

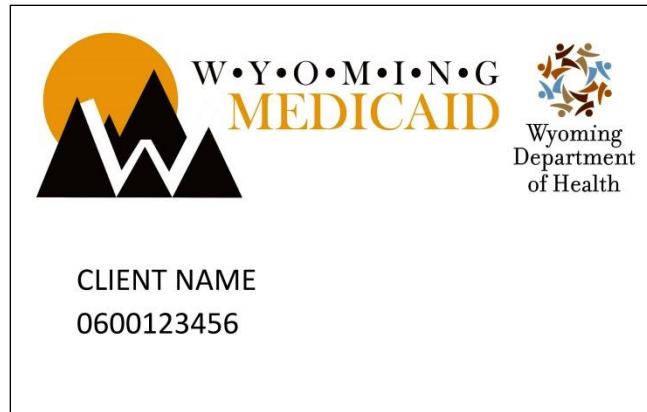
DIVISION OF HEALTHCARE FINANCING

DENTAL MANUAL ICD-10

January 1, 2021



Wyoming
Department
of Health



Overview

Thank you for your willingness to serve clients 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 ([2.1, Quick Reference](#)). Fee schedules list Medicaid covered codes, provide clarification of indicators, such as whether a code requires prior authorization and the number of days in which follow-up procedures are included. Not all codes are covered by Medicaid or are allowed for all taxonomy codes (provider types). It is the providers' responsibility to verify this information. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4, CDT, and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service. Providers may elect to utilize CPT or CDT codes as applicable. However, all codes pertaining to dental treatment must adhere to all state guidance and federal regulation. Providers utilizing a CPT code for Dental services will be bound to the requirements of both manuals.

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

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific department such as Dental Services, EDI, or Medical Policy ([2.1, Quick Reference](#)).

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

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.

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Chapter One – General Information

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1.1 How the Dental 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 – Quick Reference guide, telephone numbers and addresses and web sites for help and training
Three	Provider Responsibilities – Obligations and rights as a Medicaid provider. The topics covered include enrollment changes, civil rights, group practices, provider-patient relationship, and record keeping requirements.
Four	Utilization Review – Fraud and abuse definitions, the review process, and rights and responsibilities.
Five	Client Eligibility – How to verify eligibility when a client 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) – Explains the advantages of exchanging documents electronically. Secured Provider Web Portal registration process
Nine	Wyoming Specific HIPAA 5010 Electronic Specifications – This chapter covers the Wyoming Specific requirements pertaining to electronic billing. Wyoming payer number and electronic adjustments/voids
Ten	Important Information – This chapter covers important billing information such as coding, definitions of supervision and face-to-face visit requirements.
Eleven	Dental Covered Services – This chapter provides information such as: definitions, procedure code ranges, documentation requirements, covered and non-covered services, and billing examples.
Appendices	Appendices – Provide key information in an at-a-glance format. This includes the Provider Manual Version Control Table, and last quarters Provider Notifications.

1.2 Updating the Manual

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

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

RA banner notices appear on the first page of the proprietary Wyoming Medicaid Remittance Advice (RA), which is available for download through the Secured Provider Web Portal after each payment cycle in which the provider has claims processed or "in process." This same notice also appears on the RA payment summary email that is sent out each week after payment, and is published to the "What's New" section of the website.

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 wycustomersvc@conduent.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 ([2.1, Quick Reference](#)).

NOTE: Provider bulletins and State Letter email notifications are sent to the email addresses on-file with Medicaid and are sent in two (2) formats, plain text and HTML. If the HTML format is received or accepted then the plain text format is not sent.

1.2.1 RA Banner Notices Samples

RA banners are limited in space and formatting options and are used to notify providers quickly and often refer providers elsewhere for additional information.

Sample RA Banner:

ATTENTION ALL DENTAL PROVIDERS

Please review the Dental provider manual for updates to all dental codes. D9222 and D9239 have been added as new sedation codes and D9986 will now replace D0000 for reporting of missed/broken appointments.

Sample RA Payment Summary (weekly email notification):

-----Original Message-----

From: Wyoming Medicaid [<mailto:wycustomersvc@conduent.com>]
Sent: Thursday, May 28, 2015 5:17 AM
To: Provider Email Name
Subject: Remittance Advice Payment Summary

On 05/27/2015, at 05:16, Wyoming Medicaid wrote:

Dear Provider Name,

The following is a summary of your Wyoming Medicaid remittance advice 123456 for 05/27/2015, an RA Banner with important information may follow.

RA PAYMENT SUMMARY

To: Provider Name
NPI Number: 1234567890
Provider ID: 111111111

Remittance Advice Number: 123456

Amount of Check: 16,070.85


The RA banner notification will appear here when activated for the provider's taxonomy (provider type)

1.2.2 Medicaid Bulletin Notification Sample

Medicaid bulletin email notifications typically announce billing changes, new codes requiring prior authorization, reminders, up and coming initiatives, etc.

Sample bulletin email notification (HTML format)


From: Wyoming Medicaid [mailto:wycustomersvc@conduent.com]



Wyoming Medicaid

To view this email as a web page, go [here](#).

- Medicaid Website
- Manuals & Bulletins
- Fee Schedules
- What's New
- Links
- Web Portal Tutorials



Attention Providers: Prior Authorization Vendor Change

Beginning with dates of service February 1, 2020 and forward, Wyoming Medicaid will be changing the vendor processing Prior Authorization (PA) requests for surgical and medical procedures and vision codes which require PA. Formerly handled by the Medical Policy unit within the Fiscal Agent (Conduent), these PA requests will now be processed by WYhealth.

WYhealth will begin accepting requests on January 2, 2020 for any dates of service February 1, 2020 and after. Dates of service prior to February 1, 2020 should continue to be submitted as they currently are, even after January 2, 2020.

Additionally, unlisted procedure codes will require a prior authorization starting with dates of service February 1, 2020. If your office knows in advance that a service will be coded with an unlisted CPT code, prior authorization **MUST** be requested in advance of the procedure. If a procedure is planned but is changed to one with an unlisted code once the surgery has begun, then the office will have **five (5) business days** to initiate the request for prior authorization.

Conduent Medical Policy will continue to process PA requests for all dates of service for:

- Pharmaceutical J-Codes that require PA
 - Tysabri IV Infusion Treatment (J2323)

To review the provider manuals online, please visit <https://wymedicaid.portal.conduent.com/manuals.html>.

To verify if a procedure code requires prior authorization, please review the fee schedule located online at https://wymedicaid.portal.conduent.com/fee_schedule.html or contact Provider Relations at 800-251-1268.

If there are any questions regarding this change, please contact the Utilization Management Coordinator, Amy Buxton at 307-777-7531 or amy.buxton@wyo.gov.

STOP MEDICAID FRAUD Help identify and combat Medicaid Fraud by visiting the website or contacting the Fraud Hotline:
<https://health.wyo.gov/healthcarefin/program-integrity/>
• 1-855-846-2563

WYhealth is a Medicaid health management and utilization management program offered by the Wyoming Department of Health through Optum. Medicaid clients and providers will benefit from a wide array of programs and services offered and coordinated by Optum. Visit <https://www.wyhealth.net/tpa-ap-web/> for more information

[Unsubscribe](#)

Be sure to add wycustomersvc@conduent.com to your address book to ensure the proper delivery of your Wyoming Medicaid updates and weekly payment summary information.

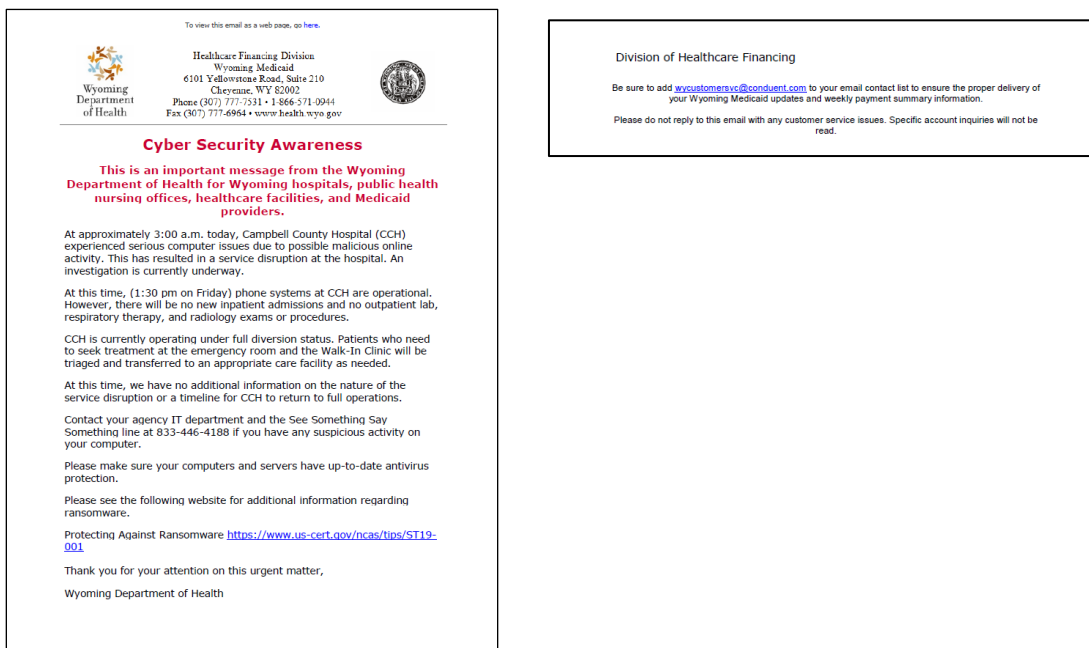
Wyoming Medicaid, Provider Relations, PO Box 667, Cheyenne, WY 82003

Please do not reply to this email with any customer service issues. Specific account inquiries will not be read. For assistance, contact Provider Relations at 1-800-251-1268
<https://wymedicaid.portal.conduent.com/>

1.2.3 Wyoming Department of Health (WDH) State Letter/Sample

WDH email notifications typically announce significant Medicaid policy changes, RAC, and other audits.

Sample WDH email notification (HTML format)



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

Conduent is the fiscal agent for Medicaid. They process all claims and adjustments, with the exception of pharmacy. They also answer provider inquiries regarding claim status, payments, client 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.

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

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2.1 Quick Reference

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Dental Services – Interactive Voice Response (IVR) System	Tel (800)251-1270 24 / 7	N/A	<ul style="list-style-type: none"> • Payment inquiries • Client eligibility • Medicaid client number and information • Lock-in status • Authorization of Medical Necessity • Medicare Buy-In data • Service limitations • Client third party coverage information <p>NOTE: The client's Medicaid ID number or social security number is required to verify client eligibility.</p>
Claims PO Box 547 Cheyenne, WY 82003-0547	N/A	N/A	<ul style="list-style-type: none"> • Claim adjustment submissions • Hardcopy claims submissions • Returning Medicaid checks
Dental Service PO Box 667 Cheyenne, WY 82003-0667	Tel (888)863-5806 9-5pm MST M-F Fax (307)772-8405	https://wymedicaid.portal.conduent.com/provider_home.html	<ul style="list-style-type: none"> • Bulletin/manual inquiries • Claim inquiries • Claim submission problems • Client eligibility • How to complete forms • Payment inquiries • Request Field Representative visit • Training seminar questions • Timely filing inquiries • Verifying validity of procedure codes • Claim void/adjustment inquiries • WINASAP training • Web Portal training
EDI Services PO Box 667 Cheyenne, WY 82003-0667	Tel (800)672-4959 OPTION 3 9-5pm MST M-F Fax (307)772-8405	https://wymedicaid.portal.conduent.com	<ul style="list-style-type: none"> • EDI Enrollment Forms • Trading Partner Agreement • WINASAP software • Technical support for WINASAP • Technical support for vendors, billing agents and clearing houses • Web Portal registration/password resets • Technical support for Web Portal
Conduent EDI Solutions	N/A	https://edisolutionsmmis.portal.conduent.com/gcro/	<ul style="list-style-type: none"> • Download WINASAP software • Submit and view EDI files
Medical Policy PO Box 667 Cheyenne, WY 82003-0667	Tel (800)251-1268 OPTIONS 1,1,4,3 9-5pm MST M-F (24/7 Voicemail Available) Fax (307)772-8405	https://wymedicaid.portal.conduent.com/manuals.html	<p>Authorization for Medical Necessity for dates of service prior to 01/01/2021</p> <ul style="list-style-type: none"> • Dietitian • Chiropractic <p>Prior Authorization requests for:</p> <ul style="list-style-type: none"> • Dental Services • Hospice Services: Limited to clients residing in a nursing home • Injections that require PA (listed in 6.13. Prior Authorization) • Severe Malocclusion

Getting Help When Needed

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
<p>Provider Relations PO Box 667 Cheyenne, WY 82003-0667</p> <p>(IVR Navigation Tips available on the website)</p> <p>wycustomersvc@conduent.com</p>	<p>Tel (800)251-1268</p> <p>9-5pm MST M-F (call center hours)</p> <p>Fax (307)772-8405</p> <p>24 / 7 (IVR availability)</p>	<p>https://wymedicaid.portal.conduent.com</p> <p>https://wymedicaid.portal.conduent.com/contact.html</p>	<ul style="list-style-type: none"> • Provider enrollment questions • Bulletin/Manuals inquiries • Authorization for Medical Necessity Requirements • Claim inquiries • Claim submission problems • Client eligibility • Claim void/adjustment inquiries • Form completion • Payment inquiries • Request Field Representative visit • Training seminar questions • Timely filing inquiries • Troubleshooting prior authorization problems • Verifying validity of procedure codes
<p>Third Party Liability (TPL)</p> <p>PO Box 667 Cheyenne, WY 82003-0667</p>	<p>Tel (800)251-1268 OPTION 2</p> <p>9-5pm MST M-F Fax (307)772-8405</p> <p>Select Option 2 for Medicare or estate and trust recovery assistance</p> <p>THEN</p> <p>Select Option 2 for callers who are with an insurance company, attorney's office, or child support enforcement</p> <p>OR</p> <p>Select Option 3 for Medicare and Medicare Premium payments</p> <p>OR</p> <p>Select Option 4 for estate and trust recovery inquires</p>	<p>N/A</p>	<ul style="list-style-type: none"> • Client accident covered by liability or casualty insurance or legal liability is being pursued • Estate and Trust Recovery • Medicare Buy-In status • Reporting client TPL • New insurance coverage • Policy no longer active • Problems getting insurance information needed to bill • Questions or problems regarding third party coverage or payers • WHIPP program
<p>Transportation Services PO Box 667 Cheyenne, WY 82003-0667</p>	<p>Tel (800)595-0011</p> <p>9-5pm MST M-F (24/7 Voicemail Available)</p> <p>Fax (307)772-8405</p>	<p>https://wymedicaid.portal.conduent.com/client/</p>	<p>Client inquiries:</p> <ul style="list-style-type: none"> • Prior authorize transportation arrangements • Request travel assistance • Verify transportation is reimbursable

Getting Help When Needed

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
<p>WYhealth (Utilization and Care Management)</p> <p>PO Box 49 Cheyenne, WY 82003-0049</p>	<p>Tel (888)545-1710</p> <p>Nurse Line: (OPTION 2)</p> <p>Fax PASRRs Only (888)245-1928 (Attn: PASRR Processing Specialist)</p>	<p>http://www.WYhealth.net/</p>	<ul style="list-style-type: none"> • Diabetes Incentive Program • DMEPOS Covered Services manual • Educational Information about WYhealth Programs • ER Utilization Program • Medicaid Incentive Programs • P4P • Questions related to documentation or clinical criteria for DMEPOS • SBIRT <p>Prior Authorization for:</p> <ul style="list-style-type: none"> • Acute Psych • Durable Medical Equipment (DME) or Prosthetic/Orthotic Services (POS) • Extended Psych • Extraordinary heavy care • Gastric Bypass • Genetic Testing • Home Health • Psychiatric Residential Treatment Facility (PRTF) • PT/OT/ST/BH PAs after service threshold has been met • Surgeries that require PA (listed in 6.13, Prior Authorization) • Transplants • Vagus Nerve Stimulator • Vision services that require PA (listed in 6.13, Prior Authorization) • Unlisted Procedures
Aids Drug Assistance Program (ADAP)	<p>Tel (307)777-5800</p> <p>Fax (307)777-7382</p>	N/A	<p>1) Prescription medications</p> <p>2) Program information</p>
<p>Maternal & Child Health (MCH) /Children Special Health (CSH)</p> <p>Public Health Division 122 West 25th Street 3rd Floor West Cheyenne, WY 82002</p>	<p>Tel (307)777-7941 Tel (800)438-5795</p> <p>Fax (307)777-7215</p>	N/A	<ul style="list-style-type: none"> • High Risk Maternal • Newborn intensive care • Program information
Social Security Administration (SSA)	Tel (800)772-1213	N/A	Social Security benefits
Medicare	Tel (800)633-4227	N/A	Medicare information
<p>Division of Healthcare Financing (DHCF)</p> <p>122 West 25th St, 4th Floor West Cheyenne, WY 82002</p>	<p>Tel (307)777-7531 Tel (866)571-0944</p> <p>Fax (307)777-6964</p>	<p>https://health.wyo.gov/healthcarefin/</p>	<ul style="list-style-type: none"> • Medicaid State Rules • State Policy and Procedures • Concerns/Issues with State Contractors/Vendors • Developmental Disability Services
<p>DHCF Program Integrity</p> <p>122 West 25th St, 4th Floor West Cheyenne, WY 82002</p>	Tel (855)846-2563	N/A	<p>Client or Provider Fraud, Waste and Abuse</p> <p>NOTE: Callers may remain anonymous when reporting</p>

Getting Help When Needed

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Stop Medicaid Fraud	Tel (855)846-2563	https://health.wyo.gov/healthcarefin/program-integrity/	<ul style="list-style-type: none"> Information and education regarding fraud, waste, and abuse in the Wyoming Medicaid program To report fraud, waste and abuse
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
Change Healthcare	Tel (877)209-1264 (Pharmacy Help Desk) Tel (877)207-1126 (PA Help Desk)	http://www.wyicaid.org/	<ul style="list-style-type: none"> Pharmacy prior authorization Enrollment Pharmacy manuals FAQs
Customer Service Center (CSC) , Wyoming Department of Health 3001 E. Pershing Blvd, Suite 125 Cheyenne, WY 82001	Tel (855)294-2127 TTY/TDD 1-855-329-5205 (Clients Only , CSC cannot speak to providers) 7am-6pm MST M-F Fax (855)329-5205	https://www.wesystem.wyo.gov	<ul style="list-style-type: none"> Client Medicaid applications Eligibility questions regarding: <ul style="list-style-type: none"> Family and Children's programs Tuberculosis Assistance Program Medicare Savings Programs Employed Individuals with Disabilities
Wyoming Department of Health Long Term Care Unit (LTC)	Tel (855)203-2936 8-5pm MST M-F Fax (307)777-8399	N/A	<ul style="list-style-type: none"> Nursing home program eligibility questions Patient Contribution Waiver Programs Inpatient Hospital Hospice Home Health
Wyoming Medicaid	N/A	https://wyicaid.portal.consumer.com	<ul style="list-style-type: none"> Provider manuals HIPAA electronic transaction data exchange Fee schedules On-line Provider Enrollment Frequently asked questions (FAQs) Forms (e.g., Claim Adjustment/Void Request Form) Contacts What's new Remittance Advice Retrieval EDI enrollment form Trading Partner Agreement Secured Provider Web Portal Training Tutorials
Magellan Healthcare, Inc.	Tel (307)459-6162 8-5pm MST M-F (855)883-8740 After Hours	https://www.magellanofwyoming.com/	<ul style="list-style-type: none"> Care Management entity Services that require PA with dates of service 10/1/2020 and forward (listed in 6.13. Prior Authorization)

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 client eligibility, service limitations, third party coverage, electronic transaction questions, and provider payment issues

2.3 How to Write for Help

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

Reasons to write vs. calling:

- **Appeals** – Include the claim that is believed to have been denied or paid erroneously, all documentation previously submitted with the claim, explanation for request, 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 ([2.3.1, Provider Inquiry Form](#)). Providers may copy the form in this manual. Provider Relations will respond to the provider inquiry within ten business days of receipt.

2.3.1 Provider Inquiry Form

Provider Inquiry Form					
1. Provider Name and Address			2. Provider/NPI Number		3. Telephone Number
			4. Person to contact in Provider's Office		5. Date of Inquiry
6. Client Name: Last, First MI.			7. Medicaid ID Number		8. Dates of Service
9. Proc. Code	10. Charge	11. RA Date	12. MED Record Number		13. Transaction Control Number
14. Nature of Inquiry					
15. Fiscal Agent Response					
6. Client Name: Last, First, MI.			7. Medicaid ID Number		8. Dates of Service
9. Proc. Code	10. Charge	11. RA Date	12. MED Record Number		13. Transaction Control Number
14. Nature of Inquiry					
15. Fiscal Agent Response					

Mail completed form to:

Wyoming Medicaid
 Attn: Provider Relations
 PO Box 667
 Cheyenne, WY 82003-0667

NOTE: Click image above to be taken to a printable version of this form.

2.4 How to Get a Provider Training Visit

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

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

Due to the rural and frontier nature, and weather, in Wyoming visits are generally conducted during the warmer months only. For immediate assistance, a provider should always contact Provider Relations ([2.1, Quick Reference](#)).

2.5 How to Get Help Online

The address for Medicaid's public website is <https://wymedicaid.portal.conduent.com/>. This site connects Wyoming's provider community to a variety of information, including:

- Answers to the providers frequently asked Medicaid questions
- Claim, prior authorization, and other forms for download
- Free download of latest WINASAP software and latest WINASAP updates
- Free download of WINASAP Training Manuals and Tutorials
- Medicaid publications, such as provider handbooks and bulletins
- Payment Schedule
- Primary resource for all information related to Medicaid
- Wyoming Medicaid Secured Provider Web Portal
- Wyoming Medicaid Secured Provider Web Portal tutorials

The Medicaid Secured Provider Web Portal delivers the following services:

- **278 Electronic Prior Authorization Requests** – Ability to submit and retrieve prior authorization requests and responses electronically via the web
- **Data Exchange** – Upload and download of electronic HIPAA transaction files
- **Remittance Advice Reports** – Retrieve recent Remittance Advices
 - Wyoming Medicaid proprietary RA
 - 835 transaction

- **User Administration** – Add, edit, and delete users within the provider's organization who can access the Secured Provider Web Portal
- **837 Electronic Claim Entry** – Interactively enter dental, institutional, and medical claims without buying expensive software
- **PASRR entry**
- **LT101 Look-Up**

2.6 Training Seminars/Presentations

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

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3.1 Enrollment/Re-Enrollment

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

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

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

Categorical Risk Level	Screening Requirements
LIMITED Includes: <ul style="list-style-type: none"> Physician and non-physician practitioners, (includes nurse practitioners, CRNAs, occupational therapists, speech/language pathologist audiologists) and medical groups or clinics Ambulatory surgical centers Competitive Acquisition Program/Part B Vendors: End-stage renal disease facilities Federally qualified health centers (FQHC) Histocompatibility laboratories Hospitals, including critical access hospitals, VA hospitals, and other federally-owned hospital facilities Health programs operated by an Indian Health program Mammography screening centers Mass immunization roster billers Organ procurement organizations Pharmacy newly enrolling or revalidating via the CMS-855B application Radiation therapy centers Religious non-medical health care institutions Rural health clinics Skilled nursing facilities 	<p>Verifies provider or supplier meets all applicable Federal regulations and State requirements for the provider or supplier type prior to making an enrollment determination</p> <p>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</p> <p>Conducts database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.</p>
MODERATE Includes: <ul style="list-style-type: none"> Ambulance service suppliers Community mental health centers (CMHC) Comprehensive outpatient rehabilitation facilities (CORF) Hospice organizations Independent Clinical Laboratories Independent diagnostic testing facilities 	<p>Performs the "limited" screening requirements listed above</p> <p>Conducts an on-site visit</p>

Provider Responsibilities

Categorical Risk Level	Screening Requirements
<ul style="list-style-type: none"> Physical therapists enrolling as individuals or as group practices Portable x-ray suppliers Revalidating home health agencies Revalidating DMEPOS suppliers 	
<p>HIGH</p> <p>Includes:</p> <ul style="list-style-type: none"> Prospective (newly enrolling) home health agencies Prospective (newly enrolling) DMEPOS suppliers Prosthetic/orthotic (newly enrolling) suppliers Individual practitioners suspected of identity theft, placed on previous payment suspension, previously excluded by the OIG, and/or previously had billing privileges denied or revoked within the last ten (10) years 	<p>Performs the “limited” and “moderate” screening requirements listed above.</p> <p>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.</p> <p>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</p> <p>Categorical Risk Adjustment: CMS adjusts the screening level from limited or moderate to high if any of the following occur:</p> <ul style="list-style-type: none"> 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— <ul style="list-style-type: none"> 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 <p>Has been subject to a final adverse action as defined in §424.502 within the previous ten (10) years</p>

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

Provider Responsibilities

- 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 Medicaid website ([2.1, Quick Reference](#)).

3.1.1 Order, Referring, and Prescribing Providers (ORP)

Wyoming Medicaid requires that order, 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.

Taxonomies that may order, refer, or prescribe	
Taxonomy	Taxonomy Description
All 20s	Physicians (MD, DO, interns, residents and fellows)
111N00000X	Chiropractic
1223s	Dentists
152W00000X	Optometrists
176B00000X	Midwife
213E00000X	Podiatrist
225100000X	Physical Therapists
225X00000X	Occupational Therapists
231H00000X	Audiologist
235X00000X	Speech Therapist
363A00000X	Physician Assistants (PA)
363Ls	Nurse Practitioners

Taxonomies always required to include an ORP/attending NPI	
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
225I00000X	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
282N00000X	General Acute Care Hospital
282NR1301X	Critical Access Hospital (CAH)
283Q00000X	Psychiatric Hospital
283X00000X	Rehabilitation Hospital
323P00000X	Psychiatric Residential Treatment Facility
111N00000X	Chiropractors
231H00000X	Audiologist
133V00000X	Dietitians

3.1.2 Enrollment Termination

3.1.2.1 License/Certification

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

3.1.2.2 Contact Information

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

- Current licensing information
- Facility or name changes
- New ownership information
- New telephone or fax numbers
- Physical, correspondence, or payment address change
- New email addresses
- Tax Identification Number

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

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

3.1.2.3 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.

3.1.2.4 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 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.

3.1.3 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 Provider Relations, attention Enrollment Services ([2.1, Quick Reference](#)).

3.2 Accepting Medicaid Clients

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 clients 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 client and the provider is both a medical and a financial one. If a client presents himself or herself as a Medicaid client, the provider must determine whether the provider is willing to accept the client 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 client eligible one (1) month may not necessarily be eligible the next month.

NOTE: Presumptive Eligibility may begin or end mid-month.

Provider Responsibilities

It is the providers' responsibility to determine all sources of coverage for any client. If the client 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 ([7.2.1, Third Party Resources Information Sheet](#)) to Medicaid. The provider may not discriminate based on whether or not a client is insured.

Provider may not discriminate against Wyoming Medicaid clients. Providers must treat Wyoming Medicaid clients 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 client.

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

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

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 client, outlining the specific services and financial charges for a specific date of service, with the client agreeing to the financial responsibility for the charges

3.2.2.1 Accepting a Client as Medicaid after Billing the Client

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

- Prior to submitting the claim to Medicaid, the provider must refund the entire amount previously collected from the client to him or her for the services rendered; and
- The twelve (12) month timely filing deadline will not be waived ([6.14, Timely Filing](#)).

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

- Prior to billing Medicaid, the provider must refund the entire amount previously collected from the client to him or her for the services rendered; and
- The 12 month (365 days) timely filing deadline will be waived ([6.14, Timely Filing](#)).

NOTE: Medicaid will not pay for services rendered to the clients until eligibility has been determined for the month services were rendered.

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

3.2.2.2 Mutual Agreements between the Provider & Client

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

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

3.2.3 Missed Appointments

Appointments missed by Medicaid clients **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 clients directly.

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

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

NOTE: For clients who miss dental appointments, Wyoming Medicaid has a tracking process as detailed in [11.1, No Show Appointments/Broken Appointments](#).

3.3 Medicare Covered Services

Claims for services rendered to clients 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 client's Medicare eligibility should be directed to the Social Security Administration ([2.1, Quick Reference](#)).

3.4 Medical Necessity

The Medicaid Program is designed to assist eligible clients 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 client'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 (see provider agreement), the provider must accept payment from Medicaid as payment in full for a covered service.

The provider may never bill a Medicaid client:

- 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 client:

- If the provider has not billed Medicaid, the service provided is not covered by Medicaid, and, prior to providing services, the provider informed the client in writing that the service is non-covered and he/she is responsible for the charges
- If a provider does not accept a patient as a Medicaid client (because they cannot produce a Medicaid ID card or because they did not inform the provider they are eligible)
- If the client is not Medicaid eligible at the time the provider provides the services or is on a plan that does not cover those particular services. Refer to the table above for guidance

- If the client has reached the threshold on physical therapy, occupational therapy, speech therapy, behavioral health services, chiropractic services, prescriptions, and/or office/outpatient hospital visits.

NOTE: The provider may contact Provider Relations or the IVR to receive service thresholds for a client ([2.1, Quick Reference](#)).

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

3.6 Medicaid ID Card

It is each provider's responsibility to verify the person receiving services is the same person listed on the card. If necessary, providers should request additional materials to confirm identification. It is illegal for anyone other than the person named on the Medicaid ID Card to obtain or attempt to obtain services by using the card. Providers who suspect misuse of a card should report the occurrence to the Program Integrity Unit or complete the Report of Suspected Abuse of the Medicaid Healthcare System Form ([4.9.1, Referral of Suspected Fraud and Abuse Form](#)).

3.7 Verification of Client Age

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

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

3.8 Verification Options

One (1) Medicaid ID Card is issued to each client. 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 client may state that they are covered by Medicaid, but not have any proof of eligibility. This can occur if the client 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 client eligibility:

- Contact Dental Services.

Provider Responsibilities

- Email/Fax a list of identifying information to Dental Services for verification. Send a list of beneficiaries for verification and receive a response within five (5) business days.
- Call the Dental Services Interactive Voice Response (IVR) System. IVR is available 24 hours a day seven (7) days a week. The IVR System allows 30 minutes per phone call. ([2.1. Quick Reference](#))
- Use the Ask Wyoming Medicaid feature of the Secured Provider Web Portal ([2.1. Quick Reference](#))

3.8.2 Fee for Service

Several independent vendors offer web-based applications and/or swipe card readers that electronically check the eligibility of Medicaid clients. These vendors typically charge a monthly subscription and/or transaction fee. A complete list of approved vendors is available on the Medicaid website.

3.9 Freedom of Choice

Any eligible non-restricted client 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 clients when providers participating in the Medicaid Program administer the services. If services are available in Wyoming within a reasonable distance from the client's home, the client 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

Craig

Idaho

Montpelier

Pocatello

Idaho Falls

Montana

Billings

Bozeman

Nebraska

Kimball

Scottsbluff

South Dakota

Deadwood

Custer

Rapid City

Spearfish

Belle Fourche

Utah

Salt Lake City

Ogden

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

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

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

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

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

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

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

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 clients. The following elements are not limited to, but include:

- The record must be typed or legibly written
- The record must identify the client 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 client, the progress at each visit, any change in diagnosis or treatment, and the client'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 client, 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.

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

3.11.2 Retention of Records

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

3.11.3 Access to Records

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

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

3.11.4 Audits

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

Audits may include, but are not limited to:

- Examination of records;
- Interviews of providers, their associates, and employees;
- Interviews of clients;
- 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 clients;
- Examination of prescriptions written for clients;
- Determination of whether the healthcare provided was medically necessary;
- Random sampling of claims submitted by and payments made to providers;
- Audit of facility financial records for reimbursement; and/or
- Actual records review may be extrapolated and applied to all services billed by the provider.

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

Medicaid reserves the right to make unscheduled visits (i.e., when the client's health may be endangers, when criminal/fraudulent activities are suspected, etc.).

Medicaid is authorized to examine all provider records in that:

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

3.12 Tamper Resistant RX Pads

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

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

- Written Prescriptions: As of October 1, 2008 prescriptions must contain all three (3) of the following characteristics:
 1. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement, all written prescriptions must contain:
 - Some type of “void” or illegal pantograph that appears if the prescription is copied.
 - May also contain any of the features listed within category one, recommendations provided by the National Council for Prescription Drug Programs (NCPDP) or that meets the standards set forth in this category.
 2. One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. This requirement applies only to prescriptions written for controlled substances. In order to meet this requirement all written prescriptions must contain:
 - Quantity check-off boxes PLUS numeric form of quantity values OR alpha AND numeric forms of refill value.
 - Refill Indicator (circle or check number of refills or “NR”) PLUS numeric form of refill values OR alpha AND numeric forms of refill values.
 - May also contain any of the features listed within category two, recommendations provided by the NCPDP, or that meets the standards set forth in this category.
 3. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all written prescriptions must contain:
 - Security features and descriptions listed on the FRONT of the prescription blank.
 - May also contain any of the features listed within category three (3), recommendations provided by the NCPDP, or that meets the standards set forth in this category.
- Computer Printed Prescriptions: As of October 1, 2008 prescriptions must contain all three (3) of the following characteristics:
 1. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement all prescriber’s computer generated prescriptions must contain:
 - Same as Written Prescription for this category
 2. One (1) or more industry-recognized features designed to prevent the erasure or modification of information printed on the prescription by the prescriber. In order to meet this requirement all computer generated prescriptions must contain:
 - Same as Written Prescription for this category

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

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

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4.1 Utilization Review

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

- Review of claims submitted for payment (pre and post payment reviews)
- Reviews of medical records and documents related to covered services
- Audit of medical records and client interviews
- Review of client Explanation of Medical Benefits (EOMB) 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 clients. No action is taken without a complete investigation. To file a complaint, please submit the details in writing and attach supporting documentation to:

Division of Healthcare Financing
122 West 25th St, 4th Floor West
Attn: Program Integrity Unit
Cheyenne, WY 82002
Or contact: (855)846-2563

<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 client agrees to the release of medical records to the Division of Healthcare Financing when the accept Medicaid benefits.

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

4.4 Client Lock-In

In designated circumstances, it may be necessary to restrict certain services or “lock-in” a client to a certain physician, hospice, pharmacy, or other provider. If a lock-in

restriction applies to a client, the lock-in information is provided on the Interactive Voice Response System ([2.1, Quick Reference](#)).

A participating Medicaid provider who is not designated as the client's primary practitioner may provide and be reimbursed for services rendered to lock-in clients 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 client
- 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 client. Contact Provider Relations in circumstances where coverage of a lock-in client is unclear ([2.1, Quick Reference](#)).

4.5 Pharmacy Lock-In

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

When a pharmacy is chosen to be a client's designated Lock-In provider, notification is sent to that pharmacy with all important client identifying information. If a Lock-In client 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 client. The client may be counseled to contact the Medicaid Pharmacy Case Manager at (307)777-8773 in order 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 client lock-in status as stated above. The entire pharmacy staff should be notified of current Lock-In clients.
- Review and monitor all drug interactions, allergies duplicate therapy, and seeking of medications from multiple prescribers. Be aware that the client 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 client for more information and/or contacting the prescriber. Document the finding and outcomes. The Wyoming Board of Pharmacy will be contacted when early refills and cash payment are allowed without appropriate clinical care and documentation.

When doctor shopping for controlled substances is suspected, please contact the Medicaid Pharmacy Case Manager at (307)777-8773. The Wyoming Online Prescription Database (WORx) is online with 24/7 access for practitioners and pharmacists. The WORx program is managed by the Wyoming Board of Pharmacy at <https://worxpdp.com/> and can be used to view client profiles with all scheduled II through IV prescriptions the client 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 his or her 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 ([2.1, Quick Reference](#)). Overrides may be approved for true emergencies (auto accidents, sudden illness, etc.).

Any Wyoming Medicaid client 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 ([2.1, Quick Reference](#)).

For more information regarding the Pharmacy Lock-In Program, refer to the Medicaid Pharmacy Provider Manual ([2.1, Quick Reference](#)).

4.6 Hospice Lock-In

Clients 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 ([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 clients. Medicaid may utilize the services of a Professional Review Organization (PRO) to assist in these functions.

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

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

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

4.8 Provider Responsibilities

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



4.9 Referral of Suspected Fraud and Abuse

If a provider becomes aware of possible fraudulent or program abusive conduct/activity by another provider, or eligible client, the provider should notify the Program Integrity Unit in writing. Return a completed Report of Suspected Abuse of the Medicaid Healthcare System to, or call, or reference the below website:

Division of Healthcare Financing
122 West 25th St, 4th Floor West
Attn: Program Integrity Unit
Cheyenne, WY 82002
Or contact: (855)846-2563

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

4.9.1 Report of Suspected Abuse of the Medicaid Healthcare System Form

 Wyoming Department of Health	Healthcare Financing Division Wyoming Medicaid 6101 Yellowstone Road, Suite 210 Cheyenne, WY 82002 Phone (307) 777-7531 • 1-866-571-0944 Fax (307) 777-6964 • www.health.wyo.gov	
---	---	---

NAME(s) OF Wyoming Medicaid CLIENT/PROVIDER: _____

ADDRESS OF Wyoming Medicaid CLIENT/PROVIDER: _____

TELEPHONE NUMBER OF Wyoming Medicaid CLIENT/ PROVIDER: _____

Please give a brief description of how the Medicaid client/provider is abusing the Wyoming Medicaid healthcare system. (If possible, give dates of occurrence.)

PLEASE CHECK ONE: EMERGENCY CARE ☐ NON-EMERGENCY CARE ☐

Signature of Person Reporting Abuse _____ Date _____

ADDRESS: _____ Telephone # _____

The above confidential information shall only be used to determine what action is necessary by the Wyoming Department of Health, Division of Healthcare Financing.

RETURN THIS FORM TO:
Program Integrity Unit
Division of Healthcare Financing
6101 Yellowstone Rd.
Suite 210
Cheyenne, WY 82002

NOTE: Click image above to be taken to a printable version of this form.

4.10 Sanctions

The Division of Healthcare Financing (DHCF) may invoke administrative sanctions against a Medicaid provider when a credible allegation of fraud, abuse, waste, and/or non-compliance with Provider Agreement and/or Medicaid Rules exists, or who is under sanction by another regulatory entity (i.e. 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 ([2.1, Quick Reference](#)).

4.11 Adverse Actions

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

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5.1 What is Medicaid?

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

5.2 Who is Eligible?

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

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

NOTE: Incarcerated persons are automatically ineligible for Wyoming Medicaid. If a client 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 (SSI) 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 – clients 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.
- **Program for All Inclusive Care for the Elderly (PACE)** – Individuals over the age of 55 assessed to be in need of nursing home level of care, with income less than or equal to 300% of the SSI Standard, receive all services coordinated through the PACE provider. This program is currently available in Laramie County only.
- **Kid Care CHIP** – To be eligible for this program the following criteria must be met:
 - A United States citizen, a lawful qualified non-citizen (refugee or asylum) or a lawful, permanent alien who has lived in the United States for at least 5 consecutive years;
 - A Wyoming resident;
 - **Less than 19 years of age (not past the month of their 19th birthday);**
 - Not eligible for or already enrolled in Medicaid
 - Not currently covered by health insurance nor has had health insurance during the last 30 days, except as provided for under section 4.7;
 - 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 (EID)

Employed Individuals with Disabilities 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 (ALEN)

A non-citizen who meets all eligibility factors under a Medicaid group except for citizenship and social security number is eligible for emergency services. This does not include dental services.

5.3 Eligibility Determination

5.3.1 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/AVANCE_ONLINE_APP/Landing.action or by telephone at 1-855-294-2127.
- Presumptive Eligibility (PE) applicants may also apply through a qualified provider or qualified hospital for the PE programs.

5.3.2 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 ([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) ([2.1, Quick Reference](#)).

Medicaid assumes no financial responsibility for services rendered prior to the effective date of a client'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 client meets eligibility criteria during each month of the retroactive period. If the SSA deems the client eligible, the period of original entitlement could precede the application date beyond the 90 day retroactive eligibility period and/or the 12 month (365 days) timely filing deadline for Medicaid claims ([6.14, Timely Filing](#)). This situation could arise for the following reasons:


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

5.4 Client Identification Cards

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

If a client has been on Medicaid previously and have reapplied they will not receive a new Medicaid card. Client who would like a new card should call 1-800-251-1269.

Sample Medicaid ID card:

 CLIENT NAME 0600123456	<p>Client: Present this card to your healthcare provider and inform them if you have any other insurance. It is against the law for anyone else to use this card. View current coverages, find a provider, or replace your card by visiting our website or by calling 1-800-251-1269. To speak to a nurse at any time (24/7) about your health, call 1-888-545-1710. To renew your eligibility or to report changes of address, name or other personal information call the Eligibility Customer Service Center at 1-855-294-2127.</p> <p>Self-service options available at: https://wymedicaid.portal.conduent.com</p> <p>THIS CARD DOES NOT GUARANTEE CURRENT ELIGIBILITY OR PAYMENT FOR SERVICES.</p> <p>Providers: Please verify the identity, current eligibility, and service coverage (including items requiring prior authorization) of the client by visiting our website or calling 1-800-251-1269.</p>
--	--

NOTE: Kid Care CHIP clients will also use this card.

5.5 Other Types of Eligibility Identification

5.5.1 Medicaid Approval Notice

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

NOTE: Refer to “Verification Options” ([3.8, Verification Options](#)) on ways to verify a client's eligibility.

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6.1 Electronic Billing

Wyoming Medicaid requires all providers to submit claims electronically. There are two (2) exceptions to this requirement:

- Providers who do not submit at least 25 claims in a calendar year
- Providers who do not bill diagnosis codes on their claims

If a provider is unable to submit electronically, the provider must submit a request for an exemption in writing and must include:

- Provider Name, NPI, and contact name and phone number.
- The calendar year for which the exemption is being requested
- Detailed explanation of the reason for the exemption request

Mail requests to:

Wyoming Medicaid
Attn: Provider Relations
PO Box 667
Cheyenne, WY 82003-0667

A new exemption request must be submitted for each calendar year. Wyoming Medicaid has free software or applications available for provider to bill electronically ([Chapter 8, Electronic Data Interchange \(EDI\)](#)).

6.2 Basic Paper Claim Information

The 2012 ADA Claim Form is the only dental claim form that will be accepted. Claims that do not follow Medicaid provider policies and procedures will be returned unprocessed with a letter. When a claim is returned because of billing errors and/or missing attachments, the provider may correct the claim and return it to Medicaid for processing.

NOTE: 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 ([6.12, Resubmitting Versus Adjusting Claims](#)).

NOTE: Claims are to be submitted only after service(s) have been rendered, not before. For deliverable items (i.e. dentures, DME, glasses, hearing aids, etc.) the date of service must be the date of delivery, not the order date.

6.3 Authorized Signatures

All paper claims must be signed by the provider or the providers' authorized representative. Acceptable signatures may be either handwritten, a stamped facsimile, typed, computer generated, or initialed. The signature certifies all information on the claim is true, accurate, complete, and contains no false or erroneous information. Remarks such as signature on file or facility names will not be accepted.

6.4 The Dental Claim Form

ADA American Dental Association® Dental Claim Form										
HEADER INFORMATION										
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prior Authorization <input type="checkbox"/> EPSDT / Title XIX										
2. Predetermination/Prior Authorization Number										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION										
3. Company/Plan Name, Address, City, State, Zip Code										
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)										
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code										
13. Date of Birth (MM/DD/YYYY) 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#)										
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)										
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)										
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)										
6. Date of Birth (MM/DD/YYYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#)										
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other										
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code										
PATIENT INFORMATION										
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other										
19. Reserved For Future Use										
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code										
21. Date of Birth (MM/DD/YYYY) 22. Gender <input type="checkbox"/> M <input type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist)										
RECORD OF SERVICES PROVIDED										
24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty	30. Description	31. Fee	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)					34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)			31a. Other Fee(s)		
1	2	3	4	5	6	7	8	9	10	
11	12	13	14	15	16	17	18	19	20	
21	22	23	24	25	26	27	28	29	30	
31	32	33	34	35	36	37	38	39	40	
34a. Diagnosis Code(s)					A _____ C _____			32. Total Fee		
(Primary diagnosis in "A")					B _____ D _____					
35. Remarks										
AUTHORIZATIONS										
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.										
X _____ Patient/Guardian Signature Date _____										
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										
X _____ Subscriber Signature Date _____										
ANCILLARY CLAIM/TREATMENT INFORMATION										
38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N) <input type="checkbox"/>										
(Use "Place of Service Codes for Professional Claims")										
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										
41. Date Appliance Placed (MM/DD/YYYY)										
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										
43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										
44. Date of Prior Placement (MM/DD/YYYY)										
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident										
46. Date of Accident (MM/DD/YYYY) 47. Auto Accident State										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)										
48. Name, Address, City, State, Zip Code										
49. NPI 50. License Number 51. SSN or TIN										
52. Phone Number () - 53a. Additional Provider ID										
TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.										
X _____ Signed (Treating Dentist) Date _____										
54. NPI 55. License Number										
56. Address, City, State, Zip Code 55a. Provider Specialty Code										
57. Phone Number () - 58. Additional Provider ID										

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 J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J435D)

To reorder call 800.947.4746
 or go online at adacatalog.org

6.4.1 Instructions for Completing the Dental Claim Form

Claim Item	Title	Required	Action
1	Type of transaction	X	Mark "Statement of Actual Services."
2	Predetermination/ Prior Authorization	X	(When applicable) Enter Prior Authorization number here.
3	Insurance Company/ Dental Benefit Plan		
4	Other dental or medical coverage	X	(When applicable) Mark appropriate box. If no, skip to box 18. If yes, complete boxes 5-11
5	Subscriber name	X	(When applicable) Enter policyholder's name.
6	Date of birth	X	(When applicable) Enter policyholder's date of birth
7	Gender	X	(When applicable) Enter policyholder's gender
8	Subscriber identifier	X	(When applicable) Enter policyholder's social security number or policy number
9	Plan/Group number	X	(When applicable) Enter policyholder's plan/group number
10	Relationship to primary subscriber	X	(When applicable) Mark appropriate box
11	Other carrier name and address	X	(When applicable) Enter carrier name and address
12	Policyholder/ Subscriber Information	X	(When applicable) Enter the primary subscriber's name, address, city, state, and zip code
13	Date of Birth	X	(When applicable) Enter the primary subscriber's date of birth (MMDDCCYY)
14	Gender	X	(When applicable) Enter the primary subscriber's gender
15	Subscriber Identifier	X	(When applicable) Enter the primary subscriber's SSN or ID#
16	Plan/Group Number	X	(When applicable) Enter the primary subscriber's plan/group number
17	Employer Name	X	(When applicable) Enter the primary subscriber's employer name
18	Patient information- relationship to primary subscriber	X	Mark applicable box
19	Reserved for Future Use		No entry required
20	Name and address of patient	X	Enter name and address of patient
21	Patient date of birth	X	Enter patient's date of birth
22	Gender		No entry required
23	Patient ID/account number	X	Enter the patients 10 digit client ID number
24	Procedure Date	X	Enter date services were rendered
25	Area of oral cavity		(When applicable) Enter quadrant or arch.

Common Billing Information

Claim Item	Title	Required	Action
			<ul style="list-style-type: none"> • UR- Upper Right • UL – Upper Left • LL- Lower Left, • LR – Lower Right • UA – Upper Arch • LA – Lower Arch
26	Tooth system		No entry required
27	Tooth numbers (s) or letter(s)	X	(When applicable) Enter tooth number (s) or letter (s). For supernumerary teeth – add an S after the tooth code (e.g. supernumerary tooth A becomes AS) (15+50=65)
28	Tooth surface	X	(When applicable) Enter tooth surface: <ul style="list-style-type: none"> • B – Buccal surface • D – Distal surface • F – Facial surface • I – Incisal surface • L – Lingual surface • M – Mesial surface • O – Occlusal surface
29	Procedure code	X	Enter appropriate CDT –code
29a	Diagnosis Pointer		No entry required
29b	Qty		Enter the units of service
30	Description		No entry required
31	Fee	X	Enter usual and customary charges for the procedure
31a	Other Fees	X	(When applicable) Enter the amount paid by another dental plan. Do not enter prior Medicaid payments. This box is reserved for third party coverage only. If this amount is more than 40% of the total claim, providers do not need to attach an EOB
32	Total fee	X	Add together all of the fees listed in item 31 and enter the total amount in this field
33	Missing teeth information		No entry required
34	Diagnosis List Qualifier		No entry required
34a	Diagnosis Codes		No entry required
35	Remarks		No entry required – Notes in this box will not be reviewed by Medicaid
36	Patient/Guardian Signature	X	No entry required
37	Subscriber signature		No entry required
38	Place of treatment	X	Office=11 Hospital=21 Other=99
39	Number of enclosures		No entry required
40	Is treatment for orthodontics		No entry required
41	Date appliance placed		No entry required

Common Billing Information

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

6.5 Examples of Billing

6.5.1 Client has Medicaid Only

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX									
2. Predetermination/Preauthorization Number									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION									
3. Company/Plan Name, Address, City, State, Zip Code Wyoming Medicaid PO Box 667 Cheyenne, WY 82003									
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)									
12. Policyholder/Subsriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, Jane 123 This Town This Town, WY 82009									
13. Date of Birth (MM/DD/CCYY) 01/01/2001				14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F		15. Policyholder/Subsriber ID (SSN or ID#) 0600XXXXXX			
16. Plan/Group Number				17. Employer Name					
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)									
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)									
5. Name of Policyholder/Subsriber in #4 (Last, First, Middle Initial, Suffix)									
6. Date of Birth (MM/DD/CCYY)		7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subsriber ID (SSN or ID#)					
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code									
PATIENT INFORMATION									
18. Relationship to Policyholder/Subsriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other								19. Reserved For Future Use	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)					
RECORD OF SERVICES PROVIDED									
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty	30. Description	31. Fee
11/01/2014		JP			D0150		1	COMP ORAL EVAL-NEW ESTAB PAT	60.00
11/01/2014		JP			D0274		1	BITE WING FOUR FILMS	44.00
33. Missing Teeth Information (Place an "X" on each missing tooth.)					34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)			31a. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10
32	31	30	29	28	27	26	25	24	23
22	21	20	19	18	17				
34a. Diagnosis Code(s)					A. _____ C. _____			32. Total Fee	
(Primary diagnosis in "A")					B. _____ D. _____			104.00	
35. Remarks									
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION				
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.					38. Place of Treatment <input checked="" type="checkbox"/> 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")				
X SIGNATURE ON FILE 11/01/2014 Patient/Guardian Signature Date					40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)				
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.					41. Date Appliance Placed (MM/DD/CCYY)				
X SIGNATURE ON FILE 11/01/2014 Subscriber Signature Date					42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)				
					43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)				
					44. Date of Prior Placement (MM/DD/CCYY)				
					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident				
					46. Date of Accident (MM/DD/CCYY)				
					47. Auto Accident State				
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)					TREATING DENTIST AND TREATMENT LOCATION INFORMATION				
48. Name, Address, City, State, Zip Code Dental Office 123 That Town This Town, WY 82009					53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X TREATING DENTIST 11/01/2014 Signed (Treating Dentist) Date				
49. NPI		50. License Number		51. SSN or TIN		54. NPI 1112224440		55. License Number 9999	
52. Phone Number (307) 555-5555					56. Address, City, State, Zip Code 123 That Town This Town, WY 82009				
52a. Additional Provider ID					57. Phone Number (307) 555-5555				
					58. Additional Provider ID				

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6.5.2 Client has Medicaid and Third Party Liability (TPL)

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																				
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX																				
2. Predetermination/Preauthorization Number																				
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																				
3. Company/Plan Name, Address, City, State, Zip Code Wyoming Medicaid PO Box 667 Cheyenne, WY 82003																				
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																				
4. Dental? <input checked="" type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)																				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) Parent																				
6. Date of Birth (MM/DD/CCYY) 01/01/1960		7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#) XXX-XX-XXXX																
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Dependent <input type="checkbox"/> Other																		
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code Other Dental Plan 124 That Town This Town, WY 82001																				
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																				
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, Jane 123 This Town This Town, WY 82009																				
13. Date of Birth (MM/DD/CCYY) 01/01/2001		14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#) 0600XXXXXX																
16. Plan/Group Number		17. Employer Name																		
PATIENT INFORMATION																				
18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other																				
19. Reserved For Future Use																				
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																				
21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)																
RECORD OF SERVICES PROVIDED																				
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty	30. Description	31. Fee										
1	11/01/2014		JP			D0150		1	COMP ORAL EVAL - NEW ESTAB PAT	60.00										
2	11/01/2014		JP			D0274		1	BITE WING FOUR FILMS	44.00										
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
33. Missing Teeth Information (Place an "X" on each missing tooth)						34. Diagnosis Code List Qualifier		(ICD-9 = B; ICD-10 = AB)		31a. Other Fee(s)										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s)		A	C	32. Total Fee
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A")		B	D	104.00
35. Remarks																				
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION										
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.										38. Place of Treatment <input type="checkbox"/> 11 (e.g. 11=office, 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) <input type="checkbox"/>								
X SIGNATURE ON FILE 11/01/2014 Patient/Guardian Signature Date										40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		44. Date of Prior Placement (MM/DD/CCYY)						
X SIGNATURE ON FILE 11/01/2014 Subscriber Signature Date										45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident		46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State						
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
48. Name, Address, City, State, Zip Code Dental Office 123 That Town This Town, WY 82009										53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. <input checked="" type="checkbox"/> TREATING DENTIST 11/01/2014 Signed (Treating Dentist) Date										
49. NPI 1112223330		50. License Number 307 - 555 - 5555		51. SSN or TIN		54. NPI 1112223330		55. License Number 9999		56a. Provider Specialty Code 122300000X										
52. Phone Number (307) 555 - 5555		52a. Additional Provider ID		57. Phone Number (307) 555 - 5555		58. Additional Provider ID														

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

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 or go online at adacatalog.org

6.6 Reimbursement Methodologies

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

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

6.7 Usual and Customary Charges

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

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

6.7.1 Invoice Charges

- 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 explaining the age of the invoice (i.e. 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, etc. may be used only if the provider no longer has access to the invoice, and is unable to obtain a replacement from the supplier/manufacturer, and a letter with explanation is included.
- Items must be clearly marked (i.e. how many calories are in a can of formula, items in a case, milligrams, ounces, etc.)

6.8 Prior Authorization

Medicaid requires Prior Authorization (PA) on selected services and equipment. **Approval of a PA is never a guarantee of payment.** A provider should not render services until a client'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.

Common Billing Information

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 PA:


Services Requiring PA	PA Requirements
Cone Beam CT Capture and Interpretation	See Chapter 11 – Covered Services
Specialized Denture Services	See Chapter 11 – Covered Services
Implant Services and Fixed Prosthesis (Bridges)	See Chapter 11 – Covered Services
Oral and Maxillofacial Surgery	See Chapter 11 – Covered Services
Orthodontics/Severe Malocclusion Program	See Chapter 11 – Covered Services

6.8.1 Requesting Prior Authorization

Providers must request a PA from Medical Policy. Prior Authorizations will not be issued after a procedure is complete. The provider must obtain a PA prior to rendering services.

Providers must complete a Medicaid Prior Authorization Form ([6.8.1.1, Medicaid Prior Authorization Form](#)) for all requests.

6.8.1.1 Medicaid Prior Authorization Form



Wyoming
Department
of Health

Prior Authorization Request
To Avoid Delays – Please fill out Completely

☐ ADD
☐ MODIFY
☐ CANCEL

PATIENT INFORMATION						
1. DOB		2. AGE		3. MEDICAID ID #		
4. PATIENT NAME (Last, First, MI)						
PROVIDER INFORMATION						
5. PAY-TO PROVIDER NPI #				6. TAXONOMY		
7. PAY-TO PROVIDER NAME						
8. STREET ADDRESS						
9. CITY, STATE, ZIP CODE						
10. TELEPHONE				11. CONTACT NAME		
SERVICE INFORMATION						
12. PROPOSED DATES OF SERVICE		12a. FROM			12b. TO	
13. SERVICE DESCRIPTION	14. PROC CODE	15. MODIFIER(S)	16. UNITS	17. ESTIMATED COST	18. TREATING PROVIDER NPI NUMBER	
19. PLEASE ATTACH SUPPORTING DOCUMENTATION SHOWING MEDICAL NECESSITY Applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the prescribed service. Additional documentation may be attached when necessary.						
20. PLEASE NOTE BELOW WHICH MODIFICATIONS ARE REQUESTED						
21. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.						
SIGNATURE OF PROVIDER:				DATE:		
22. PENDING AUTHORIZATION GIVEN BY			22a. DATE	22b. PRIOR AUTHORIZATION #		
AUTHORIZATION (FOR FISCAL AGENT USE ONLY)						
AUTHORIZATION IS VALID FOR SERVICES	FROM DATE	TO DATE			PRIOR AUTHORIZATION #	
COMMENTS / EXPLANATION						

WYOMING MEDICAID Attn: MEDICAL POLICY • PO BOX 667 • CHEYENNE, WY 82003-0667
1-800-251-1268 •• FAX: (307) 772-8405

Rev. 7/2014

NOTE: Click image above to be taken to a printable version of this form.

6.8.1.2 Instructions for Completing the Medicaid Prior Authorization Form

Completing the Medicaid Prior Authorization Form for medical services		
*Denotes Required Field		
NOTE: Is this an Add, Modify, or Cancel request?		
Field Number	Title	Action
1*	Date of Birth	Enter MMDDYY of client's date of birth.
2	Age	Enter client's age.
3*	Medicaid ID Number	Enter the client's ten (10)-digit Medicaid ID number.
4*	Patient Name	Enter Last Name, First Name and Middle Initial exactly as it appears on the Medicaid ID card.
5*	Pay-To Provider NPI #	Enter the Pay to Provider, Group, Clinic, or Department NPI Number.
6*	Pay To Provider Taxonomy	Enter the Pay To Provider, Group, Clinic, or Department Taxonomy. This is not the tax ID
7*	Pay To Provider Name	Enter the Pay To Provider, Group, Clinic, or Department Name.
8	Street Address	Enter the Pay To Provider Street Address.
9	City, State, Zip Code	Enter the Pay To Provider City, State and Zip Code.
10*	Telephone – Contact Person	Enter phone number of the contact person for this prior authorization.
11*	Contact Name	Enter the name of the person that can be contacted regarding this Prior Authorization.
12*	Proposed Dates of service	Enter what date(s) of service the provider intending to perform services. The first date of treatment should be listed in 12a and the last date of treatment should be listed in 12b.
13*	Service Description	Enter the service that the provider is requesting.
14*	Procedure Code	Dental Code(s) for the service(s) being requested
15*	Modifier(s)	Modifier needed to bill the procedure on the claim – If no modifiers needed – put N/A or leave blank.
16*	Unit(s)	Enter number of each service requested.
17*	Estimated Cost	Enter <u>usual and customary charge</u> amount for the <u>total of all units</u> for each service being requested.
18*	Treating Provider NPI Number	Enter the Treating Provider NPI Number – Needs to be a Wyoming Medicaid Provider.
19*	Supporting Documentation	Please attach all documentation to support medical necessity. Applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the prescribed service. Additional documentation may be attached when necessary.
20	Modifications	Detail the changes that are needed by the provider from the original approved request.
21*	Signature	The form needs to be signed and dated by the entity requesting the prior authorization of services.
22	Pending Authorization	If called in for a verbal authorization, put the name of the person giving the PA number and date.

NOTE: The Prior Authorization Request Form information must match the lines on the claim that are being billed.

6.8.2 Prior Authorization Status Inquiry

Once a PA status is determined, providers will be able to view their determinations on the Provider Portal, including the 10-digit PA number. The complete 10-digit PA number must be entered in box 23 of the CMS-1500 02-12 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.

Statuses include approved, denied, or pending. **Used PAs will not be viewable on the Portal.** 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. If a PA request is in a pending status, it is either the result of an emergency request made over the phone to Medical Policy, or the form and/or documentation are incomplete. A claim cannot be billed using a PA number from a pending request.

NOTE: For PAs that are pending for additional information, the missing information will be needed before the item or service can be considered for approval. The request is not being automatically denied. It is imperative this information be supplied to the appropriate agency within a timely manner.

To view a PA status:

1. Log into the [Medicaid Secure Provider Portal](#).
 - a. From the secured Home page, select Prior Authorization Inquiry listed at the bottom of the Inquiries column
 - b. Search the PA using Provider Medicaid ID, Client ID, and/or PA number.
 - i. Make sure to complete all required fields
 - ii. From and To Dates of Service fields are limited to a 6 month (180 days) span.
 - iii. If searching by Client ID and no Client ID is entered, the results will show all PAs for the provider
 - c. Click Submit.
 - d. Click the PA number (Auth Num) to view the PA detail page.
 - i. From the detail page there is the option to print a paper copy.

6.9 Billing of Deliverables

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

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

Common Billing Information


- Client is not eligible on the delivery date but was eligible on the prep date
- Client 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,” ([6.9.1, Order vs Delivery Date Exception Form](#)).
- Complete the form and fax or mail it to the address at the bottom of the form
- Once the form is signed by the State, it will be returned to the provider and must be a part of the client’s permanent clinical record
- The provider may then bill the claim using the order date as the date of service

NOTE: 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 client and the DOS, the money paid will be recovered.

6.9.1 Order vs Delivery Date Exception Form



Wyoming
Department
of Health



ORDER VS DELIVERY DATE BILLING ATTESTATION FORM

PROVIDER NAME: _____ NPI: _____

PROVIDER RETURN EMAIL: _____

CLIENT NAME: _____ MEDICAID ID#: _____

PROCEDURE CODE & DESCRIPTION: _____

ORDER DATE: _____ DELIVERY DATE: _____

DENTAL PROVIDERS

OUR OFFICE IS UNABLE TO BILL THIS PROCEDURE USING THE DELIVERY/SEAT DATE DUE TO:

☐ CLIENT WAS ELIGIBLE ON THE PREP DATE AND WAS NOT ELIGIBLE FOR WYOMING MEDICAID ON THE DELIVERY/SEAT DATE

☐ CLIENT 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:

☐ CLIENT WAS ELIGIBLE ON THE ORDER DATE AND WAS NOT ELIGIBLE FOR WYOMING MEDICAID ON THE DELIVERY DATE (IN-OFFICE OR BY MAIL)

☐ CLIENT 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:

☐ CLIENT WAS ELIGIBLE ON THE ORDER DATE AND WAS NOT ELIGIBLE FOR WYOMING MEDICAID ON THE DELIVERY DATE (IN-OFFICE OR BY MAIL)

☐ CLIENT DID NOT RETURN FOR ITEM AFTER SEVERAL ATTEMPTS TO CONTACT DUE TO: _____

PROVIDER'S SIGNATURE

DATE

APPROVED _____
DENIED

DATE

STATE PROGRAM MANAGER, TITLE

THIS FORM MUST BE COMPLETED AND EMAILED TO: dustin.brown@wyo.gov

NOTE: Click the image above to be taken to a printable version of this form.

6.10 Submitting Attachments for Electronic Claims

Providers may either upload their documents electronically, or complete the Attachment Cover Sheet and mail or email their documents.

Steps for submitting electronic attachments:

- The fiscal agent has created a process that allows providers to submit electronic attachments for electronic claims. Providers need only follow these steps:
 1. Mark the attachment indicator on the electronic claim. 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). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf
 2. Log onto the [Secured Provider Web Portal](#).
 3. Under the submissions menu select Electronic Attachments.
 4. Complete required information – Information must match the claim as submitted i.e. DOS, client information, provider information, and the name of the attachment must be identical to what was submitted in the in the electronic file (with no spaces).
 5. Navigate to the location of the electronic attachment on the provider's computer.
 6. Click Upload.
 7. For support and additional information, refer to [Chapter 8](#) and [Chapter 9](#) or contact EDI Services ([2.1, Quick Reference](#)).

NOTE: Providers may not attach a document to many claims at one time. Attachments must be added per claim. If the 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.adj

Steps for submitting paper attachments by mail:

- The fiscal agent has created a process that allows providers to submit paper attachments for electronic claims. Providers need only follow these two (2) simple steps:
 1. Mark the attachment indicator on the electronic claim and indicate by mail as the submission method. 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). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.
 - The data entered on the form must match the claim exactly in DOS, client information, provider information, etc.

2. Complete the Attachment Cover Sheet ([6.10.1, Attachment Cover Sheet](#)) and mail it with the attachment to Claims ([2.1, Quick Reference](#)).

Steps for submitting paper attachments by email:

- The fiscal agent has created a process that allows providers to submit paper attachments for electronic claims. Provider need only follow these two (2) simple steps:
 1. Mark the attachment indicator on the electronic claim and indicate by mail as the submission method. 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). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.
 - The data entered on the form must match the claim exactly in DOS, client information, provider information, etc.
 2. Complete the Attachment Cover Sheet ([6.10.1, Attachment Cover Sheet](#)) and email it with the attachment to wycustomersvc@conduent.com ([2.1, Quick Reference](#)).
 - All emails must come secured and cannot exceed 25 pages.

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

6.10.1 Attachment Cover Sheet

Attachment Cover Sheet

Please use this form when submitting a claim electronically which requires attachments. The supporting documentation (EOB, medical records, etc.) must be attached to this cover sheet. If the documentation is received without a cover sheet 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, including the Attachment Type and Attachment Control Number. Also, 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 Provider or NPI
Number:

Client Name:

Medicaid ID Number:

Claim From Date of Service:
(MM/DD/YY)

Claim To Date of Service:
(MM/DD/YY)

Attachment Control Number:
(Required)

Must include no spaces and match the 837 file exactly

TCN:
(Required)

Attachment Type:
(Required)

☐ 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 Data 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

RETURN THIS DOCUMENT WITH ATTACHMENTS TO:

Wyoming Medicaid

Attn: Claims

PO Box 547

Cheyenne, WY 82003-0547

NOTE: Click the image above to be taken to a printable version of this form.

6.11 Remittance Advice

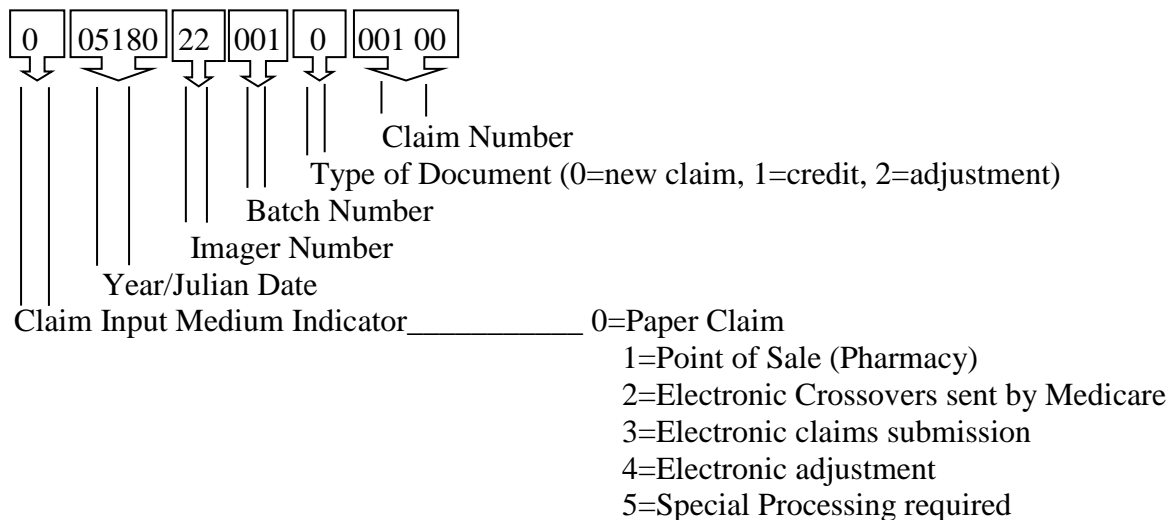
After claims have been processed weekly, Medicaid distributes a Medicaid proprietary Remittance Advice (RA) to providers. The RA plays an important communication role

Common Billing Information

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. As of April 1 2020, all providers will receive electronic remittance advices. No paper remittance advices shall be mailed from the Agency after March 31, 2020. 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.

The RA is organized in the following manner:

- The first page or cover page is important and should not be over looked as it may include an RA Banner notification from Wyoming Medicaid ([1.2.1, RA Banner Notices/Samples](#))
- Claims are grouped by disposition category.
 - Claim Status PAID group contains all the paid claims.
 - Claim Status DENIED group reports denied claims.
 - Claim Status PENDED group reports claims pended for review. Do not resubmit these claims. All claims in pended status are reported each payment cycle until paid or denied. Claims can be in a pended status for up to 30 days.
 - Claim Status ADJUSTED group reports adjusted claims.
- All paid, denied, and pended claims and claim adjustments are itemized within each group in alphabetic order by client last name.
- 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:



- The RA Summary Section reports the number of claims transactions and total payment or check amount.

Common Billing Information

6.11.1 Sample Dental Remittance Advice

WYOMING DEPARTMENT OF HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 00/00/00

R E M I T T A N C E A D V I C E

TO: SAMPLE PROVIDER R.A. NO.: 0101010 DATE PAID: 00/00/00 PROVIDER NUMBER: 123456789/1234567890 PAGE: 1
TRANS-CONTROL-NUMBER BILLED MCARE COPAY OTHER DEDUCT- COINS MCAID WRITE TREATING
LI SVC-DATE PROC/MODS UNITS AMT. PAID AMT. INS. IBLE AMT. PAID OFF PROVIDER S PLAN
* * * CLAIM TYPE: DENTAL * * * CLAIM STATUS: DENIED
ORIGINAL CLAIMS:

* BRADY TOM RECIP ID: 0000012345 PATIENT ACCT #: 00000
0-03000-22-000-0006-10 185.00 0.00 0.00 0.00 0.00
LI: 001 10/22/15 D0140 1 68.00 0.00 0.00 0.00 0.00 1234567891 K KIDA
LINE EOB(S): 97

* MANNING PEYTON RECIP ID: 0800000001 PATIENT ACCT #: 00001
0-03000-22-000-0006-12 350.00 0.00 0.00 0.00 0.00
LI: 001 11/22/15 D1120 1 73.00 0.00 0.00 0.00 0.00 1234567891 K QMB
LINE EOB(S): 88

REMITTANCE ADVICE

TO: SAMPLE PROVIDER R.A. NO.: 0101010 DATE PAID: 00/00/00 PROVIDER NUMBER: 1234567890 PAGE: 2

REMITTANCE T O T A L S

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	-----	535.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PENDEDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	-----	0.00	0.00
AMOUNT OF CHECK:			-----		0.00

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

88 ONLY ONE PROPHYLAXIS (ADULT OR CHILD) PER SIX MONTHS WITHOUT
DOCUMENTATION OF MEDICAL NECESSITY.

1

97 THE RECIPIENT IS NOT COVERED FOR THE TYPE OF SERVICE BILLED.

1

6.11.2 How to Read the Remittance Advice

Each claim processed during the weekly cycle is listed on the Remittance Advice with the following information:

FIELD NAME	HEADER DESCRIPTION																						
To	Provider Name																						
R.A. Number	Remittance Advice Number assigned.																						
Date Paid	Payment date.																						
Provider Number	Medicaid provider number/NPI number																						
Page	Page Number																						
Last, MI, and First	The client's name as found on the Medicaid ID Card.																						
Recip ID	The client's Medicaid ID Number.																						
Patient Acct #	The patient account number reported by the provider on the claim.																						
Trans Control Number	Transaction Control Number: The unique identifying number assigned to each claim submitted.																						
Billed Amt.	Total amount billed on the claim																						
Mcare Paid	Amount paid by Medicare																						
Copay Amt.	The amount due from the client for their co-payment.																						
Other Ins.	Amount paid by other insurance.																						
Deductible	Medicare deductible amount.																						
Coins Amt.	Medicare coinsurance amount.																						
Mcaid Paid	The amount paid by Medicaid																						
Write off	Difference between Medicaid paid amount and the provider's billed amount.																						
Header EOB(s)	Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA																						
Li	The line item number of the claim.																						
Svc date	The date of service.																						
Proc / Mods	The procedure code and applicable modifier.																						
Units	The number of units submitted.																						
Billed Amt.	Total amount billed on the line.																						
Mcare Paid	Amount paid by Medicare																						
Copay Amt.	The amount due from the client for their co-payment.																						
Other Ins.	Amount paid by other insurance.																						
Deductible	Medicare deductible amount.																						
Coins Amt.	Medicare coinsurance amount.																						
Mcaid Paid	The amount paid by Medicaid																						
Write off	Difference between Medicaid paid amount and the provider's billed amount.																						
Treating Provider	The treating provider's NPI number.																						
S	How the system priced each claim. For example, claims priced manually have a distinct code. Claims paid according to the Medicaid fee schedule have another code. Below is a table which describes these pricing source codes:																						
	<table> <tr> <td>A= Anesthesia</td><td>M= Manually Priced</td></tr> <tr> <td>B= Billed Charge</td><td>N= Provider Charge</td></tr> <tr> <td>C= Percent-of-Charges</td><td>O= Relative Value Units TC</td></tr> <tr> <td>D= Inpatient Per Diem Rate</td><td>P= Prior Authorization Rate</td></tr> <tr> <td>E= EAC Priced Plus Dispensing Fee</td><td>R= Relative Value Unit Rate</td></tr> <tr> <td>F= Fee Schedule</td><td>S= Relative Value Unit PC</td></tr> <tr> <td>G= FMAC Priced Plus Dispensing Fee</td><td>T= Fee Schedule TC</td></tr> <tr> <td>H= Encounter Rate</td><td>X= Medicare Coinsurance and Deductible</td></tr> <tr> <td>I= Institutional Care Rate</td><td>Y= Fee Schedule PC</td></tr> <tr> <td>K= Denied</td><td>Z= Fee Plus Injection</td></tr> <tr> <td>L= Maximum Suspend Ceiling</td><td></td></tr> </table>	A= Anesthesia	M= Manually Priced	B= Billed Charge	N= Provider Charge	C= Percent-of-Charges	O= Relative Value Units TC	D= Inpatient Per Diem Rate	P= Prior Authorization Rate	E= EAC Priced Plus Dispensing Fee	R= Relative Value Unit Rate	F= Fee Schedule	S= Relative Value Unit PC	G= FMAC Priced Plus Dispensing Fee	T= Fee Schedule TC	H= Encounter Rate	X= Medicare Coinsurance and Deductible	I= Institutional Care Rate	Y= Fee Schedule PC	K= Denied	Z= Fee Plus Injection	L= Maximum Suspend Ceiling	
A= Anesthesia	M= Manually Priced																						
B= Billed Charge	N= Provider Charge																						
C= Percent-of-Charges	O= Relative Value Units TC																						
D= Inpatient Per Diem Rate	P= Prior Authorization Rate																						
E= EAC Priced Plus Dispensing Fee	R= Relative Value Unit Rate																						
F= Fee Schedule	S= Relative Value Unit PC																						
G= FMAC Priced Plus Dispensing Fee	T= Fee Schedule TC																						
H= Encounter Rate	X= Medicare Coinsurance and Deductible																						
I= Institutional Care Rate	Y= Fee Schedule PC																						
K= Denied	Z= Fee Plus Injection																						
L= Maximum Suspend Ceiling																							
Plan	The Medicaid and State Healthcare Benefit Plan the client is eligible for (Section A.3).																						
Line EOB(s)	Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA																						

6.11.3 Remittance Advice Replacement Request Policy

If providers are unable to obtain a copy from the web portal, a paper copy may be requested. To request a printed replacement copy of a Remittance Advice, complete the following steps:

- Print the Remittance Advice (RA) replacement request form
- For replacement of a complete RA contact Provider Relations ([2.1, Quick Reference](#)) to obtain the RA number, date and number of pages
- Replacements of a specific page of an RA (containing a requested specific claim/TCN) will be three (3) pages (the cover page, the page containing the claim, and the summary page for the RA)
- Review the below chart to determine the cost of the replacement RA (based on total number of pages requested – For multiple RAs requested at the same time, add total pages together)
- Send the completed form and payment as indicated on the form
 - Make checks to Division of Healthcare Financing
 - Mail to Provider Relations ([2.1, Quick Reference](#))

The replacement RA will be emailed, faxed or mailed as requested on the form. Email is the preferred method of delivery, and RAs of more than ten (10) pages will not be faxed.

RAs less than 24 weeks old can be obtained from the Secured Provider Web Portal, once a provider has registered for access ([8.5.2.1, Secured Provider Web Portal Registration Process](#)).

Total Number of RA Pages	Cost for Replacement RA
1-10	\$2.50
11-20	\$5.00
21-30	\$7.50
31-40	\$10.00
41-50	\$12.50
51+	Contact Provider Relations for rates

6.11.3.1 Remittance Advice (RA) Replacement Request Form

Remittance Advice (RA) Replacement Request Form
(Print clearly)

Provider Name (as enrolled with Wyoming Medicaid): _____

Provider NPI: _____ Provider Taxonomy: _____

OR

Wyoming Medicaid Provider ID: _____

Please complete as much of the following as possible, to enable us to locate your requested RA:

To request a complete RA:

RA Number: _____

RA Date: _____

RA Amount: _____

To request a single RA page (includes cover sheet and summary and the page with the specific claim):

Specific Claim TCN: _____

Specific Claim Client ID and Date of Service: _____

Delivery Method (select one):

☐ Email Address (preferred): _____

☐ Fax Number (over 10 pages cannot be faxed): _____

☐ Mailing Address: _____

Return this form, along with appropriate payment (make checks payable to the Division of Healthcare Financing), to:

Wyoming Medicaid
Attn: Provider Relations
PO Box 667
Cheyenne, WY 82003-0667

Enclosed Check Info:

Total Amount: _____

Check Number: _____

Your RA will be sent to you by your above chosen method within 10 business days of receipt.
Contact Provider Relations at 1-800-251-1268, press 1, 5, 0 for questions

NOTE: Click the image above to be taken to a printable version of this form.

6.11.4 Obtain an RA from the Web

Providers have the ability to view and download their last 24 weeks of RAs from the Medicaid website, refer to [Chapter 8, Electronic Data Interchange \(EDI\)](#).

6.11.5 When a Client Has Other Insurance

If the client 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, refer to [Chapter 7](#) of this manual. To assist providers in filing with the other carrier, the following information is provided on the RA directly below the denied claim:

- Insurance carrier name;
- Name of insured;
- Policy number;
- Insurance carrier address;
- Group number, if applicable; and
- Group employer name and address, if applicable.

The information is specific to the individual client. The Third Party Resources Information Sheet ([7.2.1, Third Party Resources Information Sheet](#)) should be used for reporting new insurance coverage or changes in insurance coverage on a client's policy.

6.12 Resubmitting Versus Adjusting Claims

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

Action	Description	Timely Filing Limitation
VOID	Claim has paid; however, the provider would like to completely cancel the claim as if it was never billed.	May be completed any time after the claim has been paid.
ADJUST	Claim has paid, even if paid \$0.00; however, the provider would like to make a correction or change to this paid claim.	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 or a single line has denied. The provider may resubmit on a separate claim.	One (1) year (365 days) from the date of service.

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

The deadlines for resubmitting and adjusting claims are different:

- Provider may resubmit any denied claim or line within 12 months (365 days) of the date of service.
- Provider may adjust any paid claim within six (6) months (180 days) of the date of payment.

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

6.12.2 Resubmitting a Claim

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

How to Resubmit:

- Review and verify EOB codes on the RA/835 transaction and make all corrections and resubmit the claim.
 - Contact Provider Relations for assistance ([2.1, Quick Reference](#)).
- **Claims must be submitted with all required attachments with each new submission.**
- If the claim was denied because Medicaid has record of other insurance coverage, enter the missing insurance payment on the claim or submit insurance denial information when resubmitting the claim to Medicaid.

6.12.2.1 When to Resubmit to Medicaid

- **Claim Denied** – Providers may resubmit to Medicaid when the entire claim has been denied, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the explanation of benefits (EOB) code on the RA/835 transaction, make the appropriate corrections, and resubmit the claim.
- **Paid Claim with One (1) or More Line(s) Denied** – Provider may resubmit the individually denied lines.
- **Claim Returned Unprocessed** – When Medicaid is unable to process a claim it will be rejected or returned to the provider for corrections and to resubmit.

6.12.3 Adjusting or Voiding Paid Claims

When a provider identifies an error on a paid claim, the provider must submit an [Adjustment/Void Request Form](#). If the incorrect payment was the result of a keying error (paper claim submission), by the fiscal agent contact Provider Relations to have the claim corrected ([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. The replacement (debit) claim will have almost the same TCN as the credit transaction, except the 12th digit will be a two (2), indicating an adjustment, whereas the credit will have a one (1) in the 12th digit indicating a credit.

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

6.12.3.1 When to Request an Adjustment

- When a claim was overpaid or underpaid.
- When a claim was paid, but the information on the claim was incorrect (such as client ID, date of service, procedure code, diagnoses, units, etc.)
- 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 40% of the total claim charge.
 - For the complete policy regarding Third Party Liability, refer to [Chapter 7](#).

NOTE: Cannot complete an adjustment when the mistake is the pay-to provider number or NPI.

6.12.3.2 When to Request a Void

Request a void when a claim was billed in error (such as incorrect provider number, services not rendered, etc.).

6.12.3.3 How to Request an Adjustment/Void

To request an adjustment, use the Adjustment/Void Request Form ([6.12.3.2 Adjustment/Void Request Form](#)). The requirements for adjusting/voiding a claim are as follows:

- An adjustment/void can only be processed if the claim has been paid by Medicaid.
- Medicaid must receive individual claim adjustment requests within six (6) months (180 days) of the claim payment date.
- A separate Adjustment/Void Request Form must be used for each claim.
- If the provider is correcting more than one (1) error per claim, use only one (1) Adjustment/Void Request Form and include all corrections on the one (1) form.
 - If more than one (1) line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the “Reason for Adjustment or Void” section on the form or simply state, “refer to the attached corrected claim.”

6.12.3.4 Adjustment/Void Request Form

Adjustment/void Request Form	
EXHIBIT 6.9	
ADJUSTMENT/VOID REQUEST FORM	
SECTION A: CHECK BOX 1a), 1b) OR 2)	
<input type="checkbox"/> 1a) CLAIM ADJUSTMENT: Attach a copy of the claim with corrections made in BLUE ink . DO NOT USE HIGHLIGHTER <input type="checkbox"/> 1b) VOID CLAIM: Attach a copy of the claim or Remittance Advice. Complete Sections B and C. If attaching a check, the check should be payable to Division of Healthcare Financing (DHCF) .	<input type="checkbox"/> 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 RA. If manual check attach the check from the DHCF or if EFT make check payable to the DHCF for the entire remit amount.
SECTION B	
TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:	
1. 17-DIGIT TCN: <div style="border: 1px solid black; width: 100px; height: 1.2em; margin: 2px 0;"></div>	2. PAYMENT DATE: <div style="border: 1px solid black; width: 100px; height: 1.2em; margin: 2px 0;"></div>
3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER: <div style="border: 1px solid black; width: 100px; height: 1.2em; margin: 2px 0;"></div>	4. PROVIDER NAME: <div style="border: 1px solid black; width: 100px; height: 1.2em; margin: 2px 0;"></div>
5. 10-DIGIT CLIENT NUMBER: <div style="border: 1px solid black; width: 100px; height: 1.2em; margin: 2px 0;"></div>	6. 10-DIGIT PA NUMBER: <div style="border: 1px solid black; width: 100px; height: 1.2em; margin: 2px 0;"></div>
7. REASON FOR ADJUSTMENT OR VOID: <div style="border: 1px solid black; width: 100%; height: 1.2em; margin: 2px 0;"></div>	
SECTION C: SIGNATURE AND DATE REQUIRED	
PROVIDER SIGNATURE: _____ DATE: _____ <div style="text-align: center;"> RETURN ALL REQUESTS TO: WYOMING MEDICAID ATTN: CLAIMS PO BOX 547 CHEYENNE, WY 82003-0547 </div>	
REMARKS/STATUS: _____ <div style="text-align: right;">(FOR INTERNAL USE ONLY)</div>	
CASH CONTROL NUMBER: _____ ADJUSTED BY: _____ DATE: _____	

NOTE: If a provider wants to void an entire RA, contact Provider Relations ([2.1, Quick Reference](#)). Click the image above to be taken to a printable version of this form.

6.12.3.5 How to Complete the Adjustment/Void Request Form

Section	Field #	Field Name	Action
A	1a, 1b	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 the RA. Attach all supporting documentation required to process the claim, i.e. EOB, EOMB, consent forms, invoice, etc.
		Void Claim	Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the Remittance Advice.
		Sections B and C must be completed.	
B	1	17-digit TCN	Enter the 17-digit transaction control number assigned to each claim from the Remittance Advice.
	2	Payment Date	Enter the Payment Date
	3	Nine (9) digit Provider or ten (10) digit NPI Number	Enter provider’s nine (9)-digit Medicaid provider number or ten (10)-digit NPI number, if applicable.
	4	Provider Name	Enter the provider name.
	5	Ten (10) digit Client Number	Enter the client’s ten (10)-digit Medicaid ID number.
	6	Ten (10) digit PA Number	Enter the ten (10)-digit Prior Authorization number, if applicable.
	7	Reason for Adjustment or Void	Enter the specific reason and any pertinent information that may assist the fiscal agent.
C		Provider Signature and Date	Signature of the provider or the providers’ authorized representative and the date.

6.12.3.6 Adjusting a claim electronically via an 837 transaction

Wyoming Medicaid accepts claim adjustments electronically, refer to Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications ([9.12, 837 Dental Claims Transactions](#)) for complete details.

6.13 Credit Balances

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

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

1. Working off the credit balance: By taking no action, remaining credit balances will be deducted from future claim payments. The deductions appear as credits on the provider's RA(s)/835 transaction(s) until the balance owed to Medicaid has been paid.
2. Sending a check, payable to the "Division of Healthcare Financing," for the amount owed. This method is typically required for providers who no longer

submit claims to Medicaid or if the balance is not paid within 30 days. A notice is typically sent from Medicaid to the provider requesting the credit balance to be paid. The provider is asked to attach the notice, a check, and a letter explaining that the money is to pay off a credit balance. Include the provider number to ensure the money is applied correctly.

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

6.14 Timely Filing

The Division of Healthcare Financing adheres strictly to its timely filing policy. The provider must submit a clean claim to Medicaid within 12 months (365 days) of the date of service. A clean claim is an error free, correctly completed claim, with all required attachments, that will process and approve to pay within the twelve 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 (i.e. dentures, DME, glasses, hearing aids, etc.) the date of service must be the date of delivery, not the order date.

6.14.1 Exceptions to the Twelve Month (365 days) Limit

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

Exceptions Beyond the Control of the Provider	
When the Situation is:	The Time Limit is:
Medicare Crossover	A Claim must be submitted within 12 months (365 days) of the date of service or within six (6) months (180 days) from the payment date on the Explanation of Medicare Benefits (EOMB), whichever is later
Client is determined to be eligible on appeal, reconsideration, or court decision (retroactive eligibility)	Claims must be submitted within six (6) months (180 days) of the date of the determination of retroactive eligibility. The client 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 client as a Medicaid client 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 a SSI award notice or a notice from WDH.

Exceptions Beyond the Control of the Provider	
When the Situation is:	The Time Limit is:
Client 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 client 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 client as a Medicaid client and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing.
Provider finds their records to be inconsistent with filed claims, regarding rendered services. This includes dates of service, procedure/revenue codes, tooth codes, modifiers, admission or discharge dates/times, treating or referring providers or any other item which makes the records/claims non-supportive of each other.	Although there is no specific time limit for correcting errors, the corrected claim must be submitted in a timely manner from when the error was discovered. If the claim exceeds timely filing, the claim must be sent with a cover letter requesting an exception to timely filing citing this policy.

6.14.2 Appeal of Timely Filing

A provider may appeal 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 Relations (dates, times, call reference number, who was spoken with, etc.) or
- A Medicaid computer or policy problem beyond the provider's control prevented the provider from finalizing the claim within 12 months (365 days) of the date of service

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

6.14.2.1 How to Appeal

The provider must submit the appeal in writing to Provider Relations ([2.1, Quick Reference](#)) and should include the following:

- Documentation of previous claim submission (TCNs, documentation of the corrections made to the subsequent claims);
- Documentation of contact with Provider Relations;
- An explanation of the problem; and
- 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.

6.15 Important Information Regarding Retroactive Eligibility Decisions

The client 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 client 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 client for the services being billed to Medicaid would need to be refunded prior to a claim being submitted to Medicaid.

NOTE: The provider determines at the time they are notified of the client's eligibility if they are choosing to accept the client as a Medicaid client. If the provider does not accept the client, 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.

NOTE: Inpatient Hospital Certification: A hospital may seek admission certification for a client 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 WYhealth ([2.1, Quick Reference](#)).

6.16 Client Fails to Notify Provider of Eligibility

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

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

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

6.17 Billing Tips to Avoid Timely Filing Denials

- File claims soon after services are rendered.
- Carefully review EOB 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 Relations ([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

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

Chapter Seven – Third Party Liability

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7.1 Definition of a Third Party Liability

7.1.1 Third Party Liability (TPL)

TPL is defined as the right of the department to recover, on behalf of a client, from a third party payer the costs of Medicaid services furnished to the client.

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 client. 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 clients.

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 client'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 client. 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)
 - Client's estate
 - Title 25

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 Disability Insurance Payments

If the disability insurance carrier pays for health care items and services, the payments must be assigned to Wyoming Medicaid. The client 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 client may be treated as income for Medicaid eligibility purposes.

7.1.4 Long-Term Care Insurance

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

7.1.5 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 clients with health insurance coverage other than Wyoming Medicaid. If the provider of service(s) does not bill the liable third party, the claim will be denied. Providers will receive claim denial information on their remittance advices along with the claims billing addresses for the liable third parties. Providers will be required to bill the liable third parties.

NOTE: 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

NOTE: 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 client. The contribution providers make to Medicaid in the TPL arena is significant. Their cooperation is essential to the functioning of the Medicaid Program and to ensuring prompt payment.

At the time of client intake, the provider must obtain Medicaid billing information from the client. 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 in order for claims to be processed properly. Other insurance information may be reported to Medicaid using the Third Party Resources Information Sheet. Claims should not be submitted prior to billing TPL/Medicare.

7.2.1 Third Party Resources Information Sheet

Third Party Resources Information Sheet	
<input type="checkbox"/> NEW <input type="checkbox"/> CHANGE	
CLIENT NAME:	CLIENT MEDICAID ID NUMBER:
CLIENT DOB:	CLIENT SSN:
INSURANCE COMPANY NAME:	INSURANCE COMPANY ADDRESS:
TYPE OF COVERAGE: <input type="checkbox"/> Major Medical <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Surgical <input type="checkbox"/> Other	POLICY HOLDER
START DATE (MM/DD/YY):	END DATE (MM/DD/YY):
POLICY NUMBER:	GROUP NUMBER:
RELATIONSHIP OF CLIENT TO CASE HEAD: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Self(1) <input type="checkbox"/> Spouse(5) <input type="checkbox"/> Legal Guardian(9) </div> <div> <input type="checkbox"/> Absent Parent(2) <input type="checkbox"/> Brother/Sister(6) </div> <div> <input type="checkbox"/> Other(3) <input type="checkbox"/> Uncle/Aunt(7) </div> <div> <input type="checkbox"/> Parent(4) <input type="checkbox"/> Grandparent(8) </div> </div>	
NAME OF PROVIDER:	
COMPLETED BY:	DATE SUBMITTED:
RETURN TO: WYOMING MEDICAID PO BOX 667 CHEYENNE, WY 82003 FAX (307) 772-8405	
<hr/> FISCAL AGENT USE ONLY	
AUTHORIZED BY:	DATE:
INPUT BY:	DATE:

NOTE: Click image above to be taken to a printable version of this form.

Medicaid maintains a reference file of known commercial health insurance as well as a file for Medicare Part A and Part B entitlement information. Both files are used to deny claims that do not show proof of payment or denial by the commercial health insurer or by Medicare. Providers must use the same procedures for locating third party payers for Medicaid clients as for their non-Medicaid clients.

Providers may not refuse to furnish services to a Medicaid client because of a third party's potential liability for payment for the service (S.S.A. §1902(a)(25)(D)) ([3.2 Accepting Medicaid Clients](#)).

7.2.2 Provider is not enrolled with TPL Carrier

Medicaid will **no** longer accept a letter with a claim indicating that a provider does not participate with a specific health insurance company. The provider must work with the insurance company and/or client to have the claim submitted to the carrier. Providers cannot refuse to accept Medicaid clients who have other insurance if their office does not bill other insurance. However, a provider may limit the number of Medicaid clients s/he is willing to admit into his/her 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.

7.3 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 client with access to other insurance does not cooperate or follow the applicable rules of his or her other insurance plan.

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

NOTE: If a procedure code requires a prior authorization (PA) for Medicaid payment, but PA is not required by TPL/Medicare, it is still **highly** recommended to obtain a PA through Medicaid in case TPL/Medicare denies services.

Third Party Liability

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.

- 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 – TPL paid amount will be indicated in box 29 Amount Paid:

ENT? K)		28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
		\$	\$	
33. BILLING PROVIDER INFO & PH # ()				

- CMS 1500 – Medicare paid amount will **not** be indicated on the claim; a COB must be attached for claim processing.
- UB-04 – TPL/Medicare amount will be indicated in box 54 Prior Payments:

CREATION DATE		TOTALS	
50 PAID AMT	51 PRIOR PAYMENTS	52 EST. AMOUNT DUE	53 NPI
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			100

- Dental – TPL/Medicare amount will be indicated in box 31A Other Fees:

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

- If the TPL payer paid less than 40% of the total billed charges, included the appropriate claim reason and remark codes or attach an explanation of benefits (EOB) with the electronic claim (Electronic Attachments).
- 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.

NOTE: Medicaid will accept refunds from a provider at any time. Timely filing will not apply to adjustments where money is owed to Medicaid ([6.14, Timely Filing](#)).

Third Party Liability

- If a denial is obtained from the third party payer/Medicare that a service is not covered, attach the denial to the claim ([6.10, Submitting Attachments for Electronic Claims](#)). The denial will be accepted for one (1) calendar year or benefit plan year, as appropriate, but will still need to be attached with each claim.
- If verbal denial is obtained from a third party payer, type a letter of explanation on official office letterhead. The letter must include:
 - Date of verbal denial
 - Payer's name and contact person's name and phone number
 - Date of Service
 - Client'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.

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

- In situations involving litigation or other extended delays in obtaining benefits from other sources, Medicaid should be billed as soon as possible to avoid timely filing. If the provider believes there may be casualty insurance, contact TPL Unit ([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 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 Wyoming Medicaid Fiscal Agent's TPL ([2.1, Quick Reference](#)) prior to responding to such requests.
- If the client 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 clients, 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.

7.3.1 How TPL 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, etc.). 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.

TPL is applied to claims at the header level. Medicaid does not apply TPL amounts line by line.

Example:

- The total claim billed to Medicaid is for \$100.00, with a Medicaid allowable for the total claim of \$50.00. TPL has paid \$25.00 for only the second line of the claim. The claim will be processed as follows: Medicaid allowable (\$50.00) minus the TPL paid amount (\$25.00) = \$25.00 Medicaid Payment.

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

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

7.3.1.1 Previous Attempts to Bill Services Letter



(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
PO Box 547
Cheyenne, WY 82002-0547

NOTE: Do not submit this form for Medicare or automobile/casualty insurance.
Click image above to be taken to a printable version of this form.

7.3.2 Acceptable Proof of Payment or Denial

Documentation of proper payment or denial of TPL/Medicare must correspond with the client'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 (i.e. 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 client has other applicable insurance, providers who bill electronic and web claims will need to submit the claim COB information provided by the other insurance company for all affected services. For claims submitted through the Medicaid website, see the Web Portal Tutorials on billing secondary claims.

For clients with three insurances, tertiary claims cannot be submitted through the Medicaid Web Portal and will need to be sent in on paper, with both EOBs and a cover sheet indicating that the claim is a tertiary claim.

7.3.4 Blanket Denials and Non-Covered Services

When a service is not covered by a client'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 client's file to be used as proof of denial for **one calendar year or benefit plan year**, as appropriate. The non-covered status must be reviewed and a new letter obtained at the end of **one calendar year or benefit plan year**, as appropriate.

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

7.3.5 TPL and Copays

A client with private 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 client'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 in order 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 in order for it to be reviewed and processed appropriately.

Chapter Eight – Electronic Data Interchange (EDI)

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8.1 What is Electronic Data Interchange (EDI)?

In its simplest form, 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, etc. 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
- X12N 276/277 Claims Status Request and Response
- X12N 278 Request for Prior Authorization and Response
- X12N 277CA Implementation Guide Error Reporting
- X12N 835 Claim Payment/Remittance Advice
- X12N 837 Dental, Professional and Institutional Claims
- X12N 999 Functional Acknowledgement

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

8.4 Sending and Receiving Transactions

Medicaid has established a variety of methods for providers to send and receive EDI transactions. The following table is a guide to understanding and selecting the best method.

EDI Options				
Method	Requirements	Access Cost	Transactions Supported	Contact Information
Bulletin Board System (BBS) The BBS is an interactive, menu-driven bulletin board system for uploading and downloading transactions.	Computer Hayes-compatible 9600-baud or greater asynchronous modem Dial-up connection utility (e.g., ProComm, Hyperterminal, etc.) File decompression utility Software capable of formatting and reading EDI transactions Telephone connectivity	Free	X12N 270/271 Eligibility Benefit Inquiry and Response X12N 276/277 Claims Status Request and Response X12N 278 Request for Prior Authorization and Response X12N 277CA Implementation Guide Error Reporting X12N 835 Claim Payment/Remittance Advice X12N 837 Dental, Professional and Institutional Claims X12N 999 Functional Acknowledgement	EDI Services Telephone: (800)672-4959 9-5pm MST M-F OPTION 3 Website: https://edisolutionsmmis.portal.conduent.com/gcro/
Web Portal The Medicaid Secure Web Portal provides an interactive, web-based interface for entering individual transactions and a separate data exchange facility for uploading	Computer Internet Explorer 5.5 (or higher) or Netscape Navigator 7.0 (or higher). Whichever browser version is used, it must support 128-bit encryption Internet access Additional requirements for uploading and	Free	X12N 270/271 Eligibility Benefit Inquiry and Response X12N 276/277 Claims Status Request and Response X12N 278 Request for Prior Authorization and Response X12N 277CA Implementation Guide Error Reporting X12N 835 Claim Payment/Remittance Advice	EDI Services Telephone: (800)672-4959 9-5pm MST M-F OPTION 3 Website: https://wymedicaid.portal.conduent.com

Electronic Data Interchange

EDI Options				
Method	Requirements	Access Cost	Transactions Supported	Contact Information
and downloading batch transactions.	downloading batch transactions: File decompression utility. Software capable of formatting and reading EDI transactions		X12N 837 Dental, Professional and Institutional Claims* X12N 999 – Functional Acknowledgement NOTE: Only the 278 and 837 transactions can be entered interactively.	
WINASAP5010 Windows Accelerated Submission and Processing (WINASAP) is a Windows-based software application that allows users to enter and submit dental, professional and institutional claims electronically using a personal computer.	Computer Hayes-compatible 9600-baud asynchronous modem Windows 98 (or higher) operating system Pentium processor 25 megabytes of free disk space 128 megabytes of RAM Monitor resolution of 800 x 600 pixels Telephone connectivity	Free	X12N 837 Dental, Professional and Institutional Claims X12N 277CA Implementation Guide Error Reporting X12N 999 – Functional Acknowledgement	EDI Services Telephone: (800)672-4959 9-5pm MST M-F OPTION 3 Website: https://edisolutionsmmis.portal.conduent.com/gcro/

8.5 EDI Services

8.5.1 Getting Started

The first step the provider needs to complete before the provider is able to start sending electronic information is to complete the EDI Enrollment Application. The application is located on the Medicaid website ([2.1, Quick Reference](#)) under “Forms” and “Enrollment/Agreement Forms”.

Once the form is completed and sent to Medicaid the provider will be sent an EDI Welcome Letter which will include a User Name and Password. Below are the benefits of using Web Portal and WINASAP and instructions for registering.

NOTE: Web Portal Tutorials and WINASAP Tutorials are published to the Medicaid website ([2.1, Quick Reference](#)).

8.5.2 Web Portal

The Web Portal allows all trading partners to retrieve and submit data via the internet 24-hours a day, seven (7) days a week from anywhere.

What can the provider do with Web Portal?

- Submit claims
- Upload claim attachments ([6.10, Submitting Attachments for Electronic Claims](#))
- Retrieve Medicaid Remittance Advices (stores the last 24 RAs).
- Submit Ask Wyoming Medicaid questions.
- Submit and retrieve Prior Authorization requests and responses (limited to PAs processed by Medical Policy ([6.8, Prior Authorization](#))).
- Perform LT101 Inquires
- Enter PASRR
- The Office Administrator may set up additional users and give them only the access that they need.
- Build Claims Templates to save standard information such as
 - NPI numbers
 - Procedure Codes
 - Fees

8.5.2.1 Secured Provider Web Portal Registration Process

- Go to the Medicaid website: <https://wymedicaid.portal.conduent.com>.
- Select Provider.
- Select Provider Portal from the left hand menu.
- Under “New Providers” select Web Portal to register.
- Enter the following information from the EDI Welcome Letter:

- Provider ID: Trading Partner/Submitter ID.
 - Trading Partner ID: Trading Partner/Submitter ID.
 - EIN/SSN: The Providers tax-id as entered on the EDI application.
 - Trading Partner Password: Password/User ID – Must be entered exactly as shown on the welcome letter.
- Select Continue
 - Confirm that the information that the provider has entered is correct. If it is, choose Continue, if not re-enter information.
- Additional Trading Partner IDs:
 - If the provider needs to enter additional Trading Partner IDs enter the ID and the Trading Partner password on this page.
 - If the provider does not have any additional Trading Partner IDs select continue.

8.5.2.2 Creating an Office Administrator

The providers Office Administrator will be the person responsible for adding and deleting new users as necessary for the provider's organization along with any other privileges selected.

1. Select "Create a new user"
 - a. Enter a unique user ID, last name, first name, email address and phone number for the person that the provider wants to be the office administrator.
 - b. Confirm the information entered is correct.
 - c. This completes the web registration for the office administrator, an email will be sent to the email address entered with a one (1) time use password.
 - d. Once the provider receives the single use password, log in using this (it is easiest to copy and paste this directly from the email to avoid typographical errors). It must be changed upon logging in for the first (1st) time. Return to the home page and log in
2. All permissions will be set once the provider has logged in. To do this, select update or remove users. Enter the provider user ID and select search. When the user information is brought up, click on the user ID link.
 - a. Select which privileges the provider wishes to have. Once the provider has chosen these privileges click Submit.

8.5.2.3 Creating Additional Users

1. Return to the home page and choose Manage Users.
 - a. Follow the steps as listed above.

8.5.3 WINASAP

WINASAP allows all Trading Partners to submit claims 24-hours a day, seven (7) days a week from any computer with a dial up modem over an analog phone line that the

provider has installed the software on. WINASAP5010 software can be downloaded from the Conduent EDI Solutions website ([2.1, Quick Reference](#)) or the provider can call EDI Services ([2.1, Quick Reference](#)) and request a CD to be mailed to the provider.

Requirements:

- Windows 98 Second Edition, Windows NT, Windows 2000 (Service Pack 3), Windows XP or Windows 7 operating system
- Pentium processor
- CD-ROM drive
- 25 Megabytes of free disk space
- 128 Megabytes of RAM
- Monitor resolution of 800 x 600 pixels
- Hayes compatible 9600 baud asynchronous modem
- Telephone connectivity

8.5.3.1 WINASAP Start-up

1. Download program from the Conduent EDI Solutions website or install the program from the CD the provider requested.
 - a. When the welcome screen appears click next
 - b. Read and accept the terms of the Software License Agreement
 - c. Enter User Information
 - d. Choose Destination Location
 - e. Confirm provider current settings and choose Next
 - f. Check Yes, launch the program file and Finish.
2. Creating a WINASAP login
 - a. The user ID auto fills as ADMIN
 - b. Tab to password and type ASAP
 - i. The user ID and password are the same for everyone using WINASAP, we suggest that the provider does not change them
 - c. After successfully logging in choose ok
3. Steps that must be completed
 - a. The screen will automatically open the first (1st) time the provider runs the program that says Open Payer
 - i. Select Wyoming Medicaid and choose OK
 - ii. Choose File and Trading Partner – Enter the following
 - iii. Primary Identification: Enter the provider Trading Partner ID from the EDI Welcome Letter
 - iv. Secondary Identification – Re-enter the provider Trading Partner ID (primary and secondary identification will be the same)
 - b. Trading Partner Name:
 - i. Entity Type: select person or non-person.
 1. Choose person if the provider is an individual such as; a waiver provider, physician, therapist, or nurse practitioner

2. Choose non-person if the provider is a facility such as; a hospital, pharmacy or nursing home.
- c. Enter the providers last name, first name and middle initial (optional)
OR the organization name
 - i. Contact Information:
 1. Contact Name: provider Name
 2. Telephone Number: Enter provider phone number
 3. Fax Number: Enter provider fax number (optional)
 4. Email: Enter provider email address
4. The following criteria must be completed:
 - a. WINASAP5010 Communications:
 - i. Host Telephone Number: This phone number is listed as the Submission Telephone Number on the EDI Welcome Letter. Enter it with no spaces, dashes, commas, or other punctuation marks.
 - ii. User ID Number: Enter providers Password/User ID exactly as it appears.
 - iii. User Name: Enter providers User Name exactly as it appears.
 - iv. Choose Save

8.6 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.

NOTE: 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.

8.7 Scheduled Web Portal Downtime

Scheduled Web Portal Downtime			
What is Impacted	Functionality Impact	Why	Downtimes

Electronic Data Interchange

Entire website (Provider/Client) Static web pages <ul style="list-style-type: none">• https://wymedicaid.portal.com/duent.com	Website not available	Regular scheduled maintenance	<ul style="list-style-type: none">• 4 a.m. – 4:30 a.m. MST Saturdays• 3 p.m. – 6 p.m. MST Sundays
Secured Provider Web Portal <ul style="list-style-type: none">• https://wymedicaid.portal.com/duent.com/provider_home.html	Verification of claims submission will not be available	Regular scheduled maintenance	<ul style="list-style-type: none">• 10 p.m. – 12 a.m. (midnight) Sundays

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9.1 Wyoming Specific HIPAA 5010 Electronic Specifications

This chapter is intended for trading partner use in conjunction with the ASC X12N Standards for Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf. This section outlines the procedures necessary for engaging in Electronic Data Interchange (EDI) with the Government Healthcare Solutions EDI Clearinghouse (EDI Clearinghouse) and specifies data clarification where applicable.

9.2 Transaction Definitions

- 270/271 – Health Care Eligibility Benefit Inquiry and Response
- 276/277 – Health Care Claim Status Request and Response
- 278/278 – Health Care Services – Request for Review and Response; Health Care Services Notification and Acknowledgement
- 835 – Health Care Claim Payment/Advice
- 837 – Health Care Claim (Professional, Institutional, and Dental), including Coordination of Benefits (COB) and Subrogation Claims

Acknowledgement Transaction Definitions

- TA1 – Interchange Acknowledgement
- 999 – Implementation acknowledgement for Health Care Insurance
- 277CA – Health Care Claim Acknowledgement

9.3 Transmission Methods and Procedures

9.3.1 Asynchronous Dial-up

The Host System is comprised of communication (COMM) servers with modems. Trading partners access the Host System via asynchronous dial-up. The COMM machines process the login and password, then log the transmission.

The Host System will forward a confirmation report to the trading partner providing verification of file receipt. It will show a unique file number for each submission.

The COMM machines will also pull the TA1s and 999s from an outbound transmission table, and deliver to the HIPAA BBS Mailbox system. The trading partner accesses the mailbox system via asynchronous dial-up to view and/or retrieve their responses.

9.3.1.1 Communication Protocols

The EDI Clearinghouse currently supports the following communication options:

- XMODEM
- YMODEM
- ZMODEM
- KERMIT

9.3.1.2 Teleprocessing Requirements

The general specifications for communication with EDI Clearinghouse are:

- Telecommunications: Hayes-compatible 2400-56K BPS asynchronous modem
- File Format: ASCII text data
- Compression Techniques – EDI Clearinghouse accepts transmission with any of these compression techniques, as well as non-compression:
 - PKZIP will compress one (1) or more files into a single ZIP archive.
 - WINZIP will compress one (1) or more files into a single ZIP archive.
- Data Format:
 - 8 data bit
 - 1stop bit
 - no parity
 - full duplex

9.3.1.3 Teleprocessing Settings

- ASCII Sending
 - Send line ends with line feeds (should not be set)
 - Echo typed characters locally (should not be set)
 - Line delay 0 millisecond
 - Character delay 0 milliseconds
- ASCII Receiving
 - Append line feeds to incoming line ends should not be checked
 - Wrap lines that exceed terminal width
 - Terminal Emulation VT100 or Auto

9.3.1.4 Transmission Procedures

SUBMITTER	HOST
Dials Host 1(800) 334-2832 or (800) 334-4650	Answers call, negotiates a common baud rate, and sends to the Trading Partner:
Prompt: “Please enter provider Logon=>”	
Enters User Name (From the EDI Welcome Letter) <CR>	Receives User Name and sends prompt to the Trading Partner:
Prompt: “Please enter provider password=>”	
Enters Password/User ID (From the EDI Welcome Letter) <CR>	Receives Password/User ID and verifies if Trading Partner is an authorized user. Sends HOST selection menu followed by a user prompt:
Prompt: “Please Select from the Menu Options Below=>”	
Enters Desired Selection <CR> #1. Electronic File Submission: Assigns and sends the transmission file name then waits for ZMODEM (by default) file transfer to be initiated by the Trading Partner. #2. View Submitter Profile #3. Select File Transfer Protocol: Allows the provider to change the protocol for the current submission only. The protocol may be changed to (k) ermit, (x) Modem, (y) Modem, or (z) Modem. Enter selection [k, x, y, z]: #4. Download Confirmation #9. Exit & Disconnect: Terminates connection.	
Enters “1” to send file <CR>	Receives ZMODEM (or other designated protocol) file transfer. Upon completion, initiates file confirmation. Sends file confirmation report. Sends HOST selection menu followed by a user prompt=>
Prompt: “Please Select from the Menu Options Below=>”	

9.3.2 Web Portal

The trading partner must be an authenticated portal user who is a provider. Only active providers are authorized to access files via the web. Provider must have completed the web registration process. ([8.5.2.1, Secured Provider Web Portal Registration Process](#))

Trading partners can submit files via the web portal in two (2) ways:

- Upload an X12N transaction file – The trading partner accesses the web portal via a web browser and is prompted for login and password. The provider may select files from their PC or work environment and upload files.
- Enter X12N data information through a web interface – The trading partner accesses the web portal via a web browser and is prompted for login and password. Data entry screens will display for entering transaction information.

NOTE: Providers can retrieve their response files via the web portal by logging in and accessing their transaction folders.

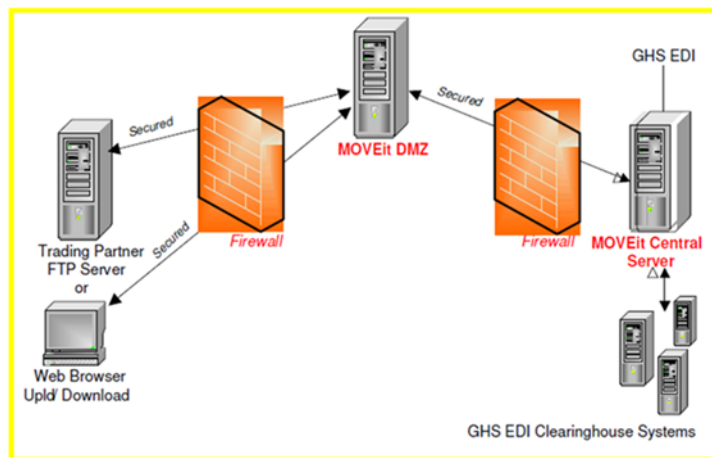
Transaction files can be uploaded and downloaded through the Secured Provider Web Portal at <https://wymedicaid.portal.conduent.com>.

Transaction transmission is available 24-hours a day, seven (7) days a week. This availability is subject to scheduled and unscheduled host downtime.

9.3.3 Managed File Transfer (MOVEit)

EDI Clearinghouse supports Managed File Transfer using a product suite called MOVEit. In the diagram below, trading partners can deliver files to or retrieve files from the MOVEit DMZ site. EDI Clearinghouse does corresponding pickups from and deliveries to the DMZ via an agreed upon schedule with Medicaid and trading partner.

Diagram 3. MOVEit Managed File Transfer



9.4 Acknowledgement and Error Reports

The following acknowledgement reports are generated and delivered to trading partners:

- TA1 – Will be used to report invalid Trading Partner Relationship Validation to Provider/Trading Partner.
- 999 – Will be used to acknowledge Syntax Validation (Positive, Negative or Partial) – to Provider/Trading Partner.
- 277CA – Claims Acknowledgement will be used to provide accept/reject information regarding submitted claims/request – to Provider/Trading Partner.

9.4.1 Confirmation Report

When a trading partner submits an X12N transaction, a receipt is immediately sent to the trading partner to confirm that EDI Clearinghouse received a file, and shows a unique file number for each submission. The Host System will forward a Confirmation Report to the trading partner indicating:

- Verification of file receipt
- If the file is accepted or rejected
- Identified as an X12N at a high level

If a file fails this preliminary check, it will not continue processing.

The Confirmation Report includes the following information:

- Date and time file was received
- File number
- Payer code (Wyoming Medicaid 77046)
- Submission format
- Type of transaction
- Number of claims and batches
- Status of Production or Test
- Additional messages that can be added as a communication to trading partners or may indicate the reason the file is invalid.

9.4.2 Interchange Level Errors and TA1 Rejection Report

A TA1 is an ANSI ASC X12N Interchange Acknowledgement segment used to report receipt of individual interchange envelopes. An interchange envelope contains the sender, receiver, and data type information within the header. The term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. Refer to the TR3 documents for a description of Envelopes and Control Structures.

The TA1 reports the syntactical analysis of the interchange header and trailer. The TA1 allows EDI Clearinghouse to notify the trading partner that a valid X12N transaction

envelope was received; or if problems were encountered with the interchange control structure or the trading partner relationship.

The TA1 is unique in that it is a single segment transmitted without the GS/GE envelope structure.

If the data can be identified, it is then checked for trading partner relationship validation.

- If the trading partner information is invalid, the data is corrupt or the trading partner relationship does not exist, a negative confirmation report is returned to the submitter. Any major X12N syntax error that occurs at this level will result in the entire transaction being rejected, and the trading partner will need to resubmit their X12N transaction.
- If the trading partner information is valid, the data continues processing for complete X12N syntax validation.

9.4.3 999 Implementation Acknowledgements

The 999 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group and the implementation guide compliance.

For more information on the relationship between the 999 transaction set and other response transaction sets, refer to the ASC X12N Standards for Electronic Data Interchange Technical Report Type 3 (TR3).

The 999 contains information indicating if the entire file is HIPAA 5010 compliant or not.

9.4.3.1 Batch and Real-Time Usage

There are multiple methods available for sending and receiving business transactions electronically. Two (2) common modes for EDI transactions are batch and real-time.

- **Batch** – In a batch mode the sender does not remain connected while the receiver processes the transactions. Processing is usually completed according to a set schedule. If there is an associated business response transaction (such as a 271 Response to a 270 Request for Eligibility), the receiver creates the response transaction and stores it for future delivery. The sender of the original transmission reconnects at a later time and picks up the response transaction.
- **Real-Time** – In real-time mode the sender remains connected while the receiver processes the transactions and returns a response transaction to the sender.

The 999 contains information indicating if the entire file is HIPAA 5010 compliant or not.

9.4.4 Data Retrieval Method

Secured Web Portal

The web portal allows all trading partners to retrieve data via the internet 24-hours a day, seven (7) days a week. Each provider has the option of retrieving the transaction responses and reports themselves or allowing billing agents and clearinghouses to retrieve on their behalf. The trading partner will access the Secured Provider Web Portal system using the user ID and password provided upon completion of the enrollment process ([8.5.2.1, Secured Provider Web Portal Registration Process](#)). Contact EDI Services for more information ([2.1, Quick Reference](#)).

9.5 Testing

Submitters (software vendors, billing agents, clearinghouses, and providers) who have created their own electronic X12 transaction software are required to test their software. Contact EDI Services for more information ([2.1, Quick Reference](#)). By testing the submitter is validating their software prior to submitting production transactions.

While in test mode for HIPAA 5010 the provider will not be able to submit production files until testing is complete and the providers software is approved.

If a production HIPAA 5010 file is submitted while in test mode the file will fail with a TA1 error ([9.4.2, Interchange Level Errors and TA1 Rejection Report](#)).

9.5.1 Testing Requirements

Contact EDI Services and explain that the provider is ready to test the provider software.

- Testing via EDIFECS
 - Submitters cannot obtain direct Internet access to EDIFECS, the EDI Services call center staff will set this up at the provider's request.
 - A user ID and password will be generated for the providers use.
 - The provider is required to submit test files through EDIFECS.
 - The provider is required to address any errors discovered during testing prior to moving on to testing with the EDI Clearinghouse.
 - After the provider's software has received approval provide EDI Services with the EDIFECS certification.
- Testing with EDI Clearinghouse
 - The call center will have the provider submit a test file.
 - After 24-hours contact the call center for test file results.
 - Make corrections based on the TR3s and Wyoming Specific HIPAA 5010 Specifications.
 - Resubmit test files as necessary.
 - Successful completion of the testing process is required before a submitter will be approved for production.

A separate testing process must be completed for each type of transaction i.e. 270/271, 276/277, 837 etc.

Each test transmission is validated to ensure no format errors are present. Testing is conducted to verify the integrity of the format not the integrity of the data. However, in order to simulate a true production environment, we request that test files contain realistic healthcare transaction data. The number of test transmissions required depends on the number of format errors in a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to Wyoming Specific HIPAA 5010 Specifications or HIPAA mandated changes.

9.6 270/271 Eligibility Request and Response

Health Care Eligibility Benefit Inquiry Request and Response for Wyoming Medicaid

This section is for use along with the ANSI ASC X12 Health Care Eligibility Request & Response 270/271. It should not be considered a replacement for the TR3's, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

NOTE: The page numbers listed below in each of the tables represent the corresponding page number in the Technical Report Type3 (TR3) ANSI ASC X12N Consolidated Guide; Health Care Eligibility Benefit Inquiry and Response for the 270/271 005010X279 & 005010X279A1, June 2010.

9.6.1 ISA Interchange Control Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.5	Header	ISA	08	Enter 100000 Followed by spaces

9.6.2 GS Functional Group Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.7	Header	GS	03	Enter 77046

9.6.3 Access Methods Supported by Wyoming Medicaid

- Access by Member ID number for subscriber
- Access by Member Card ID number
- Access by Social Security Number, and Date of Birth (Format CCYYMMDD) for the subscriber
- Access by Social Security Number, and Name for the subscriber (Any non-alphanumeric character including spaces that are included in the last name or the first name may cause the inquiry to not be successfully processed)
- Access by Name (Any non-alphanumeric character including spaces that are included in the last name or the first name may cause the inquiry to not be successfully processed), Sex, and Date of Birth for the subscriber

NOTE: References to “Subscriber” are taken from the ANSI ASC X12N Consolidated Guide; Health Care Eligibility Benefit Inquiry and Response for the 270/271 005010X279 & 005010X279A1 and are synonymous with Member.

9.6.4 270 Eligibility Request

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 72	2100A	NM1	03	Wyoming Medicaid
Page 79	2100B	NM1	08	NOTE: SV should be used only when a Wyoming Provider is an Atypical Provider/non-medical.
Page 80	2100B	NM1	09	NOTE: Enter Wyoming Medicaid Provider ID when NM108 is SV.

9.6.5 271 Eligibility Response

No Wyoming specific requirements.

9.7 276/277 Claim Request and Response

Health Care Claim Status Request and Response for Wyoming Medicaid

This section is for use along with the ANSI ASC X12 Health Care Claim Status Request and Response 276/277. It should not be considered a replacement for the TR3's, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

NOTE: The page numbers listed below in each of the tables represent the corresponding page number in the Technical Report Type3 (TR3) ANSI ASC X12N Health Care Claim Status Request and Response for the 276/277 005010X212, August 2006.

9.7.1 ISA Interchange Control Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.5	Header	ISA	08	Enter 100000 Followed by spaces

9.7.2 GS Function Group Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.7	Header	GS	03	Enter 77046

9.7.3 276 Claim Status Report

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 46	2100B	NM1	09	NOTE: Enter the nine (9) digit Wyoming Medicaid Provider ID when a Wyoming Provider is an Atypical Provider/non-Medicaid
Page 51	2100C	NM1	08	NOTE: SV should be used only when a Wyoming Provider is an Atypical Provider/non-medical.
Page 73	2210D	REF	01	The Line Item Control Number inquiry is not supported by Wyoming Medicaid. The Claim Status Response will return all claim line items.
Page 73	2210D	REG	02	The Line Item Control Number inquiry is not supported by Wyoming Medicaid. The Claim Status Response will return all claim line items.

9.7.4 277 Claim Status Response

No Wyoming specific requirements.

9.8 278 Request for Review and Response

Health Care Services Request for Review/Response for Wyoming Medicaid

This section is for use along with the ANSI ASC X12 Health Care Prior Authorization Request and Response 278. It should not be considered a replacement for the TR3's, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

NOTE: The page numbers listed below in each of the tables represent the corresponding page number in the Technical Report Type3 (TR3) ANSI ASC X12N Health Care Services Review – Request for Review and Response for the (278) 005010X217, May 2006.

9.8.1 ISA Interchange Control Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.5	Interchange Control Header	ISA	08	Enter 100000 Followed by spaces

9.8.2 GS Function Group Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.7	Functional Group Header	GS	03	Enter 77046

9.8.3 278 Prior Authorization Request – Data Clarifications Inbound

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 73	2010A	NM1	09	Enter 77046

9.8.4 X12N 278 Health Care Services Review – Response to Request for Review – Outbound for Wyoming Medicaid

9.9 835 Claim Payment/Advice

Health Care Claim Payment Advice for Wyoming Medicaid

9.9.1 Payment/Advice

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 107	1000B	REF	01	If the provider does not have an NPI then REF01 will contain “PQ” (Payee Identification) and REF02 will contain the Wyoming Medicaid Provider ID.
Page 108	1000B	REF	02	If the provider does not have an NPI then REF01 will contain “PQ” (Payee Identification) and REF02 will contain the Wyoming Medicaid Provider ID.
Pages 207-208	2110	REF	01	Either HPI or G2 will be displayed. NOTE: G2 will be displayed only for WY Medicaid Atypical Providers
Page 208	2110	REF	02	NOTE: Enter the nine (9) digit Wyoming Medicaid Provider ID when a Wyoming Provider is an Atypical/non-medical.

9.10 837 Professional Claims Transactions

Wyoming Medical Professional Claims

This section is for use along with the ANSI ASC X12 Health Care 837 Claims Transactions. It should not be considered a replacement for the TR3s, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

NOTE: The page numbers listed below in each of the tables represent the corresponding page number in the Technical Report Type3 (TR3) ANSI ASC X12N Consolidated Guide Health Care Claim: Professional (837), 005010X222/005010X222A1, June 2010

9.10.1 ISA Interchange Control Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.3	Header	ISA	01	Enter 00
Appendix C Page C.4	Header	ISA	03	Enter 00
Appendix C Page C.4	Header	ISA	06	Enter Trading Partner ID
Appendix C Page C.5	Header	ISA	08	Enter 100000 Followed by spaces

9.10.2 GS Functional Group Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.7	Functional Group Header	GS	02	Enter Trading Partner ID
Appendix C Page C.7	Functional Group Header	GS	03	Enter 77046

9.10.3 837 Professional

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 72	Header	BHT	06	Wyoming Medicaid only accepts the CH code.
Page 80	1000B	NM1	03	Enter Wyoming Medicaid.
Page 80	1000B	NM1	09	Enter 77046.
Page 83	2000A	PRV	03	If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.
Page 115	2000B	HL	04	Enter 0. The subscriber is always the patient; therefore, the dependent level will not be utilized.
Page 116-117	2000B	SBR	01	Enter P (Primary-Payer Responsibility Sequence Number code) Client has only Medicaid Coverage.
Page 123	2010BA	NM1	09	Enter the ten (10) digit Wyoming Medicaid Client ID.
Page 134	2010BB	NM1	03	Enter Wyoming Medicaid.
Page 134	2010BB	NM1	08	Enter PI (Payer Identification).
Page 134	2010BB	NM1	09	Enter 77046.

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 140	2010BB	REF	01	If 'XX' is used to pass the NPI number in 2010AA, NM109, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then submit 'G2' (Provider Commercial Number) in 2010BB REF01, and submit the Wyoming Medicaid Provider Number in the 2010BB REF02.
Page 140-141	2010BB	REF	02	If 'XX' is used to pass the NPI number in 2010AA, NM109, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then submit 'G2' (Provider Commercial Number) in 2010BB REF01 and submit the Wyoming Medicaid Provider number in 2010BB REF02.
Page 161	2300	CLM	05:3	Void/Adjustment (Frequency Type Code) should be six (6) (Adjustment) only if paid date was within the last six (6) months (180 days) (12 month (365 days) timely filing will be waived), or seven (7) (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.
Page 262-263	2310A	REF	01	If 'XX' is used to pass the NPI Number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 262-263	2310A	REF	02	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in the REF01 and the Wyoming Medicaid Provider ID in REF02.

Wyoming HIPAA 5010 Electronic Specifications

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 269-270	2310B	REF	01	If 'XX' is used to pass the NPI number in NM10, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 269-270	2310B	REF	02	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted the enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 300	2320	SBR	09	Do not use code MC.
Page 427	2410	LIN	03	Enter the 11 digit National Drug Code (NDC). NDC's less than 11-digits will cause the service line to be denied by Wyoming Medicaid. Do not enter hyphens or spaces within the NDC. NOTE: Only the first iteration of Loop 2410 will be used for claims processing. If two (2) or more NDCs need to be reported for the same procedure code on the same claim, the procedure code must be repeated on a separate service line with the first iteration of Loop 2410 used to report each unique NDC. For more information consult the Wyoming Medicaid website (https://wymedicaid.portal.conduent.com).
Page 436	2420A	PRV	03	If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.
Page 437	2420A	REF	01	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 471	2420 F	REF	01	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 472	2420F	REF	02	If 'XX' is used to pass the NPI number is NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and Wyoming Medicaid Provider ID in REF02.

9.11 837 Institutional Claims Transactions

Wyoming Medicaid Institutional Claims

This section is for use along with the ANSI ASC X12 Health Care 837 Claims Transactions. It should not be considered a replacement for the TR3s, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

NOTE: The page numbers listed below in each of the tables represent the corresponding page number in the Technical Report Type3 (TR3) ANSI ASC X12N Consolidated Guide Health Care Claim: Institutional (837), 005010X223/005010X223A/1005010X223A2, June 2010.

9.11.1 ISA Interchange Control header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.4	Header	ISA	06	Enter Trading Partner ID
Appendix C Page C.5	Header	ISA	08	Enter 100000 followed by spaces

9.11.2 GS Functional Group Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.7	Functional Group Header	GS	02	Enter Trading Partner ID
Appendix C Page C.7	Functional Group Header	GS	03	Enter 77046

9.11.3 837 Institutional

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 77	1000B	NM1	03	Enter Wyoming Medicaid
Page 77	1000B	NM1	09	Enter 77046
Page 147	2300	CLM	05:3	Void/Adjustment (Frequency Type Code) should be 6 (Adjustment) only if paid date was within the last six (6) months (180 days) (12 month (365 days) timely filing will be waived), or seven (7) (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.

9.12 837 Dental Claims Transactions**Wyoming Medicaid Dental Claims**

This section is for use along with the ANSI ASC X12 Health Care 837 Claims Transactions. It should not be considered a replacement for the TR3s, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

NOTE: The page numbers listed below in each of the tables represent the corresponding page number in the Technical Report Type3 (TR3) ANSI ASC X12N Consolidated Guide Health Care Claim: Dental (837), 005010X224/005010X224A1/005010X224A2, June 2010.

9.12.1 ISA Interchange Control Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.4	Header	ISA	06	Enter Trading Partner ID
Appendix C Page C.5	Header	ISA	08	Enter 100000 followed by spaces

9.12.2 GS Functional Group Header

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Appendix C Page C.7	Functional Group Header	GS	02	Enter Trading Partner ID
Appendix C Page C.7	Functional Group Header	GS	03	Enter 77046

9.12.3 Dental

TR3Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 75	1000B	NM1	03	Enter Wyoming Medicaid
Page 75	1000B	NM1	09	Enter 77046
Page 125	2010BB	NM1	03	Enter Wyoming Medicaid
Page 125	2010BB	NM1	08	Enter PI (Payer Identification)
Page 125	2010BB	NM1	09	Enter 77046
Page 126	2010BB	N3	01	Enter PO Box 547
Page 127	2010BB	N4	01	Enter Cheyenne
Page 128	2010BB	N4	02	Enter WY
Page 128	2010BB	N4	03	Enter 82003
Page 149	2300	CLM	05:3	Void/Adjustment (Frequency Type Code) should be six (6) (Adjustment) only if paid date was within the last six (6) months (180 days) (12 month (365 days) timely filing will be waived), or seven (7) (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.

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10.1 Claims Review

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

10.2 Coding

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

- Use Current Dental Terminology (CDT) coding book
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend coding classes offered by certified coding specialists.

10.3 Importance of Fee Schedules and Provider's Responsibility

Procedure codes listed in the following sections are subject to change at any time without prior notice. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedules on the website or contact Dental Services ([2.1, Quick Reference](#)). Fee schedules list Medicaid covered codes, limitations, and provide clarification of indicators such as whether a code requires prior authorization. Not all codes are covered by Medicaid. It is the provider's responsibility to verify this information.

10.4 Master Fee Schedule

When using the fee schedule at the Medicaid website, refer to the Master Fee Schedule indicated by M01 for all dental codes.



10.5 By Report or Manually Priced Codes

Certain dental codes are manually priced or by report. By report dental codes are noted on the fee schedule by MP and will be paid at 70% of billed charge for dates of service prior to 01/01/2021. For 01/01/2021 and forward dates of service, by report dental codes will be paid at 68.25%. Retrospective reviews may reveal inappropriate codes being billed or paid. After review by the Division of Healthcare Financing and the Department of Oral Health, if it is determined that the billing was inappropriate, federal regulations require that Medicaid recover any overpayment. Documentation should always support billing.

10.6 Dental Provider Client Acceptance Form Requirement

Each quarter the Division of Healthcare Financing must collect data from the Medicaid dental providers regarding accepting Medicaid clients into their practice. In order to comply with this requirement, a provider must complete the Dental Provider Client Acceptance Form ([10.6.1 Dental Provider Client Acceptance Form](#)). This form relays the required information to the Division. All dental providers will be required to complete this form as a new enrolled provider and annually. Dental providers will only be required to complete this form quarterly if there have been changes to their office policies on accepting Medicaid clients. If no changes have occurred, the dental provider will only need to complete this form annually in July.

10.6.1 Dental Provider Client Acceptance Form

 Wyoming Department of Health	Healthcare Financing Division Wyoming Medicaid 6101 Yellowstone Road, Suite 210 Cheyenne, WY 82002 Phone (307) 777-7531 • 1-866-571-0944 Fax (307) 777-6964 • www.health.wyo.gov	
---	--	--

Dental Provider Client Acceptance Form

Billing Provider Name:

Provider NPI Number:

Provider Address:

Provider Phone:

Person completing form:

Date form completed:

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

Dentist Signature _____ Date _____

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

Return this form to:
Division of Healthcare Financing, Medicaid
Attn: Dental Program Manager
6101 Yellowstone Road, Suite 210
Cheyenne, WY 82002

NOTE: Click image above to be taken to a printable version of this form.

10.7 Supernumerary Teeth

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

10.8 Dental Services Performed in an IHS/Tribal Clinic

For information on services performed in an IHS/Tribal Clinic see the latest [Tribal Provider Manual](#).

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Covered Services

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11.1 No Show Appointments/Broken Appointments

Dental Code Range: D9986

Appointments canceled or missed by Medicaid clients cannot be billed to Medicaid. Medicaid recognizes the concern of missed/broken appointments and for tracking purposes only has created code D9986. Providers will not be reimbursed for this code. When submitting a claim to Medicaid for missed/broken appointments an amount of \$0.00 should be entered in box 31 (fee) of the claim form. This line will show as a denial on the Remittance Advice. If a provider's policy is to bill all patients for missed appointments/broken appointments, the provider may bill Medicaid clients.

11.2 Examinations

11.2.1 Examinations for Children (Ages 0-20)

Dental Code Range: D0120-D0180

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

11.2.2 Examinations for Adults

Dental Code Range: D0120-D0191

- **D0120 or D0150** – Oral evaluations, **reimbursable** once every six (6) months.
- **D0140** – Limited oral evaluations, **reimbursable** twice every 12 months.
- **D0191** – Assessment of a patient, reimbursable to clients on the Nursing Home (NH) plan once every 12 months only if the client has not been to a dentist within the last year.
- **D0412** - If the provider and/or client would like all of the 3rd molars removed at time of surgery, only teeth that are documented to be symptomatic should be billed to Medicaid.

11.3 Radiographs and Diagnostic Imaging

Dental Code Range: D0210-D0330

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

- **D0210** – Intraoral complete series* – **reimbursable** every five (5) years for clients of any age.
- **D0330** – Panoramic film* – **reimbursable** every five (5) years for clients five (5) years and older.
- **D0270, D0272, or D0274** – Bitewing x-rays –**reimbursable** once every year for clients of any age.
- **D0220** – Intraoral first film
- **D0230** – Each additional film after the first (as needed).

NOTE: A maximum of seven (7) periapicals are allowed per visit.

- **D0367** – Cone Beam CT Capture and Interpretation with Field of view of Both Jaws – **reimbursable** when providers are performing an implant, exposure of un-erupted tooth for the purpose of orthodontic bonding, jaw surgery **for clients age 0-20**, or a request has been made by a Cleft Palate team for diagnostic purposes related to a client's cleft palate/lip treatment. A Prior Authorization will be required for this code ([6.8.1, Requesting Prior Authorization](#))
- **D0210 or D0330** is reimbursable once every five (5) years.

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

11.4 Preventive Dental Care

11.4.1 Preventative Dental Care for Children

Dental Code Range: D1110 - D1354

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

11.4.2 Preventative Dental Care for Adults

Dental Code Range: D1110

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

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

11.5 Periodontal Treatment

11.5.1 Periodontal Treatment for Children

Dental Code Range: D4210-D4999

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

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

11.5.2 Periodontal Treatment for Adults

Dental Code Range: D4346 and D4355

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

11.6 Prosthetics Removable

11.6.1 Prosthetics Removable for Children

Dental Code Range: D5110-D5899

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

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

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

Contact Dental Services ([2.1, Quick Reference](#)) for denture benefit availability.

11.6.2 Prosthetics Removable for Adults

Dental Code Range: D5410-D5761

Relines and repairs to existing removable appliances are covered.

- **D5410-D5422** – Denture/partial adjustments,
 - For dates of service prior January 1, 2021 this service is limited to two (2) per 12 month period.
 - For dates of service January 1, 2021 and forward this service is limited to two (2) per arch per 12 month period
- **D5510-D5721** – Other services include the repair of a broken denture base, repair or replacement of broken clasps, replacement of teeth.
- **D5730-D5761** – Denture/partial relines
 - For dates of service prior January 1, 2021 this service is limited to two (2) per 12 month period.
 - For dates of service January 1, 2021 and forward this service is limited to once every three (3) years.

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

Contact Dental Services ([2.1, Quick Reference](#)) for denture benefit availability.

11.7 Extractions

11.7.1 Extractions for Children

Dental Code Range: D7111-D7250

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

11.7.2 Extractions for Adults

Dental Code Range: D7111-D7510

- Extractions are reimbursable for those teeth that demonstrate radiographically, pathologic, pulpal involvement, periapical infection, periodontally involved teeth of the class IV category, and large carious lesions that **the eligible client wants extracted even though they have been informed of alternate treatment remedies**. Current radiographs and other clinical documentation of teeth that are extracted must be maintained in the patient record.
- **D5710**- Incision and drainage is reimbursable when an emergency extraction cannot be performed due to health reasons or in the case of gingival infection, pericoronal or lateral abscess due to periodontal pathology.

11.8 Oral and Maxillofacial Surgery

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

11.8.1 Oral and Maxillofacial Surgery for Children


Dental Code Range: D7111-D7999

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

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

Orthognathic surgery is only covered when required to complete treatment for severe malocclusion. The client must be approved for orthodontic treatment through the Medicaid Severe Malocclusion program to be considered for corrective jaw surgery. The following oral surgery codes require an approval prior to performing the services, from Medicaid, in the form of a Prior Authorization (PA): D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, and D7950. Prior Authorizations will not be issued after a procedure is completed. Providers must obtain a PA prior to rendering services and at the time of the Severe Malocclusion request ([6.8.1, Requesting Prior Authorization](#)). Requests for Oral and Maxillofacial surgery must include the Consideration for Oral Surgery Form, shown below. If the provider and/or client would like all of the 3rd molars removed at time of surgery, only teeth that are documented to be symptomatic should be billed to Medicaid.

11.8.1.1 Consideration for Oral Surgery Form



Wyoming
Department
of Health

CONSIDERATION FOR ORAL SURGERY RELATED TO ORTHODONTIC APPROVAL

ORAL SURGEON NAME: _____

NPI: _____

DATE OF CONSULTATION: _____

CLIENT NAME: _____

MEDICAID ID#: _____

REFERRING DENTIST NAME: _____

CONDITION REFERRED FOR: _____

WERE XRAYS AND/OR RECORDS SENT WITH THIS REFERRAL? ☐ YES ☐ NO

BASED ON YOUR EXAMINATION AND REVIEW OF THE RECORDS, PLEASE PROVIDE YOUR TREATMENT PLAN FOR THIS CLIENT RELATED TO THEIR SURGERY/ORTHODONTIC NEEDS. PROCEDURE CODES, FEES, AND TIMELINES SHOULD BE INCLUDED IN YOUR RECOMMENDATIONS.

ARE THERE ANY ALTERNATIVE RECOMMENDATIONS FOR THIS CLIENT?

DID THE CLIENT REPORT ANY OF THE FOLLOWING CONDITIONS:

<input type="checkbox"/> JAW PAIN	<input type="checkbox"/> JOINT PAIN	<input type="checkbox"/> FACIAL PAIN
<input type="checkbox"/> HEADACHES	<input type="checkbox"/> EAR PAIN	<input type="checkbox"/> GRIND TEETH
<input type="checkbox"/> JOINT POP	<input type="checkbox"/> LOCKED JAW	<input type="checkbox"/> LIMITED MOUTH OPENING
<input type="checkbox"/> PROBLEMS WITH MASTICATION		
<input type="checkbox"/> STRESS RELATED TO THEIR APPEARANCE		

 DENTIST'S SIGNATURE

 DATE

RETURN THIS FORM WITH ANY SUPPORTING DOCUMENTATION TO THE ADDRESS BELOW

Wyoming Medicaid
Attn: Medical Policy
PO Box 667
Cheyenne, WY 82003-0067
WYMedPol@conduent.com

NOTE: Click the images above to be taken to a printable version of this form.

11.8.2 Oral and Maxillofacial Surgery for Adults

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

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

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

11.9 Anesthesia

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

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

11.10 Dental Services Performed in an FQHC/RHC

Dental services that are performed in an FQHC/RHC must be billed on the most current ADA claim form/837D. Dental services will receive an encounter rate that is established by Wyoming Medicaid and includes ALL services provided during the encounter and is considered to be an all-inclusive rate.

11.10.1 Dental (Other Than Orthodontics) Claims

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

Example:

Covered Services

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

Line	Procedure Code	Date	Amount	NPI
1	D9999	1/5/19	Fee encounter rate	Treating Provider NPI
2	D1120	1/5/19	\$0.00	Treating Provider NPI
3	D0240	1/5/19	\$0.00	Treating Provider NPI
4	D1120	1/5/19	\$0.00	Treating Provider NPI

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

Refer to the [Dental Fee Schedule](#) for age limitation.

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

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

11.11 Services Covered for Children Only

11.11.1 Restorative Treatment

Dental Code Range: D2140-D2394 and D2510-D2664

Restorative treatment is limited to those services essential to restore and maintain adequate dental health. Pins and special preparations are reimbursed separately from the restoration. Temporary restorations are reimbursable only as a result of palliative or emergency treatment. When more than one (1) surface is involved, and one (1) continuous filling is used, select the appropriate code from the range of D2140-D2394. When there are separate fillings on each surface, the one (1) surface codes (D2140 and D2391) are to be used. Records must clearly indicate each filling is treatment for a separate surface of decay.

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

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

11.11.2 Crowns

Dental Code Range: D2710-D2934

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

NOTE: For clients under the age of 14, a pre-treatment request may be submitted prior to the treatment, if the tooth has not been treated with a root canal therapy and the dentist substantiates the need for a permanent crown prior to the age of 14 to preserve the integrity of the tooth structure. Send this request to Wyoming Medicaid Attn: Dental Services.

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

11.11.3 Labial Veneers

Dental Code Range: D2961-D2962

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

11.11.4 Endodontics

Dental Code Range: D3110-D3330

The fee for endodontic treatment will include all necessary radiographs during treatment, including preoperative and postoperative radiographs. Root canal therapy for permanent teeth includes, extirpation, treatment, filling of root canals and all necessary radiographs, including a post-treatment radiograph. Emergency endodontic procedures, i.e., open tooth to drain, may be performed prior to root canal therapy. Endodontic treatment will only be reimbursed for situations where adequate bone viability can be documented. A radiograph demonstrating the completed endodontic treatment is required to be a part of the clinical procedure and must be included in the patient's permanent clinical record. Pulpal therapy for primary teeth is reimbursable for those teeth only not near exfoliation.

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

11.11.5 Apicoectomy

Dental Code Range: D3410-D3426

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

11.11.6 Implant Services and Fixed Prosthesis

Dental Code Range: D6010-D6199 and D6205-D6999

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

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

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

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

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

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

NOTE: If the tooth/teeth to be replaced were not lost due to the above conditions, Wyoming Medicaid will not pay for an implant or fixed bridge. The


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

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

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

All implant codes and fixed prosthesis require an approval, prior to performing the services, in the form of a Prior Authorization (PA). Prior Authorizations ([6.8.1, Requesting Prior Authorization](#)) will not be issued after a procedure is complete. The provider must obtain a PA prior to rendering services. Prior Authorizations must also include a Tooth Replacement (Implant) Request Form, shown below.

11.11.6.1 Tooth Replacement (Implant) Request Form



Wyoming
Department
of Health

TOOTH REPLACEMENT (IMPLANT) REQUEST

PRIOR AUTHORIZATION ATTACHMENT

CLIENT NAME: _____

CLIENT ID: _____

CLIENT DOB: ____/____/____
Month Day Year

CLIENT CURRENT PHONE #: (____) ____-____

REQUESTING DENTIST: _____

REQUESTING DENTIST'S PHONE #: (____) ____-____

NPI: _____

1. TOOTH NUMBER(S) TO BE REPLACED _____
2. CONDITION OF NEIGHBORING TEETH _____
3. WAS THE TOOTH/TEETH TO BE REPLACED LOST DUE TO:

☐ CONGENITALLY MISSING _____
☐ LOSS DUE TO TRAUMA (DATE OF ACCIDENT _____)
☐ LOSS DUE TO ABNORMAL PATHOLOGY NOT RELATED TO PERIODONTAL DISEASE OR CARIOUS LESIONS

DESCRIBE CIRCUMSTANCES: _____

4. TREATMENT BEING REQUESTED- INCLUDE CODES _____

5. DOES THIS CLIENT CURRENTLY HAVE ANY TYPE OF REPLACEMENT IN PLACE? ☐ YES ☐ NO
6. IF YES, WHAT IS CURRENTLY IN PLACE? _____
7. IS THIS CLIENT FREE OF GINGIVITIS? ☐ YES ☐ NO PERIODONTAL DISEASE ☐ YES ☐ NO
8. IS THIS CLIENT FREE OF TOBACCO USE? ☐ YES ☐ NO
9. IF NO, HAS THIS CLIENT BEEN REFERRED TO THE WYOMING QUIT LINE (1-800-784-8669)? _____

SIGNATURE OF PROVIDER _____

DATE _____

THIS FORM IS TO BE INCLUDED WITH A PRIOR AUTHORIZATION REQUEST FORM.

A COMPLETE COPY OF THE CLIENT'S CLINICAL RECORDS MUST BE INCLUDED WITH THIS REQUEST FORM. THE PROVIDER SHOULD ALSO PROVIDE ANY ADDITIONAL DOCUMENTATION TO SUBSTANTIATE THIS REQUEST INCLUDING ORAL HYGIENE REPORTS AND PROGRESS NOTES. PLEASE SEND THIS REQUEST TO THE ADDRESS BELOW.

Wyoming Medicaid
Attn: Medical Policy
PO Box 667
Cheyenne, WY 82003-0067
WYMedPol@conduent.com

NOTE: Click the images above to be taken to a printable version of this form.

11.11.7 Biopsy of Oral Tissue – Soft

Dental Code Range: D7286

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

11.11.8 Occlusal Orthotic Device

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

- **D7880** - An occlusal splint may be provided to a client if the client has been diagnosed with Temporomandibular Joint Dysfunction (TMJ). A report of TMJ diagnosis and complete treatment plan including any physical therapy, and/or drugs used to treat symptoms must be submitted with the claim. This must be billed on the delivery date.
- **D9944** - Occlusal guard-hard, full arch. Prior authorization required with documented medical necessity. Prior authorizations will not be issued after impressions have been taken. The provider must obtain a PA prior to rendering services. This must be billed on the delivery date.
- **D9945** - Occlusal guard-soft, full arch. Prior authorization required with documented medical necessity. Prior authorizations will not be issued after impressions have been taken. The provider must obtain a PA prior to rendering services. This must be billed on the delivery date.

11.11.9 Nitrous Oxide/Analgesia

Dental Code Range: D9230

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

11.11.10 Behavior Management

Dental Code Range: D9920

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

11.11.11 Hospital Calls – Ambulatory Surgical Centers (ASC) or Hospital Outpatient

- Medicaid covers only those services that are medically necessary and cost-efficient. It is the provider's responsibility to be knowledgeable regarding covered services, limitations and exclusions of the Medicaid Program. Therefore, if providers, without getting mutual agreement of the client, deliver services and are subsequently denied Medicaid payment because services were not covered or the services were covered but not medically necessary and/or cost-efficient, providers may not obtain payment from the client.
- If the provider and the client mutually agree in writing to services, which are not covered (or are covered but not medically necessary and/or cost-efficient), and the provider informs the client of their financial responsibility prior to rendering service, then, the provider may bill the client for the services rendered.
- Medicaid will cover dental services in an outpatient or hospital setting if it has been determined that it is medically necessary and the client cannot tolerate dental services in-office for one (1) of the following reasons:
 - The provider has attempted the procedure and the client was uncooperative and the client and/or staff were put at risk for injury.
 - For clients under the age of five (5) who have demonstrated uncooperative behavior during routine visits and performing restorative dentistry in-office would be dangerous for the client and/or staff.
 - Clients who have documented developmental delays and have demonstrated uncooperative behavior in an office setting. A diagnosis of a developmental and/or physical delay is not an automatic reason to schedule a client for a hospital dental call.
 - Clients who have been unresponsive to treatment in the office (i.e. local anesthesia not effective, IV sedation not achieved).
 - The client is considered medically compromised and an in-office attempt may be dangerous for the client. Documentation from the client's physician stating the condition(s) that compromise the client must be a part of the client's records and available to Medicaid if requested.

NOTE: Each of the above situations **MUST** be documented clearly in the client's clinical records to adequately demonstrate medical necessity.

- Additionally, the service must be:
 - Consistent with the diagnosis and treatment of the patient's condition.
 - In accordance with standards of good medical/dental practice.
 - Required to meet the dental needs of the patient and undertaken for reasons other than the convenience of the patient or his/her dentist.
 - Performed in the least costly setting required by the patient's condition.

- **D9420** – Hospital or Ambulatory Surgical call may be billed out by the dentist along with dental procedures that are performed in the facility on the ADA Claim Form.

11.11.12 Other Drugs and Medications

Dental Code Range: D9630

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

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

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

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

11.11.13 Space Maintenance

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

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

11.11.14 Tobacco Counseling

Dental Code Range: D1320

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

11.11.15 Orthodontics

Dental Code Range: D8000-D8999

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

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

11.11.15.1 Referral to the Severe Malocclusion Program

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

- If the client does not appear to meet the Severe Malocclusion Program, there is a parent handout available on the website to assist in explaining why the client does not meet the criteria. ([2.1, Quick Reference](#))
- No referral form is needed for ages 12-18 for D8660.
- Orthodontists may also provide consultations to walk in clients ages 12-18 with no referral.
- If a provider finds it medically necessary for a child under the age of 12 to be part of the Severe Malocclusion Program, a Referral to Severe Malocclusion Program – Under 12 Form ([11.11.15.1.1, Referral to Severe Malocclusion Program – Under 12 Form](#)) should be sent to the Medicaid Program Manager. A PA will be required for these clients for the consultation (D8660).
 - The form must be filled out completely and the child should not be provided services by the orthodontist until a PA is issued.

11.11.15.2 Submitting Records for Approval/Denial

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

- Verify client eligibility prior to rendering services to the client.
- Verify age appropriateness.
- Verify the code/service has not been billed previously. (One (1) lifetime benefit)

The orthodontist may collect records on a new client. The records should include the Severe Malocclusion Request Form ([11.11.15.2.1, Severe Malocclusion Request Form](#)), color photos, and x-rays of the client. These, along with the Medicaid Prior Authorization Request Form ([6.8.1.1, Medicaid Prior Authorization Form](#)), should be submitted to Wyoming Medicaid at:

Wyoming Medicaid
Attn: Medical Policy
PO Box 667
Cheyenne, WY 82003-0067
WYMedPol@conduent.com

- Each case will be reviewed, and based on qualifying criteria, will be forwarded to the State Orthodontic Consultant for review; OR
- The case will be administratively denied and a letter will be mailed to the client and the orthodontist with the reason why it was denied.

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

- Cleft palate deformities with a recommendation from the Cleft Palate Team.
- Impacted anterior teeth – Considered when it is demonstrated that the tooth or teeth is or are impacted (soft or hard); not indicated for extraction and treatment planned to be brought into occlusion. Arch space must be available for correction.
- Deep Impinging Overbite – Considered when the lower incisors are destroying the soft tissue of the palate and there is tissue laceration and/or clinical attachment loss.
 - Color Photographic documentation will be required.
- Anterior Crossbite – Considered when clinical attachment loss and recession of the gingival margin are present.
 - Color Photographic documentation will be required.
- Severe Traumatic Deviation.
 - Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology.

- Congenitally missing teeth are not considered a Severe Traumatic Deviation. Missing teeth should be indicated on Part 2 (Diagnostic Information) of the Severe Malocclusion Request Form ([11.11.15.2.1, Severe Malocclusion Request Form](#)).
- A narrative should be written on Part 2 (Diagnostic Information) of the Severe Malocclusion Request Form ([11.11.15.2.1, Severe Malocclusion Request Form](#)) explaining what the deviation is.
- A minimum HLD index score of 30 is required to qualify for the program. All cases will be reviewed by the Orthodontic Consultant and the Medicaid Program Manager and if special circumstances apply, a lower score may be approved.

Cases that are forwarded on to the Orthodontic Consultant will be sent with all attached x-rays, color photos, and the completed Severe Malocclusion Request Form ([11.11.15.2.1, Severe Malocclusion Request Form](#)) from the orthodontist.

- After the consultant reviews the case, he/she will document his/her recommendation and return the entire case back to the Medicaid Program.
- If the case is approved, Medicaid will issue a Prior Authorization (PA) to the provider, for treatment to be started.
- If denied, the orthodontist will be sent a denial letter with an explanation.

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

- An oral surgeon consultation form ([11.8.1.1, Consideration for Oral Surgery Form](#)) will be included with this letter to the orthodontist.
- The referring orthodontist should send this form along with any x-rays with the client to the oral surgeon.
- The oral surgeon will be responsible for completing this form and returning it to the Medicaid Medical Policy team.
- The Medicaid Medical Policy team will add this to the client's file and re-submit the case to the orthodontic consultant for consideration.
- If approved, the orthodontist and the oral surgeon will each be issued a PA for their portions of the treatment.
- If denied, the orthodontist, the oral surgeon, and the client will be sent a denial letter.

NOTE: A PA is only valid if the client is eligible for Medicaid on the date of service.

Cases that are submitted to the program as transfers from other states may be evaluated and approved with the intent of completing treatment that was already started. The requesting orthodontist should indicate on their request how much time is expected to complete the treatment. When approved, the State Orthodontic Consultant will also evaluate the length of time needed to complete the case. A PA will be issued for the

D8670 and the number of units determined to complete the case will be approved. If the client does not have orthodontic bands/brackets on one of the arches, D8080/D8090 may be authorized for a partial payment, if the requesting orthodontist anticipates banding this arch.

An orthodontist may request reconsideration of a denied application.


- The orthodontist must write a request letter stating the reason for the request. Any additional supporting documentation should be sent to Medical Policy for re-consideration.
- Medical Policy will forward this on to the orthodontic consultant for re-consideration. The request will only be sent back to the orthodontic consultant if the orthodontist has provided new evidence supporting the request. The orthodontic consultant will then provide a new review of the request.
- Requests for reconsideration that do not have any new information to support the request will be denied by Medical Policy and a letter will be sent to the orthodontist with an explanation.
- If reconsideration is approved, a [Prior Authorization Approval](#) letter will be sent to the provider informing them that the client has been approved for treatment.
- The provider must also indicate on their claim form in box 30, that the client has entered the retention phase.

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

- **D8660** – Pre-Orthodontic Consultation, once per lifetime per client
 - A PA is only required for this code for children under the age of 12 if the provider finds it medically necessary for a child to be part of the Severe Malocclusion Program early for Interceptive treatment.
- **D8080** – Comprehensive Orthodontic Treatment (ages 12-14), once per lifetime per client.
- **D8090** – Comprehensive Orthodontic Treatment (ages 15-18), once per lifetime per client.
- **D8670** – Periodic Orthodontic Treatment, maximum of eight (8) payments; Maximum of one (1) payment per three (3) month period.
- **D8680** – Orthodontic Retention and Removal
 - This may be authorized for clients who have moved here from another state and are unable to or do not plan to continue treatment.
- **D8703** – Maxillary replacement of Lost/Broken Retainer, once per lifetime per client.
- **D8704** – Mandibular replacement of Lost/Broken Retainer, once per lifetime per client.
- **D8060** – Interceptive Orthodontic Treatment

- This will only be authorized for clients who are ages 6-11 and meet the interceptive treatment criteria ([11.11.15.1.1, Referral to Severe Malocclusion Program – Under 12 Form](#)).
- **D8690** – Final Balance Payment
 - This code to be billed for client's who lose eligibility during treatment. A Prior Authorization is required.

11.11.15.2.1 Severe Malocclusion Request Form

 WYOMING MEDICAID SEVERE MALOCCLUSION TREATMENT REQUEST FORM				
CLIENT NAME	CLIENT ID	CLIENT DATE OF BIRTH	EXAM DATE	LOCATION
PROVIDER GROUP NAME	GROUP NPI	TREATING PROVIDER NAME	TREATING NPI	FEE
PART 1. TREATMENT REQUESTED				
FULL TREATMENT <input type="checkbox"/>		INTERCEPTIVE TREATMENT <input type="checkbox"/>		TRANSFER CASE <input type="checkbox"/>
REQUIRES MAXILLO-FACIAL SURGERY?		# OF MONTHS:		
YES <input type="checkbox"/>		NO <input type="checkbox"/>		
EXPLAIN:				
PART 2. DIAGNOSTIC INFORMATION				
STAGE OF DENTITION:		PRIMARY <input type="checkbox"/> PERMANENT <input type="checkbox"/> MIXED <input type="checkbox"/>		
SKELETAL CLASSIFICATION		TMJ YES <input type="checkbox"/> NO <input type="checkbox"/>		
Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 <input type="checkbox"/>				
POSTERIOR CROSSBITE		TEETH INVOLVED:		
YES <input type="checkbox"/> NO <input type="checkbox"/>				
MISSING TEETH (indicate related teeth)				
ECTOPIC ERUPTION (EXCLUDING 3RDs):		LOCATION		
YES <input type="checkbox"/> NO <input type="checkbox"/>				
MISSING				
IMPACTED				
ANKYLOSED				
SUPERNUMERARY				
SEVERE TRAUMATIC DEVIATION (explain):				
YES <input type="checkbox"/> NO <input type="checkbox"/>				
PART 3. BRIEF INITIAL OPINIONS				
ORAL HYGIENE:		GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/>		
RESTORATIONS COMPLETE:		YES <input type="checkbox"/> NO <input type="checkbox"/>		
(if no- please explain plan)				
PART 4. HLD INDEX (see instructions for scoring guidelines)				
				HLD SCORE
CLEFT PALATE DEFORMITIES: indicate with an X				
IMPACTED ANTERIOR TEETH: indicate with an X				
DEEP IMPINGING OVERBITE: indicate with an X only if tissue destruction				
ANTERIOR CROSSBITE: indicate with an X only if tissue destruction				
SEVERE TRAUMATIC DEVIATION: must document in Part 2- score 15 pts				
OVERJET IN mm				x1+
OVERBITE IN mm				x1+
MANDIBULAR PROTRUSION IN mm				x5+
OPENBITE IN mm				x4+
ECTOPIC ERUPTION: count each tooth				x3+
ANTERIOR CROWDING (score 1 pt for max and 1 pt for mand -- the max # of pts for this is 10)				x5+
POSTERIOR UNILATERAL CROSSBITE: 4 points				
TOTAL POINTS				
Treatment Narrative (provide any additional information that will substantiate your request for treatment):				
PLEASE NOTE: the HLD scoring is a guideline for your use and reference for the program consultant. You will still be required to send in photographs and supporting radiographs. The program will make the final decision regarding medical necessity and scoring criteria.				
MAIL COMPLETE REQUEST ALONG WITH PA FORM TO: WYOMING MEDICAID, ATTN: MEDICAL POLICY, PO BOX 667, CHEYENNE, WY 82003-0067 WYMEDPOL@conduent.com				
I certify that I am the Performing Provider and that the medical necessity information is true, accurate, and complete, to the best of my knowledge.				
I certify that I performed the above noted examination on this client.				
PERFORMING PROVIDER SIGNATURE		PRINT NAME		DATE

NOTE: Click the images above to be taken to a printable version of this form.

11.11.15.3 Billing Instructions for Severe Malocclusion Program (SMP)

The Severe Malocclusion Program will issue a Prior Authorization (PA) to each provider for each client. The PA will authorize the specific treatment for the client. The provider is only permitted to bill for services authorized within the PA. It is the responsibility of the provider to check client eligibility for each date of service. To check eligibility, call the IVR at (800)251-1270 or Dental Services at (888)863-5806.

- **D8660** – Pre-orthodontic treatment visit. This code will be paid once per lifetime per client unless the client has been placed on a hold by the State to monitor growth or oral hygiene progress. The State can issue a PA for a 2nd

consultation at a time determined appropriate by the State Orthodontic Consultant and program manager.

- PA is only required for this code for children under the age of 12 if the provider finds it medically necessary for a child to be part of the Severe Malocclusion Program or if the client is having a 2nd consultation.
 - The provider may not bill any other services with this visit. The fee indicated includes exam, records, all photos, diagnostic casts, and x-rays.
 - Providers who offer this service as part of a free consultation to all of their patients should not bill Medicaid for this service. If a client is screened with no records for application consideration and the client returns on a 2nd visit to have records taken, the provider can bill for this service at that visit.
- **D8080 (age 12-14) or D8090 (age 15-20)** – Comprehensive orthodontic treatment. The provider may not bill any other services with this visit. The fee indicated includes exam, banding, retention, and all photos during the treatment phase. This code will only be paid once per lifetime per client.
 - If the client has a primary insurance, the D8080 or D8090 must be billed to the primary insurance before billing Medicaid. A primary EOB must be attached when submitting the claim.
 - If the primary insurance does not cover orthodontic services, the EOB that states orthodontics are not covered must be attached to all claims submitted throughout treatment.
 - If the primary insurance covers orthodontic treatment, the primary insurance must be billed before each claim can be submitted (including D8670, quarterly payments) and the EOB must be attached to all claims submitted. When the maximum benefit from the primary insurance is met, attach a copy of the final EOB to each subsequent claim.
 - Providers must bill Medicaid for their full treatment amount for D8080 or D8090.
- **D8670** – Periodic orthodontic treatment visit (as part of the PA) reimburses per quarter (maximum of four (4) quarters per year for not more than 24 months).
 - When billing for periodic treatment visits, the claim should contain the actual date of service for each time the client was seen during the quarter. These dates of service should be on separate lines of the claim with the fee for each line showing \$0.00. The last line should have the last date of service for the quarter with the fee of \$300.00. The client must be seen within the quarter for the provider to bill this code. The provider will be paid the quarterly payment as long as the client is seen within the quarter and the provider has not exceeded eight (8) payments in the authorized treatment time period (typically 24 months).
 - Due to the federal government's match to this program, tracking of each time a client is seen in the office for orthodontic adjustments is required to be reported.

- Once orthodontic bands are removed and the retention phase has begun, the provider may continue to bill D8670 (quarterly payments) until the total amount of the PA has been paid. Once the total has been paid to the provider, the provider may no longer bill for any orthodontic services without a new PA.
 - When bands are removed and the retention phase begins, the client must be seen at least once per quarter in order for the provider to bill the D8670 (quarterly payments).
- When the client enters retention, the provider is responsible for sending in a final photo of the client to Medicaid to be included in the client's State records.
 - **Billing Example:**
Client comes to provider's office for periodic treatment visits on 1/2/15, 2/2/15, and 3/2/15. The provider should bill as follows:
Line 1: 1/2/2015 D8670 \$0.00
Line 2: 2/2/2015 D8670 \$0.00
Line 3: 3/2/2015 D8670 \$300.00
- **D8690** - If the client becomes ineligible for Medicaid at any time during treatment, the provider will be paid the balance of the original Prior Authorization (PA). Providers must request this payment by submitting a final claim. The final claim must contain the following:
 - Date of service must be the last day the client was seen during the last month of eligibility.
 - **Example:** Client was seen 1/2/19, 2/2/19, 2/19/19 and 3/2/19. Client's eligibility ended 2/28/19. The final date of service should be 2/19/19.
 - Procedure code must be D8690, Orthodontic Treatment. Indicate in box 30 (Description), "PA balance for Orthodontic Treatment".
 - A separate PA number for this code will be required to bill.
 - Fee must be the total balance due from the original Prior Authorization (PA).
- **D8680** – Orthodontic Retention and Removal (removal of appliances and/or bands and construction and placement of retainers) reimburses \$600.00. **This code is to be billed by providers who are accepting orthodontic clients from other states who will not be continuing treatment.** This code will only be paid once per lifetime per client.
- **D8703** – Maxillary replacement of lost or broken retainer reimburses \$150.00.
- **D8704** – Mandibular replacement of lost or broken retainer reimburses \$150.00.

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

- **D8060** – Interceptive orthodontic treatment for transitional dentition (6-11 years). The provider may not bill any other services with this visit and the fee

indicated includes exam, banding, retention, all photos, and follow-up visits. This code will be paid once per lifetime.

11.11.15.4 Wyoming Medicaid Interceptive Criteria

- Interceptive orthodontic treatment may be approved for ages 6-11 and will only be billable by enrolled orthodontists.
- Interceptive orthodontic treatment may be authorized for mixed dentitions where early intervention could result in avoiding a future crippling malocclusion, or reducing the need for complex comprehensive appliance therapy.
- The goal of the interceptive treatment is to reduce the severity of the malformation/malocclusion, mitigate its cause, and to prevent subsequent occlusal conditions that could cause a worsening malocclusion.
- Interceptive treatment will be evaluated on a case-by-case basis and may be authorized by the program only if there is clear evidence of immediate need for treatment based on the established criteria.
- A client with a pre-qualifying condition may not display sufficient need to have the orthodontic service approved immediately. The State Orthodontic Consultant will review each case for timing and will discuss the plan with the requesting orthodontist if there is need. It is imperative that the treatment request form provide adequate documentation of immediate need and treatment planning.
- It will be the provider's responsibility to inform the parent/guardian that if interceptive treatment is approved their child may not be eligible for full comprehensive treatment later, depending on the severity of their condition.
- The provider has full responsibility for maintaining documentation to justify the services provided and billed to Medicaid.
- Cases that are denied can be resubmitted at appropriate intervals as determined by the client's orthodontist and the State Orthodontic Consultant.
- Space maintenance appliances (D1510, D1515) are billable separately from D8060 Interceptive Orthodontic Treatment if necessary prior to Interceptive Treatment.
- Diagnostic Criteria for Interceptive Orthodontic Treatment (D8060) is as follows:
 - Cleft and other craniofacial anomalies.
 - Overjet of more than 10mm.
 - Anterior crossbite-class III mandibular prognathism or reverse overjet.
 - Anterior openbite greater than 3mm.
 - Impeded eruption of teeth due to crowding, displacement, presence of supernumerary teeth, retained primary teeth, (and) any pathologic cause, or impacted anterior teeth.
- HLD (Handicapping Labio-Lingual Deviation) index scoring will be collected for documentation purposes, but will not be part of the qualifying criteria for this program.

11.11.16 Dental Services Performed in an FQHC/RHC

Dental services that are performed in an FQHC/RHC must be billed on the most current ADA claim form/837D. Dental services will receive an encounter rate that is established by Wyoming Medicaid and includes ALL services provided during the encounter and is considered to be an all-inclusive rate.

11.11.16.1 Dental Orthodontic Services

Dental Code Range: D8000-D8999

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

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

- D8999 – Must be billed on line one with the encounter rate
- Additional detail lines must be billed with appropriate covered CDT codes showing each service provided and billed with a zero (0) dollar amount.
- All charges for the same visit must be submitted on one (1) claim.
- Prior authorization (PA) numbers must be on all claims for the client's orthodontic visits.
- Provider may bill Medicaid for the initial banding and then quarterly (including all of the dates the child was seen for orthodontic adjustments during the quarter). The facility will not bill each time the child is in the facility for orthodontic treatment, only once per quarter.
- Actual dates of service must be included on the quarterly claim.
- No other dental codes may be billed on an orthodontic claim. Only codes in the D8000-D8999 range can be on the claim.

Example:

Child is banded on 1/5/2019 and returns on 2/12/2019, 3/20/2019 and 4/30/2019 for adjustments. Bill as follows

Claim number 1:

Line	Procedure Code	Date	Amount	NPI
1	D8999	1/5/2019	Fee encounter rate	Treating Provider NPI
2	D8080	1/5/2019	\$0.00	Treating Provider NPI

Claim number 2:

Line	Procedure Code	Date	Amount	NPI
1	D8999	1/5/2019	Fee encounter rate	Treating Provider NPI
2	D8080	1/5/2019	\$0.00	Treating Provider NPI

(This claim will not be submitted until the last date of service on the quarter, 4/30/2019)

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

11.11.16.2 End of Treatment

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

11.11.16.3 Discontinued Treatment

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

11.11.16.4 Resuming Treatment

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

11.11.17 Health Check – EPSDT

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program was enacted by Congress mandating states provide eligible children under the age of 21 with well-child screening, diagnostic and medically necessary treatment services through their Medicaid programs. Services provided under EPSDT include periodic screening to include dental, vision and hearing, as well as any medically necessary treatment. As part of the requirements for providing EPSDT services under the federal Medicaid program the state is required to publish a periodicity schedule which meets reasonable standards of dental care. The periodicity instructions and table that the state has chosen are listed below. The EPSDT program in Wyoming is referred to as Health Check.

11.11.17.1 Suggested Procedures for Health Check Dental Services

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

Covered Services

- 12 years and older
 - Repeat six (6) –12 year procedures every six (6) months.
 - **Assessment and/or Removal of Third Molars** – as needed.
 - Transition to adult dental care

Appendix

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APPENDIX A – DENTAL MANUAL VERSION CONTROL TABLE

Revision Date	Change(s)
01/01/2021	Chapter 2 – Getting Help When Needed
	2.1 Quick Reference Guide – updated CSC address and URL and DOS indicators on threshold information
	Chapter 10 – Important Information
	10.5 By Report or Manually Priced Codes – Added rate reduction for 2021
	Chapter 11 – Covered Services
	11.6.1 Prosthetics Removable for Children – Added 2021 denture reline/adjustment frequency policy change
	11.6.2 Prosthetics Removable for Adults – Added 2021 denture reline/adjustment frequency policy change

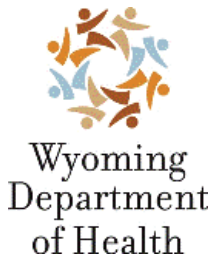
APPENDIX B – Provider Notifications Log

Active Date(s)	Notification Type	Title	Audience
11/2/20	Bulletin	Medicaid Budget Reduction Changes	341600000X, 231H00000X, 332S00000X, 111N00000X, 1223G0001X, 122300000X, 1223X0400X, 1223P0221X, 1223P0300X, 1223S0112X, 1223E0200X, 251K00000X, 251S00000X, 261Q00000X, 261QA0005X, 322D00000X, 133V00000X, 332B00000X, 335E00000X, 251E00000X, 282N00000X, 282NR1301X, 275N00000X, 283Q00000X, 283X00000X, 171R00000X, 291U00000X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 314000000X, 367A00000X, 367500000X, 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X, 364SP0808X, 207KA0200X, 207L00000X, 207SG0201X, 207N00000X, 2085R0202X, 207P00000X, 207Q00000X, 207R00000X, 207RC0000X, 207RE0101X, 207RG0100X, 207RG0300X, 207RX0202X, 207RN0300X, 207RP1001X, 207RR0500X, 207T00000X, 204D00000X, 207V00000X, 207VG0400X, 207VX0000X, 207W00000X, 207Y00000X, 207ZP0105X, 2080N0001X, 208100000X, 363A00000X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X, 2084P0800X, 208600000X, 207X00000X, 2086S0120X, 2082S0099X, 208G00000X, 2086S0129X, 208800000X, 213E00000X, 323P00000X, 261QA1903X, 261QE0700X, 261QR0208X, 261QR0401X, 225X00000X, 225100000X, 235Z00000X, 177F00000X, 344600000X, 347C00000X, 152W00000X, 156FX1800X
11/13/202	Bulletin	2020 1099 & W-9 Update Reminder	All Providers

Appendix

11/19/20	RA Banner	Wyoming Medicaid Enrollment Vendor Transition	All Providers
12/16/20	Bulletin	Kid Care CHIP Medical & Outpatient Claims Reprocessing	All Providers
12/21/20	State Letter	Vaccine Partner Update December 2020	All Providers
12/23/20	Bulletin	Update to Denture Adjustment and Relines Frequency Policy	Taxonomies beginning with 12

Bulletin – Medicaid Budget Reduction Changes



To view this email as a web page, go [here](#).

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



November 1, 2020

Attention WY Medicaid Providers

The Wyoming Department of Health is in the process of implementing a variety of budget reductions due to declining state revenues. On August 26, 2020, Director Ceballos provided general information on these budget reductions. As outlined in the Wyoming Department of Health's Biennium 2021-2022 Budget Reduction Proposal, Division of Healthcare Financing, Table 5, the 2021/22 State General Fund budget will be reduced by \$46,550,796 and its total budget by \$95,537,448. Specifically, there will be a 2.5% reduction to most provider rates for a total reduction of \$22,640,000 (State General Fund and Federal Funds combined).

Effective January 1, 2021, Wyoming Medicaid will implement the below reductions.

Hospitals	Outpatient Prospective Payment System (OPPS) conversion factors will be adjusted to result in a 2.5% reduction in payment in the April 2021 OPPS implementation for the effective date of January 1, 2021. Inpatient APR DRG hospital base rates will be adjusted to result in a 2.5% reduction in payment
RBRVS, Anesthesia, Radiology	-RBRVS conversion factor will be adjusted to \$35.94 & -Anesthesia conversion factor will be adjusted to \$25.84 -Radiology conversion factor will be adjusted to \$33.42
Fee Schedule	Individual rates for codes not paid through RBRVS will be reduced by 2.5%
Dental	All dental rates will be reduced by 2.5%
Nursing Facility/Swing Bed/NH Hospice	Nursing Facility, Swing Bed, and NH Hospice per diem rates will be reduced by 2.5%
PRTF	PRTF per diem rates will be reduced by 2.5%
Chiropractic	Chiropractic services will be eliminated effective January 1, 2021.
Title 25	Title 25 per diem rate will be reduced to \$610.00 per day.

CME/Children's Mental Health Waiver	All codes with the exception of T2025 will be reduced by 2.5%
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For detailed information on changes by procedure or billing code, the fee schedule on the Medicaid website will reflect the updated information on or after January 1, 2021:

https://wymedicaid.portal.conduent.com/fee_schedule.html

Please watch for additional budget information and impacts in the upcoming months.

Be sure to add wycustomersvc@conduent.com to your email contact list to ensure the proper delivery of your Wyoming Medicaid updates and weekly payment summary information.

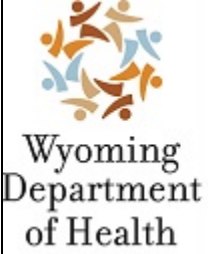
Please do not reply to this email with any customer service issues. Specific account inquiries will not be read.

Deployment Information:

- Deployment Date: 11/2/20
- Deployment Time: 3:30 PM
- Audience:
 - Taxonomies: 341600000X, 231H00000X, 332S00000X, 111N00000X, 1223G0001X, 122300000X, 1223X0400X, 1223P0221X, 1223P0300X, 1223S0112X, 1223E0200X, 251K00000X, 251S00000X, 261Q00000X, 261QA0005X, 322D00000X, 133V00000X, 332B00000X, 335E00000X, 251E00000X, 282N00000X, 282NR1301X, 275N00000X, 283Q00000X, 283X00000X, 171R00000X, 291U00000X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 314000000X, 367A00000X, 367500000X, 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X, 364SP0808X, 207KA0200X, 207L00000X, 207SG0201X, 207N00000X, 2085R0202X, 207P00000X, 207Q00000X, 207R00000X, 207RC0000X, 207RE0101X, 207RG0100X, 207RG0300X, 207RX0202X, 207RN0300X, 207RP1001X, 207RR0500X, 207T00000X, 204D00000X, 207V00000X, 207VG0400X, 207VX0000X, 207W00000X, 207Y00000X, 207ZP0105X, 2080N0001X, 208100000X, 363A00000X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X, 2084P0800X, 208600000X, 207X00000X, 2086S0120X, 2082S0099X, 208G00000X, 2086S0129X, 208800000X, 213E00000X, 323P00000X, 261QA1903X, 261QE0700X, 261QR0208X, 261QR0401X, 225X00000X, 225100000X, 235Z00000X, 177F00000X, 344600000X, 347C00000X, 152W00000X, 156FX1800X

Bulletin – 2020 1099 & W-9 Update Reminder

To view this email as a web page, go [here](#).



Wyoming Medicaid

IRS W-9

The State Auditor's policy is to accept only the most current published version of the [IRS W-9 \(Rev. 10-2018\)](#) Form. **Original documentation is currently required for the voided check and bank letters. If sending in a voided check or bank letter, a W-9 must accompany it. Faxed or emailed W-9s will be accepted.**

- [IRS W-9 \(Rev. 10-2018\)](#) Form is available on the [SAO website](#).
- All W-9's submitted on outdated forms will be returned unprocessed.
- Electronic or stamped signatures are NOT accepted

Voided Check Requirements:

- Original check, printed by your financial institution
- No temp checks are accepted
- Must include name and address
- Must have no alterations to the check beyond the written "VOID"

Bank Letter Requirements:

- On Bank Letterhead
- Dated within one (1) year
- Account name must match what is listed on the W9
- Account and Routing Numbers
- Account type – Checking or savings (not ACH or EFT)
- Original Signature of bank representative

When 1099's Are Returned, Medicaid Payments Are Held

ALL PAY-TO PROVIDERS

In preparation of the State Auditor's mailing of the 1099 Forms in January 2021, it is imperative for pay-to providers' addresses to be correct with the SAO and Medicaid.

1099 Forms will not be forwarded by the Post Office and when returned to the SAO as

undeliverable your Medicaid payments will be placed on hold until an [IRS W-9 \(rev. 10-2018\)](#) Form is completed and processed.

PAY-TO PROVIDERS

- Did you have a change of address in 2020?
 - No - No action required
 - **Yes - Action may be required**
- Did you complete the IRS W-9 Form at the time of the address change?
 - **No - Action is required**
 - Yes - No action required
- If action is required DO NOT DELAY!
 - Only the [IRS W-9 \(rev. 10-2018\) Form](#) will be accepted, all other versions will be returned unprocessed.
 - Complete and mail the form to:

Wyoming Medicaid
Attn: Enrollment
PO Box 667
Cheyenne, WY 82003-0667

NOTE: Behavioral Health/DD providers (taxonomy 251C00000X), to avoid delays mail your completed W-9 Form to the address above BUT also notify the Behavioral Health Division of your new address.

[Unsubscribe](#)

Be sure to add wycustomersvc@conduent.com to your address book to ensure the proper delivery of your Wyoming Medicaid updates and weekly payment summary information.

Wyoming Medicaid, Provider Relations, PO Box 667, Cheyenne, WY 82003

Please do not reply to this email with any customer service issues. Specific account inquiries will not be read. For assistance, contact Provider Relations at 1-800-251-1268

<https://wymedicaid.portal.conduent.com/>

Deployment Information:

- Deployment Date: 11/13/20
- Deployment Time: 10:30 AM
- Audience: All Providers

RA Banner – Wyoming Medicaid Enrollment Vendor Transition

COMING SOON!

WYOMING MEDICAID WOULD LIKE TO ANNOUNCE THE TRANSITIONING OF THE MEDICAID PROVIDER ENROLLMENT AND PROVIDER UPDATES TO OUR NEW VENDOR, HHS TECH GROUP.

WITH THIS TRANSITION THERE WILL BE A NEW PROVIDER PORTAL SPECIFICALLY FOR PROVIDERS TO COMPLETE ENROLLMENTS, RE-ENROLLMENTS, MAKE UPDATES, AND UPLOAD DOCUMENTS TO THEIR MEDICAID PROVIDER FILE.

IN ADDITION TO THE ENROLLMENT/UPDATE PORTAL HHS WILL HAVE A PROVIDER ENROLLMENT CALL CENTER TO ASSIST WITH QUESTIONS.

MORE INFORMATION TO COME!


TO STAY UP-TO-DATE ON THIS TRANSITION PROVIDERS ARE ENCOURAGED TO VISIT THE "ENROLLMENT TRANSITION" SECTION THAT WILL BE ADDED TO THE WHAT'S NEW PAGE ON THE WEBSITE,
[HTTPS://WYMEDICAID.PORTAL.CONDUENT.COM/NEW.HTML](https://wymedicaid.portal.conduent.com/new.html)

Deployment Information:

- Deployment Start Date: 11/19/20
- Deployment End Date: **TBD**
- Audience: All Providers

Bulletin – URGENT! DECEMBER PAYMENT DATE CHANGES – MEDICAID

To view this email as a web page, go [here](#).



Wyoming Medicaid

Attention Providers and Billers!

Important Medicaid Payment Date Changes for December

2020 DECEMBER CHANGES IN MEDICAID'S PAYMENT SCHEDULE					
***** <i>READ NOTES BELOW</i> *****					
WEEK OF	WYOMING MEDICAID PAYMENT DATES	STATE AUDITOR'S PAYMENT DATES	EFT TRANSMIT DATES <i>(Banks have up to 3 business days to post to accounts)</i>	CHECK MAIL DATES	SUGGESTED BILL DATES **
MONDAY 12/21/2020	TUESDAY 12/22/2020	WEDNESDAY 12/23/2020	MONDAY 12/28/2020	MONDAY 12/28/2020	DECEMBER 16, 17, 18, 19 & 20
MONDAY 12/28/2020	TUESDAY 12/29/2020	WEDNESDAY 12/30/2020	THURSDAY 12/31/2020	THURSDAY 12/31/2020	DECEMBER 23, 24, 25, 26 & 27

NOTE: Medicaid's Normal Weekly Payment Schedule: Medicaid payment runs on Wednesdays, the State Auditor's Office runs payment on Thursdays and EFT (electronic fund transfers) & check mail dates occur on Fridays. The above schedule documents changes to this schedule. Keep in mind, the EFT date is the date the SAO transmits the payment to banks (financial institutions) and they have up to three (3) business days to post to accounts.

**** NOTE :** Submitting claims on suggested bill dates DOES NOT guarantee payment.

The [2020 Payment Exceptions](#) schedule on the Medicaid website has been updated to reflect these changes.

[Unsubscribe](#)

Be sure to add wycustomersvc@conduent.com to your address book to ensure the proper delivery of your Wyoming Medicaid updates and weekly payment summary information.

Wyoming Medicaid, Provider Relations, PO Box 667, Cheyenne, WY 82003

Please do not reply to this email with any customer service issues. Specific account inquiries will not be read. For assistance, contact Provider Relations at 1-800-251-1268

<https://wymedicaid.portal.conduent.com/>

Deployment Information:

- Deployment Date: 12/7/20
- Deployment Time: 10:40 AM
- Audience: All Providers

State Letter – Vaccine Partner Update December 2020

To view this email as a web page, go [here](#).



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



December 18, 2020

Ref: SP-2020-088

Dear WDH Partner:

The COVID-19 vaccine is arriving in states and is currently in limited supply. States will continue to receive limited allocations in the coming weeks. At this time, the vaccine is being administered to specific populations. Those who will be eligible to receive the vaccination in the next several weeks include:

- ▶ Persons working in healthcare who have regular potential for exposure to COVID-19 patients;
- ▶ Persons who have regular exposure to those who are potentially positive for COVID-19, or those who are exposed to infectious materials.
- ▶ Persons who reside in a long-term care facility or setting.

A more detailed list of the groups included in this first phase, Phase 1a, can be found [here](#). COVID-19 vaccine is being allocated to counties and then further allocated to hospitals and local public health agencies. Five counties received vaccine during the week of December 14. Going forward, all counties will receive allocations of vaccine. As vaccine becomes available, local public health or hospitals will reach out to agencies and entities that employ individuals who fit within the Phase 1a group to make plans for administering vaccine to those individuals. This

communication may not be immediate, but will occur as soon as vaccine becomes available to specific groups. Scheduling will take place once the vaccine is available

locally through hospitals or local public health agencies. As additional vaccine becomes available, local public health agencies will continue to reach out to specific groups as they become eligible to receive the vaccine.

Vaccination of long-term care and assisted living facility residents is being coordinated through a federal partnership with two national pharmacy chains, as well as with local public health offices. This effort will tentatively begin in early January.

Due to limited vaccine availability and the need to vaccinate groups in Phase 1a, vaccine is not yet available for other groups or the general public. We do not have an exact timeframe for when the vaccine will be more readily available, but expect it will be months before the general public will be able to receive the vaccine. As such, it is important to continue following our primary recommendations of wearing masks, social distancing, frequent handwashing, and staying home when ill.

Please visit the [Wyoming Department of Health website](#) for more COVID-19 vaccine resources. Information on the remainder of the phases will be forthcoming as we move forward in vaccinating Wyoming. If you have any additional questions, please contact Angie Van Houten, Community Health Section Chief, at angie.vanhouten@wyo.gov or 307-777-2067.

Sincerely,

A handwritten signature in blue ink that reads "Stephanie Pyle".

Stephanie Pyle, MBA, Senior Administrator
Public Health Division
Wyoming Department of Health

SP/ts

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Deployment Information:

- Deployment Date: 12/21/2020
- Deployment Time: Approx. 3:15 PM
- Audience: All Providers

State Letter – Vaccine Partner Update December 2020

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Sincerely,

A handwritten signature in blue ink that reads "Stephanie Pyle". The signature is written in a cursive, flowing style.

Stephanie Pyle, MBA, Senior Administrator
Public Health Division
Wyoming Department of Health

SP/ts

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Deployment Information:

- Deployment Date: 12/21/2020
- Deployment Time: Approx. 3:15 PM
- Audience: All Providers

Bulletin – Update to Denture Adjustment and Reline Frequency Policy



Wyoming Medicaid

To view this email as a web page, go [here](#).

-  [Medicaid Website](#)
-  [Manuals & Bulletins](#)
-  [Fee Schedules](#)
-  [What's New](#)

NEW



[Links](#)



[Web Portal Tutorials](#)

Attention Providers

Upcoming Policy Change for Removable Prosthetics for Children

Effective starting January 1, 2021, the policy on Denture Alignment and Reline Frequency is changing. Under the new policy:

- Codes D5730-D5761 for relines will only be allowed **once every three (3) years**.
- Codes D5410-D5422 will be limited to two (2) adjustments **per arch** per 12 month period

These codes will no longer conflict with each other.

This policy change will be reflected in the upcoming Quarterly Manual Updates for January 1, 2021. For questions please call Dental Services at 888-863-5806.



Help identify and combat Medicaid Fraud by visiting the website or contacting the Fraud Hotline:

• <https://health.wyo.gov/healthcarefin/program-integrity/>

• 1-855-846-2563

WYhealth is a Medicaid health management and utilization management program offered by the Wyoming Department of Health through Optum. Medicaid clients and providers will benefit from a wide array of programs and services offered and coordinated by Optum. Visit <https://www.wyhealth.net/tpa-ap-web/> for more information



[Unsubscribe](#)

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<https://wymedicaid.portal.conduent.com/>

Deployment Information:

- Deployment Date: 12/23/2020

- Deployment Time: 10:00 AM
- Audience: Dental Providers
 - Taxonomies: Beginning with 12