appropriate authorizing agencies for their pending/emergency PA procedures (*see Section 6.13* Prior Authorization).

6.13.2 Prior Authorization Status Inquiry

The BMS will receive approved and denied PAs (278 transactions) from Telligen, CCW (HCBS), DD Waivers (HCBS), Change Healthcare, Magellan Healthcare (CME). 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 PA 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 field 63 of the UB-04 claim form. For placement in an electronic X12N 837 Institutional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at www.wpshealth.com/resources/files/med_a_837i_companion.pdf.

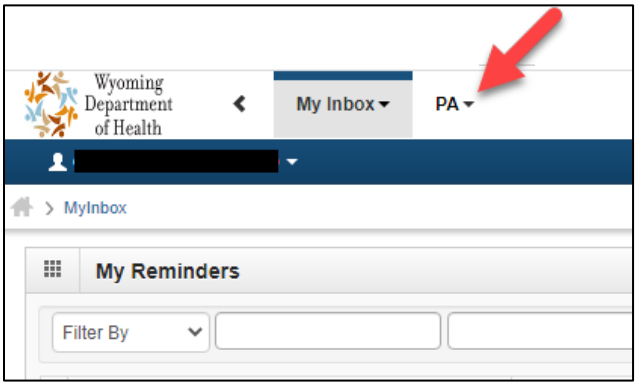
Used PAs will be viewable on the Provider Portal.

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

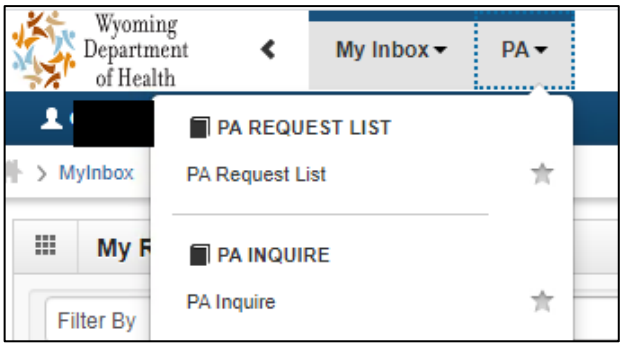
1. Log in to the Medicaid Portal (*see Section 2.1* Quick Reference).

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

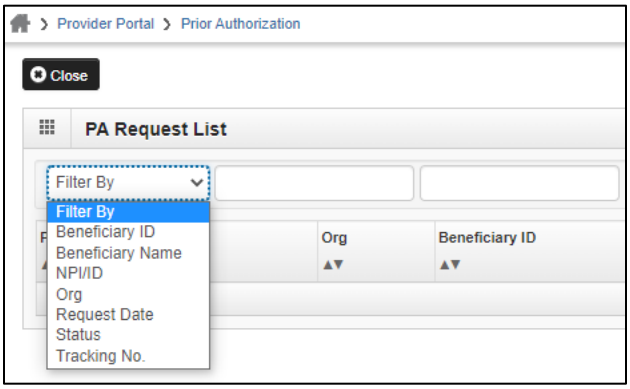
2. Once the user is logged into to the Provider Portal and selects Prior Authorization Access from the Provider Profile drop-down list, PA appears next to "My Inbox".



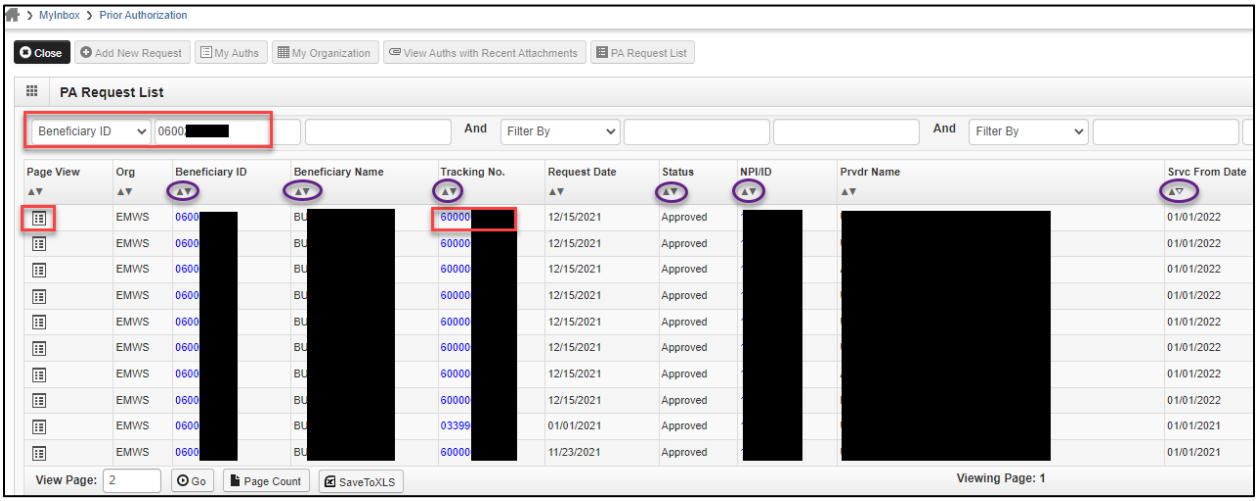
3. From the PA drop-down list, select **PA Request List** (do not have PA number) or **PA Inquire** (have PA number).



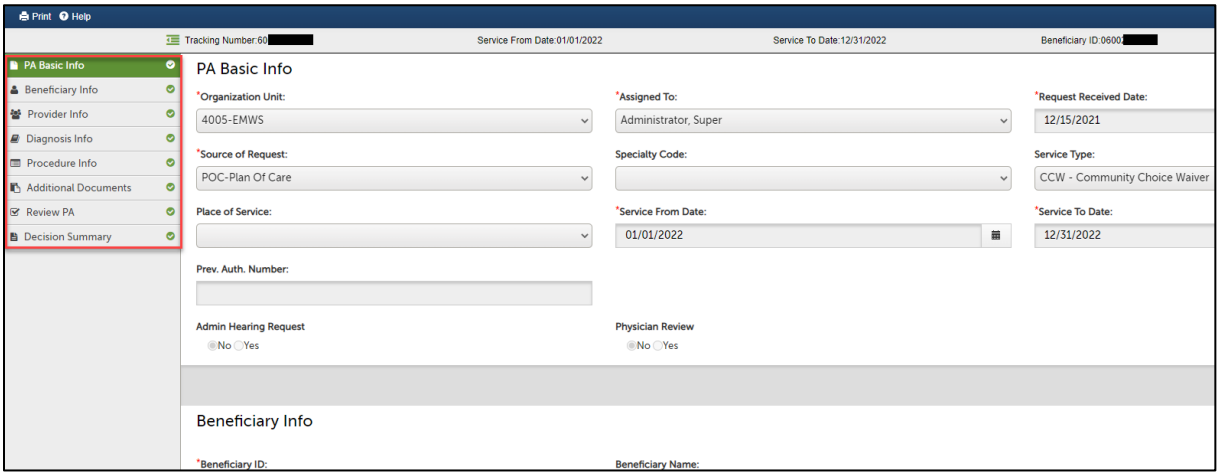
> Providers inquiring on PAs may select PA Request List and filter (search) in various ways, such as PA Tracking No., Beneficiary (Member) ID, Beneficiary (Member) Name, Status.



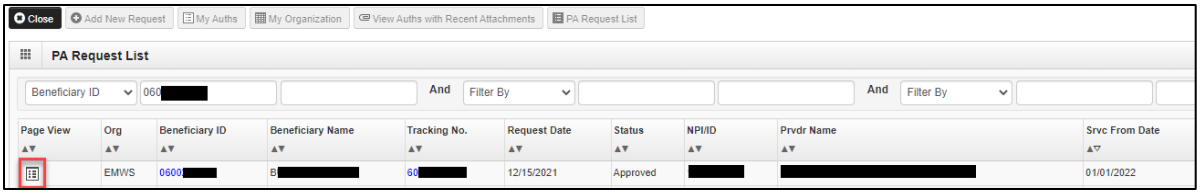
Example of a search by the Beneficiary (Member) ID- Select **Beneficiary ID** in the first drop-down list, then enter the 10-digit Medicaid Member ID number and select Go. Below is partial information that is displayed.



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.

6.14 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 (6.14.1.1 Sample of Systematically Generated Provider Portal Attachment Coversheet) for that specific claim or download and complete the Attachment Coversheet (6.14.1.2 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 and Provider Portal
- 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

6.14.1 Attachment Coversheets

There a two (2) Attachment Coversheets:

- Attachment Coversheet systematically generated and printed from the Provider Portal (*see Section 6.14.1.1* 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 6.14.1.2* Attachment Coversheet and Instructions)

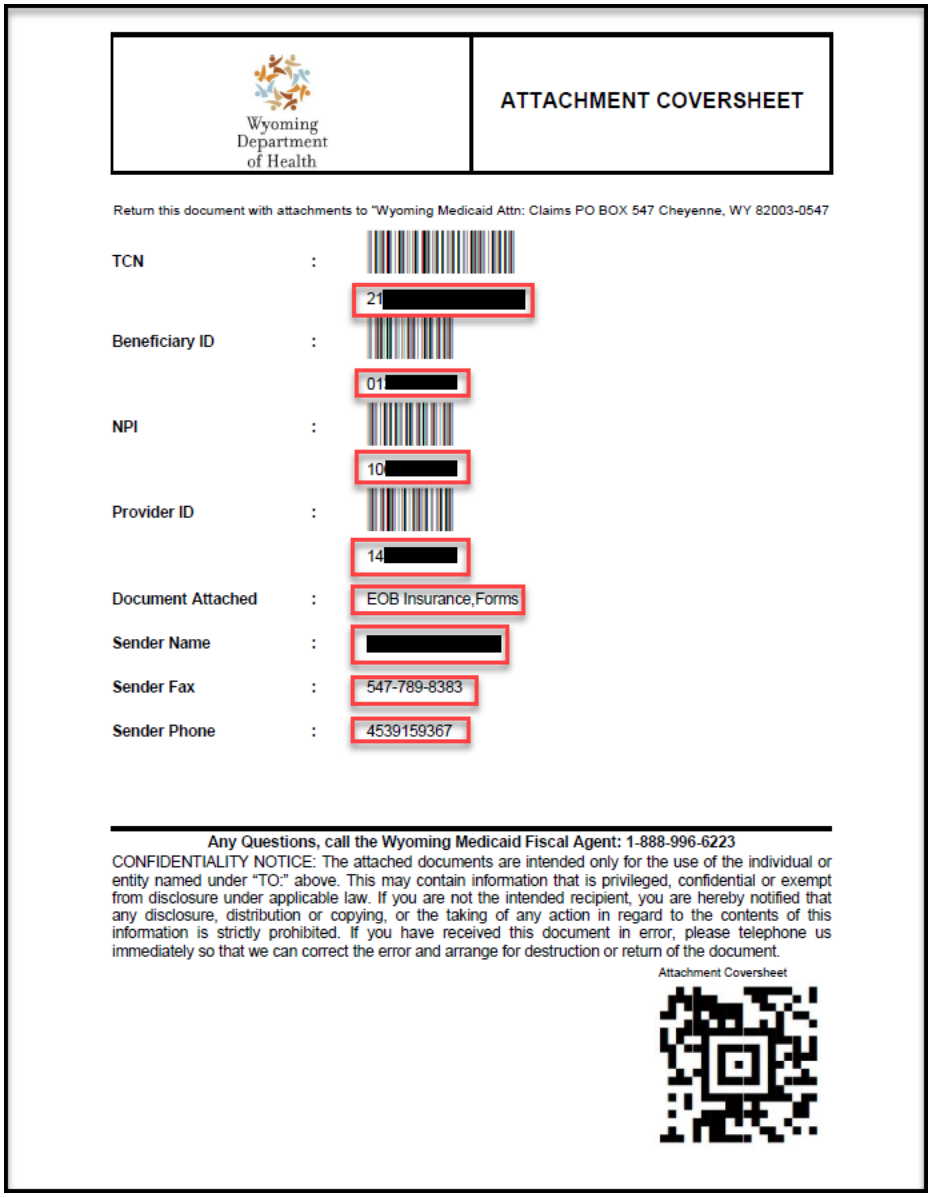
- This coversheet can be downloaded and must be filled in by the Provider
- The data entered on the form must match the claim exactly in DOS, Member information, pay-to Provider NPI, and so on. the complete instructions are provided with the form (Section 6.14.1.2 Attachment Coversheet and Instructions)

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 Outreach 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.

6.14.1.1 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

6.14.1.2 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

This form is located on the Medicaid website.

6.15 Sterilization, Hysterectomy, and Abortion Consent Forms

When providing services to a Medicaid Member, certain procedures or conditions require a consent form to be completed and attached to the claim. This section describes the following forms and explains how to prepare them:

- Sterilization Consent Form
- Hysterectomy Consent Form
- Abortion Certification Form

6.15.1 Sterilization Consent Form and Guidelines

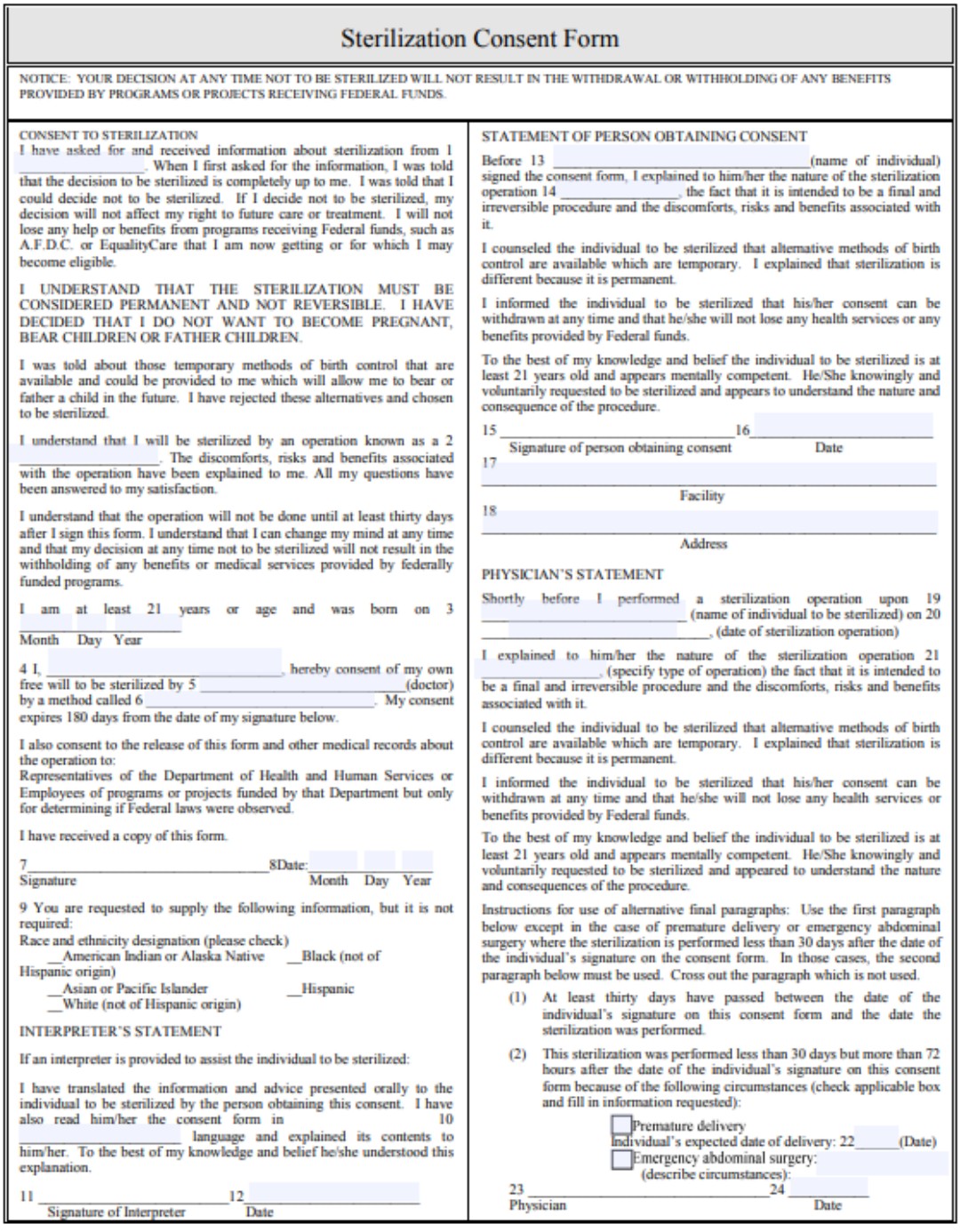
Federal regulations require that Members give written consent prior to sterilization; otherwise, Medicaid cannot reimburse for the procedure.

The Sterilization Consent Form may be obtained from the fiscal agent or copied from this manual. As mandated by Federal regulations, the consent form must be attached to all claims for sterilization-related procedures.

All sterilization claims must be processed according to the following Federal guidelines:

FEDERAL GUIDELINES
The waiting period between consent and sterilization must not exceed 180 days and must be at least 30 days, except in cases of premature delivery and emergency abdominal surgery. The day the Member signs the consent form and the surgical dates are not included in the 30-day requirement. For example, a Member signs the consent form on July 1. To determine when the waiting period is completed, count 30-days beginning on July 2. The last day of the waiting period would be July 31; therefore, surgery may be performed on August 1.
In the event of premature delivery, the consent form must be completed and signed by the Member at least 72-hours prior to the sterilization, and at least 30-days prior to the expected date of delivery.
In the event of emergency abdominal surgery, the Member must complete and sign the consent form at least 72-hours prior to sterilization.
The consent form supplied by the surgeon must be attached to every claim for sterilization related procedures; such as, ambulatory surgical center clinic, physician, anesthesiologist, inpatient or outpatient hospital. Any claim for a sterilization related procedure which does not have a signed and dated, valid consent form will be denied. All blanks on the consent form must be completed with the requested information. The consent form must be signed and dated by the Member, the interpreter (if one is necessary), the person who obtained the consent, and the physician who will perform the sterilization. The physician statement on the consent form must be signed and dated by the physician who will perform the sterilization, on the date of the sterilization or after the sterilization procedure was performed. The date on the sterilization claim form must be identical to the date and type of operation given in the physician's statement.

6.15.1.1 Sterilization Consent Form



Sterilization Consent Form

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from 1 _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or EqualityCare that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a 2 _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on 3 _____
Month Day Year

4 I, _____, hereby consent of my own free will to be sterilized by 5 _____(doctor) by a method called 6 _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

7_____8Date: _____
Signature Month Day Year

9 You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)
__American Indian or Alaska Native __Black (not of Hispanic origin)
__Asian or Pacific Islander __Hispanic
__White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in 10 _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

11 _____12_____
Signature of Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

Before 13 _____(name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation 14 _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

15 _____16_____
Signature of person obtaining consent Date

17 _____
Facility

18 _____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon 19 _____ (name of individual to be sterilized) on 20 _____, (date of sterilization operation)

I explained to him/her the nature of the sterilization operation 21 _____, (specify type of operation) the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's expected date of delivery: 22_____(Date)
☐ Emergency abdominal surgery:
(describe circumstances):

23 _____24 _____
Physician Date

This form is located on the Medicaid website.

6.15.1.2 Instructions for Completing the Sterilization Consent Form

Important tips for completing the Sterilization Consent Form:

- Print legibly to avoid denials, The entire form must be legible
- The originating practitioner has ownership of this form and must supply correct, accurate copies to all involved billing parties
- Fields 7, 8 and 15, and 16 must be completed prior to the procedure
- All fields may be corrected; however, **corrections must be made with one (1) line through the error and must be initialed**
    - The person that signed the line is the only person that can make the alteration
    - Whiteout/Correction Tape will not be accepted when making corrections
- Every effort should be taken to complete the form correctly without any changes

Section	Field #	Action
Consent to Sterilization	1	Enter the name of the physician or the name of the clinic from which the Member received sterilization information.
	2	Enter the type of operation (no abbreviations).
	3	Enter the Member's date of birth (MM/DD/YY). Member must be at least 21 years.
	4	Enter the Member's name.
	5	Enter the name of the physician performing the surgery.
	6	Enter the name of the type of operation (no abbreviations).
	7	The Member to be sterilized signs here.
	8	The Member dates signature here.
	9	Check one (1) box appropriate for Member. This item is requested but ***not required***.
Interpreter's Statement	10	Enter the name of the language the information was translated to.
	11	Interpreter signs here.
	12	Interpreter dates signature here.
Statement of person obtaining consent	13	Enter Members name.

Section	Field #	Action
Statement of person obtaining consent **Physician's Statement**	14	Enter the name of the operation (no abbreviations).
	15	The person obtaining consent from the Member signs here.
	16	The person obtaining consent from the Member dates signature here.
	17	The person obtaining consent from the Member enters the name of the facility where the person obtaining consent is employed. The facility name must be completely spelled out (no abbreviations).
	18	The person obtaining consent from the Member enters the complete address of the facility in #17 above. Address must be complete, including state and zip code.
	19	Enter the Member's name.
Physician's Statement	20	Enter the date of sterilization operation.
	21	Enter type of operation (no abbreviations).
	22	Check applicable box: • If premature delivery is checked, the Provider must write in the expected date of delivery here. • If emergency abdominal surgery is checked, describe circumstances here.
	23	• Physician performing the sterilization signs here.
	24	Physician performing the sterilization dates signature here.

6.15.2 Hysterectomy Acknowledgment of Consent

The Hysterectomy Acknowledgment of Consent Form must accompany all claims for hysterectomy-related services; otherwise, Medicaid will not cover the services. The originating physician is required to supply other billing Providers (for example, hospital, surgeon, anesthesiologist, and so on) with a copy of the completed consent form.

Information on attaching documents to electronic claims, refer to *Section 6.14* Submitting Attachments for Electronic Claims.

6.15.2.1 Hysterectomy Acknowledgement Consent Form

Wyoming Department of Health

Hysterectomy Acknowledgment of Consent Form

Member Name _____ **Member ID** _____

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

PART A

Complete **PART A** if consent is obtained **PRIOR** to surgery.

It is anticipated that _____ (Physician) will perform a hysterectomy on me. I understand that there are medical indications for this surgery. It has been explained to me and I understand that this hysterectomy will render me permanently incapable of bearing children.

Diagnosis _____

Member Signature _____ **Date** _____

Signature of Person Explaining Hysterectomy _____ **Date** _____

PART B

Complete **PART B** if consent is obtained **AFTER** surgery.

On _____ (mm/dd/yyyy), _____ (Physician) performed a hysterectomy on me. I understand that there were medical indications for this surgery. Prior to the procedure the doctor again explained to me that this surgery would render me permanently incapable of bearing children.

Diagnosis _____

Member Signature _____ **Date** _____

Signature of Person Explaining Hysterectomy _____ **Date** _____

PART C

Complete **PART C** if NO consent is obtained.

Diagnosis _____

Check which is applicable:

☐ Other reason for sterility _____

☐ Previous tubal **Date** (*mm/dd/yyyy*) _____

☐ Emergency situation (*describe*)

WYBMS-Hysterectomy Consent

Physician Signature _____ **Date** _____

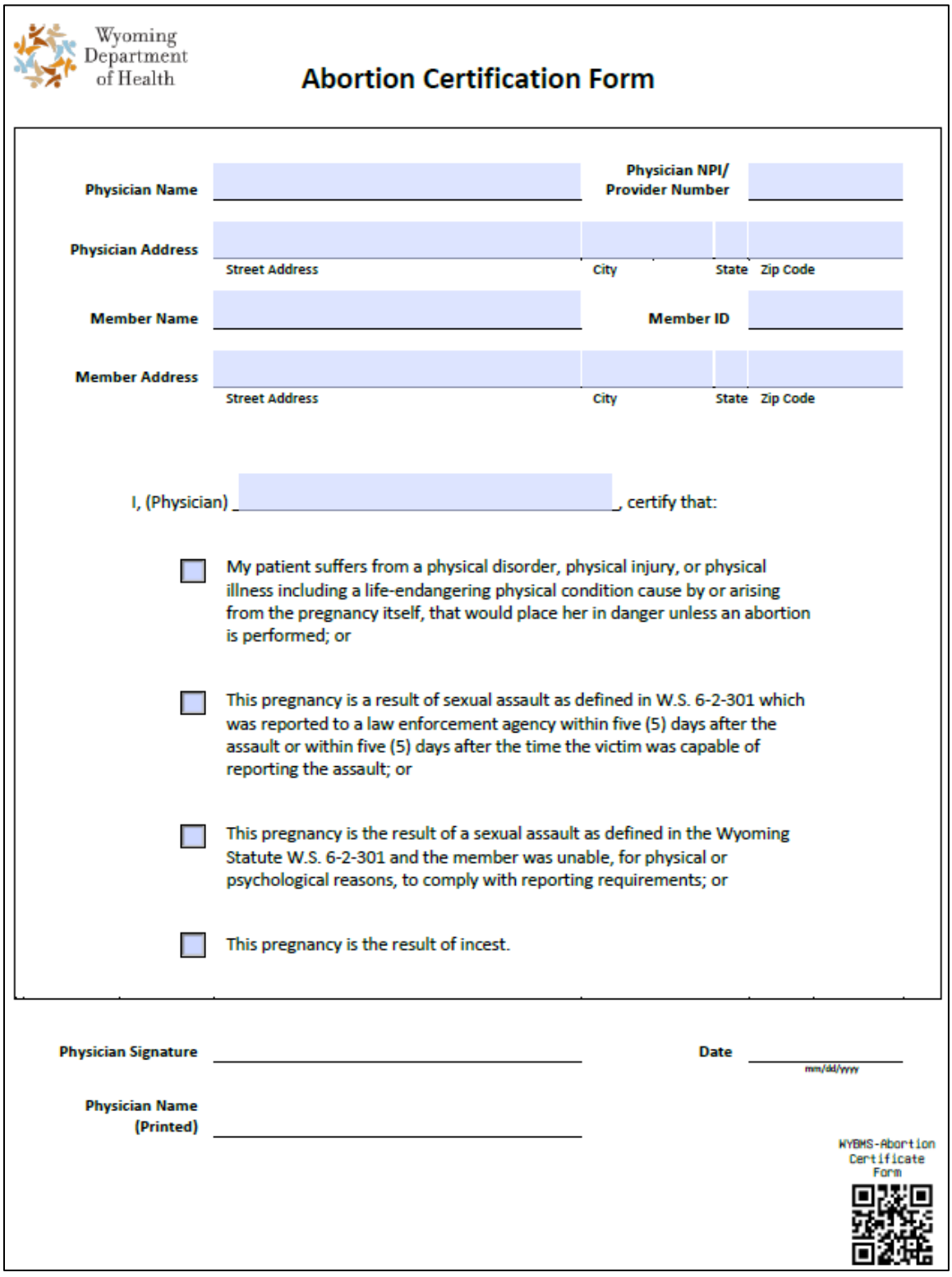
This form is located on the Medicaid website.

Section	Action
Header Information	Enter Member's name.
	Enter Members Medicaid ID.
	Enter pay-to Provider name.
	Ener pay-to Provider NPI or Provider number.
Part A	Enter the name of the physician performing the surgery.
	Enter the narrative diagnosis for the Member’s condition.
	The Member receiving the surgery signs here and dates.
	The person explaining the surgery signs here and dates.
Part B	Enter the date and the physician’s name that performed the hysterectomy.
	Enter the narrative diagnosis for the Member’s condition.
	The Member receiving the surgery signs here and dates.
	The person explaining the surgery signs here and dates.
Part C	Enter the narrative diagnosis for the Member’s condition.
	Check applicable box: • If “other reason for sterility” is selected, the Provider must write what was done. • If “previous tubal” is selected, the Provider must enter the date of the tubal. • If “emergency situation” is selected, the Provider must enter the description.
	• The physician who performed the hysterectomy signs here and dates.

6.15.3 Abortion Certification Guidelines

The Abortion Certification Form must accompany claims for abortion-related services; otherwise, Medicaid will not cover the services. This requirement includes, but is not limited to, claims from the attending physician, assistant surgeon, anesthesiologist, pathologist, and hospital.

6.15.3.1 Abortion Certification Form



Wyoming Department of Health

Abortion Certification Form

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

Physician Address _____
Street Address City State Zip Code

Member Name _____ **Member ID** _____

Member Address _____
Street Address City State Zip Code

I, (Physician) _____, certify that:

☐ My patient suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition cause by or arising from the pregnancy itself, that would place her in danger unless an abortion is performed; or

☐ This pregnancy is a result of sexual assault as defined in W.S. 6-2-301 which was reported to a law enforcement agency within five (5) days after the assault or within five (5) days after the time the victim was capable of reporting the assault; or

☐ This pregnancy is the result of a sexual assault as defined in the Wyoming Statute W.S. 6-2-301 and the member was unable, for physical or psychological reasons, to comply with reporting requirements; or

☐ This pregnancy is the result of incest.

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

Physician Name (Printed) _____

WYBMS-Abortion Certificate Form

This form is located on the Medicaid website.

6.15.3.2 Instructions for Completing the Abortion Certification Form

Action
Enter the name of the attending physician or surgeon.
Enter the pay-to Provider physicians NPI or Provider number.
Enter the pay-to Provider physician's address.
Enter the name of the Member receiving the surgery.
Enter the Members Medicaid ID number.
Enter the Member's address.
Enter the name of the attending physician or surgeon.
Check the option (1, 2, 3, or 4) that is appropriate.
The physician or surgeon performing the abortion will sign and date here.
The physician or surgeon performing the abortion will print their name here.

6.16 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 HIPPA 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.

6.16.1 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 and 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 Member's 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.

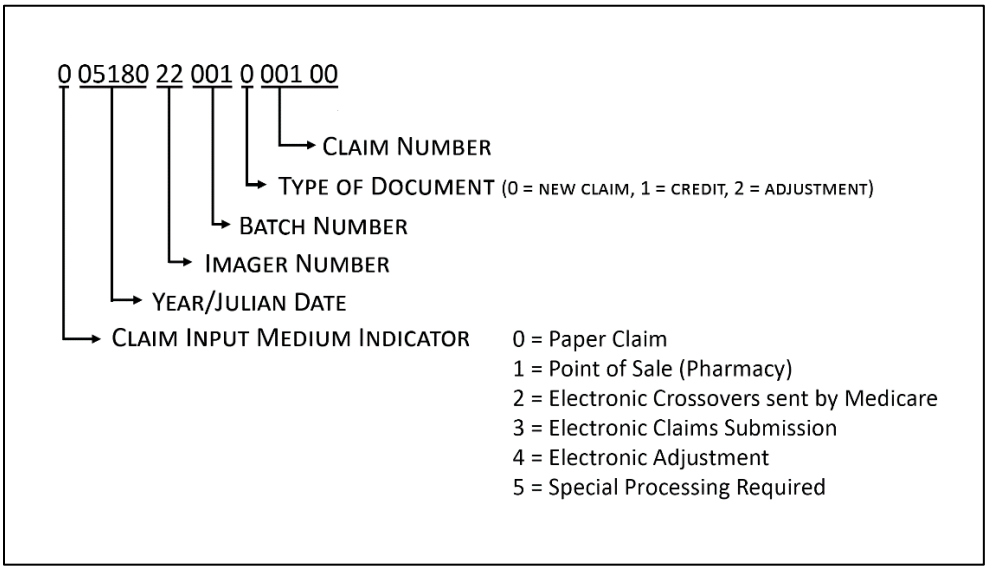
6.16.2 Remittance Advice General Information and Definitions

- 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.
- 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.

6.16.3 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 Attachments 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 Attachments
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.

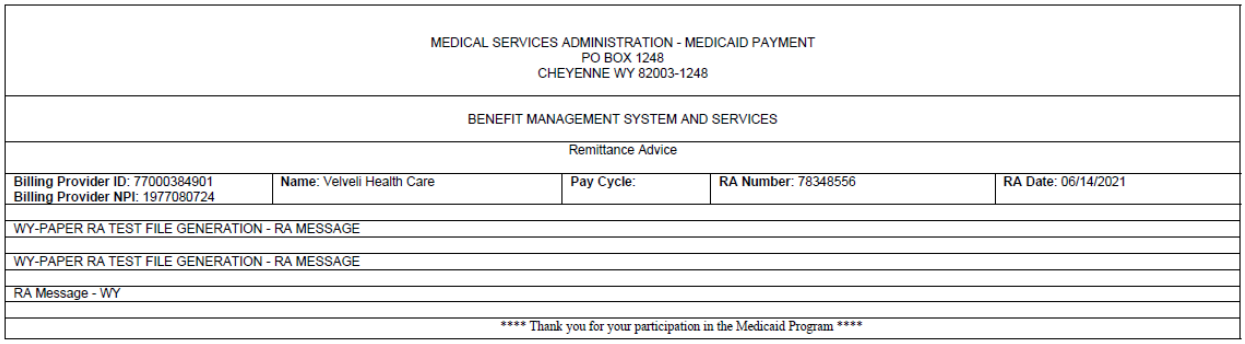
6.16.4 Locating the Medicaid Paper Remittance Advice within the Provider Portal

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

7. Log in to the secure Provider Portal.
8. Select the **Provider Access** profile.
9. Select the **Archived Documents** from the My Inbox drop-down list.
10. Select **Paper RA** from the **Document Type** drop-down list.
11. Select **Paper RA** from **Document Name** drop-down list.
12. Select **Go**. Paper RAs display.
13. Select the blue link to open the RA.

6.16.5 Sample Remittance Advices and How to Read the Remittance Advice

6.16.5.1 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

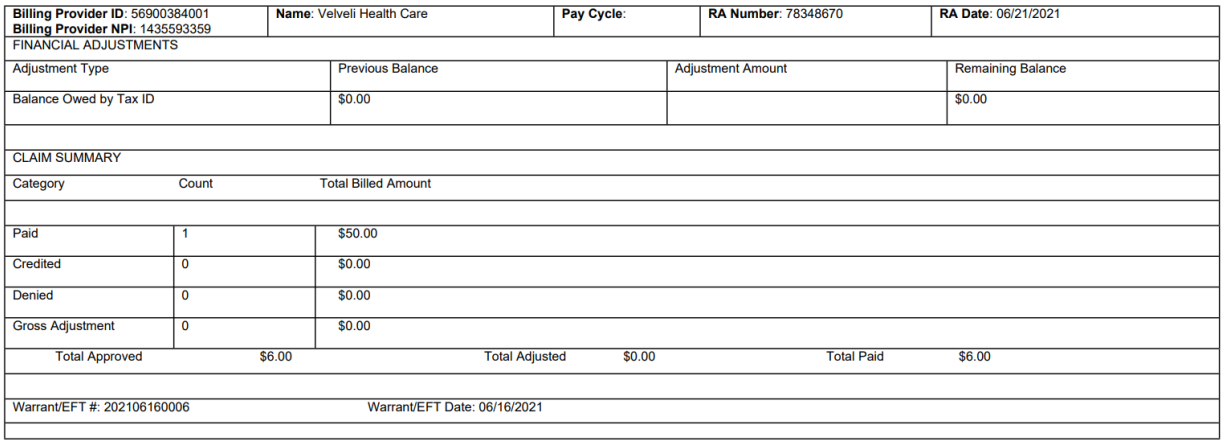
RA Message - WY

**** 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.

6.16.5.2 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.

Summary Page Field Name	Notes
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) 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. • 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.

6.16.5.3 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.

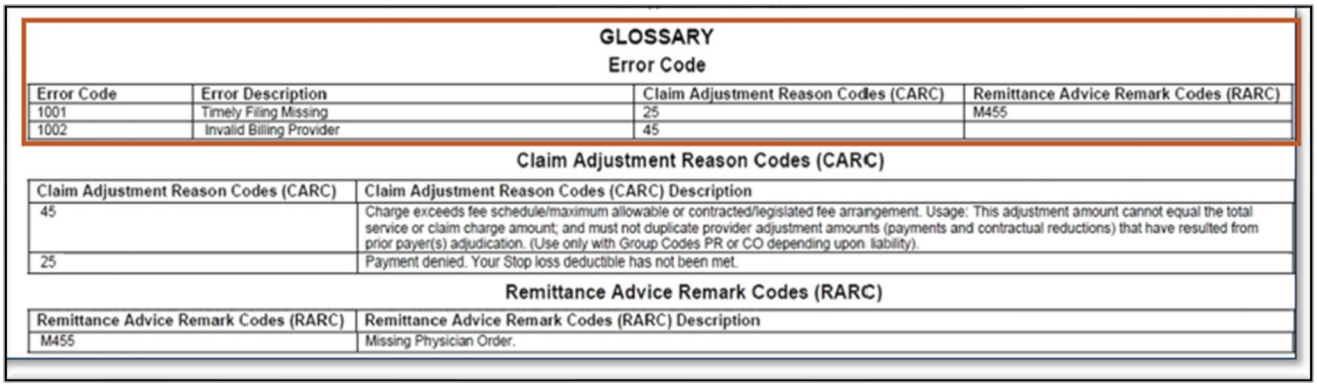
6.16.5.4 Sample Remittance Advice (Detail Page) with a Denied Claim

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.

6.16.5.5 Sample 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.

6.16.5.6 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

6.16.5.7 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: 49934000301 **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.

6.16.5.8 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

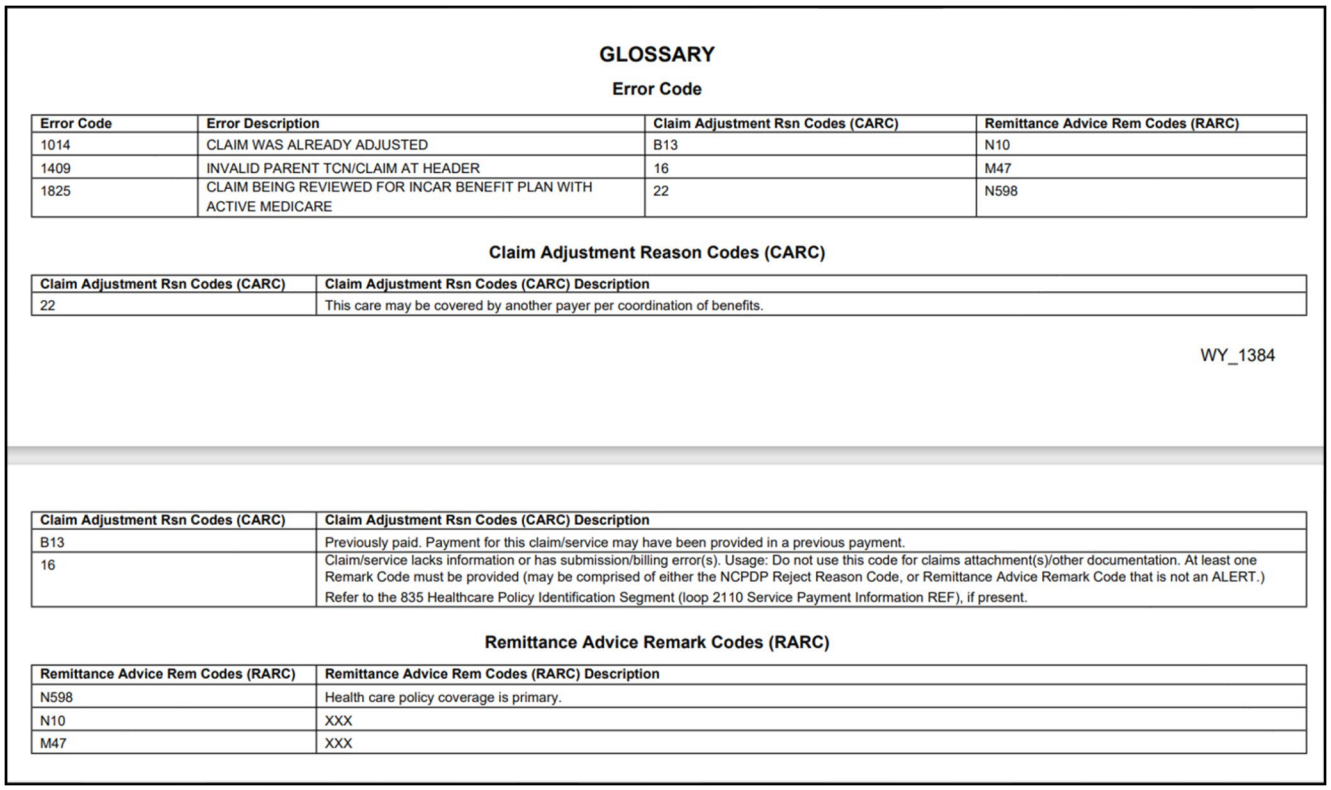
AP/AR Netting $20.00

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 and Provider Portal 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).

6.16.6 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.

6.17 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 lines:** • For Professional, Waiver, and Dental claims the Provider may choose to adjust this paid claim or resubmit only the denied line(s) as a new claim. For UB (Inpatient/Outpatient) claims the Provider **mus**t adjust the partially paid claim.	Must be completed within six (6) months (180 days) after the claim has paid UNLESS the result will be a lower payment being made to the Provider, then no time limit.
RESUBMIT	**Claim has denied entirely,** The Provider may resubmit on a new claim.	One (1) year (365 days) from the date of service.

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

The deadlines for resubmitting and adjusting claims are different:

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

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

6.17.2 Resubmitting a Claim

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

How to Resubmit:

- Review and verify the 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

6.17.2.1 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 transactions, make the appropriate corrections, and resubmit the claim.
- Paid Claim with One (1) or More Line(s) Denied**:**
    - For Professional, Waiver, and Dental claims, the **Providers may resubmit the individually denied lines as a new claim or adjust the partially paid claim.**
    - **For UB (Inpatient/Outpatient) claims, the Provider must adjust the partially paid claim.**
- Claim Returned Unprocessed**:** When Medicaid is unable to process a claim, it will be rejected or returned to the Provider for corrections and to resubmit

6.17.3 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 6.17.3.5* How to Complete the Adjustment/Void Request Form) or submit an electronic claim adjustment or void (see *Section 6.17.3.6* Adjusting or Voiding a Claim Electronically via an 837 Transaction). 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.

6.17.3.1 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.

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

6.17.3.2 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).

6.17.3.3 How to Request an Adjustment or Void

To adjustment 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 6.17.3.4* Adjustment/Void Request Form). The requirements for adjusting/voiding a claim are as follows:

- An adjustment/void can only be processed if the claim has been paid by Medicaid
- Medicaid must receive individual claim adjustment requests within 6 months (180 days) of the claim payment date
- A separate Adjustment/Void Request Form must be used for each claim
- If the Provider is correcting more than one (1) error per claim, use only one (1) Adjustment/Void Request Form and include all corrections on the one (1) form

- Correct all items that should be corrected and attach this corrected claim to the Adjustment/Void form
- Indicate "Corrected Claim" as the reason for adjustment

6.17.3.4 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

WYEMS-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 Medicaid website.

6.17.3.5 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 an EOB, EOMB, consent forms, invoice. Both Section B and C must be completed.
	1b	Void Claim	Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the RA. Sections B and C must be completed.
	2	Cancellation of the Entire Remittance Advice	Mark this box **only** when every claim on the RA is incorrect. Attach the RA. Complete only Section C
B	1	17-digit TCN	Enter the 17-digit transaction control number (TCN) assigned to each claim from the RA
	2	Payment Date	Enter the Payment Date
	4	Provider Name	Enter the Provider name.
	3	NPI/Provider Number	Enter Provider's ten (10)-digit NPI number or nine (9)-digit Medicaid Provider ID
	5	Member ID	Enter the Member's ten (10)-digit Medicaid ID number
	6	Member Name	Enter the Member's first and last name.
	7	Prior Authorization Number	Enter the ten (10)-digit PA number, if applicable.
	8	Reasons for Adjustment or Void	Either choose the appropriate option and indicate the correction in the table as well as within the attached claim form, or for more than one change, enter "See Corrected Claim"
C		Provider Signature and Date	Signature of the Provider or the Providers' authorized representative and the date.

6.17.3.6 Adjusting or Voiding a Claim Electronically via an 837 Transaction

Wyoming Medicaid Wyoming Medicaid prefers claim adjustments and voids on paid claims to be submitted electronically, see Chapter 8 – Electronic Data Interchange and Provider Portal in this manual 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.

6.18 Credit Balances

A credit balance occurs when a Providers' 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.

6.19 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.

6.19.1 Exceptions to the Twelve Month (365 days) Limit

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

Exceptions Beyond the Control of the Provider	
When the Situation is:	**The Time Limit is:**
Medicare Crossover	A claim must be submitted within 12 months (365 days) of the date of service **or** within 6 months (180 days) from the payment date on the Explanation of Medicare Benefits (EOMB), **whichever is later.**
Member is determined to be eligible on appeal, reconsideration, or court decision (retroactive eligibility)	Claims must be submitted within 6 months (180 days) of the date of the determination of retroactive eligibility. The Member must provide a copy of the dated letter to the Provider to document retroactive eligibility. If a claim exceeds timely filing, and the Provider elects to accept the Member as a Medicaid Member and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be an SSI award notice or a notice from WDH.
Member is determined to be eligible due to agency corrective actions (retroactive eligibility)	Claims must be submitted within 6 months (180 days) of the date of the determination of retroactive eligibility. The Member must provide a copy of the dated letter to the Provider to document retroactive eligibility. If a claim exceeds timely filing, and the Provider elects to accept the Member as a Medicaid Member and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing.
Provider finds their records to be inconsistent with filed claims, regarding rendered services. This includes dates of service, procedure/revenue codes, tooth codes, modifiers, admission or discharge dates/times, treating or referring Providers or any other item which makes the records/claims non-supportive of each other.	Although there is no specific time limit for correcting errors, the corrected claim must be submitted in a timely manner from when the error was discovered. If the claim exceeds timely filing, the claim must be sent with a cover letter requesting an exception to timely filing citing this policy.

6.19.2 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 that prevented the Provider from finalizing the claim within 12 months (365 days) of the date of service

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

> Appeals for claims that denied appropriately will be automatically denied. The appeals process is not an apt means to resubmit denied claims nor to submit supporting documentation. Doing so will result in denials and time lost to correct claims appropriately.

6.20 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 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).

6.21 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
- 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.

6.22 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.

6.23 Telehealth

Telehealth is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the Member is performed via a real time interactive audio and video telecommunications system. This means that the Member must be able to see and interact with the off-site practitioner at the time services are provided via telehealth technology. Telehealth services must be properly documented when offered at the discretion of the Provider as deemed medically necessary.

It is the intent that telehealth services will provide better access to care by delivering services as they are needed when the Member is residing in an area that does not have specialty services available. It is expected that this modality will be used when travel is prohibitive or resources will not allow the clinician to travel to the Member's location.

Each site will be able to bill for their own services as long as they are an enrolled Medicaid Provider (this includes out-of-state Medicaid Providers). Providers shall not bill for both the spoke and hub site unless, the Provider is at one location and the Member is at a different location even though the pay to Provider is the same. Examples include Community Mental Health Centers and Substance Abuse Treatment Centers. A single pay to Provider can bill both the originating site (spoke site) and the distant site Provider (hub site) when applicable. See below for billing and documentation requirements.

6.23.1 Covered Services

Originating Sites (Spoke Site)

The Originating Site or Spoke site is **the location of an eligible Medicaid Member** at the time the service is being furnished via telecommunications system occurs.

Authorized originating sites are:

- Hospitals
- Office of a physician or other practitioner (this includes medical clinics)
- Office of a psychologist or neuropsychologist
- Community mental health or substance abuse treatment center (CMHC/SATC)
- Office of an advanced practice nurse (APN) with specialty of psych/mental health
- Office of a Licensed Mental Health Professional (LCSW, LPC, LMFT, LAT)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Skilled nursing facility (SNF)
- Indian Health Services Clinic (IHS)
- Hospital-based or Critical Access Hospital-based renal dialysis centers (including satellites). Independent Renal Dialysis Facilities are not eligible originating sites.
- Developmental Center
- Family Planning Clinics
- Public Health Offices

Distant Site Providers (Hub Site)

The location of the physician or practitioner providing the professional services via a telecommunications system is called the Distant Site or Hub Site. A medical professional is not required to be present with the Member at the originating site unless medically indicated. However, to be reimbursed, services provided must be appropriate and medically necessary.

Examples of physicians/practitioners eligible to bill for professional services are:

- Physician
- Advanced Practice Nurse with specialty of Psychiatry/Mental Health
- Physician's Assistant
- Psychologist or Neuropsychologist
- Licensed Mental Health Professional (LCSW, LPC, LMFT, LAT)
- Board Certified Behavior Analyst
- Speech Therapist

Provisionally licensed mental health professionals cannot bill Medicaid directly. Services must be provided through an appropriate supervising Provider. Services provided by non-physician practitioners must be within their scope(s) of practice and according to Medicaid policy.

For Medicaid payment to occur, interactive audio and video telecommunications must be permitting real-time communication between the distant site physician or practitioner and the patient with sufficient quality to assure the accuracy of the assessment, diagnosis, and visible evaluation of symptoms and potential medication side effects. All interactive video telecommunication must comply with HIPAA patient privacy regulations at the site where the patient is located, the site where the consultant is located, and in the transmission process. If distortions in the transmission make adequate diagnosis and assessment improbable and a presenter at the site where the patient is located is unavailable to assist, the visit must be halted and rescheduled. It is not appropriate to bill for portions of the evaluation unless the exam was actually performed by the billing Provider. The billing Provider must comply with all licensing and regulatory laws applicable to the Providers' practice or business in Wyoming and must not currently be excluded from participating in Medicaid by state or federal sanctions.

6.23.2 Non-Covered Services

Telehealth does not include a telephone conversation, electronic mail message (email), or facsimile transmission (fax) between a healthcare practitioner and a Member, or a consultation between two health care practitioners asynchronous "store and forward" technology.

Medicaid will not reimburse for the use or upgrade of technology, for transmission charges, for charges of an attendant who instructs a patient on the use of the equipment or supervises and monitors a patient during the telehealth encounter, or for consultations between professionals.

The originating site fee is not billable if the Member uses their own equipment, such as a personal phone, tablet, or computer.

6.23.3 Documentation Requirements

- Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented, and monitored
- Providers need to develop and document evaluation processes and patient outcomes related to the telehealth program, visits, Provider access, and patient satisfaction
- All service Providers are required to develop and maintain written documentation in the form of progress notes the same as if they originated during an in-person visit or consultation with the exception that the mode of communication (such as, teleconference) should be noted
- Documentation must be maintained at the Hub and Spoke locations to substantiate the services provided. Documentation must indicate that the services were rendered via telehealth and must clearly identify the location of the Hub and Spoke Sites

6.23.4 Billing Requirements

To obtain Medicaid reimbursement for services delivered through telehealth technology, the following standards must be observed:

- Telehealth Consent must be obtained if the originating site is the Member's home
- The services must be medically necessary and follow generally accepted standards of care
- The service must be a service covered by Medicaid
- Claims must be made according to Medicaid billing instructions
- The same procedure codes and rates apply as for services delivered in person
    - The modifiers to indicate a telehealth service is "GT" or "95", which must be used in conjunction with the appropriate procedure code to identify the professional telehealth services provided by the Distant Site Provider (for example, procedure code 90832 billed with modifier GT). The **GT** or **95 modifier MUST be billed by the Distant Site.** Using the GT or 95 modifier does not change the reimbursement fee.
- When billing for the Originating Site facility fee, use procedure code Q3014. A separate or distinct progress note is not required to bill Q3014. Validation of service delivery would be confirmed by the accompanying practitioner's claim with the GT or 95 modifier indicating the practitioner's service was delivered via telehealth. Medicaid will reimburse the originating site Provider the lesser of charge or the current Medicaid fee.

> Providers cannot bill for Q3014 if Members used their own equipment, such as personal phones or computers.

- Additional services provided at the originating site on the same date as the telehealth service may be billed and reimbursed separately according to published policies and the National Correct Coding Initiative (NCCI) guidelines

- For ESRD-related services, at least one (1) face-to-face, "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a qualified Provider
- Care Management Entity service Providers (CME Providers) are to use Place of Service code 02-Telehealth per their Provider agreement with Magellan Healthcare. CME Providers are NOT to use the "GT" modifier or "Q3014-Telehealth Originating Site Facility Fee" codes for virtual services.

> If the patient or legal guardian indicate at any point that they want to stop using the technology, the service should cease immediately, and an alternative appointment set up.

6.23.4.1 Billing Examples

Example 1a: Originating (Spoke) Site Provider – **location of the Wyoming Medicaid Member**:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/19	Q3014	20.00	1

Example 1b: Distant (Hub) Site Provider – location of the Wyoming Medicaid enrolled Provider:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/19	99214 GT	120.00	1

Example 2: Hub Site and Spoke Site services are provided at different locations but by the same pay-to Provider:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/19	Q3014	20.00	1
01/01/19	99214 GT	120.00	1

6.23.5 Telehealth Consent

The telehealth consent form is no longer required by Wyoming Medicaid. Consent must still be obtained by the Provider from the Member by one of the following methods:

- Verbally
- Email

- Text Message

This information must be properly documented by the Provider and kept on file.

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

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 must 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 in the month received. 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 services 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 party. 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 proper 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 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 Members.

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

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

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

7.2.4 Third Party Disallowance

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

liable third party and receive reimbursement. At the close of the 60-day period, Wyoming Medicaid will automatically recoup the original payment it made on the claims.

Providers are instructed not to attempt to adjust their claims during the 60-day period as the claims will be locked. At the conclusion of the 60-day period, claims will be automatically adjusted by the BMS. Additionally, Providers are instructed not to submit a manual refund payment (cash, check, money order, and so on) so as to avoid duplication of the automated adjustment process.
Providers are encouraged to work directly with Wyoming Medicaid's vendor, Health Management Systems (HMS), to access the online TPL Disallowance Portal (see Chapter 8 – Electronic Data Interchange and Provider Portal) and to obtain assistance throughout the disallowance process (*see Section 2.1* Quick Reference).

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

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

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

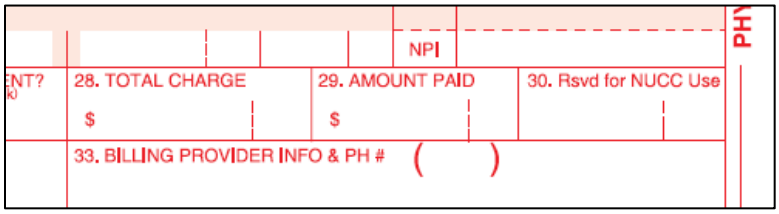
If prior authorization is not obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.

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

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

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

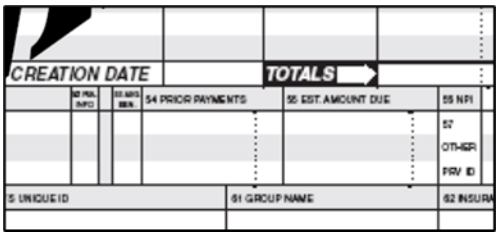
- **Field 29: Amount Paid**
  - **Enter total amount the other payers (Medicare or other insurance) paid on the covered services only.**



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

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

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



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

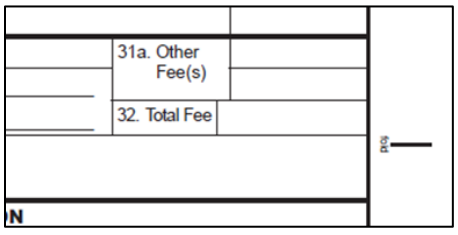
Inpatient claims will apply Other Insurance (TPL) and Medicare at the header level of the claim.

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

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

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

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



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

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

- If the TPL payer paid less than 67% of the calculated Medicaid allowed amount, include the appropriate claim reason codes on the claims. Attaching the explanation of benefits (EOB) to the electronic claim is encouraged (see *Section 6.14* 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 6.19* 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 6.14* 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 (*see Section 0*

- 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 the 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 or 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.

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 and 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 Web Portal Tutorials on billing secondary claims.

For Members with three insurances, tertiary claims can be submitted through the Provider Portal and Providers are required to attach both EOBs 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**. The non-covered status must be reviewed and a new letter obtained at the end of **one calendar year or benefit plan year**.

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

Example:

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

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

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 and Provider Portal

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 Wyoming Medicaid Companion Guide is intended for trading partner use in conjunction with the ASC X12N Standards for Electronic Data Interchange Technical Report Type 3 (TR3).

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 located on the Medicaid website (SFTP).

EDI Options				
Method	**Computer Requirements**	**Access Cost**	**Transactions Supported**	**Contact Information**
Provider 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	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**
			X12N TA1 Interchange Acknowledgement **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 WY BMS 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 Provider 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 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 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 Provider Training, Tutorials and Workshops section of the Medicaid website (*see Section 2.1* Quick Reference) for the Provider

Web Registration Tutorial and the Multiple Provider Web Registration which provide 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 an 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 RAs 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 or void • Resubmit denied and 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 Users

Through the Wyoming Medicaid website new billing agents and clearinghouses (BA/CH) must enroll as a BA/CH to access the Provider Portal. Within the Provider Portal, BA/CHs will be 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 or 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's 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 nine (9) digit BMS Provider ID number beginning with the number five (5). This Provider ID will also be the BA/CH's trading partner ID (TPID), this is only the case for a "new" BA/CH. Also, they will 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 Billing Agent and Clearinghouse Key Points and Terminology

- New BA/CHs enrolling September 18, 2021 and after are assigned a 9-digit Provider ID which is also their Trading Partner ID (TPID).
  - This Provider ID begins 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 are converted and assigned a 9-digit Provider ID beginning with the number five "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 Administrator's will initially create their personal user ID through Okta Single Sign-On (SSO) registration process.
- BA/CH Provider Domain Administrator's will then complete the new enrollment steps on the Medicaid Website, (www.wyomingmedicaid.com) and select BA/CH Enrollment within the Provider drop-down list.
- After enrolling and signing the Trading Partner Agreement (TPA), BA/CHs will be redirected to the Provider Portal where they will select the BMS Domain and create a profile.
- Testing is recommended for new BA/CH, refer to the Wyoming Medicaid EDI Companion Guide (located on the Medicaid website) for instructions.

> Visit the Medicaid website for the Billing Agent/Clearinghouse Enrollment 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:

BA/CH Profile Name	Access Rights
	• 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 Associate 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 7.2.4* 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 & Medicaid Services (https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html): The official HIPAA website of the Centers for Medicare & Medicaid Services.
- Washington Publishing Co. (http://www.wpc-edi.com/hipaa/HIPAA_40.asp): The official website 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. They 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. This is regardless of whether the incorrect payment was the result of Medicaid, fiscal agent, Provider error, or other cause.

9.2 Coding

Standard use of medical coding conventions is required when billing Medicaid. 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 CPT-4, HCPCS Level II, and ICD-9-CM or ICD-10 coding books
- For claims that have dates of service spanning across the ICD-10 implementation date (10/1/15):
    - Outpatient claims**:** use diagnosis codes based on the FIRST (1st) date of service
    - Inpatient claims**:** use diagnosis codes based on the LAST date of service
- Use the current version of the NUBC Official UB Data Specifications Manual
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend coding classes offered by certified coding specialists
- Use the correct unit of measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II coding books. One (1) unit may equal “one (1) visit” or “15 minutes.” Always check the long version of the code description.
- Effective April 1, 2011, the National Correct Coding Initiative (NCCI) methodologies were incorporated into Medicaid’s claim processing system to comply with Federal legislation. The methodologies apply to both CPT Level I and HCPCS Level II codes.

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

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

- Coding denials cannot be billed to the Member but can be reconsidered per Wyoming Medicaid Rules, Chapter 16. For the complete appeal process, *see Section 2.3.2* How to Appeal.

9.3 Importance of Fee Schedules and Provider's Responsibility

Procedure codes and revenue codes listed in the following chapters 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 Provider's responsibility to verify this information. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service.

9.4 Interpretation Services

The Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (DHHS) enforces Federal laws that prohibit discrimination by healthcare and human service Providers that receive funds from the DHHS. Such laws include Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act of 1990.

In efforts to maintain compliance with this law and ensure that Medicaid Members receive quality medical services, interpretation service should be provided for Members who have Limited English Proficiency (LEP) or are deaf/hard of hearing. The purpose of providing services must be to assist the Member in communicating effectively about health and medical issues.

- Interpretation between English and a foreign language is a covered service for Medicaid Members who have LEP. LEP is defined as "the inability to speak, read, write, or understand the English language at a level that permits an individual to interact effectively with healthcare Providers."
- Interpretation between sign language or lip reading and spoken language is a covered service for Medicaid Members who are deaf or hard of hearing. Hard of hearing is defined as "limited hearing which prevents an individual from hearing well enough to interact effectively with healthcare Providers."

> Refer to Chapter 21 Covered Services – Interpreter Services of the CMS 1500 Provider Manual posted on the Medicaid website for more details (*see Section 2.1* Quick Reference).

Chapter 10 – Outpatient Services

10.1 General Coverage Principle and Definitions

Medicaid covers almost all outpatient services when they are medically necessary. This chapter provides covered services information that applies specifically to outpatient services provided within an Ambulatory Surgical Center, Critical Access Hospital, and General Hospital.

10.1.1 Ambulatory Surgical Center

Appropriate Bill Type: **83X**

Pay-to Provider Taxonomy: **261QA1903X**

Ambulatory Surgical Center (ASC) services are services provided in a licensed, freestanding ambulatory surgical center. Surgical center services do not include practitioner or anesthesiologist services. ASC services must be provided by or under the direction of a licensed practitioner.

When ASC providers submit services on the UB-04 form (837I), the claim will be processed using the OPPS methodology, and when services are submitted on the CMS-1500 form (837P), the claim will be reimbursed via RBRVS or the Medicaid Fee Schedule.

10.1.1.1 Covered Services

Facility services include items and services furnished by an ASC in connection with a procedure normally covered on an outpatient basis in a hospital. Covered surgical procedures can only be rendered by a licensed ASC (*see Section 10.12* Sterilization and Hysterectomies and *Section 10.13* Surgical Services). No inpatient services are allowed to be performed at an ASC. ASC facility services may include, but are not limited to the following:

- Nursing, technical, and other related services involved in Member care
- Use of surgical facility, including operating and recovery room, Member preparation area, waiting room, and other facility areas used by the Member
- Drugs, medical equipment, oxygen, surgical dressings, and other supplies directly related to the surgical procedure
- Splints, casts, and equipment directly related to the surgical procedures
- Administrative, record keeping, and housekeeping items and services
- Anesthesia materials
- Diagnostic procedures directly related to the surgical procedure, including those procedures performed before the surgery
- Blood and blood products

- Dental services performed at an ASC must be billed using procedure code 41899 (unlisted procedure, dentoalveolar structures; such as, removal of teeth).

> ASCs must bill the same procedure codes as the practitioner. Providers should code all services using standard coding guidelines and the rules established by the American Medical Association.

10.1.2 Critical Access Hospital (CAH)

Appropriate Bill Types: **11X-14X & 85X**

Pay-to Provider Taxonomy: **282NR1301X**

A hospital that meets ALL of the following CMS criteria:

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

10.1.3 General Acute Care Hospital

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

10.1.4 Outpatient Services

Outpatient services are preventative, diagnostic, therapeutic, rehabilitative, or palliative services or items that are medically necessary. These services are furnished by a general or critical access hospital

enrolled in the Medicaid program under the direction of a physician, dentist, or other appropriate practitioner. Services provided in the emergency room of the hospital are defined as outpatient services.

- Medically necessary outpatient hospital services are covered pursuant to written orders by a physician, staff under the supervision of a physician, a dentist, or other appropriate practitioner
- Services are considered outpatient services when the treatment is expected to keep the patient less than 24 hours. This is regardless of the hour of admission, whether or not a bed is used, and whether or not the patient remained in the hospital past midnight.
- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes. For inpatient information *see Chapter 11* – Critical Access Hospital and General Hospital Inpatient.
- When a patient receives outpatient services from a different facility each facility bills as appropriate. Services that were rendered as outpatient are billed as outpatient by that facility and the inpatient services are billed as inpatient by that facility.

10.1.4.1 Reimbursement

The three (3) categories of outpatient services listed above (Ambulatory Surgical Centers, Critical Access Hospitals and General Hospitals) are based off of OPPS – a Medicare based outpatient hospital reimbursement methodology which is used by Wyoming Medicaid to reimburse for outpatient services (*see Section 10.17* Reimbursement, Definitions, Billing Tips, and Guidelines).

10.2 Abortion

10.2.1 Covered Services

Legal (therapeutic) abortions and abortion services will only be reimbursed by Medicaid when a physician certifies in writing that any one (1) of the following conditions has been met:

- The Member suffers from a physical injury or physical illness, including endangering the physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion was performed
- The pregnancy is the result of sexual assault as defined in Wyoming Statute W.S. 6-2-301, which was reported to a law enforcement agency within five (5) days after the assault or within five days after the time the victim was capable of reporting the assault
- The pregnancy is the result of sexual assault as defined in Wyoming Statute W.S. 6-2-301, and the Member was unable for physical or psychological reasons to comply with the reporting requirements
- The pregnancy is the result of incest

10.2.2 Billing Requirements

An Abortion Certification Form (*see Section 6.15.3.1* Abortion Certification Form) must accompany all claims from the attending physician, assistant surgeon, anesthesiologist, and hospital. The attending physician is required to supply all other billing Providers with a copy of the consent form.

- In cases of sexual assault, submission of medical records is not required prior to payment. However, documentation of the circumstances of the case must be maintained in the Member's medical records.
- Other abortion related procedures, including spontaneous, missed, incomplete, septic, and hydatiform mole do not require the certification form. However, all abortion related procedure codes are subject to audit, and all pertinent records must substantiate the medical necessity and be available for review.

> Reimbursement is available for those induced abortions performed during periods of retroactive eligibility only if the Abortion Certification Form (*see Section 6.15.3.1* Abortion Certification Form) was completed prior to performing the procedure.

10.3 Ambulance Services

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

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

Ambulance Services must be billed using the CMS-1500 claim form and must follow the policy defined for those programs. Refer to Chapter 11 – Covered Services – Ambulance of the CMS-1500 Provider Manual posted to the Medicaid website (*see Section 2.1* Quick Reference).

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

10.4 Diabetic Training

Revenue Code: **0942**

Procedure Code Range: **G0108-G0109**

Physicians and nurse practitioners managing a Member's diabetic condition are responsible for ordering diabetic training sessions. Certified Diabetic Educators (CDE) or dietitians may furnish outpatient diabetes self-management training.

10.4.1 Covered Services

Individual and group diabetes self-management training are covered. Curriculum will be developed by individual Providers and may include, but is not limited to:

- Medication education
- Dietetic/nutrition counseling
- Weight management
- Glucometer education
- Exercise education
- Foot/skin care
- Individual plan of care services received by the Member

10.4.2 Documentation Requirements

- Documentation should reflect an overview of relative curriculum and any services received by the Member
- The Diabetic Education Certificate is not required to be submitted with each claim

10.5 Durable Medical Equipment

Durable Medical Equipment (DME) must be billed using the CMS-1500 form/837P and must follow the policy defined for that program. Refer to the Medicaid website for a copy of the Durable Medical Equipment General and Covered Services Manual (*see Section 2.1* Quick Reference).

10.6 Emergency Department Services

Revenue Code Range: **0450–0459**

Procedure Code Range: **99281–99285**

Emergency Services are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily function
- Serious dysfunction of any bodily organ or part

The facility must be available 24 hours a day.

Emergency department services provide evaluation, management, treatment and prevention of unexpected illness or injuries.

"Per visit" means: all occurrences of a service provided on the same date of service during a separate visit.

- If more than one visit to an emergency room takes place on the same date of service, the second or subsequent visits to the emergency room must be for medically necessary services. Any same-day subsequent visits to the ER must have medical documentation *of all visits* attached to the claim to receive reimbursement.
- All services provided to the Medicaid Member by the hospital on the same day must be billed on a single claim (*see Section 10.17* Reimbursement, Definitions, Billing Tips, and Guidelines)

> If a significant surgery is performed in the emergency room, enter a HCPCS surgery code. Otherwise, a CPT Evaluation or Management code can be reported.

10.6.1 Covered Services

The hospital will be reimbursed for the facility charge for the Emergency Department Visit and any separately coverable ancillary services provided to the Member while in the Emergency Department.

> Members who regularly present themselves to an outpatient department of a hospital for primary non-emergency services should be reported to the Program Integrity Manager at the Division of Health Care Financing (*see Section 2.1* Quick Reference).

10.6.2 Billing Requirements

- If a significant surgery is performed in the emergency room, enter a HCPCS surgery code on the claim. Otherwise, a CPT Evaluation or Management code can be reported.
- A co-payment of $3.65 is also required for non-emergency visits to the emergency room. This amount will be automatically deducted from the emergency room payment (*see Section 6.11* Co-Payment Schedule).
    - Determination of a claim's status of emergent/non-emergent is determined based on the Type of Admission/Visit Code (*see Section 6.11* Co-Payment Schedule).
- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes (*see Chapter 11* – Critical Access Hospital and General Hospital Inpatient).
- When a patient receives outpatient services from a different hospital each facility bills as appropriate. Services that were rendered as outpatient are billed as outpatient by that facility and the inpatient services are billed as inpatient by that facility.
- Physician services are billed and paid separately via CMS-1500/837P.

10.6.3 Limitations

- The 12 visits per calendar year threshold for Members age 21 and older will apply to non-emergency visits to the emergency room. *See Section 6.9.3* Office and Outpatient Hospital Visits Once Threshold is Met for more information.
    - Determination of a claim's status of emergent/non-emergent is determined based on the Type of Admission/Visit Code (*see Section 6.11* Co-Payment Schedule).
- Ancillary charges will be paid. Providers can resubmit claims, with medical necessity supplied, or Members can be billed for denied visits that are not medically necessary (*see Section 6.9* Service Thresholds).

10.7 Laboratory Services

Revenue Code Range: 030X–031X

Procedure Codes: 36415, G0027, G0306, G0307, G0477 & 80000–89999

Medicaid covers tests provided by hospital outpatient services when the following requirements are met:

- Services are ordered by physicians, dentists, or other Providers within the scope of their practice as defined by law
- Hospitals must have a current Clinical Laboratory Improvement Amendments (CLIA) number on file
- Wyoming Medicaid will only cover medically necessary tests. Tests derived through court order will not be reimbursed by Wyoming Medicaid.

> Non-covered services include routine handling charges, stat fees, post-mortem examination and specimen collection fees for throat cultures and pap smears.

Modifier L1 – unrelated lab update

CMS implemented new status indicator Q4 (conditionally packaged laboratory tests) for laboratory CPT codes. This status indicator works like the other Q indicators in that if it is the only service on a claim, the service will be reimbursed separately.

Q4 allows the I/OCE to process the claim and assign reimbursement for the services when Q4 services are the only services on the claim. **For a "lab only" claim, there is no longer a reason to apply the L1 modifier.**

Modifier L1 has not been deleted because there may still be circumstances when it is appropriate to append the modifier. CMS did not change any of the criteria for applying the modifier, so all rules are

still in place. **But if the claim is for laboratory services only, status indicator Q4 erases the necessity of appending the modifier.**

Critical Access Hospitals should use bill type 141 when billing for unrelated lab services.

10.7.1 CLIA Requirements

The type of CLIA certificate required to cover specific codes is listed in the table below. These codes are identified by Center for Medicare and Medicaid Services (CMS) as requiring CLIA certification; however, Medicaid may not cover all of the codes listed. Refer to the fee schedule located on Medicaid website for actual coverage and fees. Content is subject to change at any time, without notice (*see Section 2.1* Quick Reference).

> Codes within the below table are NOT Wyoming Medicaid specific. It is the Provider's responsibility to ensure the codes being billed are covered by Wyoming Medicaid.

CLIA CERTIFICATE TYPE	ALLOWED TO BILL						
REGRISTRATION, COMPLIANCE, OR ACCREDITATION (LABORATORY) (1)	G0103	G0123	G0124	G0141	G0143	G0144	G0145
	G0147	G0148	G0306	G0307	G0328	17311	17312
	17313	17314	17315	78110	78111	78120	78121
	78122	78130	78191	78270	78271	78272	
	0001U-0083U						
	80000-89999 (UNLESS OTHERWISE SPECIFIED ELSEWHERE IN THIS TABLE)						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE LABORATORY (CLIA TYPE 1) SECTION AND ALL CODES FOR PPMP (CLIA TYPE 4) SECTION AND WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
PROVIDER-PERFORMED MICROSCOPY PROCEDURES (PPMP) (4)	81000	81001	81015	81020	89055	89190	G0027
	Q0111	Q0112	Q0113	Q0114	Q0115		
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE PPMP (CLIA TYPE 4) SECTION AND ALL CODES FOR WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
WAIVER (2)	80305	81002	81025	82044 QW	82150 QW	82270	82272

CLIA CERTIFICATE TYPE	ALLOWED TO BILL						
	82274 QW	82962	83026	83036 QW	84830	85013	85025 QW
	85651	86618 QW	86780 QW	87502 QW	87631 QW	87633 QW	87634 QW
	87651 QW						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE WAIVER (CLIA TYPE 2) SECTION AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
NO CERTIFICATION	PROVIDERS WITHOUT A CLIA MAY BILL ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (SEE BELOW)						

QW modifier is used to bypass CLIA requirements. A QW next to a laboratory code signifies that a QW modifier should be used.

CODES EXCLUDED FROM CLIA REQUIREMENTS									
80500	80502	81050	82075	83013	83014	83987	86077	86078	86079
86910	86960	88125	88240	88241	88304	88305	88311	88312	88313
88314	88329	88720	88738	88741	89049	89220			

The Integrated Outpatient Code Editor has numerous edits that verify combinations of lab codes billed on the same claim to determine if they are on the NCCI Table 1 and Table 2 documents as invalid combinations of codes. Please review these documents on Medicare's website if the Provider has questions regarding denials for mutually exclusive lab codes.

For updated Medicare CLIA information please visit: http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Categorization_of_Tests.html

10.7.2 Genetic Testing

Revenue Code Range: 030X-031X

Procedure Codes: 81200-81599 & 96040

Prior Authorization (*see Section 6.13* Prior Authorization) is required for all genetic testing codes, except 81420 and 81507. Prior Authorization documentation must include the following:

10.7.2.1 Covered Services

Medicaid covers genetic testing under all of the following conditions:

- There is reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists
- Test results will influence decisions concerning disease treatment or prevention
- Genetic testing of children might confirm current symptomatology or predict adult-onset diseases and findings might result in medical benefit to the child or as the child reaches adulthood
- Referral is made by a genetic specialist (codes 81223 and 81224) or a specialist in the field of the condition to be tested
- All other methods of testing and diagnosis have met without success to determine the Member's condition such that medically appropriate treatment cannot be determined and rendered without the genetic testing.
- Counseling is provided by healthcare professional with education and training in genetic issues relevant to the genetic tests under consideration.
- Counselor is free of commercial bias and discloses all (potential and real) financial and intellectual conflicts of interest.
- Process involves individual or family and is comprised of ALL of the following:
    - Calculation and communication of genetic risks after obtaining 3-generation family history
    - Discussion of natural history of condition in question, including role of heredity
    - Discussion of possible impacts of testing (such as psychological, social, or limitations of nondiscrimination statutes)
    - Discussion of possible test outcomes (such as positive, negative, or variant of uncertain significance)
    - Explanation of potential benefits, risks, and limitations of testing
    - Explanation of purpose of evaluation (such as to confirm, diagnose, or exclude genetic condition)

- Identification of medical management issues, including available prevention, surveillance, and treatment options and their implications
- Obtaining informed consent for genetic test

- **Code 81519**: All of the following conditions must be met and documented in the prior authorization request.
  - The test will be performed within 6 months of the diagnosis
  - Node negative (micrometastases less than 2mm in size are considered node negative)
  - Hormone receptor positive (ER-positive or PR-positive)
  - Tumor size 0.6-1.0 cm with moderate/poor differentiation or unfavorable features (such as angiolymphatic invasion, high nuclear grade, or high histologic grade) OR tumor size >1 cm
  - Unilateral disease
  - Her-2 negative
  - Patient will be treated with adjuvant endocrine therapy
  - The test result will help the patient make decisions about chemotherapy when chemotherapy is a therapeutic option
- **Code 81599:** All of the following conditions must be met and documented in the prior authorization request.
  - Patient must be post-menopausal
  - Pathology reveals invasive carcinoma of the breast that is estrogen receptive (ER) positive, Her2-negative
  - Lymph node-negative or has 1-3 positive lymph nodes
  - Patient has no evidence of distant metastasis
  - Test result will be used to determine treatment choice between endocrine therapy alone, vs. endocrine therapy plus chemotherapy

> The test is not to be ordered if the physician does not intend to act upon the test result.

10.7.2.2 BRCA Testing and Counseling

The U.S. Preventive Services Task Force (USPSTF) recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for

evaluation for BRCA testing (81211-81217 and 81162-81167). Medicaid covers BRCA testing when the following criteria are met:

- Personal and/or family history of breast cancer, especially if associated with young age of onset, OR
- Multiple tumors, OR
- Triple-negative (such as, estrogen receptor, progesterone receptor, and human epidermal growth factor receptor 2-negative) or medullary histology, OR
- History of ovarian cancer, AND
- 18 years or older.

10.8 Long-Acting Reversible Contraceptive Insertion

Wyoming Medicaid reimburses professional services for immediate postpartum IUD or contraceptive implant insertion procedures if billed separately from the professional global obstetric procedure.

Medicaid does not reimburse facility services for the immediate postpartum IUD or contraceptive implant insertion procedure. These inpatient services may not be unbundled on the hospital's facility claim.

Medicaid reimburses for the IUD or contraceptive implant device in one of the following ways:

- As a separate professional claim submitted by the facility's medical group number when the facility supplies the device.
- As part of the professional claim when the device is supplied by the Provider performing the insertion.

> When billing for an IUD or contraceptive implant device, the Provider must use the appropriate HCPCS code and NDC.

Procedure Code	Description
11981	• Insertion, non-biodegradable drug delivery implant
11982	• Removal, non-biodegradable drug delivery implant
11983	• Removal with reinsertion, non-biodegradable drug delivery implant

Billing Requirements

Practitioner Group LARC Device Billing on the CMS 1500 Form/837P Claims Transaction

- Practitioner Group NPI as billing Provider and enter the treating Provider NPI

- Date of Service must be the same as the Date of Insertion
- LARC Device Covered Services or CPT Codes:

Procedure Code	NDC	LARC Device Name
J7296	Required	Kyleena
J7297	Required	Liletta
J7298	Required	Mirena
J7300	Required	Paragard
J7301	Required	Skyla
J7307	Required	Nezplanon

10.9 Obstetrical Ultrasounds

Revenue Codes: **032X–035X, 040X, 061X**

Procedure Code Range: **76801–76828**

Medicaid covers obstetrical ultrasounds during pregnancy when medical necessity is established for one (1) or more of the following conditions:

- Establish date of conception
- Discrepancy in size versus fetal age
- Early diagnosis of ectopic or molar pregnancy
- Fetal Postmaturity Syndrome
- Guide for amniocentesis
- Placental localization associated with abnormal vaginal bleeding (placenta previa)
- Polyhydramnios or Oligohydramnios
- Suspected congenital anomaly
- Suspected multiple births
- Other conditions related directly to the medical diagnosis or treatment of the mother and/or fetus

Maintain all records and/or other documentation that substantiates medical necessity for OB ultrasound services performed for Medicaid

Members as documentation may be requested for post-payment review purposes.

Medicaid will not reimburse obstetrical ultrasounds during pregnancy for any of the following reasons:

- Determining gender
- Baby pictures
- Elective
- Observation for any signs of abuse
- Observation of any physical abnormality

10.10 Preventative Medicine – Members Over 21 Years of Age

10.10.1 Covered Services

- Cancer screening services
- Screening mammographies are limited to a baseline mammography between ages 35-39 and one (1) screening mammography per year after age 40. All mammograms require a referral by a practitioner.
- Annual gynecological exams, including a pap smear. One (1) per year following the onset of menses. This should be billed using an extended office visit procedure code. The actual Lab Cytology code is billed by the lab where the test is read and not by the Provider who obtains the specimen.

10.11 Radiology Services

Revenue Codes: **032X-035X, 040X, & 061X**

Procedure Codes: **70000-79999 & 90000-99999**

Radiology services are ordered and provided by practitioners, dentists, or other Providers licensed within the scope of their practice as defined by law. Imaging Providers must be supervised by a practitioner licensed to practice medicine within the state the services are provided. Radiology Providers must meet state facility licensing requirements. Facilities must also meet any additional federal or state requirements that apply to specific tests (for example, mammography). All facilities providing screening and diagnostic mammography services are required to have a certificate issued by the Federal Food and Drug Administration (FDA).

Medicaid provides coverage of medically necessary radiology services, which are directly related to the Member's symptom(s) or diagnosis when provided by independent radiologists, hospitals, and practitioners.

10.11.1 Billing Requirements

- Hospitals will only be reimbursed for the technical component of any imaging services billed.
- Multiple units performed on the same day must be billed with two (2) or more units, rather than on separate lines, to avoid duplicate denial of service.

10.11.2 Limitations

Screening mammographies are limited to a baseline mammography between ages 35 and 39 and one (1) screening mammography per year after age 40. All mammograms require a referral by a practitioner.

10.12 Sterilization and Hysterectomies

Revenue Codes: **036X or 049X**

10.12.1 Elective Sterilization

Elective sterilizations are sterilizations completed for the purpose of becoming sterile. Medicaid covers elective sterilizations for men and women when all of the following requirements are met:

- Members must complete and sign the Sterilization Consent Form at least 30 days, but not more than 180 days, prior to the sterilization procedure. There are no exceptions to the 180-day limitation of the effective time period of the informed consent agreement (for example, retroactive eligibility). This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly completed, payment will be denied. A complete Sterilization Consent Form must be obtained from the primary physician for all related services (*see Section 6.15.1* Sterilization Consent Form and Guidelines).

The 30-day waiting period may be waived for either of the following reasons:

- **Premature Delivery:** The Sterilization Consent Form must be completed and signed by the Member at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
- **Emergency Abdominal Surgery:** The Sterilization Consent Form must be completed and signed by the Member at least 72 hours prior to the sterilization procedure.
    - Members must be at least 21 years of age when signing the form
    - Members must not have been declared mentally incompetent by a federal, state or local court, unless the Member has been declared competent to specifically consent to sterilization
    - Members must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill

Before performing sterilizations, the following requirements must be met:

- The Member must have the opportunity to have questions regarding the sterilization procedure answered to their satisfaction
- The Member must be informed of their right to withdraw or withhold consent any time before the sterilization without being subject to retribution or loss of benefits
- The Member must understand the sterilization procedure being considered is irreversible
- The Member must be made aware of the discomforts and risks, which may accompany the sterilization procedure being considered
- The Member must be informed of the benefits associated with the sterilization procedure
- The Member must know that they must have at least 30 days to reconsider their decision to be sterilized
- An interpreter must be present and sign for those Members who are blind, deaf, or do not understand the language to assure the Member has been informed (*see Section 9.4* Interpretation Services)

Informed consent for sterilization may not be obtained under the following circumstances:

- If the Member is in labor or childbirth
- If the Member is seeking or obtaining an abortion
- If the Member is under the influence of alcohol or other substances which may affect their awareness

10.12.2 Hysterectomies

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and orchiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one (1) of the following:

- A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one (1) section (A, B or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the Member must sign and date Section A of this form (refer to 42 CFR 441.250 for the Federal policy on hysterectomies and sterilizations). The Member does not need to sign this form when Sections B or C apply. If this form is not properly completed, payment will be denied (*see Section 6.15.2.1* Hysterectomy Acknowledgement Consent Form).
    - If the surgery does not render the Member sterile, operative notes can be submitted in place of the form indicating reason for non-sterility

- For Members that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one (1) of the following:
    - The Member was informed prior to the hysterectomy that the operation would render the Member permanently incapable of reproducing
    - The Member was already sterile at the time of the hysterectomy and the reason for prior sterility

10.13 Surgical Services

Revenue Codes: **036X or 049X**

Procedure Code Range: **10000-69999**

Medicaid only covers surgical procedures that are medically necessary. In general, surgical procedures are covered if the condition directly threatens the life of a Member, results from trauma demanding immediate treatment, or had the potential for causing irreparable physical damage, the loss or serious impairment of a bodily function, or impairment of normal physical growth and development.

These policies follow Medicare guidelines but in cases of discrepancy, the Medicaid policy prevails.

10.13.1 Billing Requirements

Bilateral Procedures and Multiple procedures on the same date of service are handled and priced by the IOCE (*see Section 10.17* Reimbursement, Definitions, Billing Tips, and Guidelines).

> Dental services performed as an outpatient hospital service must be billed using procedure code 41899 (unlisted procedure, dentoalveolar structures; such as, removal of teeth).

10.13.2 Limitations

- Medicaid services that are considered cosmetic may be covered only when medically necessary (for example, restore bodily function or correct a deformity). Prior authorization is required.
- The following procedures will be denied:
    - Services that can only be done as inpatient (see the Inpatient Only Procedure Code list on the website (*see Section 2.1* Quick Reference)
        - Any outpatient surgeries which are denied as only allowed in the inpatient setting can be appealed
    - Cosmetic
    - Non-covered

- Unlisted procedure codes

- Durable medical equipment not considered part of the surgical procedure can be billed separately under the DME program (*see Section 2.1* Quick Reference)
- Medical/surgical supplies used in actual treatment of an outpatient are covered. A limited supply (two (2) day maximum) may be provided to a patient only if a prescription for the supply cannot be filled at a retail pharmacy or medical supplies Provider within the two (2) day time frame.
- Prescriptions for medications used in actual treatment of an outpatient are covered. A limited supply (two (2) day maximum) may be prescribed to a patient only if a prescription for the medication cannot be filled at a retail pharmacy within the two (2) day time frame.

10.14 Transplant Policy

10.14.1 Eligibility

Medically necessary organ transplants must be Prior Authorized. A Prior Authorization (PA) must be obtained before services are rendered (*see Section 6.13* Prior Authorization

10.14.2 Coordination of Care

Coordination of care will be provided by the case manager and WYhealth (*see Section 2.1* Quick Reference).

Hospitals are required to obtain prior authorization for transplants prior to admission and procedure. Prior Authorization must be requested of the appropriate vendor, Telligen (*see Section 6.13* Prior Authorization).

10.14.3 Covered Services

The only transplant covered on an outpatient basis is bone marrow for Members age 20 and under. Refer to inpatient services (*see Section 11.1.2.1* Inpatient Services) for all other transplant services.

10.14.4 Reimbursement – Outpatient Stem Cell and Bone Marrow

Medicaid reimburses for outpatient bone marrow transplantation services provided by specialized transplant physicians and facilities.

Transplant services will be reimbursed, after discharge, at 55% of billed charges. Transplant services include:

- Initial evaluation
- Procurement/Acquisition (included on facility claim)
- Facility fees

- If the physician is employed by the hospital, the charges will be combined and billed on the facility claim. If physicians are not employed by the hospital they need to be actively enrolled with Wyoming Medicaid and will bill separately.

10.14.5 Non-Covered Services

Transportation of organs is not covered.

10.15 Therapy Services

Physical Therapy: The treatment of physical dysfunction or injury by the use of therapeutic exercise and the application of modalities intended to restore or facilitate normal function or development; also called physiotherapy.

Occupational Therapy: Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Speech Therapy: Services that are necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presences of a communication disability.

Restorative (Rehabilitative) Services: Services that help patients keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the Member was sick, hurt, or suddenly disabled.

Maintenance (Habilitative) Services: Services that help patients keep, learn, or improve skills and functioning for daily living. Examples would include therapy for a child who isn't walking or talking at the expected age.

10.15.1 Physical Therapy and Occupational Therapy

Physical Therapy Revenue Code Range: **0420-0429**

Occupational Therapy Revenue Code Range: **0430 – 0439**

10.15.1.1 Covered Services

Services must be directly and specifically related to an active treatment plan. Independent physical therapy services are only covered in an office or home setting.

- Physical Therapy & Occupational Therapy**:** Services may only be provided following physical debilitation due to acute physical trauma or physical illness. All therapy must be physically rehabilitative and provided under the following conditions:
    - Prescribed during an inpatient stay continuing on an outpatient basis, or as a direct result of outpatient surgery or injury

- Manual Therapy Techniques**:** When a practitioner or physical therapist applies physical therapy and/or rehabilitation techniques to improve the Member's functioning
- Occupational Therapy interventions**:** may include the following.
    - Evaluations/re-evaluations required to assess individual functional status
    - Interventions that develop improve or restore underlying impairments

10.15.1.2 Limitations

Reimbursement includes all expendable medical supplies normally used at the time therapy services are provided. Additional medical supplies/equipment provided to a Member as part of the therapy services for home use will be reimbursed separately through the Medical Supplies Program. For specific billing information on medical supplies refer to the DME Provider Manual posted on the Medicaid website (*see Section 2.1* Quick Reference).

- Physical and Occupational therapy visits are limited per calendar year
    - 20 visits for physical therapy; 20 visits for occupational therapy
- Visits made more than once daily are generally not considered reasonable
- There should be a decreasing frequency of visits as the Member improves
- Members age 21 and over are limited to restorative services only. Restorative services are services that assist an individual in regaining or improving skills or strength.
- Maintenance therapy can be provided for Members age 20 and under

10.15.1.3 Documentation

The practitioner's and licensed physical therapist's treatment plan must contain the following:

- Diagnosis and date of onset of the Member's condition
- Member's rehabilitation potential
- Modalities
- Frequency
- Duration (interpreted as estimated length of time until the Member is discharged from physical therapy)
- Practitioner signature and date of review
- Physical therapist's notes and documented measurable progress and anticipated goals
- Initial orders certifying the medical necessity for therapy
- Practitioner's renewal orders (at least every 180 days) certifying the medical necessity of continued therapy and any changes. The ordering practitioner must certify that:

- The services are medically necessary
- A well-documented treatment plan is established and reviewed by the practitioner at least every 180 days

- 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, to include beginning time and ending time for services billed.

10.15.1.4 Billing Requirements

Dates of service at the header may cover multiple visits (span bill); however, each visit must be billed on a separate line for each individual date of service.

10.15.1.5 Prior Authorization Once Threshold is Met

For Medicaid Members, dates of service in excess of twenty (20) per calendar year, Providers will need to contact Telligen for prior authorization (*see Section 6.9* Service Thresholds).

> In the situation where a Member has two (2) separate PAs for services for PT/OT/ST beyond the threshold, a Provider cannot enter two (2) PAs on a single institutional claim. If the services are performed on the same date of service, the Provider needs to bill the services on two (2) separate claims, each with its own PA. The second claim may get denied as a conflicting claim or stating that all services on the same date of service must be billed on the same claim. If this happens, you need to send in the second claim as an appeal, refer to *Section 2.3.2* How to Appeal, indicating that the Member had two (2) types of therapy with two (2) different PAs on the same date of service so the claim can be processed. This is only valid if the services occur on the same date of service. If they are on different dates, separate claims must be billed.

10.15.2 Speech Therapy

Revenue Codes: **0440 – 0449**

10.15.2.1 Covered Services

Speech therapy services provided to Medicaid Members must be restorative for Members 21 and over. Maintenance therapy can be provided for Members 20 and under. The Member must have a diagnosis of a speech disorder resulting from injury, trauma or a medically based illness. There must be an expectation that the Member's condition will improve significantly. Services must be directly and specifically related to an active treatment plan. Independent physical therapy services are only covered in an office or home setting.

To be considered medically necessary, the services must meet all the following conditions:

- Be considered under standards of medical practice to be a specific and effective treatment for the Member's condition.
- Be of such a level of complexity and sophistication, or the condition of the Member must be such that the services required can be performed safely and effectively only by a qualified therapist or under a therapist's supervision.
- Be provided with the expectation that the Member's condition will improve significantly.
- The amount, frequency and duration of services must be reasonable.

In order for speech therapy services to be covered, the services must be related directly to an active written treatment plan established by a practitioner and must be medically necessary to the treatment of the Member's illness or injury.

In addition to the above criteria, restorative therapy criteria will also include the following:

- If an individual's expected restoration potential would be insignificant in relation to the extent and duration of services required to achieve such potential, the speech therapy services would not be considered medically necessary.
- If at any point during the treatment it is determined that services provided are not significantly improving the Member's condition, they may be considered not medically necessary and discontinued.

10.15.2.2 Limitations

The following conditions do not meet the medical necessity guidelines, and therefore will not be covered:

- For dates of service in excess of thirty (30) per calendar year, Providers will need prior authorization
- Members age 21 and over are limited to restorative services only. Restorative services are services that assist an individual in regaining or improving skills or strength
- Maintenance therapy can be provided for Members age 20 and under
- Self-correcting disorders (for example, natural dysfluency or articulation errors that are self-correcting)
- Services that are primarily educational in nature and encountered in school settings (for example, psychosocial speech delay, behavioral problems, attention disorders, conceptual handicap, intellectual disabilities, developmental delays, stammering and stuttering)
- Services that are not medically necessary
- Treatment of dialect and accent reduction
- Treatment whose purpose is vocationally or recreationally based

- Diagnosis or treatment in a school-bases setting

Maintenance therapy consists of drills, techniques, and exercises that preserve the present level of function so as to prevent regression of the function and begins when therapeutic goals of treatment have been achieved and no further functional progress is apparent or expected.

10.15.2.3 Billing Requirements

Dates of service at the header may cover multiple visits (span bill); however, each visit must be billed on a separate line for each individual date of service.

> In cases where the Member receives both occupational and speech therapy, treatments should not be duplicated and separate treatment plans and goals should be provided.

10.15.2.4 Prior Authorization Once Threshold is Met

For Medicaid Members, dates of service in excess of thirty (30) for speech therapy per calendar year, Providers will need to contact Telligen for prior authorization (*see Section 6.9* Service Thresholds).

> In the situation where a Member has two (2) separate PAs for services for PT/OT/ST beyond the threshold, a Provider cannot enter two (2) PAs on a single institutional claim. If the services are performed on the same date of service, the Provider needs to bill the services on two (2) separate claims, each with its own PA. The second claim may get denied as a conflicting claim or stating that all services on the same date of service must be billed on the same claim. If this happens, you need to send in the second claim as an appeal, refer to *Section 2.3.2* How to Appeal, indicating that the Member had two (2) types of therapy with two (2) different PAs on the same date of service so the claim can be processed. This is only valid if the services occur on the same date of service. If they are on different dates, separate claims must be billed.

10.15.3 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Telligen, including any additional clinical information that supports the request for services.
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Utilization Management Coordinator and Contract Manager, Amy Buxton (Amy.Buxton@wyo.gov).

- The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from Telligen's system. The appeal will be reviewed in conjunction with the documentation uploaded into Telligen's system.

10.16 Outpatient Non-Covered Services

The following is a list of services not covered by Medicaid:

- Acupuncture
- Autopsies
- Claims from outpatient hospitals for pharmaceuticals supplies only
- Court ordered hospital services are only covered if:
  - Service is a Medicaid covered services
  - Service does not exceed Medicaid limitations
- Dietary supplements
- Donor search expenses
- Services that are not direct patient health care, such as, – missed or canceled appointments or preparation of medical or insurance reports
- Exercise programs and programs that are primarily education, such as:
  - Cardiac rehabilitation exercise programs
  - Independent exercise programs (for example, pool therapy, swim programs, or health club Memberships)
  - Nutritional programs
  - Pulmonary rehabilitation programs
- Homemaker services
- Infertility services
- Inmates: Services provided to a person who is an inmate of a public institution or agency are not covered
- Massage services
- Maternity services not provided in a licensed health care facility unless as an emergency service
- Naturopath services
- Outpatient hospital services provided outside the United States
- Services considered experimental or investigational

> When Medicare is the primary payer on a service, co-insurance and deductibles may be covered even though it is not a Wyoming Medicaid covered service under the Qualified Medicare Beneficiary (QMB) program.

10.17 Outpatient Prospective Payment System Reimbursement, Definitions, Billing Tips, and Guidelines

Integrated Outpatient Code Editor (IOCE): the Medicare developed software which processes outpatient claims inclusive of OPPS and Non-OPPS processing which:

- Edits a claim for accuracy of the submitted data
- Assigns payment indicators
- Determines if packaging or bundling is applicable
- Determines the disposition of the claim based on generated edits
- Computes discounts, if applicable
- Determines payment adjustment, if applicable

Outpatient Prospective Payment System (OPPS): a Medicare based outpatient hospital reimbursement methodology which is used to reimburse **Critical Access Hospitals, Children's Hospitals, General Hospitals**, and **ASCs** for outpatient services.

10.17.1 Purpose and Objectives

- Predictability of outpatient payments
- Equity and consistency of those payments among Provider types
- Maintain access to quality care

10.17.2 Policy Notes

- Medicaid OPPS reimbursement is based on Medicare's program
- Division of Healthcare Financing policy will override if a disagreement exists between Medicare and Medicaid policy
- Not all codes covered by Medicare will be covered by Medicaid

10.17.3 Coding Tips

- Use current HCPCS Level II and ICD-10-CM coding books.
- Always read the complete description and guidelines in the coding books.

- Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, don't use 53899 (unlisted procedure of the urinary system) when a more specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have three (3) to five (5) levels. See the CPT coding book for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the Member must be billed with the code that is closest to the time spent. For example, a Provider spends 60-minutes with the Member. The code choices are 45 to 50-minutes or 76 to 80-minutes. The Provider must bill the code for 45 to 50-minutes.
- Revenue codes 025X (except for 0253) and 027X do not require CPT or HCPCS codes; however, Providers are advised to place appropriate CPT or HCPCS Level II codes on each line. Providers are paid based on the presence of line item CPT and HCPCS codes. If these codes are omitted, the hospital may be underpaid.
- Take care to use the correct "units" measurement. In general, Medicaid follows the definitions in the CPT -4 and HCPCS Level II billing manuals. Unless otherwise specified, one (1) unit equals one (1) visit or one (1) procedure. For specific codes, however, one (1) unit may be "each 15 minutes". Always check the long text of the code description published in the CPT-4 or HCPCS Level II coding books. For example, if a physical therapist spends 45 minutes working with a Member (97110), and the procedure bills for "each 15 minutes," it would be billed this way.

UB Field	42 – Rev Code	44 – Procedure Code	45 – Date of Service	46 – Units	47 – Total Charges
	420	97110	10/1/2020	3	$75.00

- When ASC providers submit services on the UB-04 form (837I), the claim will be processed using the OPPS methodology, and when services are submitted on the CMS-1500 form (837P), the claim will be reimbursed via RBRVS or the Medicaid Fee Schedule.

10.17.3.1 Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4 coding book, HCPCS Level II book, and other help resources (for example, CPT assistant, APC Answer Letter, and others).
- Always read the complete description for each modifier, some modifiers are described in the CPT coding book while others are in the HCPCS Level II book.
- Medicaid accepts the same modifiers as Medicare for the purposes of OPPS billing (this is not true when the procedure code is priced from the Medicaid fee schedule rather than through OPPS methodology).

10.17.4 Coding, Billing, and Edits

10.17.4.1 Bilateral Procedures

When billing bilateral procedures:

If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier "-50". They report such procedures as a single line item.

- If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), physicians do not report the procedure with modifier "-50".

UB Field	42 – Rev Code	44 – Procedure Code	45 – Date of Service	46 – Units	47 – Total Charges
	360	27301 50	10/1/2021	1	2,500.00

10.17.4.2 Inpatient Only Procedure Codes

Certain procedure codes have been designated by Medicare and accepted by Medicaid as being valid in an inpatient setting only. The presence of one (1) of these procedures on the claim without the appropriate modifiers may cause the claim to deny. A complete list of the current inpatient only procedure codes can be reviewed on the Medicaid website. (*see Section 2.1* Quick Reference)

10.17.4.3 Patient Status Codes

Bill the appropriate patient status code. Medicaid accepts patient status codes that are not reserved for national assignment.

10.17.4.4 Service on the Same Day

All services provided to the Medicaid Member by the hospital or ASC on the same day must be billed on a single claim. This requirement does not apply to reference labs, billing only for lab tests, with type of bill 14X.

10.17.4.5 Line Item Date of Service

All line items must show a valid date of service and must be within the header dates.

10.17.4.6 Recording Detailed International Classification of Diseases Diagnosis Codes

International Classification of Diseases (ICD)-10 diagnosis codes should be recorded to the greatest level of specificity using up to 7 digits when required. Under the OPPS Pricing Program, the claim will deny if the principal diagnosis field is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid for the dates of service.

10.17.4.7 Recording Detailed Current Procedural Technology Or Healthcare Common Procedure Coding System Codes

Under the OPPS Pricing Program, payment calculations are dependent on current procedural technology (CPT) ***or*** Healthcare Common Procedure Coding System (HCPCS) procedure codes at the line level. Revenue codes that are packaged do not require a procedure code; however, hospitals and ASCs are advised to use procedure codes (for example, high-cost drugs and supplies) as the presence of certain codes may affect payment. Hospitals and ASCs are also advised to ensure the accuracy of procedure codes, accompanying units, and the appropriateness of the accompanying revenue codes.

UB Field	42 – Rev Code	44 – Procedure Code	45 – Date of Service	46 – Units	47 – Total Charges	Payment Method	Payment Amount
N/A	250	N/A	10/1/2020	4	$913.13	Packaged	$0.00
N/A	250	J0475	10/1/2020	4	$913.13	APC	$1,327.51

Revenue code 0250 is normally a packaged revenue code, and does not require a procedure code; however, by adding the procedure code of J0475 to this line, the line goes from paying $0 (packaged) to paying based on the rate for the procedure code (J0475) - $1327.51.

10.17.4.8 Type of Bill

Type of Bill (TOB) acceptable on outpatient claims are 12X, 13X, 14X, 83X or 85X.

10.17.4.9 Line Item Denial and Claim Denials

The claim will not necessarily be denied if an edit causes a line item to deny. When a hospital can correct a line item that has denied, the hospital should submit an adjustment to Wyoming Medicaid (*see Section 2.1* Quick Reference). The claims processing system will then re-price the entire claim and adjust payment to the hospital as appropriate.

10.17.5 Billing Tips for Specific Services

10.17.5.1 Drugs and Biologicals

While most drugs are packaged there are some items that have a fixed payment amount and some that are designated as transitional pass-through items. Pass-through payments are generally for new drugs, biological, radiopharmaceutical agents, and medical devices. Drugs and devices having a status indicator of G and H receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. The fee is either the APC fee or a percentage of charges. Packaged drugs and biological

have their costs included as part of the service with which they are billed. The following drugs may generate additional payment:

- Vaccines, antigens, and immunizations
- Chemotherapeutic agents and the supported and adjunctive drugs used with them
- Immunosuppressive drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

10.17.5.2 Lab Services

If all tests that make up an organ or disease panel are performed, the panel code should be billed instead of the individual tests. Some panel codes are made up of the same test or tests performed multiple times. When billing one (1) unit of these panels, bill one (1) line with the panel code and one (1) unit. When billing multiple units of a panel (the same test is performed more than one (1) on the same day), bill the panel code with units corresponding to the number of times the panel was performed.

10.17.5.3 Supplies

Supplies are generally packaged so they usually do not need to be billed individually. A few especially expensive supplies are paid separately by Medicaid. Review the APC fee schedule available on the website to see which codes are paid separately (*see Section 2.1* Quick Reference).

10.17.6 How Payment is Calculated

10.17.6.1 Outpatient Prospective Payment Systems Affected Provider and Claim Types

- Critical Access Hospitals, Children's Hospitals, and General Hospitals (taxonomies which begin with 282N)
  - In and out of state Providers
- Ambulatory Surgical Centers (taxonomy 261QA1903X)
  - In and out of state Providers
- Outpatient claims only
- Does NOT impact Medicare secondary claims

10.17.6.2 The Outpatient Prospective Payment System

Most services in the outpatient setting are paid using the Ambulatory Payment Classification (APC) system developed by Medicare. The DHCF has adopted Medicare definitions and weights for APCs and

those codes paid through the APC method (*see Section 10.17.8.8* Wyoming Specific Non-Ambulatory Payment Classification Payments).

10.17.6.3 Revenue Codes and Procedure Codes

Under the OPPS Pricing Program, payment calculations are dependent on CPT OR HCPCS procedure codes at the line level. Revenue codes that are packaged do not require a procedure code; however, hospitals and ASCs are advised to use procedure codes (for example, high-cost drugs and supplies) as the presence of certain codes may affect payment. Hospitals and ASCs are also advised to ensure the accuracy of procedure codes, accompanying units, and the appropriateness of the accompanying revenue codes.

The Integrated Outpatient Code Editor (IOCE) identifies packaged services by first considering the CPT OR HCPCS code and related status indicator. If no CPT OR HCPCS code is present, the IOCE then considers the revenue codes. Line item revenue codes indicated as packaged will be reimbursed at $0.00 if no CPT OR HCPCS code is present. If a CPT OR HCPCS code is present with the packaged revenue codes, the line item will be reimbursed according to the CPT OR HCPCS code and related status indicator if appropriate.

UB Field	42 – Rev Code	44 – Procedure Code	45 – Date of Service	46 – Units	47 – Total Charges	Payment Method	Payment Amount
	270		10/1/2020	8	$149.36	Packaged	$0
	300	80053	10/1/2020	1	$84.71	Medicaid Fee Schedule	$13.29
	300	80101	10/1/2020	7	$211.19	Medicaid Fee Schedule	$121.24
	450	99284 25	10/1/2020	1	$516.96	APC	$164.02
	490	48102	10/1/2020	1	$616.00	APC	$417.08
	730	93005	10/1/2020	1	$100.65	APC	$19.52

Refer to the OPPS fee schedule appropriate for the date of service to determine the payment when paid under the APC method. For Example:

	A	B	C	D	E	F	G	H
1	**Medicare Effective Date:**		4/1/2021					
2	**Wyoming Medicaid Implementation Date:**		7/1/2021					
3								
4	*2021 Wyoming Conversion Factors:*							
5	**$ 43.81**	General Acute Care Hospitals - 0090 APC GEN CONVERSION FACTOR						
6	**$ 84.13**	Children's Hospitals - Provider Master rates Provider Charge Mode P						
7	**$ 108.36**	Critical Access Hospitals - 0086 APC CAH CONVERSION FACTOR						
8	**$ 38.55**	Ambulatory Surgical Centers (ASCs)						
9								
10	***Medicare's CY 2020 National Conversion Factor***		**$ 81.398**					
11	***Medicare's CY 2021 National Conversion Factor***		**$ 82.797**					
12								
13	**CPT/ HCPCS**	**Description (short)**	**Medicare Status Indicator**	**Wyoming Status Indicator**	**Medicare APC and Description**		**Medicare Relative Weights**	**Medicare National Payment Rates**
14			**April 2021**	**April 2021**	**April 2021**	**April 2021 APC Description**	**April 2021**	**April 2021**

	A	B	C	D	E	F	G	H
1	**Medicare Effective Date:**		10/1/2020					
2	**Wyoming Medicaid Implementation Date:**		1/1/2021					
3								
4	*2020 Wyoming Conversion Factors:*							
5	**$ 45.79**	General Acute Care Hospitals - 0090 APC GEN CONVERSION FACTOR						
6	**$ 83.59**	Children's Hospitals - Provider Master rates Provider Charge Mode P						
7	**$ 109.66**	Critical Access Hospitals - 0086 APC CAH CONVERSION FACTOR						
8	**$ 40.30**	Ambulatory Surgical Centers (ASCs)						
9								
10	***Medicare's CY 2019 National Conversion Factor***		**$ 79.490**					
11	***Medicare's CY 2020 National Conversion Factor***		**$ 81.398**					
12								
13	**CPT/ HCPCS**	**Description (short)**	**Medicare Status Indicator**	**Wyoming Status Indicator**	**Medicare APC and Description**		**Medicare Relative Weights**	**Medicare National Payment Rates**
14			**October 2020**	**October 2020**	**October 2020**	**October 2020 APC Description**	**October 2020**	**October 2020**

Some revenue codes require a CPT or HCPCS code. Line item revenue codes indicated as "CPT or HCPCS required" will be denied if a CPT or HCPCS code is not present. This information is only found in the NUBC Official UB Data Specifications Manual.

10.17.7 Status Indicators

The IOCE assigns a status indicator to each procedure code. The status indicator directs payment of the line item. Each procedure code's specific status indicator can be reviewed by using the APC online fee schedule on the website (*see Section 2.1* Quick Reference). The status indicators used the DHCF are based on the indicators used by Medicare, with DHCF specific indicators:

Status Code	Description	Comments
1	Not Covered	Indicates a service that is not covered by Medicaid (for example, a service that cannot be provided in an outpatient hospital setting or that is not a covered Medicaid benefit)
2	Paid a percentage of charges	Paid by multiplying billed charges by a hospital-specific cost-to-charge ratio

Status Code	Description	Comments
3	Other fee schedule	Indicates a service that is excluded from the APC-based methodology, such as laboratory and screening mammographies

Status Code	Medicare Description	Wyoming Use of Status Indicators
A	Services not Paid under OPPS; Paid under fee schedule or other payment system	Not paid under OPPS
B	Non-allowed item or service for OPPS	Not paid under OPPS
C	Inpatient procedure	Not paid under OPPS
D	Discontinued Codes	Not Paid under any system
E1	Items and services not covered by Medicare	Not paid under any outpatient system
E2	Items and services for which pricing information and claims data are not available	Not paid under any outpatient system
F	Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines	Not paid under OPPS. Paid at reasonable cost
G	Pass-through drugs and biologicals	Paid under OPPS; Separate APC payment includes pass-through amount
H	(1) Pass-through device categories (2) Therapeutic Radiopharmaceuticals	Paid under OPPS; (1) separate cost-based pass-through payment; (2) separate cost-based non pass-through payment
J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; (1) composite APC payment; (2) packaged if billed on the same date of service as other J1 services.
J2	Hospital Part B services that may be paid through a comprehensive APC	Paid under OPPS; (1) Comprehensive Observation; (2) If multiple visit codes with status indicator J2 are present, the visit code with the highest standard APC payment rate is chosen as the comprehensive observation APC; all other visit codes are packaged.
K	Non-pass-through drugs and biological	Paid under OPPS; separate APC payment.
L	Flu/PPV vaccines	Not paid under OPPS. Paid at reasonable cost.

Status Code	Medicare Description	Wyoming Use of Status Indicators
M	Services that are only billable to carriers and not to fiscal intermediaries	Not paid under OPPS.
N	Items and services packaged into APC rates	Paid under OPPS; Payment is packaged into payment for other services.
P	Partial Hospitalization Service	Not Paid under OPPS.
Q1	STVX-Packaged codes subject to separate payment under OPPS payment criteria.	Paid under OPPS; (1) Packaged APC payment if billed on the same date of service as a STVX procedure code; (2) separate APC payment.
Q2	T packaged codes subject to separate payment under OPPS Payment criteria.	Paid under OPPS; (1) Packaged APC payment if billed on the same date of service as a T procedure code; (2) separate APC payment.
Q3	Codes that may be paid through a Composite APC	Paid under OPPS; (1) Composite APC payment based on composite criteria; (2) Paid through a separate APC; (3) Payment is packaged into payment for other services.
Q4	Conditionally packaged laboratory services	Paid under OPPS; (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3”.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Procedure or service, not discounted when multiple	Paid under OPPS; separate APC payment.
T	Procedure or service, multiple reduction applies	Paid under OPPS; separate APC payment.
U	Brachytherapy Sources	Paid under OPPS; pays at % of Charges.
V	Clinic or emergency department visit	Paid under OPPS; separate APC payment.
Y	Non-implantable durable medical equipment (DME)	Not paid under OPPS.

10.17.8 Payment Calculators

The OPPS payment methodology strongly relies on the accurate coding of procedure codes for each service billed on the claim. These procedure codes are assigned a status indicator, which then identifies which type of Wyoming reimbursement methodology process will apply to the service line in question. Typically, the payment methodology is the assignment of APC categories which determines the reimbursement rate for the procedure code.

10.17.8.1 Ambulatory Payment Classification

The main payment method for the OPPS system is the Ambulatory Payment Classification (APC) method which is used by Medicare. The DHCF has adopted the IOCE with APC.

10.17.8.2 Composite Ambulatory Payment Classification

An APC fee calculation that takes into consideration the presence of multiple procedures performed on the same date of service and may discount the total payment due to the procedures being performed in combination rather than in separate situations. Composite APCs provide a single payment for a comprehensive diagnostic or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all the codes as a whole, rather than paying individually for each code.

Composite APCs differ from comprehensive APCs. Comprehensive APCs combine all the OPPS-covered services on the same claim into a single payment, including those that would otherwise be separately payable.

10.17.8.3 Relative Weight

The DHCF has adopted Medicare's relative weights for each APC. Each APC code is assigned a relative weight to determine how it will price for payment.

> Medicare calculates the relative weight for each procedure code based on historical claims costs and charges.

10.17.8.4 Conversion Factor

A conversion factor is a standard dollar amount that is used to translate relative weights into payment. For current conversion factors review the APC fee schedule available on the website (*see Section 2.1* Quick Reference). Medicaid has designated four (4) conversions for the following facility types:

- General Acute Care Hospitals
- Children's Hospitals
- Critical Access Hospitals
- Ambulatory Surgical Centers

10.17.8.5 Fee Calculation

In its simplest form, the calculation of an APC assigned procedure code is: (relative weight) x (conversion factor) = payment.

Medicare Effective Date: 1/1/2020
Wyoming Medicaid Implementation Date: 4/1/2020

2020 Wyoming Conversion Factors:
General Acute Care Hospitals - $45.79
Children's Hospitals - $83.59
Critical Access Hospitals - $109.66
Ambulatory Surgical Centers (ASCs) - $40.30

Medicare's CY 2019 National Conversion Factor: 79.490
Medicare's CY 2020 National Conversion Factor: 81.398

CPT/ HCPCS	Description (short)	Medicare Status Indicator	Wyoming Status Indicator		Medicare APC and Description		Medicare Relative Weights	Medicare National Payment Rates
		January 2020 (New Column)	January 2020 (New Column)	January 2020 Detailed Status Indicator (New Column)	January 2020	January 2020 APC Description	January 2020 (New Column)	January 2020 (New Column)
99284	Emergency dept visit	J2	J2	J2	5024	Level 4 Type A ED Visits	4.3542	351.79

4.3542 (relative weight) x $40.30 – Ambulatory Surgical Center (conversion factor) = $175.47 (payment)

4.3542 (relative weight) x $45.79 – General Hospitals (conversion factor) = $199.38 (payment)

10.17.8.6 Pass-Through Payments

Pass-through payments are generally for new drugs, biological, radiopharmaceutical agents, and medical devices. Drugs and devices having a status indicator of G and H receive a pass-through payment. In some instances, the procedure code may have an APC category assigned. The fee is either the APC fee or a percentage of charges.

10.17.8.7 Packaged Services

Services having a status indicator of N are considered packaged or bundled. The costs for these services are taken into account when relative weights are assigned for the other services, but are not paid separately. Medicare developed the relative weights for surgical, medical and other types of visits to reflect the packaged services in the APC methodology, such as, lines with a status indicator of N will pay $0.00.

10.17.8.8 Wyoming Specific Non-Ambulatory Payment Classification Payments

Certain procedures are not assigned an APC category but are instead referred back to the Medicaid fee schedule for pricing.

Status Code	Description	Comments
1	Not Covered	Indicates a service that is not covered by Medicaid (for example, a service that cannot be provided in an outpatient hospital setting or that is not a covered Medicaid benefit).
2	Paid a percentage of charges	Paid by multiplying billed charges by a hospital-specific cost-to-charge ratio.
3	Other fee schedule	Paid under the Medicaid fee schedule rather than determined by the APC fee schedule.

10.17.9 Charge Caps (Maximum Payout on Line Item)

If a procedure code is priced using the APC category, the claim will pay the full APC fee regardless of the billed amount submitted by the Provider, unless the Provider submits a billed charge of zero.

- This could mean that lines on the claim pay more than the submitted charge.
- If a procedure code is priced using the Medicaid fee schedule, (status indicator 3) the line will price/pay the lesser of the Medicaid allowed amount or the billed amount.
- Package procedure codes will always price/pay at zero (status indicator N).
- Those procedure codes having a status indicator reflecting that they are paid a percentage of charges are paid at a percentage of the participating hospital's charges for that service (for example, status indicators 2 and H). The percentage paid is the participating hospital's specific cost-to-charge ratio.
- Under Wyoming's OPPS, select services are paid using a percentage of charges. The actual percentage used for payment varies by Provider and is called a cost-to-charge ratio. For participating Providers (Providers that have reached a designated threshold of payments in the base year for rate setting) in Medicaid's inpatient DRG system, Medicaid uses a Medicaid cost-to-charge ratio that is calculated annually. Hospital-specific Medicaid cost-to-charge ratios may not exceed 100 percent. Non-participating hospitals are reimbursed using the average Medicaid cost to charge ratio for their Provider type (children's hospital, critical access hospital and general acute care hospital). Medicaid develops these cost-to-charge ratios from Medicare cost reports and Medicaid claims data.

10.17.10 Modifiers

Modifiers add clarification and specificity to procedures. Failure to use modifiers or use of an incorrect modifier may adversely affect the payment for some outpatient services. Not all modifiers impact payment. Wyoming Medicaid follows Medicare's guidance and allows the same modifiers.

Modifier Usage

- Modifier 51 is not accepted under OPPS.
- Modifier conflicts when billed on together on the same line:
  - CT-FX or FX-CT
  - PN-PO or PO-PN

10.17.11 Discounting

10.17.11.1 Discounted Procedures

Medicaid will discount payment for certain multiple, bilateral or discontinued procedures as described below to type "T" and non-type "T" procedures. Type "T" procedures are procedure codes assigned a status indicator of "T"

10.17.11.2 Discounting for Type "T" Procedures (Significant Procedures Subject to Discounting)

- **Multiple procedures:** Medicaid will discount payment for certain procedures when a hospital performs two (2) or more type "T" procedures on the same day for the same patient. The "T" procedure with the highest relative weight will not be discounted. The remaining "T" procedures will be multiple procedures discounted. If any of the following modifiers are present on the claim line item, the procedure will not be subject to multiple procedure discounting:
    - 76: Repeat procedure by same physician.
    - 77: Repeat procedure by another physician.
    - 78: Return to the operating room for a related procedure during the postoperative period.
    - 79: Unrelated procedure or service by the same physician during the postoperative period.
- **Bilateral procedures:** The first type "T" bilateral procedure, indicated by modifier 50 (bilateral procedure) will not be discounted. The remaining "T" bilateral procedures will be bilateral procedure discounted. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.
- **Discontinued procedures:** Medicaid will discount type "T" procedures that a hospital discontinues before completion, indicated by modifier 52 (reduced services) or 73 (discontinued outpatient procedure prior to anesthesia administration). The "T" discontinued procedure with the highest relative weight will be discounted 50 percent of the payment rate. The remaining "T" discontinued procedures will be discontinued procedure discounted. Any applicable offset will be applied prior to selecting the type "T" procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount.

10.17.11.3 Discounting for Non-Type "T" Procedures

- **Bilateral procedures:** the first non-type "T" bilateral procedure, indicated by modifier 50 (bilateral procedure) will not be discounted. The remaining non-type "T" bilateral procedures will be bilateral procedure discounted. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.

- **Discontinued procedures:** Medicaid will discount non-type "T" procedures that a hospital discontinues before completion, indicated by modifier 52 (reduced services) or 73 (discontinued outpatient procedure prior to anesthesia administration).
- **Credit received from the manufacturer for a replaced medical device:** When the credit for the device is 50% or more of the total cost of the device, the Provider will need to indicate this on their claim by using a value code of "FD" and indicating the total amount of the credit.

10.17.12 Observation and Direct Admission Services

Medicaid will reimburse for observation services regardless of admitting diagnosis. Observation services are either packaged or paid separately under an APC category, dependent upon other services billed on the claim.

- Observation services are billed using revenue code 0762.
- Procedure code G0378 (hospital observation services, per hour) is appropriate for all conditions or types of admission to observation.
- The unit indicator for G0378 must be the total number of hours the Member was in observation.
- Procedure code G0379 (direct admission of Member for hospital observation care) is appropriate if the Member was directly admitted to the hospital for observation such as a referral from a community physician, rather than admittance through the emergency room or clinic.
- The unit indicator for G0379 should be 1.

10.17.12.1 Reimbursement

Observation services will be priced as packaged unless one (1) of the following conditions are met:

- 8 or more units of procedure code G0378 are billed or an appropriate obstetric diagnosis code is billed along with at least one (1) unit of procedure code G0378; and
- No services with a status code of "T" were provided on the same date of services as the G0378; and
- One (1) or more of the following procedure codes are billed on the day of or the day prior to the observations services:
  - 99205: Office or outpatient visit, new
  - 99215: Office or outpatient visit, established

OR

- No services with a status code of "T" were provided on the same date of services as the G0378; and

- Eight (8) or more units of procedure code G0378 are billed on the same date or the day after a high-level emergency department visit or critical care service or an appropriate obstetric diagnosis code is billed along with at least one (1) unit of procedure code G0378; and
- One (1) or more of the following procedure codes are billed on the day of or the day prior to the observation services:
    - 99284**:** Emergency department visit (Level 4)
    - 99285**:** Emergency department visit (Level 5)
    - 99291**:** Critical care, first hour

Observation services billed with one (1) of the listed visit procedure codes (99205, 99215, 99284, 99285, and 99291) but not meeting other criteria listed will be packaged.

10.17.12.2 Direct Admissions

If the claim does not meet the criteria below, procedure code G0379 will be priced as packaged.

Direct Admission (G0739) will be reimbursed by APC category if:

- Both procedure code G0378 (hourly observation) and G0379 (direct admission) have the same date of service; and
- No services with a status indicator of T (significant procedure) or V (clinic or emergency department visit) or procedure codes triggering an APC category of 0617 (critical care) were provided on the same day or day prior to the observation.
- Payment will be determined by the number of observation hours indicated which will control which APC category the procedure code G0379 will fall into.

10.17.12.3 National Drug Code Billing Requirements

Review *Chapter 6* – Common Billing Information for requirements on billing NDC codes with certain drug related procedure codes.

10.17.13 Outpatient Prospective Payment System Quarterly Updates

Outpatient hospital claims are processed through the 3M groupers. OPPS updates occur the first of each quarter. The online APC-Based Fee Schedule posted to the Wyoming Medicaid website will be updated approximately the 20th day following the quarterly update: [Wyoming Medicaid Outpatient Prospective Payment System Information (https://www.wyomingmedicaid.com/portal/OPPS-Information)](https://www.wyomingmedicaid.com/portal/OPPS-Information).

Chapter 11 – Critical Access Hospital and General Hospital Inpatient

11.1 General Coverage Principles and Definitions

Medicaid covers almost all inpatient hospital services when they are medically necessary. This chapter provides covered services information that applies specifically to inpatient hospital services. Like all health care services received by Medicaid Members, these services must meet the general requirements listed in Chapters 1 through 8 of this manual.

11.1.1 Critical Access Hospital

A Critical Access Hospital (CAH) is A hospital that meets the following CMS criteria:

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

11.1.1.1 General Acute Care Hospital

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

11.1.2 Psychiatric Hospital

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

11.1.2.1 Inpatient Services

Inpatient Services are those services for which the Medicaid Member was admitted as an inpatient to the hospital facility, regardless of the length of stay.

- For payment purposes, inpatient services require at least a 24 hour stay unless the stay falls under the less than 24 hour stay for transfers (*see Section 11.6.2* Outpatient Services Followed by Inpatient Services).
- Medically necessary inpatient hospital services are covered pursuant to written orders by a physician or staff under the supervision of a physician, a dentist or other appropriate practitioner.
- Facilities are required to send medications (either prescriptions or already filled) home with Members upon discharge.
- Services are considered inpatient services when the patient is admitted as an inpatient to the facility, regardless of the hour of admission, whether or not a bed is used and whether or not the patient remained in the hospital past midnight.
    - Inpatient stays are subject to the submission of Inpatient Monitoring Reports – refer to Telligen for details.
    - When a Member receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes. (*see Section 11.6* Inpatient Billing Guidelines)
- Wyoming Medicaid Rule, Chapter 29, Section 3 requires all inpatient hospitals to complete a weekly census for any Wyoming Medicaid Member admitted, resident, or discharged during the week. The census is due no later than 5 PM each Friday. For more information regarding this requirement, visit the Wyoming Department of Health, Inpatient Census Reporting page (https://health.wyo.gov/healthcarefin/medicaid/inpatient-census-reporting/) on how to complete the census and the penalties for not doing so.

11.2 Abortion

Abortions are not allowed to be billed on an inpatient basis (*see Section 10.2* Abortion).

11.3 Psychiatric Services

For Members 21 and over Medicaid will reimburse for acute stabilization provided in acute care general or critical access hospitals.

For Members 20 and under Medicaid will reimburse for acute stabilization and extended psychiatric care provided in acute care general or critical access hospitals.

> Inpatient or outpatient hospital services provided to a Member between ages 21 and 64 at an Institution for Mental Disease (IMD) are a **non-covered service** pursuant to federal Medicaid regulation. This includes Medicare crossover claims for dual eligible Members. An IMD is defined as a hospital, nursing facility, or other institution of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases.

11.3.1 Acute Psychiatric Admissions Requirement

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

- The Member must have been diagnosed with a psychiatric illness by a licensed mental health professional.
- Symptoms of the illness must be in accord with those described in the Diagnostic Statistical Manual of Mental Disorders, Edition V (DSM-V).
- One (1) or more of the following must be present:
  - Member presents with suicidal ideation and intention, which represents significant risk of harm, medically significant self-mutilation, and/or recent lethal attempt to harm self, such that 24-hour a day hospitalization and observation are necessary for the patient's safety.
  - Member presents with a recent history of grossly disruptive or delusional and/or violent behavior representing clear and present danger of serious harm to others.
  - The Member's psychiatric condition severely impairs their basic functional capacity as evidenced by disorganized, uncontrolled thinking or behavior that represents a genuine and proximal risk of danger to self-such that 24-hour a day nursing and medical treatment is required.
  - Diagnosis and/or treatment is/are clearly unsafe or impossible to be provided in an ambulatory setting and can only be accomplished with 24-hour intensive nursing and medical care.

> The above criteria must be met for any involuntary psychiatric placement for Medicaid eligible Members. For involuntary psychiatric placements for non-Medicaid eligible Members, see the Title 25 Billing Manual located on the Medicaid website (*see Section 2.1* Quick Reference).

11.3.1.1 Billing Requirements

Services, including involuntary psychiatric placements for Medicaid eligible Members, must be prior authorized within one (1) working day of admission through Telligen (*see Section 2.1* Quick Reference and *section 6.13* Prior Authorization.

11.3.2 Billing Examples

When billing for inpatient psychiatric services, prior authorizations must be obtained for the entire coverage period, including the date of discharge. If a prior authorization does not include the date of discharge, claims will be denied. Contact Telligen (*see Section 2.1* Quick Reference) for questions or corrections on prior authorizations. If any days are denied as non-covered then Providers should not include those units on their line item(s). The claim would need to be corrected as follows:

Below are two (2) billing examples for inpatient psychiatric services.

Example 1a – **Invalid Billing**:

- Member is admitted 1/22/2020 and is discharged 2/11/2020.
    - Coverage period is entered as 1/22/2020 – 2/11/2020 on the claim
    - Patient Status is indicated as discharged
- A Prior Authorization is obtained for the following:
    - Effective for Dates of service 1/22/2020 – 2/10/2020
    - Approved for Dates of service 1/22/2020 – 2/8/2020
    - Denied for Dates of service 2/9/2020 – 2/10/2020
- The claim indicates 2 non-covered days, value code 81, to correspond with the days denied on the PA
- Line 1 of the claim is billed for 16 units of 0124
- Line 2 of the claim is billed for 2 units of 0214
- **The claim denies**

Example 1b – **Valid Billing**:

- Member is admitted 1/22/2020 and is discharged 2/11/2020.
    - Coverage period is entered as 1/22/2020 – 2/11/2020 on the claim
    - Patient Status is indicated as discharged
- A Prior Authorization is obtained for the following:
    - Effective for Dates of service 1/22/2020 – 2/11/2020
    - Approved for Dates of service 1/22/2020 – 2/8/2020

- Denied for Dates of service 2/9/2020 – 2/10/2020

- The claim indicates 2 non-covered days, value code 81, to correspond with the days denied on the PA
- Line 1 of the claim is billed for 18 units of 0124
  - Value code 80 indicates 18 units
- **The claim processes**

Example 2a – **Invalid Billing**:

- Member is admitted outpatient 1/20/2020
- Member is admitted inpatient 1/21/2020 and is discharged 1/29/2020
  - Coverage period is entered as 1/20/2020 – 1/29/2020 on the claim
  - Patient Status is indicated as discharged.
- A PA is obtained for the following:
  - Effective for Dates of service 1/20/2020 – 2/4/2020
  - Approved for Dates of service 1/20/2020 – 1/26/2020 and 1/29/2020 – 2/4/2020
  - Non-Approved for 1/27/2020 – 1/28/2020
- The claim indicates 1 non-covered day, value code 81, for the outpatient stay
- Line 1 of the claim is billed for 8 units of 0124 with date of service 1/20/2020
  - Value code 80 indicates 8 units
- Lines 2-6 are billed for additional services with date of service 1/20/2020
- **The claim processes incorrectly**

When the PA does not deny dates of service but does not list them as approved, they are considered non-covered days. Additionally, the claim should only include services provided during the covered days. To correct the claim bill as follows:

Example 2b – **Valid Billing**:

- Member is admitted outpatient 1/20/2020
- Member is admitted inpatient 1/21/2020 and is discharged 1/29/2020
  - Coverage period is entered as 1/20/2020 – 1/29/2020 on the claim
  - Patient Status is indicated as discharged.
- A PA is obtained for the following:
  - Effective for Dates of service 1/20/2020 – 2/4/2020
  - Approved for Dates of service 1/20/2020 – 1/26/2020 and 1/29/2020 – 2/4/2020

- Non-Approved for 1/27/2020 – 1/28/2020

- The claim indicates 3 non-covered days, value code 81, for the outpatient stay and the days not approved on the PA
- Line 1 of the claim is bills for 6 units of 0124 with date of service 1/21/2020
  - Value code 80 indicates 6 units
- **The claim processes correctly**

11.4 Sterilization and Hysterectomies

11.4.1 Elective Sterilization

Elective sterilizations are sterilizations completed for the purpose of becoming sterile. Medicaid covers elective sterilizations for men and women when all of the following requirements are met:

- Members must complete and sign the Sterilization Consent Form at least 30 days, but not more than 180 days, prior to the sterilization procedure. There are no exceptions to the 180 day limitation of the effective time period of the informed consent agreement (for example, retroactive eligibility). This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly complete, payment will be denied. A complete Sterilization Consent Form must be obtained from the primary physician for all related services (*see Section 6.15.1* Sterilization Consent Form and Guidelines)

The 30 day waiting period may be waived for either of the following reasons:

- Premature Delivery**:** The Sterilization Consent Form must be completed and signed by the Member at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
- Emergency Abdominal Surgery**:** The Sterilization Consent Form must be completed and signed by the Member at least 72 hours prior to the sterilization procedure.
- Members must be at least 21 years of age when signing the form.
- Members must not have been declared mentally incompetent by a federal, state or local court, unless the Member has been declared competent to specifically consent to sterilization.
- Members must not be confined under civil or criminal status in a correctional rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing sterilizations, the following requirements must be met:

- The Member must have the opportunity to have questions regarding the sterilization procedure answered to their satisfaction.

- The Member must be informed of their right to withdraw or withhold consent any time before the sterilization without being subject to retribution or loss of benefits.
- The Member must understand the sterilization procedure being considered is irreversible.
- The Member must be made aware of the discomforts and risks, which may accompany the sterilization procedure being considered.
- The Member must be informed of the benefits associated with the sterilization procedure.
- The Member must know that they must have at least 30 days to reconsider their decision to be sterilized.
- An interpreter must be present and sign for those Members who are blind, deaf, or do not understand the language to assure the Member has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the Member is in labor or childbirth
- If the Member is seeking or obtaining an abortion
- If the Member is under the influence of alcohol or other substances which may affect their awareness

11.4.1.1 Billing Requirements

Diagnosis Code: **Z30.2**

Surgical Code: **Must be an ICD-10-PCS sterilization code**

- The above surgical codes and diagnosis code must accompany one another on a claim. Anytime one (1) of the surgical sterilization procedure codes is present on an inpatient claim, the diagnosis code of Z30.2 (sterilization) must also be present. Likewise, if diagnosis Z30.2 is present on an inpatient claim, one (1) of the above surgical sterilization procedures must also be present. If only the surgical sterilization code or diagnosis code is present, the claim will deny.
- If both the above criteria are met then the system will verify that a delivery took place by identifying that a surgical obstetrical procedure is present, combined with a diagnosis code in the O20 – O92 range. If the obstetrical procedure and diagnosis code are not present the claim will deny.

11.4.2 Hysterectomies

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies,

oophorectomies, salpingectomies and orchiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one (1) of the following:

- A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one (1) section (A, B or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the Member must sign and date section A of this form (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The Member does not need to sign this form when sections B or C apply. If this form is not properly completed, payment will be denied (*see Section 6.15.2* Hysterectomy Acknowledgment of Consent).
    - If the surgery does not render the Member sterile, operative notes can be submitted in place of the form indicating the reason for non-sterility.
- For Members that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one (1) of the following:
    - The Member was informed prior to the hysterectomy that the operation would render the Member permanently incapable of reproducing.
    - The Member was already sterile at the time of the hysterectomy and the reason for prior sterility.

11.5 Transplant Services

Medicaid reimburses for organ and bone marrow transplantation services provided by specialized transplant physicians and facilities.

11.5.1 Eligibility

Medically necessary organ transplants must be prior authorized. Prior authorization must be obtained before services are rendered.

11.5.2 Coordination of Care

Coordination of care will be provided by the case manager and WYhealth.

Hospitals are required to obtain prior authorization for transplants listed below prior to admission and procedure. Telligen will complete prior authorizations (*see Section 6.13* Prior Authorization).

11.5.3 Covered Services

Medicaid covered transplants include:

Transplant	Members 20 years and under	Members 21 years and over
Bone Marrow	Covered service	Covered service
Heart	Covered service	Not a covered service
Heart/Lung	Covered service	Not a covered service
Kidney	Covered service	Covered service
Pancreas	Covered service	Not a covered service
Lung	Covered service	Not a covered service
Liver	Covered service	Covered service

Liver transplants require an average score between 10-40. Scores 10-15 are considered to be on the lowest end of the requirement for liver transplants. Three (3) tests must be performed: total bilirubin, INR, and creatinine.

11.5.4 Reimbursement

Transplant services will be reimbursed, after discharge, at a Provider specific percentage of billed charges. Transplant services include:

- Initial evaluation
- Procurement or Acquisitions (included on facility claim)
- Facility fees
    - If the physician is employed by the hospital, the charges will be combined and billed on the facility claim. If physicians are not employed by the hospital, they need to be actively enrolled with Wyoming Medicaid and will bill separately.
- Follow-up care for inpatient transplants using Medicare's standard global period. This period refers to the time frame during which all services integral to the surgical procedure are covered by a single payment.

11.6 Inpatient Billing Guidelines

11.6.1 Present on Admission Indicator

Refer to *Section 6.6* Provider Preventable Conditions.

11.6.2 Outpatient Services Followed by Inpatient Services

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

> When billing for Members that start as observation and then are moved to inpatient, Providers want to ensure these Members are admitted on day one (1) or day two (2) at the latest. Inpatient admission should always take place within 48 hours of outpatient admission.

- Coverage period (FL 6) for the claim must be the date the Member was first seen for outpatient services through the inpatient discharge date.
- The admit date (FL 12) must be the date the Member was admitted to inpatient services.
- All outpatient services should be included on the claim, using the correct dates of service.
- The outpatient services will be considered in the APR DRG claims reimbursement calculations.

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

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

11.6.3 Reimbursement for Inpatient Hospital Claims

Effective for discharge dates on or after February 1, 2019, inpatient hospital claims will be paid via the All Patient Refined Diagnosis-Related Grouping (APR DRG) methodology.

The Level of Care reimbursement methodology is in effect for discharge dates on or before January 31, 2019 for inpatient hospital claims.

11.6.4 All Patient Refined Diagnosis Related Grouping Reimbursement for Inpatient Hospital Claims

All Patient Refined Diagnosis Related Groupings (APR DRG) allow both Providers and payers to categorize complex patient claims data into more than 1,200 unique groups for analysis and payment. Wyoming Medicaid will use 3M's APR DRG grouping and pricing software to classify cases and to determine a prospective rate. This methodology will improve and refine the allocation of available funds based on patient acuity and service complexity. DRG payments will be made on a per discharge basis, with the continuing goal of encouraging the management of cost and efficiency. 3M's APR DRG Version 33 will be used for implementation and future inpatient claim processing.

A DRG Code and price is assigned based on many factors from the claim. Those can include, but may not be limited to:

- Principal Diagnosis
- Secondary Diagnoses
- POA Indicators
- Surgical Procedures
- Patient Age
- Patient Gender
- Discharge Status

Access the 3M website (www.aprdrgassign.com).

The WY DRG Calculator and 3M DRG New Facility or Provider (One Time) User Account Registration Instructions are located on the Wyoming Medicaid website, Diagnosis Related Grouping page (https://www.wyomingmedicaid.com/portal/Diagnosis-Related-Grouping).

11.6.5 Diagnosis Related Grouping High Cost Outlier Reimbursement

High-cost outlier cases will receive additional payment. High-cost outlier cases are defined as those cases for which allowable submitted charges exceed the DRG threshold. When the total charges on a claim exceed the established outlier threshold for a given DRG, an increased payment may be calculated to compensate for the additional cost of care to the patient. To determine if additional payment will be made, the hospital will need a completed claim and their rates calculated for their specific hospital for the dates of service on the claim. If the hospital does not have hospital-specific rates, the statewide rates will be used.

Chapter 12 – Comprehensive Outpatient Rehabilitation Facility

12.1 Comprehensive Outpatient Rehabilitation Facility

A Comprehensive Outpatient Rehabilitation Facility (CORF) provides coordinated comprehensive outpatient rehabilitation services at one (1) fixed location. A CORF must provide at least these three (3) components of rehabilitation services to qualify for certification as a CORF:

- Physician Supervision
- Physical therapy
- Social or psychological services
    - This is a core CORF service and must be reasonable and medically necessary and directly related to the Physical Therapy, Occupational Therapy, Speech Language Pathology or Respiratory Therapy plan of treatment.

In addition, the CORF may also provide any of the following services:

- Behavioral Health treatments/services
- Drugs and biologicals which cannot be self-administered
- Occupational therapy (restorative)
- Speech therapy
- Orthotics and prosthetics
- Medical supplies and equipment
    - CORFs may not bill for the supplies they furnish except for those cast and splint supplies that are used in conjunction with the corresponding current CPT codes (29XXX series).
- Nursing services
- Respiratory Therapy
    - Services must be provided by a Respiratory Therapist not a Respiratory Technician.

12.1.1 Billing Requirements

All CORF Providers must bill using taxonomy 261QR0401X and bill type 75X. A CORF must also bill using CPT or HCPCS codes to report their full range of services. All CORF services must be billed to Medicare primary for Medicare or Medicaid dual eligible Members. Providers who cannot bill Medicare primary or enroll with Medicare should not provide services to dual eligible Members.

Service Provided	Revenue Code	CPT or HCPCS Code
Respiratory Therapy	041X	
Physical Therapy	042X	

Service Provided	Revenue Code	CPT or HCPCS Code
Occupational Therapy	043X	
Speech Language Pathology	044X	
Nursing Services	055X	HCPCS G0128
Immunizations	0636	
Vaccine Administration	0771	CPT 90471
Behavioral Health Treatments/Services	090X, 091X	CPT 96152 Social & Psychological Services

CORF services must be specific to the needs of the Member and must be directed toward the restoration of safe, functional independence. Maintenance or general conditioning is not considered appropriate in the CORF setting.

Physical, occupational or speech therapy provided in the CORF will count towards the threshold for all Members.

Chapter 13 – End Stage Renal Disease

13.1 End Stage Renal Disease

End Stage Renal Disease (ESRD) services may be a freestanding facility or a hospital-based facility, which provides inpatient, outpatient, and/or home dialysis.

Wyoming Medicaid pays an ESRD State-developed per treatment payment rate which will be determined annually. The ESRD State-developed rate provides a bundled, per treatment payment to ESRD facilities that includes all renal dialysis services furnished for outpatient maintenance dialysis, including drugs and other biological products.

Revenue Code: 0821, 0831, 0841, 0851 - Other revenue codes are billable under this program but at least one (1) of these must be present to be considered a dialysis claim. Only one (1) of these revenue codes can be billed per date of service.

Procedure Code: 90951 through 90970 or 90999 – Other procedure codes are billable under this program but at least one (1) of these must be billed with the above revenue code to be considered a dialysis claim.

For the purpose of this policy, this chapter refers to freestanding clinics. If the facility is an IHS ESRD facility, refer to *Chapter 17* – Indian Health Services.

13.2 Billing Requirements

- ESRD Providers are responsible for the procurement, delivery and maintenance of the equipment and supplies.
- The facility may bill for all medically necessary services for home dialysis.
- Services provided outside the ESRD scope must be billed under other applicable programs and guidelines.
- Personal attendants are not covered.
- Claims should be billed with an appropriate bill type – see ESRD Coding Criteria table below.
- NDC numbers must be billed with all J-codes.
- Medicaid will use the Medicare ESRD PPS consolidated billing list for the specific calendar year. This list is not all inclusive. The list is located at: https://www.cms.gov/medicare/payment/prospective-payment-systems/end-stage-renal-disease-esrd/esrd-pps-consolidated-billing. If billing for laboratory services, ESRD Providers MUST have a valid CLIA on file.

13.3 ESRD Coding Criteria

13.3.1 Coding Criteria Table

Bill Type: **72X**

Taxonomy: **261QE0700X**

Type of Service	Coding Criteria	Date of Service Effective Date
Dialysis	All claims must include a revenue code 0821, 0831, 0841, or 0851 with a procedure code 90951 through 90970 or 90999	ESRD State-developed per treatment payment rate (encounter rate)
Lab	80000-89999 Must have valid CLIA on file	0.00 per line
All other services	36400-36420; 90658; 90732; 90740; 90747; A4206 to A4259; A4265; A4300 to A5200; G0008; G0010: J0120 to J9999; Q4081	0.00 per line

13.3.2 ESRD Coding Additional Information

- The above criterion does not apply to Medicare crossover claims, claims for any other bill type, or for denied lines.
- Claims or claim lines that are billed with a CPT code not on the coding criteria list will be denied.
- Codes within the above ranges that are not normally covered by Medicaid will not be covered for ESRD claims either.

Example Claim:

Revenue Code	Procedure Code	Date of Service Beginning	Date of Service End	Line Paid Amount
0821	90951	01/05/2023	01/05/2023	307.47
0270	A4657	01/05/2023	01/05/2023	0.00
0636	J0887	01/05/2023	01/05/2023	0.00
0821	90962	01/07/2023	01/07/2023	307.47
0250	J3490	01/07/2023	01/07/2023	0.00
0270	A4657	01/07/2023	01/07/2023	0.00
0636	J1270	01/07/2023	01/07/2023	0.00

Revenue Code	Procedure Code	Date of Service Beginning	Date of Service End	Line Paid Amount
Total of Claim Paid				$614.94

Chapter 14 – Federally Qualified Health Centers

14.1 Federally Qualified Health Centers

Revenue Code: **0520 – 0528 Medical**

Procedure Code: **D8999 – Orthodontics & D9999 – Dental**

> **For covered services refer to Chapters 11 through 26 by Provider type in the CMS 1500 Provider Manual.** Dental services must be billed on the ADA dental claim form. Refer to the Dental Provider Manual located on the Medicaid website (*see Section 2.1* Quick Reference).

A Federally Qualified Health Center (FQHC) is a community-based organization that provides comprehensive primary and preventative care, including medical, dental and mental health or substance abuse services to persons of all ages, regardless of their ability to pay.

> Services for Members eligible for the BCC or COLR Benefit Plans are not covered in an FQHC setting.

14.1.1 Covered Services

Reimbursement is available for one encounter per day per eligible Member unless it is necessary for the Member:

- To be seen by different health professionals with different specialties; or
- To be seen multiple times per day due to unrelated diagnoses
    - When a Member is seen by Providers of the same specialty within the same visit, services rendered are reimbursable as one face-to-face encounter

A medical visit is a face-to-face encounter between a Member and:

- Dental Professional (ADA Dental Claim Form)
- Nurse Practitioner
- Nurse Midwife
- Physician
- Physician's Assistant
- Visiting Nurse

Medical visits can also consist of:

- Medical nutrition therapy
- Diabetes outpatient self-management training

A dental visit is a face-to-face visit between a Member and a:

- Dentist
- Orthodontist
- Dental care team specialist supervised by one of the above

Other health visits are a face-to-face encounter between a Member and:

- Clinical Psychologist
- Clinical Social Worker
- Other health professional for mental health services

> When a practitioner is performing services outside the FQHC facility, services cannot be billed under the FQHC NPI number. The services will need to be billed under the practitioner's NPI on a professional/837P claim.

14.1.2 Reimbursement Guidelines

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. On Medicaid primary encounter claims, the claim will be reimbursed at the encounter rate and will not be reduced when the submitted charges are less. The rate includes, but is not limited to:

- Therapeutic services
- Diagnostic Services
- Tests
- Supplies
- Lab
- Radiology

> For dental treatment refer to the Dental Manual.

Billing for Long Acting Reversible

- Billing for the LARC device will need to be completed on a CMS 1500 claim form/837P electronic claims transaction.
- Wyoming Medicaid will reimburse professional services for immediate postpartum IUD or contraceptive implant insertion procedures if billed separately from the professional global obstetric procedure.

- Medicaid does not reimburse facility services for the immediate postpartum IUD or contraceptive implant insertion procedure. These inpatient services may not be unbundled on the hospital's facility claim.
- Medicaid reimburses for the IUD or contraceptive implant device in one of the following ways:
  - As a separate professional claim submitted by the facility's medical group number when the facility supplies the device
  - As part of the professional claim when the device is supplied by the Provider performing the insertion
- Providers should bill their 340B acquisition cost OR if purchased outside 340B Program enter usual and customary charges for devices.
- The group Provider will be reimbursed the lesser of the Provider's billed amount or the Medicaid allowed amount.
- There should be correlating UB and CMS 1500 claims for the insertion and for the actual LARC device.
- Group Providers should not submit a device claim when the encounter was for removal of a device only.
- **FQHC/RHC Facility Encounter Billing on the UB Form/837I Claims Transaction**
  - FQHC/RHC Facility NPI as the pay-to Provider and enter an attending Provider NPI

> When billing for an IUD or contraceptive implant device, the Provider must use the appropriate HCPCS code and NDC.

  - LARC Covered Services or CPT Codes

Procedure Code	Description
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug deliver implant

  - **Encounter Billing Example:**
    - Member had an appointment at the FQHC Facility on 1/20/2020 for contraceptive services and received a contraceptive implant

Revenue Code	Procedure Code	Amount
520 (encounter revenue code)	T1015 (encounter procedure code)	$220.00

Revenue Code	Procedure Code	Amount
517	11981	$0.00
517	99215	$0.00

- **Practitioner Group LARC Device Billing on the CMS 1500 Form/837P Claims Transaction**
  - Practitioner Group NPI as billing Provider and enter the treating Provider NPI (same as the attending on the encounter claim)
  - Date of service must be Date of Insertion and the same as the date on the encounter claim
  - LARC Device Covered Services or CPT Codes

Procedure Code	NDC Requirement	LARC Device Name
J7296	Required	Kyleena
J7297	Required	Liletta
J7298	Required	Mirena
J7300	Required	Paragard
J7301	Required	Skyla
J7307	Required	Nexplanon

All LARC device codes require an NDC.

  - Device Billing Example:

Procedure Code	NDC	Billed Amount
J7301	00000-00-000	340B acquisition cost OR if purchased outside 340B Program enter usual & customary charge

14.1.3 Billing Requirements

- Multiple encounters within the FQHC, on the same day, with different practitioners are still considered one (1) encounter UNLESS the Member suffers illness or injury requiring treatment unrelated to the first encounter or if the Members have both a medical visit and other health visit, as defined above.

- Claims must be billed with revenue and procedures codes for both the encounter and detail line items.
- All services provided during the encounter must be billed on a separate line.
- Claims must have a minimum of two (2) line items, the first would be the encounter line and the second line item is detail (both must include a revenue and procedure code combination).
- Encounter lines will be billed with a 0520 revenue code paired with:
  - Procedure code T1015 for a general encounter.
  - Bill the total usual and customary charges for the visit.
- Detail line items will be billed with:
  - Any appropriate outpatient revenue code paired with any appropriate procedure code (for questions regarding appropriate pairing of revenue codes and procedure codes, use the current version of the NUBC Official UB Data Specifications Manual).
  - Document each procedure that occurred during the encounter.
  - Include a detailed line item for the office visit or health check procedure code if appropriate.
  - Procedure codes 99381-99385 or 99391-99395 for EPSDT encounter.
  - Use modifier 32 to indicate a health check encounter that results in a referral to a specialist.
  - Bill the detail line items at $0.00.
- Appropriate Bill Type(s)
  - 77X
- Pay-to Provider's Taxonomy
  - 261QF0400X

> If billing Medicare as primary, bill the claim following Medicare's rules (codes).

14.1.3.1 Billing Examples

Member comes to the FQHC for complaint of cough and sees a physician. No additional tests or treatments are administered. The Member is given a prescription for antibiotics and released.

Revenue Code	Procedure Code	Amount
0520 (encounter revenue code)	T1015 (encounter procedure code)	$175.00
0517	99213	$0.00

This Member is a child who has come to the FQHC for a health check visit. The health check is conducted, and in addition, a urine culture is run while the Member is there.

Revenue Code	Procedure Code	Amount
0520 (encounter revenue code)	T1015 (encounter procedure code)	$220.00
0517	99381	$0.00
0300	87086	$0.00

For further information refer to the Health Check – EPSDT section in the CMS-1500 Provider Manual.

Chapter 15 – Home Health

15.1 Home Health

Home Health services are intended to be a temporary transitional program to assist Members with care required after an acute health incident or an institutionalized stay. Home Health services are to provide medical support and education to the Member and any caregiver regarding the Member's new medical needs. Home Health is never intended to be a long-term solution. For Members with long term needs, Home Health is available initially while the Member and any caregiver are educated about the new medical needs and determines what the long-term solution will be for meeting the needs of the Member. Long term solutions may include additional or alternate care givers, waiver programs, higher levels of care such as nursing facilities, and the Member providing for their own needs as he or she is able.

Long Term custodial care services are not covered under the home health state plan benefit. Long term custodial care is defined as care that has moved beyond the acute state (has become clinically stable) and is expected to be needed for the rest of the Member's life.

Medicare certified or State Licensed Home Health agencies can provide Home Health services. These agencies may be independent or based in a hospital, nursing home, Senior Center, or Public Health agency. Agencies that are not Medicare certified must continue to meet the Conditions of Participation for Medicare and will need to be licensed by the Division of Healthcare Licensing and Survey.

Home Health agencies are unable to bill for the sale or rental of Durable Medical Equipment unless they are separately enrolled as a DME Provider. For specific billing instructions refer to the DME General and DME Covered Services Provider Manuals on the Medicaid website (*see Section 2.1* Quick Reference).

15.1.1 Supervision

Supervision is defined as: The Registered Nurse (RN) shall be immediately available to the home health aide for consultation in person or by telephone. The supervising RN must make a supervisory visit to the home at least every 60 days. The supervisory visit is not a Medicaid billable service.

15.1.2 Criteria

Service must be:

- Ordered by a physician
- Documented in a signed and dated Plan of Care/Medicare 485 Form that is reviewed and revised as medically necessary by the attending physician at least once every 60 days
- Medically necessary
- Three or fewer encounters per day for any combination of home health aide and skilled nursing services

- An encounter is defined as all home health services provided in a single day that could be provided in a single visit to the Member, regardless of how many actual visits to the Member are actually complete

  Example: Shower, shampooing, nail care, and dressing *can all be* completed at the same time, so, even if the shower is in the morning and nail care is completed in the afternoon, this is one encounter.

- A separate encounter is not to be billed due to the convenience of the Provider nor due to scheduling issues or conflicts. A separate encounter can be billed when services must be separated due to orders or medical necessity, such as wound dressings being changed multiple times per day, or medication being given in the morning or at bedtime, or assistance with nutritional intake multiple times per day.

- Expected to last six months or less

15.2 Covered Services

- Skilled nursing services provided by a Registered Nurse (RN) for Member's condition while in the acute phase
- Home health aide services delegated and supervised by a Registered Nurse (RN)
  - Each Home Health Aide visit **must include** at least one or more of the following:
    - Bath (bed, sponge, tub, shower, or shampooing hair)
    - Nail or skin care (applying lotion does not constitute personal care)
    - Oral hygiene
    - Toileting and elimination
    - Safe transfers/assisted ambulation
    - Assist with dressing (not grooming alone)
    - Assisted range of motion/positioning
    - Assisted nutrition or fluid intake (meal set-up or prep or feeding assist/supervision)

Home Health Aid services must be related to the Member's skilled need (SN, PT, OT, ST). Without a related skilled need, HHA services are not covered.

- Physical therapy services provided by a qualified licensed physical therapist
- Speech therapy services provided by a qualified licensed therapist
- Occupational therapy services provided by a qualified registered or certified therapist

- Personal care services (PCS) provided to children and adolescents under the age of 21 years under EPSDT
- Medical social services provided by a qualified licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW) -prepared person supervised by an MSW

> MSW services are not to be used in place of appropriate behavioral health referrals to community resources. Regular therapy is not appropriate under the MSW benefit. MSW services are to be used to assist the Member in coordination with and accessing community resources to meet their needs.

15.2.1 Limitations

The following services are not covered through home health:

- Long term custodial care
- Homemaker services
- Respite care
- Home delivered meals
- Services for Members who are hospital patients or residents of skilled nursing facilities
- Services for Members that are inappropriate in the Member's home setting
- Services for Members that are extensive or for long periods and/or are not cost effective
- Services for Members where the desired outcome could be better and faster accomplished in another setting
- Services for Members where the Member must be compliant to achieve measured success and the Member is not compliant

15.2.2 Documentation Requirements

For all documentation of services provided:

- If the Member is receiving home health services only, visit notes must state home health services and detail the specific services provided
- If the Member is receiving both home health services and waiver services, visit notes must state either home health services or waiver services as appropriate and detail the specific services provided
- The Plan of Care/Medicare 485 Form must list all services the Member is receiving, regardless of pay source. This includes waiver, private duty nursing, and so on, and frequency of the services to portray a clear picture of all services the Member is receiving

- Adequate documentation justifying medical necessity must be kept. Any plans extending past 120 days (two consecutive 60-day plan periods) will be reviewed
- New Members ordered to home health care must have documentation of a face-to-face visit with the ordering practitioner within the 90 days preceding the beginning of home health. This face-to-face visit can be in the hospital, clinic, nursing home, or other clinical setting.
- Home Health Agencies that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and date
    - Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry
    - The Agency must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown

15.2.3 Billing Requirements

Appropriate Bill Type(s): **33X, 32X**

Pay-to Provider's Taxonomy: **251E00000X**

The Agency expects Home Health providers to begin using EVV to submit electronically validated visits and generate claims no later than January 1, 2024. The Agency expects all contracted Home Health provider agencies to either utilize the CareBridge EVV solution – at no cost to providers – or to successfully integrate your chosen EVV solution with CareBridge. The requirements for a compliant EVV system are outlined in the *21st Century Cures Act*, a federal law that requires all states to implement EVV. Refer to *Section 15.2.3.1* Members with Medicare and Medicaid Billing Requirements, for billing requirements for dually eligible (Medicare and Medicaid) Members.

- Prior authorizations (PA) are required for all services and are reviewed by Telligen (*see Section 6.13* Prior Authorization)
- Prior authorization requests must be submitted within 10 business days of the start of services
- Providers who perform any of the following Home Health services will be required to use EVV:

Home Health Revenue Codes		
Revenue Code	**Description**	**Unit**
0551	Skilled Nursing	Per visit
0421	Physical Therapy	Per visit
0441	Speech Therapy	Per visit
0431	Occupational Therapy	Per visit

Home Health Revenue Codes		
Revenue Code	**Description**	**Unit**
0571	Home Health Aide	Per visit
0561	Medical Social Worker	Per visit

Do not place procedure codes on the claim.

Personal Care Services Revenue Code		
Revenue Code	**Description**	**Unit**
0579	Personal Care Attendant	Per 15 minute sessions
T1019	Personal Care Services	N/A

For personal care services, the Provider must bill the revenue code 0579 with the T1019 on the line to get paid. **PCS requires prior authorization**. Please send a written request via email to the Utilization Management Coordinator, Amy Buxton (amy.buxton@wyo.gov) for the prior authorization.

15.2.3.1 Members with Medicare and Medicaid Billing Requirements

Condition codes are designed to allow the collection of information related to the patient, particular services, service venue, and billing parameters which impact the processing of an Institutional claim.

Some examples of this information are provided below:

- Employment status
- Qualified clinical trial
- Same day transfer
- Home care giver available
- Cost outlier and pregnancy indicator

> These codes are integral to the institutional claim, both the UB and the electronic 837I.

When billing Wyoming Medicaid for Members who have Medicare primary, the following Medicare information must be reported on the claim:

- Applicable value codes
- Occurrence codes
- Occurrence span codes
- Claim adjustment reason codes (CARCs)
- Remittance advice reason codes (RARCs)
- Condition codes
- Claim filing indicator
- Revenue codes
- Source codes:
  - XA: Condition Stable
  - XB: Not Homebound
  - XC: Maintenance Care
  - XD: No Skilled Service

Note: When a member is dually eligible (Medicare and Medicaid) and one of the above source codes does not apply, Medicare must be billed as primary.

In the patient's medical records, it should state why the Member does not meet the requirements for Medicare payment (Medicare is not applicable) as the Member is homebound.

15.2.3.2 Commercial Insurance and Medicaid

When billing with commercial insurance (TPL) through the EVV system or directly to the BMS system.

- Use appropriate revenue codes, condition codes, diagnosis codes, and attending physician
- Do not bill with procedure codes
- Do not span bill; each date of service must be billed on a separate line
- Bill using appropriate units
- Prior authorization number must be placed on the claim
- Plans of Care/Medicare 485 Form, Physician Orders, documentation of face-to-face visit, and documentation of non-homebound status for Medicare/Medicaid dual Members stating the

Member would not be eligible for services under the Medicare Home Health (see Section Quick Reference Quick Reference).

- Commercial insurance (TPL) Partially or Fully Paid

  When the commercial insurance (TPL) has paid (partially or fully) on the claim, providers are to submit the claim directly to the BMS system. Providers can submit claims via direct data entry (DDE) in the Provider Portal, upload batch claim files, or submit HIPAA electronic claim transactions.

  - Providers are to enter TPL information at the header and include the appropriate CARCs and dollar amounts on the claim line(s).

    > The EOB must be the original EOB from the commercial insurance (TPL) and not from the providers electronic health record (EHR) system.

  - If the EOB is not received within 30 days, the claim will be denied and the provider will need to submit a new claim.

- Commercial insurance (TPL) Denied Payment

  When the commercial insurance has denied payment for any reason, the provider must submit the claim in the EVV system.

  - For example,
    - Primary commercial insurance denied the claim due to the member's plan maximum benefit being reached
    - The member's plan has a limited benefit

  The EVV system will create and send the claim to the BMS system. The claim will post Medicaid edit 7141 – TPL on-file not on the claim. Home health claims posting this edit will be held in the "in process" status for 30 days. Home health providers have 30 days to attach the commercial insurance (TPL) EOB, which should indicate the reason services were denied by the commercial insurance (TPL). Once this EOB is attached to the claim, the claim will be reviewed and processed accordingly.

  > The EOB must be the original EOB from the commercial insurance (TPL) and not from the providers electronic health record (EHR) system.

  If the EOB is not received within 30 days, the claim will be denied and the provider will need to submit a new claim.

15.2.3.3 Completing An Adjustment

- If a provider initiated a claim in the CareBridge system, any adjustments must be made in the CareBridge system.
- If a provider initiated a claim in the BMS system due to their being a primary insurance to Medicaid, the adjustment must be completed in the BMS system.

15.2.3.4 Prior Authorization

- Prior authorizations requests must be submitted within ten business days of the start of services
- Requests submitted without a signed and dated 485 or physician's detailed order will not be processed
- Requests must be submitted under the home health revenue codes above, not using HCPCS or CPT codes
- Requests for PRN visits must be submitted after the visit has occurred, but within five (5) business days, as a separate episode, and with documentation of the medical necessity of the PRN visit including the clinical notes from that visit
- For facility discharges, be sure to upload the discharge summary from the facility and any applicable therapies (PT, OT, ST)
- For wound care related requests, be sure to include current detailed wound specific information including frequency of care, drainage, wound measurements
- For IV medication related requests, include current medication orders with frequency and duration, and how often administration is to be completed
- For Pediatric G-Tube Care: Members age 20 and younger, when medically necessary, one (1) SN visit per month for review of the placement and patency of the G-Tube will be approved. Other PRN visits will be reviewed according to the PRN visit requirements.
- Technical denials will be issued by Telligen for the following:
    - No signed/dated 485 or physician's orders
    - Failure of the Provider to respond to requests for additional information
    - Incorrectly submitted codes (such as using HCPCS or CPT codes instead of Revenue Codes)

Prior Authorization requests can be denied for two basic reasons: Administrative reasons such as incomplete or missing forms and documentation, and so on; or the Member does not meet the established criteria for coverage of the item.

Following a denial for administrative reasons, the Provider may send additional information in order to request that the decision be reconsidered. If the information is received within thirty (30) days of the denial, with a clearly articulated request for reconsideration, it will be handled as such. If the information is received more than thirty days after the denial, it will be a new Prior Authorization

request. As such, a new Prior Authorization form must be submitted, and all information to be considered must accompany it.

15.2.3.5 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Telligen, including any additional clinical information that supports the request for services.
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Utilization Management Coordinator and Contract Manager, Amy Buxton (Amy.Buxton@wyo.gov).
    - The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from Telligen's system. The appeal will be reviewed in conjunction with the documentation uploaded into Telligen's system.

Chapter 16 – Hospice

16.1 Hospice

Appropriate Bill Type(s): **81X-82X**

Pay-to Provider's Taxonomy: **251G00000X**

Hospice care is provided by a public agency or a private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A participating hospice Provider must meet the Medicare conditions of participation for hospices to be enrolled. Hospice care is an interdisciplinary approach to caring for the psychological, social, spiritual, and physical needs of dying Members. This service is a special way of caring for a Member whose disease cannot be cured. It is primarily a program of care delivered in a person's home that provides reasonable and necessary medical and support services for the management of a terminal illness.

16.1.1 Electing Hospice Services

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 Member lock-in (see Section 4.4 Member Lock-In).

Providers must complete and submit the Wyoming Department of Health Hospice Benefit Election Form (*see Section 16.1.1.1* Hospice Benefit Election Form) as this is the only form that will be accepted.

The Hospice Benefit Election Form and physician certification of terminal illness ***must be mailed or emailed*** to Provider Services (*see Section 2.1* Quick Reference) ***and faxed or emailed*** to the Long Term Care Unit (*see Section 2.1* Quick Reference).

- Hospice services must be requested as soon as the individual is considered to be terminal. The form must be submitted timely to alleviate individuals not being approved for services and claims being denied. Providers not completing the process timely will not be approved for claim submission past timely filing.
- If an individual is approved for Medicaid after they started receiving Hospice Services, the Medicaid Hospice Benefit Election Form (*see Section 16.1.1.1* Hospice Benefit Election Form) must be submitted with the physician certification of terminal illness as soon as the individual is determined eligible. The Medicare Hospice Election form must be attached. The date of the Medicaid Hospice Benefit Election Form must be the date of the Medicare Election form. *This form must be submitted to the Medicaid LTC Worker* ***and*** *Acentra Health. Information is below.*
- When the Member elects hospice services and is residing in a nursing facility, the hospice Provider must complete and submit the Hospice NH Room & Board Request Form (*see Section 16.1.1.2* Hospice NH Room & Board Request Form) to be assigned a rate for revenue

code 0658. As of 10/18/2021, Prior authorization is not required. *This form must be submitted to the Medicaid LTC Worker **and** Acentra Health. Information is below.*

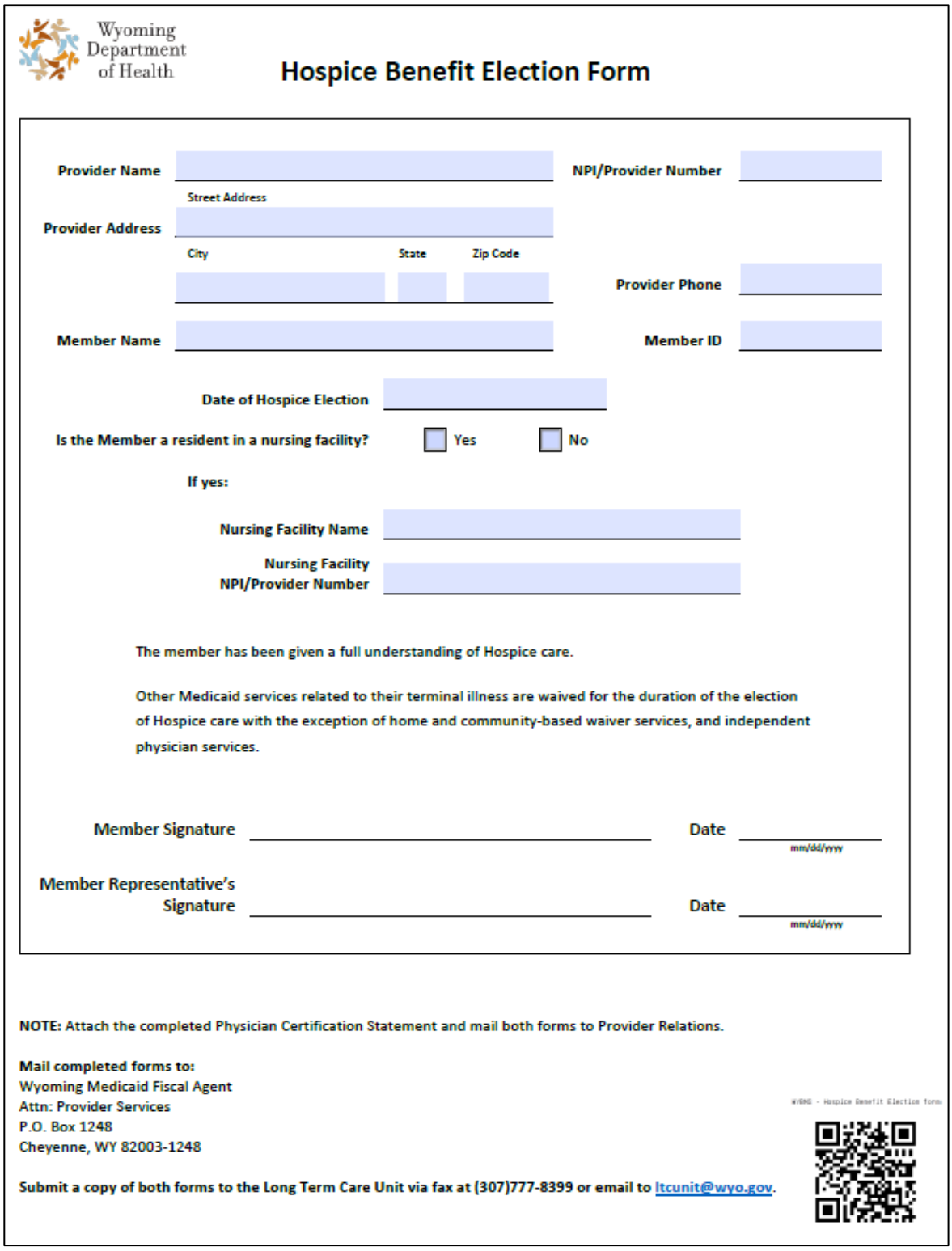
The Medicaid Hospice Benefit form, physician certification of terminal illness, and if appropriate, the Hospice NH Room and Board Request form must be submitted to the Long Term Care Eligibility Unit at ltcunit@wyo.gov ***and*** sent to Acentra Health at Wyprovideroutreach@cns-inc.com or the following address:

Wyoming Medical Fiscal Agent
Attn: Provider Services
P.O. Box 1248
Cheyenne, WY 82003-1248

If forms are not submitted, claims can be denied.

Submitting the Hospice Benefit Election Form does not guarantee the Member is eligible for hospice benefits. The Long Term Care Unit needs to be provided the Hospice Election form before they can make a final eligibility determination.

16.1.1.1 Hospice Benefit Election Form



Wyoming Department of Health

Hospice Benefit Election Form

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

Provider Address Street Address _____

City _____ State _____ Zip Code _____

Provider Phone _____

Member Name _____ **Member ID** _____

Date of Hospice Election _____

Is the Member a resident in a nursing facility? ☐ Yes ☐ No

If yes:

Nursing Facility Name _____

Nursing Facility NPI/Provider Number _____

The member has been given a full understanding of Hospice care.

Other Medicaid services related to their terminal illness are waived for the duration of the election of Hospice care with the exception of home and community-based waiver services, and independent physician services.

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

Member Representative's Signature _____ **Date** _____ mm/dd/yyyy

NOTE: Attach the completed Physician Certification Statement and mail both forms to Provider Relations.

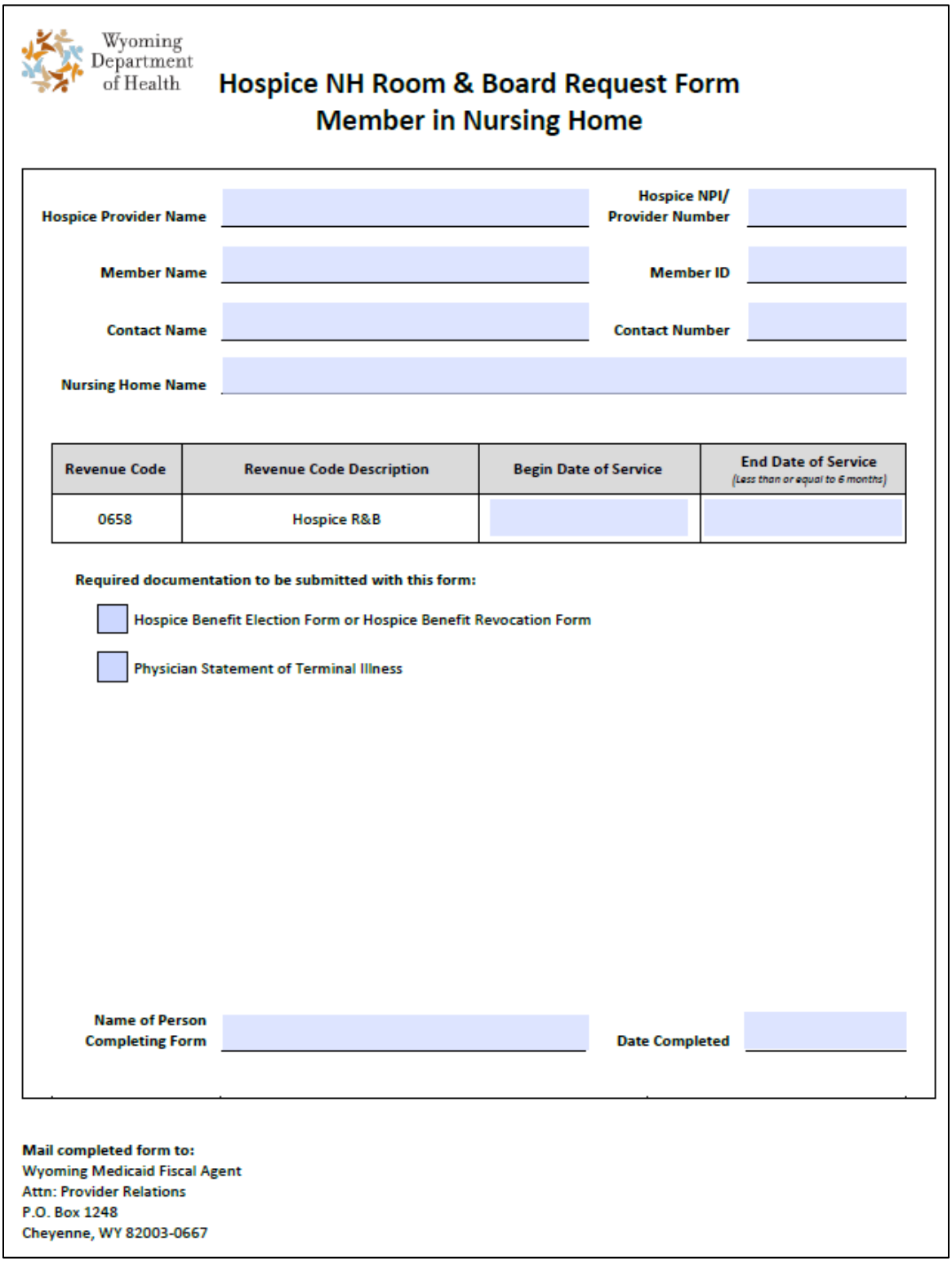
Mail completed forms to:
Wyoming Medicaid Fiscal Agent
Attn: Provider Services
P.O. Box 1248
Cheyenne, WY 82003-1248

Submit a copy of both forms to the Long Term Care Unit via fax at (307)777-8399 or email to ltcunit@wyo.gov.

WYBMS - Hospice Benefit Election form

This form is located on the Medicaid website.

16.1.1.2 Hospice NH Room & Board Request Form



Wyoming Department of Health

Hospice NH Room & Board Request Form
Member in Nursing Home

Hospice Provider Name		**Hospice NPI/ Provider Number**	
Member Name		**Member ID**	
Contact Name		**Contact Number**	
Nursing Home Name			

Revenue Code	Revenue Code Description	Begin Date of Service	End Date of Service *(Less than or equal to 6 months)*
0658	Hospice R&B		

Required documentation to be submitted with this form:

☐ Hospice Benefit Election Form or Hospice Benefit Revocation Form

☐ Physician Statement of Terminal Illness

Name of Person Completing Form		**Date Completed**	

Mail completed form to:
Wyoming Medicaid Fiscal Agent
Attn: Provider Relations
P.O. Box 1248
Cheyenne, WY 82003-0667

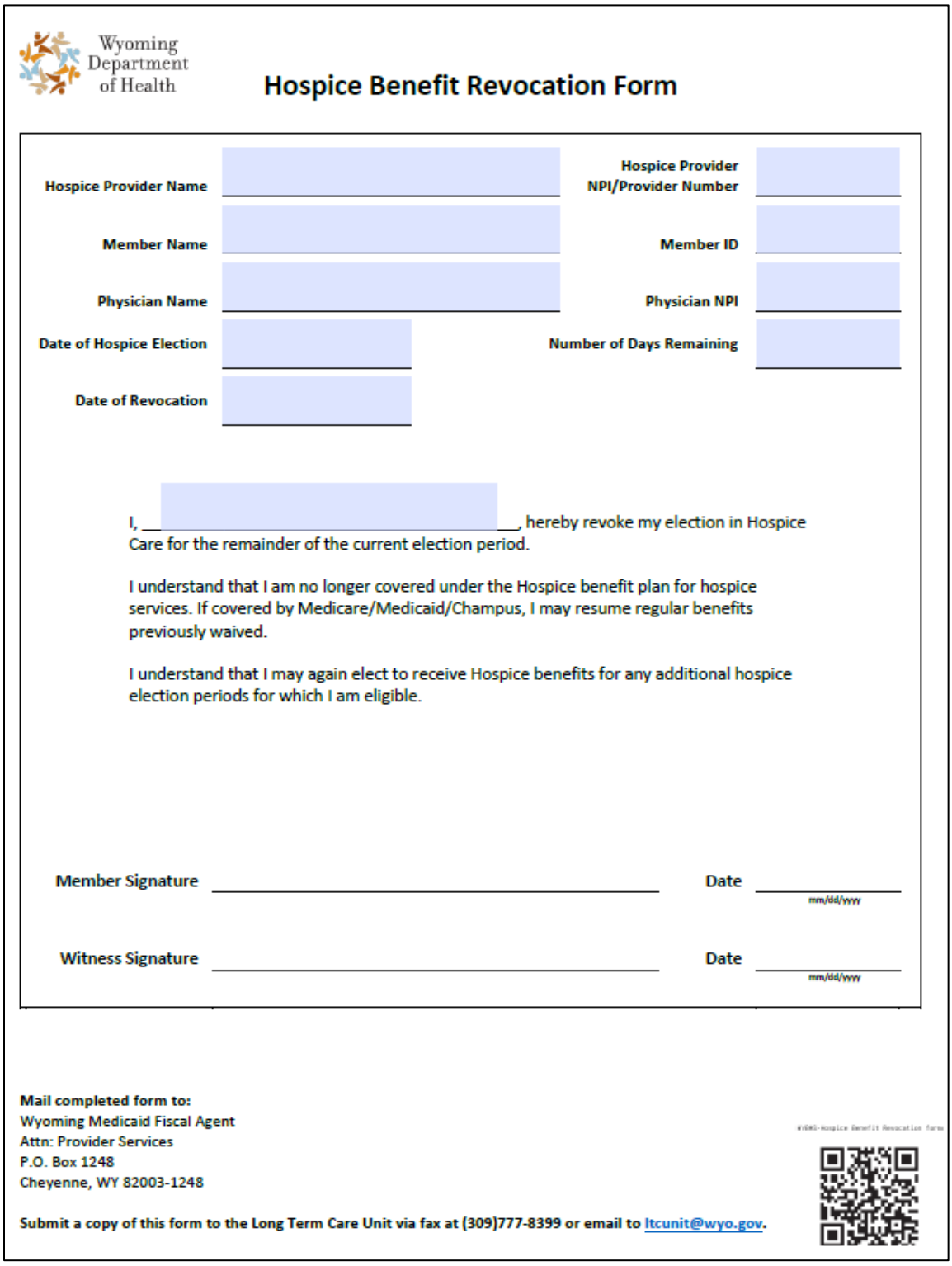
This form is located on the Medicaid website.

16.1.2 Hospice Benefit Revocation

When a Member chooses to revoke their hospice election, a copy of the Hospice Benefit Revocation Form (*see Section 16.1.2.1* Hospice Benefit Revocation Form) must be submitted to Wyoming Medicaid Provider Services and the Long Term Care Unit (*see Section 2.1* Quick Reference). The hospice lock-in will be removed from the Member's file and they will be able to receive services as applicable.

> Only the WDH Hospice Revocation Form will be accepted by Medicaid.

16.1.2.1 Hospice Benefit Revocation Form



Wyoming Department of Health

Hospice Benefit Revocation Form

Hospice Provider Name		**Hospice Provider NPI/Provider Number**	
Member Name		**Member ID**	
Physician Name		**Physician NPI**	
Date of Hospice Election		**Number of Days Remaining**	
Date of Revocation			

I, _____, hereby revoke my election in Hospice Care for the remainder of the current election period.

I understand that I am no longer covered under the Hospice benefit plan for hospice services. If covered by Medicare/Medicaid/Champus, I may resume regular benefits previously waived.

I understand that I may again elect to receive Hospice benefits for any additional hospice election periods for which I am eligible.

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

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

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

Submit a copy of this form to the Long Term Care Unit via fax at (309)777-8399 or email to ltcunit@wyo.gov.

WDH-Hospice Benefit Revocation Form

This form is located on the Medicaid website.

16.1.3 Covered Services

Hospice care program services will be available to Medicaid eligible Members of any age and may be provided in a home setting, nursing facility, or freestanding hospice facility when the Member meets the following criteria:

- A Member is certified by a physician as being terminally ill – meaning that a physician has certified that if the illness runs its normal course, the Member's life expectancy is six (6) months or less.
- The Member or designee has completed a Hospice Benefit Election Form (*see Section 16.1.1.1* Hospice Benefit Election Form), which must be submitted to Medicaid along with the physician certification of terminal illness.
- An individual must be determined financially eligible through the Department of Health Long Term Care Unit before receiving hospice services.

The hospice Provider is responsible for medical care and services related to the terminal illness which are provided to the Member who has elected palliative care. The hospice Provider can bill for:

Revenue Code	Procedure Code	Description
0651	N/A	Routine home care (day 1 through day 60)
0651	G0493	61 days and beyond – skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition
0651	G0494	61 days and beyond – skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition
0651	G0162	Service Intensity Add-On (SIA) services for the last 7 days of a Member's life when provided by a Registered Nurse or Social Worker in the last seven (7) days of the Member's life. • 16 max daily units (4 hours/day, 15 minutes = 1 unit)
0652	N/A	Continuous home care
0655	N/A	Inpatient respite care
0656	N/A	General inpatient care
0658	N/A	Nursing facility room and board
0659	N/A	Inpatient hospice room and board

Services provided in an inpatient setting must conform to the written plan of care. General inpatient hospital care may be required for procedures necessary for pain control and acute or chronic symptom management.

Hospice Member lifetime 60-day limit:

- A Member's hospice days will be calculated over a lifetime, meaning they will never reset.
- Once a Member exceeds 60 days the Provider must bill with the procedure code.
- It is the Provider's responsibility to track the number of days for each Member.
- Error Code 7063: Hospice Limit: Member exceeded 60 days or received 60 or less of routine home care & procedure code G0493 or G0494 was not billed or was billed with rev code 0651.

SIA services:

For claims to process to payment,

- Medicaid must have the Member's date of death on file and the dates of service are within the prior seven (7) days. Claims will be held as "in process" for 30 days pending the date of death and will deny after 30 days if no date of death is received.
- The SIA service is only billable in conjunction with routine home care (revenue code 0651).

> Hospice Members under the age of 21 (Pediatric Hospice Election) are allowed concurrent care and reimbursement of medical care through the usual and customary billing procedures. All other Provider and facility claims will be processed without the requirement of the Hospice Exemption Form (services unrelated to the Member's terminal illness.

Level of Care	Bill Type	Revenue Code
Routine Home Care	82X	0651
The hospice Provider is to bill the routine home care rate for each day the Member is under their care and another level of care is not reimbursed. The rate is a per diem rate. See billing information below table.		
Continuous Home Care	82X	0652
Continuous home care is to be provided by the hospice only during a period of crisis. Bill the continuous home care rate when continuous home care is provided. Reimbursement is for every hour or part of an hour of care furnished up to a maximum of 24 hours a day. A minimum of at least eight (8) hours a day must be provided. One (1) unit equals one (1) hour of service. The rate is an hourly rate.		
Inpatient Respite Care	81X	0655
Respite care is reimbursed to an approved inpatient facility for a maximum of five (5) consecutive days at a time including the date of admission but not counting the date of discharge. The rate is a per diem rate.		

Level of Care	Bill Type	Revenue Code
General Inpatient Care	81X	0656
The hospice is to bill the general inpatient rate when general inpatient care is provided. If the Member is discharged from general inpatient care as deceased, the general inpatient rate is billed for that day. If they are discharged to home, the appropriate home care rate is billed on a separate claim form. The rate is a per diem rate.		
Nursing Facility Hospice Room and Board	81X	0658
The hospice Provider is to bill the nursing facility room and board component when the individual is a nursing facility resident. The hospice Provider is responsible for paying the nursing facility. Use the Provider number assigned to the hospice Provider for nursing facility resident's room and board. Revenue codes 0652, 0656, and 0659 cannot be billed with revenue code 0658. The rate is a per diem rate. **NOTE:** For this rate to be assigned, the hospice Provider needs to complete and submit the Hospice NH Room & Board Request Form (*see Section 16.1.1.2* Hospice NH Room & Board Request Form) when the Member elects hospice services (*see Section 16.1.1* Electing Hospice Services).		
Inpatient Hospice Room and Board	81X	0659
The hospice Provider is to bill the inpatient hospice room and board rate for each day a Member is in the hospice facility receiving care or in the inpatient hospice facility receiving respite care. Revenue codes 0652, 0656, and 0658 cannot be billed with revenue code 0659. The rate is a per diem rate. There is no Member copay.		

16.1.3.1 Billing Examples

Routine Home Care Payments

Revenue code: **0651**

Procedure code: **G0493, G0494, G0162**

- **Billing Example 1:**
  - Coverage from and to date span (header): 11/01/2022 – 11/30/2022
  - Member reaches 61 days on 11/16/2022

61 days and beyond G0493 (RN) or G0494 (LPN)

  - Submit one (1) claim with two (2) lines and appropriate service dates on each line
    - Dates of service on the lines **must be different** and accurate
  - Submitted charges need to be the Providers usual and customary charges

Line	Revenue Code	Procedure Code	Dates of Service	Units	Submitted Charges (Usual and Customary)	Approved Amount
Line 1	0651	Do not enter a procedure code	11/01/2022 – 11/15/2022	15	$3,200.00	$2,828.10
Line 2	0651	G0493	11/16/2022 – 11/30/2022	15	$1,700.00	$2,235.15

- **Billing Example 2:**
  - Coverage from and to date span (header): 11/1/2022 – 11/25/2022
  - Member reaches 61 days on 11/16/2022
    - 61 days and beyond G0493 (RN) or G0494 (LPN)
  - Date of death on file for Member is 11/25/2022
    - Patient Status: Expired
  - Service Intensity Add-On (SIA) services for the last seven (7) days of a Member's life: G0162
  - For this example, the Provider used the max units each day – seven (7) days x 16 units = 112 total units
  - Submit one (1) claim with three (3) lines and appropriate service dates on each line
    - Dates of service on the lines **must be different** and accurate
    - Submitted charges need to be the Providers usual and customary charges

Line	Revenue Code	Procedure Code	Dates of Service	Units	Submitted Charges (Usual and Customary)	Approved Amount
Line 1	0651	Do not enter a procedure code	11/01/2022 - 11/15/2022	15	$3,200.00	$2,828.10
Line 2	0651	G0494	11/16/2022 - 11/25/2022	10	$1,135.00	$1,490.10
Line 3	0651	G0162	11/19/2022 - 11/25/2022	112	$2,176.96	$1,576.96

- **Billing Example 3:**
  - Coverage from and to date span (header): 11/1/2022 – 11/25/2022

Date of death on file for Member is 11/25/2022

- Patient Status: Expired

Service Intensity Add-On (SIA) services for the last seven (7) days of a Member's life: G0162

- For this example, the Provider provided three (3) hours of SIA each day - seven (7) days x 12 units = 84 total units

- Submit one (1) claim with two (2) lines and appropriate service dates on each line
  - Dates of service on the lines must be different and accurate
  - Submitted charges need to be the Providers usual and customary charges

Line	Revenue Code	Procedure Code	Dates of Service	Units	Submitted Charges (Usual and Customary)	Approved Amount
Line 1	0651	Do not enter a procedure code	11/01/2022 – 11/25/2022	25	$5,333.33	$4,713.50
Line 2	0651	G0162	11/19/2022 – 11/25/2022	84	$1,632.72	$1,182.72

16.1.4 Nursing Facility Resident

For Members residing in the nursing facility, the hospice Provider is responsible for billing the room and board charges, and reimbursing the nursing facility for their portion of the care. The hospice Provider must request a rate for nursing home care by completing the Hospice NH Room & Board Form (*see Section 16.1.1.2* Hospice NH Room & Board Request Form). This form should be submitted with the Hospice Election Form and the physician statement of terminal illness (*see Section 16.1.1* Electing Hospice Services).

The hospice Provider is responsible for the professional management of the individual's hospice care, and the nursing facility will provide room and board.

Patient contribution is allocated across claims at 100% in the order the claims are received and processed. For example, if a Member is a resident of a nursing facility and is receiving nursing facility hospice services in the same month, the patient contribution would be taken from total amount paid from the first Provider (nursing facility or hospice Provider) to bill and be paid until the patient contribution is satisfied. If payment to the first Provider does not exhaust the Member's patient contribution, the remaining patient contribution will be applied to the next Provider's paid claim. This may mean that the Provider who billed for the Member for the second half of the month will be collecting the patient contribution and the Provider billing for the first half of the month will receive a

zero patient contribution assignment. For subsequent months, the full patient contribution will be applied to the hospice claim.

In both cases the Providers need to determine the order in which claims should be billed, and how the patient contribution will be transferred between Providers. Wyoming Medicaid cannot advise Providers how to handle this business-related transaction.

Nursing homes will receive pro-rated patient contribution letters; however, these are not for billing purposes. The facilities will use these letters to determine how the patient liability funds will be distributed between facilities.

If a claims adjustment is submitted with a pro-rated patient contribution letter, the adjustment will be returned.

The nursing home will not be able to submit any claims for a Member who has elected hospice care. (*see Section 18.3* Members Under Hospice Care).

16.1.5 Reimbursement

For Medicaid to reimburse a hospice Provider, the following need to be completed as applicable:

- A physician certification statement of terminal illness certifying the Member's medical prognosis is a life expectancy of six (6) months or less if the terminal illness runs its normal course sent to Provider Services.
    - A copy must also be sent via fax or email to the Long Term Care Unit (*see Section 2.1* Quick Reference).
- A Wyoming Medicaid Hospice Benefit Election Form (*see Section 16.1.1.1* Hospice Benefit Election Form) has been completed. Only the WDH Medicaid Hospice Benefit Election Form will be accepted.
    - Members who are eligible for both Medicare and Medicaid (dual eligible) must elect hospice under both programs.
    - A copy must also be sent via fax or email to Long Term Care Unit (*see Section 2.1* Quick Reference).
- The hospice Provider must request a rate for nursing home care when the Member is residing in the nursing home by submitting a Hospice NH Room & Board Request Form (16.1.1.2 Hospice NH Room & Board Request Form) to Provider Services.
- Providers billing revenue code 0659 will need to provide a certification as a licensed inpatient hospice facility.

Reimbursement rates are determined specific to each hospice for each of the allowed revenue codes and will be re-determined on an annual basis. These rates are all inclusive and cover the services and supplies used in the care of the Member, including:

- Drugs and biological

- Home health aide or homemaker services
- Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control
- Durable medical equipment and supplies assisting in the use of durable medical equipment

16.1.6 Services Unrelated to the Terminal Illness

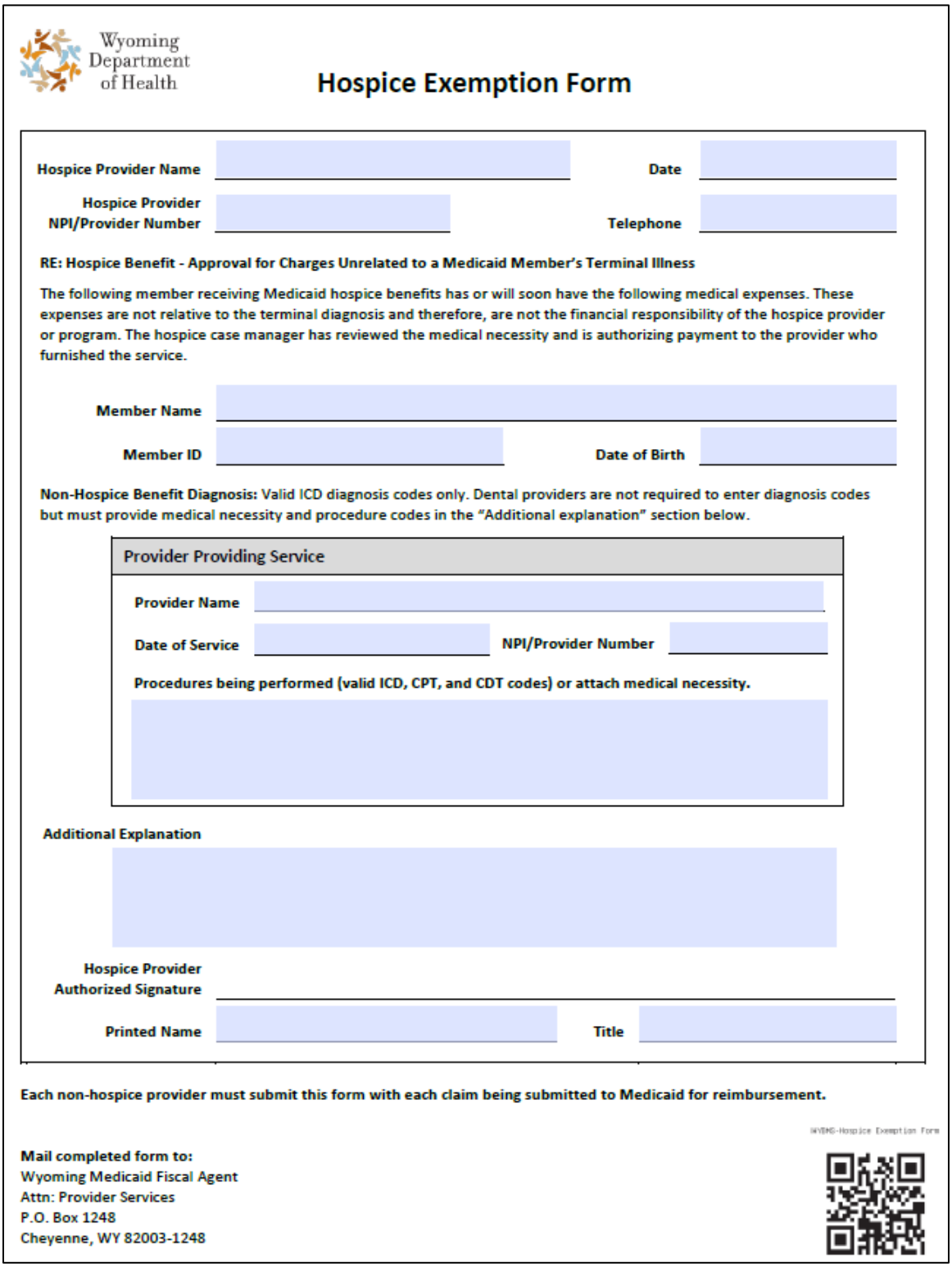
For services unrelated to the Member's terminal illness, the hospice Provider must provide the Hospice Exemption Form to the billing Provider in order for the Provider to be reimbursed. The service must be unrelated to the Member's terminal illness to qualify.

This form must be submitted with the claim or sent as an attachment (paper or electronic) if the claim is billed electronically. **Waiver Service Providers will not need the exemption form.**

Dental treatment/services are limited to palliative treatment and emergency services.

> Providers may either attach the Hospice Benefit Election Form electronically to the claim or complete the Attachment Cover Sheet and mail or email the form (*see Section 6.15* Submitting Attachments for Electronic Claims) to Provider Services (*see Section 2.1* Quick Reference).

16.1.6.1 Hospice Exemption Form



Wyoming Department of Health

Hospice Exemption Form

Hospice Provider Name _____ **Date** _____

Hospice Provider NPI/Provider Number _____ **Telephone** _____

RE: Hospice Benefit - Approval for Charges Unrelated to a Medicaid Member's Terminal Illness

The following member receiving Medicaid hospice benefits has or will soon have the following medical expenses. These expenses are not relative to the terminal diagnosis and therefore, are not the financial responsibility of the hospice provider or program. The hospice case manager has reviewed the medical necessity and is authorizing payment to the provider who furnished the service.

Member Name _____

Member ID _____ **Date of Birth** _____

Non-Hospice Benefit Diagnosis: Valid ICD diagnosis codes only. Dental providers are not required to enter diagnosis codes but must provide medical necessity and procedure codes in the "Additional explanation" section below.

Provider Providing Service

Provider Name _____

Date of Service _____ **NPI/Provider Number** _____

Procedures being performed (valid ICD, CPT, and CDT codes) or attach medical necessity.

Additional Explanation

Hospice Provider Authorized Signature _____

Printed Name _____ **Title** _____

Each non-hospice provider must submit this form with each claim being submitted to Medicaid for reimbursement.

WYDMS-Hospice Exemption Form

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 Medicaid website.

Chapter 17 – Indian Health Services

17.1 Indian Health Services – Including 638 Tribal Facilities

This information is intended to assist Providers in billing on the institutional (UB) claim form for covered services. Billing requirements should be applied and utilized when submitting a claim. All services must be provided within the four (4) walls of the facility, mobile clinic or an area leased or designated in a facility unless designated as a Tribal FQHC.

Appropriate Bill Type(s): **13X, 77X**

Pay-to Provider Taxonomy: **261QP0904X**

Indian Health Services (IHS), an agency of the US Public Health Services within the Department of Health and Human Services, is the principal Federal health care Provider for American Indian or Alaska Natives.

A Tribal 638 Facility is a facility or location owned and operated by a federally recognized American Indian Tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic, and rehabilitation services to tribal Members.

Paramount to the goals of IHS is raising the American Indian or Alaska Natives' health status to the highest possible level.

Indian Health Services provides comprehensive health care services, outpatient services including but not limited to medical, vision, dental, preventative services, and so on.

17.1.1 Reimbursement

Indian Health Services are reimbursed through an encounter method. The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. 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.

An encounter is a face-to-face visit with an enrolled health care professional such as:

- Physician
- Physician’s assistant
- Nurse practitioner
- Nurse midwife
- Psychologist
- Social worker
- Dental professional (ADA Dental Claim Form, see Chapter 28 – Covered Services - Dental Services of the Tribal Manual located on the Medicaid website)
- Physical, Occupational, or Speech therapist
- Dietitian

- Chiropractor
- Mental Health Professional
- Home Health service Provider

17.1.1.1 Encounter Rate

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes, but is not limited to:

- Therapeutic services
- Diagnostic services
- Tests
- Supplies

Payment for multiple encounters on the same date of service will be allowed only if the services are categorically different or are provided for distinct and separate diagnoses. Different categories of allowable services shall include but are not limited to practitioner services, mental/behavioral health, optometric services, physical therapy, occupational therapy, speech therapy, medical social worker, laboratory, radiology, VFC Administration and Health Check Screening.

17.1.2 Billing Requirements

To receive the all-inclusive encounter rate, services must be provided within the “four 4 walls” of the clinic. Services billed at the encounter rate include:

Revenue Code	Description – within the IHS/638 Facility
0300	Laboratory
0400	Imaging/Radiology
0421	Physical Therapy
0431	Occupational Therapy
0441	Speech Therapy
0500	Medical Encounter
0519	Optometric Encounter
0529	Audiology, Chiropractic, Public Health Services - Home Visits Encounter
0561	Medical Social Worker

Revenue Code	Description – within the IHS/638 Facility
0571	Home Health Aide
0771	VFC Administration
0779	Health Check Screening
0821	ESRD Encounter
0914	Psychiatric/Psychological Services – Individual Therapy
0915	Psychiatric/Psychological Services – Group Therapy
0942	Diabetes Education or Dietician
0987	Hospital Encounter (IHS physician at the hospital)

All claims for the services above must:

- Have a minimum of two (2) line items, the 1st would be the encounter line and the 2nd, 3rd, 4th, and so on line items are the detail.
- Both lines must have a revenue and procedure code combination.
- **Encounter lines** will be billed with one of the above encounter revenue codes paired with:
  - Procedure code T1015 for general encounter.
  - Bill the encounter line at the encounter rate
- **Detail line items** will be billed with:
  - An appropriate outpatient revenue code (excluding the encounter revenue codes) paired with an appropriate procedure code (for questions regarding appropriate pairing of revenue codes and procedure codes, use the current version of the NUBC Official UB Data Specifications Manual).
  - Document each procedure that occurred during the visit.
  - Include a detailed line item for each office visit or health check procedure code if appropriate.
  - Bill the detail line items at $0.00

> Multiple encounters on the same day must be billed on separate claims. For multiple encounters to pay the diagnosis or treatment of the Member must be different that the 1st encounter.

17.1.2.1 Billing Examples

Example 1: Member comes to the IHS/Tribal facility for complaint of cough and sees a physician. No additional tests or treatments are administered.

- **Claim #1**

Revenue Code	Procedure Code	Amount
0500 (Medical Encounter)	T1015 (Encounter Procedure Code)	$391.00
0517	99213	$0.00

Example 2: Member comes to the clinic for a medical appointment and a urine culture is run. The Member then goes to the optometrist for an eye check.

- **Claim #1**

Revenue Code	Procedure Code	Amount
0500 (Medical Encounter)	T1015 (Encounter Procedure Code)	$391.00
0517	99213	$0.00
0520	87086	$0.00

- **Claim #2 (same date of service as Claim #1)**

Revenue Code	Procedure Code	Amount
0519 (Optometric Encounter)	T1015 (Encounter Procedure Code)	$391.00
0517	92012	$0.00

Example 3: Member goes to Substance Abuse and Recovery Center and goes to individual therapy. The Member then works with a Peer Specialist on goals related to the treatment plan.

- **Claim #1**

Revenue Code	Procedure Code	Amount
0914 (Psychiatric Encounter)	T1015 (Encounter Procedure Code)	$391.00
0517	H0047 (individual therapy)	$0.00

- **Claim #2 (same date of service as Claim #1)**

Revenue Code	Procedure Code	Amount
0500 (Medical Encounter)	T1015 (Encounter Procedure Code)	$391.00
0942	H2015 (peer specialist)	$0.00

Example 4: A Member younger than 21, comes in and attends multiple appointments while they are there. They see a physician for leg pain, the physical therapist for therapy and a counselor for individual therapy.

- **Claim #1 - Physician Encounter**

Revenue Code	Procedure Code	Amount
0500 (Medical Encounter)	T1015 (Encounter Procedure Code)	$391.00
0517	99213	$0.00

- **Claim #2 - Physical Therapy Encounter (same date of service as Claim #1)**

Revenue Code	Procedure Code	Amount
0421 (Physical Therapy Encounter)	T1015 (Encounter Procedure Code)	$391.00
0429	97110	$0.00

- **Claim #3 - Behavioral Health Encounter (same date of service as Claim #1 and #2)**

Revenue Code	Procedure Code	Amount
0914 (Psychiatric Encounter)	T1015 (Encounter Procedure Code)	$391.00
0919	90832	$0.00

These are only examples and the appropriate encounter and non-encounter codes and procedure codes should be used.

17.1.2.2 Non-Emergency Medical Transportation

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

Wyoming Medicaid enrolls taxi Providers (344600000X), non-taxi ride Providers (347C00000X), and lodging Providers (177F00000X) to provide covered services.

For the IHS policy on travel services, see Chapter 24 – Covered Services – Non-Emergency Medical Transportation of the Tribal Manual located on the Medicaid website.

> Non-Emergency Medical Transportation Services (NEMT) cannot be billed as an encounter. Claims for transportation must be billed on a CMS-1500 professional claim and adhere to the fee schedule for appropriate codes.

Chapter 18 – Skilled Nursing Facility and Swing Bed Services

18.1 Skilled Nursing Facility and Swing Bed Services

Skilled Nursing Facilities (SNF) provide long term care to Members who are unable to live independently safely, including room and board, dietary needs, laundry services, nursing services, minor medical services, surgical supplies, over the counter medications, and the use of the equipment and facilities.

Swing Bed services are those long-term care services provided in the hospital setting in place of transferring the Member to the skilled nursing facility, and are subject to the same policy as those services provided in the skilled nursing facilities.

18.1.1 Covered Services

For the most current list of covered items review Attachment A in Chapter 7 of the State of Wyoming rules at: https://rules.wyo.gov/.

Services provided in the skilled nursing facility or swing beds are reimbursed based on a per diem payment that is all inclusive of the care for the patient for the day. This care includes but is not limited to the following sections.

- **General** nursing services
  - All general nursing services, including but not limited to:
    - Administration of oxygen and related medication
    - Hand feedings
    - Incontinency care
    - Restorative nursing care
    - Tray service
- **Therapy services**
  - Physical Therapy
  - Speech Therapy
  - Occupational Therapy

> If the facility is unable to provide therapy in the facility or chooses to send the Member to an external therapist, the facility is responsible for the therapy charges as part of the Medicaid per diem.

- **Gross supply and individually distributed items**

  Medical supply and drug items stocked at nursing stations or on the floor in gross supply and distributed individually in small quantities, such as:
  - Alcohol

- Applicators
- Cotton balls
- Band-Aids
- Gloves
- Ostomy supplies
- Tongue depressors

- **Oxygen and Over-the-counter drugs, nutritional supplements and products**
  - Over-the-counter drugs and products as designated by the FDA are covered and are included in the nursing facility's per diem rate and cannot be reimbursed separately.
  - Insulin and diabetic supplies are considered over-the-counter drugs and supplies.
  - Over-the-counter nutritional supplements used for tube feeding or oral feeding, even when prescribed by a physician.
- **Physician ordered medical supplies/equipment**
  - Medical supplies and equipment ordered by a physician for use by a Member residing in a nursing facility are covered and are included in the nursing facility's per diem rate and cannot be reimbursed separately.
- **Reusable Items**

  Items used by individual patients, but which are reusable and expected to be available, such as:
  - Ice bags
  - Bed rails
  - Canes
  - Crutches
  - Walkers
  - Wheelchairs
  - Traction equipment
  - Other durable medical equipment
- **Laundry services**

  Laundry services for routine nursing facility requirements and Members personal clothing.
- **Nursing Facility/Swing Bed Transportation**

  The cost for non-ambulance Member transportation is included in the facilities per diem rate and includes:

- Patient returns home after discharge from facility
- Patient returns to facility after discharge from hospital
- To/from appointments outside the facility
- Non-emergent transport to the hospital

For ambulance services, refer to the Ambulance Services section in the CMS-1500 Provider Manual posted to the Medicaid website (*see Section 2.1* Quick Reference).

The Provider should make an effort to select the most efficient and cost-effective mode of transportation for resident care which may include utilizing a facility owned vehicle or contracted outside service.

- **Prescription Drugs**

  Prescription drug services are handled through the pharmacy program, and all prescription drugs must be filled at an enrolled pharmacy. Skilled nursing facilities and swing bed units will not be reimbursed for the distribution of pharmacy drugs or products to Members, outside of the per diem. Please contact Change Healthcare for any pharmacy related questions (*see Section 2.1* Quick Reference).

- **Room and Board**
  - Semi-Private Room

    Medicaid reimburses for room and board for a semi-private room which is included in the per diem.

    If a Member wishes to stay in a private room within the nursing facility, the facility and Member/ have the following options:

    - The facility can choose to bill Medicaid as normal, and accept the semi-private room reimbursement amount as payment in full for the private room, **OR**
    - The Member or responsible party for the nursing home Member can choose to pay for the private room in full, not the difference between the semi-private room and private room rates.

    Important! The nursing home may not “balance bill” the Member for the cost difference between the semi-private and the private room and then submit a claim to Medicaid for the semi-private room.

18.1.1.1 Covered Services Included in the Per Diem Rate

- ABD Pads
- Adhesive tape
- Aerosol, other types
- Air Mattresses, Air P.R. Mattresses
- Airway-Oral
- Alcohol Plaster

- Alcohol Sponges
- Alternating Pressure Pads
- Applicators, Cotton-tipped
- Applicators, Swab-eez
- Aquamatic K Pads (Water-Heated Pad)
- Arm Slings
- Asepto Syringes
- Baby Powder
- Bandages
- Bandages-Elastic or Cohesive
- Band-Aids
- Basins
- Bed Frame Equipment (for certain immobilized bed patients)
- Bed Rails
- Bedpans, All Types
- Beds; Manual, Electric, Clinitron
- Bedside tissues
- Bibs
- Blood Infusion Sets
- Bottle, Specimen
- Canes, All Types
- Cannula-Nasal
- Catheter-Indwelling
- Catheter Plugs
- Catheter Trays
- Catheter (any size)
- Colostomy Bags
- Combs
- Commodes, All Types
- Composite Pads
- Cotton Balls
- Crutches, All Types
- Decubitus Ulcer Pads/Dressings
- Denture Cleaner/Soak
- Denture Cups
- Deodorants
- Diapers
- Disposable Underpads
- Donuts
- Douche Bags
- Drain Tubing
- Drainage Bags
- Drainage Sets
- Drainage Tubes
- Dressing Tray
- Dressing, All Types
- Enema Soap
- Enema Supplies
- Enema Unit
- Equipment and Supplies for Diabetic blood and urine testing

Eye Pads

- Fingernail Clipping and Cleaning
- Flotation Pads and/or Turning Frames
- Gastric Feeding Unit, Including Bags
- Gloves, Unsterile and Sterile
- Green Soap
- Hair Care, Basic
- Heat Cradle
- Heel Protector
- Hydraulic Patient Lifts
- I.V. Needles

Ice Bags

Incontinency Pads and Pants

Infusion Arm Boards

Inhalation Therapy Supplies

- Irrigations Trays

Lines, Extra

- Massages (by facility personnel)
- Medical Social Services
- Medicine Dropper
- Nasal Catheter, Insertion and Tube
- Nasal Tube Feeding and feeding bags
- Needles – Hypodermic, Scalp Vein
- Non-Legend Nutritional Products
- Nursing Supplies and Dressing

Feeding Tubes

- Flotation Mattress or Biowave mattress
- Foot Cradle, all types
- Gauze Sponges
- Gowns, Hospital
- Hair Brushes
- Hand Feeding
- Heating Pads
- Hot Pack Machine
- Hypothermia Blankets
- I.V. Trays

Incontinency Care

Influenza Vaccine

Infusion pumps, Enteral and Parenteral

Irrigation Bulbs

- Jelly, Lubricating

Lotion, Soap and Oil

- Mattresses, All Types
- Medicine Cups
- Nasal Catheter
- Nasal Gastric Tubes
- Nebulizer and Replacement kit
- Needles (various sizes)
- Nursing Services (all) (see Section)
- Ostomy Supplies; Adhesive, Appliance, Belts, Fact Plates, Flanges, Gaskets, Irrigation sets, Night

Drains, Protective Dressings, Skin Barriers, Tail Closures

- Overhead Trapeze Equipment
- Over-the-Counter Drugs as designated by the FDA (refer to *Section 18.1.1* Covered Services)
- Oxygen Concentrators
- Oxygen Delivery Systems, Portable or Stationary
- Oxygen Mask
- Oxygen, Gaseous and Liquid

Pads

Pitcher

- Plastic Bib
- Prescription Drugs (refer to *Section 18.1.1* Covered Services)
- Pumps (Aspiration and Suction)
- Pumps for Alternating Pressure Pads
- Respiratory Equipment; Ambu Bags, Cannulas, Compressors, Humidifier, IPPS Machines and Circuits, Mouthpieces, Nebulizers, Suction Catheters, Suction Pumps, Tubing, and so on
- Restraints
- Room and Board - Semi-private room (refer to *Section 18.1.1* Covered Services)
- Sand Bags
- Scalpel
- Shampoo
- Shaves
- Shaving Cream
- Shaving Razors
- Sheepskin
- Side Rails
- Soap
- Special Diets
- Specimen Cups
- Sponges
- Steam Vaporizer
- Sterile Pads
- Sterile Saline for Irrigation
- Sterile Water for Irrigation
- Stomach Tubes
- Suction Catheter
- Suction machines
- Suction Tube
- Surgical Dressings (including sterile sponges)
- Surgical Pads
- Surgical Tape
- Suture Removal Kit
- Suture Trays
- Syringes (all sizes)
- Syringes, disposable
- Tape (non-allergic or butterfly)
- Tape-for laboratory tests

- Testing Sets and Refills (S&A)
- Therapy Services (*refer to Section 18.1.1.2* Covered Services Permitted to be Billed Outside the Per Diem Rate)
- Toenail Clipping and Cleaning
- Tongue Depressors
- Toothbrushes
- Toothpaste
- Tracheostomy Sponges
- Transportation (refer to *Section 18.1.1* Covered Services*)*
- Trapeze Bars
- Tray Service
- Underpads
- Urinals, male and female
- Urinary Drainage Tube
- Urinary Tube and Bottle
- Urological Solutions
- Walkers, all types
- Water Circulating Pads
- Water Pitchers
- Wheelchairs: Amputee, Geriatric, Heavy Duty, Hemi, Lightweight, One Arm Drive, Reclining Roll-about, Semi-Reclining, Standard, and so on

The fee schedule on the Medicaid website (*see Section 2.1* Quick Reference) will indicate whether a specific procedure code is allowed outside of the nursing home per diem for a long-term care resident. All charges must be billed by a Provider outside of the nursing facility.

18.1.1.2 Covered Services Permitted to be Billed Outside the Per Diem Rate

Certain items are permitted to be billed outside of the per diem. These items include those that are customized or specialized for a specific Member's use that would not be functional or beneficial to any other Member such as:

- Ambulance services, *when medically necessary*
- Customized wheelchairs and seating systems, *when medically necessary*
- Dental
- Hearing Aids
- Mental Health services
- Medical Services including
    - Laboratory, radiology, surgical procedures

- Orthotics
- Physician and other practitioner services,
    - Excluding Therapy Services: Physical, Occupational and Speech Therapy
- Prosthetics

> The fee schedule on the Medicaid website (*see Section 2.1* Quick Reference) will document whether a specific procedure code is allowed outside of the per diem for a long-term care resident. All charges must be billed by a Provider outside of the nursing facility.

18.2 Patient Contributions

The Long Term Care Unit (*see Section 2.1* Quick Reference) establishes the patient contribution upon admission to the nursing facility.

- Medicaid receives the initial and updated patient contribution amounts, which Providers can view in the Provider Portal when completing a Member eligibility verification (Eligibility Profile).
- The nursing facility will be sent the initial Patient Contribution Notice from the Long Term Care Unit (*see Section 2.1* Quick Reference)
- If the Long Term Care Unit (*see Section 2.1* Quick Reference) changes the patient contribution, they will send an updated Patient Contribution Notice to the facility.
    - The facility then can adjust their previously **paid** Medicaid claim, if applicable (*see Section 6.17.3* Adjusting or Voiding Paid Claims).
    - Prior to submitting an adjustment, verify the Patient Contribution is updated in the Provider Portal.
- The Long Term Care Unit sends Patient Contribution Notices for each Member every calendar year.
    - For example:
        - An initial Patient Contribution Notice starting in July, is effective until the end of December and the facility will be sent a notice valid for the following calendar year, January - December.
        - A notice stating a change in patient contribution for September forward is valid for September – December. The facility will be sent a notice valid for the following calendar year, January - December.
- For questions or updates regarding Patient Contribution amounts contact the Long Term Care Unit (*see Section 2.1* Quick Reference*).*

- If Medicare primary and making payment on a claim and the Member is dually eligible for QMB (Qualified Medicare Beneficiary) and Nursing Home (NH) otherwise known as QMB Plus, a patient contribution cannot be collected by the facility. Providers are prohibited from collecting Medicare cost sharing amounts including patient contribution from a Medicare beneficiary who is QMB Plus. If the Member's countable resources exceed $2,000.00, contact the Wyoming Department of Health's Long Term Care Unit for assistance (*see Section 2.1* Quick Reference)

> Only paid claims can be adjusted (*see Section 6.18* Resubmitting Versus Adjusting Claims)

18.2.1 Multiple Facilities Billing and Patient Contribution

The original nursing home will receive a Patient Contribution Notice for each Member. When a resident transitions from one facility to another these facilities will need to work together to determine how the patient liability (contribution) funds will be distributed between the two facilities.

- Nursing Facility vs. Nursing Facility

  Patient contribution is allocated across claims at 100% in the order the claims are received and processed.

  For example, if a Member is a resident of two (2) facilities in the same month, the patient contribution would be taken from total amount paid from the first facility to bill and be paid until the patient contribution is satisfied. If payment to the first facility does not exhaust the Member's patient contribution, the remaining patient contribution will be applied to the next facilities paid claim. This may mean that the Provider who billed for the Member for the second half of the month will be collecting the patient contribution and the Provider billing for the first half of the month will receive a zero (0) patient contribution assignment.

- Nursing Facility vs. Hospice Services Provided within the Nursing Facility

  Patient contribution is allocated across claims at 100% in the order the claims are received and processed.

  For example, if a Member is a resident of a nursing facility and is receiving nursing facility hospice services in the same month, the patient contribution would be taken from total amount paid from the first Provider (nursing facility or hospice Provider) to bill and be paid until the patient contribution is satisfied. If payment to the first Provider does not exhaust the Member's patient contribution, the remaining patient contribution will be applied to the next Provider's paid claim. This may mean that the Provider who billed for the Member for the second half of the month will be collecting the patient contribution and the Provider billing for the first half of the month will receive a zero (0) patient contribution assignment. For subsequent months, the full patient contribution will be applied to the hospice claim.

In both cases the Providers need to determine the order in which claims should be billed, and how the patient contribution will be transferred between Providers. Wyoming Medicaid cannot advise Providers how to handle this business-related transaction.

If a claims adjustment is submitted with the explanation to pro-rate a patient contribution due to a multiple facility transition the adjustment will be returned.

18.2.2 Long Term Care Insurance Plans

Some Members may have a Long Term Care (LTC) Insurance plan. It is important to ask the Members if they have an LTC Plan upon admission to the nursing facility.

- LTC Insurance will become primary to Medicaid
- The nursing facility will need to verify with the LTC Insurance the following:
    - Determine if the policy has an elimination period
    - What the policy covers
    - If it is time-limited or has a lifetime benefit
    - How to submit claims to the LTC Insurance plan

18.2.2.1 Billing Requirements

- When the Member has LTC Insurance, the nursing facility must bill this insurance prior to billing Medicaid.
- The nursing facility must receive either a denial or payment from the LTC Insurance plan before Medicaid can be billed.
- Once the LTC Insurance plan has been billed and the nursing facility has either received a denial or payment, the nursing facility can then bill Medicaid.
- The LTC Insurance will need to be included on the claim as commercial insurance.
- In some cases, the LTC Insurance plan may pay more than the Medicaid per diem rate, leaving nothing for Medicaid to pay. Patient contribution will be applied to claims when there is an LTC Insurance policy.

18.2.2.2 Long Term Care Plan Billing Example:

Scenario 1: The Member does not have a patient contribution amount:

- Dates of service: 06/01/2023 through 06/30/2023, 30 Units
- Medicaid information:
    - Medicaid per diem rate: $201.50
    - Medicaid reimbursement: 30 units x $201.50 per diem rate = $6,045

- LTC insurance payment: $2,500
- Building the Medicaid as secondary payer claim:
  - Submitted charges (same as on the LTC claim): $6,045
  - Additional Insurance Section at the Header of the claim:
    - LTC Plan Name (HIPAA transaction)
    - Payer ID: 99999 (enter the payer ID if known, or enter 99999)
    - Claim Filing Indicator: CI-Commercial insurance
    - Amount Paid: $2,500 (LTC payment amount)
    - Enter Claim Adjustment Reason Code (CARC): PR 2 $3,545 (PR2 is required to be used)

      Submitted charges, LTC paid amount, and CARC amounts must equal out so that all charges are accounted for.

      In this example:

      - Submitted charges: $6,045
      - LTC paid amount: 2,500
      - CARC (PR2) amount: 3,545 (the difference between $6,045 and $2,500)
  - Medicaid Payment: $3,545

Scenario 2: Member has a patient contribution:

- Dates of service: 06/01/2023 through 06/30/2023, 30 Units
- Medicaid information:
  - Medicaid per diem rate: $201.50
  - Medicaid reimbursement: 30 units x $201.50 per diem rate = $6,045
- LTC insurance payment: $2,500
- Patient contribution amount: $800
- Build the Medicaid as secondary payer claim the same as "Scenario 1"
- Medicaid Payment: $3,545.00 minus $800 = $2,745

18.3 Members Under Hospice Care

For Members that are nursing home residents and receiving hospice care, no payment will be made to the nursing facility or swing bed. Room and board will be billed by and paid to the hospice Provider. The hospice Provider is required to reimburse the nursing facility for the nursing facility's contracted rate (*see Section 16.1.4* Nursing Facility Resident).

18.4 Evaluations That Must be Completed

The following evaluations must be completed prior to admission into skilled nursing or swing bed facilities:

- PASRR Level I Preadmission Screening and Resident Review – PASRRs may be entered at any time, no matter the date the assessment was completed.
- PASRR Level II if triggered by the PASRR Level I
    - LT101 - LT101s are valid for up to 365 days. If an LT101 has not expired, a new one need not be requested. An LT101 would be required in the following cases and if one has not been completed within 365 days if:
    - Members are applying for Medicaid nursing home services, or
    - Member is actively eligible for Medicaid services, or
    - PASRR Level I determination requires a PASRR Level II
        - If an individual has made a change for the better

The following evaluation must be completed prior to admission into an ICF/ID (315P taxonomy):

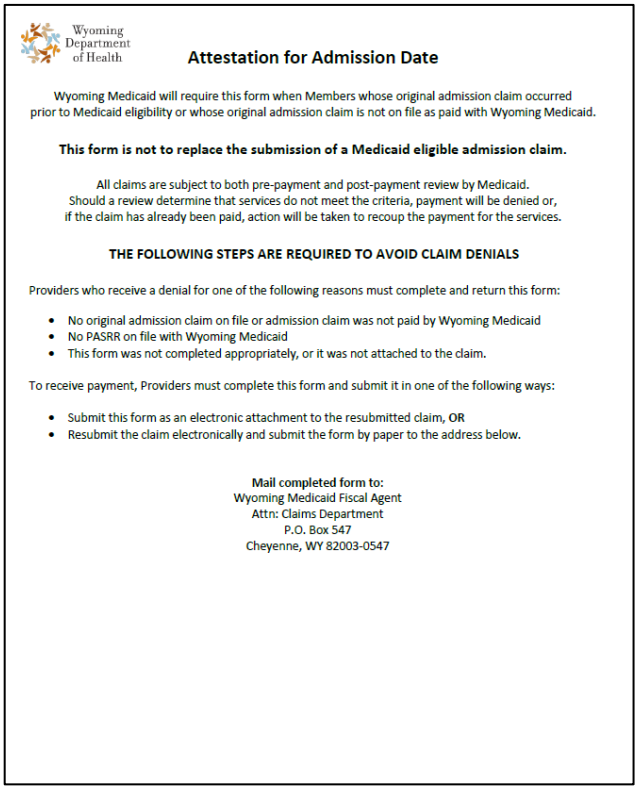
- LT-MR-104

An Attestation for Admission Date Form (*see Section 18.4.1* Attestation for Admission Date Form) must be completed and submitted with the claim or emailed to Wyoming Provider Outreach (wyprovideroutreach@cns-inc.com), when:

- Previous claim denied for no original admit claim on file with Wyoming Medicaid
- Previous claim denied for no PASRR Level I and/or Level II on file with Wyoming Medicaid
- Previous claim denied for no Attestation for Admission Date Form attached to the claim
- Previous claim denied for the Attestation for Admission Date Form not completed appropriately

> For instructions regarding Submitting Attachments, *see Section 6.14* Submitting Attachments for Electronic Claims.

18.4.1 Attestation for Admission Date Form



Wyoming Department of Health

Attestation for Admission Date

Wyoming Medicaid will require this form when Members whose original admission claim occurred prior to Medicaid eligibility or whose original admission claim is not on file as paid with Wyoming Medicaid.

This form is not to replace the submission of a Medicaid eligible admission claim.

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

THE FOLLOWING STEPS ARE REQUIRED TO AVOID CLAIM DENIALS

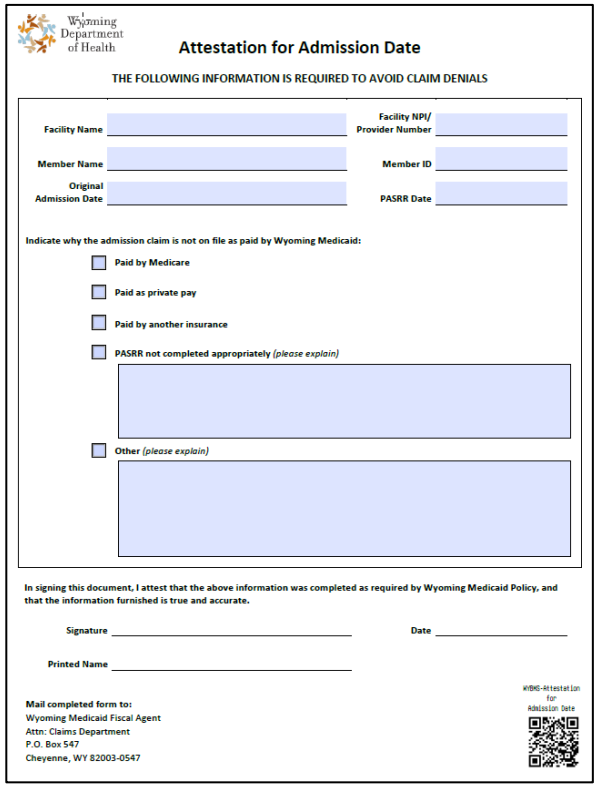
Providers who receive a denial for one of the following reasons must complete and return this form:

- No original admission claim on file or admission claim was not paid by Wyoming Medicaid
- No PASRR on file with Wyoming Medicaid
- This form was not completed appropriately, or it was not attached to the claim.

To receive payment, Providers must complete this form and submit it in one of the following ways:

- Submit this form as an electronic attachment to the resubmitted claim, **OR**
- Resubmit the claim electronically and submit the form by paper to the address below.

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



Wyoming Department of Health

Attestation for Admission Date

THE FOLLOWING INFORMATION IS REQUIRED TO AVOID CLAIM DENIALS

Facility Name _____ Facility NPI/ Provider Number _____

Member Name _____ Member ID _____

Original Admission Date _____ PASRR Date _____

Indicate why the admission claim is not on file as paid by Wyoming Medicaid:

- ☐ **Paid by Medicare**
- ☐ **Paid as private pay**
- ☐ **Paid by another insurance**
- ☐ **PASRR not completed appropriately** *(please explain)*
- ☐ **Other** *(please explain)*

In signing this document, I attest that the above information was completed as required by Wyoming Medicaid Policy, and that the information furnished is true and accurate.

Signature _____ Date _____

Printed Name _____

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

WYBMS-Attestation for Admission Date

This form is located on the Medicaid website.

18.4.1.1 Instructions for Completing the Attestation for Admission Date Form

- Read the form completely.
- Fill out all required information completely and accurately to ensure processing:
  - Facility Name
  - Facility NPI/Provider Number
  - Member Name
  - Member ID - enter the Member's Medicaid ID number
  - Original Admission Date (this is the date the Member was first accepted into the nursing facility)
  - PASRR (Level I and/or Level II) Date(s)
- Indicate why the admission claim is not on file as paid by Wyoming Medicaid by checking the appropriate box and providing an explanation where requested.
- Attest and complete remainder of form.

3. Attach to the claim or email to Wyoming Provider Outreach (wyprovideroutreach@cns-inc.com).

> For residents with a previous admit to the same skilled nursing facility, the previous stay must be billed through the date of discharge using the patient status code of "discharged". If not, future claims will deny for the Member not being properly discharged. Claims in history can be adjusted and corrected to show the correct date of discharge.

18.4.2 LT101 (Medicaid Evaluation of Medical Necessity)

The LT101 is a functional assessment performed by a Public Health Nurse under contract with the Division of Healthcare Financing. The LT 101 assesses how someone functions independently and captures the burden of care or how much assistance the Member needs in performing Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and social and cognitive functioning. This determines whether an applicant or Member meets nursing facility level of care for Medicaid nursing facility services, swing bed services, Home and Community Based Services (HCBS), or Community Choices Waiver (CCW).

- LT101s are valid for 365 days after completion.
- Facilities must request an LT101 electronically through the Wyoming Department of Health Application Gateway (https://gateway.health.wyo.gov/). If the facility does not have access, please email the Level of Care Assessment Coordinator with the HCBS Section, Sherry Mitchell at loc.assessment@wyo.gov to request access. The WDH will not accept faxed LT101 requests.

> If corrections are needed after an LT101 has been submitted, contact loc.assessment@wyo.gov. Within the request, include what needs changed and why.

18.4.3 LT101s are Required Under the Following Conditions

All conditions apply to nursing and swing bed facilities. This does not apply to Medicare only Skilled Nursing Facilities that do not participate in Medicaid. An LT101 is valid for 365 days from date of completion and is needed in the following conditions:

- Prior to nursing facility admission
  - If the Member is applying for Medicaid (an application must be sent in at the same time or prior to requesting the LT101)
  - If the Member has a PASRR Level I that has triggered a PASRR Level II
- Upon transfer to another nursing facility if the current LT101 on file is older than 365 days.

- Upon re-admission to a nursing facility after a previous discharge. “Discharge” does not include temporary absence from the facility for treatment in a hospital, home visit or a trial community stay, provided such a temporary absence is no longer than thirty consecutive days and the Member was not considered "discharged" from the facility.
- Significant change in condition for the better.
- Upon re-determination of Medicaid eligibility following a loss of eligibility for any reason.

18.4.4 Pre-Admission Screening and Resident Review

The Pre-Admission Screening and Resident Review (PASRR) process encompasses PASRR Level 1 and Level II.

Federal law requires all individuals, regardless of payment source, who apply as for new admissions to Medicaid Nursing Home Facilities on or after January 1, 1989, must be screened prior to admission for mental illness (MI) and intellectual disabilities (ID).

PASRR Level I**:** The purpose of the Level I is to screen for potential diagnosis of mental illness or intellectual disabilities. Such a determination will result in a referral for a Level II.

Routine annual Level I screenings are no longer required by Medicaid. If the Level I does not result in a referral to Level II, it need never be performed again unless a significant change in the resident’s condition indicates that a Level II evaluation is needed or if there is a transfer to another facility.

Mental status changes that result in a new diagnosis or that trigger a significant change to the total score on the Brief Interview for Mental Status (BIMS) or the Patient Health Questionnaire (PHQ9) on the Minimum Data Set (MDS) would result in a significant change of condition.

Please refer to http://pasrrassist.org/resources/mds-30/what-considered-significant-change-condition for more information on significant changes of condition.

PASRR Level II**:** The purpose of the Level II is to more accurately identify mental illness or intellectually disabled and assess whether the individual needs specialized services and nursing facility level of care.

Dementia, including Alzheimer’s disease and other dementias, is excluded from the definition of serious mental illness for PASRR purposes unless there is a behavioral component. An individual is considered to have dementia if he or she has a primary diagnosis of dementia as described in the DSM (current edition), or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above. A primary diagnosis of a serious mental illness supersedes a secondary diagnosis of dementia and the individual must be referred for a Level II evaluation.

- Individuals for whom respite care is provided (under HCBS Waiver) in a nursing facility must be treated like any other nursing facility admission, therefore, all PASRR and LT101 requirements apply prior to admission
- Any individual who's PASRR Level I screening indicates the presence or probability of mental illness or intellectual disabilities must be referred to the State. This authority has been delegated by contract to Telligen (*see Section 2.1* Quick Reference).
- A PASRR Level II determination must be completed prior to admission to be appropriate for nursing facility payment.
- If the individual is appropriate for nursing facility placement, the need for specialized services will be determined.
    - If an individual seeking admission to a nursing facility has Mental Illness or Intellectual Disabilities and is found to be inappropriate for nursing facility placement, the nursing facility may not admit the individual.
    - If an individual already residing a nursing facility has Mental Illness or Intellectual Disabilities and is found to be inappropriate for nursing facility placement, the Provider must cooperatively arrange with the state for the resident's orderly discharge from the facility.
    - Adverse determinations carry the right of appeal for the resident.

> PASRR is not a requirement for CHOW (Change of Ownership) completion. However, the skilled nursing facility will want to ensure that the admitted residents that need a PASRR evaluation have one on file and all residents are evaluated as appropriate.

18.4.4.1 Transfer

A PASRR Level I and PASRR Level II is required upon transfer from one facility to another facility.

- In the case of a transfer of a resident with Intellectual Disabilities or Mental Illness from the nursing facility to a hospital or to another nursing facility the transferring nursing facility is responsible for ensuring that copies of the most recent PASRR Level I and II (if applicable) and Resident Assessment reports accompany the transferring resident.

18.4.4.2 Categorical Determinations that do Not Require a Level II Prior to Admission

Pursuant to Federal guidelines, the Division of Healthcare Financing has defined certain categories of conditions that automatically constitute appropriateness for nursing facility placement. The State may override the categorical determination and refer the individual for a Level II where appropriate.

- **Categorical 4:** Appropriate for nursing facility placement due to terminal illness – Verified in writing by a physician. This constitutes a Level II determination of "appropriate specialized services not required".
- **Categorical 5:** Appropriate for nursing facility placement due to severe medical conditions – This determination may only be applied to an individual with Mental Illness or Intellectual Disabilities who is comatose, ventilator dependent, functions at the brain stem level, OR has a diagnosis such as COPD, severe Parkinson's disease, amyotrophic lateral sclerosis, congestive heart failure (CHF), cardiovascular accident (CVA), Huntington's Disease, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end stage renal disease (ESRD), severe diabetic neuropathy or refractory anemia. The condition must result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. This constitutes a Level II determination of "appropriate, specialized services not required".
- **Categorical 6:** Convalescent care for an acute physical illness – This determination applies only to an individual with Mental Illness or Intellectual Disabilities who has an acute physical illness which required hospitalization; AND does not meet all the criteria for an exempt hospital discharge. This categorical determination is limited to 120 days. When it becomes apparent the individual will require nursing facility placement longer than 120 days, the nursing facility must complete a new PASRR Level I and the Level II prior to the end of the 120 days. A Level II determination must be rendered before permanent nursing facility placement can be made.
- **Categorical 7:** Provisional placements – Pending further assessment in cases of delirium, where an accurate diagnosis cannot be made until the delirium clears, or for respite of caregivers. This categorical determination is limited to 14 days. If it becomes apparent the individual will require nursing facility placement longer than 14 days, a new PASRR Level I and Level II must be completed prior to the end of the 14 days. A Level II determination must be rendered before permanent nursing facility placement can be made.
- **Categorical 8:** Emergency placement – For an individual with Mental Illness or Intellectual Disabilities for the individual's protection. This categorical determination is limited to seven (7) days, at which time the nursing facility must complete a new PASRR Level I and Level II prior to the end of the 7 days. The determination must be rendered before permanent nursing facility placement can be made.

18.5 Medicaid Reimbursement

Medicaid will not reimburse a nursing facility for services provided to any individual who has not been screened at Level I.

- Payment will commence as of the Level I date or admission date, whichever is later.
- No retroactive payment will be made.

> Refer to the Provider Training and Tutorials posted on the Medicaid website for instructions on how to enter the PASRR Level I on the Provider Portal.

Medicaid will not reimburse a nursing facility for services provided to any individual with MI or ID who is admitted prior to completion of a PASRR Level II.

- Payment will commence upon the date of determination of appropriate placement.
- No retroactive payment will be made.
- The nursing facility may be subject to withdrawal of Medicaid certification if such a person is admitted to the facility before a Level II determination is rendered.

Medicaid will not reimburse a nursing facility for services provided to any individual who has previously been found to be inappropriate for nursing facility placement due to the need for specialized services.

- Any individual who has received such a determination must be re-evaluated and determined to be appropriate before any placement will be allowed.
- Date of admission is covered
- Medicaid does not pay for date of death (***Do not deduct*** one [1] day from R & B units and value code 80 count)
- Medicaid does not pay for date of discharge (***Do not deduct*** one [1] day from R & B units and value code 80 count)
- Reserve bed days and leave days are not covered by Medicaid - use value code 81 to report

18.5.1 Reserve Bed Days

Reserve bed days during a resident's temporary absence are not covered unless the resident is absent from the facility for less than 24 hours. In these instances, the absence is to be billed to Medicaid as a normal covered day.

For days the resident is absent from the facility for 24 hours or more, bill these as non-covered days, using value code 81. Value codes and accommodation units must total the number of days within the coverage period.

A Provider may bill a Member or the Member's responsible party for reserved bed days if the facility has informed them in writing of their financial responsibility before services are rendered.

18.6 Billing Requirements

With the implementation of the new claims processing system, Wyoming Medicaid requires that all other parties – Medicare and other long term care insurance – if applicable, be exhausted prior to Medicaid making payment. The appropriate value codes, occurrence codes, occurrence span codes, and claims adjustment reason codes must be reported on the claim. Failure to accurately report codes on claims result in claims being denied.

Value Code	Value Code Description	Value Code Amount
80	Medicaid Covered Days	Number of Days
81	Medicaid Non-Covered Days	Number of Days
82	Medicare Co-Insurance Days	Number of Days

Occurrence Code	Occurrence Code Description	Occurrence Code Value
A3	Medicare Benefits Exhausted Date	Date
22	Medicare Skill Care End Date	Date
24	Date Insurance Denied	Date
55	Date of Death	Date

Occurrence Span Code	Occurrence Span Code Description	Occurrence Span Code Value
70	SNF Qualifying Stay Dates – 3-day hospital stay	From Through Dates
74	non-covered level of care Dates	From Through Dates

18.6.1 Nursing Home and Swing Bed Facility Billing Examples

- Nursing Home
  - Revenue Codes: 0100 – Room & Board
  - Appropriate Bill Type: 21X, 23X

Pay-to Provider's Taxonomy: 31400000X, 315P00000X, 283Q00000X (State Hospital Only)

- **Swing Bed**
  - Revenue Code: 0100- Room & Board
  - Appropriate Bill Type: 18X

Pay-to Provider's Taxonomy: 275N00000X

18.6.2 Billing Examples

18.6.2.1 Medicaid Primary Billing Examples and Scenarios

Medicaid is primary when the Member does not have a qualifying stay, no Medicare coverage, or skilled level of care ended.

> All room and board (R & B) charges and units must be wrapped up into the first line for revenue code 0100 or 0101. Line 1 on the claim MUST always be R & B revenue codes.

- Examples:
  - Covered dates: 1/1/2023 – 1/31/2023, all covered days
    - Line 1: 0100, 31 units, 1/1/2023 – 1/31/2023, $7,000.00
    - Value code 80 = 31
  - Covered dates: 1/1/2023 – 1/31/2023 with non-covered days
    - Line 1: 0100, 25 units, 1/1/2023 – 1/31/2023, $5,000.00
    - Value code 80 = 25
    - Value code 81 = 6

Scenario 1 – Medicaid is Primary:

- NH claim – rev code 0100
- TOB 21X
- Medicare – No Medicare coverage
- Other Insurance – No other insurance

- Medicaid Primary
- Admit date: 7/25/22
- LT101 date: 7/20/22
- PASRR Level I date: 7/24/22 (no PASRR Level II was triggered)
- Patient status: 30 (still a patient)

Header Information	**Coverage Dates**		**Value Code**	**Value Code Value**
Admit Date: 7/25/22	7/25/22	7/31/22	80	7
Line 1 Information	**Date**	**Units**	N/A	N/A
0100	7/25/22	7	N/A	N/A

Scenario 2 – Medicaid Primary with Discharge of Death of Member:

- NH claim – rev code 0100
- TOB 21X
- Medicare – No Medicare coverage
- Other Insurance – No other insurance
- Medicaid only
- Admit date: 7/25/22
- LT101 date: 7/20/22
- PASRR Level I date: 7/24/22
- Patient status: 20 (death) – Medicaid does not pay for the date of discharge or the date of death, do NOT deduct this day from the total units billed, the BMS system will make this deduction automatically.
- Member's date of death: 7/31/22

Header Information	**Statement Covers Period (from/through)**		**Value Code**	**Value Code Value**
Admit Date: 7/25/22	7/25/22	7/31/22	80	6
Line 1 Information	**Date**	**Units**	81	1
0100	7/25/22	7	N/A	N/A

Scenario 3 – Medicaid Primary with Leave Days:

- NH claim – rev code 0100
- TOB 21X
- Medicare – No Medicare coverage
- Other Insurance – No other insurance
- Medicaid Primary
- Admit date: 7/25/22
- LT101 date: 7/20/22
- PASRR Level I date: 7/24/22
- Patient status: 30 (still a patient)
- 5 therapeutic leave days – 8/3/21 – 8/7/22 – physical therapy

Header Information	**Coverage Dates**		**Value Code**	**Value Code Value**	**Occurrence Code**	**Occurrence Date**
Admit Date: 7/25/22	8/1/22	8/31/22	80	26	35	8/3/22
N/A	N/A	N/A	81	5	N/A	N/A
Line 1 Information	**Date**	**Units**	N/A	N/A	N/A	N/A
0100	8/1/22	26	N/A	N/A	N/A	N/A

Scenario 4 – Medicaid Primary with PASRR after Admit Date:

- NH claim – rev code 0100
- TOB 21X
- Medicare – No Medicare coverage
- Other Insurance – No other insurance
- Medicaid only
- Admit date: 7/25/22
- LT101 review date: 7/20/22
- PASRR Level I date: 7/30/22
- Patient status: 30 (still a patient)

Header Information	Coverage Dates		Value Code	Value Code Value
Admit Date: 7/25/22	7/25/22	7/31/22	80	2
N/A	N/A	N/A	81	5
Line 1 Information	**Date**	**Units**	N/A	N/A
0100	7/30/22	2	N/A	N/A

18.7 Patient-Driven Payment Model (PDPM)

The Center for Medicare and Medicaid Services (CMS) is ending support for the Resource Utilization Group (RUG-IV) on federally required assessments for residents in Nursing Homes and Skilled Nursing Homes as of October 1, 2023. Patient-Driven Payment Model (PDPM) will replace the RUG-IV system for Wyoming Medicaid in the future.

Effective October 1, 2023, Wyoming Medicaid will require a concurrent Optional State Assessment (OSA) be completed with the same Assessments Reference Data (ARD), on each federally required assessment submitted. The OSA contains legacy MDS Section G Activities of Daily Living (ADL) functional items and other Minimum Data Set (MDS) items that will be removed from the federal Omnibus Budget Reconciliation Act (OBRA) assessments that will be occurring at the same time. This includes several items such as A0300, D0200, D0300, G0110, K0510, O0100, O0450, O0600, O0700, and X0570, which are needed to allow a RUG-based case mix score to be calculated and the current RUG-based reimbursement methodology to continue beyond October 1, 2023.

Wyoming Medicaid is sympathetic to nursing homes concerning the duplication of information in the OSA which may increase the administrative burden of completing the MDS. We recommend nursing homes begin reviewing their internal software systems for OSA compatibility, in preparation of the implementation of the OSA requirement, to determine if data input fields can be streamlined that are duplicative. Again, the completion of the OSA is needed to continue reimbursement under a RUG-based resident classification system until Wyoming Medicaid has enough data and time to model rates for use in the transition to the Patient Driven Payment Model (PDPM).

Visit the Centers for Medicare & Medicaid Services, Minimum Data Set 3.0 Resident Assessment Instrument Manual page (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual) where CMS has posted the OSA Item Set, OSA Manual, and OSA Change History table.

An OSA is required to be performed on the following assessments, and is required for all assessments that meet one (1) of the definitions for any payer (Medicaid, Medicare, Private, Other):

- ***Assessment Schedules After PDPM Implementation*** (Post-October 1, 2019)

  Medicare Prospective Payment System (PPS) Required Assessments

- Five (5) Day Admissions
- Interim Payment Assessment (IPA)
- Medicare PPS Part A Discharge

- ***Omnibus Budget Reconciliation Act (OBRA) Required Assessments [No Change]***
  - Admission Assessment (comprehensive)
  - Annual Reassessment (comprehensive)
  - Significant Change is Status Reassessment (comprehensive)
- ***Quarterly Assessment***

  Essentially, any assessment that a Provider performs today for WY case-mix purposes requires the submission of an OSA starting October 1, 2023.

18.8 Census Requirements

Effective April 1, 2019, nursing facilities are no longer required to submit a census report to Wyoming Medicaid or their contractor.

18.9 Wyoming Medicaid Member Death Reporting

Pursuant to Wyoming Department of Health, Division of Healthcare Financing (Wyoming Medicaid) rules, Providers are required to notify the Department of Health, Division of Healthcare Financing of the death of any Wyoming Medicaid Member in their facility within three (3) working days of the Member's death.

Email or mail the Medicaid Member Death Report Form (*see Section 18.9.1* Medicaid Member Death Report Form), it is located below for the Providers' use to report this information. Send or email it promptly to:

HMS Estate Recovery
333 W Hampden Ave
Suite 425
Englewood, CO 80110
Phone: 1-888-996-6223 (1-888-WYO-MCAD)
Email form as an attachment: wyreferrals@gainwelltechnologies.com

18.9.1 Medicaid Member Death Report Form

Wyoming Department of Health

Medicaid Member Death Report Form

Pursuant to Wyoming Department of Health, Division of Healthcare Financing (Wyoming Medicaid) rules, Providers are required to notify the Department of Health, Division of Healthcare Financing of the death of any Wyoming Medicaid Member in their facility within three (3) working days of the Member's death.

Member Information

Member Name _____ **Member ID** _____

Member Address
(Prior to entering nursing home.)
_____ _____ _____ _____
Street Address City State Zip Code

Social Security Number _____ **Date of Birth** _____

Marital Status _____ **Date of Death** _____

Guardian, Next of Kin, or Power of Attorney Information

Contact Name _____ **Contact Number** _____

Contact Address
_____ _____ _____ _____
Street Address City State Zip Code

Provider Information

Provider Name _____ **Contact Number** _____

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

Person Completing Form

Name of Person Completing Form _____ **Date** _____

Please send the completed form via mail or FAX it promptly to the address below.

Mail completed form to:
HMS Estate Recovery
333 W Hampden Ave.
Suite 425
Englewood, CO 80110
Phone: 1-888-996-6223 (1-888-WYO-MCAD)
Email form as an attachment: wyreferrals@gainwelltechnologies.com

WYBMS-Medicaid Member Death Report form

This form is located on the Medicaid website.

18.10 Extraordinary Care

Revenue Code: **0101 – Room & Board (Prior Authorization is required)**

Appropriate Bill Type: **21X, 23X**

Pay-to Provider's Taxonomy: **31400000X, 315P00000X**

Extraordinary Care is for Members that require service beyond the average resident. They have an MDS Activities of Daily Living Sum score of ten (10) or more and require special or clinically complex care as recognized under the Medicare RUG-III classification system. Extraordinary Care requires a prior authorization from Telligen (*see Section 2.1* Quick Reference).

The extraordinary care Member's cost and service requirements must clearly exceed supplies and services covered under a facility's per diem rate. The cost of Members' extraordinary care shall not be included in the annual cost reports.

Patient contribution amounts will be applied to claims for approved Extraordinary Care Members. *See Section 18.2* Patient Contributions for more information regarding patient contribution.

> Refer to *Section 18.6.1* Nursing Home and Swing Bed Facility Billing Examples for billing requirements. Extraordinary revenue code 0101 will appear on Line 1 of the claim instead of the nursing home R & B revenue code 0100.

18.10.1 Criteria

Extraordinary care Members services are covered when the below criteria is met, the services are individualized, specific, and consistent with symptoms or confirmed diagnosis, and not in excess of the Member's needs.

Medical conditions considered under extraordinary care criteria:

- Ventilator Dependence allows for automatic qualification without additional criteria being met.
- Tracheostomy requiring routine care that cannot be performed by the Member because the submitted records provide documentation of cognitive or physical impairment that limits self-care of the tracheostomy with the potential to result in tracheostomy and related complications.
- Morbid Obesity (ICD 10 E66.01) documented BMI and extreme limitation in mobility as documented by recent PT/OT or MD evaluation of ambulation, ROM and deficiencies in ability to independently perform basic hygiene and other ADLs. Other limitations not addressed in these guidelines but documented by a medical professional will be considered.
- Psychiatric care for Members with significant behaviors that cannot otherwise be safely cared for in a standard nursing facility setting without increased staffing or special accommodations. This includes Members with significant physical aggression, delirium and/or psychosis.

> See next section for additional information on psychiatric condition requirements.

- Other conditions where special care or clinically complex care is required will be evaluated on a case-by-case basis.

18.10.2 Documentation

- Completed Admission Certification Skilled Nursing Extraordinary Care form including clinical justification documentation. Form can be found at wymedicaid.telligen.com.
- Completed Rate Request Form. (Part of Admission Certification Skilled Nursing Extraordinary Care Form)
- If the request is for behavioral health extraordinary care Members, *see Section 18.10.4* Enhanced Psychiatric Conditions Considered Under Extraordinary Care Criteria for the additional documentation that must be included with the request.

18.10.3 Additional Requirements

- Continued stay reviews must be completed at 15 days, 30 days, 90 days and yearly thereafter. If medical evaluation shows difference or change in services needed, notify Telligen (*see Section 2.1* Quick Reference).
- If a Member has a change in services needed, the Provider can submit new cost information for consideration of a rate adjustment. Incremental revenue of negotiated rates will offset against the applicable cost report. Notify Myers & Stauffer of changes for modification to reimbursement (800)336-7721.
- Include all costs for residents under extraordinary care negotiated rates; cost reports will be adjusted during rate setting.

18.10.4 Enhanced Psychiatric Conditions Considered Under Extraordinary Care Criteria

Adult Members presenting with a Severe and Persistent Mental Illness (SPMI) with long term psychiatric and behavioral health needs, which exhibit challenging and difficult behaviors that is beyond traditional skilled nursing home care as recognized, may qualify under the Extraordinary Care Criteria. Extraordinary Care requires a prior authorization from Telligen (*see Section 2.1* Quick Reference).

Any requests for a behavioral health extraordinary care member, the documentation must include the following prior to any review by the Division of Healthcare Financing:

- A treatment plan that specifies both medical and behavioral strategy

- A stabilization plan to include both internal policies and plans for community-based supports and if necessary transfer opportunities
- External resources, agreements, working partnerships for inpatient stabilization (if behavior escalates to a point where for their safety or those of the other patients or staff), with a written agreement to return Member to resident location upon stabilization and recommendation plan in place.
- List of primary care and psychiatric doctors
- Packet must include clinical justification and financial request as with any other extraordinary care Member
- Other conditions where special care or clinically complex care is required will be evaluated on a case-by-case basis by Telligen
- Criteria are subject to change

18.10.5 Specific Criteria

All criteria must be met:

- The Member has an SPMI as defined by the following
  - The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders
  - Prior to admission (admission to hospital stabilization or nursing home), the Global Assessment of Functioning (GAF) score is 40 or lower
- The level of impairment is confirmed by a Level II Pre-Admission Screening and Resident Review (PASRR) evaluation (42 CFR 483.128) (*see Section 18.4.4* Pre-Admission Screening and Resident Review).
- The Member is currently in a psychiatric hospital; or has had one (1) or more past hospitalizations; or is exhibiting behaviors that place him or her at risk of psychiatric hospitalization
- The Member exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care, including one (1) of the following:
  - Combative and assaulting behaviors (physical abuse toward staff, or self-abuse / self-injurious behaviors)
  - Sexually inappropriate behaviors (touching or grabbing others)
  - Other challenging and difficult behaviors related to the individual's psychiatric illness

OR

- Exhibits the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements

18.10.6 Continued Eligibility Criteria

Continued stay is applicable when the Member either:

- Exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care, including one (1) of the following:
    - Combative and assaulting behaviors (physical abuse toward staff, or self-abuse / self-injurious behaviors)
    - Sexually inappropriate behaviors (touching or grabbing others)
    - Other challenging and difficult behaviors related to the individual's psychiatric illness

OR

- Exhibits the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements

18.10.7 Discharge from Extraordinary Care Criteria

Discharge from extraordinary care criteria is contingent upon the following:

- The consistent absence of unsafe behaviors as outlined in *Section 18.10.5* Specific Criteria within consistently structured enhanced care; and
- The anticipation that the Member will not exhibit the unsafe behavior if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements

> These criteria must be closely observed and monitored during a continuous period of at least three (3) months (quarterly).

Additional determining criteria for discharge include the following:

- Monitoring of medication stability/consistency
- Treatment compliance
- Appropriate living arrangements upon discharge
- Arrangement of aftercare for continued services

18.10.8 Documentation

- New Requests must contain a completed packet, required documentation and cost review. Prior Authorization (PA) is required for all Medicaid Members (*see Section 6.13* Prior Authorization).

- Extraordinary Care Member packets can be submitted to Telligen (*see Section 2.1* Quick Reference).
- Continued Stay Reviews must contain a completed Continued Stay Form and all required documentation. Form can be found at wymedicaid.telligen.com. Prior Authorization (PA) is required for all Medicaid Members.
- Annual Cost Reviews for extraordinary care Members rates will be done in conjunction with July 1 rate effective date reviews.
- Continued Stay Utilization Review must be completed at 15 days, 30 days, 90 days and yearly thereafter, or as needed if medical or psychiatric evaluation shows difference or change in services.
- If the Member has a change in services needed, the Provider can submit new cost information for consideration of a rate adjustment. Notify Myers & Stauffer of change for modification to reimbursement (800) 336-7721.
- Include all costs for residents under extraordinary care negotiated rate; as incremental revenue of negotiated rate is offset against applicable cost repost.

Chapter 19 – Rural Health Clinics

19.1 Rural Health Clinics

Revenue Code: **0520, 0521**

Dental Encounter Codes: D9999 (dental) and D8999 (orthodontics)

> **For covered services refer to Chapters 11 through 26 by Provider type in the CMS 1500 Provider Manual.** Dental services must be billed on the ADA dental claim form. Refer to the Dental Provider Manual located on the Medicaid website (*see Section 2.1* Quick Reference).

The purpose of a Rural Health Clinic (RHC) program is to improve access to primary care in underserved rural areas. RHCs are required to use a team approach to provide outpatient primary care, and basic laboratory services.

> Services for Members eligible for the BCC or COLR Benefit Plans are not covered in an RHC setting.

19.1.1 Covered Services

A visit is a face-to-face encounter between a Member and:

- Clinical psychologist
- Clinical social worker
- Dental professional (ADA Dental Claim Form)
- Nurse practitioner
- Nurse midwife
- Physician
- Physician's assistant
- Visiting nurse

> When a practitioner is performing services outside the RHC facility, services cannot be billed under the RHC NPI number. The services will need to be billed under the practitioner's NPI on a professional/837P claim.

19.1.2 Reimbursement Guidelines

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. 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. The rate includes, but is not limited to:

- Therapeutic services
- Diagnostic services
- Tests
- Supplies
- Lab
- Radiology

> For dental treatment refer to the Dental Manual.

Billing for Long Acting Reversible

- Billing for the LARC device will need to be completed on a CMS 1500 claim form/837P electronic claims transaction.
- Effective January 1, 2022, Wyoming Medicaid will reimburse professional services for immediate postpartum IUD or contraceptive implant insertion procedures if billed separately from the professional global obstetric procedure.
- Medicaid does not reimburse facility services for the immediate postpartum IUD or contraceptive implant insertion procedure. These inpatient services may not be unbundled on the hospital's facility claim.
- Medicaid reimburses for the IUD or contraceptive implant device in one of the following ways:
    - As a separate professional claim submitted by the facility's medical group number when the facility supplies the device
    - As part of the professional claim when the device is supplied by the Provider performing the insertion
- Providers should bill their 340B acquisition cost OR if purchased outside 340B Program enter usual and customary charges for devices.
- The group Provider will be reimbursed the lesser of the Provider's billed amount or the Medicaid allowed amount.
- There should be correlating UB and CMS 1500 claims for the insertion and for the actual LARC device.

- Group Providers should not submit a device claim when the encounter was for removal of a device only.
- **FQHC/RHC Facility Encounter Billing on the UB Form/837I Claims Transaction**
  - FQHC/RHC Facility NPI as the pay-to Provider and enter an attending Provider NPI

> When billing for an IUD or contraceptive implant device, the Provider must use the appropriate HCPCS code and NDC.

  - LARC Covered Services or CPT Codes

Procedure Code	Description
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug deliver implant

  - Encounter Billing Example:
    - Member had an appointment at the FQHC Facility on 1/20/2020 for contraceptive services and received a contraceptive implant

Revenue Code	Procedure Code	Amount
520 (encounter revenue code)	T1015 (encounter procedure code)	$220.00
517	11981	$0.00
517	99215	$0.00

- Practitioner Group LARC Device Billing on the CMS 1500 Form/837P Claims Transaction
  - Practitioner Group NPI as billing Provider and enter the treating Provider NPI (same as the attending on the encounter claim)
  - Date of service must be date of insertion and the same as the date on the encounter claim
  - LARC Device Covered Services or CPT Codes

Procedure Code	NDC Requirement	LARC Device Name
J7296	Required	Kyleena
J7297	Required	Liletta
J7298	Required	Mirena
J7300	Required	Paragard

Procedure Code	NDC Requirement	LARC Device Name
J7301	Required	Skyla
J7307	Required	Nexplanon

> All LARC device codes require an NDC.

- Device Billing Example:

Procedure Code	NDC	Billed Amount
J7301	00000-00-000	340B acquisition cost OR if purchased outside 340B Program enter usual & customary charge

19.1.3 Billing Requirements

- The place of service must be the office, not the hospital, emergency room, home, nursing facility, and so on.
- Multiple encounters within the same facility, on the same day, with different health professionals are still considered one (1) encounter UNLESS the patient suffers illness or injury requiring additional diagnosis or treatment after the first encounter.
- Claims must be billed with revenue and procedure codes for both the encounter information and detailed line item information.
- Claims will have a minimum of two (2) line items, the first would be the encounter line and the second line item is detail (both must include a revenue code and a procedure code combination).

19.1.3.1 Encounter Line

The encounter line will be billed with Revenue Code 0521 paired with:

- Procedure code T1015 for general encounter.
- Bill the total usual and customary charges for visit.

19.1.3.2 Detailed Line Items

Detailed line items will be billed with:

- Any appropriate outpatient revenue code paired with any appropriate procedure code.
- Document each procedure that occurred during the encounter.
- Include a detailed line item for the office visit or health check procedure code if appropriate.

- Procedure codes 99381-99385 or 99391-99395 for EPSDT encounter.
- Use modifier 32 to indicate a health check encounter that results in a referral to a specialist.

- Bill the detail line items at $0.00
- For questions regarding appropriate pairings of revenue codes and procedure codes, refer to the NUBC Official WB Data Specifications Manual.

> If billing Medicare as primary, bill the claim following Medicare's rules (codes).

19.2 Billing Examples

Member comes to the RHC for complaint of a cough and sees a physician. No additional tests or treatments are administered. The Member is given a prescription for antibiotics and released.

Revenue Code	Procedure Code	Amount
0521 (encounter revenue code)	T1015 (encounter procedure code)	$175.00
0517	99213	$0.00

This Member is a child who has come to the RHC for a health check visit. The health check is conducted, and in addition, a urine culture is run while the Member is there.

Revenue Code	Procedure Code	Amount
0521 (encounter revenue code)	T1015 (encounter procedure code)	$220.00
0517	99381	$0.00
0300	87086	$0.00

Chapter 20 – Psychiatric Residential Treatment Facility

20.1 Psychiatric Residential Treatment Facility

Appropriate Bill Type(s): **11X**

Pay-to Provider's Taxonomy: **323P00000X**

Psychiatric Residential Treatment Facility (PRTF) is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents under age 21, who have long-term illnesses or serious emotional disturbances that are not likely to respond to short-term interventions and have failed to respond to community-based interventions.

PRTFs provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality, pro-active treatment. In addition to diagnostic and treatment services, PRTFs should also provide instruction and support toward attainment of developmentally appropriate basic living skills and daily living activities that will enable children and adolescents to live in the community upon discharge.

The focus of a PRTF is on improvement of a Member's symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; unless evidence shows family therapy would be detrimental to the Member. Unless otherwise indicated, the program should facilitate family participation in the treatment planning, implementation of treatment planning, and timely, appropriate discharge planning, which includes assisting the family in accessing wrap-around services in the community.

Who should be admitted to a PRTF – A Member may be appropriate for admission to a PRTF if they have a psychiatric condition which cannot be reversed with treatment in an outpatient treatment setting and the condition is characterized by severely distressing, disruptive and/or immobilizing symptoms which are persistent and pervasive.

Who should not be admitted to a PRTF – A Member who is experiencing acute psychiatric behaviors is not appropriate to be admitted to a PRTF. PRTF services are not the entry point to accessing inpatient psychiatric services.

PRTF services must:

- Be provided under the direction of a physician.
- Provide active treatment.
- Be provided before the individual reaches age 21, per CFR 42§441.151, or if the individual was receiving services just prior to turning 21, the services must cease at the time the individual no longer requires services or the date at which the individual reaches age 22.

The PRTF must:

- Work closely with the appropriate school entity to ensure adherence to the youth's Individual Education Plan (IEP).

- Ensure a smooth transition back to the home school or develop an alternative transition plan for those youth who are not returning to their home school.
- Ensure that there is an adequate number of multi-disciplinary staff to carry out the goals and objectives of the facility and to ensure the delivery of individualized treatment to each resident as detailed in their treatment plan.

20.1.1 Psychiatric Residential Treatment Facility Physical Layout

A PRTF is a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis. A PRTF that is a part of a hospital or other facility must be a distinct, stand-alone unit/building separate from the hospital or other type of facility.

Members who meet the PRTF level of care are not to be co-mingled with Members who are not at a PRTF level of care at any time. For example: a Member in a facility's PRTF cannot co-mingle with another Member (regardless of payment source) who may be in the facilities RTC unit (should they have both) during meals, schooling, therapies, or in living quarters.

20.1.2 Physical Separation

If more than one (1) type of program or facility is operated on the same piece of property, organizations should take steps to ensure that the programs or facilities can be easily identified as separate entities to those entering the property. Areas that Providers are encouraged to consider include:

- **Documentation of Physical Separation:** the areas of the property occupied by the various programs should be clearly marked on campus maps and when buildings are shared, documentation of the parts of buildings occupied by different programs/facilities on floor plans should be clear and are readily available to surveyors or auditors.
- **Entrances and Signage:** when sharing a common property (such as, same piece of land), the most ideal situation would be to have separate entrances, but when this is not feasible, the organization should use signage which clearly identifies and directs those entering the property or campus to the different facilities. Buildings should be clearly marked with signs that identify the programs or facilities that are located within them. For programs that must be open to the general public (outpatient clinic), there must not be physical barriers which prevent access or which would signal to those seeking services that the services would not be available to the general public (for example, locked gate to the property).
- **Building Space:** Distinct buildings for each program or facility is best for maintaining separateness between programs and facilities. If building space is shared, physical separation of the programs/facilities must be managed within the structure. Again, dividing the building space between programs in a manner that provides for clear and distinct separation of the programs and costs is the goal.
    - Programs that share a building must be clearly separated by floors, wings, or other building sections. Living areas must not be shared and beds from different programs should not be

intermixed or commingled within the same building section. “Swing” beds or units that are variously used by one program or another depending on census are not acceptable. For example, there cannot be beds that are sometimes utilized by an RTC and sometimes used by a PRTF.

- When a building is occupied by more than one (1) program or facility, utilization of separate building entrance for each program is preferable. When this is not possible, separate entrances to each program from a common building lobby could be used. Again, signage within the building should clearly identify the specific program or facility areas.

- **Common Areas**
  - Recreational Areas: If a PRTF and an RTC, for example, are operated on the same property, each program should have separate recreational space for its residents. If there are also common recreational spaces used by both programs (such as, gyms or other indoor or outdoor sporting and recreation areas), the use of these common areas should be scheduled by the different programs or facilities for separate use and the individuals receiving services from distinct programs should not use the facilities at the same time.
  - Dining Areas: If a PRTF and RTC, for example, are operated on the same property, each program should have separate dining space for its residents. If common dining room areas are used by different programs/facilities, they should be used at separately scheduled times and the individuals receiving services from distinct programs/facilities should not use the same dining area at the same time.
  - Treatment Areas: When an organization is providing both PRTF and outpatient services, for example, on the same campus or facility, separate areas must be used for treatment.

20.2 Psychiatric Residential Treatment Facility Requirements

Pursuant to 42 CFR § 483.352, the PRTF must meet all the requirements identified in subpart D, which include: State accreditation (§441.151), certification of need for the services (§441.152), the team certifying need for services (§441.153), active treatment (§441.154), components of an individual plan of care (§441.155), and the team involved in developing the individual plan of care (§441.156). The way a PRTF organizes itself is critical to its success in complying with federal regulations.

All PRTFs must be accredited by one (1) of the organizations identified in 42 CFR §441.151(a)(2)(ii):

- Joint Commission, or
- The Commission on Accreditation of Rehabilitation Facilities, or
- The Council on Accreditation of Services for Families and Children

Out of state PRTFs must be certified by The Center for Medicare and Medicaid Services (CMS), in conjunction with their state’s licensing and survey agency as a PRTF, in order to enroll as a PRTF Provider with Medicaid.

In state PRTFs must be certified as a PRTF by the Division of Healthcare Financing, in conjunction with the Office of Healthcare Licensing and Surveys and CMS, should they meet all the PRTF criteria.

20.3 Letter of Attestation

Each PRTF that provides inpatient psychiatric services to individuals under 21 must attest, in writing, that the facility is in compliance with CMS's standard governing the use of restraint and seclusion (42 CFR Subpart G-Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21). This attestation must be signed by the facility director and is required for Provider enrollment.

A facility enrolling as a Medicaid Provider must meet this requirement at the time it executes a Provider agreement with Medicaid.

To download a copy of the Attestation Letter, go to the Medicaid website under the Forms page.

20.4 Reporting of Serious Occurrences

The facility must report each serious occurrence to the Division of Healthcare Financing (State Medicaid Agency). Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in 42 CFR § 483.352, and resident's suicide attempt.

All PRFT incidents and serious occurrences must be submitted electronically; faxed forms are no longer accepted.

Submit a Psychiatric Rehabilitation Treatment Facility (PRTF) Incident Report

42 CFR 483.374(b) states: In case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

42 CFR §483.374(c) states: "In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the CMS regional office. Staff must report the death of any resident to the CMS regional office by not later close of business the next business day after the resident's death. Staff must document in the resident's record that the death was reported to the CMS regional office."

20.5 Covered Services

Services related to the Member's treatment plan and provided by a PRTF are included in the PRTF per diem. This includes room and board and licensed treatment. A practitioner or facility that is outside of the PRTF may bill for covered ancillary services to Medicaid as long as they are an enrolled Wyoming Medicaid Provider.

Facilities are required to send medications (either prescriptions or already filled) home with Members upon discharge.

Medicaid does not cover any educational services or room and board in a Residential Treatment Center (RTC). Medicaid may pay for medically necessary treatment or therapy to an RTC Member when the Provider is an enrolled Wyoming Medicaid Provider.

20.6 Revenue Code

0919 – Psychiatric/psychological services (room and board)

> Medicaid reimbursement is determined on the first date of service.

20.6.1 Prior Authorizations

- Prior authorization requests must be submitted three (3) days prior to the Member's planned admission.
- For prior authorizations requirements, review the Telligen Provider manual (*see Section 2.1* Quick Reference).
- For court ordered Members, a copy of the court order must be submitted as part of the prior authorization request. Court orders will be reviewed and must be in compliance with Wyoming Statute 14-3-429, 14-6-229 and 14-6-429.

20.7 Psychiatric Residential Treatment Facility Educational Services

Effective July 1, 2016, educational service payments will be authorized and made available by the Wyoming Department of Education for school services provided to all Wyoming Medicaid youth, regardless of court-order status.

There are several contingencies associated with the payment of educational services:

1. PRTF school programs must be certified by the Wyoming State Board of Education. To receive this certification, Providers must make a formal application to the Wyoming Board of Education, undergo a formal on-site survey, and be approved by the Board.
2. Educational service payment is contingent upon Medicaid's determination of medical necessity for the PRTF admission. Once a youth is determined to no longer meet medical necessity for the placement, education funding ceases.
3. PRTFs receiving payment for educational services are required to comply with various provisions detailed in statute, including, but not limited to the following:
    a. Comply with the federal Family Education Rights and Privacy Act;
    b. Not later than ten (10) days after discharge, transfer all records via a secure method to the resident school district or the district in which the student enrolls;

c. Create an individualized learning plan for the student that is appropriate for the learning capabilities of the student, monitors and measures the student's progress toward meeting defined goals, facilitates necessary instructional support for the student, maintains the student's permanent education records, and fulfills the state education program rules and regulations.

The current prior authorization request process with Wyoming Medicaid is not changing, and educational days will be authorized based on current criteria used for PRTF placements.

Please contact the Wyoming Department of Education for questions regarding payment for educational services or the Wyoming State Board of Education regarding the PRTF school program certification process.

20.8 Therapeutic Leave Days

Medicaid reimbursement is available for reserving beds in a PRTF for therapeutic leaves of absence of Medicaid Members less than 21 years of age at the regular per diem rate when all of the following conditions are present:

- A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the Member's habilitation plan.
- A physician's order for therapeutic leave must be maintained in the Member's file at the facility.
- In a PRTF, the total length of time allotted for therapeutic leaves in any calendar year shall be 14 days per Member. If the Member is absent from the PRTF for more than 14 days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that Member in that year.
- In no instance will Medicaid reimburse a PRTF for reserving beds for Medicaid Members when the facility has an occupancy rate of less than 90% (Based on licensed beds).

Telligen must approve and prior authorize all therapeutic leave days. Approved therapeutic leave days should be billed as normal covered days. Therapeutic leave days that are not approved by Telligen, when the Member does leave the facility, must be billed as non-covered days.

Refer to the Telligen Manuals or contact Telligen (*see Section 2.1* Quick Reference) for PRTF prior authorization, PRTF referrals, admission criteria, continued stay review criteria, discharge planning, and other important PRTF information.

20.9 Onsite Compliance Review Process

20.9.1 Purpose and Goal

The purpose of an On-Site Compliance Review (OSCR) is to verify that the PRTF is in compliance with all applicable State and Federal requirements for mental health treatment, and to monitor the quality of treatment being provided to Wyoming Medicaid beneficiaries. This verification will include a review of

adherence to all Federal and State guidelines restricting commingling should a level of care other than PRTF also be provided within the facility.

The goals of the OSCR are to:

- Access the program and services offered by the PRTF through direct observation, document review, and staff/resident interviews by experienced clinicians; and
- To provide clear, specific feedback regarding review findings to PRTF staff in order for services to be enhanced.

20.9.2 Review Team Composition

The review team will be comprised of at least two (2) but no more than five (5) Wyoming Medicaid staff and consultants. The participation of an appropriately credentialed child/adolescent psychiatrist is required. Optional team Member may include any of the clinicians listed below:

- A registered nurse
- A licensed clinical social worker
- A licensed psychologist

Team Members, in addition to the child/adolescent psychiatrist and Medicaid representative may be drawn from a variety of areas (such as, Medicaid, contractor, Department of Family Services, private sector professionals) depending on availability, existing service contracts, and appropriated funding.

20.9.3 Pre-Review Notification

Written notification of an upcoming OSCR will be provided to the PRTF administrator 24 to 48 hours prior to the time the OSCR is scheduled to begin. The notification will include:

- The anticipated schedule for the OSCR
- The names of the participating team Members
- A list of documents to be reviewed
- A list of clinical records to be reviewed

20.9.4 Overview of the On-Site Compliance Review Process

The OSCR is intended to monitor a PRTF's overall operations for compliance with legal requirements and for quality of clinical programs and services. The review inquires in to the PRTF's operations in three (3) domains:

- **Administration:** This area comprises the organizational structure and management of the facility. The facility's administrative functioning is evaluated through the review of such information as policy and procedure manuals, staff credentials, transfer agreements with

hospitals, utilization review documents, incident reports, and so on. The administrative area will account for 15% of the PRTF's overall compliance rating.

- **Program:** This area comprises the philosophy and structure of the facility's approach to treatment (what the facility believes constitutes good treatment and how they plan to carry it out). The facility's program is evaluated through the review of documents (for example, policy and procedure manuals, unit rules/regulations, unit level systems, schedules of unit activities, staff training schedules and agendas, seclusion/restraint logs, and so on), the facility tour, and staff interviews. The program area will account for 35% of the PRTF's overall compliance rating.
- **Services:** This area comprises the manner in which a PRTF's program translates into treatment of individual residents. The team particularly looks at whether or not services are delivered in such a manner as to provide maximum benefit to each child. The facility's services are evaluated through the review of clinical records and resident interviews. The services area will account for 50% of the PRTF's overall compliance rating.

The frequency with which routine reviews are scheduled is dependent upon the status of the facility at the time of its last review. Generally, the higher the facility's rating, the longer the period of time between reviews. Refer to the PRTF Status Categories below for applicable time frames. Routine OSCRs will almost always be full scale reviews, with every aspect of the PRTF being evaluated. In most cases, a routine OSCR will be completed in two (2) to three (3) days.

Reviews are conducted utilizing the following Compliance Review Instruments (CRI) which can be viewed on the Wyoming Medicaid Provider website, UB Provider Manual within the PRTF section:

- Administrative Document Review
- Facility Tour
- Program Document Review
- Staff Interview
- Staff Record & Training Review
- Resident Record Review
- Resident Interviews

At the discretion of Wyoming Medicaid, an OSCR may be conducted at any time, and the OSCR may be conducted as a partial off-site (review of records) and partial on-site (facility tour and staff/resident interviews) compliance review.

Regardless of when the next OSCR may be due, an interim review may be scheduled at any time at the discretion of Wyoming Medicaid to address specific concerns. Interim reviews may be full-scale or partial, depending upon the focus or scope of Wyoming Medicaid's concerns. Interim reviews will typically be completed in one (1) to three (3) days.

20.9.4.1 General Outline of the On-Site Compliance Review Process

- **Entrance Interview:** At the beginning of the OSCR, the review team will meet with a small group (not to exceed six (6) people) of PRTF staff selected by the facility for an overview of the OSCR process. The group will typically consist of the PRTF Administrator, Medical Director, Risk Manager (where applicable), Clinical Director, and one (1) representative each from nursing, primary therapy and direct care staff. The entrance interview is the facility's opportunity to meet the review team and inform the team of any changes, improvements, and so on that have occurred since the last review or to ask questions about the current proceedings. The review team will take this opportunity to interview the PRTF team on areas such as EBP used, average length of stay, and so on. This phase will typically take about an hour.
- **Tour of the Facility:** The review team will tour all units of the PRTF and talk informally with staff and/or residents. They will note the physical layout and appearance/atmosphere of the units, review posted information, and observe interactions between staff and residents.
- **Review of Administrative and Program Records:** A review team Member, usually the team leader, will review documents requested in the pre-OSCR notification. Information requested may include (but is not limited to) records pertaining to staff credentials and training, policy and procedure manuals, transfer agreements with hospitals, utilization review, staff training schedules and/or agendas, seclusion/restraint logs, treatment outcome data, and so on. In addition, the facility must provide the review team with a roster of all staff who provide direct services to resident. The roster should be organized according to discipline and each name should be accompanied by the staff Member's signature. All documents requested should be ready for review at the beginning of the OSCR.
- **Review of Clinical Records:** Resident records will be reviewed by the team to assess compliance with PRTF treatment requirements identified by Wyoming Medicaid policy. Charts will be selected from the census list of Wyoming Medicaid residents and all Members discharged in the previous 120 days. The PRTF must provide the review team with an organization guide to the resident record, which clearly identifies where specific documents may be found within the record.
- **Staff Interviews:** Staff to be interviewed will be identified as early in the review process as possible. When interviewing staff, review team Members will want to know whether or not there are guiding treatment principles of which ALL STAFF (from psychiatrist to cafeteria worker to therapist to resident aide to facility administrator to maintenance worker) are aware and to which ALL STAFF adhere. The team is particularly interested in how well program guidelines are carried out in practice and whether or not staff work together collaboratively, functioning as a true team.
- **Resident Interviews:** Residents to be interviewed will be identified as early in the review process as possible. When interviewing residents, review team Members will want to know whether or not residents feel they are active participants in their treatment, how knowledgeable they are about specific aspects of their treatment programs, and how they view

the program and staff's ability to help them. Refer to Provider Manual Section 18.36 for CRI-Clinical Services Section B: Resident Interviews policy.

- **Review Team Conference:** At the conclusion of the above components, the review team will meet to compile all information acquired and prepare for the Exit Interview.
- **Exit Interview:** The review team will meet with the PRTF staff (the same representatives who were present at the Entrance Interview unless changes have been discussed with the review team leader) to present an overview of the team's findings. At this time, PRTF staff may ask questions, request examples of problems cited, and so on. This phase typically will last one (1) hour or less.
- **Written Report:** Wyoming Medicaid will provide the PRTF with a written report of the review team's findings within 30 days after the close of the OSCR.

20.9.5 Psychiatric Residential Treatment Facility Status Categories

At the time of the exit interview, the PRTF will be informed of its status ruling if that can be clearly determined. Star ratings will be published in the Wyoming Medicaid PRTF newsletter and website, as well as shared with other Judicial and Child Placement Agencies throughout Wyoming. The rating categories are as follows:

Three Star (★★★)Commendation: Program and services consistently exceed standards. No problems were cited by the review team. The next OSCR will be scheduled within the next three (3) years.

Two Star (★★) Approved: Program and services consistently meet standards the majority of the time. No significant health and/or safety concerns were cited by the review team. The next OSCR will be scheduled in one (1) to two (2) years. A corrective action (CAP) may be requested at the State's discretion for findings cited.

One Star (★) Review: Overall program and services are of acceptable quality with one (1) or more specific areas of health and/or safety risk or other substandard quality directly impacting the quality and effectiveness of services delivered. A CAP must be submitted to all address findings cited. The next OSCR will be scheduled within the next six (6) to 12 months after the implementation of an approved CAP.

20.9.6 On-Site Compliance Review Rating

20.9.6.1 Probation

- Program and services are of substandard quality, or
- The facility is already on Review Status and failed to show improvement in a follow-up OSCR, or
- An isolated, non-recurring condition exists which could jeopardize the safety or well-being of residents.

A CAP must be submitted to address all problems cited in the review. The next OSCR will be scheduled within the next three (3) to six (6) months after implementation of an approved CAP. Details of required elements within the CAP are detailed further in this document.

A facility receiving this rating will be subject to the following actions taken by Wyoming Medicaid:

- A hold on new admissions
- Youth transfers will be considered
- Guardian notifications of rating will be initiated for all Wyoming Medicaid Members receiving services from the facility
- Notification of facility rating will be provided to the Facility's licensing and survey authority and the Facility's Board of Directors

20.9.6.2 Suspension

Program and services are of unacceptable quality OR an ongoing pattern of recurring conditions exist which jeopardize the lives or well-being of residents OR the facility received probation status in any two (2) OSCRs and failed to show sufficient improvement in the next follow-up OSCR. The next OSCR will be scheduled as soon as possible (no later than 30 days) after the implementation of an approved corrective action plan. The CAP must be submitted to Wyoming Medicaid for review and approval no later than seven (7) days from the close of the OSCR.

A facility receiving this rating will be subject to the following actions taken by Wyoming Medicaid:

- A hold on new admissions.
- Child transfers will be initiated.
- Guardian notifications of rating will be initiated for all Wyoming Medicaid Members receiving services from the facility.
- Notification of facility rating will be provided to the Facility's licensing and survey authority and the Facility's Board of Directors.
- A facility receiving two (2) suspension ratings during its course of enrollment with Wyoming Medicaid (does not need to be consecutive compliance reviews) will be dis-enrolled as a Wyoming Medicaid Provider. Petitions for re-enrollment will be considered on a case-by-case basis, no sooner than 24-months after dis-enrollment. Dis-enrollment could be considered by Wyoming Medicaid after one (1) suspension rating depending on the severity and scope of the findings.

20.9.6.3 Deferred

If the review team requires additional information or expert opinion in order to complete its determination, then the status ruling may be deferred. In cases of deferred status, Wyoming Medicaid must re-contact the PRTF within ten (10) days to:

- Request additional information or documentation, which must then be provided by the PRTF within ten (10) days of receiving the request; and/or
- Schedule a continuation of the OSCR, in which case additional team Members may participate in further on-site review of the facility, or
- Submit a final status ruling.

The ten (10) day request or submission response cycle will continue until a final status determination is made.

20.9.7 Corrective Action Plan

Any facility receiving a rating of Review, Probation or Suspension must submit a Corrective Action Plan (CAP). The CAP must be received by Wyoming Medicaid no later than ten (10) working days following the PRTF's receipt of its status ruling.

The CAP must address separately each concern cited in the OSCR report by:

- Proposing specific measurable actions that will be taken to correct each identified problem
- Specifying an implementation date for each corrective action
- Including supporting documentation as appropriate, such as policy or procedural changes, new or revised forms, copies of schedules of training, or staffing.

Justifications or explanations for the cited problems have no place in the CAP. Although there may be good reasons for the existence of the problems, Wyoming Medicaid is interested only in the proposed solutions. The narrative of the CAP should be succinct and to-the-point. The following format is suggested for each separate element cited:

- Description of element
- Findings
- Plan of correction
- Implementation date
- Supporting documentation (attached to the CAP and referenced in the narrative response)

20.9.7.1 Corrective Action Plan Examples

- Description of element: Psychosocial assessment contains a developmental profile

- Findings: Developmental profiles were missing from two (2) of the charts reviewed, were inadequate or incomplete in two (2) others
- Plan of correction: Program Director will provide in-service training to therapy staff on developmental history-taking and documentation. Psychosocial assessments will be reviewed for completeness through record audits by Program Director
- Implementation Date: January 1, 2008
- Supporting documentation: Attachment A: Training Logs

The CAP will include the name and telephone number of a PRTF staff Member who will work with Wyoming Medicaid towards approval of the CAP.

Wyoming Medicaid must approve or disapprove of the PRTF's proposed CAP within ten (10) days of its receipt by Wyoming Medicaid. The ten (10) day submission/ten (10) day response cycle will continue until Wyoming Medicaid approves a CAP. The PRTF must implement the CAP within 30 days of its approval.

When notifying the PRTF of its CAP approval, Wyoming Medicaid will also inform the PRTF of the anticipated time of the next follow-up OSCR.

20.9.8 Appeals Process

If the PRTF disagrees with its status ruling or has a complaint regarding Wyoming Medicaid's response to its proposed CAP, it may appeal the review team's finding pursuant to the process outlined in Section 20 of Wyoming Medicaid Chapter 16 Rule. Wyoming Medicaid must receive the facility's appeal in writing within 20 days of the date of the final status determination. If the reconsideration is not favorable, in accordance with Section 21 of Wyoming Medicaid Chapter 16 Rule, Providers may request an administrative hearing pursuant to Chapter 4.

20.9.9 On-Site Compliance Review Forms

20.9.9.1 A: Administrative Section: Document Review

1. The facility is COA, CARF, or JCAHO-accredited.
    - Yes
    - No
2. The facility's PRTF license is current.
    - Yes
    - No

3. The licenses of professional staff are current.
    - Yes
    - No
4. A roster of all staff, divided by discipline, who provide direct services to residents were provided with staff signatures.
    - Yes
    - No
5. The facility meets State-staffing requirements as outlined in 42 CFR, Part 441, Subpart D-Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs.
    - Yes
    - No
6. The facility has informed WDH of changes in PRTF administrator, Medical Director, or Clinical Director within 72 hours of the effective date of the change.
    - Yes
    - No
7. Records and documentation requested by WDH were provided at the time requested. An index or key was provided to locate required information.
    - Yes
    - No
8. The facility's policy and procedures are in accordance with WDH requirements.
    - Yes
    - No
9. The facility’s policy and procedures for transfer, discharge, and provision of services are the same for all residents, regardless of payment source.
    - Yes
    - No
10. The facility does not accept new residents who have attained the age of 21 or maintain residents who have attained the age of 22.
    - Yes
    - No

11. The facility has a signed transfer agreement with one or more general hospitals to provide any needed diagnostic and medical services to residents (Facility to provide an example of a chart note or documentation as evidence of arrangement).
    - Yes
    - No
12. The facility has arrangements with community Providers to provide specialized medical care to residents when needed (Facility to provide an example of a chart note or documentation as evidence of arrangement).
    - Yes
    - No
13. Personnel records verify that all licensed and provisionally licensed staff/Providers who participate in treatment planning have a minimum one-years' experience in treating children and adolescents who are emotionally disturbed.
    - Yes
    - No
14. The facility has informed WDH in writing of the occurrence of any serious incidents as defined in Section 18.18 within one (1) working day following their occurrence.
    - Yes
    - No
15. Records and documentation are maintained per the facility record retention policy.
    - Yes
    - No
16. The facility has a policy in place and a committee that meets regularly regarding policies on trauma informed care and bullying.
    - Yes
    - No

20.9.9.2 B: Facility Tour

1. The physical treatment environment is:

Category:	4	3	2	1
Attractive (clean, pleasant décor).				
Warm, child-friendly (pictures, plants, home-like atmosphere).				
Treatment-oriented (educational/motivational posters, treatment reminders).				

2. Program information (activity schedules, unit rules, requirements for level system) are posted in public spaces for resident reference.
    - 4
    - 3
    - 2
    - 1
3. Program information for residents (for example, unit rules, behavior care plans, and other treatment information posted on units or given to children) is:

Category:	4	3	2	1
Clear, specific.				
In age-appropriate language.				
Worded respectfully.				
Expressed in positive terms.				

4. Staff's verbal communication with children is observed to be:

Category:	4	3	2	1
Clear, specific.				
In age-appropriate language.				
Respectful.				
Expressed in positive terms.				
Delivered in friendly voice tones.				
Reflects patients individualized behavior care plan.				

5. The physical arrangement of the units indicates a high level of staff/resident interaction (professional offices located on units or close to them, no unnecessary physical barriers between staff and residents).
    - 4
    - 3
    - 2
    - 1
6. Random checks of residents' behavior program documentation (point sheets or similar documents) indicate that compliance feedback is being provided in a timely manner.
    - Yes
    - No
7. Effective safety precautions are in place for monitoring reactive children. There is a sensory room or other physical space (or items such as a sensory chart) to help children de-escalate.
    - Yes
    - No
    - Not applicable
8. Nighttime bed-monitoring procedures are established and documented. These are individualized to the needs of each resident.
    - Yes
    - No
9. Each unit has identified an appropriate place/procedure for responding to residents' physical/medical complaints.
    - Yes
    - No
10. Rules and schedules for the use of personal hygiene facilities provide adequately for the safety of residents.
    - Yes
    - No
11. Areas set aside for seclusion/restraint are clean, well-lighted/ventilated, and without doors.
    - Yes
    - No

12. All actions in each seclusion or restraint room can be continuously monitored.
    - Yes
    - No
13. The facility has adequate areas for indoor/outdoor recreation.
    - 4
    - 3
    - 2
    - 1
14. The facility provides an accredited school for residents.
    - Yes
    - No
15. There is a designated area for the provision of well-balanced meals. The menu is posted in public areas.
    - Yes
    - No
16. Areas designated for the provision of group therapy and community meetings are conducive to therapeutic interaction.
    - 4
    - 3
    - 2
    - 1
17. There is evidence of adequate facility security to minimize elopement risk.
    - 4
    - 3
    - 2
    - 1
18. Designated warm places where the residents can meet their families when they visit.
    - Yes
    - No

19. There is HIPAA compliant video conferencing availability with family for therapy sessions.
    - Yes
    - No
20. Evidence the facility follows their written policy/procedures was observed.
    - Yes
    - No

20.9.9.3 C: Program Section: Document Review

1. Behavior program used as a part of treatment is:

Category:	4	3	2	1
Clear, specific.				
Age-appropriate to the targeted group.				
Reasonable and workable in the normal course of treatment.				
Reflective of a trauma informed culture.				

2. Adequate staff in-service training is provided, as evidenced by:

Category:	Yes	No
Orientation and supervised on-the-job training is provided to new staff prior to their being assigned independent responsibilities.		
A minimum of 20 hours of in-service training (excluding training described in item 3 below) are received by each staff Member per year.		
Training topics are appropriate to the needs of residential treatment staff.		
Trainers are qualified in the area of training they provide.		
Reflect a trauma-informed care approach to treatment.		

3. All direct care staff are trained and certified in a professionally recognized method of milieu management, de-escalating problem behaviors, applying physical restraints when necessary, and providing trauma-informed care.
    - Yes
    - No
4. There is documentation that adequate clinical supervision is provided. Therapists, nursing staff, and direct care staff receive a minimum of four (4) hours of clinical supervision per month,

provided through a combination of individual supervision, group supervision, and participation in treatment team meetings. This requirement is not satisfied through training.

- 4
- 3
- 2
- 1

5. All occurrences of seclusion/restraint are documented in a facility-wide log and must be reported to the State through utilization review.
   - Yes
   - No
   - Not applicable
6. An interdisciplinary team that looks specifically at patterns and/or trends (for staff, shifts, and so on) reviews all occurrences of seclusion/restraint monthly. The team will then develop an appropriate action plan to address these occurrences, as an on-going process.
   - Yes
   - No
   - Not applicable
7. Incident reports (accidents, injuries, allegations of staff misconduct) are maintained according to policy. Documentation indicates that incidents have been handled appropriately by the PRTF staff and are reported as required.
   - Yes
   - No
8. Child abuse allegations are reported to proper authorities.
   - Yes
   - No
9. Standards have been developed for evaluating the effectiveness of the facility's program. The evaluation protocol includes, at a minimum:

Category:	**Yes**	**No**
A comparison of each resident's pre- and post-treatment functional status.		
There is a standardized process for discharge planning and development of an aftercare plan.		
A comparison of prescribed medications, pre- and post-treatment.		

10. The therapeutic curriculum used by the facility is trauma-informed and evidence-based for the population and age range being served.
    - Yes
    - No
11. Documentation indicates that the facility follows its policies and procedures in practice
    - Yes
    - No

20.9.9.4 D: Staff Interviews

1. Staff can explain ways the facility's culture and philosophy are trauma-informed.
    - 4
    - 3
    - 2
    - 1
2. Staff understands the facility's behavior program and can explain it.
    - 4
    - 3
    - 2
    - 1
3. Staff participates regularly in community meetings with residents on the treatment unit.
    - 4
    - 3
    - 2
    - 1
4. Staff reports receiving adequate clinical supervision. Staff can identify their primary supervisor and at least two (2) other people with supervisory training and/or experience to whom they can turn for information, support, and guidance. Staff perceives supervision as helpful to them in improving the quality of services they provide to residents.
    - 4
    - 3
    - 2
    - 1

5. Staff reports receiving adequate in-service training. Staff can summarize the salient points of at least one (1) training provided within the last year. Staff perceives the training they have received as relevant to their job responsibilities.
    - 4
    - 3
    - 2
    - 1
6. Staff perceives professional working relationships as cooperative and collaborative.
    - 4
    - 3
    - 2
    - 1
7. Staff communication is timely, accurate, and works for the benefit of the residents.
    - 4
    - 3
    - 2
    - 1
8. Staff perceives the facility's administration as supportive of the clinical program and responsive to its needs and problems.
    - 4
    - 3
    - 2
    - 1
9. Staff understands the proper use and documentation of special procedures (seclusion and restraint), when and how they should be used, which staff is authorized to apply them, and what other less restrictive techniques might be attempted to de-escalate difficult situations or behavior.
    - 4
    - 3
    - 2
    - 1

10. Staff is aware of the proper procedure for handling medical/physical complaints of residents.
    - 4
    - 3
    - 2
    - 1
11. Staff believes that treatment units are adequately staffed, and a policy is in place to ensure there is coverage for individual and family therapy when staff is on leave.
    - 4
    - 3
    - 2
    - 1

20.9.9.5 E: Resident Record Review

1. Resident Record:

Category:	Yes	No	Not Applicable
Well organized and legible with a key identifying the location of all required documents.			
Copies of documents verifying custody.			

2. Admission:

Category:	Yes	No
Documentation of MD recommendations and psychiatric evaluation for admission to PRTF within 30 days prior to admit.		
If admission is for a Sexually Acting Out or SO program, then a current and independent Psychosocial Assessment should be completed in advance and the findings should be reflected in the Psychiatric Recommendations.		
Parents or guardians were informed regarding medication policies (permission for medication changes, or any PRN changes), seclusion and restraint procedures, and requirements for family involvement.		

3. At admission, less restrictive treatment is not appropriate:

Category:	Yes	No
Resident failed to respond to less restrictive treatment.		
Symptom severity warrants residential treatment.		
Resident is being stepped-down from acute care or symptoms could not be controlled at lower level of care.		

4. Assessment:

Category:	Yes	No
Psychiatric evaluation completed within seven (7) days of admit		
Medical history and physical exam provided within seventy-two (72) hours of admission including medication history.		
Escalation risk/safety plan, trauma assessment, risk of sexual offense, and acting out behavior are addressed.		
Psychosocial assessment per LOC.		
Provisional discharge plan completed at intake.		

5. Assessment: Required Elements

Category:	4	3	2	1
A complete clinical case formulation is documented in the record (for example, primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).				
Documentation of presence or absence of any current medical conditions.				
A complete mental status exam, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.				
Documentation of efforts to obtain collateral information from previous treatment Providers and parent/guardian.				
Adequate information in the record to make a careful diagnostic assessment or resolve differences in diagnostic impressions.				
There is evidence that initial coordination of care has occurred.				

6. Psychosocial assessment:

Category:	4	3	2	1
Includes developmental profile.				
Includes behavioral assessment.				
Includes details regarding onset of symptoms.				
Assesses potential family resources.				
Trauma Assessment				
Risk of sexual offense and acting out behavior.				
For patients 12 and older, a substance abuse screening occurs. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.				

7. Treatment Planning: Team Composition

Category:	Yes	No
Psychiatrist or PMH-MP/psychologist and physician separate PCP from psych.		
LCSW, LPC, LMFT, LAT, Provisionally Licensed Staff/Providers, and Licensed Psychologists.		

8. Treatment Planning: Time Lines Met

Category:	Yes	No	Not Applicable
Initial plan at intake.			
Comprehensive plan within fourteen (14) days.			
Reviews: once at end of first month of stay.			
Reviews: once monthly after first month of stay.			
Treatment plans are updated within 24 hours following seclusion or restraint.			

9. Treatment Planning: Required Elements

Category:	Yes	No
If trauma and/or sexual acting out behavior has been identified, it is reflected in the treatment plan goals and interventions.		
Both resident's strengths and problem areas are addressed.		
Both family's strengths and problem areas are addressed.		
The treatment plan is individualized and consistent with diagnosis.		
Short and long term goals are objective and measurable.		
Treatment plan addresses each diagnosis separately.		
Treatment modalities and clinicians responsible are identified. Realistic and obtainable goals are put in place for kids with self-harm history.		
Family therapy goals/objectives are explained.		
Discharge plan and estimated discharge date are identified.		
If a substance use disorder is identified, it is reflected in the treatment plan goals and interventions.		

10. Treatment Planning: Reviews

Category:	Yes	No	Not Applicable
Identify changes in treatment, if needed, to address goals where progress is minimal.			
The need for residential versus less-restrictive treatment is reassessed.			
The progress in relation to projected discharge date, as measured by meeting measurable goals/objectives, is assessed.			
Goals, measurable objectives, target dates for completion are incorporated into the treatment plan.			
Treatment successes are noted.			

11. Evidence that resident and parent/guardian actively participate in treatment goals.
    - Yes
    - No

12. Evidence that psychiatrist directs treatment through comprehensive notes and participation in staffing.
    - Yes
    - No
13. Evidence of interdisciplinary collaboration in planning.
    - Yes
    - No
14. Treatment Documentation: Required Elements

Category:	**4**	**3**	**2**	**1**
Summary of content/process is detailed enough to provide an accurate clinical picture to those outside the treatment team.				
Sessions clearly have therapeutic focus.				
Outcome of session and plan for time between sessions and next session.				
Documentation that goals of treatment are communicated with all direct care staff.				

15. Treatment Documentation for all modalities:

Category:	**Yes**	**No**
Therapist's name and signature is present on treatment documentation.		
Date/length of session.		

16. Individual Therapy: Required Elements

Category:	**4**	**3**	**2**	**1**
Progress towards treatment goals is identified.				
Progress in relation to discharge date and plan for future sessions is addressed at least monthly.				
If trauma has been identified, there is evidence it is being addressed.				
The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.				
Treatment modalities are evidence-based and appropriate for the diagnoses.				
Progress notes contain a level of detail sufficient for those not directly involved in treatment to have an accurate clinical picture.				

Category:	4	3	2	1
Mental status and depression assessment.				

17. Individual Therapy is provided a minimum of one hour per week.
    - Yes
    - No
18. Family Therapy: Required Elements

Category:	4	3	2	1
Resident's response to family.				
Documentation supports family therapy focus on addressing presenting problems prior to admission and preparing for a successful transition home.				
If family is not actively involved in treatment, therapeutic intervention is addressed.				
Evidence of alternative treatment interventions when there is minimal or no progress.				
If trauma has been identified, there is evidence it is being addressed.				

19. Family Therapy is provided a minimum of one hour per week.
    - Yes
    - No
20. Group Therapy: Required Elements

Category:	Yes	No
Activities are therapeutic in nature and relate to treatment goals.		
There is evidence of resident's participation in groups.		

21. Group therapy is provided a minimum of 3 hours in at least 3 sessions per week.
    - Yes
    - No
22. Therapeutic milieu is provided 24 hours per day seven days per week.
    - Yes
    - No

23. Medication

Category:	Yes	No	Not Applicable
All orders are in chart.			
Evidence of PRN orders routinely reviewed and updated (PRN follows WDH guidelines).			
There was informed consent for meds properly executed.			
The resident was assessed for side effects.			
Administration is timely and accurate (MAR).			
There is documentation of medical history.			
Reasons for, and response to, PRN medication use is documented in MAR.			
There is no evidence of chemical restraints being used.			

24. Medication Monitoring: Required Elements

Category:	Yes	No	Not Applicable
Rationale behind the medication plan is discussed.			
When medication does not appear to be therapeutically effective, there is an aggressive plan to address.			
Evidence the lab results were received and reviewed by the clinician.			
Evidence of progress documented by the physician/addictionologist at regular intervals, appropriate to the rendered service.			
Record of previous medication trials.			
Documentation of monitoring for boxed warnings for medication.			
Metabolic parameters obtained per best practice guidelines.			
Rule out diagnoses confirmed or eliminated.			
Record contains documentation of a differential diagnosis when medical conditions are present.			

25. There is evidence that frequency of Member visits with psychiatrist is appropriate to the intensity of treatment and current risk issues.
    - Yes
    - No

26. Care of the Whole Person

Category:	Yes	No	Not Applicable
Residents have access to a primary care physician.			
Residents have access to dental/vision.			
PRTF is ensuring resident is current with EPSDT.			
PRTF is providing health care education (STDs, birth control, and so on)			
Biometrics changes are addressed by the psychiatrist and/or dietitian.			

27. Therapeutic Pass:

Category:	Yes	No	Not Applicable
Goals for pass are identified based on clinical need not programmatic standards.			
Evidence that goals were discussed with resident and family/guardian.			
Evidence of evaluation of the pass.			

28. Therapeutic Leave:

Category:	Yes	No
Authorized by physician's or PMHNP's orders.		
Not taken during 14-day assessment.		
Date/Time patient checked out/in is documented.		
Medication instructions given using non-medical language.		
Therapeutic goals for leave are discussed with resident and family/guardian.		
Required time of return is identified and documented.		
Name of person with whom leave will be spent with is documented.		
Resident's condition at check-out-in and mental status is documented.		
Name/signature of person with whom child is leaving/returning with is documented.		
There is documentation that goals were discussed with the child and their family.		
Name/signature of staff checking child out/in is documented.		

Category:	Yes	No
Medications provided/returned are noted and include number of doses.		
Outcome of leave is assessed by therapist within 72 hours of return.		
UDS completed upon return when clinically indicated.		

29. Prior to seclusion/restraint, the least restrictive effective intervention was used:

Category:	4	3	2	1
Prior to seclusion/restraint, were less restrictive attempts to de-escalate behavior utilized.				
Documentation of which less restrictive measures were used and how they failed.				

30. Seclusion/Restraint: Required Elements

Category:	Yes	No	Not Applicable
Seclusion/restraint initiated and ended only by a state approved professional.			
Personal seclusion/restraint administered by trained personnel.			
Seclusion/restraints only used for imminent threat.			

31. Seclusion/Restraint: Documentation

Category:	Yes	No	Not Applicable
Date/Time procedure started/ended.			
Names of staff involved in applying or monitoring seclusion/restraint.			
Was the precipitating event for the escalating behavior identified?			
Order obtained from state approved professional within one hour.			
Orders for children under the age of 9 are no more than one hour, 9-17 year old children are two hours, and orders for 18-21 year olds are four hours.			
Order was renewed when original order expired and why a renewal was needed was documented.			
Clear criteria for ending seclusion/restraint was identified.			
Resident's health/comfort was assessed every 15 minutes.			
Vital signs were taken every hour.			

Category:	Yes	No	Not Applicable
In-person assessment conducted by physician, PMHNP, or RN within 1 hour, regardless of length of procedure.			

32. Seclusion/Restraint: Assessment of Outcome

Category:	4	3	2	1
Resident's physical/psychological status.				
Resident's response to the restraint.				
Resulting complications.				
Seclusion/restraint ended at the earliest possible time.				

33. Seclusion/Restraint: Timelines

Category:	Yes	No
The treatment plan was modified within one working day of incident as indicated.		
Parents or guardian notified within 24 hours of the incident.		
The incident was processed with the resident by staff within 24 hours.		
Resulting complications.		

34. Provisional discharge/aftercare plan developed at intake and updated throughout treatment episode to reflect resident progress.
    - Yes
    - No

35. Provisional Aftercare Plan: Required Elements

Category:	Yes	No
Anticipated date of discharge.		
Recommendations for parents/caregivers.		
Educational summary and recommendations.		
Recommendations for mental health Providers.		

36. Final Aftercare Plan: Required Elements

Category:	Yes	No
Person/agency to who resident will be released.		
Address where resident will reside.		
Documentation that coordination of care was attempted by PRTF therapist.		
Names, addresses, and phone numbers of follow-up mental health care Providers was documented.		
Recommendations and briefing of safety plan with parents/caregivers.		
Follow up appointment with PCP, psychiatrist, and therapist including date, time, and Provider name documented.		
Documentation of functional impairments preventing completion of activities of daily living and ongoing risk.		

37. Final Aftercare Plan: Timelines Met

Category:	Yes	No
Follow up therapy appointment within 7 days of discharge.		
Medication management appointment scheduled within 30 days of discharge.		

38. Final Discharge Summary: Required Elements

Category:	Yes	No
Dates of admission and discharge.		
Progress towards treatment goals.		
Summary of reason(s) for discharge.		

39. Parents/Guardians Received:

Category:	Yes	No
Minimum of one week supply of medications.		
Written prescription for 30-day supply of medications.		
Copy of aftercare plan.		

40. Documentation that educational summary and recommendations were mailed to the resident's school within 24 hours post-discharge.
    - Yes
    - No
41. Documentation that aftercare plan and discharge summary were mailed to follow-up mental health care Providers within 2 weeks post-discharge.
    - Yes
    - No
42. Documentation indicates that the facility follows its policies and procedures in practice.
    - Yes
    - No

20.9.9.6 F: Resident Interviews

1. Residents can explain how they are encouraged to participate freely in community meetings. Residents perceive open, collaborative communication between themselves and staff.
    - 4
    - 3
    - 2
    - 1
2. Residents feel like they can safely bring concerns and challenges to staff without fear of consequences.
    - 4
    - 3
    - 2
    - 1
3. Residents participate in treatment team meetings. They are knowledgeable about their treatment goals and have helped to set them.
    - 4
    - 3
    - 2
    - 1

4. Residents understand their behavior program(s). They know what phase they are on and what is required to reach the next phase.
    - 4
    - 3
    - 2
    - 1
5. Residents report receiving timely feedback on their progress towards treatment goals.
    - 4
    - 3
    - 2
    - 1
6. Residents are knowledgeable about their medications: names, strengths, frequency of dosages, and which symptoms are targeted. They can explain possible side effects of their medications.
    - 4
    - 3
    - 2
    - 1
7. Residents are aware of the goals they need to meet before going home, targeted discharge date, and current discharge date.
    - 4
    - 3
    - 2
    - 1
8. If residents have been secluded or restrained, they understand why the seclusion/restraint was used and understood their release criteria at the time the procedure was in progress.
    - 4
    - 3
    - 2
    - 1
    - Not applicable

9. A staff Member helped them to process the incident after its conclusion.
    - Yes
    - No
    - Not applicable
10. Resident could name their triggers and at least two coping skills they can try in the future when feeling upset or out of control.
    - 4
    - 3
    - 2
    - 1
11. Does the resident feel safe when others are out of control?
    - 4
    - 3
    - 2
    - 1
12. Residents believe that medical complaints are handled in a timely and appropriate manner.
    - 4
    - 3
    - 2
    - 1
13. Residents have a positive perception of the facility's program and how they are being treated. They perceive staff as genuinely interested in their welfare and capable of helping them.
    - 4
    - 3
    - 2
    - 1
14. Residents feel they are making progress in their treatment and can explain why.
    - 4
    - 3
    - 2
    - 1

15. Resident feels the facility is warm, safe, and comfortable.
    - 4
    - 3
    - 2
    - 1
16. Resident feels satisfied with how the facility reacts with their family and they are able to contact their family regularly.
    - 4
    - 3
    - 2
    - 1
17. Residents understand the grievance policy and how to submit a complaint if they have a grievance.
    - 4
    - 3
    - 2
    - 1

Appendices

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Appendix A – Change Control Table

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

Table 1. Change Control Table

Effective Date	Changes
10/01/2024	**Chapter 1 – General Information** Section 1.4 Fiscal Agent Responsibilities: Replaced reference that Acentra Health processes all claims and adjustments, with they process all adjustments.
	Chapter 3 – Provider Responsibilities Section 3.10 Out-of-State Service Limitations: Removed reference that Medicaid has designated the WMSA to be Wyoming and selected border cities in adjacent states and removed the table of WMSA cities. Removed reference to Medicaid compensation of out of state Providers within the WMSA. Added reference to Medicaid Rule Section 7, Out-of-State Providers.
	Chapter 6 – Common Billing Information Section 6.9.2 Ages 21 and Older: Replaced Procedure Code 90839 with 90838 Section 6.10.1 Invoice Charges: Removed statement that discounted pricing or codes cannot be market out. Added that effective 07/01/2024 if any part of an invoice is missing or market out, the claim or claim line will be denied. Section 6.13 Prior Authorization: Added “and Email” to the Phone Column in the tables. Added contact info for Clubhouse Services.
	Chapter 13 – End Stage Renal Disease Section 13.1 End Stage Renal Disease: Removed “Beginning Oct 1, 2023 from second paragraph. Section 13.2 Billing Requirements: Removed first two bullets referencing dates of service Medicaid will reimburse and pay. Replaced the link to the Medicare ESRD PPS consolidated billing list. Section 13.3.1 Coding Criteria Table: Removed 10/01/2023 from Effective Date column header.
	Chapter 14 – Federally Qualified Health Centers Section 14.1.2 Reimbursement Guidelines: Removed “Effective Jan 1, 2022” from statement that Medicaid will reimburse professional services for immediate postpartum IUD or contraceptive implant insertion procedures.
	Chapter 15 – Home Health Section 15.2.3 Billing Requirements: Removed first 4 bullets referencing revenue codes, condition codes, diagnosis codes, and attending physician, PA number must be places on claim, documentation that the member would not be eligible for services under the Medicare Home Health.

Effective Date	Changes
	Section 15.2.3.2 Commercial Insurance and Medicaid: Updated section to remove info about commercial insurance processing the claim and added bullets to use appropriate revenue codes, do not bill with procedure codes, do not span bill, bill using appropriate units, PA number must be placed on claim and Plans of Care, Medicare 485 form, physician orders, documentation of face-to-face visit, and documentation of non-homebound status for Medicare/Medicaid dual Members stating the Member would not be eligible for services under the Medicare Home Health. Section 15.2.3.3 Completing An Adjustment: NEW
	Chapter 18 – Skilled Nursing Facility and Swing Bed Services Section 18.4.2 LT101 (Medicaid Evaluation of Medical Necessity): Updated the email for Sherry Mitchell.
	Appendices Appendix B – Provider Notifications Log: Updated.

Appendix B – Provider Notifications Log

Provider Notifications Log			
Active Dates	**Notification Type**	**Title**	**Audience**
September 2024	Email	U.S. Post Office No Longer Forwards Mail for Wyoming Medicaid Sent to an Incorrect Mailing Address	CMS-1500 and Dental Providers
July 2024	Email, Provider Bulletin	Updated Home Health Commercial Insurance (TPL) Billing Requirements	Home Health Providers

Wyoming Medicaid
Institutional Provider Bulletin
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U.S. Post Office No Longer Forwards Mail for Wyoming Medicaid Sent to an Incorrect Mailing Address

Attention All Providers:
The U.S. Post Office no longer forwards mail for Wyoming Medicaid sent to an incorrect mailing address. Please view the Provider Contact Us web page on the Wyoming Medicaid website where the correct Claims Department and Provider Services mailing addresses and their uses are posted online.

Updated Home Health Commercial Insurance (TPL) Billing Requirements

Attention Home Health Providers:
The billing requirements outlined below will give providers the information needed to determine when to submit a claim with commercial insurance (TPL) through the EVV system or directly to the BMS system.

When the commercial insurance (TPL) has paid (partially or fully) on the claim, providers are to submit the claim directly to the BMS system. Providers can submit claims via direct data entry (DDE) in the Provider Portal, upload batch claim files, or submit HIPAA electronic claim transactions.

- Providers are to enter TPL information at the header and include the appropriate CARCs and dollar amounts on the claim line(s).

When the commercial insurance has denied payment for any reason, the provider must submit the claim in the EVV system.

- For example,
  - Primary commercial insurance denied the claim due to the member's plan maximum benefit being reached
  - The member's plan has a limited benefit

The EVV system will create and send the claim to the BMS system. The claim will post edit 7141 – TPL on-file not on the claim. Home health claims posting this edit will be held in the "in process" status for 30 days. Home health providers have 30 days to attach the commercial insurance (TPL) EOB, which should indicate the reason services were denied by the commercial insurance (TPL). Once this EOB is attached to the claim, the claim will be reviewed and processed accordingly.

- **Important!** The EOB must be the original EOB from the commercial insurance (TPL) and **not** from the providers electronic health record (EHR) system.

If the EOB is not received within 30-days, the claim will be denied and the provider will need to start over and submit a new claim.

Contact Provider Services at 1-888-996-6223, M-F, 7 am – 6 pm MST, for assistance.