WY BMS CMS-1500 Provider Manual

Prepared for:

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

Prepared by:

CNSI
2277 Research Boulevard
Rockville, MD 20850

10/02/2023
Version 8.0
Security: N = No Restriction

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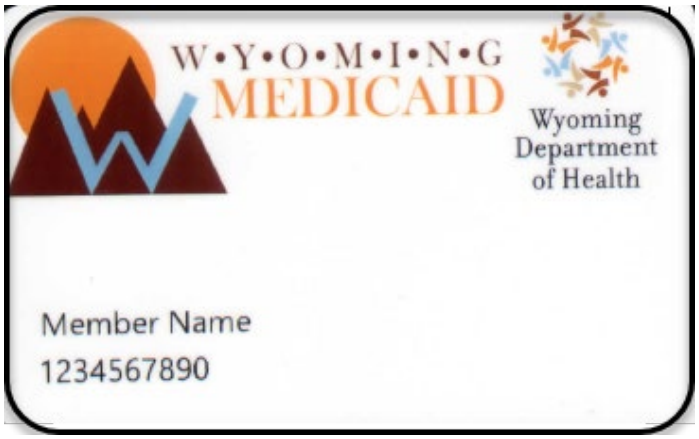
Revision History

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 throughout.
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.



Overview

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

Rule References

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

Importance of Fee Schedules and Provider's Responsibility

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

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

Getting Questions Answered

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

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

Authority

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

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

Table of Contents

Chapter 1 – General Information

1.1 How the CMS 1500 Manual is Organized

The table below provides a quick reference describing how the CMS 1500 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 web registration and directs trading partners to the Wyoming Medicaid EDI Companion Guide located on the Medicaid website.
Nine	**Important Information** – This chapter covers important billing information such as coding, definitions of supervision and face-to-face visit requirements.
Ten through Twenty-Five	**CMS-1500 Covered Services** – These chapters are alphabetical by professional service and provides information such as: definitions, procedure code ranges, documentation requirements, covered and non-covered services, and billing examples.
Appendices	**Appendices** – Provide key information in an at-a-glance format. This includes the last quarters Provider Notifications.

1.2 Updating the Manual

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

Most of the changes come in the form of provider bulletins (via email) and Remittance Advice (RA) banners, although others may be newsletters or Wyoming Department of Health letters (via email) from

state officials. The updated provider manuals will be posted on the Medicaid 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 on the Medicaid website as it is sent to Providers and will be incorporated into the provider manuals as appropriate to ensure the Provider has access to the most up to date information regarding Medicaid policies and procedures.

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

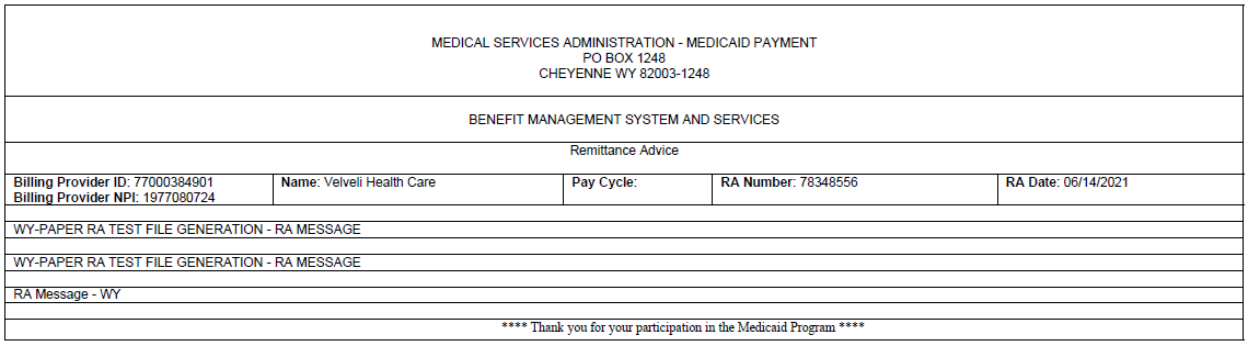
It is critical for Providers to keep their contact email address(es) up-to-date to ensure they receive all notices published by Wyoming Medicaid. It is recommended that Providers add the WYProviderServices@cns-inc.com email address, from which notices are sent, to their address books to avoid these emails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

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

1.2.1 Remittance Advice Banner Notices

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

RA 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

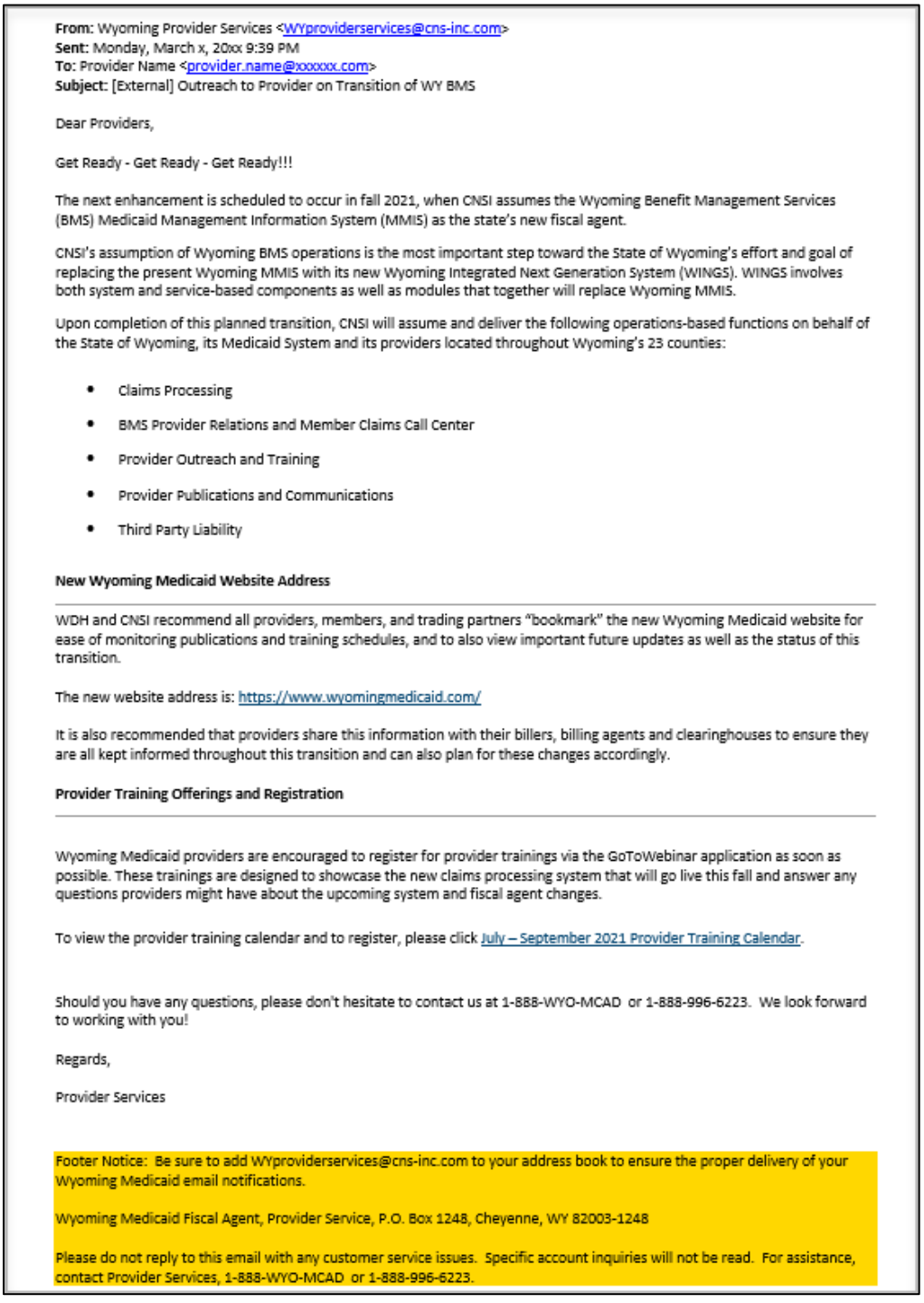
RA Message - WY

**** 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

CNSI is the fiscal agent for Medicaid. They process all claims and adjustments, except for 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/TDD
	(855) 329-5205
	(Members Only, CSC cannot speak to Providers)
	7am-6pm MST M-F
	Fax (855) 329-5205
		https://www.wesystem.wyo.gov	• Member Medicaid applications
			• Member ID Card replacements
			• Member Travel Assistance
			• Members being billed by Providers
			• Eligibility questions regarding:
			  ○ Family and Children's programs
			  ○ Tuberculosis Assistance Program
			  ○ Medicare Savings Programs
			• Employed Individuals with Disabilities(EID)
			• Verification of Services

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

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
122 West 25th St, 4th Floor West Cheyenne, WY 82002	Fax (307) 777-6964		• Concerns/Issues with State Contractors/Vendors • Developmental Disability Services
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) 24/7 IVR Availability	N/A	• Member accident covered by liability or casualty insurance, or legal liability is being pursued • EID premiums or balances • Estate and Trust Recovery • Report Member TPL • Report a new/update insurance policy • Problems getting insurance information needed to bill • Questions or problems regarding third party coverage or payers • WHIPP program • TPL Disallowance Portal

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Maternal & Child Health (MCH) /Children Special Health (CSH) Public Health Division 122 West 25th Street 3rd Floor West Cheyenne, WY 82002	Tel (307) 777-7941 Tel (800) 438-5795 Fax (307) 777-7215	N/A	• High Risk Maternal • Newborn intensive care • Program information
Medicare	Tel (800) 633-4227	N/A	• Medicare information
Magellan Healthcare, Inc.	Tel (307) 459-6162 8 am-5pm MST M-F (855) 883-8740 After Hours	https://www.magellanofwyoming.com/	• Care Management Entity Services that require Prior Authorization
Provider Services Wyoming Department of Health P.O. Box 1248 Cheyenne, WY 82003-1248 (IVR Navigation Tips) Email: WYProviderOutreach@cns-inc.com	Tel (888) WYO-MCAD or (888) 996-6223 7 am-6 pm MST M-F (call center hours) 24/7 (IVR availability) Fax (307) 460-7408	www.wyomingmedicaid.com/	• Bulletin and manual inquiries • Claim inquiries and submission problems • Member eligibility • Documentation of Medical Necessity • How to complete forms • Payment inquiries • Provider Portal assistance and training • Request Field Representative visit • Technical support for vendors, billing agents and clearinghouses • Trading Partner Registration • Training seminar questions • Timely filing inquiries • Verifying validity of procedure codes • Web Registration

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
			• Wyoming Medicaid EDI Companion Guide located on the Medicaid website
Social Security Administration (SSA)	Tel (800) 772-1213	N/A	• Social Security benefits
Stop Medicaid Fraud	Tel (855) 846-2563 **NOTE:** Remain anonymous when reporting	https://health.wyo.gov/healthcarefin/program-integrity/	• Information and education regarding fraud, waste, and abuse in the Wyoming Medicaid program • To report fraud, waste, and abuse
WYhealth (Care Management) 122 W 25th St 4th Floor Cheyenne, WY 82002	Tel (888) 545-1710 Nurse Line: (OPTION 3)	https://health.wyo.gov/healthcarefin/medicaid/wyoming-medicaid-health-management/	• Diabetes Incentive Program • Educational Information about WYhealth Programs • ER Utilization Program • Medicaid Incentive Programs • Refer a Member to the Health Management Program • Referrals to Project Juno
Telligen (Utilization Management) 1776 West Lakes Pkwy West Des Moines, IA 50266	Tel (833) 610-1057	https://wymedicaid.telligen.com/	• DMEPOS Covered Services manual • Questions related to documentation or clinical criteria for DMEPOS • Preadmission Screen and Resident Review (PASRR Level II) **Prior Authorization for:** • Acute Psych • Dental services (limited) • Severe Malocclusion • Durable Medical Equipment (DME) or Prosthetic and Orthotic Services (POS) • Extended Psych • Extraordinary heavy care • Gastric Bypass • Genetic Testing

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
			• Home Health • Psychiatric Residential Treatment Facility (PRTF) • PT, OT, ST, and BH services after service threshold • Surgeries (limited) • Transplants • Vagus Nerve Stimulator • Vision services (limited) • Unlisted Procedures
Wyoming Department of Health Long Term Care Unit (LTC)	Tel (855) 203-2936 8 am-5 pm MST M-F Fax (307) 777-8399	N/A	• Nursing home program eligibility questions • Patient Contribution • Waiver Programs • Inpatient Hospital • Hospice
Wyoming Medicaid Website	N/A	www.wyomingmedicaid.com/	• Provider manuals and bulletins • Wyoming Medicaid EDI Companion Guide located on the Medicaid website • Fee schedules • Frequently asked questions (FAQs) • Forms (such as 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

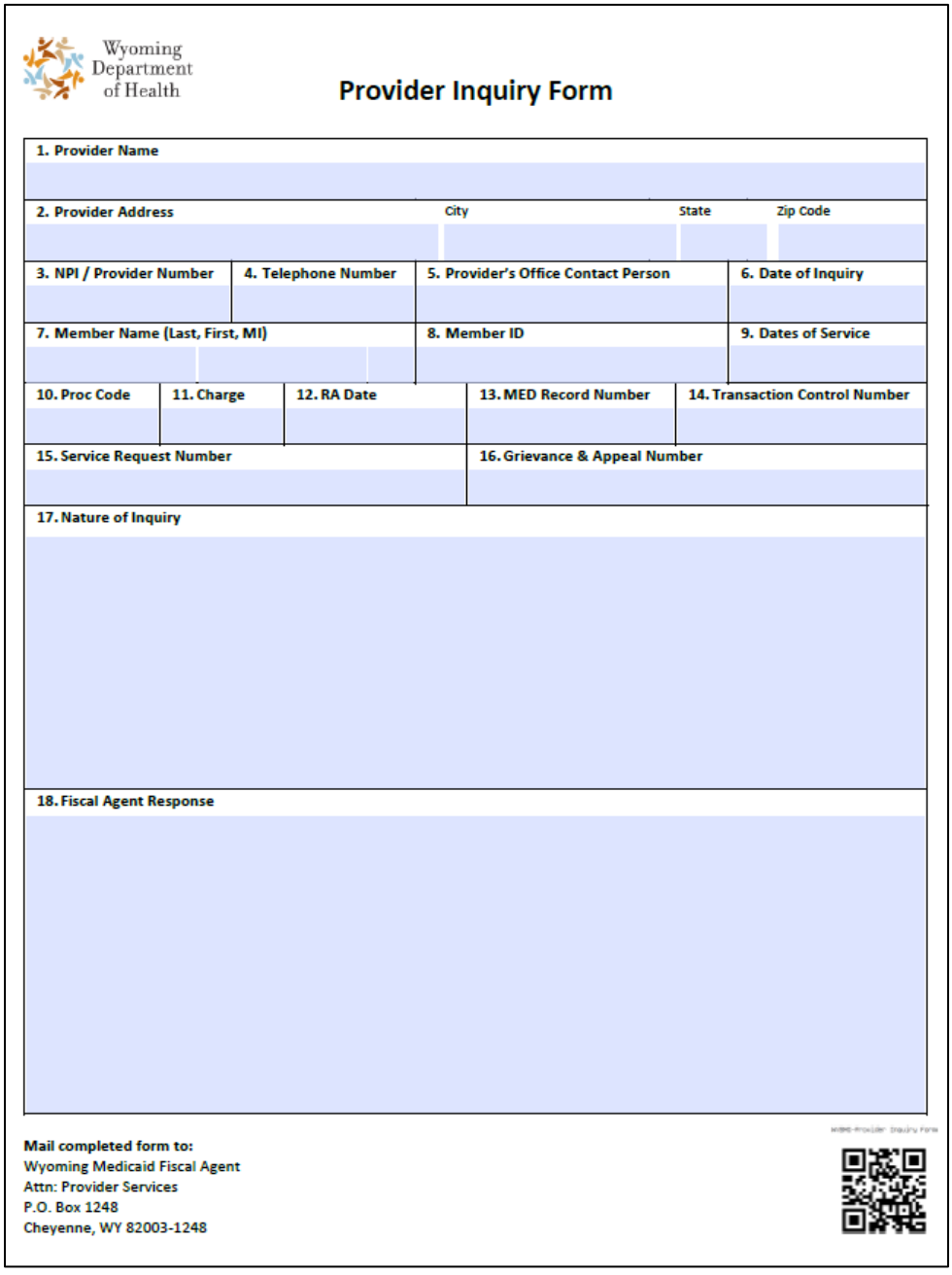
In many cases, writing for help provides the Provider with more detailed information about the Provider's claims or Members. In addition, written responses may be kept as permanent records.

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 (10) business days of receipt.

2.3.1 Provider Inquiry Form



Wyoming Department of Health

Provider Inquiry Form

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

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

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:

- 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 TCNs, documentation of the corrections made to the subsequent claims
- Documentation of contact with Provider Services
- A clean copy of the claim, along with any required attachments and required information on the attachments. A clean claim is an error free, correctly completed claim, with all required attachments that will process and pay.

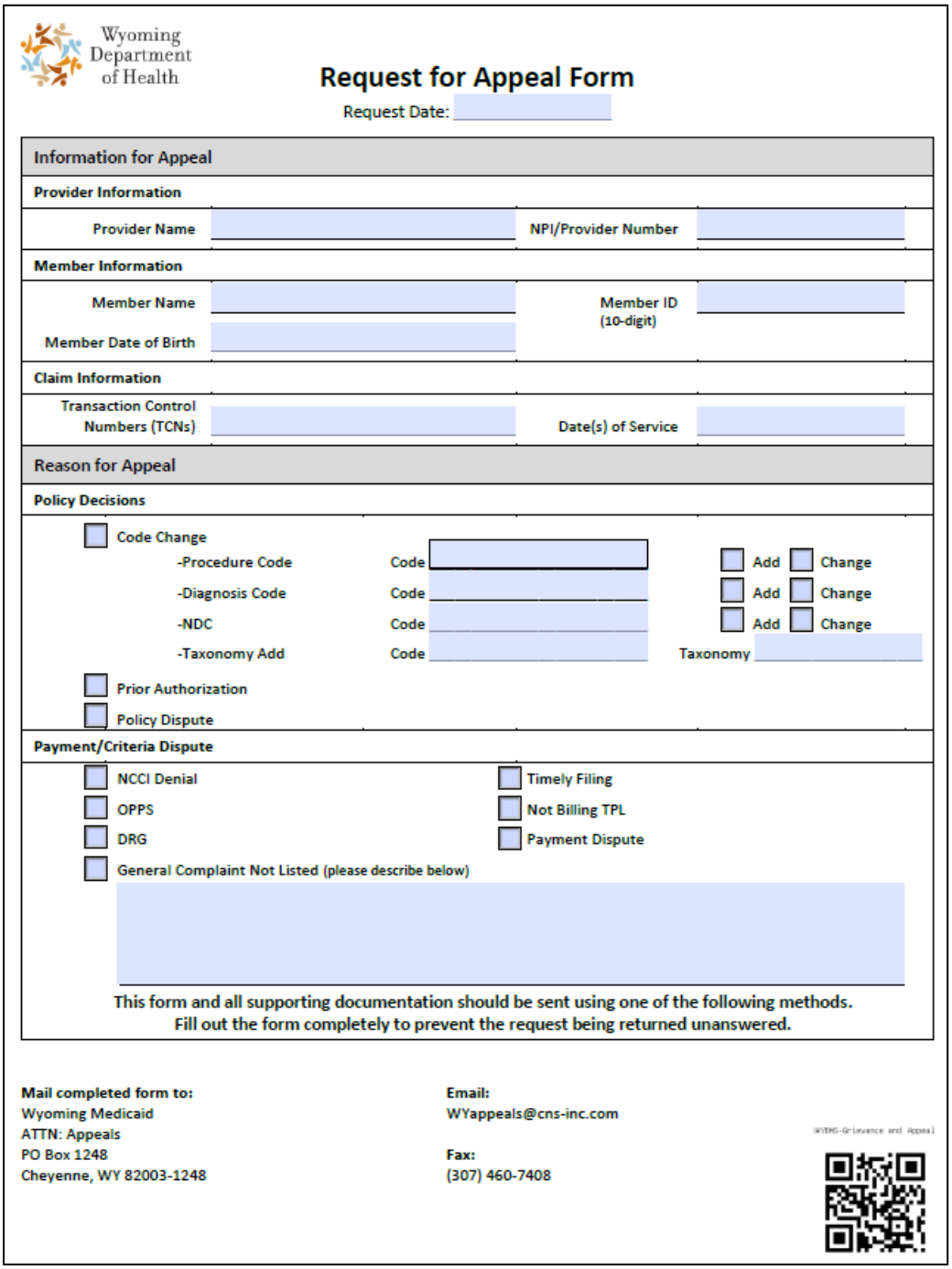
> Appeals for claims that denied appropriately or submission of attachments for denied claims will be automatically denied. The appeals process is not an apt means to resubmit denied claims nor to submit supporting documentation. Doing so will result in denials and time lost to correct claims appropriately.

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

- The First Level Appeal and Grievance Request Form (*see Section* 2.3.2.1 First Level Appeal and Grievance Request Form)
- An explanation of the problem
- Any desired supplementary documentation
- Documentation of contact with Provider Services

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

2.3.2.1 First Level Appeal and Grievance Request Form



Wyoming Department of Health

Request for Appeal Form

Request Date: _____

Information for Appeal

Provider Information

Provider Name _____ NPI/Provider Number _____

Member Information

Member Name _____ Member ID (10-digit) _____

Member Date of Birth _____

Claim Information

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

Reason for Appeal

Policy Decisions

☐ Code Change

-Procedure Code Code _____ ☐ Add ☐ Change

-Diagnosis Code Code _____ ☐ Add ☐ Change

-NDC Code _____ ☐ Add ☐ Change

-Taxonomy Add Code _____ Taxonomy _____

☐ Prior Authorization

☐ Policy Dispute

Payment/Criteria Dispute

☐ NCCI Denial ☐ Timely Filing

☐ OPPS ☐ Not Billing TPL

☐ DRG ☐ Payment Dispute

☐ General Complaint Not Listed (please describe below)

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

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

Email:
WYappeals@cns-inc.com

Fax:
(307) 460-7408

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

The Provider Portal delivers the following services:

- **Data Exchange:** Upload and download of electronic Health Insurance Portability and Accountability Act (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 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 electronic 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 and language pathologist audiologists) and medical groups or clinics • Ambulatory surgical centers • Competitive Acquisition Program and 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 or 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 and orthotic (newly enrolling) suppliers • Individual practitioners suspected of identity theft, placed on previous payment suspension, previously excluded by the OIG, 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
231H00000X	Audiologist

Taxonomies That May Order, Refer, or Prescribe (ORP)	
Taxonomy	**Taxonomy Description**
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)
261QP0904X	Public Health, Federal/Health Programs Operated by IHS

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

3.1.3 Enrollment Termination

3.1.3.1 License and Certification

Seventy-five (75) days prior to licensure and 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, at which point 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 their organization.

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, and 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 and 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 at any point during the month.

It is the Providers' responsibility to determine all sources of coverage for any Member. If the Member is insured by an entity other than Medicaid, and Medicaid is unaware of the insurance, the Provider must submit a Third Party Resources Information Sheet (*see Section 7.2.1* Third Party Resources Information Sheet) to Medicaid. The Provider may not discriminate based on whether 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 or prior authorization and bill Medicaid	Provider can bill the Member OR Provider can request authorization of medical necessity or 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 is subsequently denied Medicaid payment because the services were not covered, or the services were covered but not medically necessary 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 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 code(s), 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

- 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, or office or outpatient hospital visits (*see Section 6.7* 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, not enrolled in Wyoming Medicaid, and has 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)
- Use the Member Eligibility Inquiry via the Provider Portal on the Medicaid website (*see Section 2.1* Quick Reference): Search Wyoming Medicaid Members to determine eligibility for the current month.
    - Primary Insurance information will not be available through this function.

3.8.2 Fee for Service

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

3.9 Freedom of Choice

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

3.10 Out-of-State Service Limitations

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

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

Colorado	Montana	South Dakota	Idaho	Nebraska	Utah
Craig	Billings	Deadwood	Montpelier	Kimball	Salt Lake City

Colorado	Montana	South Dakota	Idaho	Nebraska	Utah
N/A	Bozeman	Custer	Pocatello	Scottsbluff	Ogden
N/A	N/A	Rapid City	Idaho Falls	N/A	N/A
N/A	N/A	Spearfish	N/A	N/A	N/A
N/A	N/A	Belle Fourche	N/A	N/A	N/A

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

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

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

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

- **Emergency Care**: When a Member is traveling, and an emergency arises due to accident or illness.
- **Other Care**: When a Member is referred by a Wyoming physician to a Provider outside the WMSA for services not available within the WMSA
  - i) The referral must be documented in the Provider's records. Prior authorization is **not** required unless the specific service is identified as requiring prior authorization (*see Section 6.12* Prior Authorization)
- Children in out-of-state placement

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

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

3.11 Record Keeping, Retention, and Access

3.11.1 Requirements

The Provider Agreement requires that the medical and financial records fully disclose the extent of services provided to Medicaid Members. The following 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 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 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 or when criminal or fraudulent activities are suspected).

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 reviews complaints regarding inappropriate use of services from Providers and Members. No action is taken without a complete investigation. To report fraud, waste, and abuse, please complete the Wyoming Medicaid Fraud, Waste, & Abuse Confidential Complaint Form located on the Program Integrity website.

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

4.3 Release of Medical Records

Every effort is made to ensure the confidentiality of records in accordance with Federal Regulations and Wyoming Medicaid Rules. Medical records must be released to the agency or its designee. The signed Provider Agreement allows the Division of Healthcare Financing, or its designated agents, access to all medical and financial records. In addition, each Member agrees to the release of medical records to the Division of Healthcare Financing when 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 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 hours a day, 7 days a week access for practitioners and pharmacists. The WORx program is managed by the Wyoming Board of Pharmacy at https://worxpdmp.com/ and can be used to view Member profiles

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

EMERGENCY LOCK-IN PRESCRIPTIONS

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

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

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

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

4.6 Hospice Lock-In

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

4.7 Fraud and Abuse

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

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

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

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

4.8 Provider Responsibilities

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

4.9 Referral of Suspected Fraud and Abuse

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

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, or non-compliance with the Provider Agreement 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

Providers 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 – Medicaid Administrative Hearings.

Chapter 5 – Member Eligibility

5.1 What is Medicaid?

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

5.2 Who is Eligible?

Eligibility is generally based on family income and sometimes resources and 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:

1. Children
2. Pregnant women
3. Family MAGI Adults
4. 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

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

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

5.2.4.3 Home and Community Based Waiver

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

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

5.2.5 Other

5.2.5.1 Special Groups

- **Breast and Cervical Cancer (BCC) Treatment Program**: Uninsured women diagnosed with breast or cervical cancer are income eligible at or below 250% of the FPL
    - Presumptive Eligibility (PE) for BCC allows temporary coverage for a woman who meets eligibility criteria for the full BCC Medicaid program
        - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted
- **Tuberculosis (TB) Program**: Individuals diagnosed with tuberculosis are eligible based on the SSI Standard
- **Kid Care CHIP:** To be eligible for this program the following criteria must be met.
    - A United States citizen, a lawful qualified non-citizen (refugee or asylum) or a lawful, permanent 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 4.7* Fraud and Abuse;
    - Not eligible to receive health insurance benefits under Wyoming's state employee benefit plan;
    - Not residing in a public correctional institution.
    - Financially eligible based on a MAGI income eligibility determination.

5.2.5.2 Employed Individuals with Disabilities

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

5.2.5.3 Medicare Savings Programs

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

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

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

5.3 Maternal and Child Health

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

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

Providers must be enrolled with Medicaid and MCH to receive payment for MCH services. Claims for both programs are submitted to and processed by the fiscal agent for Wyoming Medicaid (*see Section 2.1* Quick Reference). Providers are asked to submit the medical record to CSH in a timely manner to assure coordination of referrals and services.

5.4 Eligibility Determination

5.4.1 Applying for Medicaid

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

5.4.2 Determination

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

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

Medicaid assumes no financial responsibility for services rendered prior to the effective date of a Member's eligibility as determined by the WDH or the SSA. However, the effective date of eligibility as determined by the WDH may be retroactive up to 90 days prior to the month in which the application is filed, as long as the Member meets eligibility criteria during each month of the retroactive period. If the SSA deems the Member eligible, the period of original entitlement could precede the application date beyond the 90 day retroactive eligibility period 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

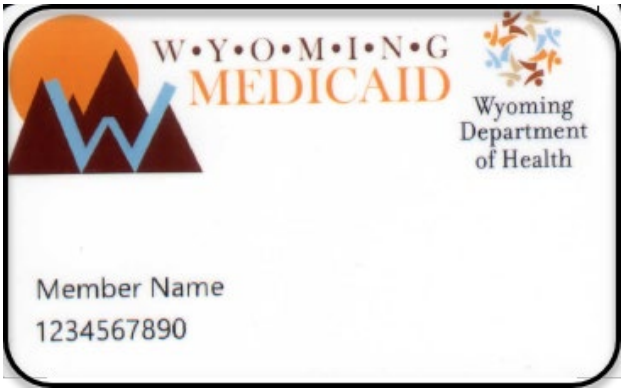
5.5 Member Identification Cards

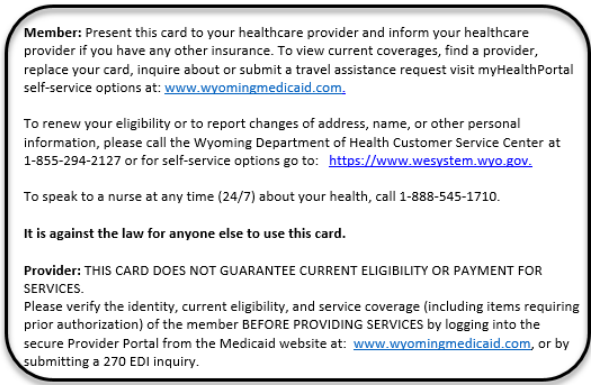
A Medicaid ID Card is mailed to Members upon enrollment in the Medicaid Program or other health programs such as the Communicable Treatment Disease Program (CTDP) and Children's Special Health

(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 re-applied, they will not receive a new Medicaid card. Members who would like a new card may contact the Customer Service Center (*see Section 2.1* Quick Reference) or print an ID card from the Member Portal, myHealthPortal.

Sample Medicaid ID card:





> Kid Care CHIP Members will also use this card.

5.6 Other Types of Eligibility Identification

5.6.1 Medicaid Approval Notice

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

> *See 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, CNSI will not accept paper claims for any Medicaid services.

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

Exceptions:

- Providers who have a Letter of Agreement (LOA) with the Wyoming Department of Health (WDH) will submit paper claims per the LOA. To minimize errors, organize the documents in the following order:
  - Top Page: LOA
  - Next Page: Paper Claim
  - Last Pages: Supporting Documentation
- Providers who must have Out of Policy exceptions done for certain nursing home Durable Medical Equipment (DME) items may continue to bill on paper.
- Providers who are working with a WDH or CNSI representative to process or special batch paper claims may continue to work with those representatives and bill on paper when necessary. This includes Providers who submit a blanket denial letter for Members with Cigna coverage that is primary to Medicaid.

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

6.2 Basic Paper Claim Information

The 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.

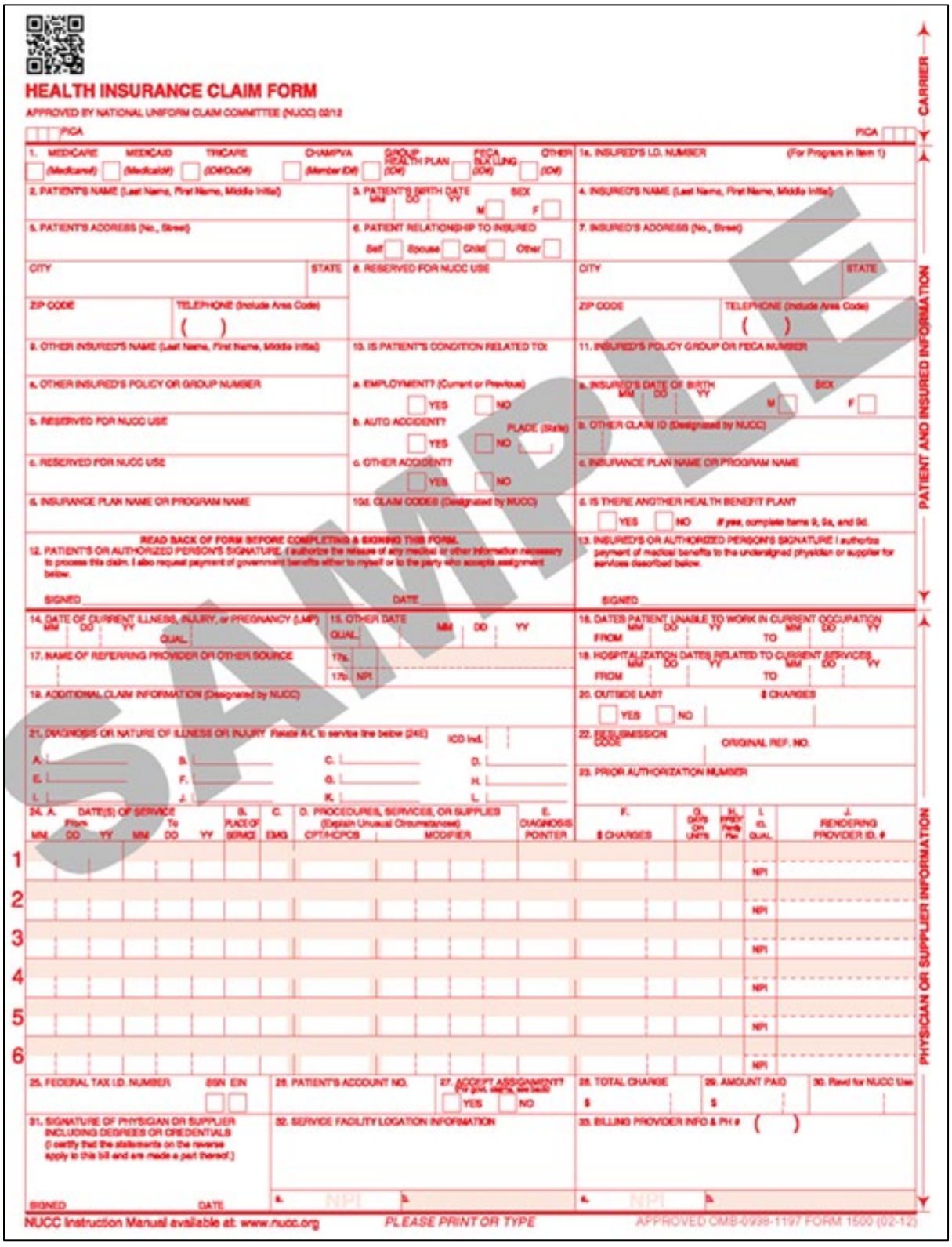
Billing errors detected after a claim is submitted cannot be corrected until after Medicaid has made payment or notified the Provider of the denial. **Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice** (*see Section 6.17* Resubmitting versus Adjusting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

> Claims are to be submitted only after service(s) have been rendered, not before. For deliverable items (such as dentures, DME, glasses, and hearing aids) 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 CMS-1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

6.4.1 Instructions for Completing the CMS-1500 Claim Form

Claim Item	Title	Required	Conditionally Required	Action/Description
1	Insurance Type	X	N/A	Place an "X" in the "Medicaid" box.
1a	Insured's ID Number	X	N/A	Enter the Members' ten (10) digit Medicaid ID number that appears on the Medicaid Identification card.
2	Patient's Name	X	N/A	Enter the Member's last name, first name, and middle initial.
3	Patient's Date of Birth/Sex	N/A	N/A	Information that will identify the patient and distinguishes persons with similar names
4	Insured's Name	N/A	X	Enter the insured's full last name, first name, and middle initial. Insured's name identifies who holds the policy if different than Patient information.
5	Patient's Address	N/A	N/A	This refers to patient's permanent residence.
6	Patient's Relationship to Insured	N/A	X	If the Member is covered by other insurance, mark the appropriate box to show relationship.
7	Insured's Address	N/A	X	Enter the address of the insured.
8	Patient Status	N/A	N/A	Indicates patient's marital and employment status
Instructions for 9a-d	Other Insurance Information	N/A	X	If item number 11d is marked, complete fields 9 and 9a-d.
9	Other Insured's Name	N/A	X	When additional group health coverage exists, enter other insured's full last name, first name and middle initial of the enrollee if different from item number 2.
9a	Other Insured's Policy or Group Name	N/A	X	Enter the policy or group number of the other insured.
9b	Reserved for NUCC Use	N/A	N/A	N/A

Claim Item	Title	Required	Conditionally Required	Action/Description
9c	Reserved for NUCC Use	N/A	N/A	N/A
9d	Insurance Plan or Program Name	N/A	X	Enter the other insured's insurance plan or program name.
10a-c	Is Patient's Condition Related to?	N/A	X	When appropriate, enter an X in the correct box to indicate whether one or more the services described in Item Number 24 are for a condition or injury the occurred on the job or as a result of an auto accident.
10d	Reserved for Local Use	N/A	N/A	N/A
11	Insured's Policy, group or FECA Number	N/A	X	Enter the insured's policy or group number as it appears on the ID card. Only complete if Item Number 4 is completed.
11a	Insured's Date of Birth, Sex	N/A	X	Enter the 8- digit date of birth (MM/DD/CCYY) and an X to indicate the sex of the insured.
11b	Insured's Employer's Name or School Name	N/A	X	Enter the Name of the insured's employer or school.
11c	Insurance Plan Name or Program Name	N/A	X	Enter the insurance plan or program name of the insured.
11d	Is there another Health Benefit Plan?	N/A	X	When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a-d.
12	Patient's or Authorized Person's Signature	N/A	N/A	Indicates there is an authorization on file for the release of any medical or other information necessary to process the claim.
13	Payment Authorization Signature	N/A	N/A	Indicates that there is a signature on file authorizing payment of medical benefits

Claim Item	Title	Required	Conditionally Required	Action/Description
14	Date of current illness, injury, or pregnancy	X	N/A	Enter the date of illness, injury, or pregnancy.
15	If Patient has had Same or Similar Illness	N/A	N/A	A patient having had same or similar illness would indicate that the patient had a previously related condition.
16	Date Patient Unable to Work in Current Occupation	N/A	N/A	Time span the patient is or was unable to work.
17	Name of Referring Physician	N/A	N/A	Enter the name and credentials of the professional who referred, ordered, or supervised the service on the claim.
17a	17a Other ID #	X	N/A	Other ID number of the referring, ordering, or supervising Provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right.
17b	NPI #	X	N/A	Enter the NPI number of the referring, ordering, or supervising Provider in Item Number 17b.
18	Hospitalization Dates Related to Current Service	N/A	X	The hospitalization dates related to current services would refer to an inpatient stay and indicates admission and discharge dates.
19	Reserved for Local Use	N/A	N/A	N/A
20	Outside lab? $ Charges	N/A	N/A	Indicates that services have been rendered by an independent Provider as indicated in Item Number 32 and related Costs.
21	ICD Indicator Diagnosis or Nature of Illness or Injury	X	N/A	Enter the ICD-9 or ICD-10 indicator. Enter the patient's diagnosis or condition. List up to 12 ICD-PCM codes. Use the highest level of specificity. Do not provide a description in this field.

Claim Item	Title	Required	Conditionally Required	Action/Description
22	Medicaid Resubmission Code	N/A	X	The code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim Provider should enter 7 to indicate this claim is an adjustment to a previously paid claim, or 8 to void a previously paid claim.
22	Original Ref Number	N/A	X	Enter the original TCN of the claim that should be adjusted or voided.
23	Prior Authorization	N/A	X	Enter the ten (10)-digit Prior Authorization number from the approval letter, if applicable. Claims for these services are subject to service limits and the 12-month (365 days) filing limit.
24	Claim Line Detail	N/A	N/A	Supplemental information is to be placed in the shaded sections of 24A through 24G as required by individual payers. Medicaid requires information such as NDC and taxonomy in the shaded areas as defined in each Item Number
24A	Dates of Service	X	N/A	Enter date(s) of service, from and to. If one (1) date of service, only enter that date under “from”. Leave “to” blank or reenter “from” date. Enter as MM/DD/YY. NDC qualifier and NDC code will be placed in the shaded area. For detailed information on billing with the corresponding NDC codes, refer to the NDC entry information following this instruction table.
24B	Place of Service	X	N/A	Enter the two (2)-digit Place of Service (POS) code for each procedure performed. 837P Situational: When the Place of Service is one of the following, the patient’s admission date is required to be entered: • 21 – Inpatient Hospital • 51 – Inpatient Psychiatric Facility

Claim Item	Title	Required	Conditionally Required	Action/Description
				• 61 – Comprehensive Inpatient Rehab
24C	EMG	X	N/A	This field is used to identify if the service was an emergency. Provider must maintain documentation supporting an emergency indicator. Enter Y for "YES" or leave blank or enter N for "NO" in the bottom, un-shaded area of the field. This field is situational, but required when the service is deemed an emergency
24D	Procedures, Services, or Supplies	X	N/A	Enter the CPT or HCPCS codes and modifiers from the appropriate code set in effect on the date of service.
24E	Diagnosis Pointer	X	N/A	Enter the Diagnosis Code Reference Letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. Do Not enter any diagnosis codes in this box.
24F	$ Charges	X	N/A	Enter the charge for each listed service.
24G	Days or Units	X	N/A	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.
24H	EPSDT/Family Plan	N/A	X	Identifies certain services that may be covered under some state plans
24I	ID Qualifier	N/A	X	If the Provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area (Wyoming Medicaid EDI Companion Guide located on the Medicaid website).
24J	Rendering Provider ID #	N/A	X	The individual rendering the service is reported in 24J. Enter the taxonomy code in the shaded area of the field. Enter the NPI number in the un-shaded area of the field. Report the Identification Number in Items 24I and 24J only when different from the data in Items 33a and 33b.

Claim Item	Title	Required	Conditionally Required	Action/Description
25	Federal Tax ID Number	N/A	N/A	Refers to the unique identifier assigned by a federal or state agency.
26	Patient's Account Number	N/A	N/A	The patient's account number refers to the identifier assigned by the Provider (optional).
27	Accept Assignment?	X	N/A	Enter X in the correct box - Indicated that the Provider agrees to accept assignment under the terms of the Medicare program
28	Total Charge	X	N/A	Add all charges in Column 24F and enter the total amount in this field.
29	Amount Paid	N/A	X	Enter total amount the patient or other payers paid on the covered services only. This field is reserved for third party coverage only, do not enter Medicare paid amounts
30	Balance Due	N/A	N/A	Enter the total amount due.
31	Signature of Physician or Supplier Including Degrees or Credentials	X	N/A	Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative. Enter date the form was signed.
32, 32a and 32b Split Field	32 -Service Facility Location Information 32a NPI Number 32b Other ID#	X	N/A	Enter the name, address, city, state, and zip code of the location where the services were rendered. Enter the NPI number of the service facility location in 32a; enter the two (2)-digit qualifier identifying the non-NPI number followed by the ID number.
33, 33a and 33b Split Field	33 -Billing Provider Info & Ph.# 33a NPI number 33b taxonomy	X	N/A	Enter the Provider's or suppliers' billing name, address, zip code and phone number. Enter the NPI number of the billing Provider in 33a. Enter the two (2)-digit qualifier identifying the non-NPI number followed by the ID number. Enter the Provider's taxonomy number in 33b.

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 Place of Service

Place of Service	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system.
03	School	A facility whose primary purpose is education
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (for example, emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal Members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal Members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for

Place of Service	Place of Service Name	Place of Service Description
		the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	N/A
11	Office	Location, Other than a Hospital, Skilled Nursing Facility, Military treatment Facility, Community Health Center, State or Local Public Health Clinic, or Intermediate Care Facility, where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a Hospital or other Facility, where the patient receives care in a private session
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24-hours a day, seven (7) days a week, with the capacity to deliver or arrange for services including some healthcare and other services.
14	Group Home	A residence, with shared living areas, where Members receive supervision and other services such as social or behavioral services, custodial service, and minimal services (for example, medication administration)
15	Mobile Unit	A facility or unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in-health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment-Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual.
19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services

Place of Service	Place of Service Name	Place of Service Description
		by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a Hospital, which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require Hospitalization or Institutionalization
23	Emergency Room – Hospital	A portion of a Hospital where emergency diagnosis and treatment of illness or injury is provided
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants
26	Military Treatment Facility	A medical facility operated by one (1) or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Services (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled, nursing care and related services to patients who require medical, nursing, or rehabilitation services but does not provide the level of care of treatment available on a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.

Place of Service	Place of Service Name	Place of Service Description
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-bases or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services are who have been discharged from inpatient treatment at a mental health facility; 24-hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services.
54	Intermediate Care Facility / Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care - Services include individual and group therapy and counseling, family counseling, laboratory test, drugs and supplies, psychological testing, and room and board
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis - Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing
58-59	Unassigned	N/A

Place of Service	Place of Service Name	Place of Service Description
60	Mass Immunization Center	A location where Providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and clinical tests independent of an institution or a physician’s office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not listed above.

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 EOMB (Explanation of Medicare Benefits)
    - **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

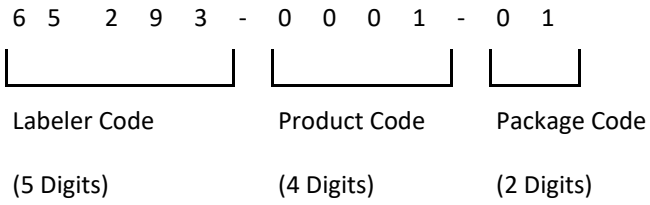
- Medicare is primary to Medicaid and must be billed first. Direct Medicare claims processing questions to the Medicare carrier.
- When posting the Medicare payment, the EOMB may state that the claim has been forwarded to Medicaid. **No further action is required, it has automatically been submitted.**
- 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 six (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 Coordination of Benefits (COB) 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 handwritten) 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 National Drug Code Billing Requirement

Medicaid requires Providers to include National Drug Codes (NDC) 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 or 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

6.6.1 Converting 10-Digit National Drug Codes to 11 Digits

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

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

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

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

6.6.2 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.

6.6.3 Billing Requirements

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

6.6.4 Submitting One National Drug Code per Procedure Code

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

Example:

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

6.6.5 Submitting Multiple National Drug Codes per Procedure Code

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

Example:

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

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

6.6.6 Medicare Crossover Claims

Because Medicaid pays Medicare coinsurance and deductible for dual-eligible Members, the NDC will also be required on Medicare crossover claims for all applicable procedure codes. Medicaid has verified that NDC information reported on claims submitted to Medicare will be included in the automated crossover claim feed to Medicaid. Crossover claim lines that are missing a required NDC will be denied.

6.6.7 CMS-1500 02-12 Billing Instructions

To report a procedure code with an NDC on the CMS-1500 02-12 claim form, enter the following NDC information into the shaded portion of field 24A:

- 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.

CMS-1500 02-12 – One (1) NDC per Procedure Code:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N460574411301														ZZ	208000000X
10	01	15				24		90378		A	100 00	1		NPI	1234444444

CMS-1500 02-12 – Two (2) NDCs per Procedure Code:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N460574411301														ZZ	208000000X
10	01	15				24		90378	KP	A	100 00	1		NPI	1234444444
N460574411301														ZZ	208000000X
10	01	15				24		90378	KQ	A	100 00	1		NPI	1234444444

Medicaid's instructions follow the National Uniform Claim Committee's (NUCC) recommended guidelines for reporting the NDC on the CMS-1500 02-12 claim form. Provider claims that do not adhere to the guidelines will be returned unprocessed.

6.7 Service Thresholds Per Calendar Year

6.7.1 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

6.7.2 Ages 21 and Older

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

- Office or 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 (such as labs and X-rays) provided during an office or 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; 90836-90839; 90845-90849; 90853; 90857;92507-92508; 92526; 92609; 96105-96146; 97010-97039; 97110-97150; 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

6.7.3 Office and Outpatient Hospital Visits Once Threshold is Met

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

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.

6.7.4 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 6.12* Prior Authorization):

- Physical therapy visits
- Occupational therapy visits
- Speech therapy visits
- Behavioral health visits (*see Section 12.8.1.1* Appeals Process)

> 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 1:00 p.m. on 4/1/2021 and Provider B for group therapy at 2:00 p.m. 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

6.8 Reimbursement Methodologies

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

- Medicaid fee schedule
- By report pricing

- Billed charges
- Invoice charges
- Negotiated rates
- Per diem
- Resource Based Relative Value Scale (RBRVS)

6.8.1 Invoice Charges

For manually priced items, an invoice that provides proof of purchase and actual costs for equipment and 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 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 and handling on the invoice. If the manufacturer does not include a shipping and 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.

- The invoice must be dated **within 12 months** (365 days) prior to the date of service being billed
  - If the invoice is older, a letter must be included with the claim explaining the age of the invoice (such as product purchased in large quantity previously, and is still in stock)
- All discounts will be taken on the invoice
- The discounted pricing or codes cannot be marked out
- A packing slip, price quote, purchase order, 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 or manufacturer, and a letter with explanation is included
- Items must be clearly marked (such as how many calories are in a can of formula, items in a case, milligrams, ounces)

6.9 Usual and Customary Charges

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

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

6.10 Co-Payment Schedule

$2.45 Co-Payment Schedule		
Procedure and Revenue Code(s)	**Description**	**Exceptions**

99201 – 99215	Office Visits only when the place of service code is 11	Co-payment requirements do not apply to:
		• Children defined as:
		  ○ Medicaid eligibility for children is under 21
		  ○ Kid Care CHIP eligibility for children is under 19
		EXCEPTION: Co-Pays Apply to the children's KIDC Benefit Plan (Kid Care CHIP Plans B & C)
		• Nursing Facility Residents
		• Pregnant Women
		• Family planning services
		• Emergency services
		• Hospice services
		• Medicare Crossovers
		• Members of a Federally recognized tribe

99341 -99350	Home Visits	
92002, 92004, 92014	Eye Examinations	

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

Co-payments are applicable per procedure code, and some claims may have more than one (1) co-payment amount.

6.11 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.**

6.12 Prior Authorization

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

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

Agency Name	Phone	Services Requiring PA
Division of Healthcare Financing (DHCF)	Contact case manager Case manager will contact the DHCF	• Community Choice Waiver (CCW) • Out-of-State Placement for LTC Facilities • Comprehensive Developmental Disability Waivers • Support Developmental Disability 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

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

Agency Name	Phone	Services Requiring PA
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, and 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

6.12.1 Requesting an Emergency Prior Authorization

Contact the appropriate authorizing agencies for their pending and emergency PA procedures (*see Section 6.12* Prior Authorization).

6.12.2 Prior Authorization Status Inquiry

The BMS will receive approved and denied PAs (278 transactions) from Telligen, CCW (DHCF), DD Waiver (DHCF), 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 23 of the CMS 1500 claim form. For placement in an electronic X12N 837 Professional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.

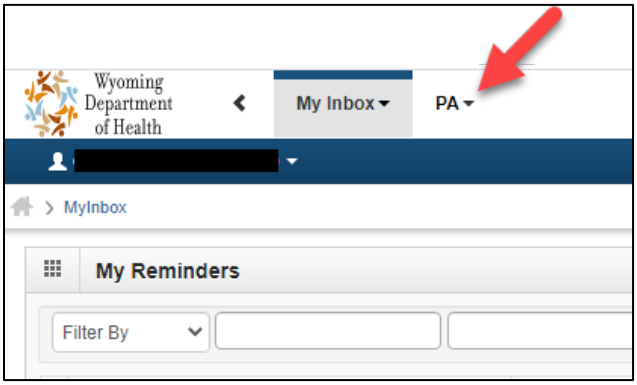
> Used PAs will be viewable on the Provider Portal.

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

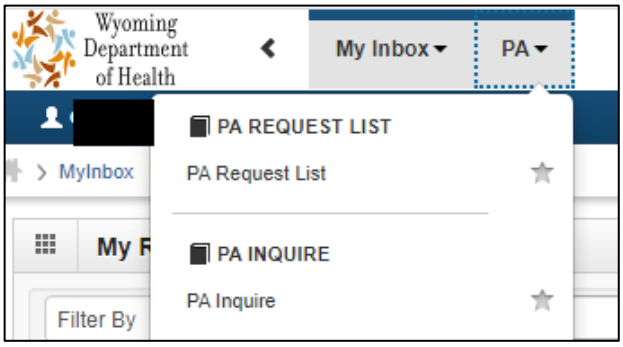
1. Log in to the Medicaid Portal (*see Section 2.1.* Quick Reference).

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

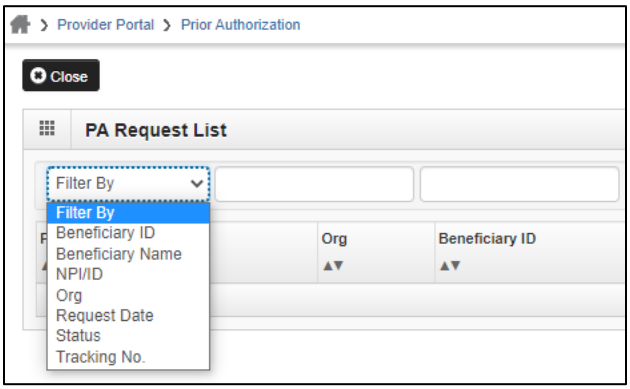
2. Once the user is logged into to the Provider Portal and selects Prior Authorization Access from the Provider Profile drop-down list, **PA** appears next to "My Inbox".



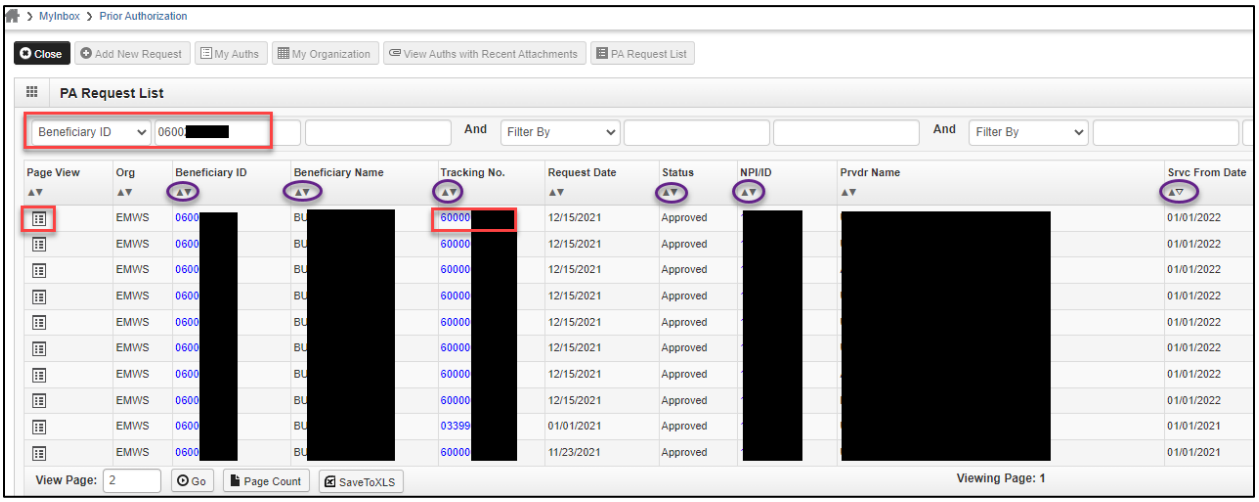
3. From the **PA** drop-down list, select **PA Request List** (do not have PA number) or **PA Inquire** (have PA number).



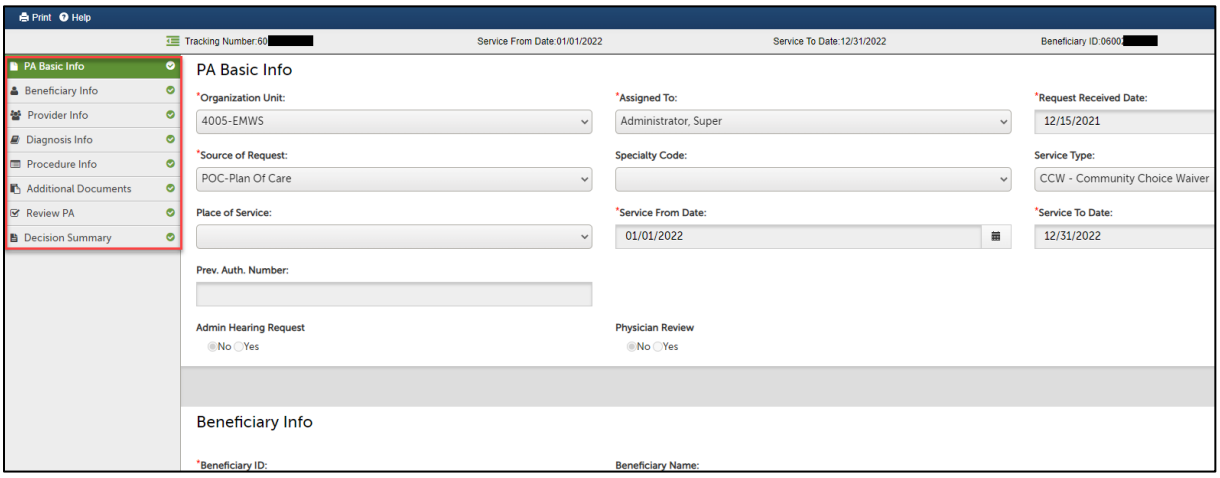
Providers inquiring on PAs may select PA Request List and filter (search) in various ways, such as PA Tracking No., Beneficiary (Member) ID, Beneficiary (Member) Name, Status.



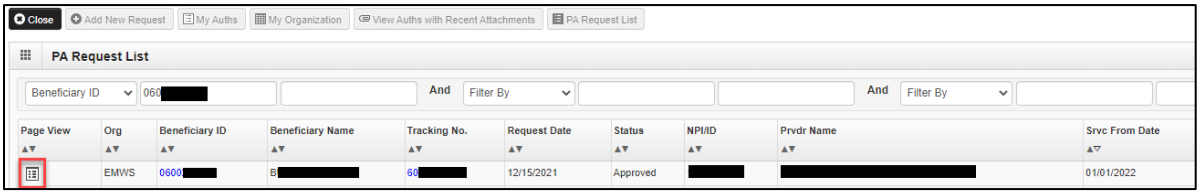
Example of a search by the Beneficiary (Member) ID- Select **Beneficiary ID** in the first drop-down list, then enter the 10-digit Medicaid Member ID number and select **Go**. Below is partial information that is displayed.



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.

6.13 Billing of Deliverables

All procedures that involve delivering an item to the Member can only be billed to Medicaid on the date the item is delivered to the Member. This includes glasses, DME products and supplies, dental appliances, and so on. The Provider is responsible for billing these procedures only on the delivery date.

DME Date of Delivery: Use the shipping date as the date of service on the claim if the Provider uses a deliver or shipping service. Use the actual date of delivery as the date of service on the claim if the Provider or supplier does the delivery or if the Member picks the item up directly. Items purchased are

to be billed using the single date of service the item was purchased on, and not a span of dates the items are intended to cover. If a Member buys a 30-day supply of incontinence supplies on 1/15/22 for use during the following month (1/15/22 – 2/14/22), the date of service would be 1/15/22 only.

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

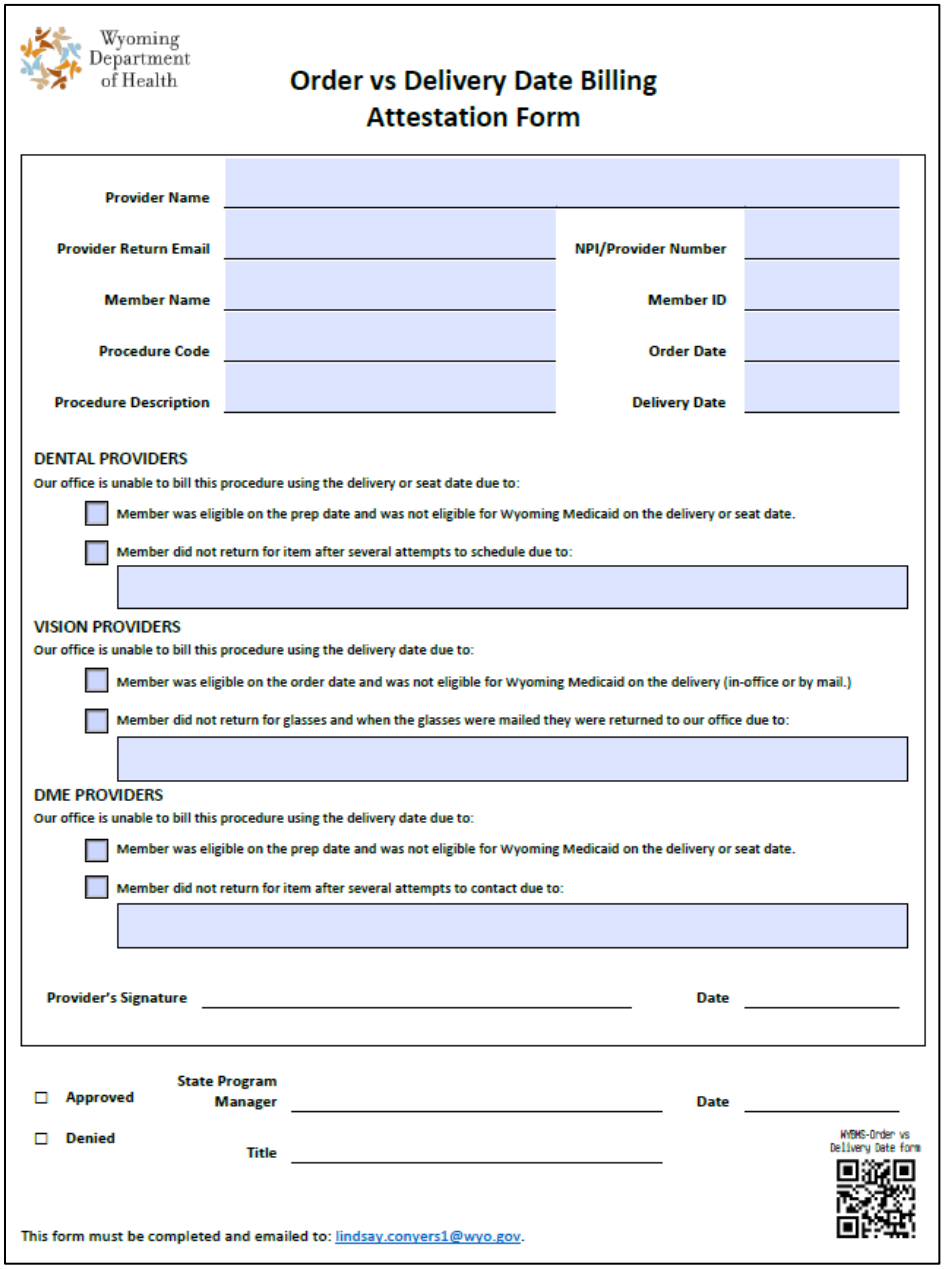
- Member is not eligible on the delivery date but was eligible on the order date
- Member does not return to the office for the delivery of the product

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

- Print the "Order vs Delivery Date Exception Form," (*see Section 6.13.1* Order vs Delivery Date Exception Form).
- Complete the form and email it to the address at the bottom of the form
- Once the form is signed by the State, it will be returned to the Provider and must be a part of the Member's permanent clinical record
- The Provider may then bill the claim using the order date as the date of service

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

6.13.1 Order vs Delivery Date Exception Form



Wyoming Department of Health

Order vs Delivery Date Billing Attestation Form

Provider Name			
Provider Return Email		NPI/Provider Number	
Member Name		Member ID	
Procedure Code		Order Date	
Procedure Description		Delivery Date	

DENTAL PROVIDERS

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

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

VISION PROVIDERS

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

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

DME PROVIDERS

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

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

Provider's Signature _____ Date _____

☐ Approved ☐ Denied

State Program Manager _____ Date _____

Title _____

WYDHS-Order vs Delivery Date form

This form must be completed and emailed to: lindsay.conyers1@wyo.gov.

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 Professional Electronic Data Interchange Technical Report Type 3 (TR3). Access the TR3 at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.

Important attachment information:

- Providers may not attach a document to many claims or TCNs at one time
- Attachments must be added per claim or TCN
- Multiple attachments can be added or uploaded to one claim or TCN
- Attachment 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 or 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, Providers can print the system generated attachment coversheet (*see Section 6.14.1.1* Sample of Systematically Generated Provider Portal Attachment Coversheet) for that specific claim or download and complete the Attachment Coversheet (see *Section 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:

- See *Chapter 8* – Electronic Data Interchange and Provider Portal

- Provider Publications and Trainings posted on 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 or claim within the BMS via the Provider Portal

6.14.1 Attachment Coversheets

There a two (2) Attachment Coversheets:

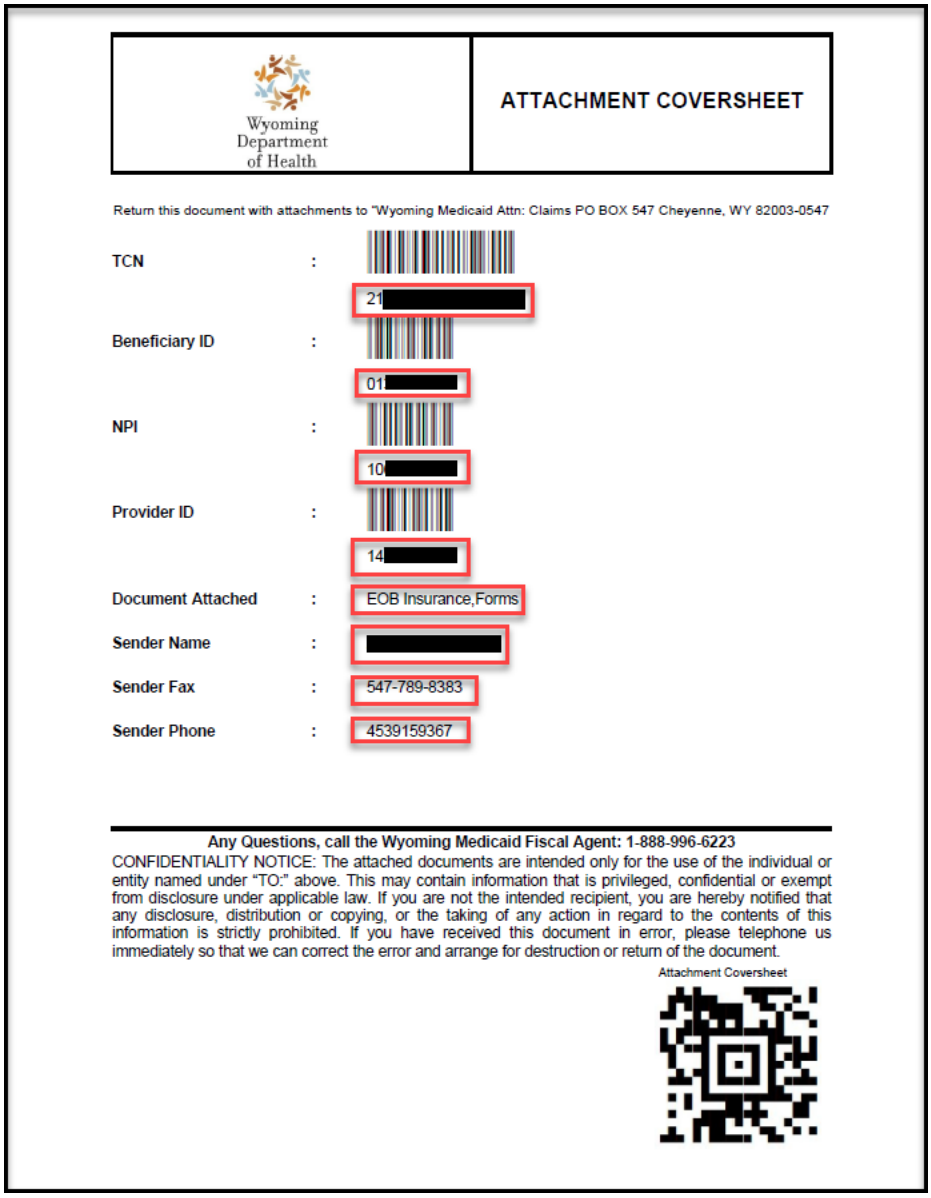
- Attachment Coversheet systematically generated and printed from the Provider Portal (*see Section 6.14.1.1* Sample of Systematically Generated Provider Portal Attachment Coversheet)
    - This coversheet can be printed at the time of direct data entry of the claim or from completing a 'Claim Inquiry' 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 or 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 (*see 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 Services email address, WYProviderOutreach@cns-inc.com, made to the Attention: Claims Department

- **All emails must come secured and cannot exceed 25 pages**

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

6.14.1.1 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

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

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, & 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 or 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, see *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** _____

6.15.2.2 Instructions for Completing the Hysterectomy Acknowledgment of Consent Form

Section	Action
Header Information	Enter Members 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

6.15.3.2 Instructions for Completing the Abortion Certification Form

Action
Enter the name of the pay-to Provider.
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 HIPAA payment file. The Agency will not mail paper remittance advices.

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

6.16.1 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* Remittance Advice Banner Notices).
- **Summary Page:** This second page provides a summary of paid, denied, credited, gross adjusted, total billed, and total paid.
- **Detail Pages:** The next pages are the claim detail pages which list the Members information, TCNs, rendering NPIs, dates of services, procedure and revenue codes, modifiers, DRG or 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.

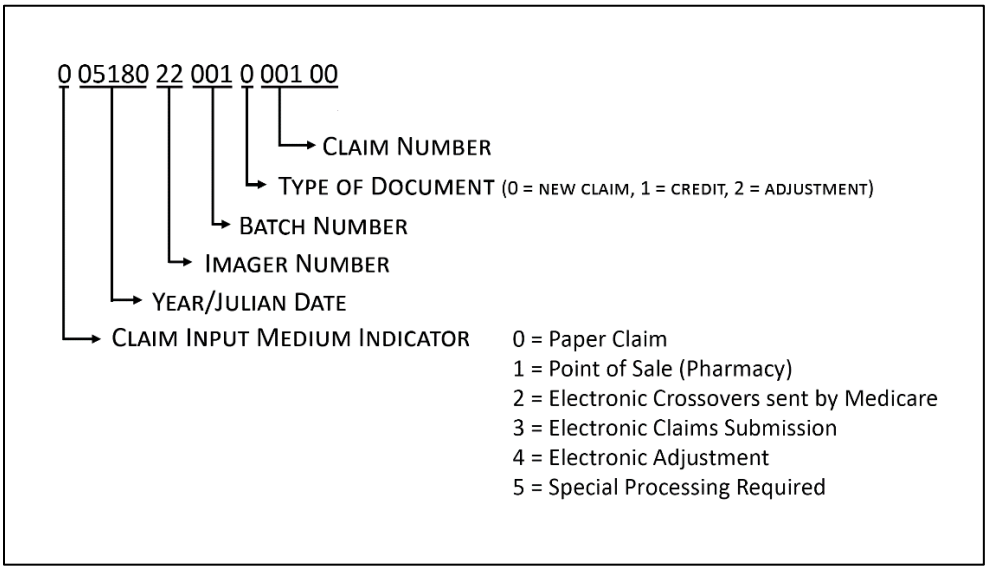
6.16.2 Remittance Advice General Information and Definitions

- 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 Attachment(s) 2 – Direct Data Entry (DDE) Claim – via Provider Portal 3 – Electronic Claim – HIPAA Compliant Transaction 4 – Adjusted Claims – Provider adjustments or BMS mass or gross adjustments 8 – Paper Claim with Attachment(s)
2nd Digit	TCN Category	1	1 – Assigned to Institutional, Professional and Dental Claims 2 – Assigned to Crossover Claims – Received via Medicare Intermediary
3rd to 7th Digit	Batch Date	5	YYDDD – Year + 3-digit Julian Date

Field	Field Description	Length	Value
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.

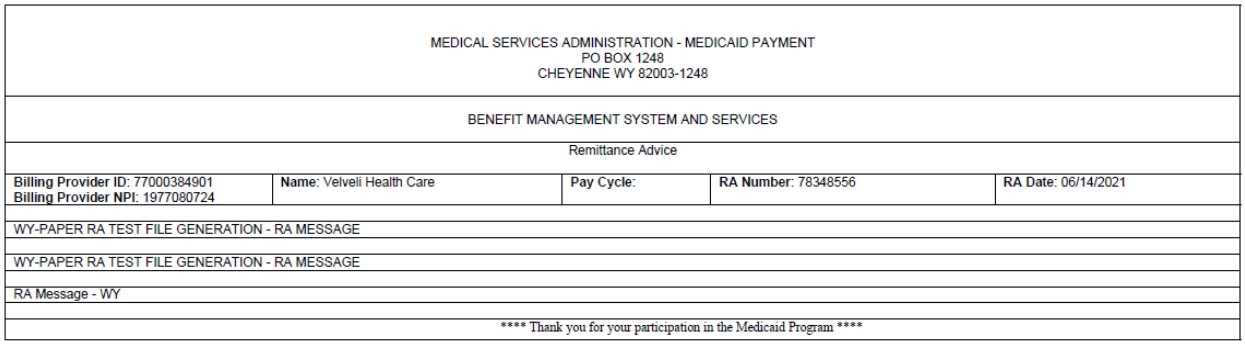
6.16.4 Locating the Medicaid Paper Remittance Advice within the Provider Portal

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

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

6.16.5 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

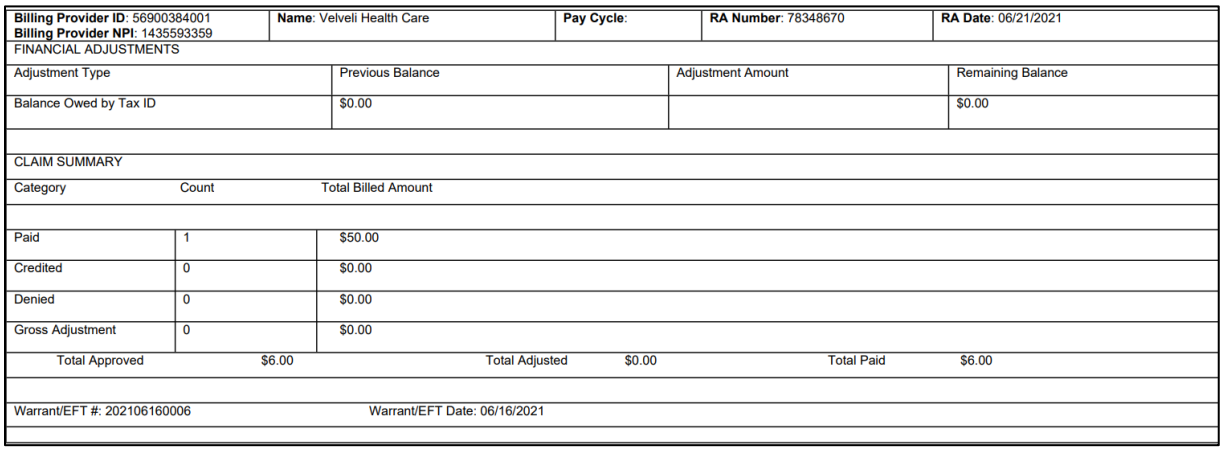
RA Message - WY

**** 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:

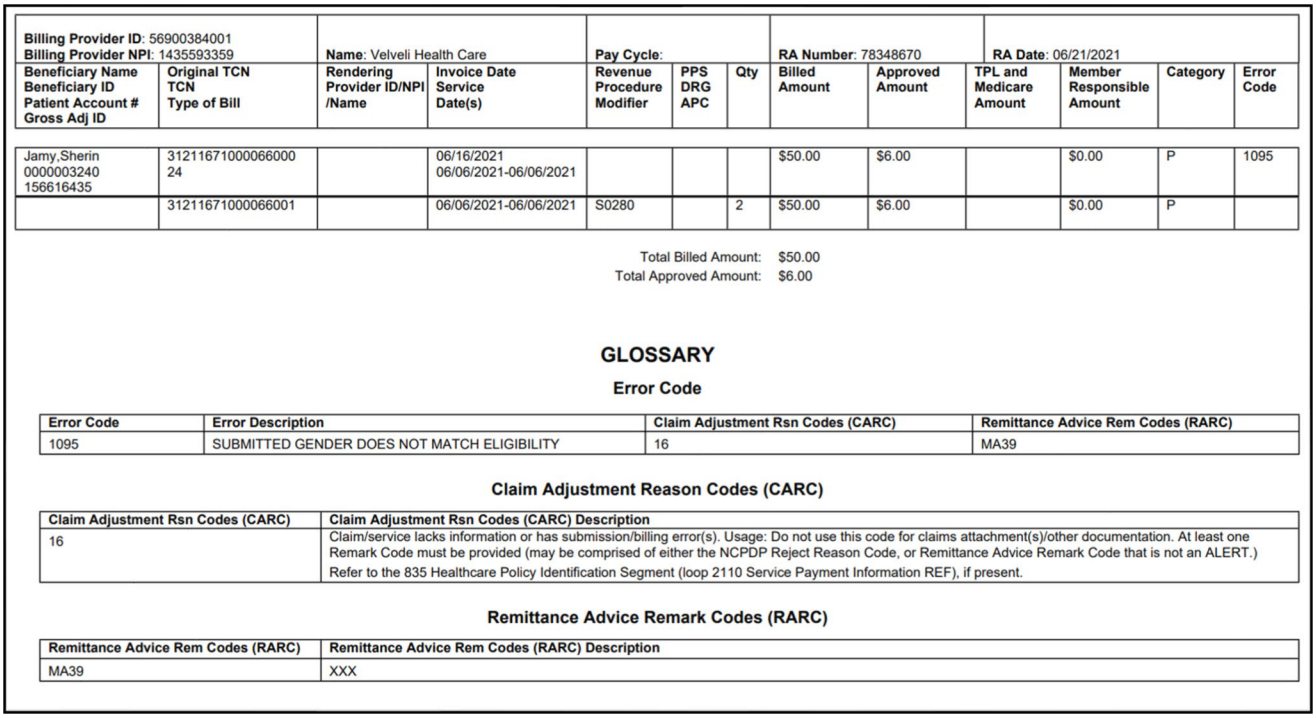
Summary Page Field Name	Notes
Billing Provider ID	Billing Provider Number.
Billing Provider NPI	Billing National Provider Identification Number.
Name	Name of Billing Provider.
Pay Cycle	Pay cycle for the Remittance Advice Report established according to the Remittance Advice Schedule.
RA Number	Remittance Advice Identification Number (system-generated for each Billing Provider).
RA Date	Date the Remittance Advice was Created.
FINANCIAL ADJUSTMENTS	Shows Financial Adjustments for the Remittance Advice.
Adjustment Type	Type of Adjustment.
Previous Balance	Previous Provider balance.
Adjustment Amount	Provider adjustment amount (+ or -).
Remaining Balance	Provider remaining balance.
CLAIM SUMMARY	Claims Summary Count.
Category	Claim Categories: • Paid • Credited (Adjustment or Void)

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

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

Detail Page Field Name	Notes
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)

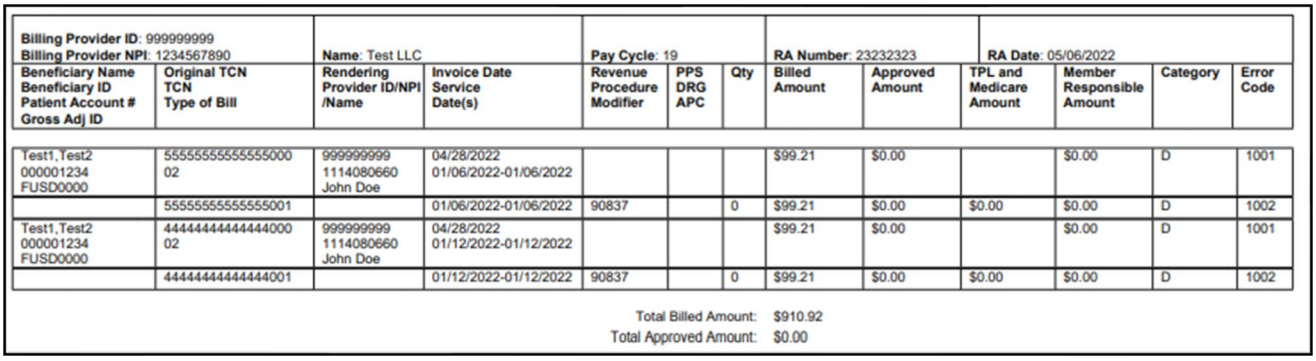
Claim Adjustment Rsn Codes (CARC)	Claim Adjustment Rsn Codes (CARC) Description
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP 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

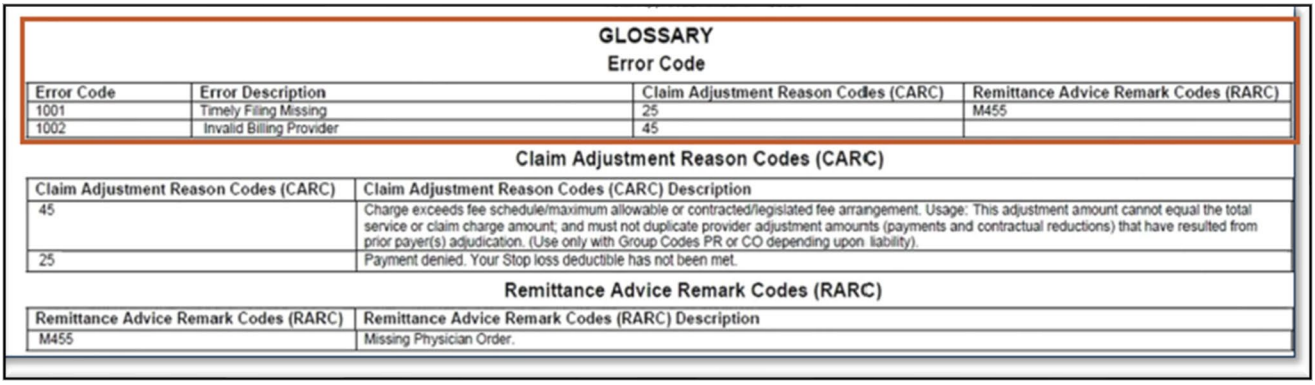


Billing Provider ID: 999999999
Billing Provider NPI: 1234567890
Name: Test LLC
Pay Cycle: 19
RA Number: 23232323
RA Date: 05/06/2022

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	

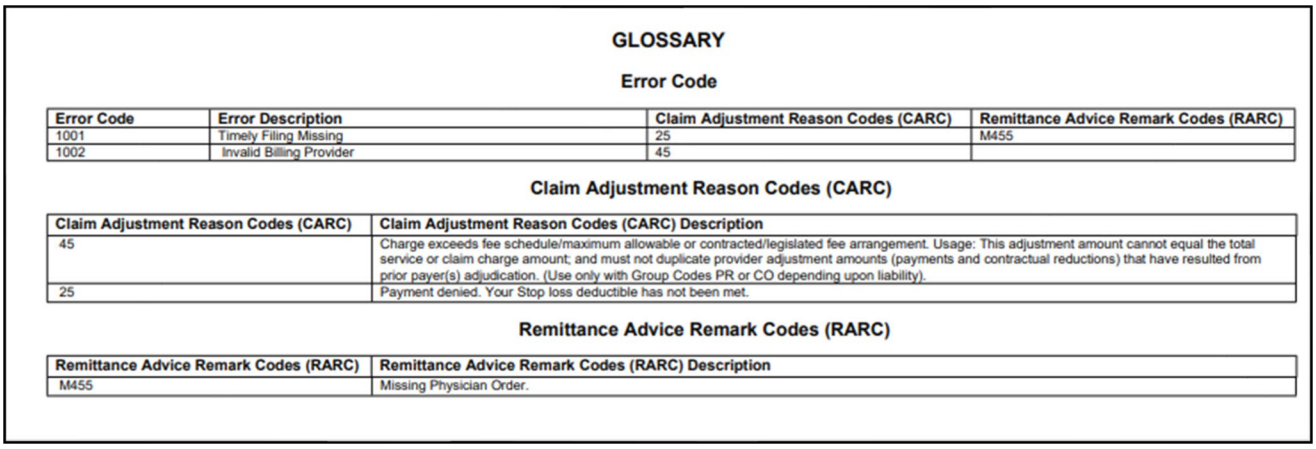
Claim Adjustment Reason Codes (CARC)

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



GLOSSARY

Error Code

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

Claim Adjustment Reason Codes (CARC)

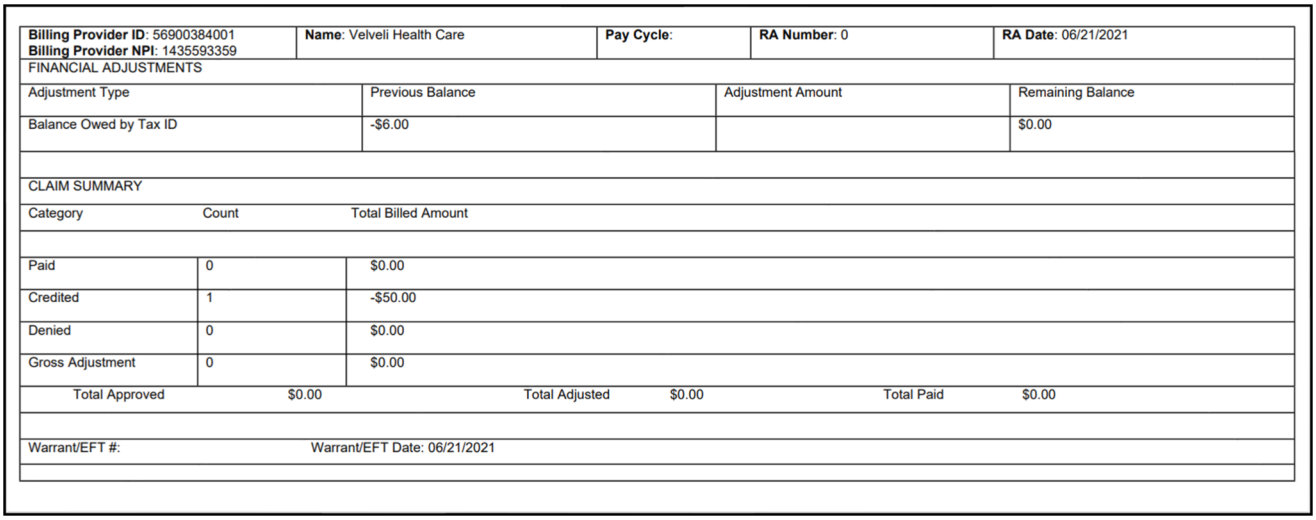
Claim Adjustment Reason Codes (CARC)	Claim Adjustment Reason Codes (CARC) Description
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment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

Remittance Advice Remark Codes (RARC)

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

6.16.5.6 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: 4993000301 Billing Provider NPI: 1005268960		Name: Velveli Health Care		Pay Cycle:			RA Number: 78348641		RA Date: 06/21/2021			
Beneficiary Name Beneficiary ID Patient Account # Gross Adj ID	**Original TCN TCN Type of Bill**	**Rendering Provider ID/NPI /Name**	**Invoice Date Service Date(s)**	**Revenue Procedure Modifier**	**PPS DRG APC**	**Qty**	**Billed Amount**	**Approved Amount**	**TPL and Medicare Amount**	**Member Responsible Amount**	**Category**	**Error Code**
Thomas,Roy 0000003184 156616435	31211661000175000 24		06/15/2021 01/30/2021-01/30/2021				$3,500.00	$3,500.00		$0.00	P	
	31211661000175001	202039930 1576193357 Velveli Health Care Velveli Health Care	01/30/2021-01/30/2021	00882		1	$3,500.00	$3,500.00		$0.00	P	
Thomas,Roy 0000003184 156616435	31211661000172000 24		06/15/2021 05/29/2021-05/29/2021				$3,500.00	$0.00		$0.00	D	
	31211661000172001		05/29/2021-05/29/2021	00882		0	$3,500.00	$0.00		$0.00	D	1232

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

GLOSSARY

Error Code

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

Claim Adjustment Reason Codes (CARC)

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

6.16.5.8 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) is to 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 line(s):** • 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 and Outpatient) claims, the Provider **must** 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 denied claim or line within 12 months (365 days) of the date of service
- Providers may adjust any paid claim within six (6) months (180 days) of the date of payment

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

6.17.2 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 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, Providers may resubmit the individually denied lines as a new claim or adjust the partially paid claim.
    - For UB (Inpatient and 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 6.17.3.4* How to Complete the Adjustment/Void Request Form).

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

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 or NPI. In this case, the original claim will need to be voided and the corrected claim submitted.

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.

6.17.3.1 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).

6.17.3.2 How to Request an Adjustment or Void

To adjust or void a claim, Providers are encouraged to complete claim adjustments and voids electronically but may complete the Adjustment/Void Request Form (see *Section 6.17.3.3* Adjustment/Void Request Form). The requirements for adjusting or voiding a claim are as follows:

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

6.17.3.3 Adjustment/Void Request Form

Wyoming Department of Health

Adjustment/Void Request Form

PART A – Request Type

☐ 1a CLAIM ADJUSTMENT
Attach a copy of the claim with corrections made in **BLUE INK**.
DO NOT USE HIGHLIGHTER
Complete both Section B and Section C.
If attaching a check, make check payable to Division of Healthcare Financing (DHCF).

☐ 1b VOID CLAIM
Attach a copy of the claim or Remittance Advice.

☐ 2 CANCELLATION OF THE ENTIRE REMITTANCE ADVICE
Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances.
Complete Section C only.
Attach Remittance Advice.
If manual check, attach the check from DHCF.
If EFT, make payable to DHCF for the entire remit amount.

PART B – Claim Information

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

Transaction Control Number (TCN) _____ Payment Date _____
Provider Name _____ NPI/Provider Number _____
Member ID _____ Prior Authorization Number _____

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

Reasons for Adjustment or Void *(Check one or more.)*
☐ Billed in error ☐ Billed incorrect units ☐ Billed incorrect procedure code(s)
☐ Billed incorrect amount ☐ Receipt of TPL or Medicare Payment ☐ Other: _____

PART C – Signature and Date

Provider Signature _____ Date _____

INTERNAL USE ONLY BELOW THIS LINE

Adjusted By _____ Date _____

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

WYBMS-Adjustment/Void form

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

6.17.3.4 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 Members first and last name.
	7	Prior Authorization Number	Enter the ten (10)-digit PA number, if applicable.
	8	Reasons for Adjustment or Void	Either choose the appropriate option and indicate the correction in the table as well as within the attached claim form, or for more than one change, enter "See Corrected Claim"

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

6.17.3.5 Adjusting or Voiding a Claim Electronically via an 837 Transaction

Wyoming Medicaid prefers claim adjustments and voids on paid claims to be submitted electronically, see *Chapter 8* – Electronic Data Interchange and Provider Portal, the Wyoming Medicaid EDI Companion Guide (located on the Medicaid website), or go to the Provider Publications and Trainings posted on 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:

- 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 RAs and 835 transactions until the balance owed to Medicaid has been paid.
- 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 and 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 twelve (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) the date of service must be the date of delivery, not the order date (see *Section 6.13.* Billing of Deliverables).

6.19.1 Exceptions to the Twelve Month (365 days) Limit

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

Exceptions Beyond the Control of the Provider	
When the Situation is:	**The Time Limit is:**
Medicare Crossover	A Claim must be submitted within 12 months (365 days) of the date of service or within six (6) months (180 days) from the payment date on the Explanation of Medicare Benefits (EOMB), whichever is later
Member is determined to be eligible on appeal, reconsideration, or court decision (retroactive eligibility)	Claims must be submitted with in six (6) months (180 days) of the date of the determination of retroactive eligibility. The Member must provide a copy of the dated letter to the Provider to document retroactive eligibility. If a claim exceeds timely filing and the Provider elects to accept the Member as a Medicaid Member and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be an SSI award notice or a notice from WDH.
Member is determined to be eligible due to agency corrective actions (retroactive eligibility)	Claims must be submitted within six (6) months (180 days) of the date of the determination of retroactive eligibility. The Member must provide a copy of the dated letter to the Provider to document retroactive eligibility. If a claim exceeds timely filing and the Provider elects to accept the Member as a Medicaid Member and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing.
Provider finds their records to be inconsistent with filed claims, regarding rendered services. This includes dates of service, procedure or revenue codes, tooth codes, modifiers, admission or discharge dates and times, treating or referring Providers or any other item which makes the records or 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 appropriate 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 (180 days) of the date of determination of retroactive eligibility.

> Inpatient Hospital Certification: A hospital may seek admission certification for a Member found retroactively eligible for Medicaid benefits after the date of admission for services that require admission certification. The hospital must request admission certification within 30 days after the hospital receives notice of eligibility. To obtain certification, contact Telligen (see *Section 2.1* Quick Reference).

6.21 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 (2) 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" or "95" 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 service(s) does not bill the liable third party, the claim will be denied. Providers will receive claim denial information on their remittance advices along with the claims billing addresses for the liable third 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

Medicaid maintains a Member reference file of verified commercial health insurance and Medicare Part A and Part B entitlement information. This file is used to deny claims that do not show proof of payment or denial by the commercial health insurer or by Medicare. Providers must use the same procedures for locating third party payers for Medicaid Members as for their non-Medicaid patients.

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

7.2.2 Provider is Not Enrolled with Third Party Liability Carrier

Medicaid will ***not*** accept a letter with a claim indicating that a Provider does not participate with a specific health insurance company. The Provider must work with the insurance company 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 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 Third Party Liability Credit Balance Audits

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

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

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

7.3 Billing Requirements

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

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

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.

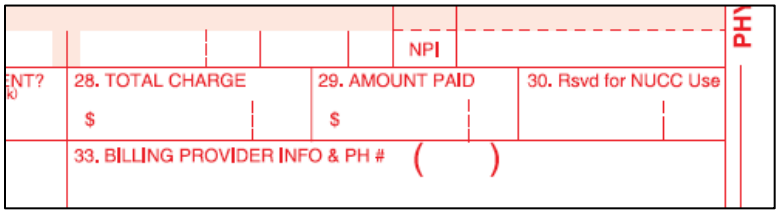
If prior authorization is not obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.

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)**

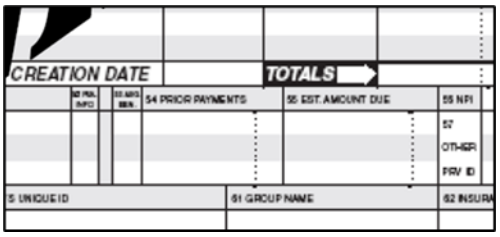
- **Field 29: Amount Paid**
  - **Enter total amount the other payers (Medicare or other insurance) paid on the covered services only.**



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

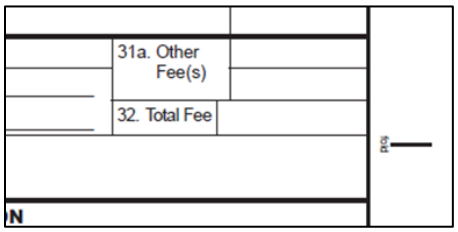
Inpatient claims will apply Other Insurance (TPL) and Medicare at the header level of the claim.

- 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.

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

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

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

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

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

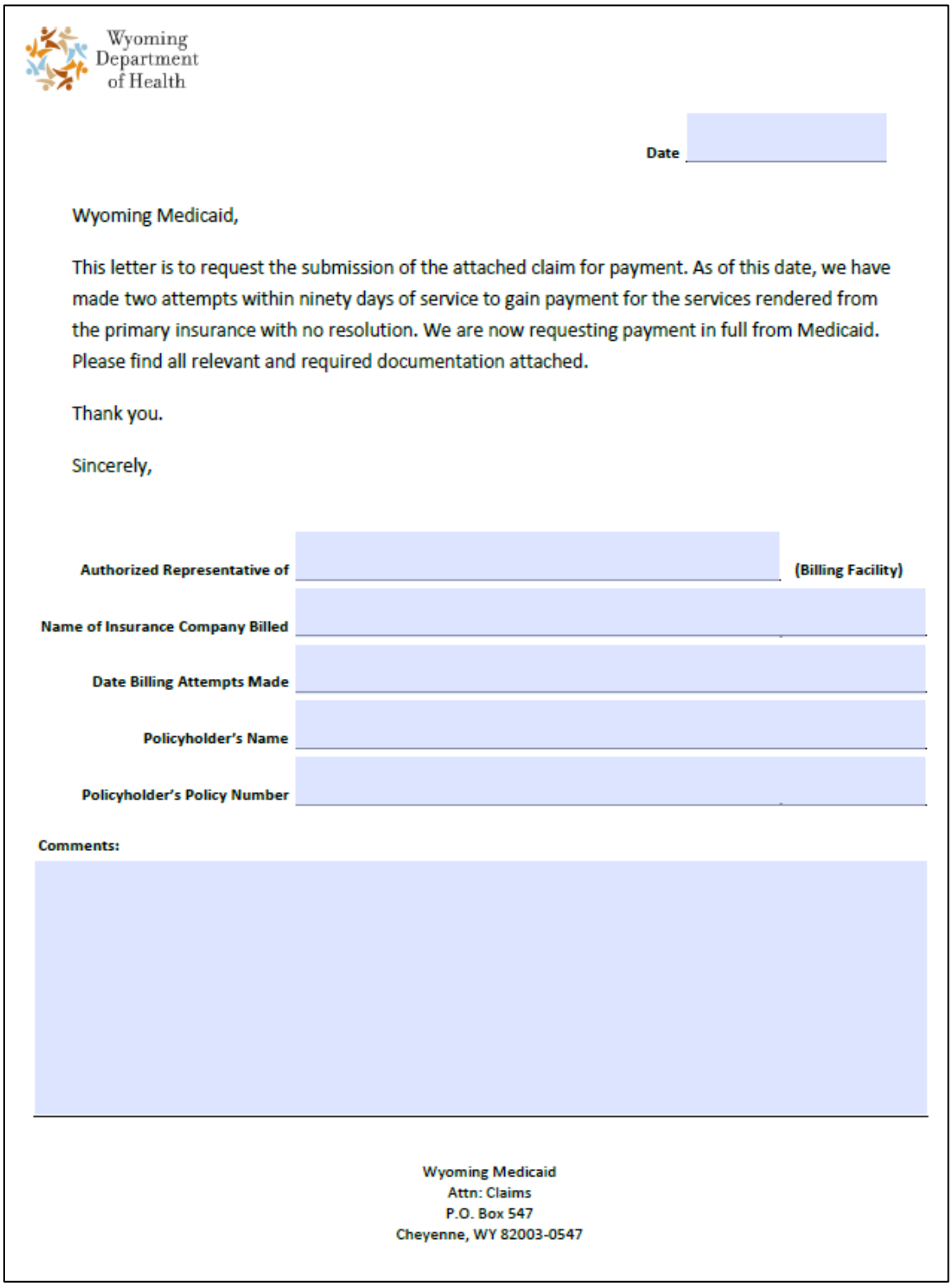
- **Claim Adjustment Reason Codes (CARC) must be entered on the service lines with the appropriate Claim Adjustment Group Code (www.x12.org/codes)**

- 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 60 days, resubmit the claims to the TPL. Wait an additional 30 days for the third-party payer to respond to the second billing. If after 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 or casualty insurance.

7.3.2 Acceptable Proof of Payment or Denial

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

7.3.3 Coordination of Benefits

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

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

For Members with three insurances, tertiary claims can be submitted through the Provider Portal 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. 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 or Other Insurance Electronic Billing Requirements:
    a. Indicate the claim requires supporting documentation: Trigger attachment indicator as Y.

b. Submit the claim to Medicaid as secondary: Enter the appropriate Payer ID (list is available on the TPL and Medicare Payer IDs web page on the WY Medicaid website).

c. Enter TPL paid amount $0.00.

d. At the line, enter full billed dollar amount and enter Claim Adjustment Reason Code (CARC) code 204.

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

7.3.5 Third Party Liability and Copays

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

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

7.3.6 Primary Insurance Recoup after Medicaid Payment

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

7.4 Medicare Pricing

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

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

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

7.4.1 Medicaid Covered Services

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

Example:

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

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

7.4.2 Medicaid Non-Covered Services

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

Example:

- Procedure Code: E0784 - (Not covered as a rental – no allowed amount has been established for Medicaid)
  - Medicaid Allowable - Not assigned
  - Medicare Allowable - 311.58
  - Medicare Paid - $102.45
  - Assigned Coinsurance and Deductible - $209.13

- First payment method option: (Medicare Allowable) $311.58 ÷ 2) = $155.79 – (Medicare Paid Amount) $102.45 = (Calculated Medicaid allowable) $53.34 Second payment method option: Coinsurance and deductible = $209.13

- Medicaid will pay the lesser of the Medicaid payment methodology or the coinsurance and deductible
  - This procedure code would pay $53.34 since it is less than $209.13

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

7.4.3 Coinsurance and Deductible

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

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

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

Chapter 8 – Electronic Data Interchange 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 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**
Web Portal The Medicaid Provider Portal provides an interactive, web-based interface for entering individual transactions and a separate data exchange facility for uploading and downloading batch transactions.	Compatible Web Browsers and Versions • Google Chrome - Version 90.0.4430.212 (Official Build) (64-bit) • Firefox - Version 88.0.1 • Microsoft Edge - Version 90.0.818.6 (Official Build) (64-bit	Free	X12N 270/271 Eligibility Benefit Inquiry and Response (Real-time allowed for Switch Vendors only) X12N 276/277 Claims Status Request and Response (Switch Vendors only) X12N 277CA Health Care Claim Acknowledgement X12N 278 Request for Prior Authorization and Response (Vendors only) X12N 835 Claim Payment/Remittance Advice X12N 837 Dental, Professional and Institutional Claims X12N 999 – Functional Acknowledgement X12N TA1 Interchange Acknowledgement	Provider Services Telephone: (888)WYO-MCAD or (888)996-6223 7-6 pm MST M-F Website: www.wyomingmedicaid.com

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

8.6 Provider Portal

The BMS or Provider Portal requires the following:

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

8.6.1 Provider Portal Features

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

- Medicaid Proprietary (paper) RA
- Upload Files
- View Provider Information

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

8.6.2 Provider (Users)

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

8.6.2.1 Key Points and Terminology

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

8.6.2.2 Provider Portal Access and Web Registration

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

- Provider Domain Administrator's will initially create their personal user ID through Okta Single Sign-On (SSO) registration process.
- Then will be required to set up an additional security feature, multi-factor authentication (MFA), to protect Provider and Member data. A detailed instruction guide on how to complete any or all three MFAs 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 will receive two (2) 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 a SFTP account • Retrieve acknowledgement responses (999, TA1, 271, 277, 277CA) • Online Batch Claims Submission (837) • Retrieve HIPAA batch responses (835) • Grievance and Appeal Submission and Monitoring • View and download Medicaid Paper 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) • Claim adjustment/void

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

8.6.3 Billing Agent and Clearinghouse

Through the Wyoming Medicaid website, new billing agents and clearinghouses (BA/CH) must enroll to access the Provider Portal. Within the Provider Portal BA/CHs can establish a Provider Domain Administrator, set up new users, manage their information, view associated Providers, perform online batch submissions, retrieve HIPAA batch responses/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 is automatically be assigned the 'Provider Domain Administrator (BA/CH user)' role.

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

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

8.6.3.1 Key Points and Terminology

- New BA/CHs enrolling September 18, 2021 and after 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 and 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: • User account maintenance for accounts under a Provider, including Associating Security Profiles and Approving New User Accounts

BA/CH Profile Name	Access Rights
Provider Access	Allows the **BA/CH user** to perform: • Manage Provider (BA/CH) information • View Associated Providers • Manage SFTP User Account • Online 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 and Medicaid Services:** https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html. This is the official HIPAA website of the Centers for Medicare & Medicaid service.
- **Washington Publishing Co.:** http://www.wpc-edi.com/hipaa/HIPAA_40.asp. This website is the official source of the implementation guides for each of the ASC X12 N transactions.

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

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

Chapter 9 – Important Information

9.1 Claims Review

Medicaid is committed to paying claims as quickly as possible. Claims are electronically processed using an automated claims adjudication system. 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 Physician Supervision Definition

Supervision is defined as the ready availability of the supervisor for consultation and direction of the individual providing services. Contact with the supervisor by telecommunication is sufficient to show ready availability, if such contact is sufficient to provide quality care. The supervising practitioner maintains final responsibility for the care of the Member and the performance of the mental health professional in their office.

Supervisor is defined as an individual licensed to provide services who takes professional responsibility for such services, even when provided by another individual or individuals.

The physical presence of the supervisor is not required if the supervisor and the practitioner are, or can easily be, in contact with each other by telephone, radio, or other telecommunications.

The supervised individual may work in the office of the supervisor where the primary practice is maintained and at sites outside that office as directed by the supervisor. Fiscal responsibility and documentation integrity for claims remains with the supervisor.

Those Provider types able to enroll with Wyoming Medicaid, even if working under the supervision of another practitioner, must enroll and be noted on the claim as the rendering Provider.

9.3 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-10 coding books

> The DSM-V, while useful for diagnostic purposes, is not considered a coding manual, and should be used only in conjunction with the above.

- 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 process on completing an appeal and completing the Request For Appeal Form, *see Section 2.3.2* How to Appeal.

9.4 Importance of Fee Schedules and Provider's Responsibility

Procedure codes listed in the following sections are subject to change at any time without prior notice. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedules on the website (see *Section 2.1* Quick Reference). Fee schedules list Medicaid covered codes, provide clarification of indicators such as whether a code requires prior authorization and the number of days in which follow-up procedures are included. Not all codes are covered by Medicaid or are allowed for all taxonomy codes (provider types). It is the 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.

9.5 Face-to-Face Visit Requirement

For practitioners ordering new Durable Medical Equipment (DME) or Prosthetic/Orthotic Supplies (POS) for a Member, the Member must have a face-to-face visit related to the condition for which the item(s) are being ordered within the previous six (6) months with the ordering or prescribing practitioner. The supplying Provider will need the date and the name of the practitioner with whom the face-to-face visit occurred for their records to bill Wyoming Medicaid for the DME or POS supplied.

This requirement is waived for renewals of existing DME or POS orders.

Chapter 10 – Covered Services – Ambulance

10.1 Ambulance Services

Procedure Code Range: **A0380-A0436**

Ambulance Providers are independent ambulances or hospital-based ambulances.

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

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

Each ambulance service provided to a Member (transport, life support, oxygen, and so on) **must be medically necessary** for all ages to be covered by Medicaid.

10.2 Covered Services

10.2.1 Emergency Transportation

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

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

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

- An emergency situation, due to an accident, injury, or acute illness; or
- Restraints are required to transport the patient (often when a psychiatric diagnosis is made); or
- The patient is unconscious or in shock; or
- Immobilization is required due to a fracture or the possibility of a fracture; or
- The patient is experiencing symptoms of myocardial infarction or acute stroke; or
- The patient is experiencing severe hemorrhaging.

10.2.2 Non-Emergency Transportation

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

- Continuous dependence on oxygen
- Continuous confinement to bed
- Cardiac disease resulting in the inability to perform any physical activity without discomfort
- Receiving intravenous treatment
- Heavily sedated
- Comatose
- Post pneumo/encephalogram, myelogram, spinal tap, or cardiac catheterization
- Hip spicas and other casts that prevent flexion at the hip
- Requirement for isolette in perinatal period
- State of unconsciousness or semi-consciousness
- The Member is determined to be an immediate danger to themselves or others at the time of transport
    - Trip report documentation must support the danger explicitly and must be attested to by a licensed clinical counsellor, physician, or psychiatrist. Transfer documents must be signed by a licensed clinic counselor or mental health professional, physician, or psychiatrist and indicate why the Member must be transported by ambulance. A signature of transfer by a discharge planner or nurse will not be accepted. Signature from the receiving facility is not needed for payment.
    - If a Member is stabilized and can be transported safely by another mode of transport, an ambulance is not covered under Medicaid (flight risk or suicidal ideation in itself would not be covered).
        - Example: A trip report indicates the Reason for Transport is “suicidal ideation”, but the Certificate of Transport signed by a valid physician indicates “danger to self or others”, the trip would be covered but may result in denials for conflicting documentation.
- Facility to facility transportation to obtain medically necessary care unavailable at the originating facility by ambulance if it would endanger the health or life of the Member to be transported by any other method

10.2.3 Definitions of Service Levels

Basic Life Support Services: A Basic Life Support (BLS) ambulance is one which provides transportation in addition to the equipment, supplies, and staff required for basic services such as the control of bleeding, splinting of fractures, treatment for shock, and basic cardiopulmonary resuscitation (CPR).

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

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

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

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

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

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

1. At least three (3) separate administrations of one (1) or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids); or
2. Ground ambulance transport, medically necessary supplies and services, and the provision of at least one (1) of the ALS2 procedures listed below:
    - Manual defibrillation/cardio version
    - Endotracheal intubation
    - Central venous line
    - Cardiac pacing
    - Chest decompression
    - Surgical airway
    - Intraosseous line

Air Ambulance Services: Medicaid covers both conventional air and helicopter ambulance services. These services are only covered under the following conditions:

- The Member has a life-threatening condition which does not permit the use of another form of transportation; or
- The Member's location is inaccessible by ground transportation; or
- Air transport is more cost effective than any other alternative

Medicaid covers air ambulance transfers of a Member who is discharged from one (1) inpatient facility and transferred and admitted to another inpatient facility when distance or urgency precludes the use of ground ambulance.

10.3 Disposable Supplies

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

10.4 Oxygen and Oxygen Supplies

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

10.5 Mileage

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

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

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

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

Rounding Rules:

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

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

10.6 Non-Covered Services

Medicaid does not reimburse for the following ambulance services:

- Transportation to receive services that are not covered services
- No-load trips and unloaded mileage (when no patient is aboard the ambulance), including transportation of life-support equipment in response to an emergency call
- Transportation of a Member who is pronounced dead before an ambulance is called
- When a Member is pronounced dead after an ambulance is called but before transport

- Transportation of a family Member or friend to visit a Member or consult with the Member's physician or other Provider of medical services
- Transportation to pick up pharmaceuticals
- A Member's return home when ambulance transportation is not medically necessary or a Member's return to a nursing facility
- Transportation of a resident of a nursing facility to receive services that are available at the nursing facility
- Air ambulance services to transport a Member from a hospital capable of treating the Member to another hospital because the Member or family prefers a specific hospital or practitioner
- Transportation of a Member in response to detention ordered by a court or law enforcement agency **(if within the first 72 hours)**
- Transportation based on a physician's standing orders
- Stand-by time
- Special attendants
- Specialty Care Transport (SCT)
- Paramedic Intercept (PI)
- When a Member has been stabilized and can be transported by another mode of transportation
- When a Member can be transported by a mode other than ambulance without endangering the Member's health, regardless of whether other transportation is available
- If a Member is an inpatient at a hospital, Medicaid does not pay separately for round trip ambulance transport for an outpatient service (for example, X-ray or other procedure) at a different hospital. This type of transport is included in the Medicaid payment to the hospital for the inpatient stay.
- Transports related to Emergency/Involuntary Detainment/Title 25 unless a Title 25 Member has been placed on the Title 25 program or is Medicaid eligible.

10.7 Multiple Member Transportation

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

10.8 Usual and Customary Charge

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

10.9 Billing Requirements

The following are the procedure codes accepted for ambulance services:

Procedure Code	Description
GROUND/Basic Life Support (BLS)	
A0380	BLS mileage (per mile)
A0382	BLS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground mileage, per statute mile
A0428	Ambulance service, basic life support, non-emergency transport, (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS, emergency)
GROUND/Advanced Life Support (ALS)	
A0390	ALS mileage (per mile)
A0398	ALS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0433	Advanced life support, level 2 (ALS 2)
Air Ambulance	
A0430	Ambulance service, conventional air services, transport, one (1) way (fixed wing)
A0431	Ambulance services, conventional air services, transport, one (1) way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile

Wyoming Medicaid does not require a separate trip report provided the request for service has been entered appropriately into the Wyoming Ambulance Trip Reporting System

https://health.wyo.gov/publichealth/ems/ems-program-2/watrs/, and marked appropriately for Wyoming Medicaid to review.

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

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

The WATRS reporting requirements apply if:

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

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

Exceptions to submitting a trip report via WATRS:

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

If submitting a paper trip report, the claim should be submitted through the usual electronic billing method, and the claim should indicate that an attachment will be coming and by what method: electronic or mail (see *Section 6.14* Submitting Attachments for Electronic Claims).

The paper trip report must include the following:

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

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

10.10 Community Emergency Medical Services

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

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

10.10.1 Enrollment

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

10.10.1.1 Community Emergency Medical Services Group Enrollment

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

10.10.1.2 Emergency Medical Technician or Paramedic Individual or Treating Enrollment

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

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

10.10.2 Covered Services

10.10.2.1 Community Emergency Medical Services – Technician (CEMS-T)

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

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

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

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

10.10.3 Community Emergency Medical Services – Clinician (CEMS-C)

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

- Within the scope of practice for the license held by the CEMS-C Provider
- Provided under the direct written or verbal order of a physician
- Coordinated with care received by the Member from other community Providers to prevent duplication of services
- Identified in a written, well documented plan of care, which may include:
    - Health assessments
    - Chronic disease monitoring and education
    - Medication compliance
    - Immunizations and vaccinations
    - Laboratory specimen collection
    - Hospital discharge follow-up care
    - Minor medical procedures

There is no WATRS documentation requirement for CEMS-C services as WATRS does not contain the ability for a Provider to report care provided outside of a call for service. Documentation of services

provided, physician's orders, and the plan of care shall be kept in the Member's comprehensive medical record maintained by the ambulance agency and supplied to the Department upon request.

10.10.4 Billing Requirements

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

Chapter 11 – Covered Services – Audiology

11.1 Audiology Services

Procedure Code Range: **V5000-V5275 and 92550-92700**

Audiology Services: A hearing aid evaluation (HAE) and basic audio assessment (BAA) provided by a licensed audiologist, upon a licensed practitioner referral, to individuals with hearing disorders.

Hearing Aid: An instrument or device designed for or represented as aiding or improving defective human hearing and includes the parts, attachments or accessories of the instrument or device.

Hearing Aid Dispenser: A person holding an active license to engage in selling, dispensing, or fitting hearing aids

11.2 Requirements

Members must be referred by a licensed practitioner. The practitioner must indicate on the referral that there is no medical reason for which a hearing aid would **not** be appropriate in correcting the Member's hearing loss.

Written orders from the licensed practitioner, diagnostic reports, and evaluation reports must be current and available upon request.

Basic Audio Assessment (BAA) under earphones in a sound attenuated room must include, at a minimum, speech discrimination tests, speech reception thresholds, pure tone air thresholds, and either pure tone bone thresholds or tympanometry, with acoustic reflexes.

Hearing Aid Evaluation (HAE) includes those procedures necessary to determine the acoustical specifications most appropriate for the individuals' hearing loss.

11.3 Reporting Standards

The audiologist's report for Medicaid Members must contain ALL of the following information:

- A physician's order stating the Member has been medically cleared for hearing aid use or documentation of medical necessity of referral to audiologist, which is retained in the Member's file.
- The results of a comprehensive audiometric exam performed by the audiologist to identify the kind of hearing loss (such as, conductive loss, sensorineural loss, or mixed loss), speech testing to include the speech reception thresholds and speech discrimination scores, and the pure-tone average.
- The kind of hearing loss, conductive loss, sensorineural loss, or mixed.
- The type of hearing aid requested – monaural or binaural – and the respective code.

- An audiogram or form that reports the hearing evaluation test or decibel loss will include for both right and left ears: Hearing thresholds at 250, 500, 1000, 2000, 4000 and 8000 Hz for air conduction and 500, 1000, 2000, and 4000 Hz for bone conduction.
- Final unaltered purchase invoice of the hearing aid(s) requested to be kept in client's file after authorization and dispensing.

Additional information for Members under the age of 19:

- If the hearing test shows an average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 hertz for that ear, a monaural aid will be allowed.
- Binaural hearing aids are reimbursed with prior authorization (PA) only under one of two circumstances:
    - Must be verified with an average hearing loss of 25 dB, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 in both ears
    - The Member is blind, and a monaural hearing aid may be contraindicated.

Additional information for Members 19 or older:

- If the hearing test shows an average hearing loss in one ear of 35 dB or greater, based on the standard PTA (500, 1000, 2000 hertz) for that ear, a monaural aid will be allowed.
- Binaural hearing aids are reimbursed with prior authorization (PA) only under one of two circumstances:
    - Must be verified with an average hearing loss of 30 dB based on the standard PTA for both ears
    - The Member is blind, and a monaural hearing aid may be contraindicated.

Binaural hearing aids are one unit for billing purposes.

A hearing aid purchased by Medicaid will be replaced no more than once in a five (5) year period unless:

- The original hearing aid has been irreparably broken or lost after the one (1)-year warranty period, AND
- The Provider's records document the loss or broken condition of the original hearing aid, AND
- The hearing loss criteria specified in this rule continues to be met, OR
- The original hearing aid no longer meets the needs of the Member and a new hearing aid is determined to be medically necessary by a licensed audiologist

The audiologist should provide a copy of the report to the Medicaid Member to take to the hearing aid dispenser (if the audiologist is not the Provider for the hearing aid). The audiologist retains the original report in the Member's medical file.

11.4 Billing Procedures

- Providers must bill for services using the procedure codes set forth and according to the definitions contained in the HCPCS Level II and CPT coding book. It is essential for Providers to have the most current HCPCS and CPT editions for proper billing.
- Providers are responsible for billing services provided within the scope of their practice and licensure
- The date of service is the date the hearing aid is delivered or the date that the repairs are completed
- A copy of the invoice (see *Section 6.8.1* Invoice Charges) must be attached to the claim. No other attachments are required (see *Section 6.14* Submitting Attachments for Electronic Claims).
- The Provider bills Medicaid for hearing aids using two (2) separate procedure codes; one (1) for the hearing aid and one (1) for the dispensing fee. The hearing aid must be billed under the appropriate procedure code(s).
- V5264- Ear molds are covered when medically necessary. This code is for one (1) mold, if a pair are provided to the Member, two (2) units should be billed.

11.5 Reimbursement

Medicaid payment for audiology services will be based on the Medicaid fee schedule.

For dates of service 12/31/2020 and prior Medicaid reimburses hearing aids either by fee schedule or invoice cost plus shipping plus 15%.

For dates of service 01/01/2021 forward, Medicaid reimburses hearing aids either by fee schedule or invoice cost, plus shipping, plus 12.13%

The dispensing fee is payable on the day the hearing aid was delivered.

> These fees are subject to change. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedule on the Wyoming Medicaid website (see *Section 2.1* Quick Reference).

11.6 Hearing Aid Repair

The following guidelines apply to the repair of hearing aids:

- The RP modifier must always be used when billing a dispensing fee on repairs.
- Repairs covered under warranty are not billable to Medicaid. If the hearing aid being repaired is under warranty, the Provider may bill the re-dispensing fee using the RP modifier but not the repair.

- Repairs not covered under warranty are billed using V5014. The Provider may bill the re-dispensing fee using the RP modifier in addition to the repair code.
- If a repair is extensive and major components are replaced AND the aid must be reprogrammed, the Provider may bill the dispensing fee but not include the RP modifier. The Provider would be reimbursed the full dispensing fee. Documentation of the reprogramming must be a part of the Member's clinical records.
- Claims must have an invoice attached (see *Section 6.8.1* Invoice Charges).
- Claims are reimbursed at invoice plus shipping only

> Cleaning and checking the functionality of a hearing aid **cannot** be billed as hearing aid repairs.

11.7 Hearing Aid Insurance

Hearing aid insurance is covered for services not covered under warranty or when the warranty expires. Use the following codes:

- X5612 Standard hearing aid insurance, per aid, annual fee.
- X5613 Advanced hearing aid insurance, per aid, annual fee.

Chapter 12 – Covered Services – Behavioral Health

12.1 Behavioral Health Services

Outpatient Behavioral Health Services are a group of services designed to provide medically necessary mental health or substance abuse treatment services to Medicaid Members to restore these individuals to their highest possible functioning level. Services may be provided by any willing, qualified Provider. Services are provided on an outpatient basis and not during an inpatient hospital stay.

Wyoming Medicaid covers medically necessary therapy services, including mental health and substance abuse (behavioral health) treatment services via the federal authority guidelines granted by the Centers for Medicare and Medicaid Services (CMS) and specified in the Code of Federal Regulation's (CFR) rehabilitative services option section. All Medicaid Members who meet the service eligibility requirements and have a need for particular rehabilitative option services are entitled to receive them.

- **"Medical necessity"** or **"Medically necessary":** A determination that a health service is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected to relieve pain or to improve and preserve health and be essential to life. The service must be:
    - Consistent with the diagnosis and treatment of the Member's condition;
    - In accordance with the standards of good medical practice among the Providers' peer group;
    - Required to meet the medical needs of the Member and undertaken for reasons other than the convenience of the Member and the Provider; and,
    - Performed in the most cost effective and appropriate setting required by the Member's condition.
- **Maintenance (Habilitative) Services:** Services that help Members keep, learn, or reach developmental milestones or improve skills and functioning for daily living that they have not yet acquired. Examples would include therapy for a child who is not walking or talking at the expected age.
- **Restorative (Rehabilitative) Services:** Services that help Members 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.
    - **Federal Medicaid Law** defines rehabilitative services as:

      "Any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to their best possible functional level" [42 C.F.R. §440.130].
- **Patients in Controlled/Baseline State:** Patients in this group may well be symptomatic, but symptoms are controlled such that they can be reasonably treated with Outpatient (OP) Services with no immediate concern for patient safety.

- **Patients in Acute State:** Patients in this group are highly symptomatic and are in need of increased Mental Health treatment. Such that, without increased OP Services, Acute Care is highly likely to be appropriate.
    - Patients in this category not only experience **decompensation (deviation from controlled/baseline state)** in functioning but the level to which the symptoms the patients are presenting are becoming a concern for their well-being.
    - Examples of this would include post-discharge from a recent inpatient setting, increased intensity of psychosis, disorganization of thought, mania, Suicidal Ideation, Homicidal Ideation, self-harm behaviors (non-superficial), increased aggression, and at times, an inability to perform ADLs.

12.1.1 Rehabilitative Services

- **What are Rehabilitative services?** “Rehabilitative” means to restore ability
    - An ability was once present, but was lost; or was present and not exercised, and ability is restored through rehabilitative services
    - Similar to other rehabilitative therapies, such as occupational therapy, skills are incrementally introduced and practiced to reach achievable and measurable goals so that rehabilitative services are no longer necessary
- Medicaid rehabilitative service Providers are required to:
    - Be familiar with and consult the Wyoming Medicaid mental health and/or substance abuse treatment rehabilitative services policy found in this Manual and its Bulletins and RA Banners.
    - Specify the type, frequency and duration of service in written treatment (rehabilitative) plan with a key focus on ensuring that all services are being directed toward specific and measurable rehabilitation goals which are developed with the Member and their family or guardian
    - Avoid billing Medicaid for provision of services that are "intrinsic elements" of another federal, state, or local program other than Medicaid.
    - Rehabilitative services should not automatically be a part of an agency's day programming and are considered an individualized service based on each Member's unique treatment needs.

Rehabilitative service documentation issues that will result in a recovery of Medicaid funds	Characteristics of Rehabilitative services that support payment
Lack of an adequate treatment plan that specifies measurable rehabilitative goals	Prepare and retain complete documentation to fully support the rehabilitative services provided, including a treatment plan developed in collaboration with the Member that is based on a clinical assessment and that specifies specific and measurable goals
Missing or inadequate documentation to support each Member encounter	Documentation must support each patient encounter and each item of service reported on the Medicaid claim form

- Examples of **exclusions** to rehabilitative option services:
  - Socialization & recreational events with no component of active treatments
  - Academic education
  - Job training/vocational services
  - **"Attendance"** in a group, psychosocial rehabilitation, individual rehabilitative services, or individual treatment program is not in and of itself a treatment plan goal.

12.2 Eligible Providers

Individual and/or Group Providers	
Board Certified Behavior Analyst (BCBA) 103K00000X	Shall be enrolled as an individual or in one (1) of the following groups: • Board Certified Behavior Analyst
Board Certified Assistant Behavior Analyst (BCaBA) 106E00000X	Shall be enrolled in one (1) of the following groups: • Board Certified Behavior Analyst
Registered Behavior Technician 106S00000X	Shall be enrolled in one (1) of the following groups: • Board Certified Behavior Analyst

Individual and/or Group Providers		
Licensed Professional Counselor (LPC) 101YP2500X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• Psychiatry	• Psychologist

Individual and/or Group Providers		
	• CMHC • SATC • Developmental Center	• Neuropsychologist • Physician
Licensed Addictions Therapist (LAT) 101YA0400X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• Psychiatry • CMHC • SATC • Developmental Center	• Psychologist • Neuropsychologist • Physician
Neuropsychologist 103G00000X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• CMHC • Physician	• SATC
Clinical Psychologist 103TC0700X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• CMHC • Physician	• SATC

Individual and/or Group Providers		
Licensed Clinical Social Worker (LCSW) 1041C0700X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• Psychiatry • CMHC • SATC • Developmental Center	• Psychologist • Neuropsychologist • Physician
Licensed Marriage and Family Therapist (LMFT) 106H00000X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• Psychiatry • CMHC • SATC • Developmental Center	• Psychologist • Neuropsychologist • Physician

Providers MUST be enrolled in a group		
Provisional Professional Counselor (PPC) 101Y00000X	Shall be enrolled in one (1) of the following groups:	
	• CMHC • Psychiatry • Psychologist • LPC • LAT • Developmental Center	• SATC • Neuropsychologist • LCSW • LMFT • Physician
Provisional Licensed Addictions Therapist (PLAT) 101YA0400X	Shall be enrolled in one (1) of the following groups:	
	• CMHC • Psychiatry • Psychologist • LPC • LAT • Developmental Center	• SATC • Neuropsychologist • LCSW • LMFT • Physician
Master of Social Worker (MSW) with Provisional License (PCSW) 1041C0700X	Shall be enrolled in one (1) of the following groups:	
	• CMHC • Psychiatry • Psychologist • LPC • LAT • Developmental Center	• SATC • Neuropsychologist • LCSW • LMFT • Physician
Provisional Marriage and Family Therapist (PMFT) 106H00000X	Shall be enrolled in one (1) of the following groups:	
	• CMHC • Psychiatry • Psychologist • LPC • LAT • Developmental Center	• SATC • Neuropsychologist • LCSW • LMFT • Physician
Registered Nurse (RN)	Shall only be enrolled in one (1) of the following groups:	

Providers MUST be enrolled in a group		
163W00000X	• CMHC	• SATC
Licensed Practical Nurse (LPN) 164W00000X	Shall only be enrolled in one (1) of the following groups:	
	• CMHC	• SATC
Case Manager 171M00000X	Shall only be enrolled in one (1) of the following groups:	
	• CMHC	• SATC
Certified Peer Specialist 175T00000X	Shall only be enrolled in one (1) of the following groups or employed by one (1) of the following facilities:	
	• CMHC • SATC	• FQHC • RHC • IHS

12.3 Requirements for Community Mental Health Centers and Substance Abuse Treatment Centers

Community Mental Health Centers (CMHC) and Substance Abuse Treatment Centers (SATC) shall meet the following criteria to be enrolled as a Medicaid Provider. Prior to enrollment as a Medicaid Provider, a mental health center shall have received certification from the Behavioral Health Division as evidence of compliance. The center shall also have resolved any compliance deficiencies within timelines specified by the certifying Division.

To become a Provider of Medicaid mental health services, an agency shall apply for certification as a mental health or substance use Medicaid Provider by submitting the Medicaid Provider certification application form and its required attachments to the Behavioral Health Division. To become a Provider of Medicaid mental health services, an agency shall be under contract with the Behavioral Health Division; and be certified by the Behavioral Health Division for the services for which the agency provides under the contract.

12.3.1 Provider's Role

Each Medicaid Provider shall:

- Be certified under state law to perform the specific services.
- Certify that each covered service provided is medically necessary, rehabilitative and is in accordance with accepted norms of mental health and substance use practice.

- Providers are required to maintain records of the nature and scope of the care furnished to Wyoming Medicaid Members.

12.3.2 Responsibilities of Mental Health and Substance Abuse Providers

- Each Member shall be referred by a licensed practitioner who attests to medical necessity as indicated by the practitioner's signature, date on the clinical assessment, and on the initial and subsequent treatment plans which prescribe rehabilitative, targeted case management, or EPSDT mental health services.
- Licensed practitioners who are eligible to refer and to sign for medical necessity are persons who have a current license from the State of Wyoming to practice as a:
    - Licensed Professional Counselor
    - Licensed Addictions Therapist
    - Licensed Psychologist
    - Licensed Clinical Social Worker
    - Licensed Marriage and Family Therapist
    - Licensed Physician
    - Licensed Psychiatric Nurse (Masters)
    - Licensed Advanced Practitioner of Nursing (Specialty area of psychiatric/mental health nursing)
- For a licensed practitioner to be authorized to refer and to sign for medical necessity, the agreement between the licensed practitioner and the Provider by which the practitioner's responsibilities under the Medicaid Mental Health Rehabilitative Option, Targeted Case Management Option, and EPSDT mental health services are specified.
- Any licensed practitioner under contract with, or employed by, a Provider shall be required to submit Medicaid claims through the Provider and to indicate the Provider as payee. All individuals providing services must have their own Provider number.
- Prior to the Providers' billing Medicaid for Mental Health Rehabilitative Option, Targeted Case Management Option, and EPSDT mental health services a licensed practitioner shall sign, date, and add their credentials to the Member's clinical assessment, written treatment plan and clinic notes.
- Licensed practitioners who sign for services that are not medically necessary and rehabilitative in nature are subject to formal sanctions through Wyoming Medicaid or referral to the relevant licensing board.

12.3.3 Qualifications for Participating Provider and Staff

TO BE ELIGIBLE TO PROVIDE MEDICAID MENTAL HEALTH CLINICAL SERVICES STAFF SHALL:

- Be employed or under contract with the Behavioral Health Division as a certified mental health center and enrolled Medicaid Provider, and
- Be licensed, provisionally licensed, or certified by the State of Wyoming, or
- Be a registered nurse (R.N.), licensed in the State of Wyoming, who has at least two years of supervised experience and training to provide mental health services after the awarding of the R.N.
- Be a clinical professional, clinical staff, or qualified as a case manager per the requirements of the service provided as pursuant to Wyoming Medicaid Rules, Chapter 13 – Mental Health Services.

TO BE ELIGIBLE TO PROVIDE MEDICAID SUBSTANCE ABUSE TREATMENT SERVICES, STAFF SHALL:

- Be employed or under contract with the Behavioral Health Division as a certified substance abuse treatment center and enrolled Medicaid Provider, and
- Be a licensed, provisionally licensed or certified by the State of Wyoming, or
- Be a registered nurse (R.N.), licensed in the State of Wyoming, who has at least two years of supervised experience and training to provide mental health services after the awarding of the R.N.
- Be a clinical professional, clinical staff, or qualified as a case manager per the requirements of the service provided as pursuant to Wyoming Medicaid Rules, Chapter 13 – Mental Health Services.

TO BE ELIGIBLE TO PROVIDE MEDICAID INDIVIDUAL REHABILITATIVE SERVICES, STAFF SHALL:

- Be employed or under contract with the Behavioral Health Division certified Medicaid Provider.
- Be eighteen years of age or older.
- A minimum general equivalent diploma, a high school diploma, or a higher degree in a discipline other than human relations.
- Complete a basic training program, including non-violent behavioral management, and
- Be supervised and meet the qualifications of a certified mental health worker as pursuant to Wyoming Mental Health Professions Board, Chapter 1 – General Provisions.
- Under the direct supervision of the primary therapist for that Member.

TO BE ELIGIBLE TO PROVIDE PEER SPECIALIST SERVICES, STAFF SHALL:

- Be employed or under contract with the Behavioral Health Division certified Medicaid Provider. Self-identify as a person in recovery from mental illness or substance abuse disorder.

- Be twenty-one years of age or older.
- Be credentialed by the Behavioral Health Division as a peer specialist, and
- Be under the direct supervision of the primary therapist for that Member.

TO BE ELIGIBLE TO PROVIDE CASE MANAGEMENT SERVICES, STAFF SHALL:

- Be employed or under contract with the Behavioral Health Division certified mental health or substance abuse treatment center and enrolled as a Medicaid Provider, and
- Be a mental health or substance abuse treatment professional, a mental health or substance abuse treatment counselor, a mental health or substance abuse treatment assistant as pursuant to Wyoming Medicaid Rules, Chapter 13 – Mental Health Services, or
- Be a Case Manager, who has achieved a bachelor's degree in a human relations discipline, is trained in case management, and who is working under the documented, scheduled supervision of a licensed mental health professional; or
- Be a registered nurse (R.N.), licensed in the State of Wyoming, who has at least two years of clinical experience after the awarding of the R.N.
- Is knowledgeable of the community and have the ability to work with other agencies
- Be under the direct supervision of the primary therapist for that Member.

All documentation, including required signatures, must be completed at the time the service is completed.

12.3.4 Quality Assurance

The quality assurance program of a Provider shall, at minimum, meet these criteria:

- Utilization and quality review criteria
- Agency standards for completeness review and criteria for clinical records
- Definition of critical incidents which require professional review and review procedures

12.3.5 Psychiatric Services

- **Psychiatric Services:** Medicaid covers medically necessary psychiatric and mental health services when provided by the following practitioners:
    - Psychiatrists or Physicians; or
    - APN/PMHNP (Advance Practice Nurse/Psychiatric Mental Health Nurse Practitioner.
- **APN/PMHNP Services:** Medicaid covers medically necessary psychiatric services when provided by an APN/PMHNP.

- The APN/PMHNP must have completed a nursing education program and national certification that prepares the nurse as a specialist in Psychiatric/Mental Health and is recognized by the State Board of Nursing in that specialty area of advance practice.

12.3.5.1 Psychologists

Medicaid covers medically necessary mental health and substance abuse disorder treatment and recovery services provided by psychologists and/or the following mental health professionals, when they are directly supervised by a licensed psychologist:

- Persons who are provisionally licensed by the Mental Health Professions Licensing Board pursuant to the Mental Health Professions Practice Act
- Psychological residents or interns as defined by the Wyoming State Board of Psychology Rules and Regulations
- Certified social worker or certified mental health worker, certified by the Mental Health Professions Licensing Board pursuant to the Mental Health Professions Practice Act

12.3.5.2 Licensed Mental Health Professionals

Medicaid covers medically necessary mental health and substance abuse disorder treatment and recovery services provided by Licensed Mental Health Professionals (LMHPs). The LMHPs include Licensed Professional Counselors, Licensed Certified Social Workers, Licensed Addictions Therapists and Licensed Marriage and Family Therapists. LMHPs may enroll independently and must bill using their own National Provider Identifier (NPI) or may enroll as Members of a Mental Health group and are required to bill with the group's National Provider Identifier (NPI) as the pay to Provider, and the individual treating Providers NPI as the rendering Provider at the line level.

12.3.5.3 Provisional Licensed Mental Health Professionals

Medicaid covers medically necessary mental health and substance abuse disorder treatment and recovery services provided by Provisional Licensed Mental Health Professionals which includes Provisional Professional Counselors, Provisional Licensed Addictions Therapists, Master of Social Work with Provisional License, and Provisional Marriage and Family Therapists. The Provisional Licensed Mental Health Professionals may enroll with a CMHC or SATC, physician, psychologist, or under the supervision of a LMHP. They must bill using their own National Provider Identifier (NPI) or may enroll as Members of a Mental Health group and are required to bill with the group's National Provider Identifier (NPI) as the pay to Provider, and their individual treating Provider NPI as the rendering Provider at the line level.

12.3.5.4 Supervision

Supervision is defined as the ready availability of the psychiatrist/physician, psychologist or LMHPs for consultation and direction of the activities of the mental health professionals in the office. Contact with the supervising practitioner (physician /psychiatrist, psychologist, or LMHPs) by telecommunication is

sufficient to show ready availability, if such contact provides quality care. The supervising practitioner maintains final responsibility for the care of the Member and the performance of the mental health professional in their office.

12.3.5.5 Reimbursement for Behavioral Health Residents and Student Interns

Medicaid Providers who sponsor residents and student interns in their practice (per Medicaid policy), should bill for Medicaid covered services provided by the resident or student intern utilizing the clinical supervisor's NPI and the HL, Intern, modifier.

12.3.6 Behavioral Health Providers Eligible for Medicare Enrollment

Taxonomy codes listed in the table below can enroll in Medicare and are required to bill Medicare prior to billing Medicaid for services rendered to Members that have Medicare as primary insurance. If a group is enrolled with one of the taxonomy codes listed in the table, the group MUST bill Medicare prior to billing Medicaid. For these groups, the rendering Provider treating a Member with Medicare as primary MUST also be enrolled in Medicare. If the rendering Provider cannot enroll in Medicare due to taxonomy code, they will not be able to treat Members that have Medicare as primary.

Taxonomy Codes Eligible for Medicare Enrollment	
Taxonomy	**Description**
2084P0800X	Psychiatrist
103G00000X	Neuropsychologist
103TC0700X	Licensed Psychologist
1041C0700X	Licensed Clinical Social Worker (LCSW)
364SP0808X	Advanced Practice Nurse Practitioner (APRN)

For behavioral health Providers that cannot enroll in Medicare due to taxonomy code, and do not belong to a group with the taxonomy codes listed in the table, these Providers can bill Medicaid directly for services rendered to Members with Medicare as primary.

12.4 Covered Services

- **Adult Psychosocial Rehabilitation or Day Treatment** (Community Mental Health and Substance Abuse Treatment Centers only) focus on both the process of recovery as well as the development of skills Members can use to cope with mental health symptoms. Skills addressed may include:
    - Emotional skills, such as coping with stress, managing anxiety, dealing constructively with anger and other strong emotions, coping with depression, managing symptoms, dealing with frustration and disappointment and similar skills.

- Behavioral skills, such as managing overt expression of symptoms like delusions and hallucinations, appropriate social and interpersonal interactions, proper use of medications, extinguishing aggressive/assaultive behavior.
- Daily living and self-care, such as personal care and hygiene, money management, home care, daily structure, use of free time, shopping, food selection and preparation and similar skills.
- Cognitive skills, such as problem solving, concentration and attention, planning and setting, understanding illness and symptoms, decision making, reframing, and similar skills.
- Community integration skills, which focus on the maintenance or development of socially valued, age-appropriate activities.
- And similar treatment to implement each enrolled Member's treatment plan.

Excludes the following services: academic education, recreational activities, meals and snacks, and vocational services and training.

> The HQ modifier for group sessions is not needed on this code.

- **Agency/Based Individual/Family Therapy:** Contact within the Provider's office or agency with the Member and/or collaterals for the purpose of developing and implementing the treatment plan for an individual or family. This service is targeted at reducing or eliminating specific symptoms or behaviors which are related to a Member's mental health or substance abuse disorder as specified in the treatment plan.
- **Peer Specialist Services** (Community Mental Health and Substance Abuse Treatment Centers only): Contact with enrolled Members (and collaterals as necessary) for the purpose of:
  - To teach and support the restoration and exercise of skills needed for management of symptoms **AND**
  - For utilization of natural resources within the community **AND**
  - Implementing the portion of the Member's treatment plan that promotes the Member to direct their own recovery and advocacy process **OR**
  - Training to parents on how best to manage their child's mental health and/or substance abuse disorder to prevent out-of-home placement

  The skills and knowledge are provided to assist the Member and/or parent to design and have ownership of their individualized plan of care. Services are person centered and provided from the perspective of an individual who has their own recovery experience from mental illness and/or substance use and is trained to promote hope and recovery, assist meeting the goals of the Member's treatment plan and to provide Peer Specialist services. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a Member's mental health and/or substance abuse disorder(s) as identified in the treatment plan. Services provided to

family members must be for the direct benefit of the Medicaid Member. This service is 15 minutes per unit.

- **Children's Psychosocial Rehabilitation** (Community Mental Health and Substance Abuse Treatment Centers only): This service is designed to address the emotional and behavioral symptoms of youth diagnosed with childhood disorders, including ADHD, Oppositional Defiant Disorder, Depression, Disruptive Behavior Disorder, and other related children's disorders. Within this service there are group and individual modalities and a primary focus on behaviors that enhance a youth's functioning in the home, school, and community. Youth will acquire skills such as conflict resolution, anger management, positive peer interaction and positive self-esteem. Treatment interventions include group therapy, activity-based therapy, psycho-educational instruction, behavior modification, skill development, and similar treatment to implement each enrolled Member's treatment plan. The day treatment program may include a parent group designed to teach parents the intervention strategies used in the program.
- **Clinical Assessment:** Contact with the enrolled Member and/or collaterals as necessary, for the purpose of completing an evaluation of the Member's mental health and substance abuse disorder(s) to determine treatment needs and establish a treatment plan. This service may include psychological testing, if indicated, and establishing DSM (current edition) diagnosis.
- **Community-Based Individual/Family Therapy: Contact** outside of the Provider's office or agency, with the Member and/or collaterals for the purpose of developing and implementing the treatment plan for an individual or family. This service is targeted at reducing or eliminating specific symptoms or behaviors which are related to a Member's mental health or substance abuse disorder as specified in the treatment plan.
- **Comprehensive Medication Services** (Community Mental Health and Substance Abuse Treatment Centers only): Assistance to Members by licensed and duly authorized medical personnel such as a licensed professional counselor, registered nurse, or licensed practical nurse, acting within the scope of their licensure, regarding day-to-day management of the recipient's medication regime. This service may include education of Members regarding compliance with the prescribed regime, filling pill boxes, locating pharmacy services, and assistance managing symptoms that don't require a prescriber's immediate attention. This service is separate and distinct from the medication management performed by physicians, physician's assistants and advanced practitioners of nursing who have prescriptive authority. This service is 15 minutes per unit.
- **Group Therapy:** Contact with two or more unrelated Members and/or collaterals as necessary, for the purpose of implementing each Member's treatment plan. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a recipient's mental health and/or substance abuse disorder(s) as identified in the treatment plan.
- **Individual Rehabilitative Services** (Community Mental Health and Substance Abuse Treatment Centers only): Contact with the enrolled Member for the purpose of implementing that portion of the Member's treatment plan targeted to developing and restoring basic skills necessary to

function independently in the home and the community in an age-appropriate manner. As well as for the purpose of restoring those skills necessary to enable and maintain independent living in the community in an age-appropriate manner, including learning skills in use of necessary community resources. Individual rehabilitative services assist with the restoration of a recipient to their optimal functional level. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a recipient's mental health and/or substance use disorder(s) as identified in the treatment plan. Services provided to family members must be for direct benefit of the Medicaid recipient. This service is 15 minutes per unit.

- **Intensive Individual Rehabilitative Services** (Community Mental Health and Substance Abuse Treatment Centers only): The short-term use of two skill trainers with one Member in order to provide effective management of particularly acute behaviors that are violent, aggressive, or self-harmful. Skill trainers who provide Intensive Individual Rehabilitative Services shall have been trained in non-violent behavioral management techniques.
- **Substance Abuse Intensive Outpatient Treatment Services** (Community Mental Health and Substance Abuse Treatment Centers only): Direct contact with two or more enrolled Members (and collaterals as necessary) for the purpose of providing a preplanned and structured program of group treatment which may include education about role functioning, illness and medications; group therapy and problem solving, and similar treatment to implement each enrolled Member's treatment plan.
- **Psychiatrist Services:** These mental health and substance abuse treatment services are covered by Medicaid when it is determined to be medically necessary and rehabilitative in nature.

12.4.1 Targeted Case Management (Community Mental Health Centers and Substance Abuse Treatment Centers Only)

Targeted Case Management for adults aged twenty-one (21) and over with serious mental illness is an individual, non-clinical service which will be used to assist individuals under the plan in gaining access to needed medical, social, educational, and other services.

The purpose of targeted case management is to foster a Member's rehabilitation from a diagnosed mental disorder or substance abuse disorder by organizing needed services and supports into an integrated system of care until the Member is able to assume this responsibility.

Targeted case management activities include the following:

- Linkage: Working with Members and/or service providers to secure access to needed services. Activities include communication with agencies to arrange for appointments or services following the initial referral process and preparing Member for these appointments. Contact with hospitalized Members, hospital/institution staff, and/or collaterals to facilitate the Member's reintegration into the community.
- Monitoring/Follow-Up: Contacting the Member or others to ensure that a Member is following a prescribed service plan and monitoring the progress and impact of that plan.

- Referral: Arranging initial appointments for Member with service providers or informing Member of services available, addresses, and telephone numbers of agencies providing services.
- Advocacy: Advocacy on behalf of a specific Member for the purpose of accessing needed services. Activities may include making and receiving telephone calls and the completion of forms, applications, and reports which assist the Member in accessing needed services.
- Crisis Intervention: Crisis intervention and stabilization are provided in situations requiring immediate attention/resolution for a specific Member. The case manager may provide the initial intervention in a crisis situation and would assist the Member in gaining access to other needed crisis services.

The Member's primary therapist (employed or contracted by the community mental health or substance abuse treatment center) will perform an assessment and determine the case management services required.

12.4.2 EPSDT Mental Health Services or Ongoing Case Management

Ongoing Case Management: Ongoing Case Management for persons under age twenty-one (21) is an individual, non-clinical service which will be used to assist individuals under the plan in gaining access to needed medical, social, educational, and other services.

The purpose of Ongoing case management is to foster a Member's rehabilitation from a diagnosed mental disorder or substance abuse disorder by organizing needed services and supports into an integrated system of care until the Member or family is able to assume this responsibility.

Ongoing case management activities include the following:

- Linkage: Working with Members and/or service providers to secure access to needed services. Activities include communication with agencies to arrange for appointments or services following the initial referral process and preparing Members for these appointments. Contact with hospitalized Members, hospital/institution staff, and/or collaterals to facilitate the Member's reintegration into the community.
- Monitoring/Follow-up: Contacting the Member or others to ensure that a Member is following a prescribed service plan and monitoring the progress and impact of that plan.
- Referral: Arranging appointments for Members with service providers or informing Members of services available, addresses and telephone numbers of agencies providing services.
- Advocacy: Advocacy on behalf of a specific Member for the purpose of accessing needed services. Activities may include making and receiving telephone calls and the completion of forms, applications, and reports which assist the Member in accessing needed services.
- Crisis Intervention: Crisis Intervention and stabilization are provided in situations requiring immediate attention/resolution for a specific Member. The case manager may provide the initial intervention in a crisis situation and would assist the Member in gaining access to other needed crisis services.

The Member's primary therapist will perform an assessment and authorize the case management services required.

12.4.3 Limitations to Mental Health and Substance Abuse Services

- Medicaid Mental Health Rehabilitative Targeted Case Management Option and EPSDT mental health services (Ongoing Case Management) are limited to those Members who meet the criteria and have a primary diagnosis of a mental or substance abuse disorder in the most current edition of the Diagnostic and Statistical Manual Disorders (DSM) or ICD equivalent.
- The Code of Federal Regulations (42 C.F.R. 441.18(c)) and Wyoming Medicaid prohibit the following activities to be billed as Targeted Case Management or Ongoing Case Management.
    - Direct delivery of a medical, educational, social, or other service to which an eligible youth has been referred;
    - Medicaid eligibility determination and redetermination activities which include outreach, application, and referral activities;
    - Transportation services;
    - The writing, recording, or entering of case notes in a case file; and
    - Coordination of the investigation of any suspected abuse, neglect, or exploitation cases.
- Specifically excluded from eligibility for Rehabilitative Option, Targeted Case Management Option and EPSDT mental health services are the following diagnoses resulting from clinical assessment:
    - Sole DSM diagnosis of intellectual disabilities
    - Sole DSM diagnosis of any Z code and services provided for a Z code diagnosis (exception for young children)
    - Sole DSM diagnosis of other unknown and unspecified cause of morbidity and mortality
    - Sole DSM diagnosis of specific learning disorders
- Habilitative services are not covered for Members twenty-one (21) years of age or older.

12.4.4 Collateral Contact

As per the Wyoming Medicaid Rules, Chapter 13 – Mental Health Services, it states the following:

"Collateral contact" means an individual involved in the Member's treatment. This individual may be a family member, guardian, healthcare professional, or person who is a knowledgeable source of information about the Member's situation who serves to support or corroborate information provided by the Member. The individual contributes a direct and exclusive benefit for the covered Member's treatment.

- A collateral is usually a spouse, family member, or friend who participates in therapy to assist the identified patient. The collateral is not considered to be a patient and is not the subject of the treatment.
- Behavioral health Providers have certain legal and ethical responsibilities to Members, and the privacy of the relationship is given legal protection. The primary responsibility is to the patient.
- The role of a collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the Member, to provide information to the therapist and never attend another session. In another case, a collateral might attend all the Member's therapy sessions and their relationship with the patient may be a focus of the treatment.
- Clinicians specializing in the treatment of children have long recognized the need to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members is common and often recommended. Parents in particular have more rights and responsibilities in their role as a collateral than in other treatment situations where the identified patient is not a minor.

12.4.4.1 Collateral Visits

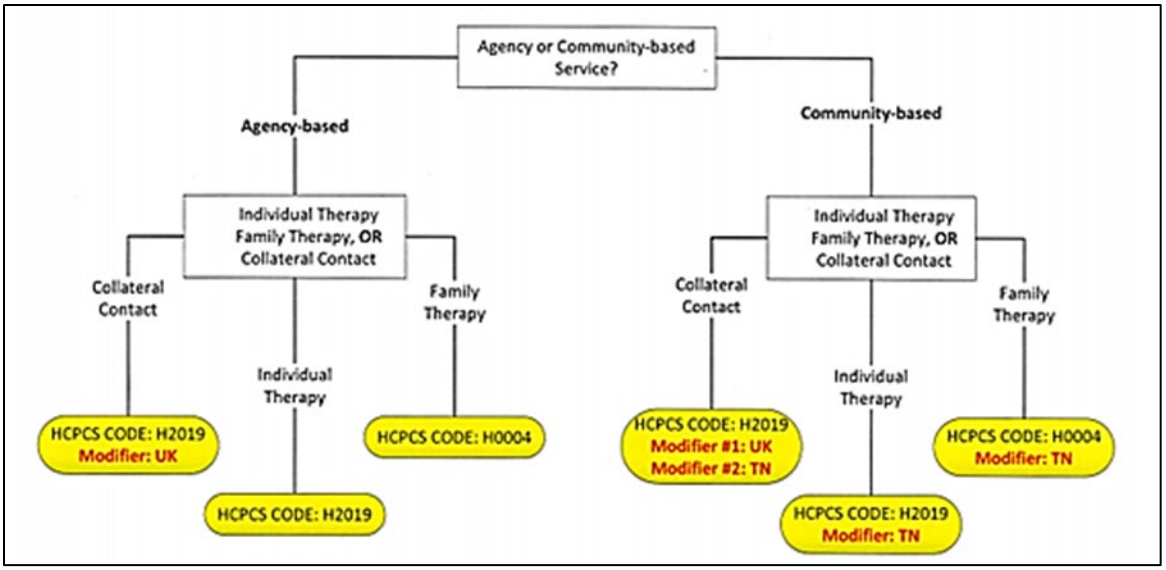
- Clinicians who work with children often treat them in the context of their family. Sometimes family members are included in sessions as collaterals.
- Child or adult abuse and similar reporting laws apply to collateral visits.
- A collateral can attend a session with the Provider with or without the Member present if medically necessary for the Member patient's treatment.
- Collaterals are not patients of the Provider. The Provider does not have the same professional responsibility for collaterals as they have for their Members.
- If a Provider thinks it is appropriate, they may offer a referral to the collateral for a follow up with another mental health professional.
- Because collaterals are not patients of the Provider, the Provider cannot bill Medicaid for treatment of the collateral.
- Collaterals are not responsible for the fees of the sessions they attend, unless they are a responsible party for payment, such as when the collateral is the parent or legal guardian of a minor patient, or the spouse of the patient.
- Information about the collateral may be entered into the clinical records with a varied range of details, depending on the clinician, the situation, the relationships between the patient and the collateral and the communication between the Provider, Member, and collateral.
- In many situations, the patient is not mandated to sign an "Authorization to Release Information" to the collateral for information shared during the visit if both collateral and patient are present in the session at the same time.

- Generally, unlike patients, collaterals do not have the right to access clinical records unless they are a parent or legal guardian of the patient.

12.4.5 Community-Based Services

Community-based services are services that are provided to a Member in their home or community rather than in institutions or other isolated settings. Community-based services should not be billed to Medicaid if the therapy is scheduled in the community for the convenience of the Provider or Member. The community-based services need to be related to a goal or objective in the treatment plan. To bill Community-based services, please use the code and the new modifier TN after the code.

There is an important policy distinction between an agency-based service and a community-based service. Agency based services are provided in a clinic or office setting. Community based services are provided outside of the Provider's office or agency and in a Member's community. There are exceptions to these service definitions. If a Provider has a contract/agreement/employment arrangement to provide services to Members elsewhere (such as in a nursing home, hospital, residential treatment center, and so on), those services are still considered to be agency-based services rather than community-based services - institutions are not considered to be community settings. These alternate service locations are considered to be an extension of, or additional place of business, for agency-based Providers. For example, if a Provider has an agreement with a nursing home to provide therapy services and travels from their agency to the nursing home, these services should still be considered agency-based services and are required to be billed as such. A second example would be if an agency-based Provider travels to a residential treatment center and conducts assessments and therapy sessions. These services would be considered agency-based services. Services provided under an agreement with another state agency (such as, DFS) are also considered to be an extension of agency-based services as well under Medicaid policy. A flowchart is provided below.



12.4.6 Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are potentially traumatic incidents that occur in a child's life. These experiences occur before a child is 18, but they remember them throughout their life. ACEs refer to specific types of trauma children may experience. These include physical, sexual, and emotional abuse, neglect, losing a parent (such as through divorce), being exposed to domestic violence, having a parent with a mental illness, having a member of the household who abuses drugs or alcohol, or having a parent who has been in jail. Children living through these experiences may suffer from adverse effects for the rest of their lives.

Children who experience these traumatic events or environments can experience challenges in their lives. Without a healthy adult to support them, they may experience toxic stress. They may encounter chronic health conditions like depression, asthma, or diabetes. If a child experiences toxic stress long-term, they may adopt unhealthy coping mechanisms such as substance abuse. When a child experiences chronic stress, it can lead to a lower tolerance for stressful situations in adulthood. Children can also experience post-traumatic stress disorder (PTSD) and other mental health issues. Assessments can be performed to determine the number of traumatic events an individual has experienced which are used to determine their ACE score. Studies have found that the risk of chronic illnesses, such as heart disease, lung disease, and cancer, is greater for people with high ACE scores. A high ACE score can also be linked to early death.

12.4.6.1 Provider Requirements for Reimbursement

Effective March 1, 2023, Wyoming Medicaid Providers who have completed the certification process detailed below are eligible for a $29 payment for conducting Adverse Childhood Experience (ACE) screenings for children with full Medicaid. Qualifying ACE screenings are eligible for payment in any clinical setting in which billing occurs through Medicaid fee-for-service.

- Fee-for-Service Payments will follow the process as outlined below and will be paid directly to the Provider submitting the claim.
    - Payment for ACE screenings for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Services (IHS) is included in the encounter rate when children are seen for regular services and are not separately reimbursable.

12.4.6.2 Guidance on Billing for Adverse Childhood Experience Screening via Telehealth

Providers may screen a patient for ACEs via telehealth if the Provider believes that the ACE screening can be administered in a clinically appropriate manner. Providers must continue to comply with all other billing procedures, Wyoming Medicaid guidelines, and confidentiality laws.

12.4.6.3 Documentation

Under the existing ACE screening policy, Providers must document all of the following:

- Assessment tool that was used,
- Documentation that the completed screening was reviewed,
- Results of the screening,
- Interpretation of results, and
- What was discussed with the Member and family, and any appropriate actions taken.

This documentation must remain in the beneficiary's medical record and be available upon request.

12.4.6.4 Certification

Eligible Wyoming Medicaid Providers must complete a certified ACEs Aware Core Training to receive reimbursement for services provided and may be required to provide proof of attestation at the request of Wyoming Medicaid.

To complete the certification, perform the following steps:

1. Register for training at ACEs Aware (https://training.acesaware.org/).
2. Complete the two (2) hour virtual training and course evaluation.
3. Obtain a copy of the certification via the ACEs Aware website.

> Currently, there is no requirement for recertification. The certification is a free two hour training and provides continuing education credits.

12.4.6.5 Covered Service Codes

The following Healthcare Common Procedure Coding System (HCPCS) is to be used to bill Wyoming Medicaid based on ACE screening results:

- HCPCS: G9919
  - Screening Performed: Result indicates patient is at high risk for toxic stress; education and interventions (as necessary) provided.
  - Providers must bill this HCPCS code when the patient's ACE score is four (4) or greater (high risk)
  - Payment: $29
- HCPCS: G9920
  - Screening Performed: Result indicates patient is at lower risk for toxic stress; education and interventions (as necessary) provided.
  - Providers must bill this HCPCS code when the patient's ACE score is between zero to three (0-3) (lower risk)
  - Payment: $29

12.4.6.6 Adverse Childhood Experience Screening Frequency

Wyoming Medicaid payment is available for ACE screenings based on the following schedule:

- Children and adolescents under age 21: Permitted for periodic ACE rescreening as determined appropriate and medically necessary, not more than once per year, per client. Children are to be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.

The Pediatric ACEs and Related Life-Events Screener (PEARLS) is used to screen children and adolescents ages zero (0) to 19 for ACEs. The PEARLS tool includes a screening for ACEs (Part 1) as well as a screening for additional adversities (Part 2). There are three (3) versions of the tool available, based on age and reporter:

- PEARLS Child Tool: Ages zero to eleven (0-11), to be completed by a parent or caregiver
- PEARLS Adolescent Tool: Ages 12-19, to be completed by a parent or caregiver
- PEARLS for Adolescent Self-Report Tool: Ages 12-19, to be completed by the adolescent

Paper copies of the PEARLS is available at:
ACEs Aware Provider Toolkit (https://www.acesaware.org/wp-content/uploads/2020/05/ACEs-Aware-Provider-Toolkit-5.21.20.pdf).

12.5 Covered Service Codes

The following matrix indicates the HCPCS Level II code, the Medicaid defined unit (for codes without a specific time span in the HCPCS Level II coding book) and acceptable modifiers (when applicable).

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
G9012	Ongoing Case Management (≤ 20 years)	Per 15 minutes	GT, HQ, HL, UK, 95	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians) Hospitals	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Case Manager, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
T1017	Adult Case Management Targeted Case Management (≥ 21 years)	Per 15 minutes	GT, HQ, HL, UK, 95	CMHC, SATC	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Case Manager, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
H0004	Family Therapy	Per 15 minutes	GT, HQ, HL, TN,UK, 95	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians) Hospitals	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
H0031	Clinical Assessment - Mental Health Assessment by non-physician **NOTE:** If the clinical assessment takes multiple days to complete, it should be billed on the day of completion per CMS and AAPC guidelines.	1 Unit/Day Max 3 Units/Year	GT, UK, HL, 95	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians) Hospitals	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
H0038	Certified Peer Specialist	Per 15 minutes	95, GT, UK	CMHC, SATC	Peer Specialist
H0038+HQ	Certified Peer Specialist with a group	Per 15 minutes	95, GT, HQ, UK	CMHC, SATC	Peer Specialist
H0046	Group Therapy – Mental health services, not otherwise specified	Per session	GT, TN, UK, HL, 95	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians) Hospitals	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
H2010	Comprehensive Medication Therapy	Per 15 minutes	N/A	CMHC, SATC, Hospitals	LPC, RN, LPN, APRN
H2014	Individual Rehabilitative Service - Skills Training and Development	Per 15 minutes	HQ, HL	CMHC, SATC	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist,

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
					Neuropsychologist, RN, LPN, Case Manager, IRS worker
H2017	Psychosocial Rehabilitation Services	Per 15 minutes	HL	CMHC, SATC	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Case Manager, Psychiatrist, APRN
H2019	Agency Based Individual Therapy	Per 15 minutes	GT, TN, UK, HL, 95	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians) Hospitals	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
S9480	Intensive Outpatient Program Intensive outpatient psychiatric services, per diem	Per session	N/A	CMHC, SATC, Hospitals	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
T2011	PASRR Level II Psychiatric Evaluation/Determination of Appropriate Placement	N/A	N/A	CMHC, Clinical Psychologist, Neuropsychologist, LPC, LCSW, LMFT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)

CPT Code	Description	1 Unit Equals	Pay-to Providers Taxonomies Allowed	Treating Provider Taxonomies Allowed
90785	Interactive complexity (list separately in addition to the code for primary procedure)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
90791	Psychiatric Diagnostic Evaluation	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
90792	Psychiatric diagnostic evaluation with medical services	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians),	Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians)
90832	Psychotherapy, 30 minutes with patient and/or family Member	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians) 364SP0808X, Taxonomies beginning with 20 (Physicians)
90833	Psychotherapy, 30 minutes with patient and/or family Member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians).	Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians)

CPT Code	Description	1 Unit Equals	Pay-to Providers Taxonomies Allowed	Treating Provider Taxonomies Allowed
90834	Psychotherapy, 45 minutes with patient and/or family Member	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
90836	Psychotherapy, 45-minutes with patient and/or family Member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, APRN, , Taxonomies beginning with 20 (Physicians)	Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians)
90837	Psychotherapy, 60 minutes with patient and/or family Member	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians
90838	Psychotherapy, 60 minutes with patient and/or family Member when performed with an evaluation and management services (list separately in addition to the code for primary procedure)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, APRN, , Taxonomies beginning with 20 (Physicians)	Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians)
90845	Psychoanalysis	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians
90846	Family Medical Psychotherapy (without the patient present)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist,	LPC, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN,

CPT Code	Description	1 Unit Equals	Pay-to Providers Taxonomies Allowed	Treating Provider Taxonomies Allowed
			LPC, LCSW, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians),	Taxonomies beginning with 20 (Physicians)
90847	Family Psychotherapy	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
90849	Multiple-Family Group Psychotherapy	CPT-Defined	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
90853	Group Medical Psychotherapy	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
96105-96146	Central Nervous System Assessments/Psychological Testing	CPT-Defined	Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)

Interpretations or an explanation of results of psychiatric services to family members, or other responsible persons, is included in the fee for psychotherapy. The following matrix indicates the CPT-4 codes

specific to psychological services. Please refer to the most current version of the CPT book.

Allowable Behavioral Health Modifiers	
Modifier(s)	**Description**
UK	Services on behalf of the Member- Collateral Contact
TN	Community-Based Setting: Rural/outside Providers' customary service area
HQ	Group setting
HL	Intern
GT	Telehealth: Via interactive audio and video telecommunications systems
95	Telemedicine

Community Mental Health Centers & Substance Abuse Treatment Centers Only		
Taxonomy	**Provider Types**	**Allowed Codes**
101Y00000X	Provisional Professional Counselor (PPC), Certified Mental Health Worker	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90832, 90834, 90837, 90845, 90847, 90849, 90853
101YA0400X	Licensed Addictions Therapist (LAT), Provisionally Licensed Addictions Therapist (PLAT), Certified Addictions Practitioner (CAP)	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90832, 90834,90837, 90845, 90847, 90849, 90853
101YP2500X	Licensed Professional Counselor (LPC)	G9012, H0004, H0031, H0046, H2010, H2014, H2017, H2019, S9480, T1017, 90791, 90785, 90832, 90834, 90837, 90846, 90847, 90849, 90853
103G00000X	Neuropsychologist	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017,T2011, 90785, 90791, 90792, 90832- 90834 ,90836-90839, 90845-90847,90849, 90853, 96101-96103, 96105, 96110-96111, 96116, 96118-96120, 96125
103TC0700X	Clinical Psychologist	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791,

		90792, 90832-90834, 90836-90839,90845-90847,90849, 90853, 96105-96146
1041C0700X	Licensed Clinical Social Worker (LCSW) and Masters of Social Work with Provisional License (PCSW)	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90832, 90834,90837, 90845, 90847, 90849, 90853
106H00000X	Marriage and Family Therapist (MFT), Provisionally Licensed Marriage and Family Therapist (PMFT)	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90832, 90834, 90837, 90845, 90849, 90853
163W00000X	RN	G9012, H0004, H0031, H0046, H2010, H2014, H2017, H2019, S9480, T1017
164W00000X	LPN	G9012, H2010, H2014
171M00000X	Case Manager	G9012, H2014, H2017, T1017
175T00000X	Certified Peer Specialist	H0038
172V00000X	Community Health Worker – Individual Rehabilitative Services Worker (IRS), Certified Addictions Practitioner Assistant (CAPA)	H2014
Taxonomies beginning with 20	Physicians	G9012, H0004,H0031, H0046, H2019, S9480, T1017, 90785, 90791, 90792, 90832- 90834, 90836-90839, 90845, 90846, 90847, 90849, 90853, 96105-96146
2084P0800X	Psychiatry and Neurology, Psychiatry	G9012, H0004, H0031, H0046, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90792, 90832-90834, 90836-90839, 90845-90847, 90849, 90853, 96105-96146
364SP0808X	Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health	G9012, H0004, H0031, H0046, H2010, H2017, S9480, T1017, T2011, 90785, 90791, 90792,90832-90834, 90836-90839, 90845-90847, 90849, 90853, 96105-96146

Hospitals Only		
Taxonomy	**Provider Types**	**Allowed Codes**
282N00000X	Hospitals	G9012, H0004, H0031, H0046, H2010, S9480, 90785, 90791, 90792, 90832-90834, 90836-

		90839, 90845-90847, 90849, 90853, 96105-96146

12.6 Non-Covered Services

- Hospital liaison services that include institutional discharge functions that are Medicaid reimbursable to the institution
- Consultation to other persons and agencies about non-Members, public education, public relations activities, speaking engagements and education
- Clinical services not provided through face-to-face contact with the Member, other than collateral contacts necessary to develop or implement the prescribed plan of treatment
- Residential room, board, and care
- Substance abuse and mental health prevention services
- Recreation and socialization services
- Vocational services and training
- Appointments not kept
- Day care
- Psychological testing done for the sole purpose of educational diagnosis or school placement
- Remedial or other formal education
- Travel time
- Record keeping time
- Time spent writing test reports except for three hours allowed for report writing by a licensed psychologist for the purpose of compiling a formal report of test findings and time spent completing reports, forms and correspondence covered under case management services
- Time spent in consultation with other persons or organizations on behalf of a Member unless:
    - The consultation is a face-to-face contact with collateral to implement the treatment plan of a Member receiving Rehabilitative Option services. **or**
    - The consultation is a face-to-face or telephone contact to implement the treatment plan of a Member receiving EPSDT Mental Health Services. **or**
    - The consultation is a face-to-face or telephone contact to implement the treatment plan of a Member receiving Targeted Case Management Services. **or**
    - The consultation is a face-to-face or telephone contact to implement the treatment plan of a Member receiving Applied Behavior Analysis treatment.

- Groups such as Alcoholics Anonymous, Narcotics Anonymous, and other self-help groups
- Driving while under the influence (DUI) classes
- Services provided by a school psychologist

12.6.1 Provisions of Mental Health and Substance Abuse Treatment Services to Residents of Nursing Facilities

Eligibility for Medicaid mental health and substance abuse services provided to enrolled Members in the nursing facility is limited to the following services under the Rehabilitative Services Option:

- Clinical Assessment
- Community-Based Individual or Family Therapy
- Group Therapy
- Psychiatric Services

12.7 Applied Behavioral Analysis Treatment

Applied Behavior Analysis (ABA) treatments are allowable to children between the ages of zero (0) to 20 years of age with a diagnosis of Autism Spectrum Disorder. ABAs are individualized treatments based in behavioral sciences that focus on increasing positive behaviors and decreasing negative or interfering behaviors to improve a variety of well-defined skills. ABA is a highly structured program that includes incidental teaching, intentional environmental modifications, and reinforcement techniques to produce socially significant improvement in human behavior. ABA strategies include reinforcement, shaping, chaining of behaviors, and other behavioral strategies to build specific targeted functional skills that are important for everyday life.

> ABA Providers must abide by all Wyoming Medicaid policies and documentation requirements.

12.7.1 Applied Behavior Analysis Providers

ABA Providers must follow the requirements set by the Board of Certified Behavior Analysts as per Behavior Analyst Certification Board (https://www.bacb.com/) to provide applied behavior analysis treatment services to Wyoming Medicaid Members.

Name	Abbreviation and Requirements http://bacb.com/credentials/
Board Certified Behavior Analysts – Doctoral **103K00000X**	**BCBA-D** Be actively certified as a BCBA in Good Standing Have earned a degree from a doctoral program accredited by the Association for Behavior Analysis International or; A certificant whose doctoral training was primarily behavior-analytic in nature, but was not obtained from an ABAI-accredited doctoral program, may qualify for the designation by demonstrating that their doctoral degree met the following criteria: (a.)The degree was conferred by an acceptable accredited institution; AND (b.) The applicant conducted a behavior-analytic dissertation, including at least 1 experiment; AND (c.) The applicant passed at least 2 behavior analytic courses as part of the doctoral program of study; AND (d.) The applicant met all BCBA coursework requirements prior to receiving the doctoral degree.
Board Certified Behavior Analysts **103K00000X**	**BCBA** **Option 1** requires an acceptable graduate degree from an accredited university, completion of acceptable graduate coursework in behavior analysis, and a defined period of supervised practical experience to apply for the BCBA examination. **Option 2** requires an acceptable graduate degree from an accredited university, completion of acceptable graduate coursework in behavior analysis that includes research and teaching, and supervised practical experience to apply for BCBA examination. **Option 3** requires an acceptable doctoral degree that was conferred at least 10 years ago and at least 10 years post-doctoral practical experience to apply for the BCBA examination.

Name	Abbreviation and Requirements http://bacb.com/credentials/
Board Certified Assistant Behavior Analyst **106E00000X**	BCaBA **1. Degree** Applicant must possess a minimum of a bachelor's degree from an acceptable accredited institution. The bachelor's degree may be in any discipline. **2. Coursework** Course work must come from an acceptable institution and cover the required content outlined in the BACB's Fourth Edition Task List and Course Content Allocation documents. **3. Experience** Applicants must complete experience that fully complies with all the current Experience Standards. **4. Examination** Applicants must take and pass the BCaBA examination.

Name	Abbreviation and Requirements http://bacb.com/credentials/
Registered Behavior Technician **106S00000X**	**RBT** **1. Age and Education** RBT applicants must be at least 18 years of age and have demonstrated completion of high school or equivalent/higher. **2. Training Requirement** The 40-hour RBT training is not provided by the BACB but, rather, is developed and conducted by BACB certificants. **3. The RBT Competency Assessment** The RBT Competency Assessment is the basis for the initial and annual assessment requirements for the RBT credential. **4. Criminal Background Registry Check** To the extent permitted by law, a criminal background check and abuse registry check shall be conducted on each RBT applicant no more than 45 days prior to submitting an application. **5. RBT Examination** All candidates who complete an RBT application on or after December 14, 2015 will need to take and pass an examination before credential is awarded.

12.7.2 Covered Services

Adaptive Behavior Assessment and Treatment Procedure Codes						
Essential Elements applied Behavior Analysis Services		**General Description**	**Descriptor**	**Code**	**Time/Units**	**Attended By and Provider Type(s)**
Assessment Codes	Development of individualized treatment plan by supervising behavior analyst/QHP	Assessment for treatment plan development	Behavior identification assessment, administered by a qualified healthcare professional, each 15 minutes of the other qualified healthcare professional's or Board Certified Behavior Analyst's (QHP/BCBA) time face-to-face with patient and/or guardian/caregiver(s) administering	97151	Per 15 Min (48 Max Units/Day)	Functional analysis of severe maladaptive behaviors in specialized settings

Adaptive Behavior Assessment and Treatment Procedure Codes						
Essential Elements applied Behavior Analysis Services		**General Description**	**Descriptor**	**Code**	**Time/Units**	**Attended By and Provider Type(s)**
	Assessment may include: Review of file information about Member's medical status, prior assessments, prior treatments Stakeholder interviews and rating scales Review of assessments by other professionals Direct observation and measurement of Member's behavior in structured and unstructured situations Determination of baseline levels of adaptive and maladaptive behaviors Functional behavior analysis		assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.			
			Behavior identification supporting assessment, administered by one technician under the direction of a QHP/BCBA, face-to-face with the patient, each 15 minutes.	97152	Per 15 Min	Member & RBT (106S00000X) or BCaBA (106E00000X) (BCBA or BCBA-D may substitute for the technician)
		Functional analysis of severe maladaptive behaviors in specialized settings	Behavior identification supporting assessment. Each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the QHP/BCBA who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized to the patient's behavior.	0362T	Per 15 Min	Member & RBT (106S00000X) or BCaBA (106E00000X) (BCBA or BCBA-D may substitute for the technician)

Adaptive Behavior Assessment and Treatment Procedure Codes						
Essential Elements applied Behavior Analysis Services		**General Description**	**Descriptor**	**Code**	**Time/Units**	**Attended By and Provider Type(s)**
Treatment Codes	Implementation and management of treatment plan by supervising behavior analyst/BCBA. Includes: Training technicians to carry out treatment protocols accurately, frequently, and consistently; record data on treatment targets; record notes; summarize and graph data. Training family members and other caregivers to implement selected aspects of the treatment plan. Ongoing supervision of technician and	Direct treatment	Adaptive behavior treatment by protocol, administered by a technician under the direction of a QHP/BCBA, face-to-face with one patient, each 15 minutes.	97153	Per 15 Min (32 Max Units/Day)	Member & RBT (106S00000X) or BCaBA (106E00000X) (BCBA or BCBA-D may substitute for the technician)
		Direct treatment of severe maladaptive behavior in specialized settings	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the QHP/BCBA who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized, to the patient's behavior.	0373T	Per 15 Min	Member & 2 or more RBTs (106S00000X) or BCaBAs (106E00000X) (BCBA or BCBA-D may substitute for the technician)
		Direct treatment by QHP	Adaptive behavior treatment with protocol modification, administered the QHP/BCBA, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	97155	Per 15 Min (16 Max Units/Day)	Member & BCBA or BCBA-D (103K00000X);may include an RBT, BCaBA and/or Caregiver
		Group Treatment	Group adaptive behavior treatment with protocol modification, administered by a technician under the direction of a	97154	Per 15 Min (32 Max Units/Day)	2 or more Members & RBT (106S00000X) or BCaBA (106E00000X) (BCBA or BCBA-D may

Adaptive Behavior Assessment and Treatment Procedure Codes						
Essential Elements applied Behavior Analysis Services		**General Description**	**Descriptor**	**Code**	**Time/Units**	**Attended By and Provider Type(s)**
	caregiver implementation. Ongoing, frequent review and analysis of direct observational data on treatment targets. Modification of treatment targets and protocols based on data. Training technicians, family members, and other caregivers to implement revised protocols.		QHP/BCBA, face-to-face with two or more patients, each 15 minutes.			substitute for the technician)
				97158	Per 15 Min (32 Max Units/Day)	2 or more Members & BCBA or BCBA-D (103K00000X)
		Family Training	Multiple-family group adaptive behavior treatment guidance, administered by QHP/BCBA (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.	97156	Per 15 Min (4 Max Units/Day)	Caregiver & BCBA or BCBA-D (103K00000X)
			Multiple-family group adaptive behavior treatment guidance, administered by QHP/BCBA (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.	97157	Per 15 Min (4 Max Units/Day)	Caregivers of 2 or more Members & BCBA or BCBA-D (103K00000X)

Definitions:

Qualified Healthcare professional (QHP): Is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within their scope of practice and independently reports the professional services. In this section, QHP refers to a Board-Certified Behavioral Analyst (BCBA)

"On-Site": Is defined as immediately available and interruptible to provide assistance and direction through the performance of the procedure, however, the QHP/BCBA does not need to be present in the room when the procedure is performed.

Direct Services: Includes direction of Registered Behavior Technicians, treatment planning/monitoring fidelity of implementation, and protocol modification

Indirect Services: Includes developing treatment goals, summarizing and analyzing data, coordination of care with other professionals, report progress toward treatment goals, develop and oversee transition/discharge plan, and training and directing staff on implementation of new/revised treatment protocols (patient not present). The AMA codes for Adaptive Behavior Services indicate that the activities associated with indirect supervision are bundled codes and are otherwise considered a practice expense and not reimbursable. The only code that can be billed for indirect services is 97151.

12.7.3 Applied Behavior Analysis Supervision of Technicians

Supervision by a QHP/BCBA is required (approximately 1 hour per 10 hours of direct care by the technician). There is no separate code for supervision, but supervision is an essential activity that is part of all the technician codes. The bill for technician time is meant to include reimbursement for total time, including supervision, even though only the technician time is measured. (The codes should be selected, however, based strictly on **face-to-face technician time**.) The professional behavior analysts perform specific activities when providing clinical supervision to ABA technicians. These are, of course, well beyond Human Resources (HR) functions, such as procedural-integrity checks and modifying and modeling modifications to a treatment protocol that has not produced the desired outcomes. These types of activities are separate from HR supervision, and adaptive behavior treatment with protocol modification code.

When a QHP/BCBA is directing the activities of a technician in person (**face-to-face contact with the patient**) for purposes such as checking procedural integrity and problem solving and/or modifying a treatment protocol that is not effective, the QHP/BCBA would bill for this time using the adaptive behavior treatment with protocol modification code. There is no separate code for QHP/BCBA supervision of technicians without the patient present. This type of supervision is included in the codes used to bill according to a technician's time and is typically considered to be 10–15 minutes of QHP/BCBA time for each hour that a technician spends face to face with a patient.

The CPT Editorial Panel regards supervision as primarily a HR function (for example, providing performance feedback, resolving employee conflicts, approving vacation, conducting annual evaluations). The CPT

Editorial Panel considers these activities practice expenses, and therefore does not publish codes to allow professionals to bill for supervision as a separate health procedure.

12.8 Limitations for Behavioral Health Services

- Report writing is not a covered service by Medicaid for any Provider type except for psychologist and neuropsychologist. New CPT codes for these Provider types went into effect January 1, 2019 for billing Wyoming Medicaid.
- Span billing is not allowed for fee for service behavioral health services. Each date of service must be billed on its own separate line.
- Group therapy is limited to two sessions per day and the sessions are not allowed to be billed consecutively. For example, a group therapy session from 10-12 p.m. and then another one from 12-2 p.m. is not allowed. There must be a minimum of one (1) hour between the two group sessions.
- The following conditions do not meet the medical necessity guidelines, and therefore are not covered:
    - Services that are not medically necessary
    - Treatment whose purpose is vocationally or recreationally based
    - Diagnosis or treatment in a school-based setting by a Provider employed by the school district
- The following conditions are subject to limitations and are not covered outside of those limitations:
    - Members age 21 and over are limited to restorative/rehabilitative services only. Restorative/rehabilitative 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

12.8.1 Prior Authorization once Thresholds are Met

For Medicaid Members with dates of service in excess of thirty (30) per calendar year, a prior authorization is required, which can be obtained through Telligen(see *Section 6.7* Service Thresholds).

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 1:00 p.m. on 4/1/2021 and Provider B for group therapy at 2:00 p.m. on 4/1/2021, it will count as two visits.

The following must be submitted with your request to Telligen for a determination to be made:

- Clinical Assessment
    - A psychological evaluation or psychosocial assessment that describes the patient's history, need to for treatment, and so on.
- A copy of the most recent treatment plan (must be reviewed every 90 days)
- Progress notes demonstrating some indication that the Member is working towards goals noted in the treatment plan, and that the services being Provider are rehabilitative in nature – meaning the services are helping the Member keep, get back, or improve skills/functioning for daily living that have been lost or impaired due to their mental health issues.

Any requests to Telligen that are for dates of service which are past timely filing will not be reviewed. Remember the expectation is to have the requests in prior to the dates of service reflected in the treatment plan. Requests that are submitted within timely will be given priority over retroactive review requests.

12.8.1.1 Appeals Process

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 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.

- 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 email 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 the Telligen system. The appeal will be reviewed in conjunction with the documentation uploaded into Telligen's system.

12.9 Documentation Requirements for All Behavioral Health Providers (including Applied Behavior Analysis Providers)

12.9.1 Provider Agreement

The Provider Agreement requires that the clinical records fully disclose the extent of treatment services provided to Medicaid Members. The following elements are a clarification of Medicaid policy regarding documentation for medical records:

- The record shall be typed or legibly written
- The record shall identify the Member on each page
- Entries shall be signed and dated by the qualified staff member providing service
- A mental health/substance abuse therapeutic record note must show length of service including time in and time out (Standard or Military time)
- The record shall contain a preliminary working diagnosis and the elements of a history and mental status examination upon which the diagnosis is based
- All services, as well as the treatment plan, shall be entered in the record. Any drugs prescribed by medical personnel affiliated with the Provider, as part of the treatment, including the quantities and the dosage, shall be entered in the record.
- The record shall indicate the observed mental health/substance abuse therapeutic condition of the Member, any change in diagnosis or treatment, and the Member's response to treatment. Progress notes shall be written for every contact billed to Medicaid
- The record must include a valid consent for treatment signed by the Member or guardian

Pursuant to Wyoming Medicaid Rules, Chapter 3 – Provider Participation, "Documentation requirements," a Provider must have completed all required documentation, including required signatures, before or at the time the Provider submits a claim to the Division of Healthcare Financing, Medicaid. Documentation prepared or completed after the submission of a claim will be deemed to be insufficient to substantiate the claim and Medicaid funds shall be withheld or recovered.

12.9.2 Documentation of Services

Documentation of the services must contain the following:

- Name of the Member
- The covered services provided and the procedure code billed to Medicaid
- The date, length of time (start and end times in standard or military format), and location of the service
- All persons involved

- Legible documentation that accurately describes the services rendered to the Member and progress towards identified goals
- Full signature, including licensure or certification of the treating Provider involved
    - Providers shall not sign for a service prior to the service being completed
- No overlapping behavioral health services, except for codes 97153 and 97155

> When providing behavioral health services to a Medicaid Member, the documentation kept must be accurate with the date and times the services were rendered (see *Sections 3.11* Record Keeping, Retention, and Access and *12.9* Documentation Requirements for All Behavioral Health Providers (including Applied Behavior Analysis Providers)). Behavioral health services cannot overlap date and time for a Member. For example, a Member being seen for group therapy on February 28th from 11:00 to 12:00 cannot also be seen for targeted case management on February 28th from 11:00 to 12:00. These are overlapping services and cannot be billed to Medicaid. Proper documentation is important to differentiate the times of services being rendered, as times cannot be billed on a CMS 1500 claim.

12.9.3 Member Records

Providers of mental health/substance abuse services under Medicaid shall maintain clinical and financial records in a manner that allows verification of service provision and accuracy in billing for services. Billed services not substantiated by clinical documentation shall be retroactively denied payment. The Provider shall be responsible for reimbursing any Medicaid payments that are denied retroactively.

Late entries made to the Member's record are allowable to supplement the clinical record. Late entries are not allowable for the purpose of satisfying record keeping requirements after billing Wyoming Medicaid.

12.9.3.1 Requirements

In addition to the general documentation requirements listed above, the following requirements shall be met:

- There shall be a separate clinical note made in each Member's clinical record for every treatment contact that is to be billed to Medicaid. More frequent documentation is acceptable and encouraged
    - A separate progress note in the clinical record for each face-to-face contact with the Member and with collaterals to implement the Member's treatment plan. Progress notes shall include:

- The name of the Medical reimbursable service rendered and procedure code billed to Medicaid
- The date, length of time (time in and time out in standard or military time format) and location of the contact
- Persons involved (in lieu of or in addition to the Member)
- Summary of Member condition, issues addressed, and Member progress in meeting treatment goals
- Signature, date, and credentials of treating staff member

- A separate progress note for Psychosocial Rehabilitation shall document:
  - The date and length of time (time in and time out in standard or military time format) of each day's contact
  - A separate progress note describing therapeutic activities provided, the procedure code billed to Medicaid, and Member's progress in achieving the treatment goal(s) to be accomplished through psychosocial rehabilitation
  - Signature, date, and credentials of treating staff member
  - Co-signature of the primary therapist on progress notes for services provided by non-licensed, certified staff, or qualified case managers
- Individual Rehabilitative Services (IRS), a separate progress note shall document each contact to be billed, including:
  - The date and length of time (time in and time out in standard or military time format) of each day's contact
  - Activities of the skill trainer and activities of the Member
  - Any significant Member behavior observed
  - The date and signature of the skill trainer
  - The location of service and the procedure code billed to Medicaid
  - Co-signature of the primary therapist on progress notes for services provided by non-licensed, certified staff, or qualified case managers
- Peer Specialist Services, a separate progress note shall document for each contact to be billed, including:
  - The date and length of time (time in and time out in standard or military time format) of each day's contact
  - Activities of the skill trainer and activities of the Member
  - Any significant Member behavior observed

        - The date and signature of the skill trainer
        - The location of service and the procedure code billed to Medicaid
        - Co-signature of the primary therapist on progress notes for services provided by a peer-specialist
    - Ongoing Case Management Services and Targeted Case Management Services, a separate progress note shall document each contact to be billed, including:
        - The date and length of time (time in and time out in standard or military time format) of each day's contact
        - The date and signature of the case manager
        - Type and description of each service and the procedure code billed to Medicaid
        - Co-signature of the primary therapist on progress notes for services provided by non-licensed, certified staff, or qualified case managers
- Each note shall show length of service, time in and time out in standard or military format.
- The Provider shall adhere to clinical records standards defined in *Section 3.11* Record Keeping, Retention, and Access.
- The Provider shall maintain an individual ledger account for each Medicaid Member who receives services. The ledger account shall indicate, at a minimum:
    - The length of contact rounded to the nearest 15- minute unit, per billing instructions. If seven (7) minutes or less of the next fifteen (15) minute unit is utilized, the unit must be rounded down. However, if eight (8) or more minutes of the next fifteen (15) minute unit are utilized, the units can be rounded up. Date ranges are not acceptable.
    - The date and type of each treatment contact
    - The appropriate Medicaid charge
    - Date that other third-party payers were billed and the result of the billing. Services noted on the individual ledger account and billed to Medicaid shall be substantiated by the clinical record documentation.

12.9.3.2 Clinical Records Content Requirement

Each Medicaid Provider shall establish requirements for the content, organization, and maintenance of Member records. The content of clinical records shall include, at a minimum:

- Documentation of Member consent to treatment at the agency. If an adult Member is under guardianship, consent shall be obtained from the guardian. In the case of minors, consent shall be obtained from a parent or the guardian. Wyoming Medicaid shall not reimburse for services delivered before a valid consent is signed.

- A Member fee agreement, signed by the Member or guardian. For Medicaid, this agreement shall include authorization to bill Medicaid, and other insurance if applicable, using the following statement, “I authorize the release of any treatment information necessary to process Medicaid/insurance claims.”
- A specific fee agreement for any Medicaid non-covered service, and the fee that an enrolled Member agrees to pay.
- Documentation that each Member has been informed of their Member rights.
- A clinical assessment/clinical intake form completed prior to the provision of treatment services which shall include at a minimum:
    - The specific symptoms/behaviors of a mental/substance abuse disorder which constitute the presenting problem
    - History of the mental/substance abuse disorder and previous treatment
    - Family and social data relevant to the mental/substance abuse disorder
    - Medical data, including a list of all medications being used, major physical illnesses, and substance abuse (if not the presenting problem)
    - Mental status findings
    - A diagnostic interpretation
    - A DSM (current edition) diagnosis
    - The clinical assessment must be updated annually at a minimum
- A diagnostic interpretation or a treatment plan shall be completed prior to or within five (5) working days of the third face-to-face contact with a licensed mental health professional
- Properly executed release of information, as applicable, and chart documentation of information received or released as a result of the written Member consent
- Testing, correspondence, and like documents or copies
- For Members receiving ten or more therapeutic contacts, a discharge summary is required and must:
    - Include each type of Medicaid service provided, detailing the Member's progress in achieving treatment goal(s) and plans for follow-up
    - Be completed within 90 days of the last contact with the Member
    - Document the reason for case closure within clinical records

12.9.4 Treatment Plans

Treatment plans for services must be based on a comprehensive assessment of an individual's rehabilitation needs, including diagnoses and presence of a functional impairment in daily living, and be reviewed every 90 days.

Treatment plans must also:

- Be developed by qualified Provider(s) working within the State scope of practice with significant input from the Member, Member's family, the Member's authorized healthcare decision maker and/or persons of the Member's choosing
- Ensure the active participation of the Member, Member's family, the Member's authorized healthcare decision maker and/or persons of the Member's choosing in the development, review and modification of these goals and services
- Specify the Member's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders
- Specify the mental health and/or substance related disorder that is being treated
- Specify the anticipated outcomes within the goals of the treatment plan
- Indicate the type, frequency, amount, and duration of the services
- Be signed by the individual responsible for developing the rehabilitation plan
- Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than 90 days
- Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan
- Include the name of the individual
- The date span of services the treatment plan covers
- The progress made toward functional improvement and attainment of the individual's goals

12.9.5 Billing Requirements

To obtain Medicaid reimbursement for services, the following standards must be observed.

- The services must be medically necessary and follow generally accepted standards of care
- Bill using the appropriate code set
- The service must be a service covered by Medicaid
- Claims must be filed according to Medicaid billing instructions

12.9.6 Time and Frequency

Time and frequency are required on all documentation and must be specific so time in and time out must be reflected on the document in standard or military format. Time can be a unit of 15 minutes depending on the Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) Level II code used to bill the service. For example, if the code is a fifteen (15) minute unit, then follow the guidelines for rounding to the nearest unit. If seven (7) minutes or less of the next 15-minute unit is utilized, the unit must be rounded down. However, if eight (8) or more minutes of the next 15-minute unit are utilized, the units can be rounded up. Date ranges are not acceptable. Please refer to the CPT and HCPCS coding books for more information on how to round a unit per code.

12.9.7 Pre-Admission Screening and Resident Review Assessments

12.9.7.1 Billing Requirements

- Submit Pre-Admission Screening and Resident Review (PASRR) Level II claims to the Medicaid Program.
- PASRR Level II assessments should be sent to Telligen (see *Section 2.1* Quick Reference).

PASRR Level II Billing Code(s)			
HCPCS Level II Code	**1 Unit Equals**	**Description**	**Taxonomies Allowed**
T2011	Per Visit	PASRR Level II Psychiatrist	101Y00000X, 101YP2500X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 20 (Physicians), 2084P0800X, 364SP0808X

Chapter 13 – Covered Services – Care Management Entity and Children's Mental Health Waiver Services

13.1 Care Management Entity and Children's Mental Health Waiver Services

Wyoming Medicaid's Care Management Entity (CME) contractor, Magellan Healthcare, serves Medicaid-covered children and youth ages four (4) through twenty (20) years of age who are experiencing serious emotional and/or behavioral challenges. The CME provides intensive care coordination services using the High Fidelity Wraparound (HFWA) model. Children and youth not currently eligible for Wyoming Medicaid through the State Plan may access CME services through the State's Children's Mental Health Waiver (CMHW) if they meet clinical and financial eligibility requirements. CMHW enrollees must actively participate in the CME program to maintain their waiver eligibility.

All youth applying for CME enrollment must meet clinical eligibility requirements which include completion of the Early Childhood Service Intensity Instrument (ECSII) for children 4-5 or, completion of the Child & Adolescent Service Intensity Instrument (CASII) for youth 6-20 and a Level of Care assessment by a Qualified Mental Health Professional that indicates clinical eligibility for enrollment and not be part of the excluded populations group:

- Youth residing in a Nursing Facility or ICF/MR;
- Youth enrolled in another managed care program;
- Youth enrolled in another HCBS waiver;
- Retroactive Eligibility (Medicaid beneficiaries for the period of retroactive eligibility);
- Any youth, who during enrollment or participation in the waiver, is determined eligible for any other excluded population (such as waiver listed above, nursing facility, or ICF/MR); or
- Other: Any other youth, upon application, whose primary need is determined to be for services that are more habilitative in nature vs the intensive rehabilitative nature of HFWA services.

13.1.1 Enrollments

CME Providers must have a current Provider agreement with Magellan Healthcare and maintain current enrollment with Medicaid as a CME Provider under taxonomy 251S00000X. Details about enrollment with Magellan Healthcare are found at https://www.magellanofwyoming.com/become-a-provider/.

13.1.2 Care Management Entity and Children's Mental Health Waiver Services

Service	Procedure Code
Family Care Coordination	T1016
Family Peer Support Partner	H0038+UK

Service	Procedure Code
Youth Peer Support Partner	H0038
Youth and Family Training and Support (for CMHW-enrolled youth only)	T1027
Respite	T2027

Refer to the CME Provider agreement or the Medicaid CME benefit plan fee schedule for current service reimbursement rates.

13.1.3 Claim Submission Requirements

For CME services with dates of service October 1, 2020 and forward, CME network Provider must submit claims for services that are authorized by the CME directly to the Wyoming Medicaid Benefit Management System (BMS). The CME reviews and authorizes CME service plans of care and transmits the authorization information to the Medicaid BMS to apply to claims submitted by CME network Providers.

13.2 Early Child and Child and Adolescent Service Intensity Instrument

Children and youth enrolling with the CME/CMHW must have either an Early Childhood Intensity Instrument (ECSII) or Child and Adolescent Intensity Instrument (CASII) evaluation by a qualified evaluator as part of the clinical eligibility determination process for enrollment into the CME/CMHW program.

13.2.1 Enrollment Requirements for Early Childhood Service Intensity Instrument and Child and Adolescent Service Intensity Instrument Evaluators

To enroll with Wyoming Medicaid as an (Early Childhood Service Intensity Instrument) ECSII or (Child and Adolescent Service Intensity Instrument) CASII evaluator (taxonomy 174400000X) to perform evaluations as an Independent Assessor (IA), one must:

- Be certified by the CMHW/CME Program Manager, as having met the evaluator training and certification guidelines
- Be currently certified as an ECSII and/or CASII Certification is demonstrated by a certificate of good standing which is issued by the CMHW/CME Program Manager to qualified evaluators
- Agree to be listed on a public facing roster for selection by youth and families seeking an evaluation
- Meet ongoing recertification requirements as specified in the applicable policy

Once the evaluator has been certified, an online enrollment for Wyoming Medicaid must be completed. To enroll as a Medicaid Provider, all Providers must complete the on-line enrollment application available on the HHS Technology website (see *Section 2.1* Quick Reference).

13.2.2 Early Childhood Service Intensity Instrument and Child and Adolescent Service Intensity Instrument Eligibility Add Form

For Members who are not currently eligible for Wyoming Medicaid, the evaluator performing the ECSII or CASII assessment will need to complete an ECSII/CASII Eligibility Add Form (One Day Add Form) and submit to Magellan Healthcare per their instructions. The form is available on the CME, Magellan Healthcare Inc., website: http://magellanofwyoming.com, under the Provider Hub, Independent Assessors section.

- Completed ECSII/CASII Eligibility Add Forms and the High Fidelity Wraparound Applications will be sent to Magellan Healthcare. The CMHW/CME Program Manager will provide the evaluator with the Member's Medicaid ID number after the online add is successfully processed.

13.2.3 Covered Services

Procedure code: H0002

- Early Childhood Service Intensity Instrument (ECSII) for children ages 4-5
  - Member must have a DSM Axis 1 or ICD diagnosis that meets the States' diagnostic criteria
  - Assessment completed within 12 months of application
  - Annual re-evaluation is required
- Child & Adolescent Service Intensity Instrument (CASII) for youth ages 6-20
  - Completed by an IA, outside of the High Fidelity Team
  - Initial CASII must be completed within 6 months of application
  - Annual re-evaluation is required

ECSII/CASII Evaluation Procedure Code			
Procedure Code	**1 Unit Equals**	**Procedure Quantity**	**Description**
H0002	1 Evaluation	1 Unit Max	Evaluation Only

The same evaluator may perform two-consecutive ECSII/CASII evaluations with the same Member. The third evaluation that is used to determine ongoing eligibility needs to be completed by a different evaluator than the one who performed the previous two assessments.

Evaluators who are involved with a youth or their family as a formal or informal support may not provide independent assessments for those youth.

Chapter 14 – Covered Services – Chiropractic Services

14.1 Coverage Indications

Effective for dates of service 06/01/2021 and forward, Chiropractic services are only covered for Members with Medicare as primary and EPSDT Members under 21 when medically necessary (*see Section 14.4* Medical Necessity**).**

For dates of service 06/01/2021 forward, all chiropractic services will require documentation (15.6, Documentation Requirements) attached on claims.

For dates of service prior to 01/01/2021, coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, such as, by use of the hands. Manual devices (such as, those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine; however, no additional payment is available for use of the device, nor does Medicaid recognize an extra charge for the device itself.

The word "correction" may be used in lieu of "treatment." The following terms, or combination of, may be used to describe manual manipulation as defined above:

- Spine or spinal adjustment by manual means
- Spine or spinal manipulation
- Manual adjustment
- Vertebral manipulation or adjustment

14.2 Covered Current Procedural Terminology Codes

99201-99205, 99211-99215

- These office visit codes are subject to a $2.45 co-pay for adults >21 years of age.
- A full schedule of co-pays and exceptions is located in *Chapter 6* – Common Billing Information.

98940, 98941, 98942

70100 -77086 Diagnostic Radiology codes

- Refer to *Chapter 22* – Covered Services – Practitioner Services(*see Section 22.21* Radiology Services) for additional information regarding radiology services.

14.3 Definitions

- **Acute:** A patient's condition is considered acute when the patient is being treated for a new injury, identified by X-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in or arrest of the progression of the patient's condition.

- **Maintenance therapy:** Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. **Maintenance therapy is not a Wyoming Medicaid covered service.**

14.4 Medical Necessity

ALL the following criteria must be met to substantiate medical necessity:

- The Member has a neuromusculoskeletal disorder
- The medical necessity for treatment is clearly documented
- Improvement is documented within the initial two (2) weeks of chiropractic care

The service will NOT be considered medically necessary if:

- No improvement is documented within the initial two (2) weeks unless the treatment is modified
- No improvement is documented within 30 days despite modification of chiropractic treatment
- The maximum therapeutic benefit has been achieved
- The chiropractic manipulation is being performed in asymptomatic person or persons without an identifiable clinical condition
- The chiropractic care is occurring in persons whose condition is neither regressing nor improving
-

14.5 Documentation Requirements

1. History as stated above
2. Description of the present illness including:
    - Mechanism of trauma
    - Quality and character of symptoms/problem
    - Onset, duration, intensity, frequency, location, and radiation of symptoms

- Aggravating or relieving factors
- Prior interventions, treatments, medications, secondary complaints
- Symptoms causing Member to seek treatment

> These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro), and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, and so on. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, such as, the symptoms must be related to the level of the subluxation that has been cited. A statement in the Member's file/chart that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination
4. Diagnosis (ICD-10 diagnosis codes will be required for dates of service 10/1/2015 and after): The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.
5. Treatment Plan: The treatment plan should include the following:
   - Recommended level of care (duration and frequency of visits)
   - Specific treatment goals
   - Objective measures to evaluate treatment effectiveness
6. Date of the initial treatment

Chapter 15 – Covered Services – Developmental Centers

15.1 Development Centers

A developmental center is a public or privately funded facility, which provides services to Members (infants/toddlers or preschool age children, ages 0-5) with developmental disabilities who have been determined to require early intervention programs, care, treatment and supervision in an appropriate setting.

A licensed practitioner is a person that is licensed within the state of Wyoming to perform specialized services (for example, physician or nurse practitioner).

15.2 General Documentation Requirements

The Provider Agreement requires that medical records fully disclose the extent of services provided to Medicaid Members. The following elements are a clarification of Medicaid policy regarding documentation for medical records (see *Section 3.11.1* Requirements):

- 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 clinical assessment upon which the diagnosis is based
- All services, as well as the treatment plan, must be entered in the record
- The record must indicate the observed condition of the Member, the progress at each visit, any change in diagnosis of treatment, and the Member's response to treatment
- Progress notes must be written for every service billed to Medicaid

The type, frequency and duration of service must be specified in the treatment plan. All services provided must track back to the Member's treatment plan.

15.3 Location

If the location on the physician's order is different from the location where the child is seen, the therapist must document the deviation from the Plan of Care in the child's record. If this occurs on a regular basis, there must be a modification of the Plan of Care.

15.4 Time and Frequency

Time and frequency are required on the physician's order and must be specific so time in and time out must be reflected on the document in standard or military format. Time is a unit of 15 minutes. If seven (7) minutes or less of the next 15-minute unit is utilized, the unit must be rounded down. However, if eight (8) or more minutes of the next 15-minute unit are utilized, the units can be rounded up. Date ranges are not acceptable. For example, six (6) minutes duration three (3) times per day is an acceptable time and frequency.

15.5 Missed Appointments or Make-Up Session

Medicaid Members have the right to refuse services. If numerous therapy sessions are missed, the therapist may offer make-up sessions; however, if the child is continually non-compliant with attendance for whatever reason, the practitioner must be informed of the missed sessions and non-compliance of the child. All communication with the child, child's family and practitioner must be documented in the child's records.

Members should be seen for the amount of time and frequency noted on the physician's order. An extra session may be billed only if the need for a make-up session is documented within the record. Billing cannot exceed the Plan of Care.

15.6 Diagnosis

When billing Medicaid for services provided at Developmental Centers, the diagnosis codes used must be:

- Consistent with the diagnosis identified by the ordering practitioner
- Related directly to the need for the services billed
- Coded to the greatest degree of specificity

Developmental Centers may not assign diagnosis codes. Diagnosis codes must be provided by the practitioner or healthcare Provider.

15.7 Covered Services

- **Diagnostic Evaluations/Assessments:** A comprehensive multidisciplinary evaluation performed by an appropriate Wyoming certified or licensed practitioner is required for all children referred. All areas will be evaluated to gain a complete developmental overview of the child.
    - Areas to be assessed will include physical development including fine and gross motor skills, cognitive development, speech development, and social and emotional development
    - Service is limited to children five (5) years of age and under
    - A licensed practitioner shall provide diagnostic evaluation services
    - Must have a written referral and the referral must list areas of concern
    - Use standardized assessment tools or criterion-based assessment
    - Written report includes:
        - Assessment tools used
        - Procedures followed
        - Findings of the evaluation/assessment

- A copy shall be provided to the referring practitioner

> Based on the individual needs of the child, the evaluation may take place in a Regional Developmental Center, the child's primary placement (if other than a Developmental Center) or the child's home.

- **Mental Health Services:** Medicaid will pay for mental health services provided by licensed mental health professionals at a Developmental Center to include licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), licensed clinical social workers (LCSW), licensed addiction therapists (LAT), and provisional licensed mental health professionals under the supervision of a licensed mental health professional.
- **Physical, Occupational, and Speech Therapy:** Medicaid covers restorative therapy services when provided by or under the direct supervision of a licensed physical, occupational, or speech therapist upon written orders from a practitioner.
  - Restorative services are services that assist an individual in regaining or improving skills or strength
  - Speech therapy includes any therapy to correct a speech disorder resulting from injury, trauma, or a medically based illness or disease
  - Service is limited to children five (5) years of age and under
  - Therapy shall be provided only after a written order is received from a licensed practitioner
  - Group therapy cannot exceed five (5) children
  - If "individual" is indicated on the Physician's Order and the child is seen in a group session, the therapist may not bill for a group session for that child
- **Specific Documentation Requirements:** Prior to providing any therapy services, the following must occur and be documented in the Member's permanent clinical record:
  - A comprehensive medical diagnostic examination by a licensed practitioner as well as a multi-disciplinary comprehensive evaluation must be completed as part of the Individual Education Plan/Individual Family Services Plan (IEP/IFSP). The IFSP must be completed for children ages 0-36 months.
  - Services must:
    - Be determined, in writing, to be medically necessary by a licensed practitioner
    - Appear on the practitioner's plan of treatment/care
    - Have original and subsequent renewal written orders, not to exceed six (6) months duration
  - The practitioner's plan of treatment/care shall contain:
    - Diagnosis and onset date of Member's condition

- Member's rehabilitation potential
- Restorative and/or maintenance program goals
- Therapy modalities determined to be medically necessary to attain the program goals
- Therapy duration (not to exceed six (6) months)
- Practitioner's signature and the date signed

- Each therapy ordered, either independently or in combination, must:
  - State treatment goals in terms of specific outcomes associated with referral diagnosis
  - Outline each therapy regime relative to stated goals, including modalities, frequency of each treatment session, and duration of each treatment session
  - Be updated with every change or renewal of physician orders (not to exceed six (6) months)
  - Be signed, including professional title, and dated by each appropriate therapist
  - Be attached to the Member's IEP/IFSP
- Ongoing documentation of services provided (progress notes) is required by each type/discipline of therapy billing Medicaid for services provided and shall include each of the following:
  - Identification of the Member on each page of the treatment record
  - Identification of the type/discipline of therapy being documented on each entry (such as, speech vs. occupational therapy)
  - Date and time(s) spent in each therapy session
  - Description of therapy activities, Member reaction to treatment and progress being made to stated goals/outcomes
  - Full signature or counter signature of the licensed therapist, professional title and date that entry was made, and the signature of the therapy assistant and date the entry was made. Licensed therapists must sign progress notes of assistants within 30 days.

15.8 Service Threshold

For Medicaid Members, dates of service in excess of twenty (20) per calendar year for each PT or OT service or thirty (30) per calendar year for each ST or BH service, Providers will need to contact Telligen to obtain prior authorization (see *Section 6.7* Service Thresholds).

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 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.

15.8.1 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 email 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.

15.9 Billing Requirements

The following procedure codes can be billed by enrolled Developmental Centers:

Developmental Centers			
HCPCS Level II Code	**Modifier**	**1 Unit Equals**	**Description**
92507		Per Instance	Individual treatment of speech language voice communication and/or auditory processing disorder (including aural rehab).
92508		Per Instance	Treatment of speech, language, voice communication, and/or auditory processing disorder (including aural rehab); group, two (2) or more individuals.
92521		Per Evaluation	Evaluation of speech fluency.
92522		Per Evaluation	Evaluation of speech fluency.
92523		Per Evaluation	Evaluation of speech sound production with evaluation of language comprehension and expression.
92524		Per Evaluation	Behavioral and qualitative analysis of voice and resonance.

Developmental Centers			
HCPCS Level II Code	**Modifier**	**1 Unit Equals**	**Description**
92526		Per Instance	Treatment of swallowing dysfunction and or oral function for feeding.
97001		Per 15 minutes	Physical therapy evaluation.
97002		Per 15 minutes	Physical therapy re-evaluation.
97003		Per 15 minutes	Occupational therapy evaluation.
97004		Per 15 minutes	Occupational therapy re-evaluation.
97110		Per 15 minutes	Therapeutic procedure, one (1) or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97112		Per 15 minutes	Therapeutic procedure, one (1) or more areas; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.
97113		Per 15 minutes	Therapeutic procedure, one (1) or more areas; aquatic therapy with therapeutic exercises.
97124		Per 15 minutes	Therapeutic procedure, one (1) or more areas; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).
97150		Per 15 minutes	Therapeutic procedure(s); group, two (2) or more individuals.
97530		Per 15 minutes	Therapeutic activities, direct (one to one) Member contact by the Provider.
97533		Per 15 minutes	Sensory integrative techniques to enhance sensory processing and promote adaptive responses of environmental demands, direct (one-on-one) Member contact by the Provider.
G9012		Per 15 minutes	Other specified case management service not elsewhere classified.
H0004		Per 15 minutes	Family Therapy – Therapist contact at the developmental center with the enrolled Member, family and/or collaterals as

Developmental Centers			
HCPCS Level II Code	**Modifier**	**1 Unit Equals**	**Description**
			necessary, for the purpose of developing and implementing the treatment plan for the enrolled Member.
H0031		Per Session	Clinical assessment – Therapist contact with the Member and/or collaterals as necessary, for the purpose of completing an evaluation of the Member's mental health and substance abuse disorder(s) and treatment needs, including psychological testing if indicated.
H0046		Per 15 minutes	Group Therapy – Therapist contact with two (2) or more unrelated Members and/or collaterals as necessary, for the purpose of implementing each Member's treatment plan.
H2019		Per 15 minutes	Agency Based Individual Therapy – Therapist contact at the developmental center with the enrolled Member and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the enrolled Member.
H2019	TN	Per 15 minutes	Community-Based Individual Therapy – Therapist contact outside the developmental center with the enrolled Member and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the enrolled Member.

Developmental Centers	
Modifier	**Description**
TN	Rural/outside Provider's customer service area

Chapter 16 – Covered Services – Dietitian Services

16.1 Dietitian Services

16.1.1 Medical Nutrition Therapy

16.1.1.1 Covered Current Procedural Terminology Codes

97802: Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes – Maximum allow 4 units per day.

97803: Medical nutrition therapy; re-assessment and intervention, individual, face -to-face with the patient, each 15 minutes – Maximum allow 4 units per day.

97804: Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes – Maximum 2 units per day.

16.1.1.2 Documentation Requirements

For Medical Nutrition Therapy (MNT), the following elements must be in the documentation:

- Date of MNT visit along with Beginning and Ending Time of visit
- ICD-10 code – defines type of visit/counseling
- Subjective Data:
    - Member's reason for visit
    - Primary care physician
    - History
        - Past and present medical
        - Nutrition including food patterns and intake
        - Weight
        - Medication
        - Exercise
- Objective Data:
    - Laboratory results (if available)
    - Height
    - Weight
    - BMI
    - Calorie Needs
    - Drug/Nutrient Interactions

- Individual Assessment of Diet/Intake:
  - Laboratory results (if available)
  - Height
  - Weight
  - BMI
  - Calorie Needs
  - Drug/Nutrient Interactions
- Plan:
  - Individualized dietary instruction that incorporates diet therapy counseling and education handouts for nutrition related problem
  - Plan for follow-up
  - Documentation of referral for identified needs
  - Send a letter to the Member's physician describing dietary instruction provided and progress. A copy of the letter should be placed in the Member's medical record
- Date and legible identity of Provider:
  - All entries must be signed and dated by the Provider

16.1.2 Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is intended to help prevent Type 2 Diabetes through a yearlong plan of care. A Member is considered eligible for these services if they have a diagnosis of prediabetes.

16.1.2.1 Covered Services

DPP services may be used only one time per Member. The clinical intervention consists of a minimum of 16 core dietitian sessions throughout a six (6) month period to facilitate weight control. After completing the initial core sessions, less intensive monthly follow-up visits maybe be utilized to ensure that beneficiaries maintain healthy behaviors.

Plan of Care:

First 6 Months of DPP Initial Core Sessions:

- Sessions 1-4: G9873 – One (1) Expanded Model (EM) Core Session
- Sessions 5-8: G9874 – Four (4) EM Core Sessions

- Sessions 9-16: G9875 – Nine (9) EM Core Sessions

> Session one (1) cannot be performed via telehealth. Sessions 2-16 can be provided via telehealth (*see Section 6.23* Telehealth). For billing purposes use the telehealth modifier, GT, to indicate this.

Second 6 Months of DPP Maintenance:

- Months 7-9:
  - G9876 – Two (2) EM Core Maintenance Sessions
    - Utilized when DPP criteria is NOT achieved
  - G9878 – Two (2) EM Core Maintenance Sessions
    - Utilized when DPP criteria IS achieved
- Months 10-12:
  - G9877 – Two (2) EM Core Maintenance Sessions
    - Utilized when DPP criteria is NOT achieved
  - G9879 – Two (2) EM Core Maintenance Sessions
    - Utilized when DPP criteria IS achieved

> These sessions can all be provided via telehealth. For billing purposes use the telehealth modifier (*see Section 6.23* Telehealth), GT, to indicate these services.

Second and Subsequent Years of DPP:

- Months 13-15: G9882 – Two (2) EM Ongoing Maintenance Sessions
- Months 16-18: G9883 – Two (2) EM Ongoing Maintenance Sessions
- Months 19-21: G9884 – Two (2) EM Ongoing Maintenance Sessions
- Months 22-24: G9885 – Two (2) EM Ongoing Maintenance Sessions

> These sessions can all be provided via telehealth. For billing purposes use the telehealth modifier, GT, to indicate these services (*see Section 6.23* Telehealth).

16.1.2.2 Billing Requirements

DPP services and non-DPP services must be billed on separate claim forms; however, multiple services for the same Member may be submitted on the same claim. The Telehealth modifier should be billed

with any G-code that is associated with a session that was furnished as a virtual make-up session (*see Section 6.23* Telehealth).

16.1.2.3 Documentation Requirements

Each HCPCS G-code should be listed with the corresponding session date of service and rendering dietitian National Provider Identifier (NPI).

Diabetes Prevention Program Providers must maintain the following electronic or paper records for 10 years following the last day of a DPP Member's receipt of services. Certain circumstances may require extension.

- Upon first session Providers must record:
- The Provider name and NPI
    - Member information, including but not limited to
        - Name
        - Wyoming Medicaid Member Identification Number
        - Age
    - Evidence that each Member meets eligibility requirements
- Upon each additional session Providers must record:
    - Session type
        - Core OR
        - Core Maintenance OR
        - Ongoing Maintenance
        - Regularly Schedule session OR
        - Make-up session
    - NPI of the Provider furnishing the session
    - Date and place of the session
    - Curriculum topic
    - The Member's weight (only required for regularly scheduled sessions)
- When Applicable, DPP Provider records must indicate when a Member has
    - Attended core sessions
    - Achieved 5% weight loss
    - Attended core maintenance session and maintained minimum weight loss
    - Attended two ongoing maintenance sessions and maintained required minimum weight loss

  - Achieved at least 9% weight loss
- DPP Providers must keep records of certain Member engagement incentives provided to Members in compliance with 42 CFR 424.210

16.2 Limitations

- Dietitian services must be ordered by a physician or nurse practitioner.
- For Medicaid Members, for dates of service prior to 01/01/2021, dates of service in excess of twenty (20) per calendar year will require authorization of medical necessity (see *Section 6.7* Service Thresholds).

Chapter 17 – Covered Services – Durable Medical Equipment Billing

17.1 Durable Medical Equipment Billing

Refer to the DME Covered Services Manual for the complete Medicaid policy.

17.1.1 Reimbursement

- For manually priced items an invoice, which provides proof of purchase and actual cost(s) for equipment and/or supplies, is required (see *Section 6.8.1* Invoice Charges). 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 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 manufacture must be the one to break down the shipping/handling on the invoice. If the manufacturer does not include an S/H breakdown on the invoice, and there is more than one item, it cannot be included in the cost of the item.

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

- Effective for dates of service beginning September 1, 2023, Medicaid will reimburse new and rental rates for Durable Medical Equipment (DME) claims at the lesser of logic pricing:
  - Provider's usual and customary charge for the service, or;
  - 90 percent (90%) of Medicare's rural or non-rural rate based on the Member's primary location ZIP code.

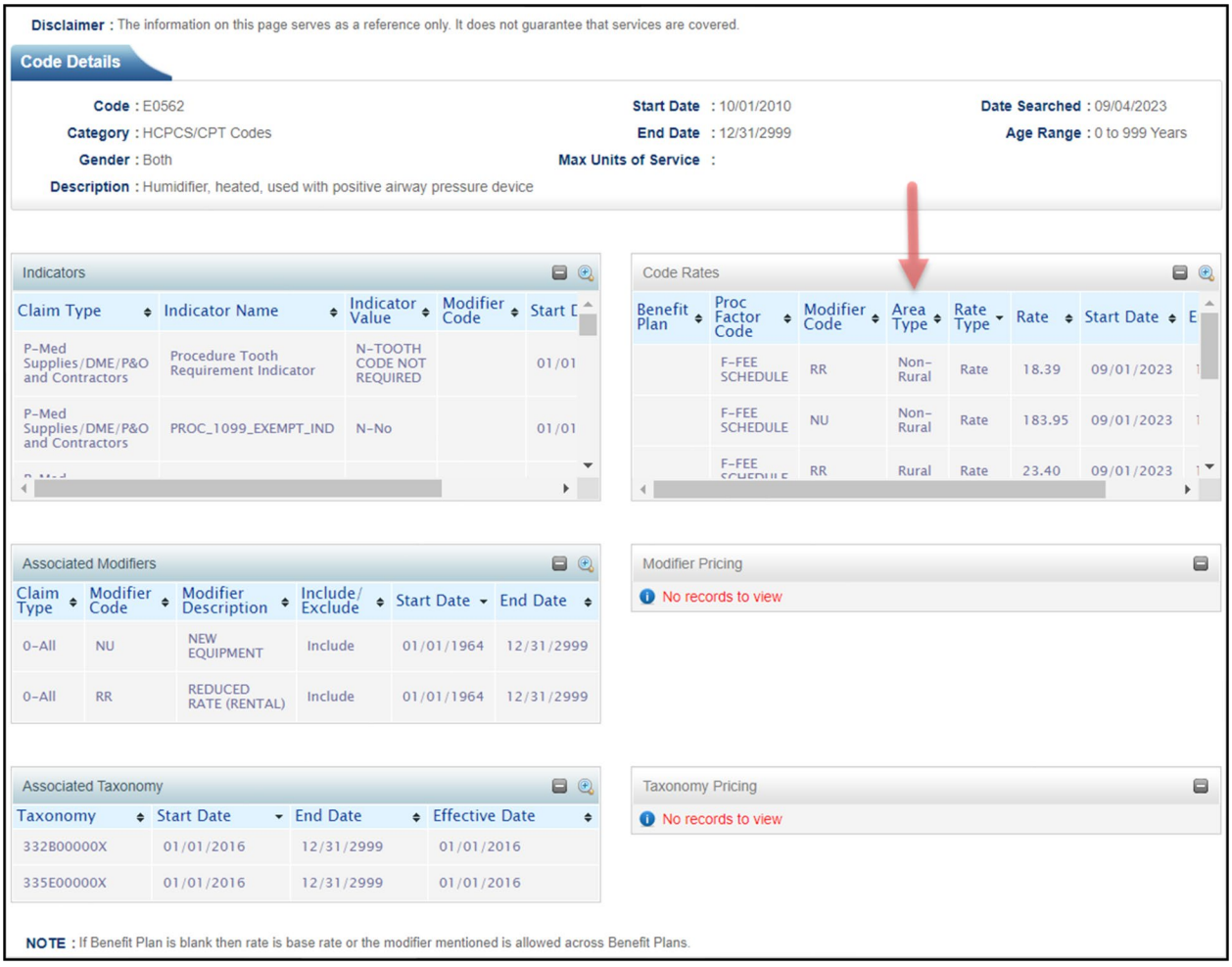
  > Manual pricing will still apply for procedure codes in which a rate is not established. Manual pricing will not consider the ZIP code and whether the area is rural or non-rural.

  The Centers for Medicare and Medicaid Services (CMS) publishes a ZIP code file indicating if it is considered a rural or non-rural location. This file is updated by CMS and is located at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/dmeposfeesched/dmepos-fee-schedule.

  Wyoming Medicaid will update the ZIP code file annually. Claims will not be retroactively priced or reprocessed if a ZIP code changes after the annual file is uploaded. The BMS (Provider Portal) will determine the ZIP code of the member and price it accordingly.

  The Medicaid online Fee Schedule displays the rural or non-rural rate and the fee for a new purchase or rental for each procedure code. If there is not a rural or non-rural indicator on the fee schedule, Medicare has established one price for all areas. The online Fee Schedule is located at: https://wyomingmedicaid.com/portal/fee-schedules.

- Sample online Fee Schedule – E0562 procedure code inquiry:



17.1.2 Order vs Delivery Date

For Date of Delivery, use the shipping date as the date of service on the claim if a delivery or shipping service is used. If the Provider or supplier completes the delivery, or if the Member picks up the item, use the actual date of delivery or pick-up as the date of service. Items purchased are to be billed using the single date of service the item was purchased on, and not a span of dates the items are intended to cover. If a Member buys a 30-day supply of incontinence supplies on 1/15/22 for use during the following month (1/15/22 – 2/14/22), the date of service would be 1/15/22 only.

If the Member is not eligible on the delivery date or does not return for the delivery, the Provider may submit an "Order vs Delivery Date Exception Form" (see *Section 6.13.1* Order vs Delivery Date Exception Form) for authorization to bill on the order date (see *Section 6.13.* Billing of Deliverables).

17.2 DME Billing Requirement Exception

For Members who are dual eligible Medicare and Medicaid, in situations where the Provider is billing for multiple units of either K0108 or E1399, and Medicare approves some units but not all units, the Provider may complete the billing requirements and exception process/steps below for additional Medicaid reimbursement if applicable. The Medicaid claim will be processed according to Wyoming Medicaid's policy for the units Medicare denied.

> This is for K0108 and E1399 only when the Member is dual eligible with Medicare and Medicaid.
>
> Providers must obtain a prior authorization (PA) through the Medicaid DME vendor.

1. Submit the claim first to Medicare according to Medicare instructions.
2. Medicare should crossover the claim electronically to Medicaid, and any units approved by Medicare will be processed to pay co-insurance and deductible as per usual. Lines that Medicare denied will deny on the crossover claim as exact duplicates conflicting with the paid lines of the same code, but the crossover claim will be in a paid status.
    a. If the crossover claim is not received electronically from Medicare the Providers will need to submit this crossover claim electronically to Medicaid (refer to the Provider Tutorials).
3. Providers need to wait for the paid crossover to appear on the Medicaid remittance advice (RA)/835 transaction before continuing the DME billing requirement exception process (Step 5)
4. Once the paid crossover claim appears on the Medicaid RA, the Provider will need to complete a CMS-1500 paper claim form. Complete the paper claim form according to Medicaid's billing requirements, not the way it was previously submitted to Medicare
    a. Bill according to Medicaid's PA, enter the PA number in box 23
    b. All units denied by Medicare must be combined onto one line with multiple units or they will deny as exact duplicates
        i. Billed charge/units must add up and match the Medicare EOMB
5. Review the invoice(s) for each item and clearly mark each line item being billed
    a. Medicaid must be able to match descriptions from the PA to the invoice(s), to assist with this process complete the K0108/E1399 Crossover Claim Form (see *Section 17.2.1* K0108/E1399 Crossover Claim Form)
6. Completing the K0108/E1399 Crossover Claim Form – the purpose of this form is to assist in matching up the descriptions of the items/components of the PA to the appropriate items on the invoice(s)

a. When entering the first item description on line 1 of the form place a one (1) next to the item on the invoice that matches it, continue the same process until all items are documented on the form

    i. Complete as many forms as necessary

7. Finalization and mailing process: Providers must include all the following in the mailing

    a. K0108/E1399 Crossover Claim Form(place on top to ensure appropriate routing)

    b. Completed CMS-1500 paper claim form

    c. Medicare's EOMB

    d. Invoice(s)

    e. Mail the documents to:

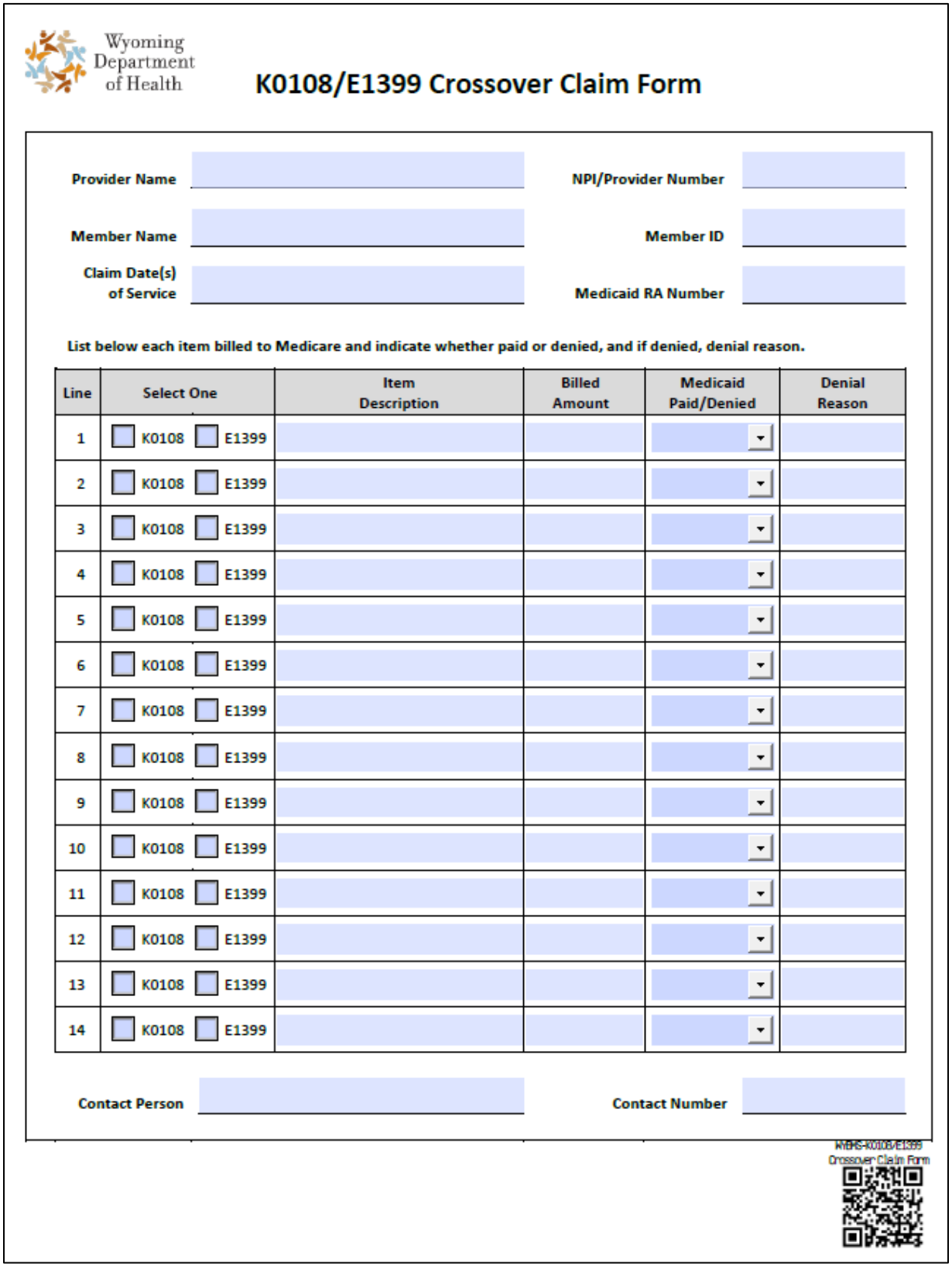
Wyoming Medicaid

ATTN: Claims Department

P.O. Box 547

Cheyenne, WY 82003-0547

17.2.1 K0108/E1399 Crossover Claim Form



Wyoming Department of Health

K0108/E1399 Crossover Claim Form

Provider Name _____ NPI/Provider Number _____

Member Name _____ Member ID _____

Claim Date(s) of Service _____ Medicaid RA Number _____

List below each item billed to Medicare and indicate whether paid or denied, and if denied, denial reason.

Line	Select One	Item Description	Billed Amount	Medicaid Paid/Denied	Denial Reason
1	☐ K0108 ☐ E1399				
2	☐ K0108 ☐ E1399				
3	☐ K0108 ☐ E1399				
4	☐ K0108 ☐ E1399				
5	☐ K0108 ☐ E1399				
6	☐ K0108 ☐ E1399				
7	☐ K0108 ☐ E1399				
8	☐ K0108 ☐ E1399				
9	☐ K0108 ☐ E1399				
10	☐ K0108 ☐ E1399				
11	☐ K0108 ☐ E1399				
12	☐ K0108 ☐ E1399				
13	☐ K0108 ☐ E1399				
14	☐ K0108 ☐ E1399				

Contact Person _____ Contact Number _____

WDH-K0108/E1399 Crossover Claim Form

Chapter 18 – Covered Services – Family Planning

18.1 Family Planning Clinics

Family planning clinics provide services that are prescribed to Members of childbearing age for the purpose of enabling them to freely determine the number and spacing of their children.

18.2 Covered Services

The following services are covered by Medicaid:

- Appropriate office visits according to CPT guidelines
- Contraceptive supplies and devices as prescribed by a healthcare Provider (limited to a three (3) month supply)
- Insertion or removal of implantable capsules are allowed with appropriate E&M procedure code
- Insertion or removal of intrauterine devices (IUD's) are allowed with an appropriate E&M procedure code
- Pap smears
- Pregnancy tests

18.3 Non-Covered Services

The following services are **not** covered by Medicaid:

- Reversal of Sterilizations
- Artificial insemination
- Fertility testing
- Infertility counseling

> Pregnant by Choice/Family Planning Waiver has specific covered and non-covered services (*see Section 23.1* Pregnant by Choice and Family Planning Waiver).

Chapter 19 – Covered Services – Health Check

19.1 Health Check – Early and Periodic, Screening, Diagnosis and Treatment Program

Procedure Code Range: **99381-99394**

The Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT):

- Brings comprehensive healthcare to children from birth up to and including 20-years of age who are eligible for Medicaid
- Has a preventive health philosophy of discovering and treating health problems before they become disabling and far more costly to treat in terms of both human and financial resources
- Examines all aspects of a child's well-being and corrects any problems that are discovered
- Is administered by the Division of Healthcare Financing (DHCF), Medicaid

> Preventative Medicine codes are not appropriate to bill for Members aged 21 and over. Providers should instead use the appropriate Evaluation & Management code for visits with adult Members.

EPSDT is a statewide program that provides children with comprehensive health screenings, diagnostic services, and treatment of any health problem detected. Defining each word of the program title will help explain the concept of EPSDT.

Early: Well Child Screens will be performed as soon as possible in the child's life (in case of a family already receiving assistance) or as soon as a child's eligibility for Medicaid is established.

Periodic: Means Well Child Screens will be performed at intervals established by medical, dental, and other healthcare experts. Periodic screens assure diseases or disabilities are detected in the early stages. Types of procedures performed will depend on age and health history of the child.

Screening: The use of examination procedures for early detection and treatment of diseases or abnormalities. Referrals are made for those in need of specialized care.

Diagnosis: The determination of the nature or cause of physical or mental disease (abnormality). A diagnosis is made through the combined use of a health history, physical, developmental, and psychological evaluations, laboratory tests, and X-rays. Practitioners who complete EPSDT examinations may diagnosis and treat health problems uncovered by the screen or may refer the child to other appropriate sources for care.

Treatment: Care provided by practitioners enrolled with Medicaid to prevent, correct, or ameliorate disease or abnormalities detected by screening and diagnostic procedures. Practitioners may screen, diagnose, and treat during one (1) office visit.

19.2 Periodicity Schedule

The periodicity schedule contains an easy reference table for Well Child Screens defined by the age of the child. Refer to the Well Child Screen Requirements table for all ages.

Key:
✓= to be performed
✖ = to be performed for Members at risk
s = subjective, by history
o = objective, by a standard testing method
s/o = objective at 12, 15, and 18 years old, subjective, by history for all other years

19.3 Reimbursement

If an abnormality or abnormalities is/are encountered or a pre-existing problem is addressed in the process of performing preventative medicine E&M service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate office/outpatient code 99201-99215 should also be reported. Modifier 25 must be added to the office/outpatient code to indicate that a significant, separate identifiable E&M service was provided by the same physician on the same day as the preventative service. The appropriate preventative medicine service is additionally reported.

Well Child Screen Requirements **For Ages Birth through 21 Years Old**				
	Newborn – 12 months	**15 months to 4 years**	**5-10 years**	**11-21 years**
History				
Initial/Interval	✓	✓	✓	✓
Measurements				
Height & Weight	✓	✓	✓	✓
Head circumference	✓	✓ (up to 24 mo.)		
Blood Pressure		✓ (start at 3 yrs)	✓	✓
Sensory Screening				
Vision	**s**	**s**	**o**	**o**
Hearing	**s**	**s**	**o**	**s/o**
Developmental / Behavioral Assessment				
	✓	✓	✓	✓
Immunizations				
Health Check Immunizations	✓	✓	✓	✓
Procedures				
Lead Screening	✓ (9-12 mo)	✓ (24 mo)		
Tuberculin Test	✖ (12 mo)	✖	✖	✖
Topical Fluoride Varnish	✓ (6–12mo)	✓ (15 m-3 yrs)		
Cholesterol Screening		✖ (24 mo-4 yrs)	✖	✖
STD Screening				✖
Pelvic Exam				✖
Anticipatory Guidance				
Injury Prevention	✓	✓	✓	✓

Well Child Screen Requirements For Ages Birth through 21 Years Old				
Violence Prevention	✓	✓	✓	✓
Sleep Positioning Counseling	✓ (up to 6 mo)			
Nutrition Counseling	✓	✓	✓	✓
Dental				
	✓(12 mo)	✓	✓	✓

All abnormalities detected during the Health Check exam should be referred to the appropriate specialist, including but not limited to a vision, dental and /or hearing specialist as necessary. The appropriate way to indicate that the Provider has referred the child is to add Modifier 32 to the preventative service code.

If any insignificant or trivial problem/abnormality is encountered while performing the preventative medicine E&M services, and does not require additional work, the office/outpatient code should not be reported.

It is of utmost importance that the appropriate CPT, modifier, and diagnosis codes are reported. For the Provider's convenience, the codes, modifiers, and diagnosis codes for EPSDT-Health Check and the most current fee schedule for the above-mentioned codes are attached. Fees are subject to change without notice.

At a minimum, these screenings must include, but are not limited to:

- Comprehensive health and developmental history
- Comprehensive unclothed physical examination
- Dental screening
- Appropriate vision testing
- Appropriate hearing testing
- Appropriate laboratory test(s) (Blood Lead Level testing is required at 12 and 24 months for all children)
- The most current copy of the immunization schedule may be found at http://www.cdc.gov/vaccines/schedules/index.html.

Diagnosis Codes to be used when Billing for EPSDT – Well Child Checks		
Diagnosis Code	**Description**	
Z76.1	Health Supervision of Foundling.	
Z76.2	Other Healthy Infant or Child Receiving Care.	
Z00.121, Z00.129	Routine Infant or Child Health Check.	
Topical Fluoride		
Procedure Code	**Modifier**	**Description**
99188	32	Topical Fluoride Varnish.
Preventative Medicine Services		
Procedure Code	**Modifier**	**Description**
99381/99391	32	Comprehensive Preventative Medicine Age 0 through 11 Months.
99382/99392	32	Early Childhood Age 1-4 Years.
99383/99393	32	Late Childhood Age 5-11 Years.
99384/99394	32	Adolescent Age 12-17 Years.
99385/99395	32	Age 18-20 Years.
Modifier		
32	Mandated Services – Referral.	

Evaluation and Management Services – New Patient		
Procedure Code	**Modifier**	**Description**
99201	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: • A problem focused history. • A problem focused exam. • Straight forward medical decision making.
99202	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: • An expanded focused history.

Evaluation and Management Services – New Patient		
Procedure Code	**Modifier**	**Description**
		• An expanded focused exam. • Straight forward medical decision making.
99203	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: • A detailed history. • A detailed exam • Medical decision making of low complexity.
99204	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: • A comprehensive history. • A comprehensive exam. • Medical decision making of moderate complexity.
99211	25	Office or other outpatient visit for the E&M of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, five (5) minutes are spent performing or supervising these services.
99212	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: • A problem focused history. • A problem focused exam. • Straight forward medical decision making.
99213	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: • An expanded problem focused history. • An expanded problem focused exam. • Straightforward medical decision making.
99214	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: • A detailed history. • A detailed exam. • Medical decision making of low complexity.

Evaluation and Management Services – New Patient		
Procedure Code	**Modifier**	**Description**
99215	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: • A comprehensive history. • A comprehensive exam. • Medical decision making of high complexity.

Please refer to the current CPT coding recourses for additional information regarding preventative services.

19.4 Detailed Information for Well Child Screens

- In some instances, Well Child Screens may not be completed at the suggested age (example: immunizations); the healthcare professional must follow recommended practices to ensure the child becomes current.
- Results may indicate further testing or referrals are needed. Healthcare professionals should complete tests or make referrals according to standard procedures and practices.
- Well Child Screens must be completed when there is no acute diagnosis applicable (such as, otitis media).
- Results may show that a high risk factor is present based on the child's environment, history, or test results. Healthcare professionals should proceed with required/recommended tests. Evaluation methods used may be different from what is indicated on the Well Child Screen Requirements table (example: a tuberculin test performed on a child who is nine (9) months of age because the child's sibling had an active case of diagnosed tuberculosis).

The following information contains additional guidelines to be used when performing Well Child Screens.

19.4.1 Initial and Interval History

The initial/interval history should be obtained from a parent or other responsible adult who is familiar with the child's health history. This must include, but is not limited to:

- Family history
- Details of birth, prenatal, neonatal periods
- Nutritional status

- Growth and development
- Childhood illness
- Hospitalizations
- Immunization history

> If a health history has been obtained previously, then update it each visit.

19.4.2 Assessments

Appropriate Developmental Screening –The following screening tools are recommended for children age birth to six (6) years:

- Prescreening Developmental Questionnaire
- Denver Developmental Screening Test
- Battelle Screening Test

Providers should administer a developmental screen appropriate to the age of the child during each Well Child Screen.

- A complete physical examination including an oral inspection
- Accurate measurements of height and weight (all measurements should be plotted on the National Center for Health Statistics Growth Charts)
- Screening for iron deficiency at the appropriate ages and/or intervals
- Children five (5) years of age and older should have a general developmental assessment including gross-motor and fine-motor skills, social-emotional skills, and cognitive and self-help skills development
- Results of development screens need to be considered in combination with other information gained through the history, physical examination, observations of behavior, and reports of observations by the parents/caregivers
- Any abnormalities detected during a Well Child Screen outside of the attending physician's scope of practice should be referred to the appropriate specialist, including vision, dental, and hearing specialists as necessary. All services provided must be medically necessary and provided in the most cost-effective manner

- Nutritional Screen – Providers should assess the nutritional status at each Well Child Screen through the following activities:
    - Inquire about dietary practices to identify unusual eating habits. Unusual eating habits include pica behavior, extended use of bottle feedings, or diets deficient or excessive in one (1) or more nutrients

> Children with nutritional problems may be referred to a licensed nutritionist or dietitian for further assessment, counseling, or education as needed.

19.4.3 Comprehensive Unclothed Physical Examination

Each comprehensive unclothed physical examination should include the following:

- Height measurement
- Weight measurement
- Standard body systems evaluation
- Observation for any signs of abuse
- Observation of any physical abnormality

During each Well Child Screen, Providers need to assess the child's growth. All measurements should be plotted on the National Center for Health Statistics (NCHS) Growth Chart.

Growth assessments should be documented in the medical record and any abnormality should be addressed as abnormal:

- If a child's height and/or weight is below the 5th percentile or above the 95th percentile, OR
- If weight for height is below the 10th percentile or above the 90th percentile (using the weight for height graph)

19.4.4 Head Circumference

An Occipital Frontal Head Circumference (OFHC) should be measured on each child four (4) years and younger at each Well Child Screen. This measurement should be plotted on the NCHS Growth Chart. OFHC should be reported abnormal if:

- It is below the 5th percentile or above the 95th percentile
- Size of the head is not following a normal growth curve, OR
- Head is grossly disproportionate to the child's length

Deviations in the shape of the head may warrant further evaluation and follow-up.

19.4.5 Blood Pressure

- All children three (3) years and older must have a blood pressure reading at each Well Child Screen
- Measurements should be taken in a quiet environment, with the correct size cuff, and with the fourth (4th) and fifth (5th) phase Korotkoff sound noted for the diastolic pressure
- Blood pressure is considered abnormal if the systolic and/or diastolic or both are above the 95th percentile. Any child with a blood pressure reading above the 95th percentile should have it repeated in 7-14 days. If the blood pressure is still elevated, the child should be rechecked again in 7-14 days. If blood pressure is elevated on the third visit, the child should receive appropriate medical evaluation and follow-up, as recommended by the American Academy of Pediatrics.

19.4.6 Vision Screen

A vision screen appropriate to the age of the child should be conducted at each Well Child Screen. Further evaluations and proper follow up should be recommended if the following conditions are present:

- Infants and children who show evidence of infection, squinting, enlarged or lazy cornea, crossed eyes, amblyopia, cataract, excessive blinking, or other eye abnormality
- An infant or child who scored abnormal on the fixation test, papillary light reflex test, alternate cover test, or the corneal light reflect test in either eye
- Three (3) to nine (9) year old children who demonstrate a visual acuity of less than 20/40 in either eye or who demonstrate a one (1) line difference in visual acuity between the two (2) eyes within the passing range; OR
- Children ten (10) years and older whose vision is 20/30 or worsen in either eye or who demonstrate a one (1) line difference in visual acuity between the two (2) eyes within the passing range

19.4.7 Topical Fluoride Varnish

Physicians can apply a topical fluoride varnish for patients who are at a moderate to high risk for dental caries:

- This application should be done in conjunction with EPSDT well child visits
- Physician offices may bill the CPT code 99188 on the CMS-1500 form
- Fluoride varnish application can be done up to three (3) times a year on children ages six (6) months (or when the first teeth erupt) through age three (3) years
- The American Academy of Pediatric Dentistry recommends the establishment of dental home no later than 12 months of age

19.4.8 Hearing Screen

A hearing screen appropriate to the age of the child should be conducted at each Well Child Screen. Further evaluations and proper follow up should be recommended if one (1) of the following conditions is present:

- Infants and children who are positive on one (1) or more of the Eight (8) Hi-Risk register items:
  - Visible congenital or traumatic deformity of the ear
- Congenital, such as atresia (no ear canal) or abnormally small ear canals
- Traumatic deformity, collapsed canals or a deformed ear that might contraindicate presence of mold or aid
- History of active drainage from the ear within previous 90 days
- History of sudden or rapidly progressive hearing loss within the previous 90 days possibly due to viral attack, trauma, and so on should be seen by a medical doctor immediately
- Acute or chronic dizziness indicates possible problems with semi-circular canals (balance)
- Unilateral hearing loss of sudden or recent onset within the previous 90 days. Could be caused by mumps, virus, head trauma, Meniere's disease, and various vascular disorders
- Audiometric air-bone gap equal to or greater than 15 decibels (dB) at 500Hz, 1000Hz, 2000Hz and 3,000Hz. Conductive or middle ear pathology can cause a difference of greater that 15dB between the air conduction test results and results by bone conduction
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal
- Pain or discomfort simply indicates there is something wrong and should be seen by a medical doctor
- Infants and children whose medical, physical, or developmental history indicates possible hearing loss
- Positive family history of hearing loss
- Viral or other non-bacterial transplacental infection
  - Defects of ear, nose, or throat system; malformed, low-set to absent pinnae; cleft lip or palate
  - Birth weight under 1500 grams
  - Unconjugated bilirubin over 24 mg/100 ml or over infant’s weight in decagrams
  - Bacterial meningitis
  - Sever asphyxia with arterial flow less than 7.25, coma, seizures or need for continuous assisted ventilation

- Children found positive when tested with pure tone screening

19.4.9 Laboratory Tests

Providers who conduct Well Child Screens must use their medical judgment when determining the applicability of performing specific laboratory tests and/or analyses. The following are basic laboratory tests that should be performed when a child reaches the required age.

19.4.9.1 Hematocrit and Hemoglobin

Hematocrit or Hemoglobin is completed at the following ages:

- Newborns (for high-risk infants)
- Two (2) months (for high-risk infants)
- 8-12 months
- 18-24 months
- Three to four (3-4) years
- 11-12 years

19.4.9.2 Blood Lead Level

- A venous blood lead level determination must be performed on children at 12 and 24 months of age
- Children who have a history of pica behavior, an environment suspect of lead exposure, or whose history/physical examination findings are suspicious should have a blood lead level follow-up
- Lead poisoning is an elevated venous blood lead level that is greater than or equal to 10 micrograms per deciliter (ug/dl)
- If an elevated blood lead level is discovered, a child should be re-screened every three (3) to four (4) months until lead levels are within normal limits. In addition, a venipuncture blood lead level should be performed annually through at least age six (6) years

Beginning at six (6) months of age and at each visit thereafter until six (6) years of age Providers must discuss with parent(s)/caregiver(s) about childhood lead poisoning interventions and assess the child's risk for exposure. A verbal interview or written questionnaire, such as the following may identify those children at high risk for lead exposure. Blood lead testing should be carried out on those children identified as high risk by this or a similar questionnaire:

- Does your child live in or regularly visit an old house built before 1950? Is your child's day care center / preschool / babysitter's home built before 1978? Does the house have peeling or chipping paint?

- Does your child live in a house built before 1978 with recent, ongoing, or planned renovation or remodeling (within the last six (6) months)?
- Do any of your children or their playmates have or had lead poisoning?
- Does your child frequently come in contact with an adult who works with lead? Examples are construction, welding, pottery, or other trades practiced in your community.
- Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead?
- Do you give your child any home or folk remedies that may contain lead?
- Does your child live near a heavily traveled major highway where the soil and dust may be contaminated with lead?
- Does your home's plumbing have lead pipes or copper with lead solder joints?

Ask any additional questions specific to situations existing in the Provider's community. Risk is determined from responses to a verbal or written questionnaire risk assessment. A subsequent verbal risk assessment can change a child's risk category. Any information suggesting increased lead exposure for previously low risk children must be followed up with a blood lead test. Medicaid will pay for samples to be taken from the home and sent to state laboratory for testing.

If answers to all questions are negative, a child is considered low risk for high doses of lead exposure. Practitioners will need to determine whether to perform additional blood lead level test beyond those required at 12 and 24 months of age.

If the answers to any questions are positive, a child is considered high risk for high doses of lead exposure. Practitioners are required to perform a venous blood lead level on children determined to be high risk. Tests need to be repeated every three (3) to four (4) months until lead levels are within normal limits. Tests should continue to be completed if the child is still considered high risk.

19.4.9.3 Tuberculin Screening

Tuberculin testing should be completed as indicated on the Well Child Screen Requirements table or more often on Members in high-risk populations (Asian refugees, Indian children, migrant children, and so on), or if historical findings, physical examinations or other risk factors so indicate.

19.4.9.4 Urinalysis

Urinalysis using a multiple dipstick method should be completed on all children at two (2) years and 13-15 years.

- Because of heightened incidence of bacteriuria in girls, they should have additional tests around three (3) years, five (5) years and eight (8) years
- Children who have had previous urinary tract infections should be re-screened more frequently

- If test results are positive but the history and physical examination are negative, the child should be tested again in seven (7) days
- If the results are positive a second time or if there are supportive findings in the history and physical examination from the first (1st) positive test, further follow-up is required
- If a male child has a urinary tract infection, a referral for further testing should be completed immediately

19.4.9.5 Other

Other laboratory tests (such as chest X-ray, Pap smear, sickle cell testing, and so on) should be completed if medically necessary.

19.4.10 Immunizations

- The immunization status of each child should be assessed at each Well Child Screen
- Assessing the immunization status of a child includes interviewing parents/caretakers, reviewing immunization history/records, and reviewing known high-risk factors to which the child may be exposed
- Immunizations needed by children at their Well Child Screen should be given on-site, provided there are not existing contradictions
- Immunizations are to be given according to the Advisory Committee on Immunization Practices (ACIP)
- Arrangements should be made with the parents/responsible adult for the completion of immunizations
- If immunizations have not been completed at the recommended age, the healthcare professional should set up a schedule to ensure the child becomes current

> The Recommended Immunization Schedule can be found at http://www.cdc.gov/vaccines/schedules/index.html.

19.4.11 Dental Screen

Oral inspections are included in Well Child Screens. Results should be included in the child's Initial/Interval History. Although an oral inspection is part of Well Child Screens, it does not substitute for an examination through a direct referral to a dentist. A child should be referred to the dentist as follows:

- When the first tooth erupts and at least yearly thereafter

- If an oral inspection reveals cavities, infection, or the child has or is developing a handicapping malocclusion or significant abnormality

> Refer back to Topical Fluoride (see *Section 19.4.7* Topical Fluoride Varnish).

19.4.12 Speech and Language Screens

Speech and language screens identify delays in development of children.

Referrals for further speech and hearing evaluations may be appropriate if one (1) or more of the following exists:

- Child is not talking at all by the age of 18 months
- Suspected hearing impairment
- Child is embarrassed or disturbed by their own speech
- Voice is monotone, extremely loud, largely inaudible, or of poor quality
- There is noticeable hyper-nasality or lack of nasal resonance
- There is undue parental concern
- Where speech is not understandable at three (3) years of age, a referral may be appropriate, as the condition may be caused by an unsuspected hearing impairment or a variety of undiagnosed conditions

19.4.13 Discussion and Counseling

Parents should have the opportunity to ask questions, to have them answered and to have sufficient time allotted for unhurried discussions. Practitioners should discuss and interpret examination results in accordance with the parents' level of understanding.

> Interpretation services are available upon request (see *Section 22.11* Interpretation Services.

Chapter 20 – Covered Services – Laboratory Services

20.1 Laboratory Services

Procedure Code Range: 36415, G0027, G0306, G0307, G0477, 80000-89999

Medicaid covers tests provided by independent (non-hospital) clinical laboratories when the following requirements are met:

- Services are ordered by physicians, dentists, or other Providers licensed within the scope of their practice as defined by law
- Services are provided in an office or other similar facility, but not in a hospital outpatient department or clinic
- Providers of lab services must be Medicaid certified
- Providers of lab services must have a current Clinical Laboratory Improvement Amendments (CLIA) certification number
- **Providers may bill Medicaid only for those lab services they have performed themselves. Medicaid does not allow pass-through billing**
- 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 culture or Pap Smears.

20.2 Clinical Laboratory Improvement Amendments Requirements

The type of Clinical Laboratory Improvement Amendment (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 the codes listed. Refer to the fee schedule located on Medicaid website (see *Section 2.1* Quick Reference) for actual coverage and fees. Content is subject to change at any time, without notice.

> 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
	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)						

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

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

20.3 Genetic Testing

Procedure Codes: **81200-81599; 96040**

Prior Authorization (*see Section 6.12* Prior Authorization) is required for all genetic testing codes, except 81420 and 81507. Prior authorization documentation must include all the following:

- 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 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 (for example, psychological, social, limitations of nondiscrimination statutes)
    - Discussion of possible test outcomes (such as, positive, negative, variant of uncertain significance)

- Explanation of potential benefits, risks, and limitations of testing
- Explanation of purpose of evaluation (for example, 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, 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 should not be ordered if the physician does not intend to act upon the test result.

20.3.1 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 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, AND
- Documentation indicates a genetic counseling visit pre or post testing

20.3.2 Counseling

Medicaid covers appropriate genetic counseling (96040) when it is provided in conjunction with performance or consideration of medically necessary BRCA testing that meets the criteria listed above. This includes follow-up genetic counseling to discuss the results of these tests. Three (3) 30-minute units (for a total of 90 minutes) are allowed per day.

Genetic counseling services may be billed by a physician when the genetic counselor is under physician supervision and is an employee of the physician. Services provided by independent genetic counselors are not a benefit of Wyoming Medicaid.

Physician specialties that may bill for BRCA genetic counseling are:

- Clinical genetics
- Family practice
- OB/GYN
- Internal medicine
- Internal medicine, medical oncology
- General surgery

20.3.3 Billing Requirements

- Prior authorization is required for BRCA pre-test counseling and must be submitted by a physician with a specialty listed above.
- Prior Authorization for BRCA Testing CPT codes will only be approved with documentation that genetic counseling will be or has been provided.
- Prior authorization requests will need to be submitted to Telligen (see *Section 2.1* Quick Reference)

- Prior authorization documents should include:
  - The reason for the test(s)
  - Previous lab results
  - How the test results will be utilized
  - How the test results will contribute to improved health outcomes
  - How the test results will alter the Member's treatment management

Chapter 21 – Covered Services – Non-Emergency Medical Transportation

21.1 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.

21.1.1 Covered Services

21.1.1.1 Taxi and Non-Taxi Rides

- Covered for adults and children
- Member must initiate the ride by contacting the Customer Service Center and select the travel request option.
- The Member will contact Ride Provider once the ride is approved
- If the ride is approved a Prior Authorization (PA) number will be generated for the Provider. The Provider will retrieve the PA number from the Provider Portal and enter it on the claim (*see Section 6.12.2* Prior Authorization Status Inquiry).

21.1.1.2 Lodging

- Covered for Members 20 years of age and younger
- Member must be inpatient or outpatient at a medical facility that is enrolled with Wyoming Medicaid
- The Member must initiate the lodging request by contacting the Customer Service Center and indicate that they are staying with an enrolled lodging Provider (see *Section 2.1* Quick Reference)
- Member must live more than 400 miles round trip from medical facility
    - Exceptions may be granted for special circumstances (several appointments over several days; very early appointments; need for direct medical supervision during outpatient recovery; and so on). The Member must contact the Customer Service Center, then select travel requests option (see *Section 2.1* Quick Reference) to request exceptions).

21.2 Billing Information

21.2.1 Taxi Rides

Procedure codes A0100, S0215

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

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

21.2.2 Non-Taxi Rides

Procedure Codes: A0110, A0080

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

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

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

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

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

21.2.3 Lodging

Procedure Code: A0180

- The Member should provide the Travel Request number for billing purposes
    - The Travel Request number will be entered as the Member's account number on the claim when billing
- Member must provide the Medicaid Member ID of the child to the lodging Provider for billing purposes

- Bill procedure code A0180 for each night of lodging – child Member must be inpatient in medical facility or outpatient and staying at lodging Provider
- All lodging claims are subject to post payment review and as such records should be kept with detail including:
  - Member information
  - Medical facility Member was patient of
  - Inpatient/outpatient status
  - Dates of stay
  - Total nights
  - Total charge
- The Member's family will need a copy of receipt/documentation to receive their per diem for the stay

Chapter 22 – Covered Services – Practitioner Services

22.1 Practitioner Services

Practitioners Include:

- Physicians (MD/DO)
- Nurse Practitioners
- Physician's Assistants
- Mental Health Providers
- Ordering, Rendering, and Prescribing Providers

22.2 Covered Services

- Abortion
- Adverse Childhood Experiences (ACEs)
- Anesthesia Services
- Dermatology
- Diabetic Training
- Family Planning
- Hysterectomies
- Imaging Services
- Immunizations
- Injections
- Interpretation Services
- Laboratory Services
- Maternity Care
- Medical Supplies
- Personal Care Services
- Practitioner Visits
- Pregnant By Choice and Family Planning Waiver
- Preventive Medicine
- Psychiatric Services
- Public Health Services

- Screening, Brief Intervention, Referral and Treatment (SBIRT)
- Sterilization
- Surgical Services
- Transplant Policy
- Vision Service

> Many unlisted procedure codes require prior authorization (*see Section 6.12* Prior Authorization). For planned services, authorization must be obtained prior to the date of service. For procedures that are planned and altered during surgery, prior authorization must be requested within three (3) business days. Please contact Telligen or review the Telligen Provider Manual for specifics (see *Section 2.1* Quick Reference).

22.3 Abortion

22.3.1 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 (5) 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

22.3.2 Billing Requirements

The Abortion Certification Form (*see Section 6.15.3.1* Abortion Certification Form) accompany all claims from the attending physician, assistant surgeon, anesthesiologist, pathologist, 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.
- Pregnancies that terminate in spontaneous abortion or miscarriage in any trimester must bill with the appropriate CPT-4 code and documentation is required in the Member's record. Prenatal visits and additional services may be billed in addition to the abortion code.
- RU-486 under the same guidelines as the legally induced abortion is covered when administered by a practitioner in the practitioner's office

> 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) is completed prior to performing the induced abortion.

22.4 Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are potentially traumatic incidents that occur in a child's life. These experiences occur before a child is 18, but they remember them throughout their life. ACEs refer to specific types of trauma children may experience. These include physical, sexual, and emotional abuse, neglect, losing a parent (such as through divorce), being exposed to domestic violence, having a parent with a mental illness, having a member of the household who abuses drugs or alcohol, or having a parent who has been in jail. Children living through these experiences may suffer from adverse effects for the rest of their lives.

Children who experience these traumatic events or environments can experience challenges in their lives. Without a healthy adult to support them, they may experience toxic stress. They may encounter chronic health conditions like depression, asthma, or diabetes. If a child experiences toxic stress long-term, they may adopt unhealthy coping mechanisms such as substance abuse. When a child experiences chronic stress, it can lead to a lower tolerance for stressful situations in adulthood. Children can also experience post-traumatic stress disorder (PTSD) and other mental health issues. Assessments can be performed to determine the number of traumatic events an individual has experienced which are used to determine their Adverse Childhood Experience (ACE) score. Studies have found that the risk of chronic illnesses, such as heart disease, lung disease, and cancer, is greater for people with high ACE scores. A high ACE score can also be linked to early death.

22.4.1 Provider Requirements for Reimbursement

Effective March 1, 2023, Wyoming Medicaid Providers who have completed the certification process detailed below are eligible for a $29 payment for conducting Adverse Childhood Experience (ACE) screenings for children with full Medicaid. Qualifying ACE screenings are eligible for payment in any clinical setting in which billing occurs through Medicaid fee-for-service.

- Fee-for-Service Payments will follow the process as outlined below and will be paid directly to the Provider submitting the claim.
    - Payment for ACE screenings for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Services (IHS) is included in the encounter rate when children are seen for regular services and are not separately reimbursable.

22.4.2 Guidance on Billing for Adverse Childhood Experience Screening via Telehealth

Providers may screen a patient for ACEs via telehealth if the Provider believes that the ACE screening can be administered in a clinically appropriate manner. Providers must continue to comply with all other billing procedures, Wyoming Medicaid guidelines, and confidentiality laws.

22.4.3 Documentation

Under the existing ACE screening policy, Providers must document all of the following:

- Assessment tool that was used,
- Documentation that the completed screening was reviewed,
- Results of the screening,
- Interpretation of results, and
- What was discussed with the Member and family, and any appropriate actions taken.

This documentation must remain in the beneficiary's medical record and be available upon request.

22.4.4 Certification

Eligible Wyoming Medicaid Providers must complete a certified ACEs Aware Core Training to receive reimbursement for services provided and may be required to provide proof of attestation at the request of Wyoming Medicaid.

To complete the certification, perform the following steps:

1. Register for training at https://training.acesaware.org.
2. Complete the two (2) hour virtual training and course evaluation.

3. Obtain a copy of the certification via the ACEs Aware website.

> Currently, there is no requirement for recertification. The certification is a free two hour training and provides continuing education credits.

22.4.5 Covered Service Codes

The following Healthcare Common Procedure Coding System (HCPCS) is to be used to bill Wyoming Medicaid based on ACE screening results:

- HCPCS: G9919
  - Screening Performed: Result indicates patient is at high risk for toxic stress; education and interventions (as necessary) provided.
  - Providers must bill this HCPCS code when the patient's ACE score is four (4) or greater (high risk)
  - Payment: $29
- HCPCS: G9920
  - Screening Performed: Result indicates patient is at lower risk for toxic stress; education and interventions (as necessary) provided.
  - Providers must bill this HCPCS code when the patient's ACE score is between zero to three (0-3) (lower risk)
  - Payment: $29

22.4.6 Adverse Childhood Experience Screening Frequency

Wyoming Medicaid payment is available for ACE screenings based on the following schedule:

- Children and adolescents under age 21: Permitted for periodic ACE rescreening as determined appropriate and medically necessary, not more than once per year, per client. Children are to be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.

The Pediatric ACEs and Related Life-Events Screener (PEARLS) is used to screen children and adolescents ages zero (0) to 19 for ACEs. The PEARLS tool includes a screening for ACEs (Part 1) as well as a screening for additional adversities (Part 2). There are three (3) versions of the tool available, based on age and reporter:

- PEARLS Child Tool: Ages zero to eleven (0-11), to be completed by a parent or caregiver
- PEARLS Adolescent Tool: Ages 12-19, to be completed by a parent or caregiver
- PEARLS for Adolescent Self-Report Tool: Ages 12-19, to be completed by the adolescent

Paper copies of the PEARLS is available at:
ACEs Aware Provider Toolkit (https://www.acesaware.org/wp-content/uploads/2020/05/ACEs-Aware-Provider-Toolkit-5.21.20.pdf).

22.5 Anesthesia Services

Procedure Code Range: **00100-01999**

Anesthesia is the process of blocking the perception of pain and other sensations. This allows Members to undergo surgery and other procedures without the distress and pain they would otherwise experience.

22.5.1 Covered Services

Medicaid covers anesthesia only when administered by a licensed anesthesiologist or a certified registered nurse anesthetist (CRNA) who remains in attendance for the sole purpose of rendering general anesthesia in order to afford the Member anesthesia care deemed optimal during any procedure.

The American Society of Anesthesiologists (ASA) relative value guide is accepted as the basis for coding and definition of anesthesia provided to Medicaid Members.

> The lower conversion factor of 21 is used in the reimbursement rate for CRNAs. This conversion factor is lower than the conversion factor for anesthesiologists. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedule on the website or contact Provider Services (see *Section 2.1* Quick Reference).

22.5.2 Billing Guidelines

- When billing ASA procedure codes, enter actual minutes for procedures where time is necessary. Fractions of time are always rounded up to the next full number
- For example, enter 65 minutes, rather than one (1) hour five (5) minutes
- For example, nine (9) minutes would be rounded up to 15 minutes
- Anesthesia units must be billed in minutes. Do not convert or change time by dividing by 15, the Medicaid's claims processing system does this automatically
- Anesthesia CPT Codes are reimbursed based on the units of the anesthesia procedure and the time units allowed. The total units are multiplied by a conversion factor to determine the allowed amount. Medical supervision is not reimbursed.
    - For example, claim is billed with 105 units: 105(units billed)/15 = 7 (Anesthesia Units). Add the anesthesia units to the base value (RVU) assigned to the procedure code: 7 + 7= 14.

Times that total by the conversion factor for that procedure code: 14 x 27.04 = $378.56 = total paid.

> The conversion factor and RVU for each anesthesia procedure code can be found on the fee schedule on the Wyoming Medicaid website (*see Section 2.1* Quick Reference).

- Anesthesia time begins when the anesthesiologist starts to prepare for the induction of the anesthesia and ends when the anesthesiologist is no longer in personal attendance. Anesthesia time is the total number of minutes the service(s) are performed.
    - For example, preparation of the induction began at 11:00 am and the anesthesiologist was no longer in attendance by 2:15 pm, total minutes would be 195 and is also the number of units to be billed
- Providers should bill the appropriate CPT-4 procedure codes for induction/injection of anesthetic agent
- When multiple procedures are performed during a single anesthetic administration, Medicaid will pay the anesthesia code representing the most complex procedure reported. The time reported is the combined total for all procedures.
- Anesthesia is a global service just as the surgical procedure for which it is given. No pre- or postoperative services will be recognized for separate payment, including those for:
    - Pain Management on the same day as surgery
    - Routine monitoring is included in the primary anesthesia and not reimbursed separately. For specific information regarding routine monitoring, refer to the current version of the ASA relative value guide.
    - Laryngoscopy codes 31505, 31515, and 31527 are incidental or included within the anesthesia time
    - Any anesthesia substance administered at the time of the procedure for circumcision, cannot be billed separately as this is considered part of the global package
- If two (2) anesthesia codes are billed on the same day, (such as, tubal ligation following vaginal delivery), documentation must be submitted with the claim to support the necessity of these services

> Anesthesiologists and CRNAs are not required to request prior authorization (PA) directly from Medicaid for any anesthesia procedure.

22.5.3 Obstetrical Exceptions

- Procedure code 01967 is a global fee per the fee schedule and should be billed as one (1) unit, not the number of minutes. The Global fee includes:
  - Establishing and maintaining the anesthesia for the time the Member requires it
  - If the anesthesia should continue into the next day, use procedure code 01996
- Anesthesia for multiple obstetrical procedures may be paid for both procedures in the following circumstances
  - Neuraxial analgesia/anesthesia for planned vaginal delivery which becomes a Cesarean delivery
    - Use procedure code 01967 to begin the procedure and discontinue its use when a C-section is imminent, then begin using procedure code 01968 and continue with straight time (minutes) as for a general surgery
  - Neuraxial analgesia/anesthesia for planned vaginal delivery followed by tubal ligation on same or the next day following delivery
    - Use procedure code 01967 for delivery
    - Use procedure code 00851 for intraperitoneal lower abdomen, tubal ligation/ transection

> Medicaid does not allow CPT 01996 on the same day as placement of an epidural catheter.

22.5.4 Modifiers

When billing for anesthesia, indicate the appropriate physical status modifier. These modifiers indicate various levels of complexity of the anesthesia service provided. If a physical status modifier is billed, additional payment will be added, if appropriate to the claim payment.

Physical Status Modifiers		
Modifier	**Description**	**Reimbursement**
P1	A normal healthy Member.	No change
P2	A Member with mild systemic disease.	No change
P3	A Member with severe systemic disease.	Additional 5%
P4	A Member with severe systemic disease that is a constant threat to life.	Additional 10%
P5	A moribund Member who is not expected to survive without the operation.	Additional 15%

P6	A declared brain-dead Member whose organs are removed for donor purposes	Not covered

The use of other optional modifiers may be appropriate.

22.5.5 Documentation Requirements

- Begin and end times must be documented in the anesthesia record and must be legible
- Anesthesia time begins when the anesthesiologist begins to prepare the Member for anesthesia care in the operating room or an equivalent area and ends when the anesthesiologist is no longer in personal attendance and the Member is safely placed under post-anesthesia supervision
- If two (2) anesthesia codes are billed on the same day, (such as, tubal ligation following vaginal delivery), documentation must be submitted with the claim to support the necessity of these services

22.6 Dermatology

Medicaid covers medically necessary services rendered in the treatment of dermatological illnesses.

22.6.1 Covered Services

- Acne surgery due to disfigurement requires prior authorization (*see Section 6.12* Prior Authorization)
- Removal of lesions suspected to be precancerous
- Removal of a benign lesion, ganglion cyst, skin tag, keloid, or wart, may be covered when medically necessary

22.6.2 Benign Lesion Removal and Destruction of Benign or Premalignant Lesions

Procedure Code: **11200 (Removal of Skin Tags**

Procedure Code: **11310 (Removal / Shave Lesion)**

Procedure Code Range: **11400-11446 (Removal)**

Procedure Code Range: **17106-17111 (Destruction)**

22.6.3 Covered Services

Benign skin lesions include seborrheic keratosis, sebaceous (epidermoid) cysts, skin tags, milia (keratin-filled cysts), nevi (moles) acquired hyperkeratosis (keratoderma), papillomas, hemangiomas and viral warts.

22.6.4 Billing Requirements

Wyoming Medicaid considers **removal of benign skin lesions** as medically necessary, and not cosmetic, when any of the following is met and is clearly documented in the medical record, operative report, or pathology report:

- The lesion is symptomatic as documented by any of the following:
  - Intense itching
  - Burning
  - Irritation
  - Pain
  - Tenderness
  - Chronic, recurrent, or persistent bleeding.
  - Physical evidence of inflammation (for example, purulence, oozing, edema, erythema, and so on)
- The lesion demonstrates a significant change in size or color
- The lesion obstructs an orifice or clinically restricts vision
- There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesional appearance, change in appearance and/or non-response to conventional treatment
- The lesion is likely to turn malignant as documented by medical peer-reviewed literature or medical textbooks
- A prior biopsy suggests the possibility of lesional malignancy
- The lesion is an anatomical region subjected to recurrent physical trauma that has in fact occurred and objective evidence of such injury or the potential for such injury is documented

Wyoming Medicaid considers **destruction of benign or malignant skin lesions** as medically necessary, and not cosmetic, when any of the following is met and is clearly documented in the medical record, operative report, or pathology report.

- An over-the-counter (OTC) product has been tried and was ineffective (when applicable)

- Lesion causes symptoms of such a severity that the patient's normal bodily functions/activities of daily living are impeded (for example, palmar or plantar warts)
- Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding
- Warts showing evidence of spread from one (1) body area to another, particularly in immunosuppressed patients
- Lesions are condyloma acuminata or molluscum contagiosum
- Cervical dysplasia or pregnancy associated with genital warts
- Port wine stains and other hemangiomas when lesions are located on the face and neck
    - Progress notes and photos documenting improvement must be kept in the patient record and available upon request

> Wyoming Medicaid does not consider removal of skin lesions to improve appearance as medically necessary. Removal of certain benign skin lesions that do not pose a threat to health or function are considered cosmetic, and as such, are not medically necessary. In the absence of any of the above indications, removal of seborrheic keratoses, sebaceous cysts, nevi (moles) or skin tags is considered cosmetic.

22.6.5 Documentation Requirements

One (1) or more of the above conditions, clearly documented in the medical record, operative report, or pathology report are required.

22.7 Diabetic Training

Procedure Code Range: **G0108-G0109**

Physicians, public health nurses, 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.

22.7.1 Covered Services

Individual and group diabetes self-management training sessions 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

22.7.2 Billing Requirements

- HCPCS Level II codes, G0108 (individual session) and G0109 (group session) should be used
- Do not bill a separate office visit on the same date of service
- For individual services, one (1) unit equals 30 minutes. A maximum of two (2) units applies
- For group services, one (1) unit equals 30 minutes. A maximum of five (5) units per individual per training session applies
- Billing is to be done under the physician, nurse practitioner or hospital's Provider number

22.7.3 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

22.8 Family Planning Services

Family planning services are to assist Members of childbearing age with learning the choices available to them to freely determine the number and spacing of their children.

Family planning services include the following:

- Initial visit
- Initial physical examination
- Comprehensive history
- Laboratory services
- Medical counseling
- Annual visits
- Routine visits

22.8.1 Covered Services

- Sterilization procedures are covered only when all Medicaid guidelines have been met (*see Section 6.15.1.1* Sterilization Consent Form)
- Contraceptives
- Cervical caps
- Male/female condom
- Contraceptive injections
- Creams
- Diaphragms
- Foams
- Insertion/removal of implantable contraceptives (Norplant and Implanon)
- Insertion/removal of IUDs
- Oral contraceptives when prescribed by a physician or nurse practitioner and dispensed a participating pharmacy
- Spermicides
- Sponges

> Pregnant by Choice/Family Planning Waiver has specific covered and non-covered services. The plan information can be found in *Section 23.1*.

22.8.2 Hysterectomies

Procedure Code Range: **58150-58294**

Refer to the following sections for information:

- *Section 6.15.2* Hysterectomy Acknowledgment of Consent
- *Section 6.15.2.1* Hysterectomy Acknowledgement Consent Form
- *Section 6.15.2.2* Instructions for Completing the Hysterectomy Acknowledgment of Consent Form

22.9 Immunizations

Procedure Code Range: **90477-90756, 99460, 99461, & 99471-99474**

Vaccines For Children (VFC) Program

Providers must enroll with the VFC program to receive and distribute VFC vaccines. The VFC program makes available, at no cost to Providers, selected vaccines for eligible children 18 years old and under. Medicaid will therefore pay only for the administration of these vaccines (oral or injection). VFC covered vaccines may change from year to year. For more information on the VFC program current VFC covered vaccines or how to enroll as a VFC Provider contact the Wyoming Immunization Program at (307)777-7952.

22.9.1 Billing Procedures: Vaccines For Children Supplied or Private Stock

Use the following guidelines when submitting claims to Medicaid:

- Providers must use a VFC provided vaccine when available and Member appropriate. If the vaccine is supplied by VFC, bill the appropriate procedure code and use the SL modifier. Codes 90477-90748 identify the vaccine product only. To report the administration of vaccine/toxoid, the appropriate administration code (see table below) must be reported in addition to the vaccine/toxoid code. Reimbursement will be made for the administration only.
- When Medicaid is the secondary payer, the Provider must submit the claim according to Medicaid guidelines. Providers that administer the VFC vaccine must submit the claim to Medicaid for reimbursement of the vaccine administration fee regardless of other insurance. Medicaid has the option to seek reimbursement for the administration fee from the primary insurer.
- Providers are reminded that use of any vaccine or immunization solely for the purpose of travel is not covered by Medicaid
- According to VFC policy, Providers may not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the Centers for Medicaid and Medicare Services (CMS) regional cap of $21.72 per dose
- Codes 90477-90748 identify the vaccine product only. To receive reimbursement for administration they must be reported in addition to an immunization administration code from the tables below.
- When a vaccine is privately obtained due to lack of availability through the VFC program, it will be reimbursed at 100% of purchase invoice. **DO NOT USE** the SL modifier in this instance. This policy applies exclusively to situation where the VFC Program has issued a notice of vaccine shortage and has specified which vaccines are affected.
- For vaccines administered to adults over 19 years of age and older, or for vaccines/toxoids not supplied by VFC, report the appropriate CPT code and administration fee. **DO NOT USE** the SL modifier. Medicaid will reimburse for the vaccine/toxoid and the administration.

- When the vaccine/toxoid product code does not contain the SL modifier, a manufacturers' invoice must be attached to the claim. The vaccine/toxoid will be reimbursed at 100% of the invoice cost.

  Exception:

  - For procedure codes 90656, 90660, 90703, 90707, and 90714, an invoice is only required for those Members age 18 years and younger. Those claims for Members 19 years and older will be reimbursed at a flat rate of $15.00 for these codes.
  - For procedure code 90658, an invoice is only required for those Members age 18 years and younger. Those claims for Members 19 years and older will be reimbursed at a flat rate of $20.00 for this code.
  - For procedure code 90715 an invoice is only required for those Members age 18 years and younger. Those claims for Members 19 years and older will be reimbursed at a flat rate of $30.00 for this code.

Administration Codes – Physician Provides Face-to-Face Vaccine Counseling	
CPT Code	**Description**
90460	Immunization administration 0-18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
90461	• Each additional vaccine/toxoid component (list separately in addition to code for 1st component) for age 0-18

Administration notes: For vaccines where the physician or other qualified health care professional provides counseling, code 90460 will be reported once for each vaccine administered. For any vaccine with multiple components (such as, DtaP or Tdap), 90461 will be reported for each additional component. If multiple vaccines are administered, "like codes" must be combined onto the same line, using multiple units to avoid denials for duplicates. Medicaid will pay up to the allowable on each unit of 90460, and $0.00 for each unit of 90461. Providers should bill their usual and customary fee for 90460 and $0.00 for 90461.

22.9.2 Billing Examples

Example 1: Provider administers the HPV vaccine, VFC supplied with physician counseling:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/21	90651 SL	$0.00	1
01/01/21	90460	$21.72	1

Example 2: Provider administers Tdap, MMR and Influenza. All are VFC supplied with physician counseling.

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/21	90707 SL	$0.00	1
01/01/21	90715 SL	$0.00	1
01/01/21	90658 SL	$0.00	1
01/01/21	90460	$65.16	3
01/01/21	90461	$0.00	4

Further Explanation: Three (3) units of 90460 (one (1) for each vaccine administered to indicate each 1st component) and four (4) units of 90461 (one (1) for each additional component of the Tdap and the MMR vaccine beyond the 1st.

Administration Codes – Face-to-Face Vaccine Counseling Not Provided by Physician	
CPT Code	**Description**
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one (1) vaccine (single or combination vaccine/toxoid). Do not report in conjunction with 90473.
90472	Each additional vaccine (single or combination vaccine/toxoid). List separately in addition to code for primary procedure (90471 or 90473).
90473	Immunization administration by intranasal or oral route; one (1) vaccine (single or combination vaccine/toxoid). Do not report with 90471.
90474	Each additional vaccine (single or combination vaccine/toxoid). List separately in addition to code for primary procedure (90471 or 90473).

For vaccinations where face to face counseling is not provided, 90471 or 90473 is reported for the first vaccine, and 90472 or 90474 (units combined for multiples) for each additional vaccine.

Example 4: Provider administers the HPV vaccine, VFC supplied, without physician counseling:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/21	90649 SL	$0.00	1
01/01/21	90471	$21.72	1

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/21	90651 SL	$0.00	1
01/01/21	90471	$21.72	1

Example 5: Provider administers Tdap, MMR and Influenza, all VFC supplied, without physician counseling:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/21	90707 SL	$0.00	1
01/01/21	90715 SL	$0.00	1
01/01/21	90656 SL	$0.00	1
01/01/21	90471	$21.72	1
01/01/21	90472	$43.44	2

Explanation of Example 5: One (1) unit of 90471 for the first (1st) vaccine, and two (2) units of 90472 for the other two (2) vaccines.

VFC is not intended for private pay patients.

22.9.3 Other Immunizations

Other immunizations include, but are not limited to:

- Synagis can only be billed via pharmacy. The Provider will only bill for the services that they provided (such as, E&M and administration). The Providers will need to work with a pharmacy to provide the medication.
- Please see instructions for Synagis on the following Pharmacy site under prior authorization: http://www.wymedicaid.org/.
- Additional Vaccines, Toxoids
    - CPT-4 codes for vaccines are to be used to bill for the vaccine product itself and are reported in addition to the immunization administration codes (90471, 90472) unless the VFC program supplied the vaccine.
    - Separate codes are available for combination vaccines. It is inappropriate to code each component of a combination vaccine separately.

The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedule on the website (*see Section 2.1* Quick Reference).

22.10 Injections

Reimbursement for J-codes and therapeutic injections include the cost of the administration fee. This cost is already calculated into the fee for each code.

> Therapeutic injections may not be billed with a J-code (see *Section 6.6* National Drug Code Billing Requirement).

If multiple drugs are included in a single injection, separate codes may be billed for the drugs, however, the administration fee should be included with only one (1) code.

For an accurate listing of codes, refer to the fee schedule on the Medicaid website (see *Section 2.1* Quick Reference).

22.10.1 Belimuab (Benlysta®)

Procedure Code: **J0490**

22.10.1.1 Covered Services

Belimumab is covered and considered medically necessary if the below requirements are met.

22.10.1.2 Billing Requirements

Prior authorization requirements (*see Section 6.12* Prior Authorization):

Wyoming Medicaid considers Belimumab medically necessary when all the following is met and is clearly documented in the medical record, operative report, or pathology report:

- The patient is 5 years of age or older for intravenous infusion administration
- The patient is 18 years of age or older for subcutaneous injection administration
- The patient has a diagnosis of active systemic lupus erythematosus (SLE) disease
- The patient has positive autoantibody test results [positive antinuclear antibody (ANA >1:80) and/or anti-dsDNA (>30 IU/mL)]
- **ONE (1) of the following:**
    - The patient is currently on a standard of care SLE treatment regimen comprised of at least one (1) of the following: corticosteroids, hydroxychloroquine, chloroquine, nonsteroidal anti-inflammatory drugs (NSAIDS), aspirin, and/or immunosuppressives (azathioprine, methotrexate, cyclosporine, oral cyclophosphamide, or mycophenolate)
    - The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the standard of care drug classes listed above

- The patient does NOT have severe active lupus nephritis [proteinuria >6 g/24-hour or equivalent or serum creatinine >2.5 mg/dL OR required hemodialysis or high-dose prednisone >100 mg/day] within the past 90 days
- The patient does NOT have severe active central nervous system lupus [for example, seizures, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis, CNS vasculitis requiring therapeutic intervention] within the past 60 days
- The patient has NOT been treated with intravenous cyclophosphamide in the previous six (6) months
- The patient is NOT currently using another biologic agent
- The patient is NOT currently being treated for a chronic infection
- The dose for intravenous administration is within the FDA labeled dosage of 10 mg/kg intravenously at two (2) week intervals for the first three (3) doses and at four (4) week intervals thereafter
- The dose for subcutaneous administration is within the FDA labeled dosage of 200 mg once weekly

Length of Approval: 12 months.

22.10.2 Botox®

Procedure Code: **J0585**

22.10.2.1 Covered Services

OnabotulinumtoxinA [Botox] is covered for the treatment of the following conditions and are considered medically necessary when specific criterion is met.

22.10.2.2 Billing Requirements

Prior authorization requirements (see *Section 6.12* Prior Authorization):

Wyoming Medicaid considers Botulinum toxin A (onabotulinumtoxinA [Botox®]) appropriate for the treatment of the following conditions and meet medical necessity criteria where it is stated:

- Incontinence with inadequate response to or intolerance of anticholinergic medications PLUS one of the following:
  - Overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency
    - At least 3 urinary urgency incontinence episodes
    - At least 24 micturitions in 3 days' time
    - Total dose: 100 units, as 0.5 mL (5 Units) injections across 20 sites into the detrusor

        - To qualify for re-treatment, ALL the following must apply:
            - At least 12 weeks must have passed since the prior treatment
            - Post-void residual urine volume must have been less than 200 mL
            - Patients must have reported at least 2 urinary incontinence episodes over 3 days
    - Urinary incontinence due to detrusor overactivity associated with a neurologic condition [for example, spinal cord injury (SCI), multiple sclerosis (MS)]
        - Total dose: 200 Units, as 1 mL (~6.7 Units) injections across 30 sites into the detrusor
        - To qualify for re-treatment, ALL the following must apply:
            - At least 12 weeks must have passed since the prior treatment
            - Post-void residual urine volume must have been less than 200 mL
            - Patients must have reported at least 2 urinary incontinence episodes over 3 days with no more than 1 incontinence-free day.
- Upper and lower limb spasticity, excluding spasticity caused by cerebral palsy
    - Patient must be 2 years of age or older
    - Upper Limb:
        - Adult total dose: Select dose based on muscles affected, severity of muscle activity, prior response to treatment, and adverse event history; Electromyographic guidance recommended
        - Patient is at least 6-weeks post-stroke
        - Pediatric total dose: 3 Units/kg to 6 Units/kg (maximum 200 Units) divided among affected muscles
    - Lower Limb:
        - Adult total dose: 300 Units to 300 Units divided across ankle and toe muscles
        - Pediatric total dose: 4 Units/kg to 8 Units/kg (maximum 300 Units) divided among affected muscles
- Cervical dystonia
    - Patient is 16 years or older
    - Base dosing on the patient's head and neck position, localization of pain, muscle hypertrophy, patient response, and adverse event history; use lower initial dose in botulinum toxin naïve patients
- Severe axillary hyperhidrosis with ALL the following:
    - Patient is 18 years or older

- Inadequate management by topical agents
- Total dose: 50 units per axilla

- Blepharospasm associated with dystonia with ALL the following:
  - Patient is 12 years or older
  - Includes benign essential blepharospasm or VII nerve disorders
  - Total dose: 1.25 Units-2.5 Units into each of 3 sites per affected eye
- Strabismus
  - Patient is 12 years or older
  - Total dose: The dose is based on prism diopter correction or previous response to treatment with Botox®
    - For vertical muscles, and for horizontal strabismus of less than 20 prism diopters: 1.25 Units-2.25 Units in any one muscle
    - For horizontal strabismus of 20 prism diopters to 50 prism diopters: 2.5 Units-5 Units in any one muscle
    - For persistent VI nerve palsy of one month or longer duration: 1.25 Units-2.5 Units in the medial rectus muscle
- Migraine headaches prevention is considered medically appropriate if the headaches are chronic with ANY ONE (1) the following criteria met:
  - Initial six (6) month trial for migraine headaches with ALL the following:
    - Occur 15-days or more per month
    - Lasting 4 hours a day or longer
    - Experienced for three (3) months or more
    - Symptoms persist despite adequate trials of a minimum of **two (2) agents** from different classes used in the treatment of chronic migraines (for example**, Angiotensin-converting enzyme inhibitors/angiotensin II receptor blockers, anti-depressants, anti-epileptics, beta blockers and calcium channel blockers**), unless the individual has contraindications to such medications.
  - Continuation of therapy after six (6) month trial for the prevention of migraines requires frequency reduced by at least seven (7) days per month.

When initiating treatment, the lowest recommended dose should be used. In treating adult patients for one or more indications, the maximum cumulative dose should not exceed 400 Units, in a 3-month

interval. In pediatric patients, the total dose should not exceed the lower of 10 Units/kg body weight or 340 Units, in a 3-month interval.

	**Botox®** can only be requested one (1) session at a time, with medical necessity provided for each session.

Botox should not be administered and will not be approved if the patient has either of the following contraindications:

- Hypersensitivity to any botulinum toxin
- Infection at proposed injection site
- Intra-detrusor injections: when the Member has a urinary tract infection or urinary retention

22.10.2.3 Non-Covered Services

- Prophylaxis of episodic migraine (<14 headache days per month)
- Treatment of hyperhidrosis in body areas other than axillary

22.10.3 Dysport®

Procedure Code: **J0586**

22.10.3.1 Covered Services

Abobotulinum toxin A [Dysport®] (Botulinum toxin type A) for the treatment of the following conditions and are considered medically necessary when specific criteria are met.

22.10.3.2 Billing Requirements

Prior authorization requirements (*see Section 6.12* Prior Authorization):

Wyoming Medicaid considers Botulinum toxin A (abobotulinumtoxinA [Dysport®]) appropriate for the treatment of the following conditions and meet medical necessity criteria where it is stated:

- Cervical dystonia associated with the following
  - with or without a history of prior treatment with botulinum toxin
- Spasticity in adults
- Lower limb spasticity in pediatric patients with ALL the following;
  - Patient is 2 years of age or older

> **Dysport®** can only be requested one (1) session at a time, with medical necessity provided for each session.

Dysport should not be administered and will not be approved if the patient has either of the following contraindications:

- Hypersensitivity to any botulinum toxin products, cow's milk protein, or any other components in the formulation
- Infection at the proposed injection site(s)

22.10.4 Myobloc®

Procedure Code: J0587

22.10.4.1 Covered Services

Botulinum toxin type B (fimabotulintoxinB [Myobloc®]) for the treatment of the following conditions and are considered medically necessary when specific criteria is met.

22.10.4.2 Billing Requirements

Prior authorization requirements *see Section 6.12* Prior Authorization:

Wyoming Medicaid considers Botulinum toxin B (fimabotulintoxinB [Myobloc®] appropriate for the treatment of the following conditions and meet medical necessity criteria where it is stated:

- Cervical dystonia with ALL the following:
  - Moderate or greater severity
  - At least 2 muscles involved
  - Absent of neck contractures (or other causes of decreased neck range of motion)
  - Absent history of other neuromuscular disorder
- Chronic Sialorrhea in adults

> **Myobloc®** can only be requested one (1) session at a time, with medical necessity provided for each session.

Myobloc should not be administered and will not be approved if the patient has either of the following contraindications:

- Hypersensitivity to any botulinum toxin products, cow's milk protein, or any other components in the formulation
- Infection at the proposed injection site(s)

22.10.5 Ocrelizumab (Ocrevus)

Procedure Code: **J2350 - ONLY NDC Approved 50242.0150.01**

22.10.5.1 Covered Services

Ocrelizumab (Ocrevus) is used for the treatment of Members with relapsing or primary progressive forms of multiple sclerosis and is considered medically necessary if the prior authorization criterion is met.

22.10.5.2 Billing Requirements

Prior Authorization Requirements *see Section 6.12* Prior Authorization:

Quantity Limits and PA issuance:

- Products comes as 300 mg/10 ml, single dose vial
- A single PA will be provided in 600 mg increments.
    - Member receives initial does of 300 mg (IV), with a second 300 mg dose two weeks later.
    - Subsequent dose is 600 mg every six (6) months

INITIAL PA APPROVAL

- Ocrelizumab for the treatment of relapsing or primary progressive forms of multiple sclerosis is considered medically necessary if ALL the following criteria are met:
    - Individual is 18 years of age and older
    - Individual must have clear, documented indication for therapy
    - Individual must be screened for and is without active hepatitis B viral infection prior to initial dose
    - A diagnosis of ANY ONE of the following:
        - Primary Progressive MS (PPMS)
            - Indications: For PPMS – This is the only agent that is FDA approved.
        - Relapsing Form of MS (RMS)
            - Patient has had adequate trials with **two** drugs from Wyoming Medicaid's preferred Drug list; **Avonex, Betaseron, Rebif, Copaxone, or Gilenya** and the preferred drugs were ineffective or caused intolerable adverse side effects. An adequate trial is eight weeks of therapy where a Member was compliant and adherent to the regimen.

RENEWAL PA CRITERIA

- Ocrelizumab is considered medically necessary for renewal only when ALL the following criteria are met:

- Documents adherence to the regimen, with no adverse side effects warranting discontinuation of therapy
- Absence of unacceptable toxicity from the agent (for example, severe upper respiratory tract infections, lower respiratory tract infections, skin infections, herpes-related infections, bronchospasm, pharyngeal or laryngeal edema, hypotension, headache, dyspnea, pyrexia, tachycardia)
- Absence of active hepatitis B infection
- Evidence of ANY ONE of the following:
  - Diagnosis of primary progressive multiple sclerosis (PPMS) shows maintenance of baseline or reduction of confirmed disability progression
  - Diagnosis of relapsing forms of multiple sclerosis (RMS) show relative reduction in annual relapse rate (ARR) to baseline

Reason(s) for denial of PA request

- Unclear indication
- Member with Relapsing-Remitting Multiple Sclerosis (RRMS) has not completed adequate trials with two (2) preferred drugs
- Active hepatitis B virus infection
- History of life-threatening infusion reaction

22.10.6 Hyaluronic Acid Derivatives Injections

Procedure Code: **J7321-J7326**

22.10.6.1 Covered Services

Hyaluronic Acid Derivatives are injected directly into the knee joint to improve lubrication and reduce the pain associated with osteoarthritis of the knee. Hyaluronic Acid Derivatives are subject to prior authorization as well as step therapy. When prior authorization criteria are met and approval given, step therapy must still be followed. The FDA has not approved intra-articular hyaluronan for joints other than the knee.

22.10.6.2 Limitations

- **Euflexxa®:** Is injected into the affected knee, 20 mg once (1) weekly for three (3) weeks, a total of three (3) injections
- **Synvisc One®:** Is injected into the affected knee, 48 mg for one (1) dose only
- **Synvisc:** Is injected into the affected knee, 16 mg once weekly for three (3) weeks, a total of three (3) injections

- **Hyalgan®:** Is injected into the affected knee, 20 mg once (1) weekly for a total of five (5) injections
- **Orthovisc:** Is injected into the affected knee, 30 mg once (1) weekly for three (3) or four (4) injections
- **Supartz®:** Is injected into the affected knee, 25 mg once (1) weekly for a total of five (5) injections
- **Gel-One®:** Is injected into the affected knee, 30 mg, for one (1) dose only

22.10.6.3 Billing Requirements

Prior Authorization requirements *see Section 6.12* Prior Authorization:

Wyoming Medicaid considers Hyaluronic Acid Derivative injections as medically necessary when all the following are met and are clearly documented in the medical record, operative report, or pathology report. ALL the following criteria must be met for approval of coverage:

- Documented diagnosis of symptomatic osteoarthritis of the knee
- Pain interferes with functional activities such as ambulation and prolonged standing
- Trial of conservative nonpharmacologic treatment, (education, physical therapy, weight loss if appropriate) has not resulted in functional improvement. **Medical records documenting these therapies must be submitted.**
- Trial of pharmacotherapy (NSAIDs, COX II Inhibitors, acetaminophen) has not resulted in functional improvement
- Prior therapy with at least one (1) intra-articular corticosteroid injection

Repeat doses of any viscosupplement will be approved only when the following criteria are met:

- At least six (6) months has elapsed since the previous injection or the last injection of the prior series
- Medical records must document significant improvement in pain and functional capacity of the knee joint

22.10.7 Reslizumab (CINQAIR)

Procedure Code: **J2786 - ONLY NDC Approved 59310.0610.31**

22.10.7.1 Covered Services

Reslizumab is the treatment for severe asthma and is covered when the following conditions in the billing requirements section are met.

22.10.7.2 Limitations:

- One infusion every 4 weeks when documented improvement is present

22.10.7.3 Billing Requirements

Prior authorization (PA) requirements (*see Section 6.12* Prior Authorization):

- Member must be 18 years and older on the date of prior authorization request
- Must be an add on maintenance treatment for patients with severe asthma and an eosinophilic phenotype
- The patient does NOT have any one (1) of the following:
    - Other eosinophilic conditions
    - Known hypersensitivity to Reslizumab or any of its excipients
    - Acute asthma symptoms
    - Acute exacerbations
    - Acute bronchospasms
    - Status asthmaticus
- Individuals must be clear from pre-existing helminth infection prior to initial dose
- Blood eosinophil count of >400 cells/mcL within 3 to 4 weeks of dosing (other symptoms of eosinophil phenotype may be considered on an individual basis)
- Severe asthma that is inadequately controlled despite standard of care (medium to high dose inhaled corticosteroids with long-acting beta agonists)
    - Symptoms at least >2 days a week
        - Decreased forced expiratory volume in 1 second (FEV1) by 20% or more from baseline
        - Decreased peak expiratory flow rate (PEFR) by 30% or more from baseline
    - Short acting beta agonist use for symptom control at least > 2 days a week
    - Severe interference with daily activities – well documented
- At least 1 asthma exacerbation requiring use of oral (systemic) corticosteroids over the last 12 months
- Compromised lung function

22.10.8 Tysabri®

Procedure Code: **J2323**

22.10.8.1 Covered Services

Tysabri® is a monotherapy treatment for relapsing forms of Multiple Sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.

Tysabri® is a treatment for inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn's Disease (CD).

> Tysabri® increases the risk of Progressive Multifocal Leukoencephalopathy (PML), an opportunistic viral infection of the brain that usually leads to death or severe disability.

22.10.8.2 Documentation Requirements

Multiple Sclerosis and Crohn's Disease Prior Authorization (PA) requirements (*see Section 6.12* Prior Authorization):

- Physician's prescription
- Must document an inadequate response to, or inability to tolerate an appropriate trial with at least one (1) of the following interferon agents:
  - Betaseron
  - Avonex
  - Rebif
  - Copaxone
  - This documentation **must** include information that states when the drug(s) was started and discontinued, and the reason the drug(s) was discontinued.
- Documentation must state the date the treating Provider and patient were enrolled in the Touch Program, and both must meet all eligibility requirements of that program. As of 11/18/2015, the first infusion can be documented with Initial Notice of Patient Authorization.

22.10.8.3 Billing Requirements

MS specific PA requirements (*see Section 6.12* Prior Authorization):

- Tysabri® must be prescribed by a neurologist enrolled in the Touch Program
- Both the Provider administering the Tysabri® and the patient receiving the Tysabri® must be enrolled in the Touch Program
- Medicaid will only authorize Tysabri® for Members that have a diagnosis of MS
- For continued PA the neurologist must submit documentation to show improvement or stabilization

- Length of PA: 12 months
- Dosage: 300 mg IV infusion every four (4) weeks
- Must be billed using the NDC number and the appropriate J-code

> Medicaid will not cover Tysabri® when used in conjunction with other medications for the treatment of progressive MS.

CD specific PA requirements (*see Section 6.12* Prior Authorization):

- Tysabri® must be prescribed by a neurologist enrolled in the Touch Program
- Both the Provider administering the Tysabri® and the patient receiving the Tysabri® must be enrolled in the Touch Program
- Patient is NOT currently taking immunosuppressant (for example, 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or inhibitors of TNF-α
- For continued PA the neurologist must submit documentation to show improvement or stabilization
- Length of PA: 12 months
- Dosage: 300 mg IV infusion every four (4) weeks
- Must be billed using the NDC number and the appropriate J-code

22.11 Interpretation Services

Procedure Code: **T1013**

Interpreter services are paid to enrolled providers who performs and bills for the medical visit, and also bills for the interpreter service as an auxiliary aid or service to the medical visit.

> Effective July 1, 2023, Wyoming Medicaid enrolled interpreters will no longer be able to bill Wyoming Medicaid directly for interpreter services. The Centers for Medicare and Medicaid Services (CMS) has stated that interpreters cannot be enrolled as Medicaid qualified providers or paid directly by Medicaid.

22.11.1 ADA Requirements

Title II and Title III of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-34 & 12181-89, prohibits discrimination on the basis of disability in a range of covered areas, including healthcare services. The ADA applies to all types of private and state and local government healthcare providers, including, but not limited to, hospitals, skilled nursing facilities, urgent care centers, physicians, dentists, optometrists, mental health providers, and medical equipment providers. Further, the ADA applies to all

services that covered entities provide, including in-person medical services, telehealth appointments and websites.

Pursuant to the ADA, healthcare providers are required to ensure that communication with people with disabilities is as effective as communication with people without disabilities. Healthcare providers are required to take affirmative steps including furnishing appropriate auxiliary aids and services, such as qualified sign language interpreters to individuals who are deaf or hard of hearing, accessible electronic technology to individuals who are blind or have low vision, and speech-to-speech translators for individuals who have speech disabilities. Further, healthcare providers may not decline to provide treatment to an individual solely because they have a disability and may need auxiliary aids and services.

Providers must:

- Furnish appropriate auxiliary aids and services where necessary to ensure that communications with patients, companions, and members of the public who are deaf or hard of hearing are as effective as communications with others;
- Review its policy and any related procedures and make any revisions necessary to ensure it is taking any necessary steps to provide effective communication with patients and companions who are deaf or hard of hearing;
- Give primary consideration to the request of a patient or companion who is deaf or hard of hearing;
- Document any assessments conducted for auxiliary aids and services in a patient's record;
- Create an auxiliary aid and service denial log; and
- Train all staff regarding the requirement to ensure effective communication with patients and companions who are deaf or hard of hearing, are blind or have low vision, or have a speech disability.

22.11.2 Limited English Proficiency (LEP)

Title VI and Department of Health and Human Services regulations, 45 C.F.R. § 80.3(b)(2), require recipients of Federal financial assistance from HHS to take reasonable steps to provide meaningful access to Limited English Proficient (LEP) persons. Recipients of HHS assistance may include hospitals, nursing homes, home health agencies, managed care organizations, universities and other entities with health or social service research programs, state, county, and local health agencies. It may also include state Medicaid agencies, state, county, and local welfare agencies, programs for families, youth, and children, Head Start programs, public and private contractors, subcontractors, and vendors, and physicians and other providers who receive federal financial assistance from HHS.

Recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. The obligation to provide meaningful access is fact-dependent and starts with an individualized assessment that balances four factors: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the recipient; (2) the frequency with which LEP

individuals come into contact with the program; (3) the nature and importance of the program, activity, or service provided by the recipient to its beneficiaries; and (4) the resources available to the grantee or recipient and the costs of interpretation and translation services. There is no "one size fits all" solution for Title VI compliance with respect to LEP persons, and what constitutes "reasonable steps" for large providers may not be reasonable where small providers are concerned.

For more information visit https://www.hhs.gov/civil-rights/for-providers/laws-regulationsguidance/guidance-federal-financial-assistance-title-vi/index.htm.

22.11.3 Covered Services

The medical Provider may only bill Medicaid for time spent with the Member in conjunction with the Medicaid healthcare services.

22.11.4 Non-Covered Services

Services Medicaid will not reimburse providers include the following:

- Inpatient or outpatient hospital services
- Intermediate Care Facilities for persons with Intellectual Disability (ICF-ID)
- Nursing facilities
- Ambulance services by public Providers
- Psychiatric Residential Treatment Facilities (PRTF)
- Comprehensive inpatient or outpatient rehabilitation facilities
- Other agencies and organizations receiving direct federal funding
- Interpreter services provided by family members or by a volunteer, associate, or friend
- Reimbursement for travel to and from the appointment
- Services provided to a Member on an ALEN program that are not emergency services

22.11.5 Billing Procedures

An interpreter used by a Wyoming enrolled Provider must adhere to national standards developed by the National Council on Interpreting in Healthcare (NCIHC).

A need for an interpreter is indicated by a Member and the Provider. The Provider may have their own interpreter Provider or one can be found at Wyoming Department of Health, Health Equity Information and Resources home page (https://health.wyo.gov/publichealth/office-of-performance-improvement-and-health-equity/multicultural/cultural/).

- Wyoming Medicaid only pays for the time spent with the Member
- The procedure code for interpretation services is T1013 when billed as an auxiliary aid or service with the medical visit's billed CPT code

- One (1) unit = 15 minutes
- When not providing services in-person, the GT modifier must be used

Additional information and resources are located at the Wyoming Department of Health, Health Equity Information and Resources home page (https://health.wyo.gov/publichealth/office-of-performance-improvement-and-health-equity/multicultural/cultural/).

Federal guidance are located at Americans with Disabilities Act.Gov, ADA Business Brief: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings (https://archive.ada.gov/hospcombr.htm).

22.11.6 Required Documentation

Documentation supporting the need for an interpreter must be in the patient's file.

Providers must maintain documentation to support that the service occurred. This includes (at minimum) the Member's name, date of service, times in and out, service provided, and signature of Provider.

22.12 Laboratory Services

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

Medicaid covers tests provided by independent (non-hospital) clinical laboratories when the following requirements are met:

- Services are ordered and provided by physicians, dentists, or other Providers within their scope practice as defined by law
- Services are provided in an office or other similar facility, but not in a hospital outpatient department or clinic
- Providers of lab services must be Medicaid certified.
- Providers of lab services must have a current Clinical Laboratory Improvement Amendments (CLIA) certification number
- Providers may bill Medicaid only for those lab services they have performed themselves. **Medicaid does not allow pass-through billing.**
- Services performed in a separate lab or hospital would need to be billed by the Provider performing the services, not the Provider ordering the services

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

22.12.1 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 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 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						
REGISTRATION, COMPLIANCE, OR ACCREDITATION (LABORATORY) (1)	G0103	G0123	G0124	G0141	G0143	G0144	G0145
	G0147	G0148	G0306	G0307	G0328	G0416	G0432
	G0433	G0434	G9143	P3000	17311	17312	17313
	17314	17315	78110	78111	78120	78121	78122
	78130	78191	78270	78271	78272		
	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)	80047 QW	80048 QW	80051 QW	80053 QW	80061 QW	80069 QW	80178 QW
	81003 QW	81007 QW	82010 QW	82040 QW	82043 QW	82044 QW	82120 QW
	82150 QW	82247 QW	82271 QW	82274 QW	82310 QW	82330 QW	82374 QW
	82435 QW	82465 QW	82523 QW	82550 QW	82565 QW	82570 QW	82679 QW
	82947 QW	82950 QW	82951 QW	82952 QW	82977 QW	82985 QW	83001 QW
	83002 QW	83036 QW	83037 QW	83516 QW	83605 QW	83655 QW	83718 QW
	83721 QW	83861 QW	83880 QW	83986 QW	84075 QW	84132 QW	84155 QW
	84295 QW	84443 QW	84450 QW	84460 QW	84478 QW	84520 QW	84550 QW

CLIA CERTIFICATE TYPE	ALLOWED TO BILL						
	84703 QW	85014 QW	85018 QW	85576 QW	85610 QW	86294 QW	86308 QW
	86318 QW	86386 QW	86618 QW	86701 QW	86803 QW	87077 QW	87210 QW
	87449 QW	87804 QW	87807 QW	87808 QW	87809 QW	87880 QW	87899 QW
	89300 QW	89321 QW	G0328 QW	G0433 QW	G0434 QW	G0477 QW	81002
	81025	82270	82272	82962	83026	84830	85013
	85651						
	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)						

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

CODES EXCLUDED FROM CLIA REQUIREMENTS									
80500	80502	81050	82075	83013	83014	83987	84061	86077	86078
86079	86485	86486	86490	86510	86580	86891	86910	86923	86927
86930	86931	86932	86945	86950	86960	86965	86985	86999	87900
88125	88240	88241	88304 TC	88305 TC	88311	88312 TC	88313 TC	88314 TC	88329
88720	88738	88741	88749	89049	89220	89240	89251	89255	89261
89272	89281	89290	89354	89398					

22.12.2 Genetic Testing

Procedure Codes: **81200-81599; 96040**

Prior Authorization (*see Section 6.12* Prior Authorization**) is required for all genetic testing codes, except 81420 and 81507. Prior authorization documentation must document the following:**

22.12.2.1 Covered Services

Medicaid covers genetic testing under the following conditions:

- There is reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists; AND
- Test results will influence decisions concerning disease treatment or prevention (in ways that not knowing the test results would not); AND
- 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; AND
- Referral is made by a genetic specialist (codes 81223 and 81224) or a specialist in the field of the condition to be tested; AND
- All other methods of testing and diagnosis have met without success to determine the Member's condition such that medically appropriate treatment can 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 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 (for example, psychological, social, limitations of nondiscrimination statutes)
    - Discussion of possible test outcomes (such as, positive, negative, variant of uncertain significance)
    - Explanation of potential benefits, risks, and limitations of testing
    - Explanation of purpose of evaluation (for example, 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 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, 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

22.12.2.2 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 81211-81217). 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; AND
- Documentation indicates a genetic counseling visit pre or post testing.

22.13 Maternity Care

Procedure Code Range: **59000-59898, 0500F, 0503F**

Maternity services include antepartum, delivery & postpartum care of a pregnant woman, according to guidelines set forth in the current edition of the CPT-4 book.

A licensed Midwife can perform services under the scope of their license that are also a covered service under Wyoming Medicaid. Please see the fee schedule for covered services by taxonomy as well as percent of physician charges.

Maternal Depression Screening Codes and Policy effective 06.01.19:

- **96127 –** BRIEF EMOTIONAL/BEHAV ASSMT - Can be billed under the mother's Id, this is most likely to occur and be billed during the six week post - partum visit. The fee has been established at $5.89
- **96161 –** CAREGIVER HEALTH RISK ASSMT - Can be billed under the baby's id number during the EPSDT visit for the first year. The fee has been established at $5.89

22.13.1 Obstetric Care Reporting

Procedure Code: 0500F

All pregnancies should be reported using this code. When a woman has her first obstetric visit, bill 0500F using the first visit's date as the date of service, even if the Provider plans to bill using a global maternity code. This should be reported as soon as possible after the first obstetrical care visit for Wyoming Medicaid to be notified of the Member's pregnancy. 0500F should only be reported once per pregnancy.

22.13.2 Postpartum Care Reporting Code

22.13.2.1 Claims with Dates of Service of 02/01/2021 – 06/30/2021

Providers billing maternity global codes (59400, 59610, 59510, or 59618) need to wait until after the postpartum visit has occurred. On the same claim with the global code or billed on a separate claim prior to or within 15 days after the global claim, the Provider needs to bill code 0503F with the date of service for the postpartum visit. This code will not pay anything additional, it is informational only. Any claims with dates of service 02/01/2021 through 06/30/2021 will deny if this code is not present on the claim or billed on a separate claim prior to or within 15 days after the global claim.

As a reminder, it is inappropriate to bill the global code unless all three components – antepartum, delivery, and postpartum care – are delivered by the same Provider/Provider's group. It is also inappropriate to bill the components separately if billing the requirements to bill the global code have been met

> Postpartum care is office-based care at approximately 6 weeks from delivery. However, it may be sooner or later based on the patient's medical needs.

22.13.2.2 Claims with Dates of Service 07/01/2021 and Later

Global maternity codes (59400, 59610, 59510, and 59618) covers only the prenatal care and delivery, and can be billed after the baby's delivery. Postpartum care is billed out separately when it occurs.

> If a Member has other insurance which has paid on the global care code and includes the postpartum care such that Providers cannot bill it separately to the other insurance, the Provider needs to bill code 0503F in addition to the global care code. This code is only allowed when other insurance has paid on the global code. 0503F reimburses the same as the standard postpartum care code 59430.

Postpartum care codes should only be billed after the office based postpartum visit has occurred. Postpartum care cannot be billed in advance.

22.13.3 Billing Requirements

22.13.3.1 Global Care for Routine Obstetric Care

According to the AMA, if the global care is provided by the same physician or same physician group, then the appropriate global code must be reported. Global services are to be billed in all cases of a single physician or group providing uncomplicated maternity care.

- **59400:** Routine OB care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care. Medicaid will reimburse only for antepartum care and delivery under this code, postpartum care will be billed separately.
- **59510:** Routine OB care including antepartum care, cesarean delivery and postpartum. Medicaid will reimburse only for antepartum care and delivery under this code, postpartum care will be billed separately.
- **59610:** Routine OB care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous C-section. Medicaid will reimburse for only antepartum care and deliver under this code; postpartum care will be billed separately.
- **59618:** Routine OB care including antepartum care, C-section and postpartum care, following attempted vaginal delivery after previous C-section. Medicaid will reimburse for only antepartum care and deliver under this code; postpartum care will be billed separately.

> The E&M services (visits) provided within the Global package are included in the antepartum care and are not to be coded separately. The date of service is the date of delivery.

The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. Antepartum care includes:

- The initial and subsequent visits
- Physical examination
- Recording of the weight, blood pressures, and fetal heart tones
- Routine chemical urinalysis
- Monthly visits up to 28-week's gestation, biweekly visits to 36 week's gestation, and then weekly visits until delivery

Maternity Billing Guidance:

For Provider supplying all of the prenatal care and delivery services for a Member who does not have other insurance:

- Bill the appropriate global billing code (such as 59400, 59610, 59510, or 59618)
- Bill the appropriate postpartum care code (such as 59430)

For Providers supplying all of the prenatal care and delivery services for a Member who has other insurance:

- Bill the global code to the other insurance according to their guidance (such as 59400, 59610, 59510, and 59618), then bill Wyoming Medicaid as secondary.
    - If the other insurance DOES NOT include postpartum in global, bill the postpartum care to the other insurance according to their guidance then bill Wyoming Medicaid as secondary.
    - If the other insurance DOES include postpartum care in the global reimbursement, bill the postpartum care directly to Wyoming Medicaid under code 0503F.

For Providers who do not provide all of the prenatal care and delivery services, bill each service under the appropriate codes (*see Section 22.13.3.2* Non-Global Services for Routine Obstetric Care).

22.13.3.2 Non-Global Services for Routine Obstetric Care

Use the following billing procedures when a patient is seen by a different physician or a different physician group for their antepartum care:

- If the total antepartum visits with the patient is 1-3, bill the appropriate E&M (Evaluation and Management) code for each visit
- Bill only one (1) of the following two (2) antepartum procedure codes (depending on the total number of antepartum visits):
    - **59425:** Antepartum care only; four (4) to six (6) visits. This code would be used in the case where the patient was only seen for four (4) to six (6) visits and then quit seeing that Provider. The Provider would not be providing services of delivery or postpartum care. If the

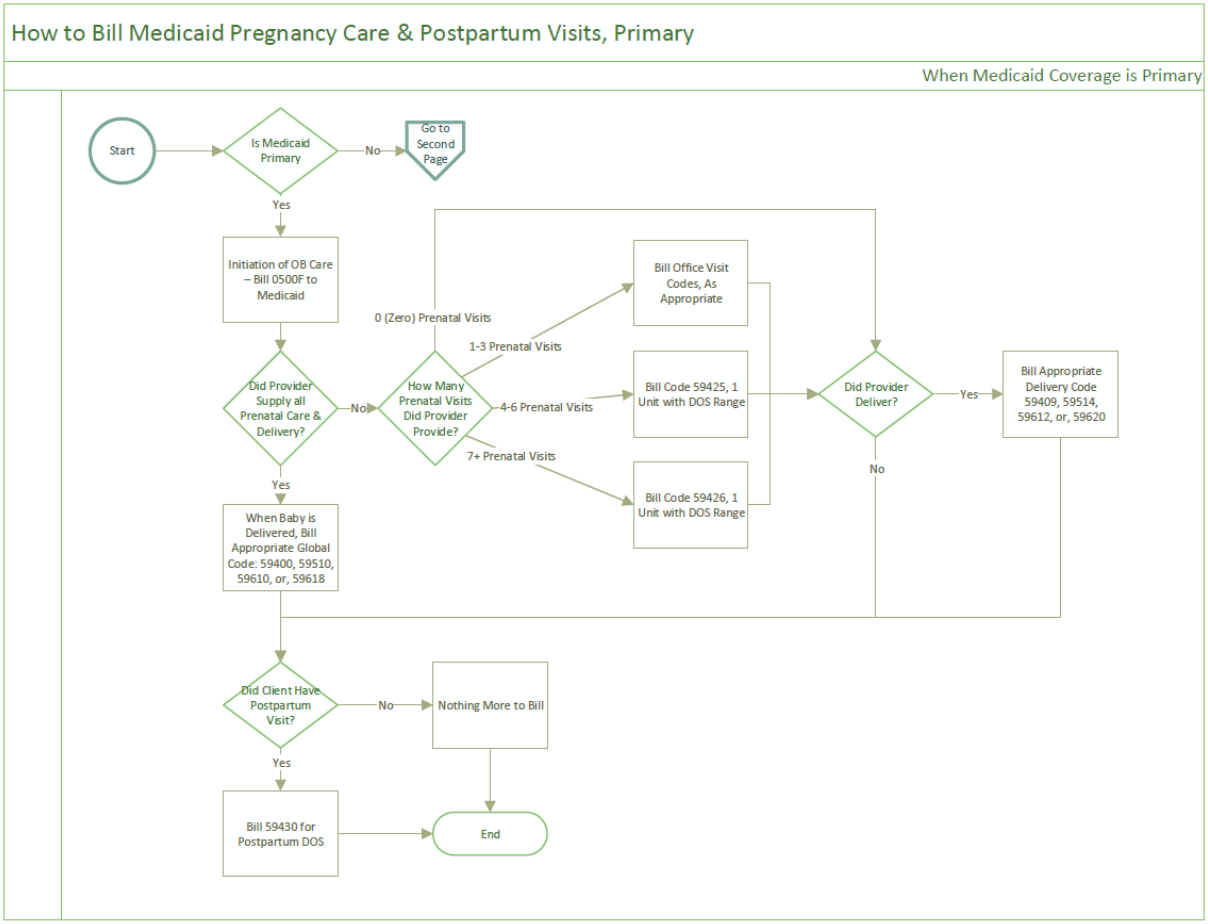
Provider saw the patient at least four (4) times and no more than six (6) times, this is the correct code the Provider would submit.

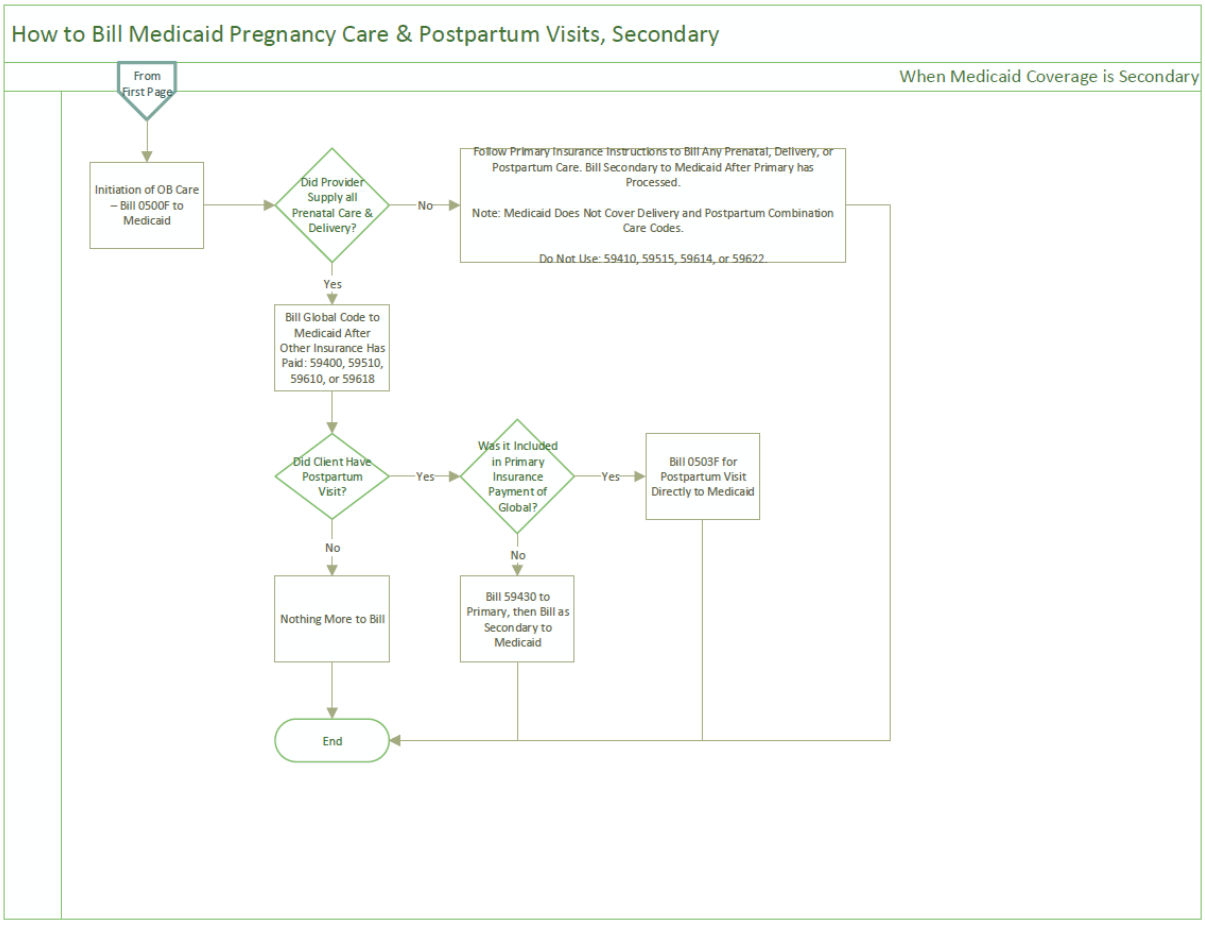
- **59426:** Antepartum care only; seven (7) or more visits. This code would be used for the patient who was seen for seven (7) or more antepartum visits, but the Provider did not provide services for delivery or postpartum care.

- Bill procedure code 59430 for postpartum care only (separate procedure). This code is to be used when the Provider did not provide the service of the delivery, but they may have provided the antepartum care.

> It is not appropriate to separately report the antepartum, delivery and postpartum care when provided by the same physician or same physician group. However, any other visits or services provided within the antepartum period, other than those listed above, should be coded and reported separately. The date of service is the date of delivery.

22.13.3.3 Maternity Care Billing Guidance





22.13.3.4 Patient Has Other Medical Conditions, or a Complicated Pregnancy

Use the following billing procedures when the patient has other medical conditions, or a complicated pregnancy:

- If the Provider needs to treat the patient for additional services due to complication of pregnancy, use the proper CPT and ICD codes to reflect the complication
- If the Provider attempts to bill a separate E&M visit and only code the encounter as a normal pregnancy code, the claim will be denied and considered unbundling of the Global Maternity package

These codes cover attendance at delivery when requested by the Provider delivering and initial stabilization of newborn. These codes may be reported in addition to the CPT-4 code for history and examination, but not in addition to the newborn resuscitation code.

When billing for a twin delivery, modifier 22 should be added to the appropriate global or delivery code and documentation must accompany the claim. Assisting Providers should bill for just the delivery with appropriate modifiers. Providers cannot bill two (2) separate delivery codes for the delivery of twins except, when one (1) twin is delivered vaginally and the other by cesarean.

Pregnancies that terminate in abortion/miscarriage in any trimester must bill with the appropriate CPT-4 code and documentation is required. Prenatal visits and additional services may be billed in addition to the abortion code.

> When billing for an assistant surgeon at a delivery, use the procedure code for delivery only with an 80 or AS modifier as appropriate. *See Section 6.15.1* Sterilization Consent Form and Guidelines for more information if the Member is considering sterilization.

22.13.3.5 Elective Inductions and Medical Necessity

Induction of labor for medical reasons is appropriate when there may be health risks to the woman or baby if the pregnancy were to continue. Some indications for inducing labor include:

- High blood pressure caused by the pregnancy
- Maternal health problems affecting the pregnancy
- Infection in the uterus
- Water has broken too early
- Fetal growth problems

Documentation, which substantiates that the patient'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.

Induction is not a covered service unless it meets the guidelines listed above. Inductions without medical necessity will be subject to post pay reviews and possible recoupment of payments to both the physician and hospital.

22.13.3.6 Obstetrical Ultrasound

Procedure Code Range: **76801-76828**

Acceptable Modifiers: **TC, 22, 26 and 52**

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

Post-payment review will be conducted on obstetrical ultrasound claims after payment is made to the Provider to ensure claims meet the Medicaid policies contained in this manual.

22.14 Medical Supplies (Disposable)

Procedure Code: 99070

Disposable medical supplies are intended for one (1) time use, not re-use, and specifically related to the active treatment or therapy of the Member for a medical illness or physical condition. These supplies have a medical purpose, are consumable and/or expendable and non-durable. This does not include personal care items. They are not to be confused with durable medical supplies/equipment. The following is a partial list:

- Ace bandage
- Sling
- Rib belt
- Straight Catheter Kit
- Surgical tray

Reimbursement may be allowed for a surgical tray if minor surgery necessitates local anesthesia and other supplies (such as, gauze, sterile equipment, suturing material) and the surgery is performed in the Provider's office. Examples of procedures requiring a major surgical tray include:

- Diagnosis biopsies
- Wound closures
- Removal of cysts or other lesions

Expendable medical supplies such as gauze, dressing, syringes, and culture plates, are included in the reimbursement rate for the office visit or test performed. The most accurate way to verify coverage for a specific service/supply is to review the fee schedule on the Medicaid website (see *Section 2.1* Quick Reference).

Supplies and materials, which do not have procedure codes, may be billed with CPT code 99070, which will reimburse billed charge up to $10.00. Claims for more than $10.00 require an attached invoice.

Claims with dates of service prior to 01/01/2021 will be reimbursed at invoice cost, plus shipping and handling, plus 15%. Claims with dates of service 01/01/2021 and forward with be reimbursed at invoice cost, plus shipping and handling, plus 12.13%. Claims billed with this code will be subject to pre- and post-payment review (see *Section 6.14* Submitting Attachments for Electronic Claims).

> Provider documentation must clearly state the supply or supplies being billed with the 99070 code.

22.15 Phototherapy for High Bilirubin Levels

Procedure Code: E0202 RR

Effective with dates of service April 1, 2015 and forward, in order to provide better access to home therapy for newborns with high bilirubin levels, and reduce the number of hospital readmissions for Wyoming Medicaid infants, Wyoming Medicaid will be allowing the below taxonomies to bill the E0202 RR (phototherapy – rental) HCPCS code.

- All physicians (20s)
- Nurse Practitioners (363Ls, 367A00000X)
- Durable Medical Equipment Suppliers (332B00000X)
- Public Health Nurse's Offices (251K00000X)

22.15.1 Billing Requirements

Procedure code E0202 with the RR (rental only) modifier may be billed using daily units with a maximum of five (5) per lifetime.

Practitioner services, such as home or office-based visits, home health visits, lab tests, and so on, should be billed as appropriate in addition to the rental of the Biliblanket or other phototherapy device.

For clinical requirements, refer to the DME Covered Services Manual on the website (see *Section 2.1* Quick Reference).

22.15.2 Phototherapy Maximum Allowable Appeal Process

Wyoming Medicaid encourages Providers to submit the initial claim to receive reimbursement for the initial five (5) days. Then, when appealing, submit an Adjustment/Void Request Form (*see Section 6.17.3.3* Adjustment/Void Request Form) with a corrected claim that has the additional units included along with medical necessity and an appeal letter to the below address.

Providers may choose to submit only one (1) claim which includes the additional units along with the medical necessity and the appeal letter to:

Division of Healthcare Financing

122 West 25th St, 4th Floor West,

Attn: DME Provider Services Manager

Cheyenne, WY 82002

22.16 EPSDT Personal Care Services

Personal care services (PCS) are provided to eligible beneficiaries to help them stay in their own homes and communities rather than live in institutional settings, such as nursing homes. PCS are allowed for children and adolescents under that age of 21 year through EPSDT. The service must be ordered by a physician and medically necessary. *See Section 16.2.3* of the *Institutional Manual* posted on the Medicaid website for more details.

22.17 Podiatry Services

Podiatry is the care and treatment of bones, soft tissues, and joints of the foot and ankle. This includes skin conditions and abnormal mechanics of the lower extremities. Podiatrists' services may overlap with other medical practitioners including orthopedist and dermatologists. Covered services are limited to medically necessary diagnostic, laboratory, radiological, and surgical procedures required for condition of the feet when provided by a medical practitioner. Consultations, routine foot care, preventative, or reconstructive procedures and screenings, x-rays, laboratory work, or similar services are not covered unless specifically required by the foot condition.

Effective July 1, 2023 Wyoming Medicaid will reimburse enrolled podiatrists for medically necessary services provided to Medicaid eligible Members.

- Previously, Wyoming Medicaid reimbursed for Medicare Part B crossover claims only. Members receiving services prior to July 1, 2023 must be dual eligible (Medicare and Medicaid).

22.18 Practitioner Visits

Procedure Code Range: **99201-99443**

Practitioner services are provided in inpatient and outpatient settings and include:

- Consultation services
- Emergency department services
- Home visits
- Hospital services
- Nursing facilities
- Office visits
- Telephone services

> Practitioner services provided to a Member between ages 22 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.

22.18.1 New Patient

Procedure Code Range: **99201-99205**

Medicaid considers a new patient to be a patient who is new to the practitioner and whose medical and administrative records need to be established. A new patient visit should be submitted once per patient lifetime per Provider. An exception may be allowed when a patient has been absent for a period of three (3) years, or more.

22.18.2 Established Patient

Procedure Code Range: **99211-99215**

Medicaid considers an established patient to be a patient that has been seen by the practitioner and whose medical and administrative records have been established.

22.18.3 After Hours Services

Medicaid reimburses physicians and practitioners who see Members in their offices rather than the emergency room, when appropriate. The following codes are only to be used when the Member is seen

in the physician/practitioner's office. The following codes may be billed in addition to Evaluation and Management codes.

Physician/Practitioner's After Hours Billing Codes	
CPT-4 Code	**Description**
99050	Services provided in the office times other than regularly scheduled office hours, or days when the office is normally closed (for example, holidays, Saturday, or Sunday) in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

Do not use these codes for seeing Members in the emergency room.

22.18.4 Consultation Services

Procedure Code Range: **99241-99245**

Consultation services are when a practitioner's opinion or advice is sought by another practitioner for further evaluation and/or management of a Member for a specific problem.

22.18.4.1 Billing Requirements

- The request and need for a consultation from the attending practitioner, along with the consultant's opinion and any service that was ordered or performed, must be documented in the Member's record and communicated to the requesting practitioner
- If subsequent to the completion of a consultation, the consultant assumes responsibility for management of all or a portion of the Member's condition(s), the follow-up consultation codes should not be used
- If an additional request for an opinion or advice regarding the same or new problem is received from the attending practitioner and documented in the medical record, the office consultation codes may be used again
- When billing for a consultation, the NPI of the referring practitioner must be provided on the claim

For an accurate listing of codes, refer to the fee schedule on the Medicaid website (see *Section 2.1* Quick Reference).

22.18.4.2 Documentation

Medicaid requires Documentation of Medical Necessity (*see Section 3.4* Medical Necessity) to be attached to a claim submitted by the consulting practitioner when a Member is seen for an additional consultation within one (1) year of the initial consultation.

22.18.5 Emergency Department Services

Procedure Code Range: **99281-99288**

Emergency department services provide evaluation, management, treatment, and prevention of unexpected illnesses or injuries. Emergency Department is defined as an organized hospital-based facility for the provision of unscheduled, episodic services to Members who present themselves for immediate attention. The facility must be available 24 hours a day.

22.18.5.1 Covered Services

Medicaid covers practitioner services performed by:

- A hospital-based emergency room practitioner
- A private practitioner who furnished emergency room services through arrangement with the hospital, OR
- A private practitioner who is called to the hospital to treat an emergency

The practitioner must document in the Member's medical record if the Member's visit to the emergency room was actually an emergency situation.

> Practitioners are requested to report any potential abuse of emergency room visits to WYhealth (see *Section 2.1* Quick Reference).

22.18.6 Home Visits

Procedure Code Range: **99341-99350**

Home visits are evaluation and management services provided by a practitioner in a private residence.

This benefit is not intended to replace those services available in the community through other agency programs, (Best Beginnings, Public Health Nurse, Home Health, and so on) but to offer the attending practitioner another alternative to care for Members.

22.18.6.1 Documentation

The following documentation must be included in the Member's medical record:

- Documentation of practitioner orders and treatment plan of care

- Documentation of observed medical condition, progress at each visit, any change in treatment, and the Member's response to treatment
- Documentation of coordination of care between office and home visit

22.18.6.2 Limitations

- Medicaid will reimburse the admitting practitioner for only one (1) initial visit per Member for each hospital stay
- A comprehensive inpatient hospital visit is not allowed within 30 days of a previous hospital admission with the same diagnosis
- Medicaid will not reimburse a comprehensive hospital inpatient exam on the same day as an office visit, nursing home visit or ER visit by the same Provider

> For initial inpatient encounters by practitioners other than the admitting practitioner use initial inpatient consultation codes or subsequent hospital care codes.

22.18.6.3 Billing Requirements

- **Initial Hospital Care (99221-99223):** All E&M services (for example, office visits) related to and provided on the same date as an inpatient hospital admission are considered part of that hospital admission
- **Subsequent Hospital Care (99231-99233):** Subsequent visits are limited to one (1) visit per day unless a Documentation of Medical Necessity is attached and approved by Medicaid. All subsequent hospital care visits are to include the medical record and the results of diagnostic studies and changes in the status since the last assessment by the practitioner (*see Section 3.4* Medical Necessity).
- **Observation or Inpatient Care Services (99234-99236):** These codes are used when the Member is admitted and discharged on the same day. These codes are used to report observation or inpatient hospital care services provided to Members admitted and discharged on the same date of service. It is not required that the Member be located in an observation area designated by the hospital as a separate unit. These codes are to be used based on the level of care the Member received rather than location.
- **Hospital Discharge Services (99238-99239):** Practitioners may bill for the final day of an inpatient hospital stay when they provide a final examination, discussion of the stay, instructions for continuing care and preparation of discharge records. These codes are only allowed when an initial or subsequent hospital visit is billed on the day of discharge.
    - To report services provided to a Member admitted to the hospital after receiving hospital observation care services on the same date, refer to the hospital inpatient billing instructions. For a Member admitted to the hospital on a date subsequent to the date of

observation status, the hospital admission is reported using the appropriate initial hospital care codes. Do not report the observation discharge in conjunction with the hospital admission.

- All evaluation and management services related to and provided on the same day as an admission to observation status are considered part of that admission. Do not report them separately. This applies regardless of the setting in which the services are provided (for example, a hospital emergency department, a physician's office or a nursing facility, and so on).
- These codes apply to all practitioner services provided on the same date of Member admission to observation status. Do not use these codes for postoperative recovery if the procedure is considered a global procedure.

- **Concurrent Care:** Inpatient hospital care provided by two (2) or more practitioners to the same Member on the same day. Practitioners who are providing concurrent care should use the subsequent hospital care billing codes. Medicaid will reimburse for these services when ALL of the following criteria are met:
  - The practitioners have different specialties or subspecialties
  - The condition or injury involves more than one (1) body system
  - The condition or injury is so severe or complex that one (1) practitioner alone cannot handle the Member's care
  - The practitioners are actively co-managing the Member's treatment

22.18.7 Critical Care Services

Procedure Code Range: 99291

Critical care is the treatment of critically ill Members experiencing medical emergencies requiring constant attendance of the practitioner. Critical care is typically provided in a critical care unit. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the Member's condition Critical Care services include:

- The interpretation of cardiac output measurements (93561, 93562)
- Chest X-rays (71010, 71015, 71020)
- Blood gases
- Data stored in computers
- Gastric intubation (43752, 91105)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94002-94003, 94660, 94662)

- Vascular access procedures (36000, 36410, 36415, 36600)
- Pulse oximetry (94760, 94762)

The critical care codes are used to report the total duration of time spent by a practitioner providing constant attention to a critically ill Member. The procedure code 99291 is to report the first 30-74 minutes of critical care and should be used only once per day even if the time spent by the physician is not continuous that day. Another procedure code 99292 is used to report each additional 30 minutes (30 minutes = 1 unit) beyond the first 74 minutes.

22.18.8 Prolonged Service

Procedure Code Range: **Face-to-face 99354-99357**
Non-face-to-face 99358-99359

Prolonged physician services, either direct face-to-face or non-face-to-face contact, may be billed to Medicaid in addition to other physician's services. This service is reported when the service is beyond the usual service in either the inpatient or outpatient setting. In addition to other physician services, including E&M services at any level.

> Prolonged services that exceed three (3) hours on the same date of service must be documented as medically necessary in the patient's medical record, including the purpose and actual time the physician was detained (*see Section 3.4* Medical Necessity).

22.18.9 Practitioner Standby Service

Procedure Code Range: **99360**

This procedure code is used to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct (face-to-face) Member contact. The physician may not be providing care or services to other Members during this period. This code is not used if the period of standby ends with the performance of a procedure subject to a "surgical" package by the physician who was on standby.

Standby service of less than 30 minutes duration on a given day is not reported separately.

Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.

> This code may not be reported in addition to CPT-4 code 99464 for attendance at delivery.

22.18.10 Inpatient Pediatric and Neonatal Critical Care

Procedure Code Range: **99291**

22.18.10.1 Covered Services

Critical care codes include the following:

- Management
- Monitoring treatment of the Member
- Parent counseling
- Direct supervision of the healthcare team in the performance of cognitive and procedural activities
- Cardiac and respiratory monitoring
- Continuous and/or frequent vital sign monitoring
- Heat maintenance
- Enteral and/or parenteral nutritional adjustments
- Laboratory service
- Oxygen

22.18.10.2 Billing Requirements

Services start with the date of admission to the NICU and may be reported only once per day, per Member. Once the neonate is no longer considered to be critically ill, the appropriate codes for subsequent hospital care should be utilized.

The following procedures are also included as part of the global descriptors:

- Chest X-rays
- Interpretation of chest X-rays
- Cardiac output measurements
- Pulse oximetry
- Blood gases and other information stored in computers
- Gastric intubation
- Ventilation management
- Temporary transcutaneous pacing
- Vascular procedures

- Umbilical venous and arterial catheters
- Arterial, central venous, or peripheral vessel catheterization
- Vascular access procedures
- Vascular punctures
- Oral or nasogastric tube placement
- Endotracheal intubation
- Lumbar puncture
- Suprapubic bladder aspiration
- Bladder catheterization
- CPAP management
- Surfactant administration
- Intravascular fluid administration
- Blood transfusion
- Monitoring of electronic vital signs
- Bedside pulmonary function testing and/or monitoring or interpretation of blood gases or O2 saturation

In addition, specific services are included in the parenthetic note following each NICU code.

> The most accurate way to verify coverage for a specific service is to review the CPT-4 book for the appropriate date of service.

22.18.11 Nursing Facilities

Procedure Code Range: **99304-99318**

A nursing facility is an entity that provides skilled nursing care and rehabilitation services to people with illnesses, injuries, or functional disabilities. Most facilities serve the elderly. However, some facilities provide services to younger individuals with special needs such as the developmentally disabled, mentally ill, and those requiring drug and alcohol rehabilitation.

22.18.11.1 Covered Services

Practitioner services are covered when they are medically necessary and are performed to meet the requirements of continued long-term care.

22.18.11.2 Billing Requirements

When a Member is admitted to the nursing facility in the course of an encounter in another site of service, such as office or emergency room, all evaluation and management service in conjunction with the admission is considered part of the initial nursing facility care if performed on the same date, and will not be reimbursed separately.

Initial Member care may be billed only once per long-term care stay unless the Member has moved to a different facility and/or changes Providers.

Evaluation and management codes billed in addition to procedure code 99304 are not reimbursed when performed on the same date as the admission.

Hospital discharge or observation discharge services performed on the same date of nursing facility admission or readmission may not be reported separately.

Discharge planning codes may not be billed on the date of the Member's death.

Two (2) subcategories of nursing facility services are recognized. Both subcategories apply to new or established Members and must be billed by the Provider.

22.18.11.3 Nursing Facility Discharge Services

Nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a Member.

- 99315 Nursing Facility discharge day management; 30 minutes or less
- 99316 Nursing Facility discharge day management, more than 30 minutes

> For an accurate listing of codes, refer to the fee schedule on the Medicaid website (see *Section 2.1* Quick Reference).

22.18.12 Office Visits

An office visit is considered evaluation and management services provided in a practitioner's office or in an outpatient or other ambulatory facility.

22.18.12.1 Billing Requirements

- Office visits for new Members must be billed using CPT-4 codes 99201-99205
- Established Members must be billed using CPT-4 codes 99211-99215

- Several codes may be used in addition to the above codes when services are provided in a physician or practitioner's office for emergency care after scheduled routine office hours
- Documentation must support the CPT-4 code(s) billed by the practitioner

> For an accurate listing of codes, refer to the fee schedule on the Medicaid website (see *Section 2.1* Quick Reference).

22.18.13 Telephone Services

Procedure Code Range: **99441-99443, limited to physician use only**

22.18.13.1 Billing Requirements

Allowed telephone evaluation and management service(s) are provided by a physician to an established patient, parent, or guardian. They should not originate from a related evaluation and management service provided within the previous seven (7) days nor lead to an evaluation and management service or procedure within the next 24-hours or soonest available appointment.

- Procedure code 99441: 5 to 10 minutes of medical discussion
- Procedure code 99442: 11 to 20 minutes of medical discussion
- Procedure code 99443: 21 to 30 minutes of medical discussion

22.19 Preventive Medicine

Procedure Code Range: **99381-99385**

22.19.1 Covered Services

For specific information on preventive health services for Members under age 21, *see Section 19.1* Health Check – .

Preventive health services for Members over 21 are:

- Cancer screening services
- Screening mammographies are limited to a baseline mammography between ages 35-39 and one (1) screening mammography per year after age 45. All mammograms require a referral.
- Annual gynecological exam 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.

> Preventative Medicine codes are not appropriate to bill for Members aged 21 and over. Providers should instead use the appropriate Evaluation & Management code for visits with adult Members.

22.20 Public Health Services

Public health clinic services are physician and mid-level practitioner services provided in a clinic designated by the Department of Health as a public health clinic.

- Services must be provided directly by a physician or by a public health nurse under a physician's immediate supervision (such as, the physician has seen the Member and ordered the service).

22.21 Radiology Services

Procedure Code Range: **70010-79999**

Radiology services are ordered and provided by practitioners, dentists, or other Providers licensed within the scope of their practice as defined by law. Radiology Providers must be supervised by a practitioner licensed to practice medicine within the state the services are provided. Imaging 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).

22.21.1 Covered Services

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.

22.21.2 Billing Requirements

For most radiology services, and some other tests, the fee schedules indicate different fees based on whether the practitioner provided only the technical component (performed the test), only the professional component (interpreted the test), or both components (also known as the global service). Practitioners must bill only for the services they provide.

- Technical components of imaging services must be performed by appropriately licensed staff (for example, X-ray technician) operating within the scope of their practice as defined by state law and under the supervision of a practitioner

- Multiple procedures performed on the same day must be billed with two (2) units to avoid duplicate denial of service

Modifier	Description	Reimbursement
26	Professional Component	30% of allowed fee
TC	Technical Component	70% of allowed fee

22.21.3 Limitations

- Screening mammographies are limited to a baseline mammography between ages 35 and 39 and one (1) screening mammography per year after age 45. All mammograms require a referral by a practitioner.
- X-rays performed as a screening mechanism or based on standing orders
- Separate consultations or procedures unless ordered by the attending practitioner

22.22 Screening, Brief Intervention, Referral, and Treatment

Screening, Brief Intervention, Referral, and Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance abuse disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. The goal of SBIRT is to make screening for substance abuse a routine part of medical care.

- **Screening** is a quick, simple way to identify patients who need further assessment of treatment for substance abuse disorders. It does not establish definitive information about diagnosis and possible treatment needs.
- **Brief intervention** is a single session or multiple sessions of motivational discussion focused on increasing insight and awareness regarding substance use and motivation toward behavior change. Brief intervention can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at-risk as well as a vehicle for engaging those in need of more extensive levels of care.
- **Brief treatment** is a distinct level of care and is inherently different from both brief intervention and specialist treatment. Brief treatment is provided to those seeking or already engaged in treatment, who acknowledges problems related to substance use. Brief treatment in relation to traditional or specialist treatment has increased intensity and is of shorter duration. It consists of a limited number of highly focused and structured clinical sessions with the purpose of eliminating hazardous and/or harmful substance use.
- **Referral** to specialized treatment is provided to those identified as needing more extensive treatment than offered by the SBIRT program. The effectiveness of the referral process to

specialty treatment is a strong measure of SBIRT success and involves a proactive and collaborative effort between SBIRT Providers and those providing specialty treatments to ensure access to the appropriate level of care.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community's specialized treatment program with a network of early intervention and referral activities that are conducted in medical and social service settings.

22.22.1 Covered Services and Billing Codes

Acceptable billing Providers for SBIRT include:

- Physician: All 20X taxonomy types
- Public Health Clinic: 251K00000X
- FQHC: 261QF0400X
- RHC: 261QR1300X
- IHS: 261QP0904X
- Nurse Practitioners: 363L
- Advanced Practitioner of Psych/Mental Health Nursing: 364SP0808X
- Certified Nurse Midwives: 367A00000X
- Nurse Anesthetists: 357500000X

Medicaid covers SBIRT services for Members 18 years of age and older.

- **H0049:** Alcohol and/or drug screening, per screening. Wyoming Medicaid recognizes the following screening tools:
    - ASSIST: Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) developed by the World health organization (WHO). Access the screening tool through their web site located at: Assist Portal home page (https://www.assistportal.com.au/#screening).
    - 5Ps: The 5Ps Prenatal Substance Abuse Screen for Alcohol and Drugs (with "5Ps")
    - Substance Use Risk Profile-Pregnancy (SURP-P)
- **H0050:** Alcohol and/or drug services, brief intervention, per 15-minute units. Maximum of four (4) units. *This code will be discontinued 6/30/2023 and replaced with the following*:
    - 99408: Alcohol and/or substance (other than tobacco) abuse structured screening (such as audit, DAST, and so on), and brief intervention (SBI) services; 15–30 minutes (effective 7/1/2023)
    - 99409: Alcohol and/or substance (other than tobacco) abuse structured screening (such as audit, DAST, and so on), and brief intervention (SBI) services; greater than 30 minutes (effective 7/1/2023)

> Providers are to bill these codes in addition to the code they will bill for the primary focus of the visit. Screening and brief intervention are not stand-alone services, rather they may be part of a medical visit with another problem focus. For example, a patient presents for migraine headaches and is given the ASSIST (H0049: screening). The ASSIST tool indicates the need for brief intervention (H0050: brief intervention). The physician would bill the most appropriate code for their services related to the initial complaint of migraine headache, in addition to the appropriate SBIRT codes.

22.22.2 Limitations

SBIRT will not be covered for Members with services limited to emergency services only.

22.23 Sterilizations and Hysterectomies

Procedure Code Range: **58150-58294, 58541-58554, 58600-58720**

22.23.1 Elective Sterilization

Elective sterilizations are sterilizations completed for the purpose of becoming sterile. Medicaid covers elective sterilizations for men and women when all 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 he/she 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 22.11* 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

22.23.2 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).

- 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

> Pregnant by Choice/Family Planning Waiver has specific covered and non-covered services (*see Section 23.1* Pregnant by Choice and Family Planning Waiver).

22.24 Surgical Services

Procedure Code Range: **10021-69990**

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.

22.24.1 Surgical Packages, Separate Surgical Procedures, and Incidental Surgical Procedures

- **Surgical Packages:** Procedures that are commonly performed as an integral part of a total service and may not be billed separately. The following services are included in the surgical package in addition to the operation.
    - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
    - Subsequent to the decision for surgery, one (1) related Evaluation and Management (E&M) encounter on the date immediately prior to or on the date of procedure (including history and physical)
    - Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
    - Writing orders
    - Evaluating the patient in the post anesthesia recovery area
    - Typical post-operative follow-up care

- **Separate Surgical Procedures:** When a procedure is performed independently of, and is not immediately related to, other services, it may be reported separately under its unique procedure code (for example, a tonsillectomy and an adenoidectomy may be billed separately), only if performed on a different day.
- **Incidental Surgical Procedures:** Incidental procedures are those procedures performed subsequent to surgery which do not add significantly to the major surgery or are rendered incidental and performed at the same time as the major surgery (for example, incidental appendectomies, incidental scar excisions).

22.24.2 Covered Services

Normal preoperative and postoperative care includes:

- Pre-Op lab and radiology
- Office examinations
- Emergency room visits, and hospital visits, including discharge management
- Routine post-operative care (The number of post-operative days for each procedure is listed within the fee schedules)

22.24.3 Limitations

Consultations and hospital admission are not considered part of the surgical package.

Services provided to diagnose or treat conditions unrelated to the surgery may be billed with a separate examination code if the primary diagnosis code reflects a different complaint or service.

For an accurate listing of codes and the number of postoperative days for each procedure, refer to the fee schedule on the Medicaid website (see *Section 2.1* Quick Reference).

22.24.4 Billing Requirements

All surgical claims for reimbursement for multiple surgical procedures must have an operative report attached (see *Section 6.14* Submitting Attachments for Electronic Claims). The following methodology applies to reimbursement for surgical procedures (refer to the CPT-4 book for correct use of modifiers):

- **Unusual Procedural Services:** When the service(s) provided is/are greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the procedure code. An operative report must accompany the claim, to include why the procedure was unusual and the 22 modifier was used, for payment to be considered.
- **Multiple Procedures:** When multiple procedures are performed during the same session, the primary procedure will be paid at 100% of the fee assigned on the fee schedule. The primary

procedure must be billed on the first line; the subsequent procedure(s) must be billed on the following line(s) using the 51 modifier, if applicable. Operative reports are required for multiple procedures. Refer to the Medicaid website for the most accurate fee schedule (see *Section 2.1* Quick Reference). An example of a multiple procedure would be a Member having an upper gastrointestinal endoscopy and a small intestine endoscopy were performed; it should be billed as follows:

Line	Unit	CPT Code	Modifier
01	1	43239	
02	1	44373	51

The 51 modifier pays at 50% of the customary rate.

- **Bilateral Procedures:** When bilateral procedures are performed during the same session, Providers should report the procedure with 1 unit of service on line 1 and 1 unit of service on line two (2) using the same procedure code with the 50 modifier. Care should be taken not to designate a procedure as bilateral when the procedure is already identified as a bilateral service in the CPT-4 definition. An example of a bilateral procedure would be a Member having a tympanostomy (tubes inserted in the ears) performed on both the left and right ears; it should be billed as follows:

Line	Unit	CPT Code	Modifier
01	1	69433	
02	1	69433	50

The 50 modifier pays at 75% of the customary rate.

- **Combination Bilateral and Multiple Surgeries:** If there is a combination of bilateral and multiple surgeries, each surgery that is not the primary procedure will require either a 50 or 51 modifier as described above in the corresponding sections. An example of a combination of multiple and bilateral procedures performed should be billed as follows:

Line	Unit	CPT Code	Modifier
01	1	31255	N/A
02	1	31255	50

Line	Unit	CPT Code	Modifier
03	1	30520	51
04	1	31256	N/A
05	1	31256	50
06	1	30930	51

22.24.5 Assistant Surgeon

Assistant surgeon fees are billed with an 80 modifier using the same procedure code billed by the primary surgeon.

22.24.5.1 Surgical Assistant Service

- Physician assistant, nurse practitioner or clinical nurse specialist service fees are billed with an AS modifier using the same procedure code billed by the primary surgeon
- Non-physician Providers (NPP) should bill with the AS modifier using the same procedure code billed by the primary surgeon
- The Provider must report the services using their own Provider identification number with the appropriate site of service
- The modifier AS is appended to the CPT-4 code(s) for the procedure(s) the NPP/APP assisted with
- Do not use modifier AS if the NPP/APP acts as an “extra” pair of hands and not a surgical assistant in place of another surgeon

22.24.5.2 Two (2) Surgeons

When two (2) surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report their distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62.

> If the co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier AS added, as appropriate. If the procedure code(s) require Prior Authorization, it is the responsibility of the individual practitioner to obtain that authorization. Example; two surgeons perform a

surgery and use the 62 modifier; both surgeons MUST receive Prior Authorization.

22.24.5.3 Modifiers

Medicaid recognizes the following list of modifiers when used in conjunction with CPT-4 surgical procedure codes:

Modifier	Description	Reimbursement
22	Unusual Procedural Services: An operative report is required.	Allowed fee plus 20%
50	Bilateral Procedures	75% of allowed fee
51	Multiple Procedures	50% of allowed fee
62	Two (2) Surgeons: An operative report is required.	100% of allowed fee
80	Assistant Surgeons	20% of allowed fee
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery	15% of allowed fee

22.24.6 Cosmetic Services

Medicaid covers cosmetic services only when it is medically necessary (for example, restore bodily function or correct a deformity). Before cosmetic services are performed, they must be prior authorized (*see Section 6.12* Prior Authorization).

Refer to the fee schedule on the Medicaid website for which codes require prior authorization (see *Section 2.1* Quick Reference).

22.24.7 Oral and Maxillofacial Surgery

Procedure Code Range: **21010-21499 & 40490-42999**

Oral and maxillofacial surgery is surgery to correct a wide spectrum of diseases, injuries and defects in the head, neck, face, jaws, and the hard and soft tissues of the oral and maxillofacial region.

22.24.7.1 Covered Services

Procedure Code Range: **21010-21499**

- Removal of tumor
- Maxillofacial Prosthetics: Introduction and Removal
- Repair, Revision and/or Reconstruction

- Temporomandibular Joint (TMJ) Treatment

Procedure Code Range: **40490-42999**

- Lips (excision and repair)
- Vestibule of mouth (incision, excision, and repair)
- Tongue and Floor of mouth (incision, excision, and repair)
- Dentoalveolar Structures (incision, excision, and other)
- Palate and Uvula (incision, repair, and other)
- Salivary Gland and Ducts (incision, excision, repair, and other)
- Pharynx, Adenoids, and Tonsils (incision, excision, repair, and other)

22.24.7.2 Billing Requirements

In order to obtain Medicaid reimbursement for services, the following standards must be observed.

- 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
- Review the entire surgical section to verify appropriate use of modifiers
- When billing dental codes refer to the dental manual

> The most accurate way to verify coverage for a specific service is to review the CPT-4 book, the CDT book, and the Medicaid fee schedule on the website (see *Section 2.1* Quick Reference).

22.24.8 Breast Reconstruction

Procedure Code Range: **19316-19499**

22.24.8.1 Covered Services

Breast reconstruction is only covered following breast cancer treatment.

22.24.8.2 Billing Requirements

Prior authorization requirements (*see Section 6.12* Prior Authorization):

Wyoming Medicaid covers surgical reconstruction following breast cancer treatment. Additional revisions may only be approved for a repeated constructive surgery based on medical necessity such as the procedures listed below:

- Secondary surgery includes implant rupture

- Wound dehiscence (bursting open)
- Wound infection
- Tattooing of the nipple (included in 19350, 19357-19369 unless the procedure is done after the global setting – then 11920 to 11921 is appropriate)

22.24.9 Breast Reduction

Procedure Code Range: **19318**

22.24.9.1 Covered Services

Breast reductions are covered and considered medically necessary if the below requirements are met.

22.24.9.2 Billing Requirements

Prior authorization requirements (*see Section 6.12* Prior Authorization):

Wyoming Medicaid considers breast reduction surgery as medically necessary, when **all** of the following is met and is clearly documented in the medical records.

- Member must be 18 years or older
- Amount to be removed from each breast is greater than or equal to 500 grams, or the total to be removed from both breasts exceeds 1000 grams
- Preoperative indications for breast surgery must include one (1) or more of the following symptoms:
  - Breast pain
  - Shoulder, neck, or back pain
  - Other persistent neurological symptoms attributable to breast size or weight.
  - Refractory intertrigo
  - Significant activities
- This procedure may be done as hospital inpatient, hospital outpatient, or in an ambulatory surgical center (ASC).

22.24.9.3 Documentation Requirements

Documentation must show medical necessity. The patient's clinical records must be specific and contain the following information:

- Current clinical notes including history, physical, and preoperative indications for breast surgery
- Height and weight
- Current bra size

- Proposed amount of tissue to be removed from each breast
- Duration of time that symptoms have persisted
- Conservative methods of treatment tried, such as weight loss or support bras
- Photographs of the shoulder to waist, front and lateral

22.24.10 Cochlear Device Implantation and Replacement

Procedure Code: **69930**

22.24.10.1 Covered Services

Wyoming Medicaid has instituted the following policy for Cochlear Device Implantation and Replacement. Medicaid reimburses for the implant, external processor and headset.

22.24.10.2 Billing Requirements

Prior authorization (*see Section 6.12* Prior Authorization) is required for the procedure, device, and replacement device only. The Member's clinical records must be specific and contain the following information:

Medicaid Members must meet all the following criteria:

- There must be a diagnosis of bilateral profound (90db hearing loss) sensorineural hearing impairment that cannot be mitigated by the use of a hearing aid in Members whose auditory cranial nerves can be stimulated
- The Member must have demonstrated that they cannot benefit from hearing amplification through a trial period of three (3) to six (6) months
- There must be freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and be free of lesions in the auditory nerve and acoustic areas of the central nervous system
- There must not be any MRI evidence of anomaly that would preclude implant.
- The Member must have the cognitive ability to use auditory clues
- The procedure may only be performed using FDA-approved devices
- Evaluation and continued treatment for cochlear transplants must be completed by a Board Certified Specialist
- Only one (1) cochlear implant per five (5) year period. An exception may be possible if the implant is proven to no longer be working sufficiently and the manufacture warranty has expired

- Initial first year calibration visits are part of the global fee for implementation. Follow up calibration visits will be covered one (1) per year if the implant is authorized or if the Member had an existing cochlear device that needs calibration.
- Additional equipment will be allowed only to replace defective equipment and will not be allowed solely to update equipment. Upgrade equipment can be evaluated once every five (5) years.
- In addition, the following criteria must be met for adults 21 and older:
    - Must be highly motivated and have appropriate expectations to complete prescribed pre- and post-surgical treatment.
- In addition, the following criteria must be met for children 20 and under:
    - Implantation will not be considered before the age of 12 months
    - Children may be pre-linguistically deafened
    - Family members or caregivers must have appropriate expectations, motivation, and resources to assist in completion of treatment and educational services
    - Family members must agree to accompany a young child to training sessions and be able to reinforce learning

> Only the procedure for implantation needs prior authorization; the device does not require a separate prior authorization and must be supplied by the hospital.

22.24.10.3 Documentation Requirements

The Member's clinical records must be specific and contain the following information:

- A complete history and physical indicating how the diagnosis of sensorineural hearing impairment was determined
- Demonstration of lack of benefit from hearing amplification through a trial period of six (6) months, using appropriate fitted amplification
- Documentation of other health conditions
- Notation that there has been active family involvement during the diagnosis and treatment sessions for a child who is to have a cochlear transplant

22.24.11 Gastric Bypass Surgery

Procedure Code Range: **43644, 43770, 43842-43843, 43846-43848**

For prior authorization of the above listed procedure codes, please contact Telligen (see *Section 2.1* Quick Reference).

22.24.12 Lumbar Spinal Surgery

Procedure Codes: 22207, 22214, 22224, 22533, 22534, 22558, 22612, 22630, 22633, 22800-22808, 22812, 22818, 22840, 22857 and 22862

22.24.12.1 Covered Services

Authorization for lumbar spinal surgery has been separated into three (3) general categories:

- Surgery related to the treatment of sciatica or other nerve root impingements where primary intervention is related to removal of an offending herniated disk
- Surgery related to mechanical and anatomical abnormalities for which spinal fusion may be appropriate treatment
- Spinal fracture or dislocation, spinal infection (These can be approved with documentation of said fracture/dislocation or infection)

22.24.12.2 Billing Requirements

Prior Authorization requirements (*see Section 6.12* Prior Authorization):

In the absence of red flag symptoms or progressive neurological symptoms or signs, Members presenting with:

- Low back pain should undergo conservative therapy, which may include the use of anti-inflammatory medications, aggressive physical therapy with home exercise program, activity modification, physical reconditioning, or facet or epidural injections
- A patient should undergo at least 12 weeks of conservative management for symptomatic spinal stenosis or spondylolisthesis
- Patients with only axial low back pain (absence of leg or neurological symptoms) and without demonstrable instability, spondylolisthesis or spinal stenosis should go through conservative therapy for at least six (6) months.

22.24.12.3 Documentation Requirements

The Member's clinical records must be specific and contain the following information:

- Office notes, including history and physical
- Detailed documentation of extent and response to conservative therapy (PT, Steroids, Anti-inflammatory Medications, and so on)

- Radiology reports for MRIs, CTs, and so on
- Complete the prior authorization form with specific procedures with CPT codes

> The requesting surgeon must personally evaluate the patient on at least two (2) occasions prior within the preceding six (6) months to requesting surgery.

22.24.12.4 Scoliosis Billing Requirements

Prior Authorization requirements (*see Section 6.12* Prior Authorization):

The treatment of idiopathic scoliosis is medically necessary for any of the following conditions:

- An increasing curve (greater than 40 degrees) in a growing child OR
- Scoliosis related pain that is refractory to conservative treatments OR
- Severe deformity (curve greater than 50 degrees) with trunk asymmetry in children and adolescents OR
- Thoracic lordosis that cannot be treated conservatively

In the absence of the above-mentioned criteria, idiopathic scoliosis surgery is considered experimental and investigational.

22.24.12.5 Scoliosis Documentation Requirements

- Office notes, including history and physical
- Detailed documentation of extent and response to conservative therapy (PT, Steroids, Anti-inflammatory Medications, and so on)
- Radiology reports for MRIs, CTs, and so on
- Complete the prior authorization form with specific procedures with CPT codes

> The requesting surgeon must personally evaluate the patient on at least two (2) occasions prior within the preceding six (6) months to requesting surgery.

22.24.13 Panniculectomy and Abdominoplasty

Procedure Codes: **15830 and 15847**

22.24.13.1 Covered Services

Panniculectomies/Abdominoplasties are covered and considered medically necessary if the below requirements are met.

22.24.13.2 Billing Requirements

Prior Authorization requirements (*see Section 6.12* Prior Authorization):

Wyoming Medicaid considers a Panniculectomy or Abdominoplasty as medically necessary when all of the following are met and clearly documented in the medical records.

- Pannus hangs at or below the level of the symphysis pubis
- Pannus causes a chronic and persistent skin condition that is refractory to at least six (6) months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics.
- Include photographs documenting the skin condition

> If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six (6) months. If the weight loss is the result of bariatric surgery, abdominoplasty or panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six (6) months.

Medicaid does not cover abdominoplasty or panniculectomy when performed primarily for **ANY** of the following indications because it is considered not medically necessary (this list may not be all-inclusive).

- Treatment of neck or back pain
- Improving appearance (such as, cosmesis)
- Repairing abdominal wall laxity or diastasis recti
- Treating psychological symptomatology or psychosocial complaints
- When performed in conjuncture with abdominal or gynecological procedures (for example, abdominal hernia repair, hysterectomy, obesity surgery) unless criteria for panniculectomy or abdominoplasty are met separately

22.24.14 Pectus Excavatum and Poland's Syndrome

Procedure Code: **21743**

22.24.14.1 Covered Services

Surgical repair of severe pectus excavatum deformities that cause functional deficit are covered and considered medically necessary when the below criteria are met.

22.24.14.2 Billing Requirements

Prior Authorization requirements (*see Section 6.12* Prior Authorization):

Wyoming Medicaid considers a Pectus Excavatum medically necessary when **ALL** of the following are met and clearly documented in the medical records.

- Medical documentation outlining evidence of complications from the sternal deformity. Complications may include but are not limited to:
  - Asthma
  - Atypical chest pain
  - Cardiopulmonary impairment documented by respiratory or cardiac function tests
  - Exercise limitation
- Frequent lower respiratory tract infections
- An electrocardiogram or echocardiogram is documented in the instance(s) of known heart disease in order to define the relationship between the sternal deformity and cardiac issues
- A CT scan of the test is completed and demonstrates a pectus index of greater than 3.25. The pectus index is calculated by dividing the transverse diameter of the chest by the anterior-posterior diameter.

In the absence of the above-mentioned criteria, surgery for pectus excavatum is considered cosmetic.

The following interventions are considered experimental and investigational secondary to their effectiveness in the treatment of pectus excavatum:

- The magnetic min-mover procedure
- The vacuum bell
- Dynamic Compression Syndrome
- Surgery for reconstruction of musculo-skeletal chest wall deformities associated with Poland's Syndrome are considered medical necessary if the syndrome causes functional deficits

22.24.15 Ptosis and Blepharoplasty Repair

Procedure Code Range: **67900-67909**

22.24.15.1 Covered Services

Surgical repair of ptosis and blepharoplasty that cause functional deficit are covered and considered medically necessary when done for medical reasons in Members who meet the criteria listed below.

22.24.15.2 Billing Requirements

Prior Authorization requirements (*see Section 6.12* Prior Authorization):

Wyoming Medicaid considers surgical repair for Ptosis and Blepharoplasty when the criteria below are met.

Ptosis (Belpharoptosis) is considered medically necessary for **ANY** of the following indications:

- Repair for laxity of the muscles of the upper eyelid causing functional visual impairment when photographs in straight gaze show the margin reflex difference (distance from the upper lid margin to the reflected corneal light reflex at normal gaze) of 2mm or less.
- Brow ptosis repair for laxity of the forehead muscles causing functional visual impairment when photographs show the eyebrow below the supra-orbital rim.
- Eyelid ectropion or entropion repair is considered medically necessary for corneal or conjunctival injury due to ectropion, entropion or trichiasis.
- Upper eyelid tightening procedures (block resection or tarsal strip with lateral canthal tightening) are considered medically necessary for Members who have refractory corneal or conjunctival inflammation related to exposure from floppy eyelid syndrome.

Canthoplasty is considered medically necessary as part of a blepharoplasty procedure to correct eyelids that sag so much that they pull down the upper eyelid so that vision is obstructed.

> Visual field testing is not routinely necessary to determine the presence of excess upper eyelid skin, upper eyelid ptosis, or brow ptosis. Each of these three (3) components can be present alone or in any combination, and each may require correction. If both a blepharoplasty and ptosis repair are requested, two (2) photographs may be necessary to demonstrate the need for both procedures: one (1) photograph should show the excess skin above the eye resting on the eyelashes, and a second (2nd) photograph should show persistence of lid lag, with the upper eyelid crossing or slightly above the pupil margin, despite lifting the excess skin above the eye off of the eyelids with tape. If all three (3) procedures (such as, blepharoplasty, blepharoptosis repair, and brow ptosis repair) are requested, three (3) photographs may be necessary.

Congenital Ptosis – Surgical correction of congenital ptosis is medically necessary to allow proper visual development and prevent amblyopia in infants and children with moderate to severe ptosis interfering with vision. Surgery is considered cosmetic if performed for mild ptosis that is only of cosmetic concern. Photographs must be available for review to document that the skin or upper eyelid margin obstructs a portion of the pupil.

Blepharoplasty is considered medically necessary for **ANY** of the following indications:

- To correct prosthesis difficulties in an anophthalmia socket

- To remove excess tissue of the upper eyelid causing functional visual impairment when photographs in straight gaze show eyelid tissue resting on or pushing down on the eye lashes (Excess tissue beneath the eye rarely obstructs vision, so the lower lid blepharoplasty is rarely covered for this indication)
- To repair defects predisposing to corneal or conjunctival irritation:
  - Corneal exposure
  - Ectropion (eyelid turned outward)
  - Entropion (eyelid turned inward)
  - Pseudotrichiasis (inward misdirection of eyelashes caused by entropion)
- To relieve painful symptoms of blepharospasm
- To treat peri-orbital sequelae of thyroid disease and nerve palsy, and peri-orbital sequelae of other nerve palsy (for example, the oculomotor nerve)

22.24.16 Septoplasty and Rhinoplasty

Procedure Code Range: **30520, 30400-30420, 30430-30450 and 30460-30462**

22.24.16.1 Covered Services

Septoplasties and Rhinoplasties are covered and considered medically necessary if the below requirements are met.

22.24.16.2 Billing Requirements

Prior Authorization requirements (*see Section 6.12* Prior Authorization):

Septoplasty is medically necessary when **ANY** of the following clinical criteria is met.

- Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medical necessary surgical procedures (for example, ethmoidectomy)
- Documented recurrent sinusitis felt to be due to a deviated septum not relieved by appropriate medical and antibiotic therapy
- Recurrent epistaxis (nosebleeds) related to a septal deformity
- Septal deviation causing continuous nasal airway obstruction resulting in nasal breathing difficulty not responding to appropriate medical therapy
- When done in association with cleft palate repair

> Septoplasty is considered experimental and investigational for all other indications (for example, allergic rhinitis) because its

effectiveness other than the ones listed above has not been established.

Rhinoplasty may be considered medically necessary only in the following limited circumstances:

- Upon individual case review, to correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect, when **ALL** of the following criteria are met:
    - Prolonged, persistent obstructed nasal breathing
    - Physical examination confirming moderate to severe vestibular obstruction
    - Airway obstruction will not respond to septoplasty and turbinectomy alone
    - Nasal airway obstruction is causing significant symptoms (for example, chronic rhinosinusitis, difficulty breathing)
    - Obstructive symptoms persist despite conservative management for three (3) months or greater, which includes, where appropriate, nasal steroids or immunotherapy
    - Photographs demonstrate an external nasal deformity
    - There is an average of 50 % or greater obstruction of nares (for example, 50 % obstruction of both nares, or 75 % obstruction of one nare and 25 % obstruction of other nare, or 100 % obstruction of one nare), documented by nasal endoscopy, computed tomography (CT) scan or other appropriate imaging modality

Documentation Requirements

For the correction of chronic non-septal nasal airway obstruction from vestibular stenosis due to trauma, disease, or congenital defect, **ALL** of the following documentation requirements must be met:

- Documentation of duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, and so on
- Documentation of results of conservative management of symptoms
- If there is an external nasal deformity, pre-operative photographs showing the standard 4-way view: anterior-posterior, right and left lateral views, and base of nose (also known as worm's eye view confirming vestibular stenosis; this view is from the bottom of nasal septum pointing upwards)
- Relevant history of accidental or surgical trauma, congenital defect, or disease (for example, Wegener’s granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity)
- Results of nasal endoscopy, CT or other appropriate imaging modality documenting degree of nasal obstruction

- When rhinoplasty for nasal airway obstruction is performed as an integral part of a medically necessary septoplasty and there is documentation of gross nasal obstruction on the same side as the septal deviation

- When it is being performed to correct a nasal deformity secondary to congenital cleft lip or palate

22.24.17 Transcranial Magnetic Stimulation

Transcranial Magnetic Stimulation (TMS)

Procedure Code Range: **90867-90868**

Diagnosis Code Range: **F32.2 & F33.2**

22.24.17.1 Covered Services

Wyoming Medicaid considers left prefrontal TMS reasonable and necessary for patients diagnosed with severe Major Depression (single or recurrent episode) as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Therefore, TMS is only allowed with the following diagnosis code(s):

- **F32.2**: Major depressive disorder, single episode, severe without psychotic features
- **F33.2**: Major depressive disorder, recurrent severe without psychotic features.

90867: Prior Authorization will only be allowed once per course of treatment. (This report is necessary to the treatment planning once per course of treatment, and must be kept as part of the permanent patient record.)

90868: Prior Authorization will be issued for up to 30 visits over a 7-week period, followed by 6 taper treatments (for a total of 36 units) the taper period is defined as up to 3 treatments in a week, 2 treatments the following week and 1 treatment in the third week.

22.24.17.2 Billing Requirements

Prior Authorization requirements (*see Section 6.12* Prior Authorization):

Wyoming Medicaid considers a TMS medically necessary when **at least one (1)** of the following are met and clearly documented in the medical records:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack or clinically significant response to four trials of such agents, in the current depressive episode, from at least two different agent classes. At least one of the treatment trials must have been administered at the adequate course of one or more drug therapies
- Inability to tolerate psychopharmacologic agents as evidenced by trials of four such agents with distinct side effects
- History of good response to TMS in a previous episode

- If patient is currently receiving electro-convulsive therapy, TMS may be considered reasonable and necessary as a less invasive treatment option

22.24.17.3 Documentation Requirements

- All documentation must be maintained in the patient's medical record and be available upon request
- Every page of the record must be legible and include appropriate patient identification, date of service(s), and must include the legible signature of the physician or non-physician practitioner
- The medical record must support the use of the selected ICD-10-CM code(s) and the submitted CPT code must describe the service performed
- The documentation must support the medical necessity of the service(s) as directed in this policy
- The attending physician or non-physician practitioner must monitor and document the patient's clinical progress during treatment
    - The attending physician or non-physician must use evidence based validated depression monitoring scales [such as Geriatric Depression Scale (GDS), The personal Health Questionnaire Depression Scale (PHQ-9) Beck Depression Scale (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomology (QIDS) or the Inventory for Depressive Symptomatology Systems Review (IDS-SR)] to monitor treatment response and the achievement of remission of symptoms

Repeat acute treatment for relapse of depressive symptoms is considered medically necessary only if the patient responded to prior treatments; specifically, at least a 50% improvement in standard rating. Additionally, this record must accompany the new prior authorization request.

22.24.17.4 Non-Covered Services

The use of TMS as a maintenance therapy is not supported by controlled clinical trial at this time and is therefore not considered medically necessary.

22.24.18 Vagus Nerve Simulation for Epilepsy

Procedure Code Range: **61850-61888, 64570, 64573**

Vagus Nerve Simulation (VNS) for Epilepsy. For prior authorization for the above listed procedure codes, please contact Telligen (see *Section 2.1* Quick Reference).

22.24.19 Varicose Vein Treatment

Procedure Code Range: **36471- 36479, 37770-37785**

22.24.19.1 Covered Services

Wyoming Medicaid considers the following procedures medically necessary for treatment of varicose veins:

- Great saphenous vein or small saphenous vein ligation/division/ stripping
- Radiofrequency endovenous occlusion (VNUS procedure)
- Endovenous laser ablation of the saphenous vein (ELAS) – also known as endovenous laser treatment (EVLT)

22.24.19.2 Billing Requirements

Prior authorization requirements (*see Section 6.12* Prior Authorization):
Incompetence at the saphenofemoral junction or saphenopopliteal junction is documented by Doppler or duplex ultrasound scanning, and **ALL** of the following criteria are met.

- Documented reflux duration of 500 milliseconds (ms) or greater in the vein to be treated
- Vein size is 4mm to 5mm or greater in diameter (not valve diameter at junction)
- Saphenous varicosities result in **ANY** of the following:
    - Intractable ulceration secondary to venous stasis
    - More than 1 episode of minor hemorrhage from a ruptured superficial varicosity; or a single significant hemorrhage from a ruptured superficial varicosity , especially if transfusion of blood is required
    - Saphenous varicosities result in either of the following and symptoms persist despite a three (3) month trial of conservative management (for example, analgesics and prescription gradient support compression stockings)
        - Recurrent superficial thrombophlebitis
        - Severe and persistent pain and swelling interfering with activities of daily living and requiring chronic analgesic medication

> A trial conservative management is not required for persons with persistent or recurrent varicosities who have undergone prior endovenous catheter ablation procedures or stripping/division/ligation in the same leg because conservative management is unlikely to be successful.

Endovenous ablation procedures are considered medically necessary for the treatment of incompetent perforating veins with vein diameter of 3.5mm or greater with outward flow duration of 500 milliseconds duration or more, located underneath an active or healed venous.

22.25 Transplant Policy

For prior authorization for transplant services, please contact Telligen (see *Section 2.1* Quick Reference).

22.25.1 Outpatient Stem Cell or Bone Marrow

The hospital performing a bone marrow/stem cell transplant on an outpatient basis must bill using procedure code 38240 or 38241 and will be reimbursed at 55% of billed charges.

22.25.2 Non-Covered Services

Transportation of organs from one (1) facility to another is not covered.

22.26 Vision Services

Vision and dispensing services are benefits for Member's ages 0-20. Limited office visits for the treatment of an eye injury or eye disease are available for Members 21 & older. A licensed ophthalmologist, optometrist, or optician, within the Scope of the Practice Act within their respective profession, may provide vision services and dispensing services.

Vision services for Members 21 and older are only reimbursable for the treatment of eye disease or eye injury based on the appropriate ICD diagnosis code and Member records must support billing of any vision services. Routine eye exams or glasses are not a covered benefit for Members 21 and older.

> Wyoming Medicaid will pay the deductible and/or coinsurance due on Medicare crossover claims for post-surgical contact lenses and/or eyeglasses, up to the Medicaid allowable.

22.26.1 Eye and Office Examinations

Procedure Code Range: **92002-92014, 99201-99215, 92018-92060, 92081-92226, 92230-92287, J7999**

22.26.1.1 Covered Services

For Members under the age of 21 years:

- Eye exams determine visual acuity and refraction, binocular vision, and eye health
  - **92002-92004:** New patient eye exams are a covered benefit for Members who are new to the Provider's practice
  - **92012-92014:** Established patient eye exams are a covered benefit once in a 365-day period unless there is medical necessity to support an additional exam

- 92015: Describes refraction and any necessary prescription of lenses and is a covered benefit once in a 365-day period unless there is a medical necessity to support an additional exam

- Office visits for the treatment of eye disease or eye injury
  - **99201-99215:** May be billed by ophthalmologists for office exams
    - **Documentation:** Eye care Provider records must reflect medical necessity and include interpretation and report, as appropriate, of the procedure
- **92018-92060, 92081-92226, 92230-92287:** Special Ophthalmological Services should be performed only when medically necessary
  - **99283:** Requires a prior authorization (*see Section 6.12* Prior Authorization)

For Members 21 years and older:

- Eye exams to diagnose an eye disease or eye injury
  - **92002-92004:** New patient eye exams are a covered benefit for Members who are new to the Provider's practice
  - **92012-92014:** Established, patient eye exams are a covered benefit once in a 365-day period unless there is medical necessity to support an additional exam
- Treatment of age-related macular degeneration (AMD)
  - **J7999:** Avastin is the allowed drug to treat AMD and it is injected into the eye to help slow vision loss from this disease
  - Billing Requirements:
    - Only an ophthalmologist can provide this treatment
    - Must be billed with an appropriate NDC
  - Dual Eligible Members (Medicare/Medicaid) Billing Requirements:
    - Bill Medicare primary according to Medicare rules

J7999 is allowed by Medicare. Medicare should be billed as primary for dual eligible Members.

- Office visits for the treatment of eye disease or eye injury.
  - **99201-99215:** Ophthalmologists may bill these codes for office exams
    - **Documentation:** Eye care Provider records must reflect medical necessity and include interpretation and report, as appropriate, of the procedure

- **92018-92060, 92081-92226, 92230-92287:** Special ophthalmological services should be performed only when medically necessary and will be subject to post-payment review of the Member's records
    - **92283:** Will require a prior authorization (*see Section 6.12* Prior Authorization)

> Routine eye exam are not covered for adult Members. Do not bill for routine eye exams for Members 21 years and older. Exam codes may pay, and then upon audit, be taken back as Medicaid abuse recovery. These codes are not limited by diagnosis at this time and should only be billed when medical necessity can be documented to show an eye disease or injury.

22.26.1.2 Non-Covered Services

Exam codes should not be billed for routine eye exams for Members over 21 years old.

22.26.2 Eyeglasses or Materials

Procedure Code Range: **V2020, V2100-V2499, V2627, V2784**

22.26.2.1 Covered Services

For Members under the age of 21 years:

- One (1) pair of eyeglasses is covered per 365 days
- **V2020:** Standard frames are covered up to $73.49. The Provider may not "balance bill" the Member for frames that cost more than the allowable amount

> Balancing billing example – When the Member selects $120 frames and Medicaid allows up to $73.49 then the optometrist should either, mutually agree in writing with the Member that the Member is responsible for the payment of the frames ($120), or, the Provider may bill Medicaid for $73.49 and accept this payment as payment in full for the frames.

- Covered eye glass lenses – only 2 units of any type of lens (V2100-V2499) are to be billed per pair of eye glasses:
    - **V2100-V2121 (V2199 requires Prior Authorization (PA)):** Single lenses
    - **V2200-V2221 (V2299 requires PA):** Bifocal lenses
    - **V2300-V2321 (V2399 requires PA)**: Trifocal lenses
    - **V2410-V2430 (V2499 requires PA):** Variable lenses

- **V2782-V2783 (require PA):** High Index Aspheric lenses
  - Aspheric lenses will only be covered when medically necessary.
- **V2784:** Polycarbonate lens (billed as an add on to a standard C-39 lens)

> Only two (2) units of any lenses can be billed on the same DOS and must be ordered as pairs. If the lens on one (1) side is aspheric or high index, then the matching lens should also be aspheric or high index, even if it does not meet the threshold.

- **V2700-V2781:** Are considered add-ons to eye glasses and require a PA (*see Section 6.12* Prior Authorization) prior to the glasses being ordered. These services are only covered by Medicaid when they are deemed medically necessary to treat a vision condition. When requesting a PA, Providers should describe, in detail, the medical condition that the add-on is needed to treat.
  - Providers should not request a PA or bill for add-ons if the doctor has not prescribed the add-on as a medically necessary procedure. The Member can be billed for these add-ons when not medically necessary and are chosen as an option. The Provider must have a written statement that these services are not covered by Medicaid and the Member understands financial responsibility.

- Medicaid will allow one (1) replacement of lenses and frames within the 12-month (365 days) period if:
  - There is a change in the prescription for the lenses, use the existing frames if possible.
  - Eyeglasses are lost or broken beyond repair – This will require documentation stating it was not due to blatant abuse or neglect

> The Provider will need to submit an electronic claim and attach necessary documentation of the medical necessity to substantiate why the replacement glasses are needed (*see Section 6.14* Submitting Attachments for Electronic Claims). The claim will then be reviewed and processed based on the above criteria.

- Repair of eyeglasses may be billed upon expiration of the warranty
- **V2623, V2629 (Prosthetic eyes) V2627 (Scleral cover shell):** Requires a prior authorization (*see Section 6.12* Prior Authorization)

22.26.2.2 Non-Covered Services

- Reimbursement for dispensing of frames, frame parts, or lenses is not allowed in addition to reimbursement for dispensing of total eyeglasses
- **Members 21 years of age and older are not covered for eyeglasses**

22.26.2.3 Reimbursement

- Obtain eligibility information from Medicaid prior to placing order for eyewear
- Verify with Member and Provider Services (see *Section 2.1* Quick Reference) if the benefit has been used in the past year
- Deliver glasses in a reasonable amount of time (typically within one to two weeks)
- Verify Member eligibility for the date of delivery
- Bill Medicaid on the delivery date of the glasses. The date of delivery must be used as the date of service on a claim.
- If the Member does not return to receive their glasses, the glasses should be mailed to the Member and the mail date used as the date of service.

> If the Member is not eligible on the delivery date or does not return for the delivery, the Provider may submit an "Order vs Delivery Date Exception Form" for authorization to bill on the order date (*see Section 6.13.* Billing of Deliverables).

22.26.3 Contact Lenses

Procedure Code Range: **V2500-V2599, 92072**

Contact lenses are covered for correction of pathological conditions when useful vision cannot be obtained with regular lenses.

22.26.3.1 Covered Services

For Members under the age of 21 years:

- **V2500-V2599:** Contact lenses require prior authorization (PA) and documentation provided must show medical necessity and state why the Member's vision cannot be corrected with eyeglasses. (see *Section 6.12* Prior Authorization)
- Contact lenses will be reimbursed at the cost of invoice, plus shipping and handling, plus 15% for dates of service prior to 01/01/2021. For dates of service 01/01/2021 and forward contact lenses will be reimbursed at invoice cost, plus shipping and handling, plus, 12.13%. (see *Section 6.14* Submitting Attachments for Electronic Claims).
- **92072:** Fitting of contact lens does not require PA, however, should only be billed when PA has been obtained for the lens.

22.26.3.2 Non-Covered Services

Contact lenses are not covered for Members 21 and older.

22.26.4 Vision Therapy

Procedure Code Range: **92065 & 99070**

Vision therapy is a sequence of activities individually prescribed and monitored by the doctor to develop efficient visual skills and processing. It is prescribed after a comprehensive eye examination has been performed and has indicated that vision therapy is an appropriate treatment option. The vision therapy program is based on the results of standardized tests, the needs of the patient, and the patient's signs and symptoms.

Research has demonstrated vision therapy can be an effective treatment option for individuals under the age of 21 or individuals with Acquired Brain Injury:

- Ocular motility dysfunctions (eye movement disorders)
- Non-strabismic binocular disorders (inefficient eye teaming)
- Strabismus (misalignment of the eyes)
- Amblyopia (poorly developed vision)
- Accommodative disorders (focusing problems)
- Visual information processing disorders, including visual-motor integration and integration with other sensory modalities

22.26.4.1 Covered Services

- **92065:** Vision Therapy can be billed for Members under the age of 21 and Members with Acquired Brain Injury that are eligible for the Comprehensive or Support Developmental Disability Waiver plans, with a qualifying medical diagnosis (see tables below)
- When administered in the office under the guidance of a practitioner
- It requires a number of office visits and depends on the severity of the diagnosed conditions
- The length of the program typically ranges from several weeks to several months
- Activities paralleling in-office techniques are typically taught to the patient to be practiced at home to reinforce the developing visual skills
- Vision therapy is capped at 32 visits per 365 days for treatment of ICD diagnosis
    - Additional visits or exceptions to these diagnosis codes will be considered on a case-by-case basis only
- **99070:** Vision Therapy training aids will be reimbursed at cost of invoice (see *Section 6.8.1* Invoice Charges). Invoices must be submitted with documentation of medical necessity to Provider Services (see *Section 2.1* Quick Reference) for consideration (see *Section 6.14* Submitting Attachments for Electronic Claims)

Diagnosis Codes for Members under 21 years old	
Diagnosis Codes	**Description**
Amblyopia	
H53.031, H53.032, H53.033	Strabismic amblyopia
H53.011, H53.012, H53.013	Deprivation amblyopia
H53.021, H53.022, H53.023	Refractive amblyopia
Strabismus (Concomitant)	
H50.11, H50.012	Monocular esotropia
H50.05	Alternating esotropia
H50.11, H50.112	Monocular exotropia
H50.15	Alternating exotropia
H50.311, H50.312	Intermittent esotropia, monocular
H50.32	Intermittent esotropia, alternating
H50.331, H50.332	Intermittent exotropia, monocular
H50.34	Intermittent exotropia, alternating
H50.43	Accommodative component in esotropia

Diagnosis Codes for Members under 21 years old	
Diagnosis Codes	**Description**
Non-strabismic disorder of binocular eye movements	
H51.11	Convergence insufficiency
H51.12	Convergence excess
H51.8	Anomalies of divergence
Ocular Motor Dysfunction	
H55.81	Deficiencies of saccadic eye movements
H55.89	Deficiencies of smooth pursuit movements

Diagnosis Codes for Members under 21 years old	
Diagnosis Codes	**Description**
Heterophoria	
H50.51	Esophoria
H50.52	Exophoria
General Binocular Vision Disorder	
H53.30	General Binocular Vision Disorder
Nystagmus	
H55.01	Nystagmus

Diagnosis Codes for Members with Acquired Brain Injury	
Diagnosis Codes	**Description**
I69.998	Disturbances of vision
S06 Family of Codes	Late effect injury intracranial injury without mention of skull fracture.

Chapter 23 – Covered Services – Pregnant by Choice

23.1 Pregnant by Choice and Family Planning Waiver

Pregnant by Choice provides family planning service to women who have received Medicaid benefits through the Pregnant Women Program. This program extends family planning options to women who would typically lose their Medicaid benefits up to two (2) months postpartum.

23.1.1 Covered Services

- Initial physical exam and health history, including Member education and counseling related to reproductive health and family planning options, including a pap smear and testing for sexually transmitted diseases
- Annual follow up exam for reproductive health/family planning purposes, including a pap smear and testing for sexually transmitted diseases where indicated
- Brief and intermediate follow up office visits related to family planning
- Necessary family planning/reproductive health-related laboratory procedures and diagnostic tests
- Contraceptive management including drugs, devices, and supplies
- Insertion, implantation or injection of contraceptive drugs or devices
- Removal of contraceptive devices
- Sterilization services and related laboratory services (when a properly completed sterilization consent form has been submitted)
- Medications required as part of a procedure done for family planning purposes
- Services must be provided by an enrolled Medicaid Provider

23.1.2 Non-Covered Services

- Services are limited to approved family planning methods and products approved by the Food and Drug Administration (FDA)
- Sterilization reversals
- infertility services or treatments
- abortions

23.1.3 Eligibility Criteria

- The Member must be transitioning from the Pregnant Women Program
- Is not eligible for another Medicaid program
- Does not have health insurance including Medicare

- Is a Wyoming resident
- Is a US Citizen
- Her age is 19 through 44 years
- She is not pregnant

23.1.4 Enrollment Process

- The Customer Service Center, Wyoming Department of Health (WDH) must be notified of the pregnancy and birth of the baby (see *Section 2.1* Quick Reference)
- The Customer Service Center, WDH will send a review form and a Pregnant by Choice Questionnaire to women eligible for the Pregnant Women Program while in the two (2) month postpartum period to determine if they are interested in the program
- If a mother allows her Medicaid benefits to lapse after the two (2) month postpartum period, she will not be eligible for the Pregnant by Choice Program
- Eligibility is determined yearly

23.2 Pregnant by Choice Covered Codes

Pregnant By Choice Covered Codes	
Covered Diagnosis Codes	**Diagnosis Code Description**
Z30.011	General counseling on prescription of oral contraceptives
Z30.013, Z30.014, Z30.018, Z30.019	General counseling on initiation of other contraceptive
Z30.012	Encounter for emergency contraceptive counseling and prescription
Z30.02	Natrl Family pln – avoid preg
Z30.09	Other general counseling and advice on contraception
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.432	Encounter for removal of intrauterine contraceptive device
Z30.433	Encounter for removal & insertion of IUD
Z30.2	Sterilization
Z30.40	Contraceptive surveillance, unspecified

Pregnant By Choice Covered Codes	
Covered Diagnosis Codes	**Diagnosis Code Description**
Z30.41	Surveillance of contraceptive pill
Z30.431	Surveillance of intrauterine contraceptive device
Z30.49	Surveillance of implantable sub dermal contraceptive
Z30.42, Z30.49	Surveillance of other contraceptive method
Z30.019, Z30.49	Surveillance of previously prescribed contraceptive methods
Z30.8	Other specified contraceptive management
Z32.02	Pregnancy examination or test, negative result
Z32.01	Pregnancy examination or test, positive result
Z11.3	Screening examination for venereal disease

Pregnant By Choice Covered Codes	
Covered Procedures	**Procedure Code Description**
99201-99203	Office/Outpatient New
99211-99213	Office/Outpatient Established
11976	Removal, implantable contraceptive capsules
11980	Implant hormone pellet(s)
11981	Implant hormone pellet(s)
11982	Remove drug implant device
11983	Remove/insert drug implant
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of Intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
58600	Division of fallopian tube
58615	Occlude fallopian tube(s)

Pregnant By Choice Covered Codes	
Covered Procedures	**Procedure Code Description**
58670	Laparoscopy tubal cautery
58671	Laparoscopy tubal block
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
80048	Basic metabolic panel (calcium, total)
80076	Hepatic function panel
81000-81015	Urinalysis
81025	Urine pregnancy test
82465	Cholesterol
82947-82948	Glucose
84703	Gonadotropin, Chorionic (HCG)
85013	Blood count
85014-85018	Blood smear exam
86592	Syphilis Test
86593	Syphilis test non-trep quant
86689	HTLV or HIV antibody, confirmatory test (EG, Western Blot)
86701	HIV – 1 – Antibody
86702	HIV – 2 – Antibody
86703	HIV – 1 and HIV – 2, single assay – antibody
87070-87081	Culture, bacterial
87110	Culture, Chlamydia

Pregnant By Choice Covered Codes	
Covered Procedures	**Procedure Code Description**
87205-87207	Smear, primary source
87209	Smear complex stain
87210	Smear wet mount saline/ink
87270	Infectious agent antigen detection Chlamydia
87274	Infectious agent antigen detection Herpes Simplex virus type 1
87320	Infectious agent antigen detection multiple step method; Chlamydia Trachomatis
87340	Infectious agent antigen detection Hepatitis B surface antigen (HBSAG)
87490	Infectious agent detection by Nucleic Acid (DNA or RNA); Chlamydia Trachomatis, direct probe technique
87491	Infectious agent detection by Nucleic Acid (DNA or RNA); Chlamydia Trachomatis, amplified probe technique
87590	N.Gonorrhoeae DNA dir prob
87591	Infectious agent detection by Nucleic Acid (DNA or RNA); Neisseria Gonorrhoeae, amplified probe technique
88141-88143	Cytopathology
88164-88167	Cytopathology
88175	Cytopath C/V auto fluid redo
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom, male, each
A4268	Contraceptive supply, condom, female, each
J0696	Injection, Ceftriaxone sodium, Per 250MG
J1050	Injection, medroxyprogesterone acetate, contraceptive 150 MG (Depo-Provera)

Pregnant By Choice Covered Codes	
Covered Procedures	**Procedure Code Description**
J7296	KYLEENA, 19.5 MG
J7300	Intrauterine copper contraceptive
J7301	Skyla 13.5MG
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive patch
J7307	Etonogestrel (Contraceptive) implant system, including implant and supplies
S4993	Contraceptive pills for birth control
T1015	Clinic encounter, per visit
58600	Ligation or transaction of fallopian tube(s) abdominal or biginal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by devices (EG, Bank, Clip, Falope Ring) Vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without tran-section)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (EG, Bank, Clip or Falope ring)
00851	Laparoscopy; tubal ligation/transaction

Chapter 24 – Covered Services – Therapy Services

24.1 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 presence 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.

Time and Frequency: Are required on all documentation and must be specific so time in and time out must be reflected on the document in standard or military format. Time can be a unit of 15 minutes depending on the Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) Level II code used to bill the service. For example, if the code is a fifteen (15) minute unit, then follow the guidelines for rounding to the nearest unit. If seven (7) minutes or less of the next 15-minute unit is utilized, the unit must be rounded down. However, if eight (8) or more minutes of the next 15-minute unit are utilized, the units can be rounded up.

24.2 Physical and Occupational Therapy

24.2.1 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 or rehabilitation techniques to improve the Member's functioning

- **Occupational Therapy** interventions may include:
  - Evaluations or re-evaluations required to assess individual functional status
  - Interventions that develop, improve, or restore underlying impairments

24.2.2 Limitations

Reimbursement includes all expendable medical supplies normally used at the time therapy services are provided. Additional medical supplies or equipment provided to a Member as part of the therapy services for home use will be reimbursed separately through the Medical Supplies Program.

- For Medicaid Members, for dates of service in excess of twenty (20) per calendar year, Providers will need to contact Telligen for prior authorization (*see Section 6.12* Prior Authorization)
  - Physical therapy visits and occupational therapy visits are counted separately (see *Section 6.7* Service Thresholds)
  - Authorizations for acute conditions can be authorized up to eight (8) visits at a time
  - Authorizations for Habilitative therapy for children can be authorized for up to 180 days at a time
- 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 20 and under

24.2.3 Documentation

The practitioners' 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
  - Outpatient physical therapy services are furnished while the Member is under their care
- 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

Practitioners and licensed physical therapist's progress notes must be completed for each date of service and contain the following:

- Identification of the Member on each page of the treatment record
- Identification of the type of therapy being documented on each entry (such as, 97530 vs. 97110)
- Date and time(s) spent in each therapy session; total treatment minutes of the Member, including those minutes of active treatment reported under timed codes and those minutes represented by the untimed codes, must be documented, to include beginning time and ending time for each service billed
- Description of therapy activities, Member reaction to treatment and progress being made to stated goals/outcomes
- Full signature or counter signature of the licensed therapist, professional title and date that entry was made and the signature of the therapy assistant and date the entry was made. Licensed therapists must sign progress notes of assistants within 30 days.

24.3 Speech Therapy

Speech (pathology) therapy services are those services 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.

24.3.1 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.

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

24.3.2 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 to obtain prior authorization (*see Section 6.12* 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-based 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.

> 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.

24.3.3 Documentation

The practitioners and licensed speech 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 speech therapy)
- Practitioner signature and date of review
- Speech 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
    - Outpatient speech therapy services are furnished while the Member is under their care
- 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

Practitioners' and licensed speech therapist's progress notes must be completed for each date of service and contain the following:

- Identification of the Member on each page of the treatment record
- Identification of the type of therapy being documented on each entry (such as, 97530 vs. 97110)

- Date and time(s) spent in each therapy session; total treatment minutes of the Member, including those minutes of active treatment reported under timed codes and those minutes represented by the untimed codes, must be documented, to include beginning time and ending time for each service billed
- Description of therapy activities, Member reaction to treatment, and progress being made to stated goals/outcomes
- Full signature or counter signature of the licensed therapist, professional title, and date that entry was made and the signature of the therapy assistant and date the entry was made. Licensed therapist must sign progress notes of assistants within 30 days

24.3.4 Prior Authorization Once Threshold is Met

For Medicaid Members, for dates of service in excess of thirty (30) per calendar year for each service, Providers will need to contact Telligen for prior authorization (see *Section 6.7* Service Thresholds).

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.

24.4 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.

Appendices

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Appendix A – Change Control Table

Table 1 provides detailed changes made to this version of the WY BMS CMS-1500 Provider Manual.

Table 1. Change Control Table

Effective Date	Changes
10/02/2023	**Chapter 6 – Common Billing Information** Section 6.1 Electronic Billing – Under Exceptions, updated bullet point for LOA.
	Chapter 7 – Third Party Liability: Added and removed sections within this chapter that caused section number changes and page number changes. Section 7.1.3 Medicare –Reorganized and added content. Section 7.1.3.1 Medicare Part A – Added definition. Section 7.1.3.2 Medicare Part B – Added definition. Section 7.1.3.3 Medicare Part C (Advantage or Replacement Plans) – Existing information from previous section 7.1.4 Medicare Replacement Plans moved here. Info reformatted and added new bullet and a note. Claim filing indicator must be Medicare Part A or B, and these claims do not crossover to Medicaid. Section 7.1.3.4 Medicare Part D – Added definition. Section 7.1.4 Medicare Supplement Plans – Moved information from previous 7.1.4 Medicare Replacement Plans to new section 7.1.3.3 Medicare Part C. Updated this section, reformatted, and added new bullet. Claim filing indicator should be commercial insurance. Section 7.3 Billing Requirements – Added note about EOB and COB. Added information under payment less than Medicaid's allowed amount for the same claim and indicate payment on approp claim form Section 7.3.1 How Third Party Liability is Applied – Updated info about CMS-1500 claims, UB-04 claims, and Dental claims. Section 7.4 Medicare Pricing – Updated the third bullet point from Part A to Part B.
	Chapter 8 – Electronic Data Interchange and Provider Portal Section 8.3 Standard Transaction Formats – Added bullet point for X12N 277CA. Removed X12N 277CA from the note on what Medicaid does not accept or generate. Section 8.5 Sending and Receiving Transactions – Added X12N 277CA to the Transactions Supported column. Section 8.6.2.3 Provider Profile Names and Access Rights (Provider User) – In the Provider Access row of the table, added 277CA to bullet for retrieve acknowledgment responses. Section 8.6.3.3 Billing Agent and Clearinghouse Profile Names and Access Rights (Billing Agent and Clearinghouse User) – In the Provider Access row of the table, added 277CA to bullet for retrieve acknowledgment responses.

Effective Date	Changes
	Chapter 13 – Covered Services – Care Management Entity and Children's Mental Health Waiver Services Section 13.1 Care Management Entity and Children's Mental Health Waiver Services – Removed "as Administered by Magellan Healthcare, Inc." from the section title. Updated this section with bullet points for eligibility. Section 13.2.2 Early Childhood Service Intensity Instrument and Child and Adolescent Service Intensity Instrument Eligibility Add Form – Removed "and the date of service for billing" from the information about completed ECSII/CASII Eligibility Add Forms.
	Chapter 17 Covered Services – Durable Medical Equipment Billing Section 17.1.1 Reimbursement – Added bulletin information for effective dates of service beginning Sept 1 2023 and added screenshot of Online Fee Schedule.
	Chapter 20 – Covered Services – Interpreter Services - REMOVED
	Chapter 22 – Covered Services – Practitioner Services Section 22.11 Interpretation Services – Removed previous information. Replaced with bulletin information. Section 22.17 Podiatry Services – Updated "active" to "enrolled" podiatrists. Updated "clients" to "members". Section 22.26.1.1 Covered Services – Added a new bullet point under "Members under the age of 21 years" for 92015: refraction 365-day period.
	Appendices Appendix A – Change Control Table – Updated table.

Appendix B – Provider Notifications Log

Provider Notifications Log			
Active Dates	**Notification Type**	**Title**	**Audience**
September 2023	BMS Banner	PA Changes for Professional Claims	All Providers
August 2023	Email, Provider Bulletin	Upcoming Changes to DME Methodology & Rates and CPAP & BiPAP Change	Durable Medical Equipment and Medical Supplies; Prosthetic/Orthotic Supplier
July 2023	BMS Banner, Email, Provider Bulletin, and What's New	Implementation of 277CA Functionality in BMS	All Providers
June 2023	Email, Provider Bulletin	Wyoming Medicaid to Cover Podiatry Services	Podiatrist

Wyoming Medicaid
CMS-1500 Provider Bulletin
October 2023, Quarter 3

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Upcoming Changes to DME Methodology & Rates and CPAP & BiPAP Change

Effective for dates of service beginning September 1, 2023, Wyoming Medicaid will reimburse new and rental rates for Durable Medical Equipment (DME) claims at the lesser of logic pricing:

1. Provider's usual and customary charge for the service, or;
2. 90 percent (90%) of Medicare's rural or non-rural rate based on the member's primary location ZIP code.

Manual pricing will still apply for procedure codes in which a rate is not established. Manual pricing will not consider the ZIP code and whether the area is rural or non-rural.

The Centers for Medicare and Medicaid Services (CMS) publishes a ZIP code file indicating if it is considered a rural or non-rural location. This file is updated by CMS and can be found at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/dmeposfeesched/dmepos-fee-schedule.

Wyoming Medicaid will update the ZIP code file annually. Claims will not be retroactively priced or reprocessed if a ZIP code changes after the annual file is uploaded. The Provider Portal will determine the ZIP code of the member and price it accordingly.

Note: Please remind all Medicaid members to update their primary addresses and contact information if there has been a change.

No Billing Changes

DME providers will not have to change how claims are billed including the use of required modifiers NU (New Equipment) or RR (Reduced Rate [Rental]).

The online fee schedule will show the rural or non-rural rate and the fee for a new purchase or rental for each procedure code. If there is not a rural or non-rural indicator on the fee schedule, Medicare has established one price for all areas. The online fee schedule can be found at: https://wyomingmedicaid.com/portal/fee-schedules.

CPAP & BiPAP Change

Effective immediately, for Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) devices that do not have integrated heated humidifier units, if deemed medically necessary, a separate unit may be approved for rental or purchase under code E0562.

- E0562 – Prior Authorization (PA) required.

Deployment Information
Deployment Date: August 3, 2023
Audiences: Durable Medical Equipment and Medical Supplies; Prosthetic/Orthotic Supplier

Implementation of 277CA Functionality in BMS

Attention all Providers, Clearinghouses and Billing Agents:
Effective July 29, 2023, Clearinghouses and Providers will receive 277CA Claims Transaction Acknowledgements. This will give Providers an immediate response for every claim they submit that has been received and processed in the Benefit Management System (BMS).

- Providers will receive the TCN number in the 277CA for each of the claims accepted in the BMS for adjudication.
- Providers will know the rejection status in the 277CA so they can resubmit the claim quickly.
- 277CAs will result in reduced claims processing time in the BMS, reduced Provider inquiries, and increased Provider satisfaction.
- 277CA flow: 837 > 999 > 277CA > Claim processed > 835.
  Note: If the 999 is rejected, there won't be a 277CA generated.
- Clearinghouses that receive the 277CA will parse out the contents to each of their Providers.
- Providers do not need to do anything; the 277CA will be sent automatically.

Note: Providers, Billing Agents and Clearinghouses are encouraged to review the updated Wyoming Medicaid EDI Companion Guide for the 277CA transaction and file details.

Deployment Information
Deployment Date: July 27, 2023
Audiences: All Providers

PA Changes for Professional Claims

Attention Providers: Changes for prior authorization requests to be used on professional/ CMS-1500/837P claims - please review if you request prior authorizations through Telligen: https://wymedicaid.telligen.com/wp-content/uploads/2023/08/Changes-on-how-to-submit-CMS-1500-Professional-837P-claim-type-Part-2-.pdf

Wyoming Medicaid to Cover Podiatry Services

Attention: Wyoming Medicaid Podiatry Providers
Prior to July 1, 2023, podiatry services were only payable by Wyoming Medicaid when Medicaid Members were dual eligible with Medicare Part B as the primary insurance.

Beginning July 1, 2023, Wyoming Medicaid will cover podiatry services for Medicaid Members who have Wyoming Medicaid as their primary insurance provider. Members who are dual eligible with Medicare or another commercial payer will also be covered.

Providers will need to ensure all claims are submitted to primary payers prior to submitting the claim to Wyoming Medicaid for reimbursement.

Please refer to the Wyoming Medicaid Fee Schedule to verify covered procedure codes.

If you have additional questions, please reach out to provider services at 1-888-996-6223.

Deployment Information
Deployment Date: June 6, 2023
Audiences: Podiatrist