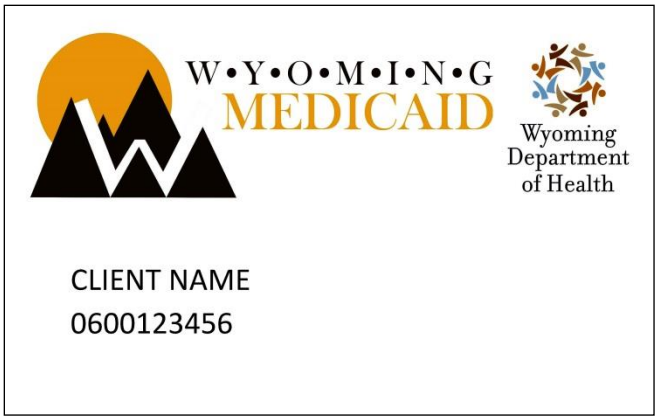
DIVISION OF HEALTHCARE FINANCING

Institutional ICD-10 Manual

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 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service. Providers may elect to utilize CPT or CDT codes as applicable. However, all codes pertaining to dental treatment must adhere to all state guidance and federal regulation. Providers utilizing a CPT code for Dental services will be bound to the requirements of both manuals.

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

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific department such as Provider Relations 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.

Contents

Chapter One – General Information

1.1 How the Institutional Manual is Organized

The table below provides a quick reference describing how the CMS 1500 Manual is organized.

Chapter	Description
Two	**Getting Help When Needed** – Telephone numbers, addresses, and web sites for help and training
Three	**Provider Responsibilities** – Obligations and rights as a Medicaid provider. The topics covered include enrollment changes, civil rights, group practices, provider-patient relationship, and record keeping requirements.
Four	**Utilization Review** – Fraud and abuse definitions, the review process, and rights and responsibilities.
Five	**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 and detailed the 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 contains important information such as claims review, coding, and fee schedule information.
Eleven through Twenty One	**Institutional UB-04 Covered Services –** These chapters contain information regarding covered services: definitions, procedure code ranges, documentation requirements, and billing requirements and examples
Appendices	**Appendices** – Provide key information in an at-a-glance format. This includes the 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:

****
ICD-10 IMPLEMENTATION OCTOBER 1, 2015

EXPECT:
1) LONGER WAIT TIMES WHEN CALLING PROVIDER RELATIONS OR EDI SERVICES
2) INCREASED POSSIBILITY OF RECEIVING A BUSY DISCONNECT WHEN EXITING THE IVR
3) DO NOT EXPECT THE AGENTS TO PROVIDE ICD-10 CODES

TROUBLESHOOTING TIPS PRIOR TO CALLING THE CALL CENTERS:

1) IF YOUR SOFTWARE OR VENDOR/CLEARINGHOUSE IS NOT ICD-10 READY--FREE SOFTWARE AVAILABLE ON THE WY MEDICAID WEBSITE (CANNOT DROP TO PAPER)
2) ICD-10 DX/SURGICAL DENIALS, VERIFY FIRST: CODES ARE BOTH ALPHA & NUMERIC, DX QUALIFIER, O VS 0, 1 VS I
3) VERIFY DOS, PRIOR TO 10/1/15 BILL WITH ICD-9 AND ON OR AFTER 10/1/15 BILL WITH ICD-10 CODES
4) INPATIENT SERVICES THAT SPAN 9/2015-10/2015 BILL WITH ICD-10

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

****

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

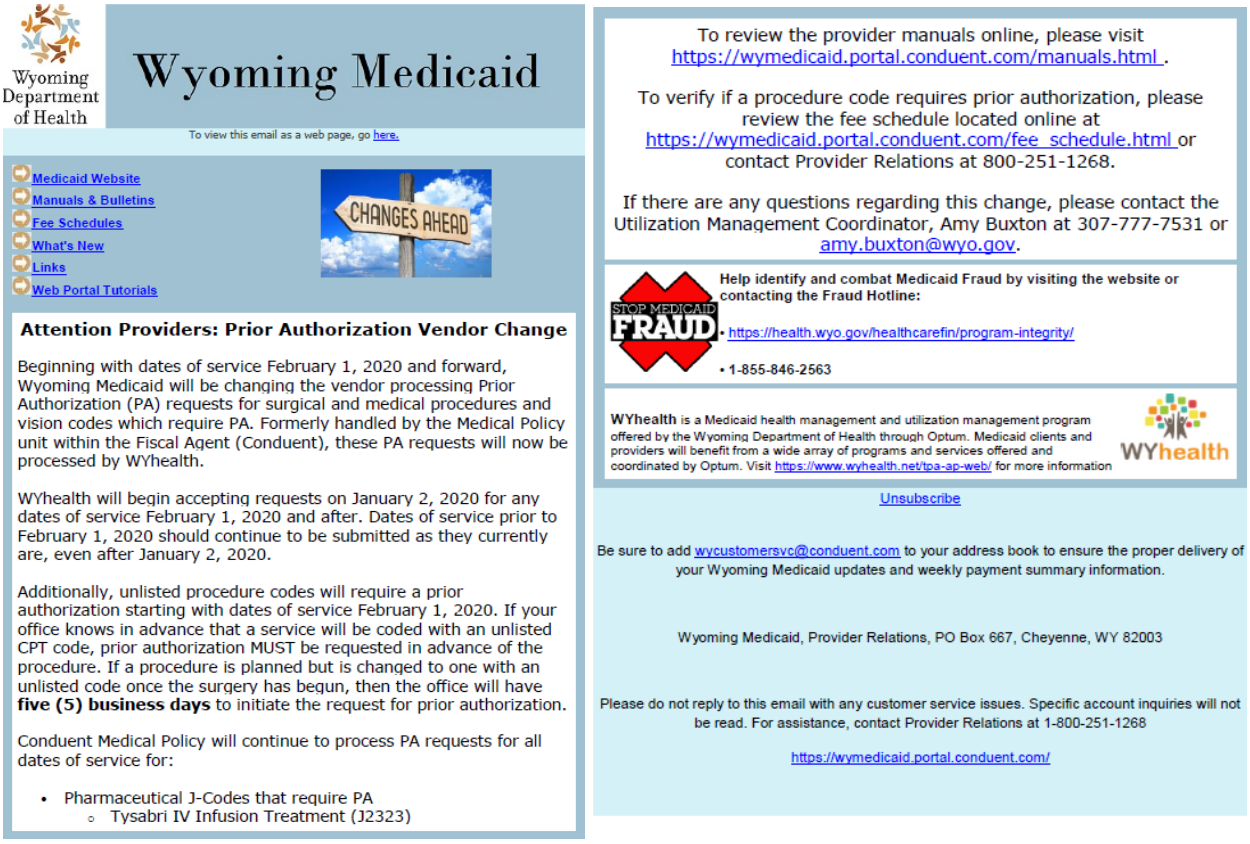
Remittance Advice Number: 123456
Amount of Check: 16,070.85
The RA banner notification will appear here when activated for the provider's taxonomy (provider type)

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 Department of Health

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

WYhealth

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

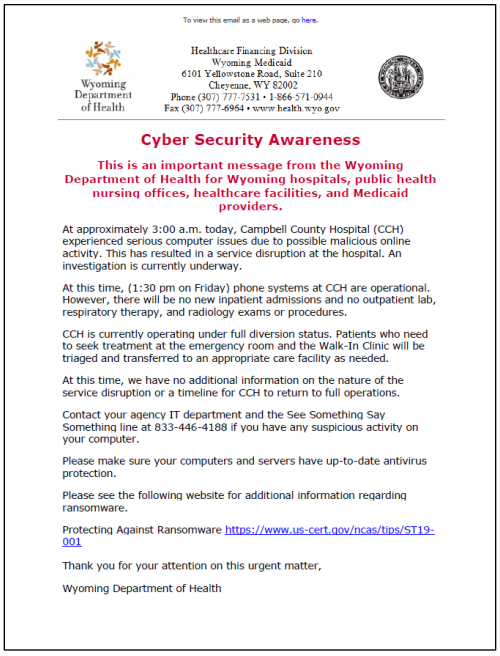
Please do not reply to this email with any customer service issues. Specific account inquiries will not be read. For assistance, contact Provider Relations at 1-800-251-1268

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)



To view this email as a web page, go here.

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

Cyber Security Awareness

This is an important message from the Wyoming Department of Health for Wyoming hospitals, public health nursing offices, healthcare facilities, and Medicaid providers.

At approximately 3:00 a.m. today, Campbell County Hospital (CCH) experienced serious computer issues due to possible malicious online activity. This has resulted in a service disruption at the hospital. An investigation is currently underway.

At this time, (1:30 pm on Friday) phone systems at CCH are operational. However, there will be no new inpatient admissions and no outpatient lab, respiratory therapy, and radiology exams or procedures.

CCH is currently operating under full diversion status. Patients who need to seek treatment at the emergency room and the Walk-In Clinic will be triaged and transferred to an appropriate care facility as needed.

At this time, we have no additional information on the nature of the service disruption or a timeline for CCH to return to full operations.

Contact your agency IT department and the See Something Say Something line at 833-446-4188 if you have any suspicious activity on your computer.

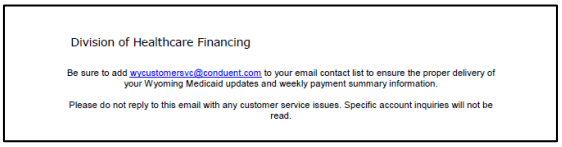
Please make sure your computers and servers have up-to-date antivirus protection.

Please see the following website for additional information regarding ransomware.

Protecting Against Ransomware https://www.us-cert.gov/ncas/tips/ST19-001

Thank you for your attention on this urgent matter,

Wyoming Department of Health



Division of Healthcare Financing

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.

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.

Chapter Two – Getting Help When Needed

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	• 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 **NOTE:** The client's Medicaid ID number or social security number is required to verify client eligibility.
Claims PO Box 547 Cheyenne, WY 82003-0547	N/A	N/A	• 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	• 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	• 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/	• 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	Authorization for Medical Necessity **for dates of service prior to 01/01/2021** • Dietitian • Chiropractic Prior Authorization requests for: • 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:
Provider Relations PO Box 667 Cheyenne, WY 82003-0667 (IVR Navigation Tips available on the website) wycustomersvc@conduent.com	Tel (800)251-1268 9-5pm MST M-F (call center hours) Fax (307)772-8405 24 / 7 (IVR availability)	https://wymedicaid.portal.conduent.com https://wymedicaid.portal.conduent.com/contact.html	• 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
Third Party Liability (TPL) PO Box 667 Cheyenne, WY 82003-0667	Tel (800)251-1268 OPTION 2 9-5pm MST M-F Fax (307)772-8405 Select Option 2 for Medicare or estate and trust recovery assistance THEN Select Option 2 for callers who are with an insurance company, attorney's office, or child support enforcement OR Select Option 3 for Medicare and Medicare Premium payments OR Select Option 4 for estate and trust recovery inquires	N/A	• 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
Transportation Services PO Box 667 Cheyenne, WY 82003-0667	Tel (800)595-0011 9-5pm MST M-F (24/7 Voicemail Available) Fax (307)772-8405	https://wymedicaid.portal.conduent.com/client/	Client inquiries: • Prior authorize transportation arrangements • Request travel assistance • Verify transportation is reimbursable

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
WYhealth (Utilization and Care Management) PO Box 49 Cheyenne, WY 82003-0049	Tel (888)545-1710 Nurse Line: (OPTION 2) **Fax PASRRs Only** (888)245-1928 (Attn: PASRR Processing Specialist)	http://www.WYhealth.net/	• 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 **Prior Authorization for:** • 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)	Tel (307)777-5800 Fax (307)777-7382	N/A	1) Prescription medications 2) Program information
Maternal & Child Health (MCH) /Children Special Health (CSH) Public Health Division 122 West 25th Street 3rd Floor West Cheyenne, WY 82002	Tel (307)777-7941 Tel (800)438-5795 Fax (307)777-7215	N/A	• High Risk Maternal • Newborn intensive care • Program information
Social Security Administration (SSA)	Tel (800)772-1213	N/A	Social Security benefits
Medicare	Tel (800)633-4227	N/A	Medicare information
Division of Healthcare Financing (DHCF) 122 West 25th St, 4th Floor West Cheyenne, WY 82002	Tel (307)777-7531 Tel (866)571-0944 Fax (307)777-6964	https://health.wyo.gov/healthcarefin/	• Medicaid State Rules • State Policy and Procedures • Concerns/Issues with State Contractors/Vendors • Developmental Disability Services
DHCF Program Integrity 122 West 25th St, 4th Floor West Cheyenne, WY 82002	Tel (855)846-2563	N/A	Client or Provider Fraud, Waste and Abuse **NOTE:** Callers may remain anonymous when reporting

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/	• 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.wymedicaid.org/	• 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	• Client Medicaid applications
			• Eligibility questions regarding:
			  ○ 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	• Nursing home program eligibility questions • Patient Contribution • Waiver Programs • Inpatient Hospital • Hospice • Home Health
Wyoming Medicaid	N/A	https://wymedicaid.portal.conduent.com	• 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/	• 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

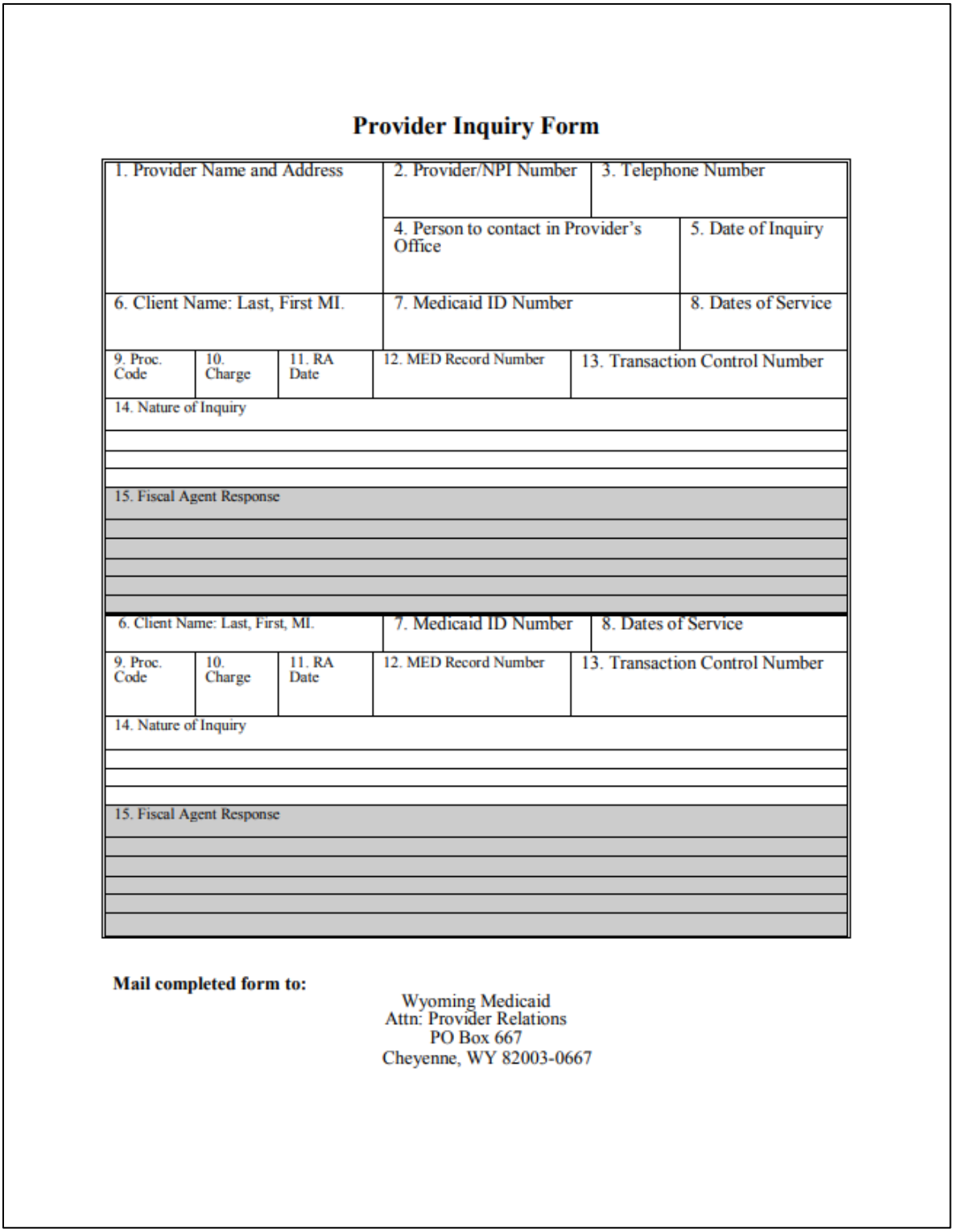
In many cases, writing for help provides the provider with more detailed information about the provider claims or clients. In addition, written responses may be kept as permanent records.

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). 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 the 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 visit generally consists of a review of the provider's claims statistics, including top reasons for denial and denial rates, and a review of important Medicaid training and resource information. Provider Training Workshops may be held during the summer months to review this information in a larger group format.

Due to the rural and frontier nature of, and weather in, Wyoming, visits are generally conducted during the warmer months only. For immediate assistance, a provider should always contact Provider 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 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.

Chapter Three – Provider Responsibilities

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

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

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

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

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

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

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

The application fee is required for the following:

- New enrollments
- Enrollments for new locations

- Re-enrollments
- Medicaid requested re-enrollments (as the result of inactive enrollment statuses)

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

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

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

To enroll as a Medicaid provider, all providers must complete the on-line enrollment application available on the Medicaid website (2.1, Quick Reference).

3.1.1 Ordering, Referring, and Prescribing Providers (ORP)

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

NOTE: Chiropractic providers will not be considered ORP providers for dates of service 01/01/2021 and forward.

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
225100000X	Physical Therapist
235Z00000X	Speech Therapist
251E00000X	Home Health
251G00000X	Hospice Care, Community Based
261Q00000X	Development Centers (Clinics/Centers)
261QP0904X	Public Health, Federal/Health Programs Operated by IHS
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 for 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 within 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 and the provider will have to resubmit once the correct information is updated. If the information is updated within the 30 days, the claim(s) will be released to complete normal processing.

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.

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 to Medicaid, attention TPL (7.2.1, Third Party Resources Information Sheet). 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 accepts the client as a Medicaid client	**Client is Covered by a LIMITED COVERAGE Medicaid Program and the provider accepts the client as a Medicaid client**	**FULL COVERAGE or LIMITED COVERAGE Medicaid Program and the provider does not accept the client as a Medicaid client**	**Client is not 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 Medicare/Medicaid Dual Eligible Clients

Dual eligible clients are those clients who have both Medicare and Medicaid. For clients on the QMB plan, CMS guidelines indicate that coinsurance and deductible amounts remaining after Medicare pays cannot be billed to the client under any circumstances, regardless of whether the provider billed Medicaid or not.

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

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

3.2.2.2 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 (365 days) timely filing deadline will not be waived (6.20, 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 (6.20, 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.

3.2.2.3 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 the 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. Policies 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 are designed to cover the cost of doing business.

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 that they are 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 (3.2.2, Provider-Patient Relationship) for guidance
- If the client has reached the threshold on physical therapy, occupational therapy, speech therapy, behavioral health services, chiropractic services and dietitian services with dates of service prior to 01/01/2021, prescriptions, and/or office/outpatient hospital visits (6.8 Service Thresholds) and has been notified that the services are not medically necessary in writing by the provider

  NOTE: The provider may contact Provider Relations or the IVR to receive service threshold information 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 Provider Relations. There is a limit of three (3) verifications per call but no limit on the number of calls.
- Fax a list of identifying information to Provider Relations for verification. Send a list of beneficiaries for verification and receive a response within ten (10) business days.
- Call the Interactive Voice Response (IVR) System. IVR is available 24 hours a day seven (7) days a week. 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 of 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 Greely, Fort Collins, and Denver Colorado are excluded from the WMSA and are not considered border cities.

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

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

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

- **Emergency Care** – When a 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 (6.14, 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 record element requirements include, but are not limited to:

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

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

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

Chapter Four – Utilization Review

4.1 Utilization Review

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

- Review of claims submitted for payment (pre and post payment reviews)
- Review of medical records and documents related to covered services
- Audit of medical records and 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 receives and reviews complaints regarding fraud, waste and abuse from providers and clients. No action is taken without a complete investigation. To file a complaint, please call or 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 they accept Medicaid benefits.

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

4.4 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://worxpdmp.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 Chapter 17, Hospice.

4.7 Fraud and Abuse

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

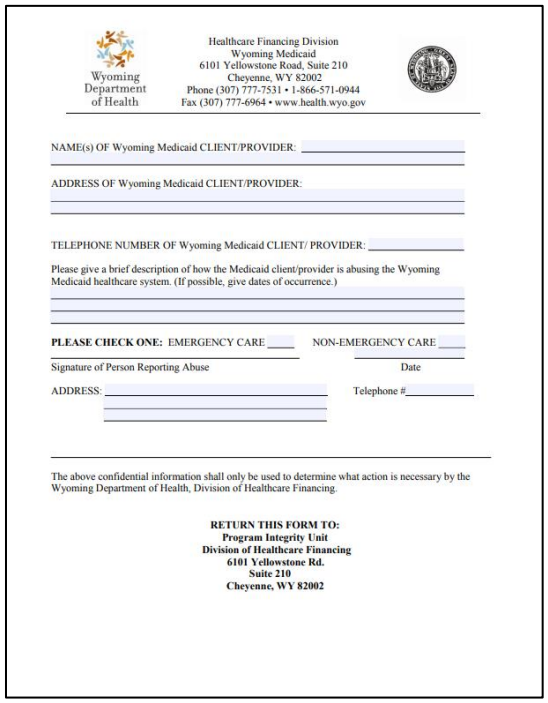
The provider is responsible for reading and adhering to applicable State and Federal regulations and the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by their 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 form to, call, or reference the Program Integrity Unit website using the contact information below:

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 the 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 the 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.”

Chapter Five – Client Eligibility

5.1 What is Medicaid?

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

5.2 Who is Eligible?

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

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

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
- Hospital
- 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 Maternal and Child Health (MCH)

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

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

122 West 25th St, 3rd Floor West
Attn: Maternal & Child Health
Cheyenne, WY 82002
(800)438-5795 or Fax (307)777-7215

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

5.4 Eligibility Determination

5.4.1 Applying for Medicaid

- Persons applying for Medicaid or Kid Care CHIP may complete the Streamlined Application. The application may be mailed to the Wyoming Department of Health (WDH). Applicants may also apply online at https://www.wesystem.wyo.gov/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

5.4.2 Determination

Eligibility determination is conducted by the Wyoming Department of Health Customer Service Center (CSC) or the Long Term Care (LTC) Unit centrally located in Cheyenne, WY (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 (6.20, Timely Filing). This situation could arise for the following reasons:

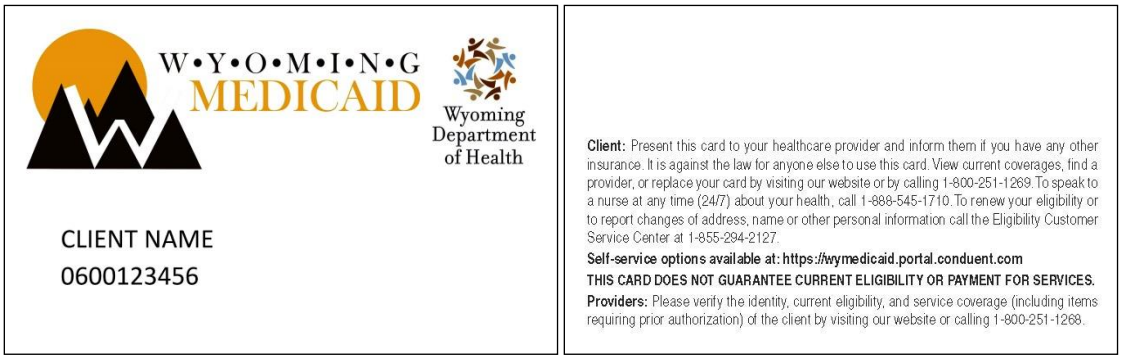
- Administrative Law Judge decisions or reversals
- Delays encountered in processing applications or receiving necessary client information concerning income or resources

5.5 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:



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

5.6 Other Types of Eligibility Identification

5.6.1 Medicaid Approval Notice

In some cases, a provider may be presented with a copy of Medicaid Approval Notice in lieu of the 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 section 3.8, Verification Options for ways to verify a client's eligibility.

Chapter Six – Common Billing Information

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, 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 providers to bill electronically (Chapter 8, Electronic Data Interchange (EDI)).

6.2 Basic Claim Information

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

- Use an original, standard, red-dropout form (CMS-1500 (02-12) and UB04)
- Use typewritten print; for best results use a laser printer
- Use a clean, non-proportional font
- Use black ink
- Print claim data within the defined boxes on the claim form
- Print only the information asked for on the claim form
- Use all capital letters
- Use correction tape for corrections

To avoid delays in processing of claims, it is recommended that providers avoid the following:

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

Claims that do not follow Medicaid provider billing policies and procedures may be returned, unprocessed, with a letter. When a claim is returned, 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.

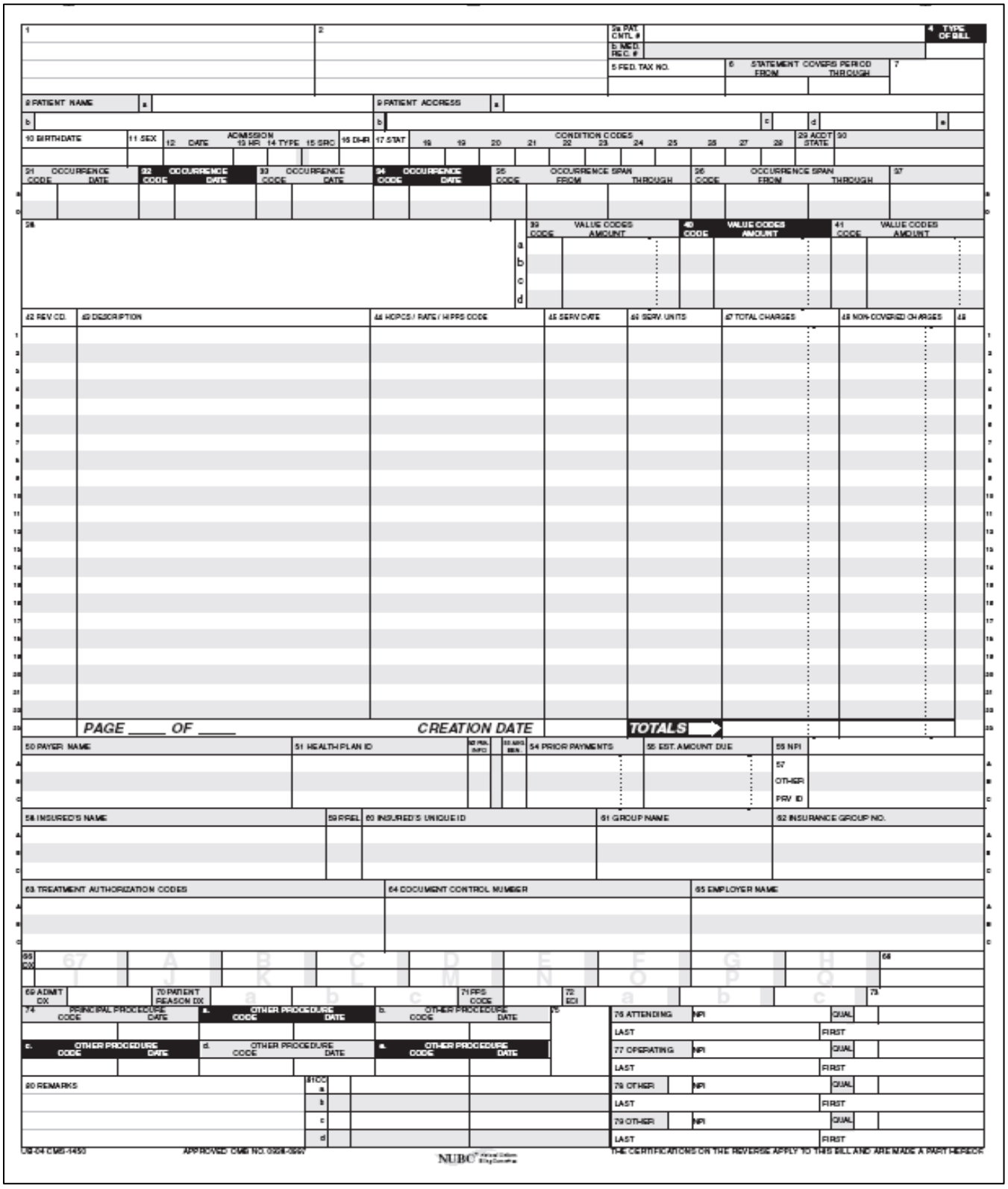
Billing errors detected after a claim is submitted cannot be corrected until after Medicaid has made payment or notified the provider of the denial. Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice (6.18, Resubmitting Versus Adjusting Claims).

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 UB-04 Claim Form



6.4.1 Instructions for Completing the UB-04 Claim Form

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

Field	Item Description	Required Outpatient	Required Inpatient	Action
				Outpatient/Inpatient Combined: Enter the date the client was first seen for outpatient services through the inpatient discharge date.
7	Future Use	N/A	N/A	
8a	Patient ID	X	X	Enter client's Medicaid number.
8b	Patient Name	X	X	Enter the client's name as shown on the front of the Medicaid card.
9	Patient Address	X	X	Enter the full mailing address of client.
10	Patient Birthdate	X	X	Enter client's birthdate (MMDDYY).
11	Patient Sex	X	X	(Optional) Enter appropriate code.
12	Admission Date	X	X	Enter the date the patient was admitted as an inpatient or the date of outpatient care.
14	Type of Admission/Visit	X	X	Enter appropriate code: 1 = Emergency 2 = Urgent Care 3 = Elective (non-emergency) 4 = Newborn 5= Trauma Physician/medical professional will need to determine if the visit or service was an emergency.
15	Source of Admission	X	X	Enter the Source of Admission Code
16	Discharge Hour	X	N/A	(When applicable) Enter the hour the client was discharged.
17	Patient Discharge Status	X	X	Enter the two (2) digit code indicating the status of the patient as noted below: Code Description 01 Home or self-care 02 Other hospital 03 SNF 04 ICF 05 Other type of institution 06 Home health organization 07 Left against medical advice 09 Admitted as IP to this hosp 20 Expired 21 Law Enforcement 30 Still a patient, used for interterm billing 40 Hospice patient died at home 41 Hospice patient died at hospital 42 Hospice patient died unknown 43 Tran to Fed Hlth Care Facility 50 Discharged to hospice- home

Field	Item Description	Required Outpatient	Required Inpatient	Action
				51 Discharged to hospice- med 61 Transferred to swing bed 62 Transferred to inp rehab facility 63 Transferred to Long Term Care Hosp 64 Trans to Mcaid Nursing Facility 65 Transferred to Psych Hospital 66 Transferred to Critical Access Hospital 70 Transfer to Other
18-28	Condition Codes	Situational	Situational	Enter if applicable
29	Accident State			If claim is for auto accident, enter the state the accident occurred in.
30	Future Use	N/A	N/A	
31-34	Occurrence Code and Dates	Situational	Situational	Enter if applicable.
35-36	Occurrence Span Codes and Dates	Situational	Situational	Enter if applicable.
37	Future Use	N/A	N/A	
38	Subscriber Name and Address	X	X	Enter client's name and address.
39-41	Value Codes and Amounts	Situational	Situational	Enter if applicable
42	Revenue Codes	X	X	Enter the appropriate revenue codes.
43	Revenue Code Description	X	X	Enter appropriate revenue code descriptions.
44	HCPCS/Rates	Situational	Situational	Enter if applicable.
45	Service Date	X	X	Enter date(s) of service.
46	Units of Service	X	X	Enter the units of services rendered for each detail line. A unit of service is the number of time a procedure is performed. If only one (1) service is performed, the numeral 1 must be entered.
48	Non-Covered Charges	Situational	Situational	Enter if applicable.
49	Future Use	N/A	N/A	
50	Payer Identification (Name)	X	X	Enter name of payer.
51	Health Plan Identification Number	X	X	(Optional) Enter Health Plan ID for payer.
52	Release of Info Certification	X	X	Enter Y for release on file
53	Assignment of Benefit Certification	X	X	Y marked in this box indicates provider agrees to accept assignment under the terms of the Medicare program.

Field	Item Description	Required Outpatient	Required Inpatient	Action
54	Prior Payments	Situational	Situational	Enter if applicable.
55	Estimated Amount Due	X	X	Enter remaining total is prior payment was made.
56	NPI	X	X	Enter Pay-To NPI.
57	Other Provider IDs	Optional	Optional	Enter legacy ID.
58	Insured's Name	X	X	Enter client or insured's name.
59	Patient's Relation to the Insured	X	X	Enter appropriate relationship to insured.
60	Insured's Unique ID	X	X	Enter client's Medicaid ID.
61	Insured Group Name	Situational	Situational	Enter if applicable.
62	Insured Group Name	Situational	Situational	Enter if applicable.
63	Treatment Authorization Codes	Situational	Situational	Enter if applicable.
64	Document Control Number	Situational	Situational	Enter if applicable.
65	Employer Name	Situational	Situational	Enter if applicable.
66	Diagnosis/Procedure Code Qualifier	X	X	Enter appropriate qualifier.
67	Principal Diagnosis Code/Other Diagnosis Codes	X	X	Enter all applicable diagnosis codes.
67	Present on Admission Indicator (shaded area)	X		Enter the appropriate POA indicator on each required diagnosis in the shaded area to the right of the diagnosis box
68	Future Use	N/A	N/A	
69	Admitting Diagnosis Code	X	Situational	Enter if applicable.
70	Patient's Reason for Visit Code	Situational	Situational	Enter if applicable.
71	PPS Code	Situational	Situational	Enter if applicable.
72	External Cause of Injury Code	Situational	Situational	Enter if applicable.
73	Future Use	N/A	N/A	
74	Principal Procedure Code/Date	Situational	Situational	Enter if applicable.
75	Future Use	N/A	N/A	
76	Attending Name/ID-Qualifier 1-G	X	X	Enter the Attending Physician's NPI, appropriate qualifier, last name, and first name.
77	Operating ID	Situational	Situational	Enter if applicable.
78-79	Other ID	Situational	Situational	Enter if applicable.
80	Remarks	Situational	Situational	Enter if applicable.

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

6.4.2 Appropriate Bill Type and Provider Taxonomy Table

Appropriate Bill Type(s)	Pay-to Provider's Taxonomy	Taxonomy Description
11X-14X	282N00000X, 283Q00000X, 283X00000X	General and Specialty Hospitals, Medical Assistance Facilities, Long Term Hospitals, Rehabilitation Hospitals, Children's Hospitals, Psychiatric Hospitals.
73X, 77X	261QF0400X	FQHC
11X-14X,85X	282NR1301X	Critical Access Hospitals (CAH).
81X-82X	251G00000X	Hospice
83X	261QA1903X	Ambulatory Surgical Centers.
72X	261QE0700X	Hospital Based Renal Dialysis Facility, Independent Renal Dialysis Facility, Independent Special Purpose Renal Dialysis Facility, Hospital Based Satellite Renal Dialysis Facility, Hospital Based Special Purpose Renal Dialysis Facility
32X, 33X	251E00000X	Home Health Agencies.
75X	261QR0401X	CORF
71X	261QR1300X	Freestanding or Provider Based RHC
21X,23X	31400000X, 315P00000X, 283Q00000X (State Hospital Only)	SNF-ICF/ID
18X	275N00000X	Hospital Swing Bed.
11X	323P00000X	PRTF
13X	261QP0904X, 261QR0400X	Indian Health Services (IHS), National Jewish Health Asthma Day Program.

6.5 Medicare Crossovers

Medicaid processes claims for Medicare/Medicaid services when provided to a Medicaid eligible client.

6.5.1 General Information

- Dually eligible clients are clients that are eligible for Medicare and Medicaid
- Providers may verify Medicare and Medicaid eligibility through the IVR (2.1, Quick Reference).

- Providers must accept assignment of claims for dually eligible clients
- Be sure Wyoming Medicaid has record of all applicable NPIs under which the provider is submitting to Medicare to facilitate the electronic crossover process
- Medicaid reimburses the lesser of the assigned coinsurance and deductible amounts or the difference between the Medicaid allowable and the Medicare paid amount for dually eligible clients as indicated on the Medicare (Explanation of Medicare Benefits) EOMB
    - Wyoming Medicaid's payment is payment in full. The client is not responsible for any amount left over, even if assigned to coinsurance or deductible by Medicare.

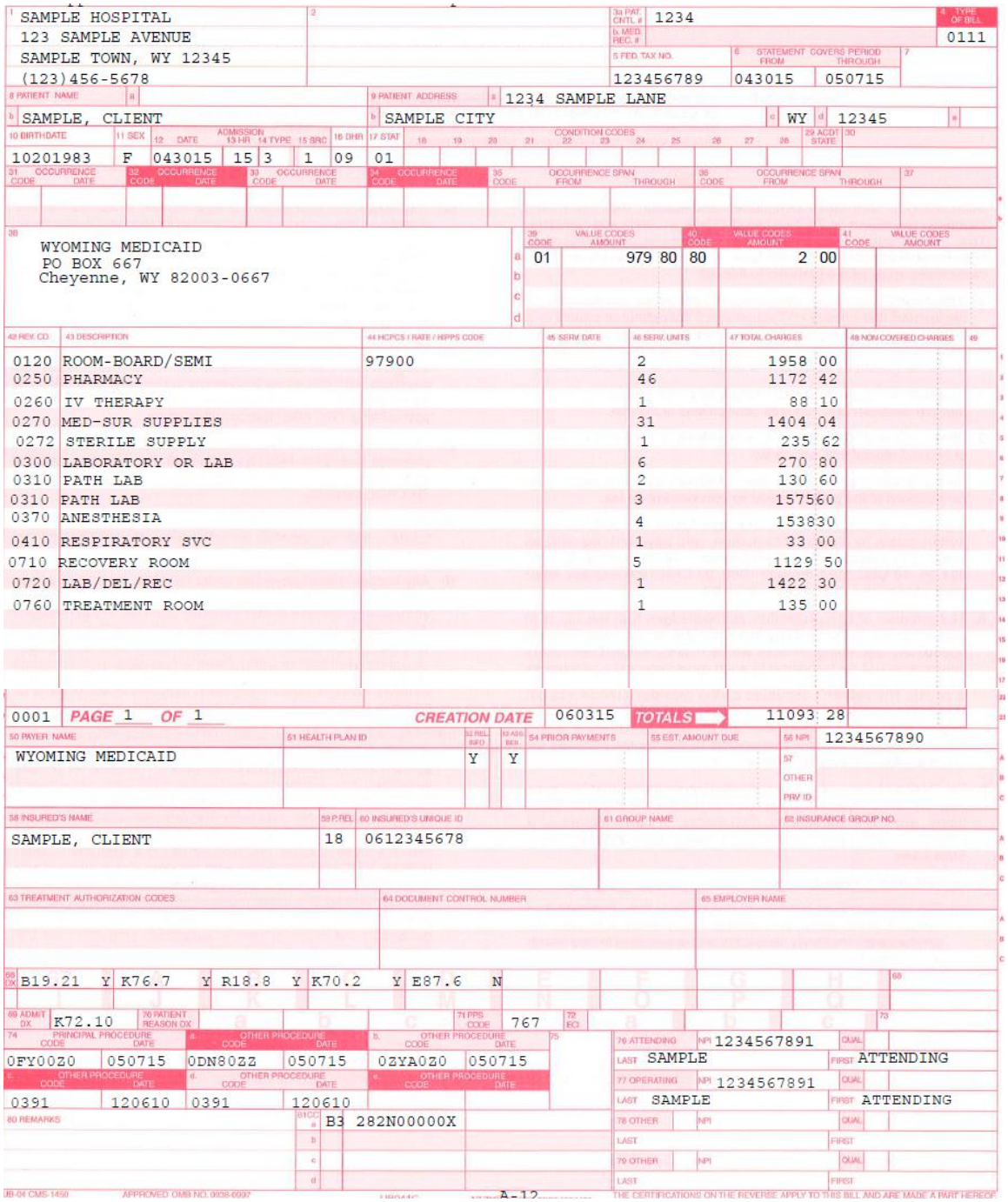
6.5.2 Billing Information

- Medicare is primary to Medicaid and must be billed first. Direct Medicare claims processing questions to the Medicare carrier.
- When posting the Medicare payment, the EOMB may state that the claim has been forwarded to Medicaid. **No further action is required, it has automatically been submitted.**
- Medicare transmits electronic claims to Medicaid daily. Medicare transmits all lines on a claim with any Medicare paid claim – If one (1) line pays, and three (3) others are denied by Medicare, all four (4) lines will be transmitted to Wyoming Medicaid.
- The time limit for filing Medicare crossover claims to Medicaid is 12 months (365 days) from the date of service or 6 months (180 days) from the date of the Medicare payment, whichever is later
- **If payment is not received from Medicaid after 45 days of the Medicare payment, submit a claim to Medicaid and include the COB (Coordination of Benefits) information in the electronic claim.** The line items on the claim being submitted to Medicaid must be exactly the same as the claim submitted to Medicare, except when Medicare denies, then the claim must conform to Medicaid policy.
- If a paper claim is being submitted, the EOMB must be attached. If the Medicare policy is a **replacement/advantage or supplement**, this information must be noted (it can be hand written) on the EOMB.

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

6.6 Examples of Billing

6.6.1 Client has Medicaid Coverage Only



1 SAMPLE HOSPITAL
123 SAMPLE AVENUE
SAMPLE TOWN, WY 12345
(123)456-5678

3a PAT. CNTL # 1234
4 TYPE OF BILL 0111
5 FED. TAX NO. 123456789
6 STATEMENT COVERS PERIOD FROM 043015 THROUGH 050715

8 PATIENT NAME: SAMPLE, CLIENT
9 PATIENT ADDRESS: 1234 SAMPLE LANE; SAMPLE CITY; WY; 12345

10 BIRTHDATE 10201983 | 11 SEX F | 12 ADMISSION DATE 043015 | 13 HR 15 | 14 TYPE 3 | 15 SRC 1 | 16 DHR 09 | 17 STAT 01

38
WYOMING MEDICAID
PO BOX 667
Cheyenne, WY 82003-0667

39 VALUE CODES AMOUNT: a 01 979 80
40 VALUE CODES AMOUNT: 80 2 00
41 VALUE CODES AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0120	ROOM-BOARD/SEMI	97900		2	1958 00	
0250	PHARMACY			46	1172 42	
0260	IV THERAPY			1	88 10	
0270	MED-SUR SUPPLIES			31	1404 04	
0272	STERILE SUPPLY			1	235 62	
0300	LABORATORY OR LAB			6	270 80	
0310	PATH LAB			2	130 60	
0310	PATH LAB			3	157560	
0370	ANESTHESIA			4	153830	
0410	RESPIRATORY SVC			1	33 00	
0710	RECOVERY ROOM			5	1129 50	
0720	LAB/DEL/REC			1	1422 30	
0760	TREATMENT ROOM			1	135 00	
0001	PAGE 1 OF 1		CREATION DATE 060315	TOTALS	11093 28	

50 PAYER NAME: WYOMING MEDICAID
51 HEALTH PLAN ID
52 REL. INFO Y | 53 ASG. BEN. Y
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER PRV ID

58 INSURED'S NAME: SAMPLE, CLIENT
59 P REL 18
60 INSURED'S UNIQUE ID 0612345678
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

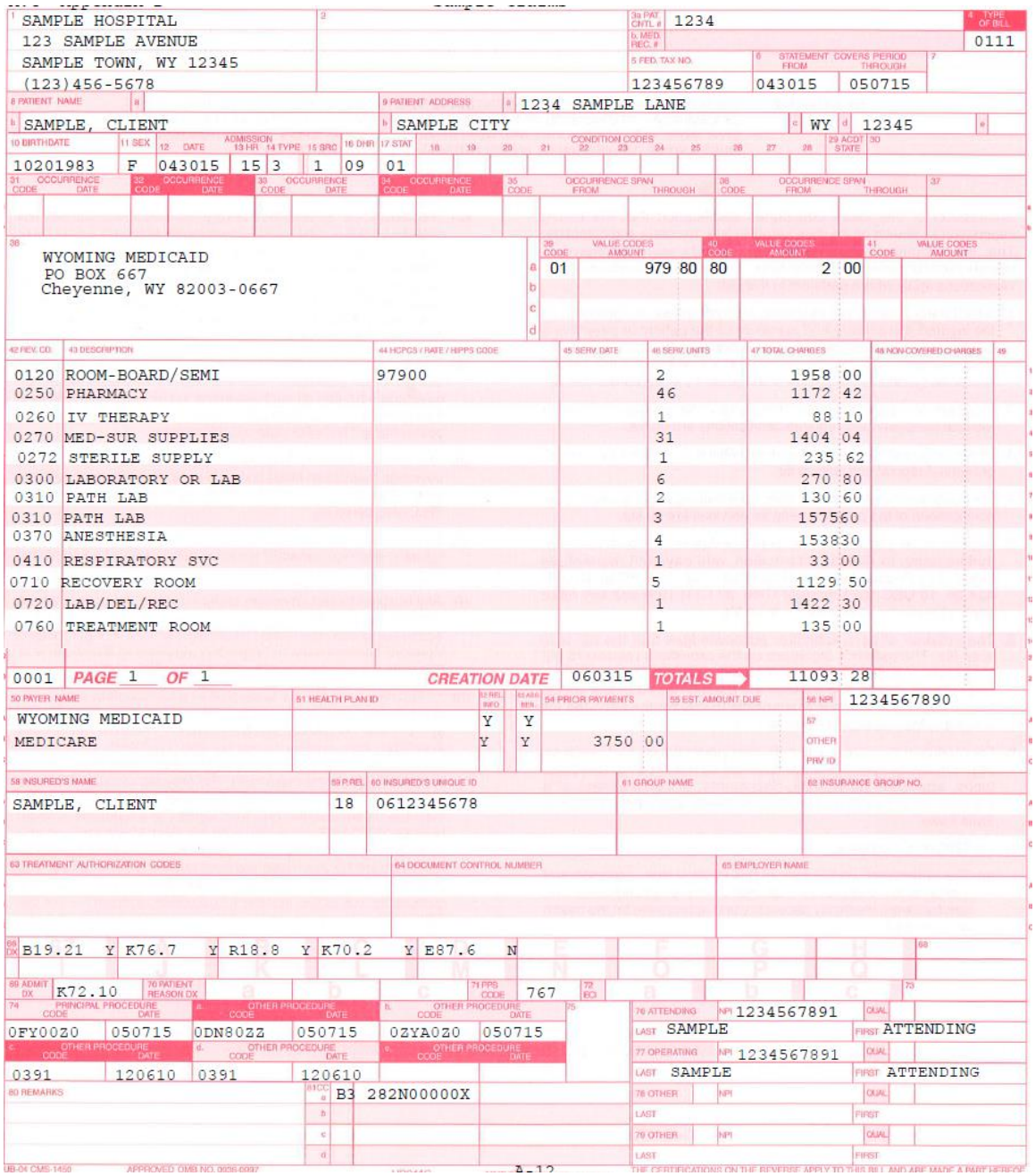
67 I/D DX: A B19.21 Y | B K76.7 Y | C R18.8 Y | D K70.2 Y | E E87.6 N
69 ADMIT DX K72.10
70 PATIENT REASON DX
71 PPS CODE 767
72 ECI
74 PRINCIPAL PROCEDURE CODE 0FY00Z0 DATE 050715
a. OTHER PROCEDURE CODE 0DN80ZZ DATE 050715
b. OTHER PROCEDURE CODE 0ZYA0Z0 DATE 050715
c. OTHER PROCEDURE CODE 0391 DATE 120610
d. OTHER PROCEDURE CODE 0391 DATE 120610
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1234567891 QUAL LAST SAMPLE FIRST ATTENDING
77 OPERATING NPI 1234567891 QUAL LAST SAMPLE FIRST ATTENDING
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81CC a B3 282N00000X

JB-04 CMS-1450 APPROVED OMB NO. 0938-0997 A-12 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

6.6.2 Client has Medicaid and Medicare



1 SAMPLE HOSPITAL
123 SAMPLE AVENUE
SAMPLE TOWN, WY 12345
(123)456-5678

3a PAT. CNTL # 1234
4 TYPE OF BILL 0111
5 FED. TAX NO. 123456789
6 STATEMENT COVERS PERIOD FROM 043015 THROUGH 050715

8 PATIENT NAME b SAMPLE, CLIENT
9 PATIENT ADDRESS a 1234 SAMPLE LANE b SAMPLE CITY c WY d 12345

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
10201983	F	043015	15	3	1	09	01

38 WYOMING MEDICAID
PO BOX 667
Cheyenne, WY 82003-0667

39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a 01	979 80	80	2 00		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0120	ROOM-BOARD/SEMI	97900		2	1958 00	
0250	PHARMACY			46	1172 42	
0260	IV THERAPY			1	88 10	
0270	MED-SUR SUPPLIES			31	1404 04	
0272	STERILE SUPPLY			1	235 62	
0300	LABORATORY OR LAB			6	270 80	
0310	PATH LAB			2	130 60	
0310	PATH LAB			3	157560	
0370	ANESTHESIA			4	153830	
0410	RESPIRATORY SVC			1	33 00	
0710	RECOVERY ROOM			5	1129 50	
0720	LAB/DEL/REC			1	1422 30	
0760	TREATMENT ROOM			1	135 00	
0001	PAGE 1 OF 1		CREATION DATE 060315		TOTALS 11093 28	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
WYOMING MEDICAID		Y	Y			1234567890
MEDICARE		Y	Y	3750 00		

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SAMPLE, CLIENT	18	0612345678		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: B19.21 Y | K76.7 Y | R18.8 Y | K70.2 Y | E87.6 N

67 ADMIT DX: K72.10 | 76 PATIENT REASON DX | 79 PPS CODE: 767 | 72 ECI

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE
0FY00Z0	050715	0DN80ZZ	050715	0ZYA0Z0	050715
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE
0391	120610	0391	120610		

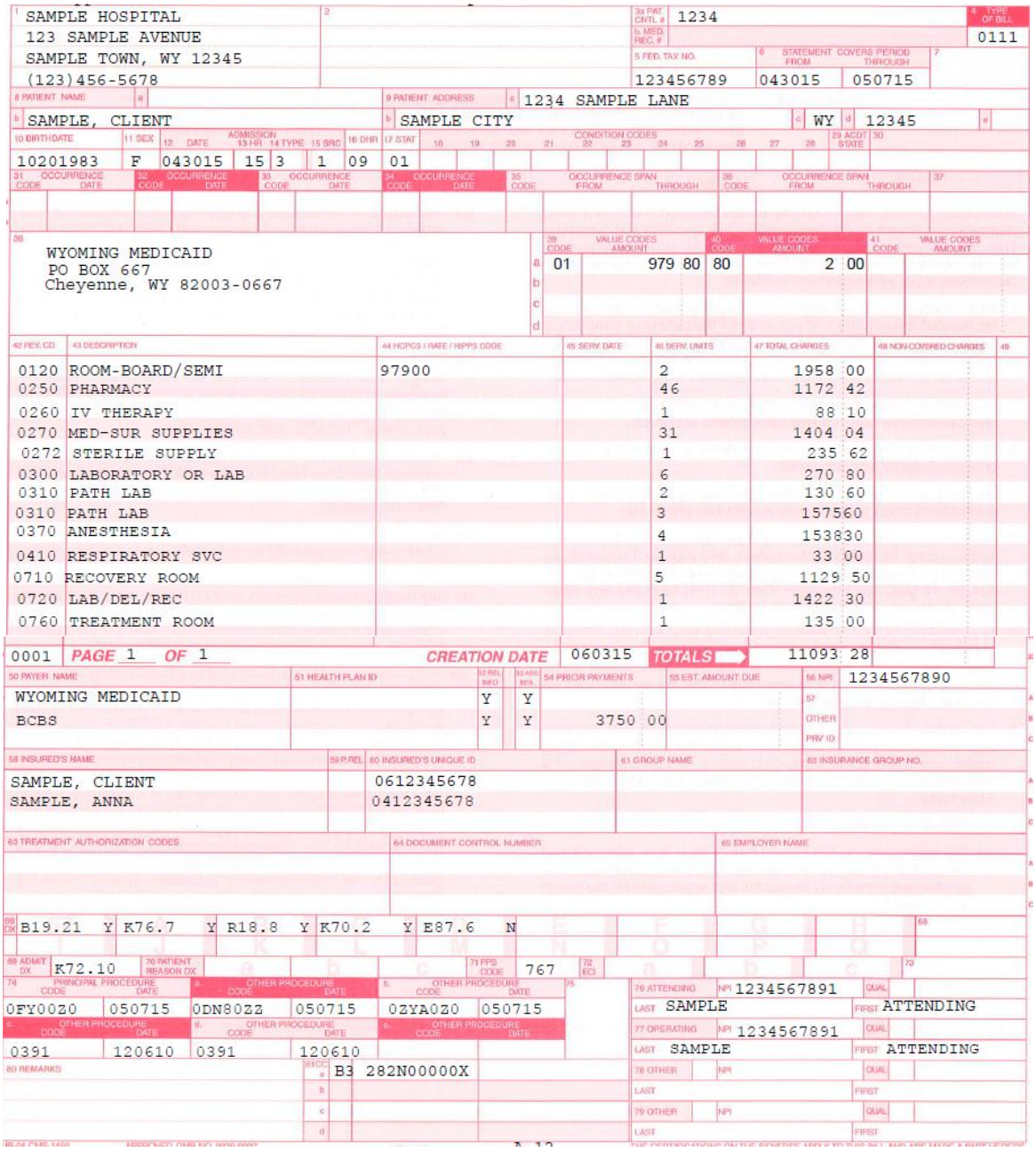
80 REMARKS | 81CC a B3 282N00000X

76 ATTENDING NPI 1234567891 LAST SAMPLE FIRST ATTENDING
77 OPERATING NPI 1234567891 LAST SAMPLE FIRST ATTENDING
78 OTHER NPI LAST FIRST
79 OTHER NPI LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 A-12 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

NOTE: When the client has dual coverage, (Medicaid and Medicare) attach the EOMB to the claim.

6.6.3 Client has Medicaid and Third Party Liability (TPL)



SAMPLE HOSPITAL
123 SAMPLE AVENUE
SAMPLE TOWN, WY 12345
(123)456-5678

1234 | 0111 | 123456789 | 043015 | 050715

SAMPLE, CLIENT | 1234 SAMPLE LANE | SAMPLE CITY | WY | 12345

10201983 | F | 043015 | 15 | 3 | 1 | 09 | 01

WYOMING MEDICAID
PO BOX 667
Cheyenne, WY 82003-0667

0120	ROOM-BOARD/SEMI	97900		2	1958 00	
0250	PHARMACY			46	1172 42	
0260	IV THERAPY			1	88 10	
0270	MED-SUR SUPPLIES			31	1404 04	
0272	STERILE SUPPLY			1	235 62	
0300	LABORATORY OR LAB			6	270 80	
0310	PATH LAB			2	130 60	
0310	PATH LAB			3	157560	
0370	ANESTHESIA			4	153830	
0410	RESPIRATORY SVC			1	33 00	
0710	RECOVERY ROOM			5	1129 50	
0720	LAB/DEL/REC			1	1422 30	
0760	TREATMENT ROOM			1	135 00	

0001 | PAGE 1 OF 1 | CREATION DATE 060315 | TOTALS 11093 28

WYOMING MEDICAID | Y | Y | 1234567890
BCBS | Y | Y | 3750 00

SAMPLE, CLIENT | 0612345678
SAMPLE, ANNA | 0412345678

DX: B19.21 Y | K76.7 Y | R18.8 Y | K70.2 Y | E87.6 N

ADMIT DX: K72.10 | PPS CODE: 767

PRINCIPAL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
0FY00Z0	050715	0DN80ZZ	050715	0ZYA0Z0	050715

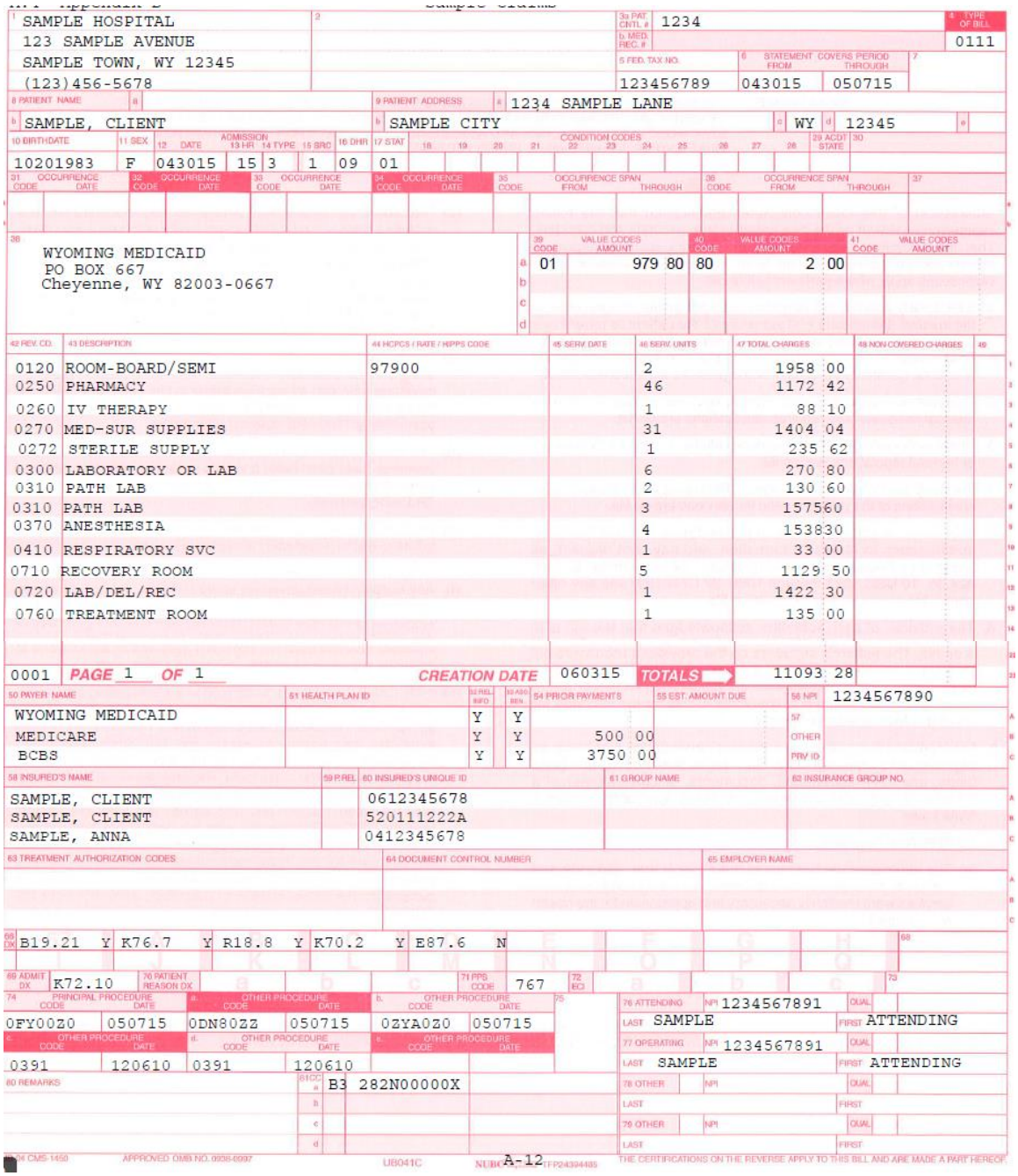
OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
0391	120610	0391	120610		

76 ATTENDING NPI 1234567891 LAST SAMPLE FIRST ATTENDING
77 OPERATING NPI 1234567891 LAST SAMPLE FIRST ATTENDING

81 CC: B3 282N00000X

NOTE: If the client has both Medicare and TPL in addition to Medicaid, attach the TPL EOB and the Medicare EOMB to the claim. If the client has TPL and Medicaid but no Medicare, attach the TPL EOB to the claim.

6.6.4 Client has Medicaid, TPL, and Medicare



SAMPLE HOSPITAL
123 SAMPLE AVENUE
SAMPLE TOWN, WY 12345
(123)456-5678

3a PAT. CNTL # 1234
4 TYPE OF BILL 0111
5 FED. TAX NO. 123456789
6 STATEMENT COVERS PERIOD FROM 043015 THROUGH 050715

8 PATIENT NAME: SAMPLE, CLIENT
9 PATIENT ADDRESS: 1234 SAMPLE LANE; SAMPLE CITY; WY; 12345

10 BIRTHDATE 10201983 | 11 SEX F | 12 ADMISSION DATE 043015 | 13 HR 15 | 14 TYPE 3 | 15 SRC 1 | 16 DHR 09 | 17 STAT 01

WYOMING MEDICAID
PO BOX 667
Cheyenne, WY 82003-0667

39 VALUE CODES a 01 979 80 | 40 VALUE CODES 80 2 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0120	ROOM-BOARD/SEMI	97900		2	1958 00	
0250	PHARMACY			46	1172 42	
0260	IV THERAPY			1	88 10	
0270	MED-SUR SUPPLIES			31	1404 04	
0272	STERILE SUPPLY			1	235 62	
0300	LABORATORY OR LAB			6	270 80	
0310	PATH LAB			2	130 60	
0310	PATH LAB			3	157560	
0370	ANESTHESIA			4	153830	
0410	RESPIRATORY SVC			1	33 00	
0710	RECOVERY ROOM			5	1129 50	
0720	LAB/DEL/REC			1	1422 30	
0760	TREATMENT ROOM			1	135 00	
0001	PAGE 1 OF 1		CREATION DATE 060315	TOTALS	11093 28	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
WYOMING MEDICAID		Y	Y		
MEDICARE		Y	Y	500 00	
BCBS		Y	Y	3750 00	

56 NPI 1234567890

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SAMPLE, CLIENT		0612345678		
SAMPLE, CLIENT		520111222A		
SAMPLE, ANNA		0412345678		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: B19.21 Y | K76.7 Y | R18.8 Y | K70.2 Y | E87.6 N

69 ADMIT DX K72.10 | 70 PATIENT REASON DX | 71 PPS CODE 767 | 72 ECI

74 PRINCIPAL PROCEDURE CODE 0FY00Z0 DATE 050715
a. OTHER PROCEDURE CODE 0DN80ZZ DATE 050715
b. OTHER PROCEDURE CODE 0ZYA0Z0 DATE 050715
c. OTHER PROCEDURE CODE 0391 DATE 120610
d. OTHER PROCEDURE CODE 0391 DATE 120610
e. OTHER PROCEDURE CODE | DATE

76 ATTENDING NPI 1234567891 QUAL | LAST SAMPLE | FIRST ATTENDING
77 OPERATING NPI 1234567891 QUAL | LAST SAMPLE | FIRST ATTENDING
78 OTHER NPI QUAL | LAST | FIRST
79 OTHER NPI QUAL | LAST | FIRST

80 REMARKS
81CC a B3 282N00000X

CMS-1450 APPROVED OMB NO. 0938-0997 | UB041C | NUBC A-12 | TFP24394485 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NOTE: If the client has both Medicare and TPL in addition to Medicaid, attach the TPL EOB and the Medicare EOMB to the claim. If the client has TPL and Medicaid but no Medicare, attach the TPL EOB to the claim.

6.7 Provider Preventable Conditions (PPC)

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

- Foreign object retained after surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma; including fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor Glycemic control including: Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity
- Surgical site infections following:
    - Coronary artery bypass graft (CABG) – Mediastinitis
    - Bariatric Surgery; including Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery
    - Orthopedic Procedures; including Spine, Neck , Shoulder, Elbow
- Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE) following Total Knee Replacement or Hip Replacement with pediatric and obstetric exceptions
- Iatrogenic Phneumothorax with Venous Catheterization
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

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

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

6.7.1 Providers Included in the PPC Review

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

6.7.2 Present on Admission (POA) Indicator

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

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

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

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

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

4. For all claims with a POA indicator of "N," request that the hospital submit an adjusted claim which identifies all charges associated with the HAC as "non-covered" and all charges not associated with the HAC as "covered."
5. Determine the APR DRG assignment and outlier payment for each of the adjusted claims received in Step 4. If the total payment is less than what was originally paid for the claim, then request a refund from the hospital for the difference. The fiscal agent for Wyoming Medicaid will maintain a listing of

these claims, including the submitted charges and payment, and the adjusted charges and payment.

6. Request medical records for all claims identified in Step 3 with a POA indicator of "U" and for a sample of claims with a POA indicator of "Y" (no more than five (5) from each hospital).
    a. For claims with a POA indicator of "Y," review medical record documentation to validate the accuracy of the assignment of the "Y" indicator by verifying that the condition was present on admission. If the review determines that the indicator should be "N", then proceed to Steps 4 and 5. Further, based on the results of the review, Wyoming Medicaid may request additional claims.
    b. For claims with a POA indicator of "U", review the medical record to determine whether the use of the "U" indicator is appropriate. If the review determines that the indicator should be "N," then proceed to Steps 4 and 5. If the review determines that the indicator should be "Y," then the claim is not a HAC. Drop from the HAC adjustment consideration.
    c. Wyoming Medicaid will monitor the results and increase or decrease the sample size in each subsequent quarter, as necessary. Wyoming Medicaid may also drop hospitals from future sampling, depending on the results of the first year of reviews.

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

6.8 Value Codes

Most frequently used value codes by Wyoming Medicaid providers:

Value code 54

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

Value Code 80 and 81

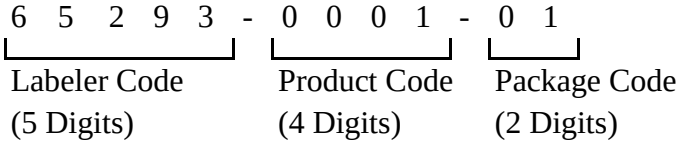
Value code 80 is to be billed as covered days and value code 81 is to be billed as non-covered days.

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

6.9 National Drug Code (NDC) Billing Requirement

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

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



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

6.9.1 Converting 10-Digit NDC's to 11-Digits

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

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

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

6.9.2 Documenting and Billing the Appropriate NDC

A drug may have multiple manufacturers so it is vital to use the NDC of the administered drug and not another manufacturer's product, even if the chemical name

is the same. It is important that providers develop a process to capture the NDC when the drug is administered, before the packaging is thrown away. It is not permissible to bill Medicaid with any NDC other than the one administered. Providers should not pre-program their billing systems to automatically utilize a certain NDC for a procedure code that does not accurately reflect the product that was administered to the client.

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

6.9.3 Billing Requirements

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

6.9.4 Submitting One NDC per Procedure Code

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

Example:

Procedure Code	Modifier	Procedure Quantity	NDC
90375		2	13533-0318-01

6.9.5 Submitting Multiple NDCs per Procedure Code

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

Example:

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

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

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

6.9.6 OPPS Packaged Services (Critical Access and General Hospitals only)

The NDC requirement does not apply to services considered packaged under OPPS. These services are assigned status indicator N. For a list of packaged services, consult the APC-Based Fee Schedule located on the Medicaid website (2.1, Quick Reference).

6.9.7 UB-04 Billing Instructions

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

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

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

6.9.7.1 UB-04 One NDC per Procedure Code

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

6.9.7.2 UB-04 Two NDCs per Procedure Code

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

NOTE: Medicaid's instructions follow the National Uniform Billing Committee's (NUBC) recommended guidelines for reporting the NDC on the UB-04 claim form. Provider claims that do not adhere to these guidelines may deny. (For placement in an electronic X12N 837 Institutional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.

6.10 Service Thresholds

6.10.1 Under Age 21

Medicaid clients under 21 years of age are subject to thresholds for:

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

6.10.2 Ages 21 and older

Medicaid clients 21 years of age and older are subject to thresholds for:

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

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

NOTE: Ancillary services (e.g. lab, x-ray, etc.) provided during an office/outpatient hospital visit that exceeded the threshold will still be reimbursed.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, BEHAVIORAL HEALTH VISITS, CHIROPRACTIC VISITS AND DIETITIAN		
Codes	**Service Threshold**	**Does not apply to:**
Procedure codes: 90785; 90791; 90792; 90832-90834; 90836-90839; 90845-90849; 90853; 90857;92507-92508; 92526; 92609; 96105-96146; 97010-97039; 97110-97150; 97161-97546; 97802-97804; 98940-98942; (all modalities on same date of service count as 1 visit) **HCPCS Level II codes:** G9012; H0004; H0031; H0038; H0046, H2010; H2014; H2017; H2019; S9480, T1017 (all modalities on same date of service count as 1 visit) **Revenue codes:** 0421-0449 (each unit counts as 1 visit)	20 physical therapy visits per calendar year 20 occupational therapy visits per calendar year 30 speech therapy visits per calendar year Behavioral Health Visits: • 2020 dates of service and prior - threshold of 30 visits per calendar year applies to clients 21 and over only • 2021 dates of service and forward - threshold applies to all clients Chiropractic Visits: • 2020 dates of service and prior - 20 chiropractic visits per calendar year • 2021 dates of service and forward – Chiropractic services are not covered Dietitian Visits: • 2020 dates of service and prior - 20 dietitian visits per calendar year • 2021 dates of service and forward - no threshold on visits	• Medicare Paid Crossovers • Inpatient and ER behavioral health services

6.10.3 Authorization of Medical Necessity

For dates of service prior to 01/01/2021, once the threshold has been reached, or once the provider is aware the threshold will be met and the client is nearing the threshold, an Authorization of Medical Necessity may be required for the following services:

- Dietitian visits
- Chiropractic visits

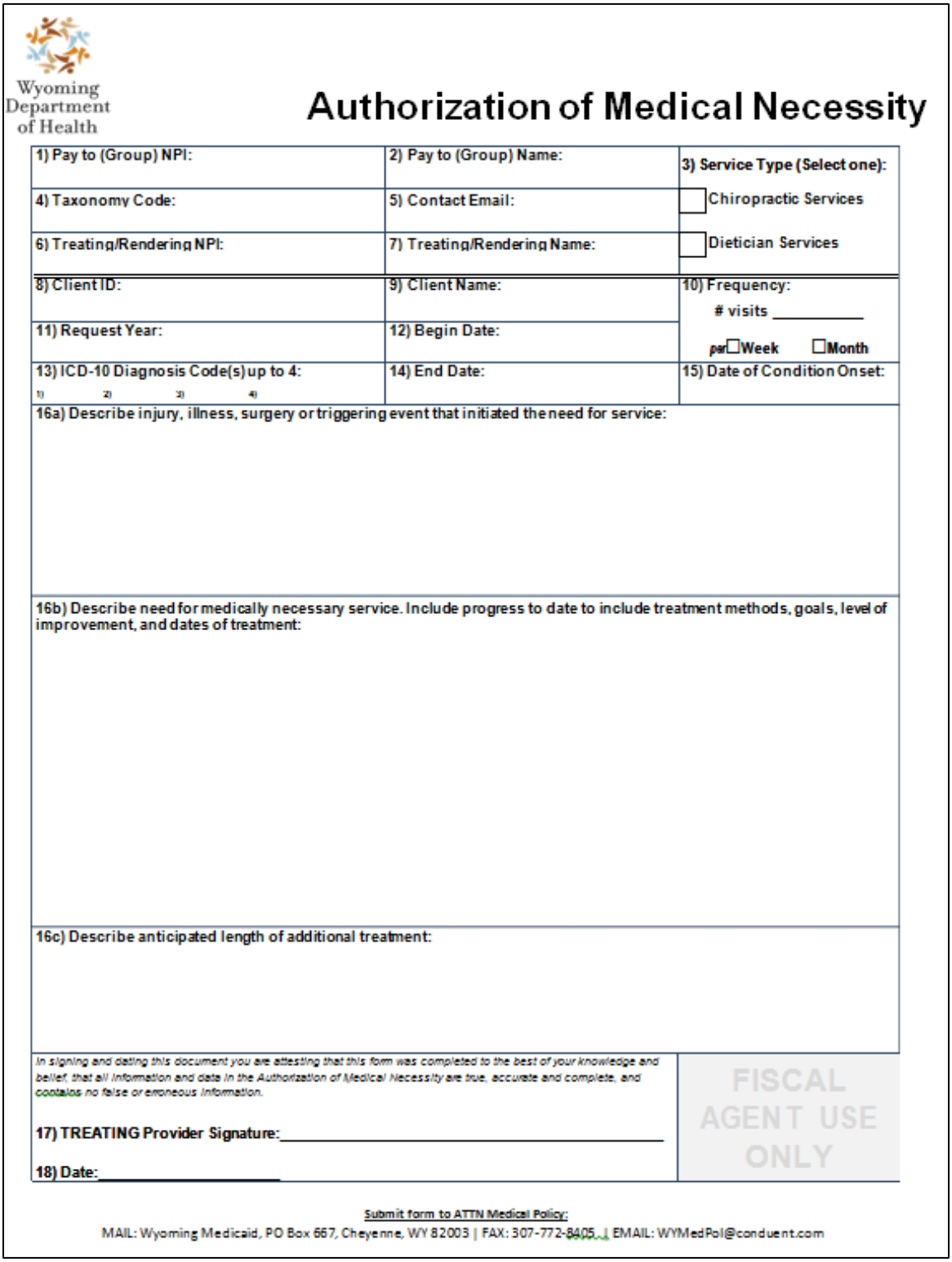
Authorizations of Medical Necessity must be submitted on the Authorization of Medical Necessity Form, below, and cite specific medical necessity. The form must be mailed to:

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

If granted, the services and length of time will be documented on the approval letter sent to the provider. For additional information, contact Medical Policy (2.1, Quick Reference).

If an Authorization of Medical Necessity request is denied, the provider may request reconsideration by supplying all originally submitted information along with additional supporting documentation to include, but not limited to, a detailed letter of explanation as to why the provider feels the denial is incorrect, additional medical records, and/or testing results. This request must be in accordance with Medicaid rules.

6.10.3.1 Authorization of Medical Necessity Request Form



Wyoming Department of Health

Authorization of Medical Necessity

1) Pay to (Group) NPI:	2) Pay to (Group) Name:	3) Service Type (Select one):
4) Taxonomy Code:	5) Contact Email:	☐ Chiropractic Services
6) Treating/Rendering NPI:	7) Treating/Rendering Name:	☐ Dietician Services
8) Client ID:	9) Client Name:	10) Frequency: # visits _____ per ☐ Week ☐ Month
11) Request Year:	12) Begin Date:	
13) ICD-10 Diagnosis Code(s) up to 4: 1) 2) 3) 4)	14) End Date:	15) Date of Condition Onset:

16a) Describe injury, illness, surgery or triggering event that initiated the need for service:

16b) Describe need for medically necessary service. Include progress to date to include treatment methods, goals, level of improvement, and dates of treatment:

16c) Describe anticipated length of additional treatment:

In signing and dating this document you are attesting that this form was completed to the best of your knowledge and belief, that all information and data in the Authorization of Medical Necessity are true, accurate and complete, and contains no false or erroneous information.

17) TREATING Provider Signature:_____

18) Date:_____

FISCAL AGENT USE ONLY

Submit form to ATTN Medical Policy:

MAIL: Wyoming Medicaid, PO Box 667, Cheyenne, WY 82003 | FAX: 307-772-8405 | EMAIL: WYMedPol@conduent.com

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

6.10.3.2 Instructions for Completing the Authorization of Medical Necessity Request Form

Box #	Field	Action
*1	Pay to (Group) NPI:	Include the 10 digit PAY TO Group NPI number. This is the provider who will bill for services.
*2	Pay to (Group) Name:	Include the PAY TO Group provider name that matches the PAY TO Group NPI.
*3	Service Type (Select one):	Select the ONE type of services that will be performed.
4	Taxonomy Code:	Enter the 10 alphanumeric taxonomy of the PAY TO Group provider.
5	Contact Email:	Enter the email of the person to contact with questions related to this request.
*6	Treating/Rendering NPI:	Include the 10 digit treating or rendering provider NPI here. This is the provider who will be completing the services indicated in this request.
*7	Treating/Rendering Name:	Enter the treating or rendering providers name that matched the treating or rendering NPI.
*8	Client ID:	Enter the 10 digit Wyoming Medicaid ID. All digits need to be included before request will be considered.
*9	Client Name:	Enter the name of the client that matches the client ID to include at least first and last name.
*10	Frequency:	Enter the number of times the services are being requested for the remaining portion on the year.
*11	Request Year:	Enter the calendar year that the services will be provided (e.g. 2019).
*12	Begin Date:	Enter the first date of services that the services will be provided above the allowed threshold amount.
*13	ICD-10 Diagnosis Code(s) up to 4:	Enter up to 4 ICD 10 diagnosis codes that relate to the reason for the request.
*14	End Date:	Enter the last date of service that the services will be requested for the client.
*15	Date of Condition Onset:	Enter the date that the condition for which the request is related began for the client. Approximations are allowed within reason.
*16a	Describe injury, illness, surgery or triggering event that initiated the need for service:	Complete with the cause of the acute condition (i.e. post-surgery, personal injury, auto accident, etc.)
*16b	Describe medically necessary rehabilitative service. Include progress to date to include treatment methods, goals, level of improvement, and dates of treatment:	A detailed explanation as to the diagnosis and need for the services. Indicate why the client has exceeded their threshold limit.
*16c	Describe anticipated length of additional treatment:	Describe the anticipated progress and length needed for the additional treatment

Box #	Field	Action
*17	Treating Provider signature:	The provider who is requesting the services must sign the form attesting to validity of request. Stamped, copied, and typed signatures will not be accepted.
*18	Signature Date:	The provider who is requesting the services must date the signature applied.

6.10.4 Office and Outpatient Hospital Visits Once Threshold is Met

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

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

Once the threshold has been reached, the process will be as follows:

- When a claim is submitted for the 13th office or outpatient hospital visit, the client will be enrolled into a care management program with our partner, WYhealth, to help manage their medical conditions and healthcare needs
- Both the client and any providers who have billed office or outpatient hospital visits for the client in that calendar year will receive a letter informing them the client has exceeded the 12 visit threshold and the client has been enrolled in the care management program
- Wyoming Medicaid will use the client's participation in the care management program to determine the medical necessity for services provided, and will continue to process additional claims for office or outpatient hospital visits according to Medicaid guidelines
- As long as the client continues to participate in the care management program, no further action is required by the provider for claims to process as normal
- Should the client choose **not** to participate in the program, the client and the provider will receive another letter informing them that office visit and outpatient hospital visit claims will need to be reviewed for medical necessity before being processed for payment
    - The review of medical necessity may include review of diagnosis codes on the claim, a call from the UM Coordinator to the provider's office, or a written request for medical records regarding the visit.
    - Providers may choose to bill the client so long as they have informed the client, in writing, prior to rendering service(s) that:
        - The service is not medically necessary, OR
        - They will not be providing medical records to help Medicaid determine the medical necessity of the visit, OR
        - They will not be billing Medicaid
- The client can begin or resume participation in the care management program at any point after meeting the threshold to reinstate claims processing without additional verification of medical necessity by the provider

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

6.10.5 Prior Authorization Once Thresholds are Met

Once the threshold has been reached, or once the provider is aware the threshold will be met and the client is nearing the threshold, a Prior Authorization may be requested for the following services (6.14, Prior Authorization):

- Physical therapy visits
- Occupational therapy visits
- Speech therapy visits
- Behavioral health visits

Requests can be made by:

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

6.11 Reimbursement Methodologies

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

- Medicaid fee schedule
- By report pricing
- Billed charges
- Encounter rate
- Invoice charges
- Negotiated rates
- Per diem
- Resource Based Relative Value Scale (RBRVS)
- Outpatient Prospective Payment System (OPPS)
- Level of Care (LOC)
- All Patients Refined Diagnosis-Related Grouping (APR DRG)

6.11.1 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 with the claim 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, 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.)

6.12 Co-Payment Schedule

<table>
<tr><th colspan="3">$3.65 Co-Payment Schedule</th></tr>
<tr><th>Procedure and Revenue Code(s)</th><th>Description</th><th>Exceptions</th></tr>
<tr><td>T1015 and 0521 Revenue Code</td><td>Rural Health Clinic encounters</td><td rowspan="3">Co-payment requirements do not apply to:

• Clients under age 21
o Medicaid eligibility for children is under 21
o Kid Care CHIP eligibility is under 19

NOTE: Co-pays Apply to KIDC Benefit Plan (Kid Care CIHP Plans B & C)

• Nursing Facility Residents
• Pregnant Women
• Family planning services
• Emergency services
• Hospice services
• Medicare Crossovers
• Inpatient Hospital stays
• Members of a Federally recognized tribe</td></tr>
<tr><td>T1015 and 0520 Revenue Code</td><td>Federally Qualified Health Center encounters</td></tr>
<tr><td>0450-0459 and 0510-0519</td><td>Outpatient hospital visits (non –emergency)</td></tr>
</table>

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

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

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

6.13 How to Bill for Newborns

When a mother is eligible for Medicaid, at the time the baby is born, the newborn is automatically eligible for Medicaid for one (1) year. However, the WDH Customer Service Center must be notified of the newborn's name, gender, date of birth, and the mom's name and Medicaid number for the newborn's Medicaid ID Card to be issued. This information can be faxed, emailed, or mailed to the WDH Customer Service Center on letterhead from the hospital where the baby was born or reported by the parent of the baby. **The provider will need to have the newborn's client ID in order to bill newborn claims.**

6.14 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.

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

Agency Name	Phone	Services Requiring PA
Division of Healthcare Financing (DHCF)	Contact case manager Case manager will contact the DHCF	• Community Choice Waiver (CCW) • Out-of-State Home Health • Out-of-State Placement for LTC Facilities • Comprehensive Developmental Disability Waivers • Support Developmental Disability Waivers
Change Healthcare	(877)207-1126	• Pharmacy
Magellan	Tel (307)549-6162 8-5pm MST M-F (855)883-8740 (after hours)	Care Management Entity services that include: • Family Care Coordination • Family Peer Support Partner

Agency Name	Phone	Services Requiring PA
	http://www.magellanofwyoming.com/	• Youth Peer Support Partner • Youth and Family Training & Support • Respite services
Medical Policy	(800)251-1268 Option 1, 1, 4, 3	• Belimuab Injections • Botox, Dysport, and Myobloc Injections • Dental Implants & fixed bridges • Hospice Services: Limited to clients residing in a nursing home • Ilaris/Cankinumab • Ocrevus/Ocrelizumab • Oral & Maxillofacial Surgeries • Pralatrexate • Reslizumab (CINQAIR) IV Infusion Treatment • Severe Malocclusion • Specialized Denture Services • Synvisc & Hylagen Injections • Tysabri IV Infusion Treatment
WYhealth (Utilization and Care Management)	(888)545-1710	• Acute Psych • Cochlear Implant – 1x/5yrs • Durable Medical Equipment (DME) • Extended Psych • Extraordinary Care • Home Health • Gastric Bypass • Genetic Testing • MedaCube • Prosthetic and Orthotic Supplies (POS) • PRTF – Psychiatric Residential Treatment Facility • PT/OT/ST/BH once threshold has been met • Surgeries (within rage 10000-99999) that requires prior authorization • Transplants • Vagus Nerve Stimulator • Vision – Lenses, Contacts, & Scleral Shells • Unlisted Codes

NOTE: Services with a threshold that not listed here require an Authorization of Medical Necessity (AOMN) to be submitted to Medical Policy (6.10.3, Authorization of Medical Necessity).

6.14.1 Requesting an Emergency Prior Authorization

In the case of a medical emergency for those services listed in the Medical Policy section of the above table, providers should contact Medical Policy by telephone. After business hours and on weekends, leave a message. Medical Policy will provide a **pending** PA number until a formal request is submitted. The formal request must be submitted within 30 days of receiving the pending PA number and must include all documentation required.

NOTE: Contact the other appropriate authorizing agencies for their pending/emergency PA procedures (6.14, Prior Authorization).

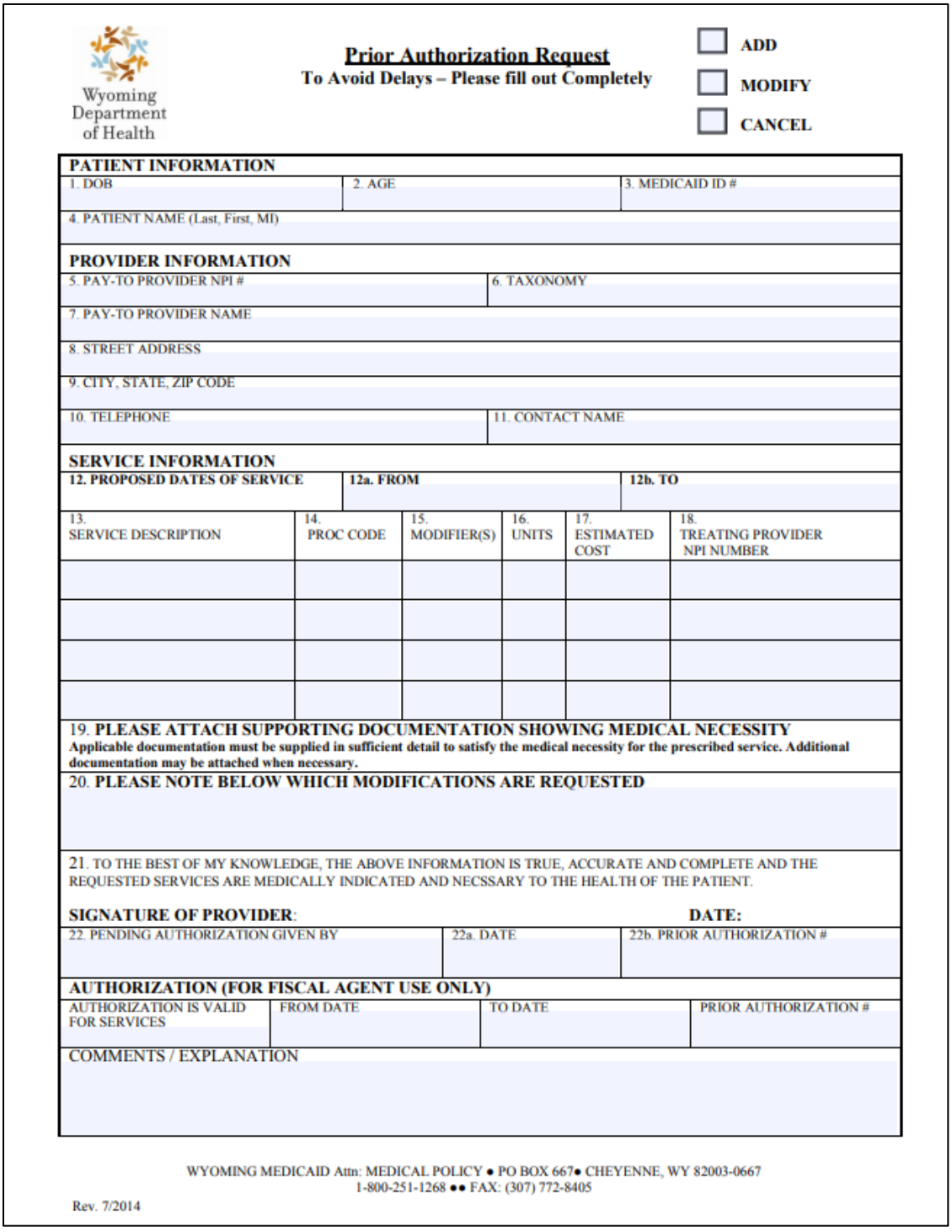
6.14.2 Requesting Prior Authorization from Medical Policy

This section only applies to providers requesting PA for those services listed in the Medical Policy section of the above table. For all other types of PA requests, contact the appropriate authorizing agencies listed above for their written PA procedures.

Providers have three (3) ways to request and receive a PA:

- Medicaid Prior Authorization Form (6.14.2.1, Medicaid Prior Authorization Form): A hardcopy form for requesting a PA by mail, email, or fax. For a copy of the form and instructions on how to complete it, refer to the following sections.
- X12N 278 Prior Authorization Request and Response. A standard electronic file format used to transmit PA requests and receive responses. For additional information, refer to Chapter 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications.
- Web-Based Entry: A web-based option for entering PA requests and receiving responses via Medicaid Secured Provider Web Portal. For direction on entering a PA request through the Secured Provider Web Portal, view the Web Portal Tutorial found on the website (2.1, Quick Reference). For additional information, refer to Chapter 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications.

6.14.2.1 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 NECSSARY 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 the image above to be taken to a printable version of this form.

6.14.2.2 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. It can be one (1) day or a date range.**
13*	**Service Description**	**Enter the service that the provider is requesting.**
14*	**Procedure Code**	**Procedure 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 usual and customary charge amount for the total of all units 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 will be billed.

6.14.3 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 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.

6.15 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. Select Browse
    6. Navigate to the location of the electronic attachment on the provider's computer
    7. Click Upload
    8. 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.

Steps for submitting paper attachments by **mail**:

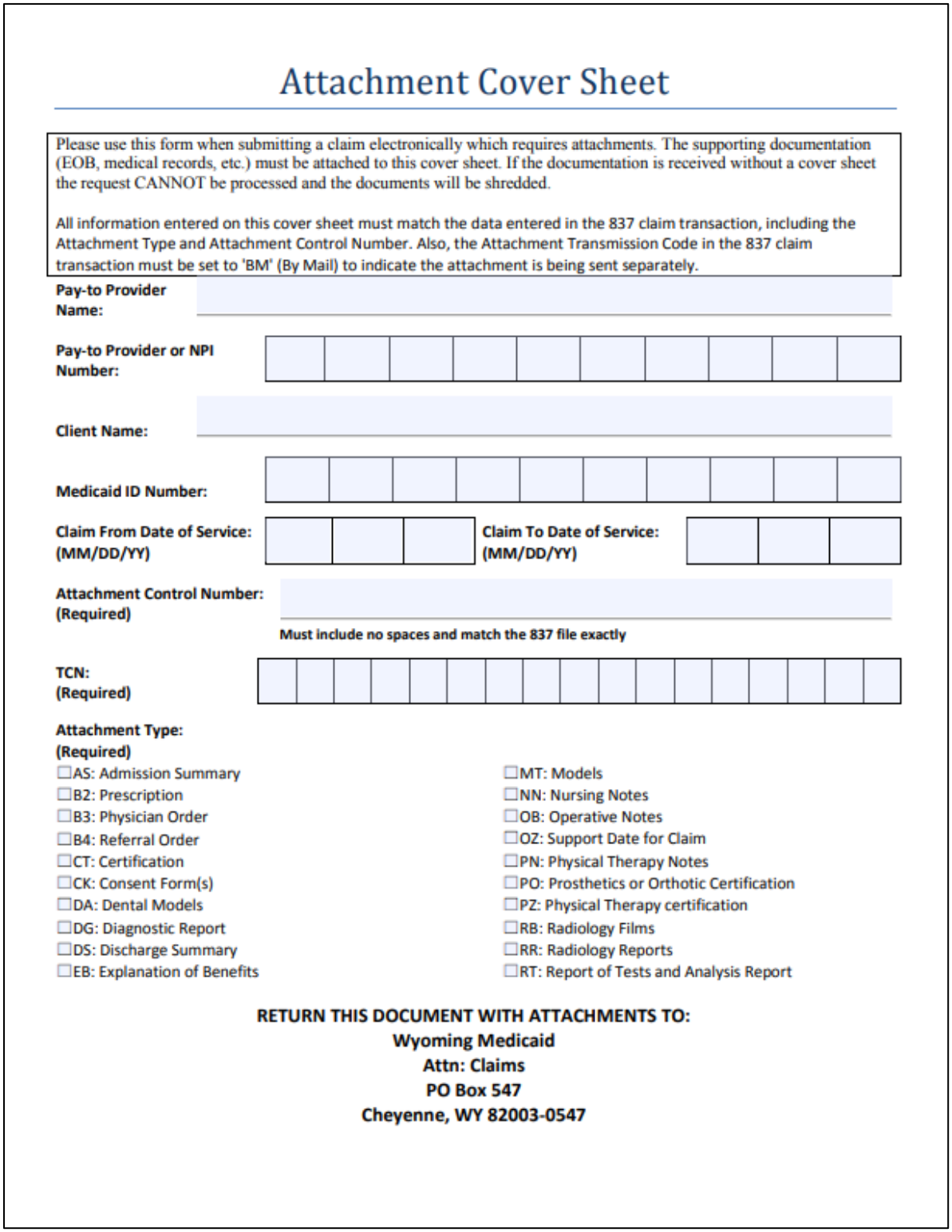
- The fiscal agent has created a process that allows providers to submit paper attachments for electronic claims. Providers need only follow these two (2) simple steps:
    1. Mark the attachment indicator on the electronic claim and indicate by mail as the submission method. For more information on 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 (6.15.1, 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 (6.15.1, Attachment Cover Sheet) and email it with the attachment to wycustomersvc@conduent.com
        - 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.

6.15.1 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 Date for Claim
- ☐ PN: Physical Therapy Notes
- ☐ PO: Prosthetics or Orthotic Certification
- ☐ PZ: Physical Therapy certification
- ☐ RB: Radiology Films
- ☐ RR: Radiology Reports
- ☐ RT: Report of Tests and Analysis Report

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.

6.16 Sterilization, Hysterectomy, and Abortion Consent Forms

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

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

6.16.1 Sterilization Consent Form and Guidelines

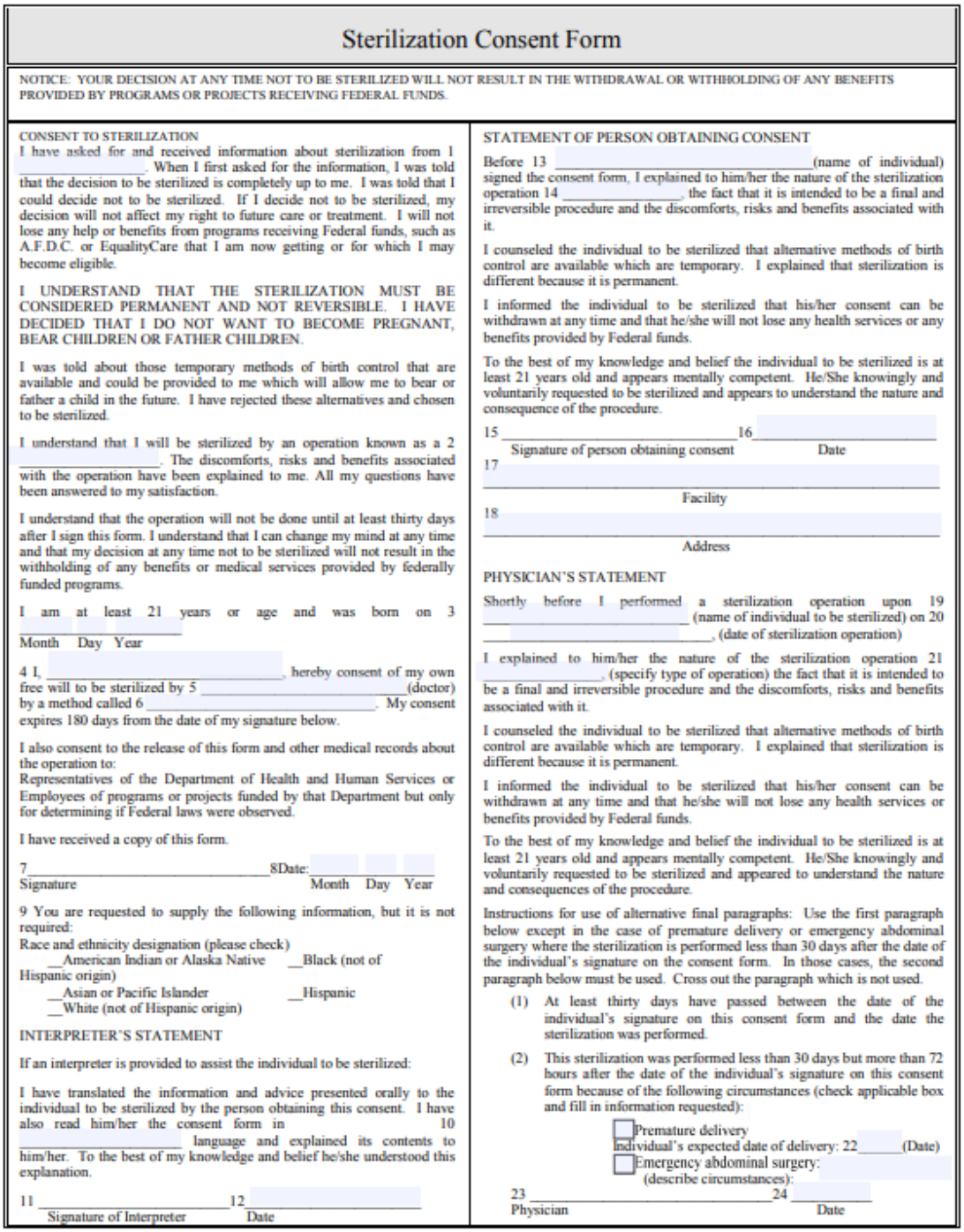
Federal regulations require that clients give written consent prior to sterilization; otherwise, Medicaid cannot reimburse for the procedure.

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

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

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

6.16.1.1 Sterilization Consent Form



Sterilization Consent Form

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

CONSENT TO STERILIZATION

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

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

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

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

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

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

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

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

I have received a copy of this form.

7_____ 8Date: ____ ____ ____
Signature Month Day Year

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

INTERPRETER'S STATEMENT

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

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

11 _____ 12 _____
Signature of Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

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

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

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

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

15 _____ 16 _____
Signature of person obtaining consent Date

17 _____
Facility

18 _____
Address

PHYSICIAN'S STATEMENT

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

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

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

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

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

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

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

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

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

23 _____ 24 _____
Physician Date

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

6.16.1.2 Instructions for Completing the Sterilization Consent Form

Important tips for completing the Sterilization Consent Form:

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

Section	Field #	Action
Consent to Sterilization	1	Enter the name of the physician or the name of the clinic from which the client received sterilization information.
	2	Enter the type of operation (no abbreviations)
	3	Enter the client's date of birth (MM/DD/YY). Client must be at least 21 years
	4	Enter the client's name
	5	Enter the name of the physician performing the surgery
	6	Enter the name of the type of operation (no abbreviations)
	7	The client to be sterilized signs here
	8	The client dates signature here
	9	Check one (1) box appropriate for client. This item is requested but NOT required.
Interpreter's Statement	10	Enter the name of the language the information was translated to
	11	Interpreter signs here
	12	Interpreter dates signature here
Statement of person obtaining consent	13	Enter clients name
Statement of person obtaining consent Physician's Statement	14	Enter the name of the operation (no abbreviations)
	15	The person obtaining consent from the client signs here
	16	The person obtaining consent from the client dates signature here
	17	The person obtaining consent from the client enters the name of the facility where the person obtaining consent is employed. The facility name must be completely spelled out (no abbreviations)
	18	The person obtaining consent from the client enters the complete address of the facility in #17 above. Address must be complete, including state and zip code
	19	Enter the client's name
Physician's Statement	20	Enter the date of sterilization operation
	21	Enter type of operation (no abbreviations)
	22	Check applicable box: • If premature delivery is checked, the provider must write in the expected date of delivery here.

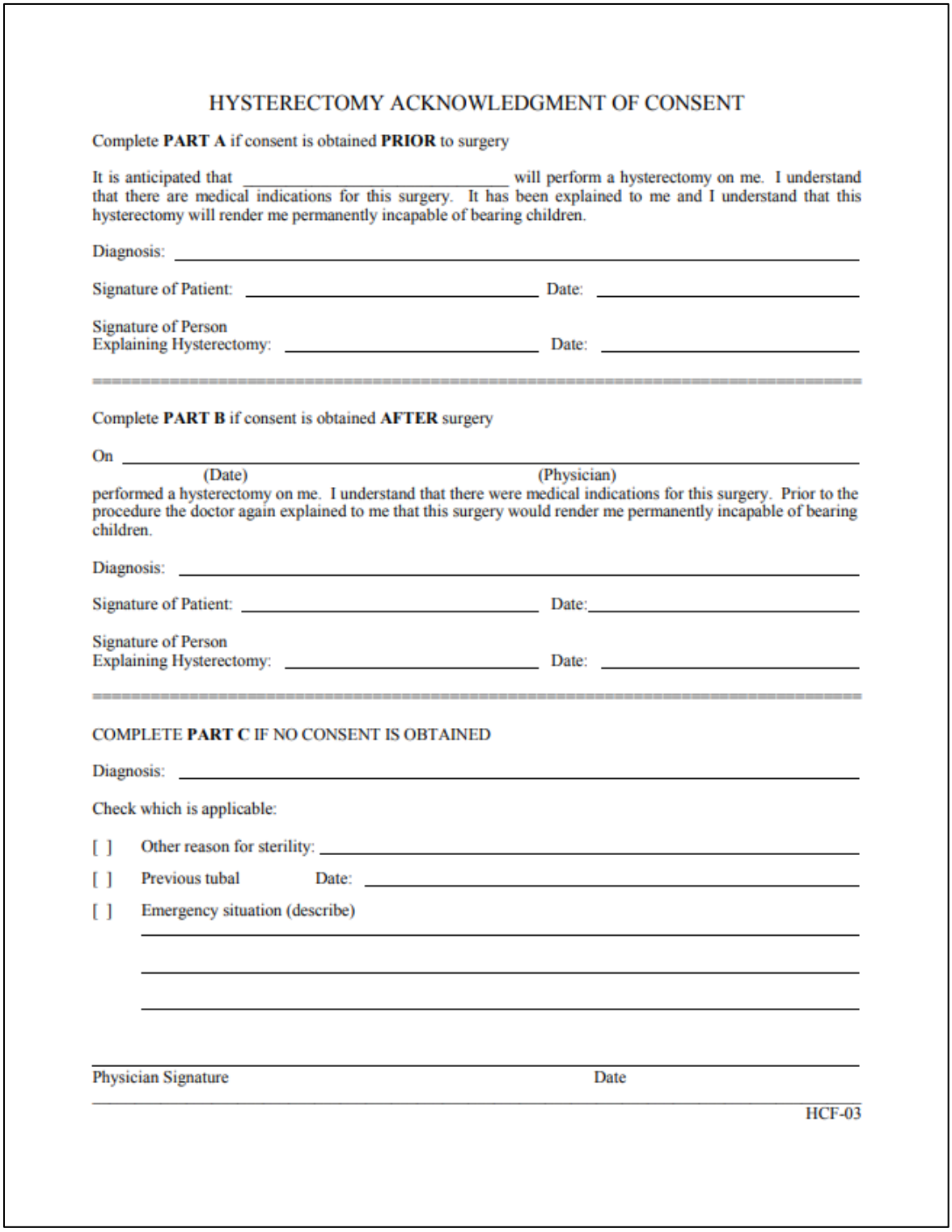
Section	Field #	Action
		• If emergency abdominal surgery is checked, describe circumstances here.
	23	• Physician performing the sterilization signs here
	24	Physician performing the sterilization dates signature here

6.16.2 Hysterectomy Acknowledgment of Consent

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

NOTE: For instructions on attaching documents to claims, refer to Section 6.15, Submitting Attachments for Electronic Claims.

6.16.2.1 Hysterectomy Acknowledgement Consent Form



HYSTERECTOMY ACKNOWLEDGMENT OF CONSENT

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

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

Diagnosis: _____

Signature of Patient: _____ Date: _____

Signature of Person
Explaining Hysterectomy: _____ Date: _____

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

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

Diagnosis: _____

Signature of Patient: _____ Date: _____

Signature of Person
Explaining Hysterectomy: _____ Date: _____

COMPLETE **PART C** IF NO CONSENT IS OBTAINED

Diagnosis: _____

Check which is applicable:

[ ] Other reason for sterility: _____

[ ] Previous tubal Date: _____

[ ] Emergency situation (describe)

_____

_____

_____

_____
Physician Signature Date

HCF-03

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

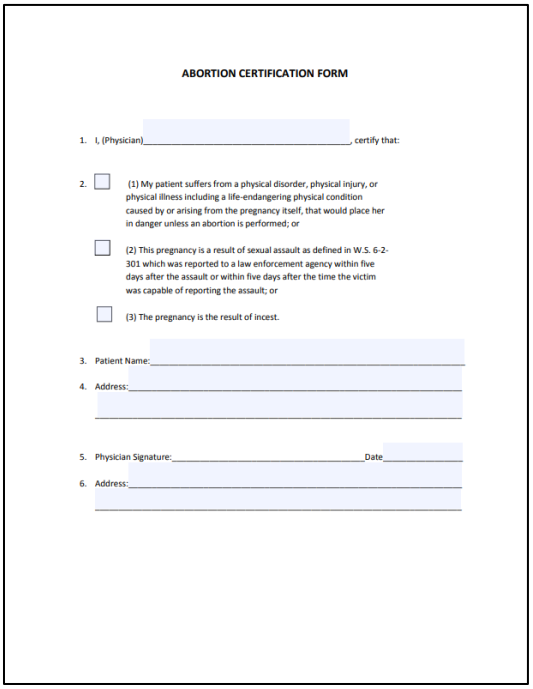
6.16.2.2 Instructions for Completing the Hysterectomy Acknowledgment of Consent Form

Section	Field #	Action
Part A	1	Enter the name of the physician performing the surgery.
	2	Enter the narrative diagnosis for the client's condition.
	3	The client receiving the surgery signs here and dates.
	4	The person explaining the surgery signs here and dates.
Part B	5	Enter the date and the physician's name that performed the hysterectomy.
	6	Enter the narrative diagnosis for the client's condition.
	7	The client receiving the surgery signs here and dates.
	8	The person explaining the surgery signs here and dates.
Part C	9	Enter the narrative diagnosis for the client's condition.
	10	Check applicable box: • If other reason for sterility is checked, the provider must write what was done. • If previous tubal is checked, the provider must enter the date of the tubal. • If emergency situation is checked, the provider must enter the description.
	11	• The physician who performed the hysterectomy signs here and dates.

6.16.3 Abortion Certification Guidelines

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

6.16.3.1 Abortion Certification Form



ABORTION CERTIFICATION FORM

1. I, (Physician)_____, certify that:

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

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

☐ (3) The pregnancy is the result of incest.

3. Patient Name:_____

4. Address:_____
_____

5. Physician Signature:_____Date_____

6. Address:_____
_____

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

6.16.3.2 Instructions for Completing the Abortion Certification Form

Field #	Action
1	Enter the name of the attending physician or surgeon
2	Check the option (1, 2, or 3) that is appropriate
3	Enter the name of the client receiving the surgery
4	Enter the client's address
5	The physician or surgeon performing the abortion will sign and date here
6	Enter the performing physician's address

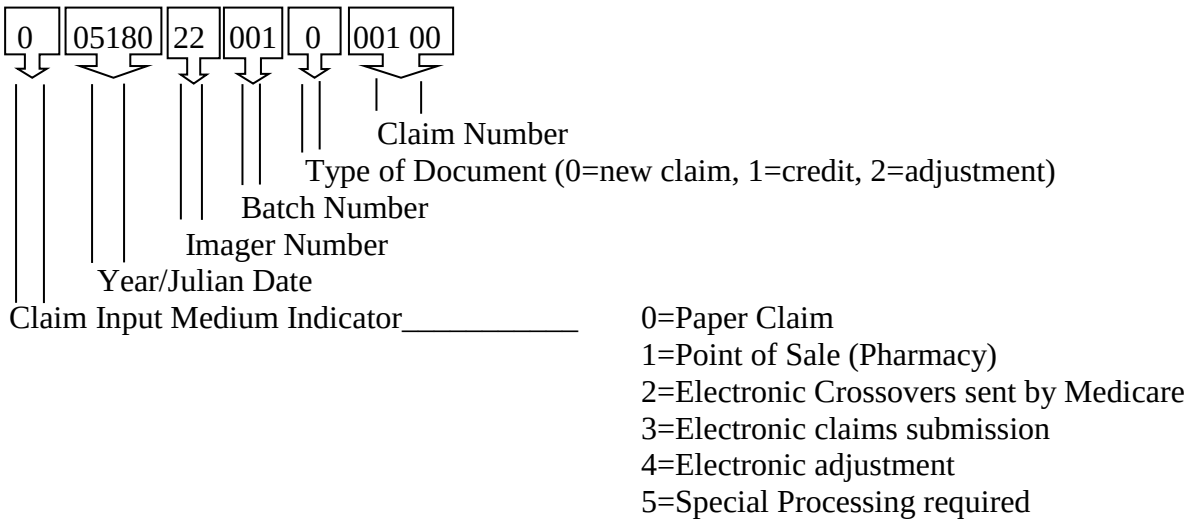
6.17 Remittance Advice

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

6.17.1 Sample Institutional Remittance Advice

```
                                        WYOMING DEPARTMENT OF HEALTH
                                      MEDICAID MANAGEMENT INFORMATION SYSTEM                    RUN DATE  00/00/00
                                        R E M I 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    OTHER    PAID BY     COPAY    WRITE            DIS
1ST-LAST DATE                PROC/MOD      REV    UNITS     AMT.       INS.    MCAID        AMT      OFF    S PLAN FEE APC FML

                 * * *  CLAIM TYPE:  OUTPATIENT                 * * *  CLAIM STATUS:  DENIED
ORIGINAL CLAIMS:

* BRADY           TOM      RECIP ID: 0000123456 PATIENT ACCT #:  00001
                3-08241-00-029-0000-08                   797.00       0.00     0.00      0.00     0.00                  HEADER
              EOB(S): 682

LI: 001 08/19/15 08/19/15                  0270     3    24.00        0.00     0.00      0.00     0.00     K DDCW M01
              LINE EOB (S): 690
LI: 002 08/19/15 08/19/15                  0272     2    54.00        0.00     0.00      0.00     0.00     K DDCW M01
              LINE EOB (S): 690
LI: 003 08/19/15 08/19/15 44310            0320     1   541.00        0.00     0.00      0.00     0.00     K DDCW MO1
              LINE EOB (S): 661
LI: 004 08/19/15 08/19/15                  0621     1    78.00        0.00     0.00      0.00     0.00     K DDCW M01
              LINE EOB (S): 690

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       4  ---------        320.00                 0.00
DENIED ADJUSTMENT CLAIMS:          NUMBER OF CLAIMS       0  ---------          0.00                 0.00
PENDED 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:

      690  SERVICE ON SAME DAY AS INPATIENT PROCEDURE CODE                                                3

            661 INPATIENT PROCEDURES AND INPATIENT SEPARATE PROCEDURES NOT PAID
```

6.17.2 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:	
	A= Anesthesia B= Billed Charge C= Percent-of-Charges D= Inpatient Per Diem Rate E= EAC Priced Plus Dispensing Fee F= Fee Schedule G= FMAC Priced Plus Dispensing Fee H= Encounter Rate I= Institutional Care Rate J= Calculated Medicaid Crossover K= Denied L= Maximum Suspend Ceiling M= Manually Priced	R= Relative Value Unit Rate S= Relative Value Unit PC T= Fee Schedule TC U= Priced by NDC V= RBRVS W= Drug Standard Rate X= Medicare Coinsurance and Deductible Y= Fee Schedule PC Z = Fee Plus Injection 1= LOC Per Diem 2= LOC Outlier Applied 3= Maximum Fee For Emergency 4= Pricing Using Procedure

FIELD NAME	HEADER DESCRIPTION	
	N= Provider Charge Rate O= Relative Value Units TC P= Prior Authorization Rate Q= DRG HCAC Pricing Reduction P= Prior Authorization Rate Q= DRG HCAC Pricing Reduction	5= APC Priced 6= APC Bundled 7= DRG Standard Rate with Outlier 8= DRG Transfer 9= DRG Transfer with Outlier
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	

6.17.3 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:

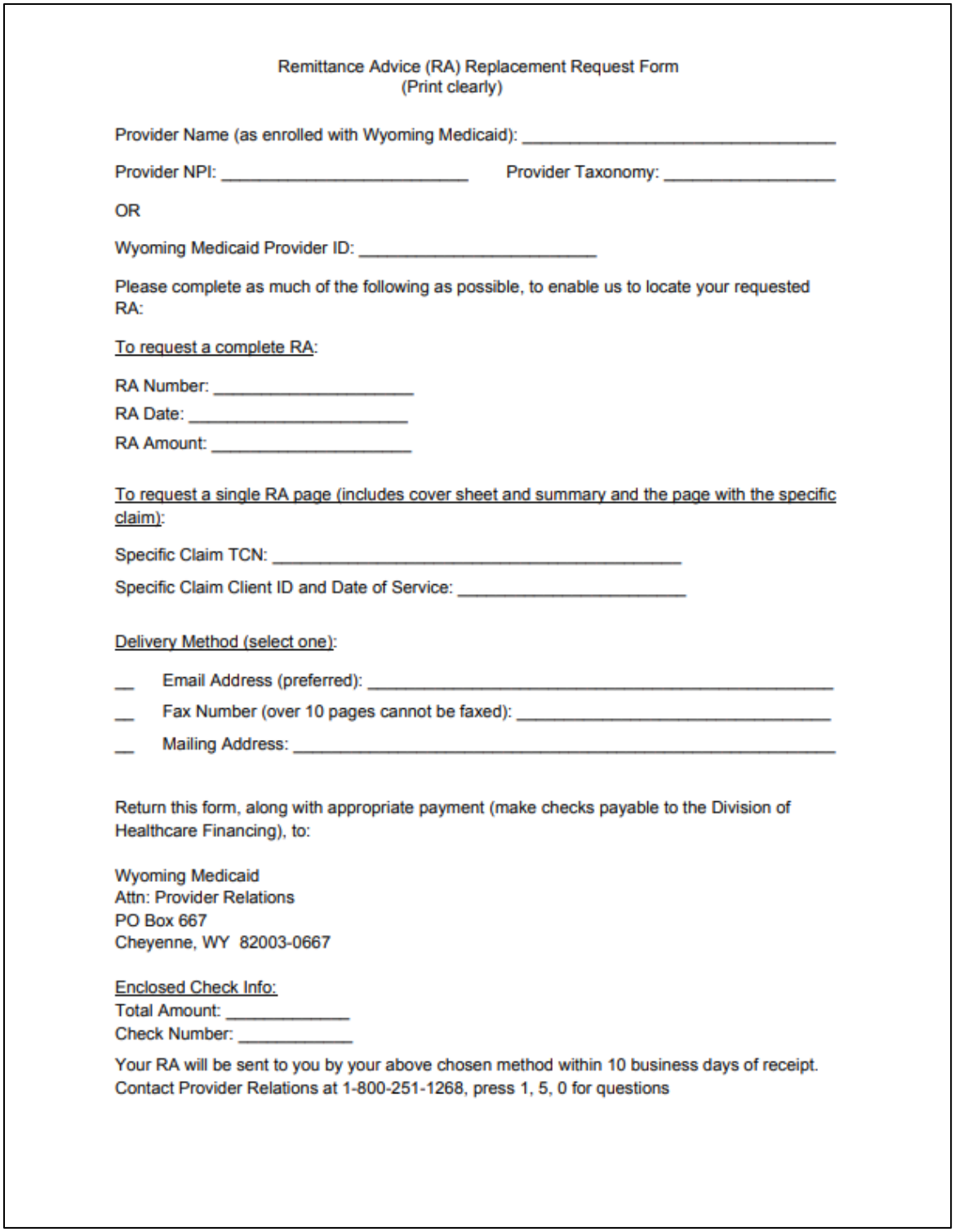
- Print the Remittance Advice (RA) replacement request form
- For replacement of a complete RA contact Provider Relations (2.1, Quick Reference) to obtain the RA number, date, and number of pages
- Replacements of a specific page of an RA (containing a requested specific claim/TCN) will be three (3) 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

6.17.3.1 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.

6.17.4 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).

6.17.5 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
- 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.

6.18 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.

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

The deadlines for resubmitting and adjusting claims are different:

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

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

6.18.2 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

6.18.2.1 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 – **Providers 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

6.18.3 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.

6.18.3.1 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: An adjustment cannot be completed when the mistake is the pay-to provider number or NPI.

6.18.3.2 When to Request a Void

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

6.18.3.3 How to Request an Adjustment or Void

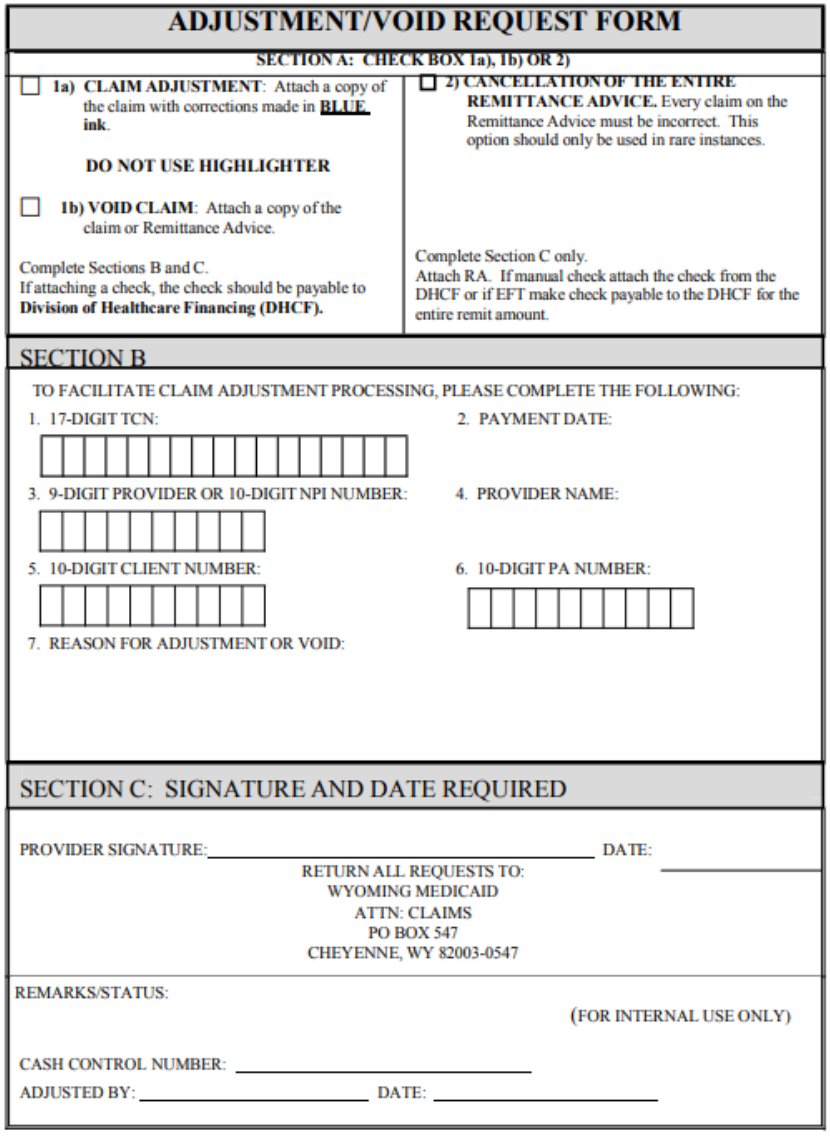
To request an adjustment or void, use the Adjustment/Void Request Form (6.18.3.1 Adjustment/Void Request Form). The requirements for adjusting/voiding a claim are as follows:

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

6.18.3.4 Adjustment/Void Request Form

Adjustment/void Request Form

EXHIBIT 6.9



ADJUSTMENT/VOID REQUEST FORM

SECTION A: CHECK BOX 1a), 1b) OR 2)

☐ **1a) CLAIM ADJUSTMENT**: Attach a copy of the claim with corrections made in **BLUE ink**.

DO NOT USE HIGHLIGHTER

☐ **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).**

☐ **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:
2. PAYMENT DATE:
3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER:
4. PROVIDER NAME:
5. 10-DIGIT CLIENT NUMBER:
6. 10-DIGIT PA NUMBER:
7. REASON FOR ADJUSTMENT OR VOID:

SECTION C: SIGNATURE AND DATE REQUIRED

PROVIDER SIGNATURE:_____ DATE: _____

RETURN ALL REQUESTS TO:
WYOMING MEDICAID
ATTN: CLAIMS
PO BOX 547
CHEYENNE, WY 82003-0547

REMARKS/STATUS:

(FOR INTERNAL USE ONLY)

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.

6.18.3.5 How to Complete the Adjustment/Void Request Form

Section	Field #	Field Name	Action
A	1a, 1b	Claim Adjustment Void Claim	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. 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.

6.18.3.6 Adjusting a claim electronically via an 837 transaction

Wyoming Medicaid accepts claim adjustments electronically, refer to Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications (9.11, 837 Institutional Claims Transactions), for complete details.

6.19 Credit Balances

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

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

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

balance to be paid. The provider is asked to attach the notice, a check, and a letter explaining that the money is to pay off a credit balance. Include the provider number to ensure the money is applied correctly.

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.

6.20 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.

6.20.1 Exceptions to the Twelve Month (365 days) Limit

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

Exceptions Beyond the Control of the Provider	
When the Situation is:	**The Time Limit is:**
Medicare Crossover	A claim must be submitted within 12 months (365 days) of the date of service **or** within 6 months (180 days) from the payment date on the Explanation of Medicare Benefits (EOMB), **whichever is later.**
Client is determined to be eligible on appeal, reconsideration, or court decision (retroactive eligibility)	Claims must be submitted within 6 months (180 days) of the date of the determination of retroactive eligibility. The 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.
Client is determined to be eligible due to agency corrective actions (retroactive eligibility)	Claims must be submitted within 6 months (180 days) of the date of the determination of retroactive eligibility. The client must provide a copy of the dated letter to the provider to document retroactive eligibility. If a claim exceeds timely filing, and the

Exceptions Beyond the Control of the Provider	
When the Situation is:	**The Time Limit is:**
	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.

6.20.2 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, that prevented the provider from finalizing the claim within 12 months (365 days) of the date of service

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

6.20.2.1 How to Appeal

The provider must submit the appeal in writing to Provider Relations (2.1, Quick Reference) and should include ALL of 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

- 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.

6.21 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 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).

6.22 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
- 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.

6.23 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.

6.24 Telehealth

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

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

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

site provider (hub site) when applicable. See below for billing and documentation requirements.

6.24.1 Covered Services

Originating Sites (Spoke Site)

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

Authorized originating sites are:

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

Distant Site Providers (Hub Site)

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

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

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

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

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

6.24.2 Non-Covered Services

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

- Group psychotherapy is not a covered service
- Medicaid will not reimburse for the use or upgrade of technology, for transmission charges, for charges of an attendant who instructs a patient on the use of the equipment or supervises/monitors a patient during the telehealth encounter, or for consultations between professionals

A visit is not considered telehealth for an originating site if the client uses their own equipment, such as personal phones or computers.

6.24.3 Documentation Requirements

- Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented, and monitored
- Providers need to develop and document evaluation processes and patient outcomes related to the telehealth program, visits, provider access, and patient satisfaction
- All service providers are required to develop and maintain written documentation in the form of progress notes the same as if they originated during an in-person visit or consultation with the exception that the mode of communication (i.e. teleconference) should be noted

- Documentation must be maintained at the Hub and Spoke locations to substantiate the services provided. Documentation must indicate that the services were rendered via telehealth and must clearly identify the location of the Hub and Spoke Sites

6.24.4 Billing Requirements

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

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

    NOTE: Providers cannot bill for Q3014 if clients used their own equipment, such as personal phones or computers.

    - Additional services provided at the originating site on the same date as the telehealth service may be billed and reimbursed separately according to published policies and the National Correct Coding Initiative (NCCI) guidelines
- For ESRD-related services, at least one (1) face-to-face, "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a qualified provider
- Care Management Entity/Children's Mental Health Waiver service providers (CME providers) are to use Place of Service code 02-Telehealth per their provider agreement with Magellan Healthcare. CME providers are NOT to use the "GT" modifier or "Q3014-Telehealth Originating Site Facility Fee" codes for virtual services.

NOTE: If the patient and/or legal guardian indicate at any point that he/she wants to stop using the technology, the service should cease immediately and an alternative appointment set up.

6.24.4.1 Billing Examples

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

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

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

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

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

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

6.24.5 Telehealth Consent

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

- Verbally
- Email
- Text Message

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

Chapter Seven – Third Party Liability

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

NOTE: When attaching an EOMB to a claim and the TPL is Medicare Replacement or Medicare Supplement, hand-write the applicable type of Medicare coverage on the EOMB (i.e. Medicare Replacement, Medicare Supplement).

Medicaid is the payer of last resort. It is a secondary payer to all other payment sources and programs and should be billed only after payment or denial has been received from such carriers.

7.1.3 Medicare

Medicare is administered by the Centers for Medicare and Medicaid Services (CMS) and is the federal health insurance program for individuals age 65 and older, certain disabled individuals, individuals with End Stage Renal Disease (ESRD) and amyotrophic lateral sclerosis (ALS). Medicare entitlement is determined by the **Social Security Administration**. Medicare is primary to Medicaid. Services covered by Medicare must be provided by a Medicare-enrolled provider and billed to Medicare first.

7.1.4 Medicare Replacement Plans

Medicare Replacement Plans are also known as Medicare Advantage Plans or Medicare Part C and are treated the same as any other Medicare claim. Many companies have Medicare replacement policies. Providers must verify whether or not a policy is a Medicare replacement policy. If the policy is a Medicare replacement policy, the claim should be entered as any other Medicare claim.

7.1.5 Medicare Supplement Plans

Medicare Supplement Plans are additional coverage to Medicare. Providers must verify whether or not a policy is a Medicare replacement or supplement policy. If the policy is a Medicare supplement policy, the supplement information should be entered as TPL on the claim. Please see section 6.6.4 for more information on submitting tertiary claims.

7.1.6 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.

7.1.7 Long-Term Care Insurance

When a long-term care (LTC) insurance policy exists, it must be treated as TPL and must be cost avoided. The provider must either collect the LTC policy money from the 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.

7.1.8 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

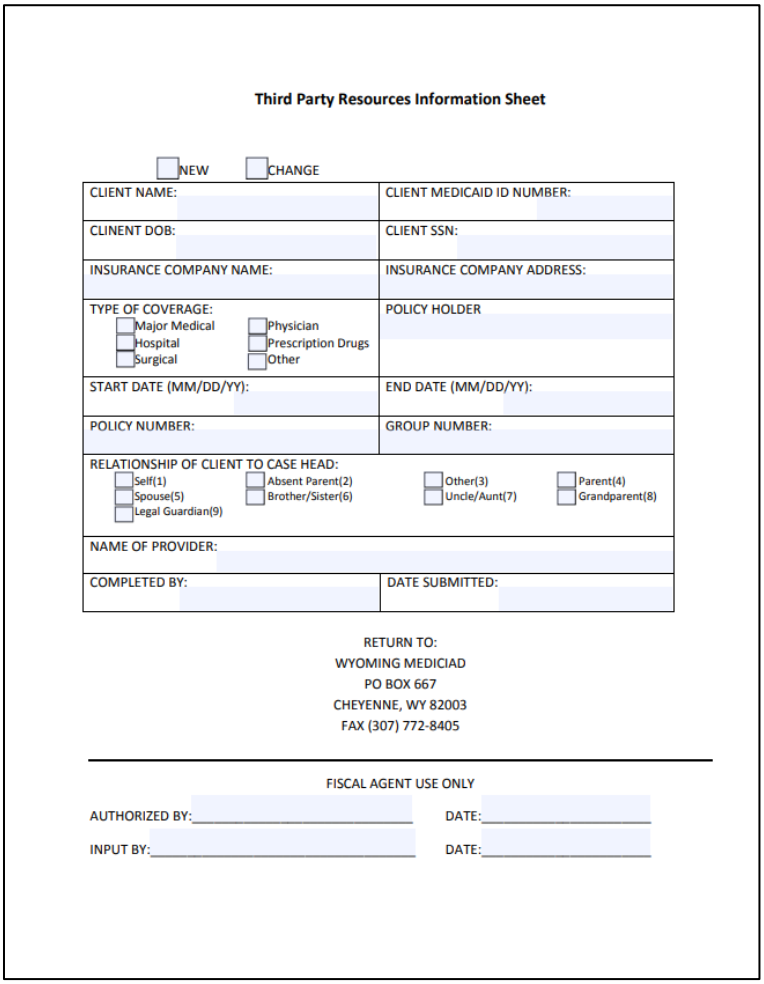
NOTE: It may be in the provider's best interest to bill the primary insurance themselves, as they may receive higher reimbursement from the primary carrier.

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

☐ NEW ☐ CHANGE

CLIENT NAME:	CLIENT MEDICAID ID NUMBER:
CLINENT DOB:	CLIENT SSN:
INSURANCE COMPANY NAME:	INSURANCE COMPANY ADDRESS:
TYPE OF COVERAGE: ☐ Major Medical ☐ Physician ☐ Hospital ☐ Prescription Drugs ☐ Surgical ☐ Other	POLICY HOLDER
START DATE (MM/DD/YY):	END DATE (MM/DD/YY):
POLICY NUMBER:	GROUP NUMBER:
RELATIONSHIP OF CLIENT TO CASE HEAD: ☐ Self(1) ☐ Absent Parent(2) ☐ Other(3) ☐ Parent(4) ☐ Spouse(5) ☐ Brother/Sister(6) ☐ Uncle/Aunt(7) ☐ Grandparent(8) ☐ Legal Guardian(9)	
NAME OF PROVIDER:	
COMPLETED BY:	DATE SUBMITTED:

RETURN TO:
WYOMING MEDICIAD
PO BOX 667
CHEYENNE, WY 82003
FAX (307) 772-8405

FISCAL AGENT USE ONLY

AUTHORIZED BY:_____ DATE:_____

INPUT BY:_____ DATE:_____

NOTE: Click the 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 they are willing to admit into their practice. The provider may not discriminate in establishing a limit. If a provider chooses to opt-out of participation with a health insurance or governmental insurance, Medicaid will not pay for services covered by, but not billed to, the health insurance or governmental insurance.

7.2.3 Medicare Opt-Out

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

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

7.3 Billing Requirements

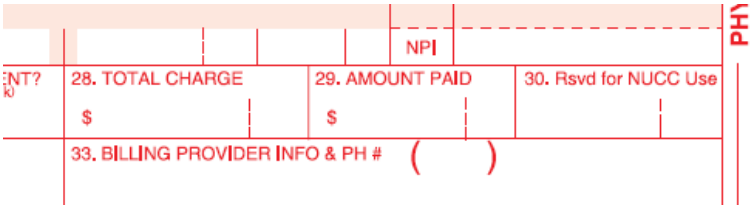
Providers should bill TPL/Medicare and receive payment to the fullest extent possible before billing Medicaid. The provider must follow the rules of the primary insurance plan (such as obtaining prior authorization, obtaining medical necessity, obtaining a referral or staying in-network) or the related 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 their other insurance plan.

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

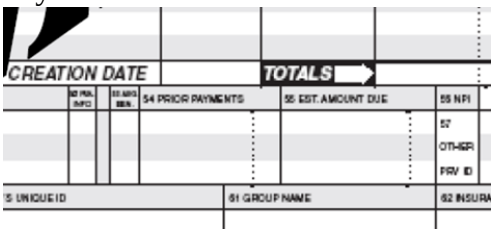
NOTE: If a procedure code requires a Prior Authorization (PA) for Medicaid payment, but a PA is not required by TPL/Medicare, it is still **highly** recommended to obtain a PA through Medicaid in case TPL/Medicare denies services.

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.

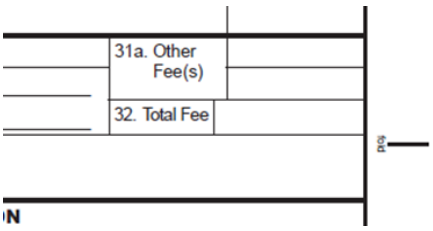
- If payment is less than Medicaid's allowed amount for the same claim, indicate the payment in the appropriate field on the claim form.
  - CMS-1500 – TPL paid amount will be indicated in box 29 Amount Paid:



  - 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:



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



- 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 (6.20 Timely Filing).

- If a denial is obtained from the third party payer/Medicare that a service is not covered, attach the denial to the claim (6.15, 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 the 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 the TPL Unit (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.

NOTE: When attaching an EOMB to a claim and the TPL is Medicare Replacement or Medicare Supplement, hand-write the applicable type of Medicare coverage on the EOMB (i.e. Medicare Replacement, Medicare Supplement).

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

Wyoming Department of Health

[Date]

Wyoming Medicaid,

This letter is to request the submission of the attached claim for payment. As of this date, we have made two attempts within ninety days of service to gain payment for the services rendered from the primary insurance with no resolution. We are now requesting payment in full from Medicaid. Please find all relevant and required documentation attached.

Thank you.

Sincerely,

Authorized Representative of _____ [Billing Facility]

Name of Insurance Company billed: _____

Date billing attempts made: _____

Policyholder's name: _____

Policyholder's policy number: _____

Comments: _____

Wyoming Medicaid
Attn: Claims
PO Box 527
Cheyenne, WY 82003-0527

NOTE: Do not submit this form for Medicare or automobile/casualty insurance. Click the 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.

7.4 Medicare Pricing

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

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

NOTE: FQHC (pay-to taxonomy 261QF0400X) and RHC (pay-to taxonomy 261QR1300X) will price solely based on Medicare Coinsurance and/or Deductible amounts.

7.4.1 Medicaid Covered Services

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

Example:

- Procedure Code 99239
    - Medicaid Allowable - $97.67
    - Medicare Paid - $83.13

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

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

7.4.2 Medicaid Non-Covered Services

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

Example:

- Procedure Code: E0784 – (Not covered as a rental – no allowed amount has been established for Medicaid)
  - Medicaid Allowable – Not assigned
  - Medicare Allowable - $311.58
  - Medicare Paid – $102.45
  - Assigned Coinsurance and Deductible - $209.13
    - First payment method option: [(Medicare Allowable 311.58 ÷ 2)] – $102.45 Medicare paid amount = $155.79 (Calculated Medicaid allowable) – (Medicare Paid Amount) $102.45 = $53.34
    - Second payment method option: Coinsurance and deductible = $209.13
  - Medicaid will pay the lesser of the Medicaid payment methodology or the coinsurance and deductible
    - This procedure code would pay $53.34 since it is less than $209.13

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

7.4.3 Coinsurance and Deductible

For clients on the QMB plan, CMS guidelines indicate that coinsurance and deductible amounts remaining after Medicare pays cannot be billed to the client under any circumstances, regardless of whether the provider billed Medicaid or not.

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

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

Chapter Eight – Electronic Data Interchange (EDI)

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 and downloading batch transactions.	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 downloading	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

EDI Options				
Method	**Requirements**	**Access Cost**	**Transactions Supported**	**Contact Information**
	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 277CAImplementation 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 the Web Portal, 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 the Web Portal?

- Submit claims
- Upload claim attachments (6.15, 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 (6.14, Prior Authorization)
- Perform LT101 Inquires
- Enter PASRR
- The Office Administrator can 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.

To activate the changes the provider will need to log out and log back in.

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**
Entire website (Provider/Client) Static web pages • https://wymedicaid.portal.conduent.com	Website not available	Regular scheduled maintenance	• 4 a.m. – 4:30 a.m. MST Saturdays • 3 p.m. – 6 p.m. MST Sundays
Secured Provider Web Portal • https://wymedicaid.portal.conduent.com/provider_home.html	Verification of claims submission will not be available	Regular scheduled maintenance	• 10 p.m. – 12 a.m. (midnight) Sundays

Chapter Nine – Wyoming HIPAA 5010 Electronic Specifications

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:

SUBMITTER	HOST
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. Providers 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.

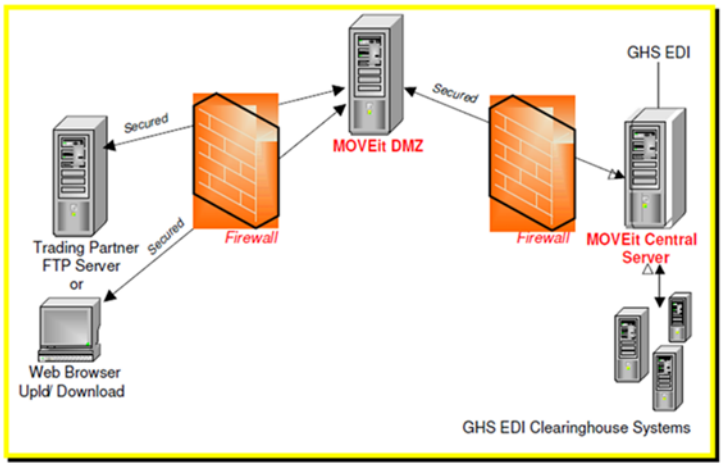
Transaction files can be uploaded and downloaded through the Secured Provider Web Portal at https://wymedicaid.portal.conduent.com.

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 and 8.4, Sending and Receiving Transactions). 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 or Client.

9.6.4 270 Eligibility Request

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

9.6.5 271 Eligibility Response

There are 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

There are 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 Medicaid 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

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
				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.
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

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
				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.
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

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
				and the Wyoming Medicaid Provider ID in REF02.
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.

Chapter Ten – Important Information

10.1 Claims Review

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

10.2 Coding

Standard use of medical coding conventions is required when billing Medicaid. 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 CPT-4, HCPCS Level II, and ICD-9-CM/ICD-10 coding books
- For claims that have dates of service spanning across the ICD-10 implementation date (10/1/15):
    - Outpatient claims – use diagnosis codes based on the FIRST (1st) date of service
    - Inpatient claims – use diagnosis codes based on the LAST date of service
- Use the current version of the NUBC Official UB Data Specifications Manual
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend coding classes offered by certified coding specialists
- Use the correct unit of measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II coding books. One (1) unit may equal "one (1) visit" or "15 minutes." Always check the long version of the code description.
- Effective April 1, 2011, the National Correct Coding Initiative (NCCI) methodologies were incorporated into Medicaid's claim processing system in order to comply with Federal legislation. The methodologies apply to both CPT Level I and HCPCS Level II codes.
    - Coding denials cannot be billed to the patient but can be reconsidered per Wyoming Medicaid Rules, Chapter 16. Send a written letter of

reconsideration to Wyoming Medicaid, Medical Policy (2.1, Quick Reference).

10.3 Importance of Fee Schedules and Provider's Responsibility

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

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

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

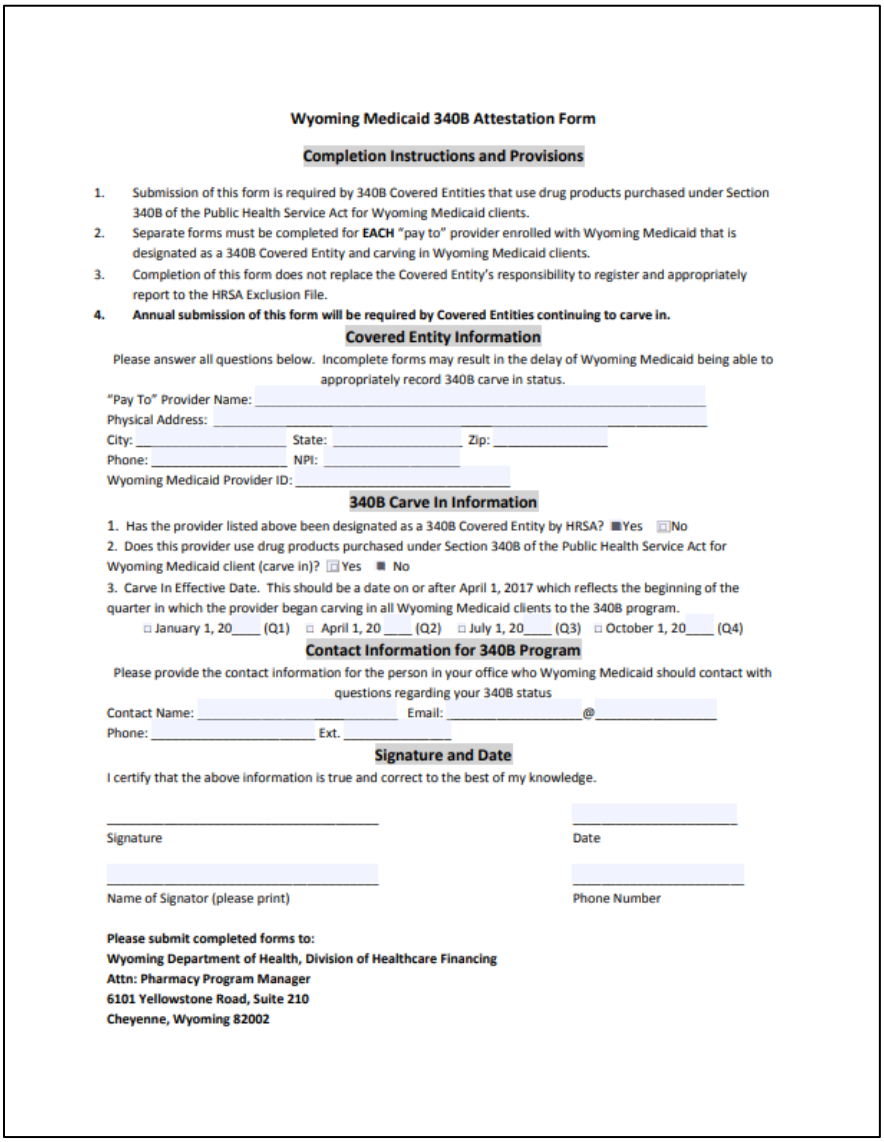
10.4 Interpretation Services

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

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

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

10.5 340B Attestation



Wyoming Medicaid 340B Attestation Form

Completion Instructions and Provisions

1. Submission of this form is required by 340B Covered Entities that use drug products purchased under Section 340B of the Public Health Service Act for Wyoming Medicaid clients.
2. Separate forms must be completed for **EACH** "pay to" provider enrolled with Wyoming Medicaid that is designated as a 340B Covered Entity and carving in Wyoming Medicaid clients.
3. Completion of this form does not replace the Covered Entity's responsibility to register and appropriately report to the HRSA Exclusion File.
4. **Annual submission of this form will be required by Covered Entities continuing to carve in.**

Covered Entity Information

Please answer all questions below. Incomplete forms may result in the delay of Wyoming Medicaid being able to appropriately record 340B carve in status.

"Pay To" Provider Name: _____
Physical Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ NPI: _____
Wyoming Medicaid Provider ID: _____

340B Carve In Information

1. Has the provider listed above been designated as a 340B Covered Entity by HRSA? ■Yes □No
2. Does this provider use drug products purchased under Section 340B of the Public Health Service Act for Wyoming Medicaid client (carve in)? □Yes ■ No
3. Carve In Effective Date. This should be a date on or after April 1, 2017 which reflects the beginning of the quarter in which the provider began carving in all Wyoming Medicaid clients to the 340B program.

□ January 1, 20____ (Q1) □ April 1, 20____ (Q2) □ July 1, 20____ (Q3) □ October 1, 20____ (Q4)

Contact Information for 340B Program

Please provide the contact information for the person in your office who Wyoming Medicaid should contact with questions regarding your 340B status

Contact Name: _____ Email: _____@_____
Phone: _____ Ext. _____

Signature and Date

I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Signature Date

_____ _____
Name of Signator (please print) Phone Number

Please submit completed forms to:
Wyoming Department of Health, Division of Healthcare Financing
Attn: Pharmacy Program Manager
6101 Yellowstone Road, Suite 210
Cheyenne, Wyoming 82002

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

Chapter Eleven – Outpatient Services

11.1 General Coverage Principle and Definitions

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

11.1.1 Ambulatory Surgical Center (ASC)

Appropriate Bill Type: **83X**

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

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

11.1.1.1 Covered Services

Facility services include items and services furnished by an ASC in connection with a procedure normally covered on an outpatient basis in a hospital. Covered surgical procedures can only be rendered by a licensed ASC (11.11, Sterilization and Hysterectomies; 11.12, Surgical Services). No inpatient services are allowed to be performed at an ASC. ASC facility services may include, but are not limited to the following:

- Nursing, technical, and other related services involved in client care
- Use of surgical facility, including operating and recovery room, client preparation area, waiting room, and other facility areas used by the client
- Drugs, medical equipment, oxygen, surgical dressings, and other supplies directly related to the surgical procedure
- Splints, casts, and equipment directly related to the surgical procedures
- Administrative, record keeping, and housekeeping items and services
- Anesthesia materials
- Diagnostic procedures directly related to the surgical procedure, including those procedures performed before the surgery
- Blood and blood products
- Dental services performed at an ASC must be billed using procedure code 41899 (unlisted procedure, dentoalveolar structures; i.e. removal of teeth). This procedure will pay at a cost to charge ratio (CCR) of .3742.

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

11.1.2 Critical Access Hospital (CAH)

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

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

A hospital that meets ALL of the following CMS criteria:

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

11.1.3 General Acute Care Hospital

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

11.1.4 Outpatient Services

Outpatient services are preventative, diagnostic, therapeutic, rehabilitative, or palliative services or items that are medically necessary. These services are furnished by a general or critical access hospital enrolled in the Medicaid program under the direction of a physician, dentist, or other appropriate practitioner. Services provided in the emergency room of the hospital are defined as outpatient services.

- Medically necessary outpatient hospital services are covered pursuant to written orders by a physician, staff under the supervision of a physician, a dentist, or other appropriate practitioner
- Services are considered outpatient services when the treatment is expected to keep the patient less than 24 hours. This is regardless of the hour of admission, whether or not a bed is used, and whether or not the patient remained in the hospital past midnight.
- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes. For inpatient information see Chapter 12, Critical Access Hospital and General Hospital Inpatient.

- When a patient receives outpatient services from a different facility each facility bills as appropriate. Services that were rendered as outpatient are billed as outpatient by that facility and the inpatient services are billed as inpatient by that facility.

11.1.4.1 Reimbursement

The three (3) categories of outpatient services listed above (Ambulatory Surgical Centers, Critical Access Hospitals and General Hospitals) are based off of OPPS – a Medicare based outpatient hospital reimbursement methodology which is used by Wyoming Medicaid to reimburse for outpatient services (11.16, OPPS Reimbursement, Billing Tips, and Guidelines).

11.2 Abortion

11.2.1 Covered Services

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

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

11.2.2 Billing Requirements

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

- In cases of sexual assault, submission of medical records is not required prior to payment. However documentation of the circumstances of the case must be maintained in the client's medical records.
- Other abortion related procedures, including spontaneous, missed, incomplete, septic, and hydatiform mole do not require the certification form. However, all

abortion related procedure codes are subject to audit, and all pertinent records must substantiate the medical necessity and be available for review.

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

11.3 Ambulance Services

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

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

Ambulance Services must be billed using the CMS-1500 claim form and must follow the policy defined for those programs. Refer to CMS-1500 Provider Manual.

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

11.4 Diabetic Training

Revenue Code: **0942**

Procedure Code Range: **G0108-G0109**

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

11.4.1 Covered Services

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

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

11.4.2 Documentation Requirements

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

11.5 Durable Medical Equipment (DME)

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

11.6 Emergency Department Services

Revenue Code Range: **0450–0459**

Procedure Code Range: **99281–99285**

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

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

The facility must be available 24 hours a day.

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

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

If more than one (1) visit to an emergency room or clinic takes place on the same date of service, the second or subsequent visits to the emergency room must be for medically necessary services. Any same-day subsequent visits to the ER must have medical documentation, of all visits, attached to the claim to receive reimbursement.

- All services provided to the Medicaid client by the hospital on the same day must be billed on a single claim (11.16, OPPS Reimbursement, Billing Tips, and Guidelines)

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

11.6.1 Covered Services

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

NOTE: Clients who regularly present themselves to an outpatient department of a hospital for primary non-emergency services should be reported to the Program Integrity Manager at the Division of Health Care Financing (2.1, Quick Reference).

11.6.2 Billing Requirements

- If a significant surgery is performed in the emergency room, enter a HCPCS surgery code on the claim. Otherwise, a CPT Evaluation/Management code can be reported.
- A co-payment of $3.65 is also required for non-emergency visits to the emergency room. This amount will be automatically deducted from the emergency room payment (6.12, Co-Payment Schedule).
    - Determination of a claim's status of emergent/non-emergent is determined based on the Type of Admission/Visit Code (6.12, Co-Payment Schedule).
- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes (Chapter 12, Critical Access Hospital and General Hospital Inpatient).
- When a patient receives outpatient services from a different hospital each facility bills as appropriate. Services that were rendered as outpatient are billed as outpatient by that facility and the inpatient services are billed as inpatient by that facility.
- Physician services are billed and paid separately via CMS-1500/837P.

11.6.3 Limitations

- The 12 visits per calendar year threshold for clients age 21 and older will apply to non-emergency visits to the emergency room. See 6.10.4 Office and Outpatient Hospital Visits Once Threshold is Met for more information.
    - Determination of a claim's status of emergent/non-emergent is determined based on the Type of Admission/Visit Code (6.12, Co-Payment Schedule).
- Ancillary charges will be paid. Providers can resubmit claims, with medical necessity supplied, or clients can be billed for denied visits that are not medically necessary (6.10 Service Thresholds).

11.7 Laboratory Services

Revenue Code Range: **030X–031X**

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

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

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

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

Modifier L1 – unrelated lab update

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

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

Modifier L1 has not been deleted because there may still be circumstances when it is appropriate to append the modifier. CMS did not change any of the criteria for applying the modifier, so all rules are still in place. **But if the claim is for laboratory services only, status indicator Q4 erases the necessity of appending the modifier.**

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

11.7.1 CLIA Requirements

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

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

CLIA CERTIFICATE TYPE	ALLOWED TO BILL						
REGRISTRATION, COMPLIANCE, OR ACCREDITATION (LABORATORY) (1)	G0103	G0123	G0124	G0141	G0143	G0144	G0145
	G0147	G0148	G0306	G0307	G0328	17311	17312
	17313	17314	17315	78110	78111	78120	78121
	78122	78130	78191	78270	78271	78272	
	0001U-0083U						
	80000-89999 (UNLESS OTHERWISE SPECIFIED ELSEWHERE IN THIS TABLE)						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE LABORATORY (CLIA TYPE 1) SECTION AND ALL CODES FOR PPMP (CLIA TYPE 4) SECTION AND WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
PROVIDER-PERFORMED MICROSCOPY PROCEDURES (PPMP) (4)	81000	81001	81015	81020	89055	89190	G0027
	Q0111	Q0112	Q0113	Q0114	Q0115		
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE PPMP (CLIA TYPE 4) SECTION AND ALL CODES FOR WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
WAIVER (2)	80305	81002	81025	82044 QW	82150 QW	82270	82272
	82274 QW	82962	83026	83036 QW	84830	85013	85025 QW
	85651	86618 QW	86780 QW	87502 QW	87631 QW	87633 QW	87634 QW
	87651 QW						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE WAIVER (CLIA TYPE 2) SECTION AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
NO CERTIFICATION	PROVIDERS WITHOUT A CLIA MAY BILL ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (SEE BELOW)						

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

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

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

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

11.7.2 Genetic Testing

Revenue Code Range: **030X-031X**

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

Prior Authorization is required for all genetic testing codes (6.14, Prior Authorization). Prior Authorization documentation must include the following:

11.7.2.1 Covered Services

Medicaid covers genetic testing under all of the following conditions:

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

- **Codes 81420, 81507** - Mother must be documented as high-risk to include ANY of the following:

- advanced maternal age >35 (at EDC),
- previous "birth" of embryo/fetus/child with aneuploidy,
- parent with known balanced translocation,
- screen positive on standard genetic screening test (FTCS, multiple marker screen of one type or another, etc),
- ultrasound finding on embryo/fetus consistent with increased risk of aneuploidy

- **Code 81519** - All of the following conditions must be met and documented in the prior authorization request:
  - The test will be performed within 6 months of the diagnosis
  - Node negative (micrometastases less than 2mm in size are considered node negative)
  - Hormone receptor positive (ER-positive or PR-positive)
  - Tumor size 0.6-1.0 cm with moderate/poor differentiation or unfavorable features (ie, angiolymphatic invasion, high nuclear grade, high histologic grade) OR tumor size >1 cm
  - Unilateral disease
  - Her-2 negative
  - Patient will be treated with adjuvant endocrine therapy
  - The test result will help the patient make decisions about chemotherapy when chemotherapy is a therapeutic option

- **Code 81599** - All of the following conditions must be met and documented in the prior authorization request:
  - Patient must be post-menopausal
  - Pathology reveals invasive carcinoma of the breast that is estrogen receptive (ER) positive, Her2-negative
  - Lymph node-negative or has 1-3 positive lymph nodes
  - Patient has no evidence of distant metastasis
  - Test result will be used to determine treatment choice between endocrine therapy alone, vs. endocrine therapy plus chemotherapy

NOTE: The test should not be ordered if the physician does not intend to act upon the test result.

11.7.2.2 BRCA Testing and Counseling

The U.S. Preventive Services Task Force (USPSTF) recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for evaluation for BRCA testing (81211-81217 and 81162-81167). Medicaid covers BRCA testing when the following criteria are met:

- Personal and/or family history of breast cancer, especially if associated with young age of onset, OR

- Multiple tumors, OR
- Triple-negative (i.e., estrogen receptor, progesterone receptor, and human epidermal growth factor receptor 2-negative) or medullary histology, OR
- History of ovarian cancer, AND
- 18 years or older

11.8 Obstetrical Ultrasounds

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

Procedure Code Range: **76801–76828**

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

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

NOTE: Maintain all records and/or other documentation that substantiates medical necessity for OB ultrasound services performed for Medicaid clients as documentation may be requested for post-payment review purposes.

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

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

11.9 Preventative Medicine – Clients Over 21 Years of Age

11.9.1 Covered Services

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

11.10 Radiology Services

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

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

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

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

11.10.1 Billing Requirements

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

11.10.2 Limitations

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

11.11 Sterilization and Hysterectomies

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

11.11.1 Elective Sterilization

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

- Clients must complete and sign the Sterilization Consent Form at least 30 days, but not more than 180 days, prior to the sterilization procedure. There are no exceptions to the 180 day limitation of the effective time period of the informed consent agreement (e.g., retroactive eligibility). This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly completed, payment will be denied. A complete Sterilization Consent Form must be obtained from the primary physician for all related services (6.16.1.1, Sterilization Consent Form).

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

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

Before performing sterilizations, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to their satisfaction
- The client must be informed of their right to withdraw or withhold consent any time before the sterilization without being subject to retribution or loss of benefits
- The client must understand the sterilization procedure being considered is irreversible
- The client must be made aware of the discomforts and risks, which may accompany the sterilization procedure being considered
- The client must be informed of the benefits associated with the sterilization procedure

- The client must know that they must have at least 30 days to reconsider their decision to be sterilized
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the client has been informed (10.4, Interpretation Services)

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

- If the client is in labor or childbirth
- If the client is seeking or obtaining an abortion
- If the client is under the influence of alcohol or other substances which may affect his/her awareness

11.11.2 Hysterectomies

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

- A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one (1) section (A, B or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client must sign and date Section A of this form (refer to 42 CFR 441.250 for the Federal policy on hysterectomies and sterilizations). The client does not need to sign this form when Sections B or C apply. If this form is not properly completed, payment will be denied (6.16.2.1, Hysterectomy Acknowledgement of Consent Form).
    - If the surgery does not render the client sterile, operative notes can be submitted in place of the form indicating reason for non-sterility
- For clients that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one (1) of the following:
    - The client was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility

11.12 Surgical Services

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

Procedure Code Range: **10000-69999**

Medicaid only covers surgical procedures that are medically necessary. In general, surgical procedures are covered if the condition directly threatens the life of a client,

results from trauma demanding immediate treatment, or had the potential for causing irreparable physical damage, the loss or serious impairment of a bodily function, or impairment of normal physical growth and development.

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

11.12.1 Billing Requirements

Bilateral Procedures and Multiple procedures on the same date of service are handled and priced by the IOCE (11.16, OPPS Reimbursement, Billing Tips, and Guidelines).

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

11.12.2 Limitations

- Medicaid services that are considered cosmetic may be covered only when medically necessary (e.g., restore bodily function or correct a deformity). Prior authorization is required.
- The following procedures will be denied:
    - Services that can only be done as inpatient (see the Inpatient Only Procedure Code list on the website (2.1, Quick Reference)
        - Any outpatient surgeries which are denied as only allowed in the inpatient setting can be appealed
    - Cosmetic
    - Non-covered
    - Unlisted procedure codes
- Durable medical equipment not considered part of the surgical procedure can be billed separately under the DME program (2.1, Quick Reference)
- Medical/surgical supplies used in actual treatment of an outpatient are covered. A limited supply (two (2) day maximum) may be provided to a patient only if a prescription for the supply cannot be filled at a retail pharmacy or medical supplies provider within the two (2) day time frame.
- Prescriptions for medications used in actual treatment of an outpatient are covered. A limited supply (two (2) day maximum) may be prescribed to a patient only if a prescription for the medication cannot be filled at a retail pharmacy within the two (2) day time frame.

11.13 Transplant Policy

11.13.1 Eligibility

Medically necessary organ transplants must be Prior Authorized. A Prior Authorization (PA) must be obtained before services are rendered (6.14, Prior Authorization).

11.13.2 Coordination of Care

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

Hospitals are required to obtain prior authorization for transplants prior to admission and procedure. Prior Authorization must be requested of the appropriate vendor, WYhealth (6.14, Prior Authorization).

11.13.3 Covered Services

The only transplant covered on an outpatient basis is bone marrow for clients age 20 and under. Refer to inpatient services (12.1.2.1, Inpatient Services) for all other transplant services.

11.13.4 Reimbursement – Outpatient Stem Cell/Bone Marrow

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

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

- Initial evaluation
- Procurement/Acquisition (included on facility claim)
- Facility fees
- If the physician is employed by the hospital, the charges will be combined and billed on the facility claim. If physicians are not employed by the hospital they need to be actively enrolled with Wyoming Medicaid and will bill separately.

11.13.5 Non-Covered Services

Transportation of organs is not covered.

11.14 Therapy Services

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

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

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

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

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

11.14.1 Physical Therapy and Occupational Therapy

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

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

11.14.1.1 Covered Services

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

- Physical Therapy & Occupational Therapy – Services may only be provided following physical debilitation due to acute physical trauma or physical illness. All therapy must be physically rehabilitative and provided under the following conditions:
    - Prescribed during an inpatient stay continuing on an outpatient basis; or as a direct result of outpatient surgery or injury
- Manual Therapy Techniques – When a practitioner or physical therapist applies physical therapy and/or rehabilitation techniques to improve the client's functioning
- Occupational Therapy interventions may include:
    - Evaluations/re-evaluations required to assess individual functional status
    - Interventions that develop improve or restore underlying impairments

11.14.1.2 Limitations

Reimbursement includes all expendable medical supplies normally used at the time therapy services are provided. Additional medical supplies/equipment provided to a client as part of the therapy services for home use will be reimbursed separately

through the Medical Supplies Program. For specific billing information on medical supplies refer to the DME provider manual.

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

11.14.1.3 Documentation

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

- Diagnosis and date of onset of the client's condition
- Client's rehabilitation potential
- Modalities
- Frequency
- Duration (interpreted as estimated length of time until the client is discharged from physical therapy)
- Practitioner signature and date of review
- Physical therapist's notes and documented measurable progress and anticipated goals
- Initial orders certifying the medical necessity for therapy
- Practitioner's renewal orders (at least every 180 days) certifying the medical necessity of continued therapy and any changes. The ordering practitioner must certify that:
  - The services are medically necessary
  - A well-documented treatment plan is established and reviewed by the practitioner at least every 180 day
- 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, to include beginning time and ending time for services billed.

11.14.1.4 Billing Requirements

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

11.14.1.5 Prior Authorization Once Threshold is Met

For Medicaid clients, dates of service in excess of twenty (20) per calendar year, providers will need to contact WYhealth for prior authorization (6.10 Service Thresholds).

11.14.2 Speech Therapy

Revenue Codes: 0440 – 0449

11.14.2.1 Covered Services

Speech therapy services provided to Medicaid clients must be restorative for clients 21 and over. Maintenance therapy can be provided for clients 20 and under. The client must have a diagnosis of a speech disorder resulting from injury, trauma or a medically based illness. There must be an expectation that the client's condition will improve significantly.

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

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

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

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

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

11.14.2.2 Limitations

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

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

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

11.14.2.3 Billing Requirements

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

NOTE: In cases where the client receives both occupational and speech therapy, treatments should not be duplicated and separate treatment plans and goals should be provided

11.14.2.4 Prior Authorization Once Threshold is Met

For Medicaid clients, dates of service in excess of thirty (30) for speech therapy per calendar year, providers will need to contact WYhealth for prior authorization (6.10 Service Thresholds).

11.14.3 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through WYhealth, including any additional clinical information that supports the request for services
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Benefit Quality Control Manager, Brenda Stout (brenda.stout1@wyo.gov).

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

11.15 Outpatient Non-Covered Services

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

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

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

11.16 OPPS Reimbursement, Definitions, Billing Tips and Guidelines

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

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

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

11.16.1 Purpose and Objectives

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

11.16.2 Policy Notes

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

11.16.3 Coding Tips

- Use current HCPCS Level II and ICD-10-CM coding books.
- Always read the complete description and guidelines in the coding books.
- Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, don't use 53899 (unlisted procedure of the urinary system) when a more specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have three (3) to five (5) levels. See the CPT coding book for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a

provider spends 60-minutes with the client. The code choices are 45 to 50-minutes or 76 to 80-minutes. The provider must bill the code for 45 to 50-minutes.

- Revenue codes 025X (except for 0253) and 027X do not require CPT or HCPCS codes; however, providers are advised to place appropriate CPT or HCPCS Level II codes on each line. Providers are paid based on the presence of line item CPT and HCPCS codes. If these codes are omitted, the hospital may be under paid.
- Take care to use the correct "units" measurement. In general, Medicaid follows the definitions in the CPT -4 and HCPCS Level II billing manuals. Unless otherwise specified, one (1) unit equals one (1) visit or one (1) procedure. For specific codes, however, one (1) unit may be "each 15 minutes". Always check the long text of the code description published in the CPT-4 or HCPCS Level II coding books. For example, if a physical therapist spends 45 minutes working with a client (97110), and the procedure bills for "each 15 minutes," it would be billed this way.

UB Field	42 – Rev Code	44 – Procedure Code	45 – Date of Service	46 – Units	47 – Total Charges
	420	97110	10/1/2015	3	$75.00

11.16.3.1 Using Modifiers

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

11.16.4 Coding, Billing and Edits

11.16.4.1 Bilateral Procedures

When billing bilateral procedures, bill the procedure code only once and bill with modifier 50.

UB Field	42 – Rev Code	44 – Procedure Code	45 – Date of Service	46 – Units	47 – Total Charges
	360	27301 **50**	10/1/2015	1	$2,500.00

11.16.4.2 Inpatient Only Procedure Codes

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

11.16.4.3 Patient Status Codes

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

11.16.4.4 Service on the Same Day

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

11.16.4.5 Line Item Date of Service

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

11.16.4.6 Recording Detailed ICD Diagnosis Codes

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

11.16.4.7 Recording Detailed CPT/HCPCS Codes

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

UB Field	42 – Rev Code	44 – Procedure Code	45 – Date of Service	46 – Units	47 – Total Charges	Payment Method	Payment Amount
	250		10/1/2015	4	$913.13	Packaged	$0.00
	250	J0475	10/1/2015	4	$913.13	APC	$1,327.51

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

11.16.4.8 Type of Bill

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

11.16.4.9 Line Item Denial and Claim Denials

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

11.16.5 Billing Tips for Specific Services

11.16.5.1 Drugs and Biologicals

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

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

11.16.5.2 Lab Services

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

11.16.5.3 Supplies

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

11.16.6 How Payment is Calculated

11.16.6.1 Outpatient Prospective Payment Systems (OPPS) Affected Provider and Claim Types

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

11.16.6.2 The Outpatient Prospective Payment System (OPPS)

Most services in the outpatient setting are paid using the Ambulatory Payment Classification (APC) system developed by Medicare. The DHCF has adopted Medicare definitions and weights for APCs and those codes paid through the APC method (11.16.8.8 , Wyoming Specific Non-APC Payments).

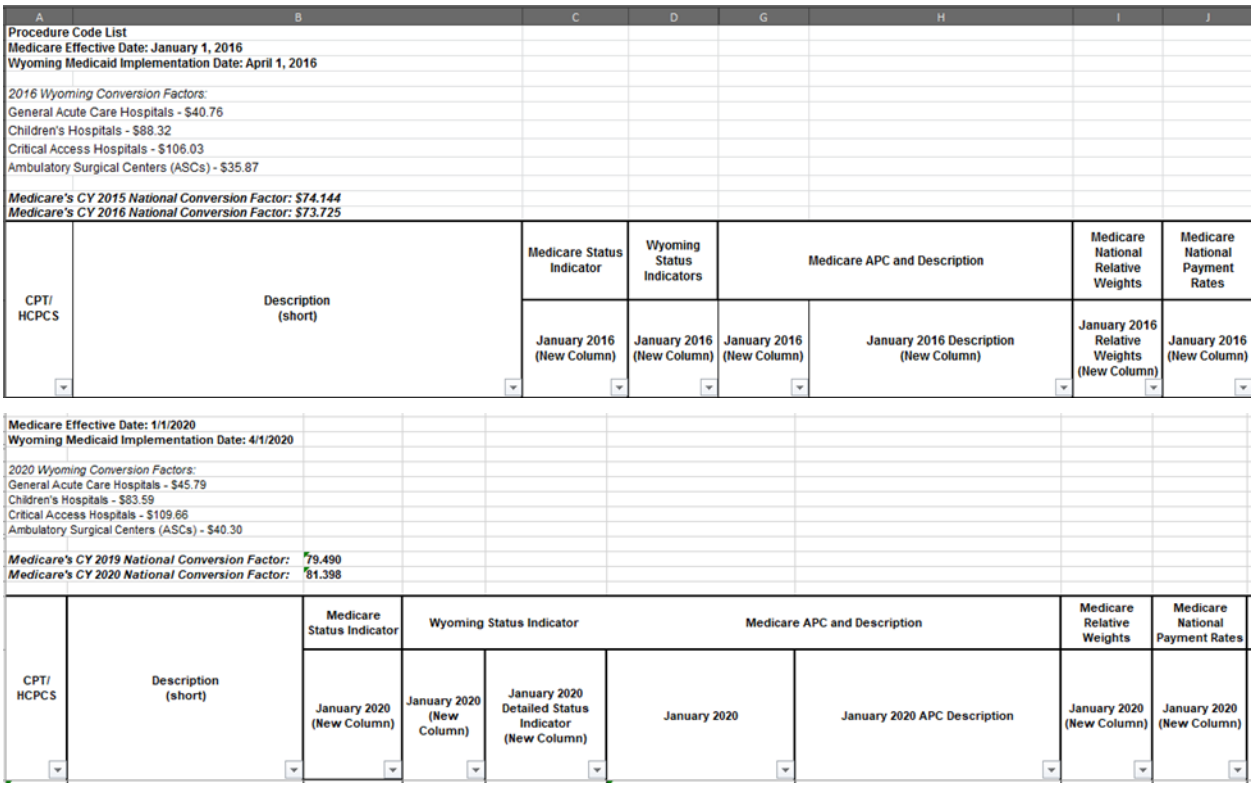
11.16.6.3 Revenue Codes and Procedure Codes

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

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

UB Field	42 – Rev Code	44 – Procedure Code	45 – Date of Service	46 – Units	47 – Total Charges	Payment Method	Payment Amount
	270		10/1/2015	8	$149.36	Packaged	$0
	300	80053	10/1/2015	1	$84.71	Medicaid Fee Schedule	$13.29
	300	80101	10/1/2015	7	$211.19	Medicaid Fee Schedule	$121.24
	450	99284 25	10/1/2015	1	$516.96	APC	$164.02
	490	48102	10/1/2015	1	$616.00	APC	$417.08
	730	93005	10/1/2015	1	$100.65	APC	$19.52

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



Procedure Code List
Medicare Effective Date: January 1, 2016
Wyoming Medicaid Implementation Date: April 1, 2016

2016 Wyoming Conversion Factors:
General Acute Care Hospitals - $40.76
Children's Hospitals - $88.32
Critical Access Hospitals - $106.03
Ambulatory Surgical Centers (ASCs) - $35.87

Medicare's CY 2015 National Conversion Factor: $74.144
Medicare's CY 2016 National Conversion Factor: $73.725

CPT/ HCPCS	Description (short)	Medicare Status Indicator	Wyoming Status Indicators	Medicare APC and Description		Medicare National Relative Weights	Medicare National Payment Rates
		January 2016 (New Column)	January 2016 (New Column)	January 2016 (New Column)	January 2016 Description (New Column)	January 2016 Relative Weights (New Column)	January 2016 (New Column)

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

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

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

CPT/ HCPCS	Description (short)	Medicare Status Indicator	Wyoming Status Indicator		Medicare APC and Description		Medicare Relative Weights	Medicare National Payment Rates
		January 2020 (New Column)	January 2020 (New Column)	January 2020 Detailed Status Indicator (New Column)	January 2020	January 2020 APC Description	January 2020 (New Column)	January 2020 (New Column)

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

11.16.7 Status Indicators

The IOCE assigns a status indicator to each procedure code. The status indicator directs payment of the line item. Each procedure code's specific status indicator can

be reviewed by using the APC online fee schedule on the website (2.1, Quick Reference). The status indicators used the DHCF are based on the indicators used by Medicare, with DHCF specific indicators:

Status Code	Description	Comments
1	Not Covered	Indicates a service that is not covered by Medicaid (e.g., a service that cannot be provided in an outpatient hospital setting or that is not a covered Medicaid benefit)
2	Paid a percentage of charges	Paid by multiplying billed charges by a hospital-specific cost-to-charge ratio
3	Other fee schedule	Indicates a service that is excluded from the APC-based methodology, e.g., laboratory and screening mammography's

Status Code	Medicare Description	Wyoming use of Status Indicators
A	Services not Paid under OPPS; Paid under fee schedule or other payment system	Not paid under OPPS
B	Non-allowed item or service for OPPS	Not paid under OPPS
C	Inpatient procedure	Not paid under OPPS
D	Discontinued Codes	Not Paid under any system
E1	Items and services not covered by Medicare	Not paid under any outpatient system
E2	Items and services for which pricing information and claims data are not available	Not paid under any outpatient system
F	Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines	Not paid under OPPS. Paid at reasonable cost
G	Pass-through drugs and biologicals	Paid under OPPS; Separate APC payment includes pass-through amount
H	(1) Pass-through device categories (2) Therapeutic Radiopharmaceuticals	Paid under OPPS; (1) separate cost-based pass-through payment; (2) separate cost-based non pass-through payment
J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; (1) composite APC payment; (2) packaged if billed on the same date of service as other J1 services.

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

11.16.8 Payment Calculators

The OPPS payment methodology strongly relies on the accurate coding of procedure codes for each service billed on the claim. These procedure codes are assigned a

status indicator, which then identifies which type of Wyoming reimbursement methodology process will apply to the service line in question. Typically the payment methodology is the assignment of APC categories which determines the reimbursement rate for the procedure code.

11.16.8.1 Ambulatory Payment Classification (APC)

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

11.16.8.2 Composite APC

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

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

11.16.8.3 Relative Weight

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

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

11.16.8.4 Conversion Factor

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

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

11.16.8.5 Fee Calculation

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

A	B	C	D	G	H	I	J
Procedure Code List							
Medicare Effective Date: January 1, 2016							
Wyoming Medicaid Implementation Date: April 1, 2016							
2016 Wyoming Conversion Factors:							
General Acute Care Hospitals - $40.76							
Children's Hospitals - $88.32							
Critical Access Hospitals - $106.03							
Ambulatory Surgical Centers (ASCs) - $35.87							
Medicare's CY 2015 National Conversion Factor: $74.144							
Medicare's CY 2016 National Conversion Factor: $73.725							
CPT/ HCPCS	**Description (short)**	**Medicare Status Indicator**	**Wyoming Status Indicators**	**Medicare APC and Description**		**Medicare National Relative Weights**	**Medicare National Payment Rates**
		January 2016 (New Column)	**January 2016 (New Column)**	**January 2016 (New Column)**	**January 2016 Description (New Column)**	**January 2016 Relative Weights (New Column)**	**January 2016 (New Column)**
99284	Emergency dept visit	J2	J2	5024	Level 4 Type A ED Visits	4.4353	326.99

Medicare Effective Date: 1/1/2020							
Wyoming Medicaid Implementation Date: 4/1/2020							
2020 Wyoming Conversion Factors:							
General Acute Care Hospitals - $45.79							
Children's Hospitals - $83.59							
Critical Access Hospitals - $109.66							
Ambulatory Surgical Centers (ASCs) - $40.30							
Medicare's CY 2019 National Conversion Factor:	**79.490**						
Medicare's CY 2020 National Conversion Factor:	**81.398**						
CPT/ HCPCS	**Description (short)**	**Medicare Status Indicator**	**Wyoming Status Indicator**		**Medicare APC and Description**	**Medicare Relative Weights**	**Medicare National Payment Rates**
		January 2020 (New Column)	**January 2020 (New Column)**	**January 2020 Detailed Status Indicator (New Column)**	**January 2020**	**January 2020 (New Column)**	**January 2020 (New Column)**
99284	Emergency dept visit	J2	J2	J2	5024	4.3542	351.79

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

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

11.16.8.6 Pass-Through Payments

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

11.16.8.7 Packaged Services

Services having a status indicator of N are considered packaged or bundled. The costs for these services are taken into account when relative weights are assigned for the other services, but are not paid separately. Medicare developed the relative weights

for surgical, medical and other types of visits to reflect the packaged services in the APC methodology, i.e. lines with a status indicator of N will pay $0.00.

11.16.8.8 Wyoming Specific Non-APC Payments

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

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

11.16.9 Charge Caps (Maximum Payout on Line Item)

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

- This could mean that lines on the claim pay more than the submitted charge. When this occurs, the Remittance Advice/835 will reflect a negative write off amount.
- If a procedure code is priced using the Medicaid fee schedule, (status indicator 3) the line will price/pay the lesser of the Medicaid allowed amount or the billed amount.
- Package procedure codes will always price/pay at zero (status indicator N).
- Those procedure codes having a status indicator reflecting that they are paid a percentage of charges are paid at a percentage of the participating hospital's charges for that service (e.g., status indicators 2 and H). The percentage paid is the participating hospital's specific cost-to-charge ratio.
- Under Wyoming's OPPS, select services are paid using a percentage of charges. The actual percentage used for payment varies by provider and is called a cost-to-charge ratio. For participating providers (providers that have reached a designated threshold of payments in the base year for rate setting) in Medicaid's inpatient DRG system, Medicaid uses a Medicaid cost-to-charge ratio that is calculated annually. Hospital-specific Medicaid cost-to-charge ratios may not exceed 100 percent. Non-participating hospitals are reimbursed using the average Medicaid cost to charge ratio for their provider type (children's hospital, critical access hospital and general acute care hospital). Medicaid develops these cost-to-charge ratios from Medicare cost reports and Medicaid claims data.

11.16.10 Modifiers

Modifiers add clarification and specificity to procedures. Failure to use modifiers or use of an incorrect modifier may adversely affect the payment for some outpatient services. The table below indicates modifiers that Medicaid will accept for outpatient hospital or ASC claims reimbursed through OPPS.

11.16.10.1 Outpatient Services Modifiers

Level I (CPT) Modifiers					Level II (HCPCS) Modifiers													
25	50	63	73	91	BL	CA	EA	FA	GA	J1	KG	LC	Q0	PO	RC	TA	V1	XE
27	52		74	95		CO	EB	F1	GG	J2	KK	LD	Q1	P1	RT	TB	V2	XP
33	58		76	96		CQ	EC	F2	GH	J3	KL	LT	QA	P2		T1	V3	XS
	59		77	97		CP	ER	F3	G0	JG	KT		QB	P3		T2	VM	XU
			78			CR	E1	F4	GR		KU		QQ	P4		T3		X1
			79			CS	E2	F5	GS		KV		QR	P5		T4		X2
						CT	E3	F6	GZ		KW			P6		T5		X3
							E	F7			KY			PN		T6		X4
								F8								T7		X5
								F9								T8		
								FX								T9		
								FY										

NOTE: Modifier Usage

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

11.16.11 Discounting

11.16.11.1 Discounted Procedures

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

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

- Multiple procedures – Medicaid will discount payment for certain procedures when a hospital performs two (2) or more type "T" procedures on the same-day for the same patient. The "T" procedure with the highest relative weight will not be discounted. The remaining "T" procedures will be multiple procedures discounted. If any of the following modifiers are present on the

claim line item, the procedure will not be subject to multiple procedure discounting:

- 76 Repeat procedure by same physician.
- 77 Repeat procedure by another physician.
- 78 Return to the operating room for a related procedure during the postoperative period.
- 79 Unrelated procedure or service by the same physician during the postoperative period.

- Bilateral procedures – The first type "T" bilateral procedure, indicated by modifier 50 (bilateral procedure) will not be discounted. The remaining "T" bilateral procedures will be bilateral procedure discounted. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.
- Discontinued procedures – Medicaid will discount type "T" procedures that a hospital discontinues before completion, indicated by modifier 52 (reduced services) or 73 (discontinued outpatient procedure prior to anesthesia administration). The "T" discontinued procedure with the highest relative weight will be discounted 50 percent of the payment rate. The remaining "T" discontinued procedures will be discontinued procedure discounted. Any applicable offset will be applied prior to selecting the type "T" procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount.

11.16.11.3 Discounting for Non-Type "T" Procedures

- Bilateral procedures – the first non-type "T" bilateral procedure, indicated by modifier 50 (bilateral procedure) will not be discounted. The remaining non-type "T" bilateral procedures will be bilateral procedure discounted. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.
- Discontinued procedures – Medicaid will discount non-type "T" procedures that a hospital discontinues before completion, indicated by modifier 52 (reduced services) or 73 (discontinued outpatient procedure prior to anesthesia administration).
- Credit received from the manufacturer for a replaced medical device – When the credit for the device is 50% or more of the total cost of the device, the provider will need to indicate this on their claim by using a value code of "FD" and indicating the total amount of the credit.

11.16.12 Observation and Direct Admission Services

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

- Observation services are billed using revenue code 0762.

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

11.16.12.1 Reimbursement

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

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

OR

- No services with a status code of "T" were provided on the same date of services as the G0378; and
- Eight (8) or more units of procedure code G0378 are billed on the same date or the day after a high level emergency department visit or critical care service or an appropriate obstetric diagnosis code is billed along with at least one (1) unit of procedure code G0378; and
- One (1) or more of the following procedure codes are billed on the day of or the day prior to the observation services:
    - 99284 – Emergency department visit (Level 4)
    - 99285 – Emergency department visit (Level 5)
    - 99291 – Critical care, first hour

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

11.16.12.2 Direct Admissions

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

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

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

11.16.12.3 NDC Billing Requirements

Review Chapter 6 for requirements on billing NDC codes with certain drug related procedure codes.

11.16.13 OPPS Quarterly Updates

For all future updates, Medicaid will make the following specific, targeted updates to the OPPS system:

- Implement the IOCE for outpatient hospital claims processing each quarter
- Annually implement adjusted OPPS conversion factors for ASCs and the three (3) hospital types (general hospitals, critical access hospitals and children's hospitals)
- Delete procedure codes that Medicare deletes

In addition, Medicaid will continue to implement the quarterly changes one (1) quarter after the information is received from CMS. However, to address providers' concerns regarding the implementation and effective date of procedure codes, quarterly updates will have the same effective date for Medicaid as for Medicare (e.g., Medicaid will implement Medicare's January updates on April 1 with an effective date of January 1). Therefore, to be paid in accordance with the most recent quarterly update, providers must resubmit/adjust (as applicable) their outpatient hospital or ASC claims after Medicaid's implementation of the quarterly changes. For example, a claim with a date of service January 10, 2011 submitted for payment on January 20, 2011 would initially be paid under the October 2010 Medicaid payment policy (since that would be in effect on January 20); after April 1, 2011, the provider could resubmit, or adjust (as appropriate) the claim for corrected payment and Medicaid would reprocess the claim to be paid under the January 2011 Medicaid payment policy.

11.16.14 Coding Tips

- Information related to the quarterly updates, and changes to OPPS policy and procedures as well as updated coding information will be published to the Medicaid web site with each quarterly update.

- The most accurate way to review information related to the current OPPS policy and coding procedures is to view the OPPS information on the web site (2.1, Quick Reference).
- There are a number of available references, resources and information sources available to assist with OPPS billing.

Chapter Twelve – Critical Access Hospital and General Hospital Inpatient

12.1 General Coverage Principals and Definitions

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

12.1.1 Critical Access Hospital (CAH)

A hospital that meets the following CMS criteria:

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

12.1.1.1 General Acute Care Hospital

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

12.1.2 Psychiatric Hospital

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

12.1.2.1 Inpatient Services

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

- For payment purposes, inpatient services require at least a 24 hour stay unless the stay falls under the less than 24 hour stay for transfers. (Section 12.6.2, Outpatient Services Followed By Inpatient Services)
- Medically necessary inpatient hospital services are covered pursuant to written orders by a physician or staff under the supervision of a physician, a dentist or other appropriate practitioner.
- Facilities are required to send medications (either prescriptions or already filled) home with clients upon discharge.
- Services are considered inpatient services when the patient is admitted as an inpatient to the facility, regardless of the hour of admission, whether or not a bed is used and whether or not the patient remained in the hospital past midnight.
    - Inpatient stays are subject to the submission of Inpatient Monitoring Reports – refer to WYhealth for details.
    - When a client receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes. (12.6, Inpatient Billing Guidelines)

12.2 Abortion

Abortions are not allowed to be billed on an inpatient basis (11.2, Abortion).

12.3 Psychiatric Services

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

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

NOTE: Inpatient/outpatient hospital services provided to a client between ages 22 and 64 at an Institution for Mental Disease (IMD) are a **non-covered service** pursuant to federal Medicaid regulation. This includes Medicare crossover claims for dual eligible clients. An IMD is defined as a hospital, nursing facility, or other institution of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases.

12.3.1 Acute Psychiatric Admissions Requirement

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

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

NOTE: The above criteria must be met for any involuntary psychiatric placement for Medicaid eligible clients. For involuntary psychiatric placements for non-Medicaid eligible clients, please see the Title 25 Billing Manual.

12.3.1.1 Billing Requirements

Services, including involuntary psychiatric placements for Medicaid eligible clients, must be prior authorized within one (1) working day of admission through WYhealth (2.1, Quick Reference and 6.14, Prior Authorization).

12.3.2 Billing Examples

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

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

Example 1a – **Invalid Billing**:

- Client is admitted 1/22/2020 and is discharged 2/11/2020.
    - Coverage period is entered as 1/22/2020 – 2/11/2020 on the claim

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

Example 1b – **Valid Billing**:

- Client is admitted 1/22/2020 and is discharged 2/11/2020.
    - Coverage period is entered as 1/22/2020 – 2/11/2020 on the claim
    - Patient Status is indicated as discharged
- A Prior Authorization is obtained for the following:
    - Effective for Dates of service 1/22/2020 – 2/11/2020
    - Approved for Dates of service 1/22/2020 – 2/8/2020
    - Denied for Dates of service 2/9/2020 – 2/10/2020
- The claim indicates 2 non-covered days, value code 81, to correspond with the days denied on the PA
- Line 1 of the claim is billed for 18 units of 0124
    - Value code 80 indicates 18 units
- **The claim processes**

Example 2a – **Invalid Billing**:

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

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

Example 2b – **Valid Billing**:

- Client is admitted outpatient 1/20/2020
- Client is admitted inpatient 1/21/2020 and is discharged 1/29/2020
  - Coverage period is entered as 1/20/2020 – 1/29/2020 on the claim
  - Patient Status is indicated as discharged.
- A PA is obtained for the following:
  - Effective for Dates of service 1/20/2020 – 2/4/2020
  - Approved for Dates of service 1/20/2020 – 1/26/2020 and 1/29/2020 – 2/4/2020
  - Non-Approved for 1/27/2020 – 1/28/2020
- The claim indicates 3 non-covered days, value code 81, for the outpatient stay and the days not approved on the PA
- Line 1 of the claim is bills for 6 units of 0124 with date of service 1/21/2020
  - Value code 80 indicates 6 units
- **The claim processes correctly**

12.4 Sterilization and Hysterectomies

12.4.1 Elective Sterilization

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

- Clients must complete and sign the Sterilization Consent Form at least 30 days, but not more than 180 days, prior to the sterilization procedure. There are no exceptions to the 180 day limitation of the effective time period of the informed consent agreement (e.g., retroactive eligibility). This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly complete, payment will be denied. A complete Sterilization Consent Form must be obtained from the primary physician for all related services (6.16.1, Sterilization Consent Form and Guidelines)

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

- Premature Delivery – The Sterilization Consent Form must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
- Emergency Abdominal Surgery – The Sterilization Consent Form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.
- Clients must be at least 21 years of age when signing the form.
- Clients must not have been declared mentally incompetent by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.

- Clients must not be confined under civil or criminal status in a correctional rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing sterilizations, the following requirements must be met:

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

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

- If the client is in labor or childbirth
- If the client is seeking or obtaining an abortion
- If the client is under the influence of alcohol or other substances which may affect his/her awareness

12.4.1.1 Billing Requirements

Diagnosis Code: Z30.2

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

- The above surgical codes and diagnosis code must accompany one another on a claim. Anytime one (1) of the surgical sterilization procedure codes is present on an inpatient claim, the diagnosis code of Z30.2 (sterilization) must also be present. Likewise, if diagnosis Z30.2 is present on an inpatient claim, one (1) of the above surgical sterilization procedures must also be present. If only the surgical sterilization code or diagnosis code is present, the claim will deny.
- If both the above criteria are met then the system will verify that a delivery took place by identifying that a surgical obstetrical procedure is present,

combined with a diagnosis code in the O20 – O92 range. If the obstetrical procedure and diagnosis code are not present the claim will deny.

12.4.2 Hysterectomies

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

- A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one (1) section (A, B or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client must sign and date section A of this form (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C apply. If this form is not properly completed, payment will be denied (6.16.2, Hysterectomy Acknowledgement of Consent).
    - If the surgery does not render the client sterile, operative notes can be submitted in place of the form indicating the reason for non-sterility.
- For clients that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one (1) of the following:
    - The client was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

12.5 Transplant Services

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

12.5.1 Eligibility

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

12.5.2 Coordination of Care

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

Hospitals are required to obtain prior authorization for transplants listed below prior to admission and procedure. WYhealth will complete prior authorizations (6.14, Prior Authorization).

12.5.3 Covered Services

Medicaid covered transplants include:

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

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

12.5.4 Reimbursement

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

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

12.6 Inpatient Billing Guidelines

12.6.1 Present on Admission Indicator (POA)

Refer to Section 6.7, Provider Preventable Conditions (PPC)

12.6.2 Outpatient Services Followed by Inpatient Services

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

- Coverage period (FL 6) for the claim must be the date the client was first seen for outpatient services through the inpatient discharge date.

- The admit date (FL 12) must be the date the client was admitted to inpatient services.
- All outpatient services should be included on the claim, using the correct dates of service.
- The outpatient services will be considered in the APR DRG claims reimbursement calculations.

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

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

12.6.3 Reimbursement for Inpatient Hospital Claims

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

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

12.6.4 APR DRG Reimbursement for Inpatient Hospital Claims

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

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

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

Access 3M via the web at: www.aprdrgassign.com.

For 3M log in and password, please contact Provider Relations (2.1, Quick Reference).

12.6.5 Level of Care Reimbursement for Inpatient Hospital Claims

NOTE: Effective for discharge dates on or before January 31, 2019.

The level of care reimbursement system is based on a per discharge Level of Care (LOC) methodology that recognizes differences in the costs for treating patients. Payment is based on the principal diagnosis, which can be found in FL 67 on the UB-04 (the first diagnosis listed on a paper claim or equivalent 837I loop and segment) for the patient. Medicaid uses ten (10) levels of care with rates based on either hospital-specific or statewide rates. Participating hospitals are reimbursed at Level of Care, plus a statewide capital reimbursement fee. If the facility is not given a capital reimbursement fee, then the LOC amount will be considered the total reimbursement. The Levels of Care and their criteria are as follows:

Inpatient Category	LOC Criterion	Discharge prior to 2/1/19	Discharge 2/1/19 and after
Kidney Transplant	• Prior authorized transplant services; AND • ICD-10 surgical procedure code of 0TY00Z0-0TY10Z2	LOC 7	DRG Processing-Refer to 3M for payment details
Heart/Heart-Lung Transplant	• Prior authorized transplant services; AND • ICD-10 surgical procedure code of 02YA0Z0-0BYM0Z2	LOC 8	DRG Processing-Refer to 3M for payment details
Liver Transplant	• Prior authorized transplant services; AND • ICD-10 surgical procedure code of 0FY00Z0-0F700Z2	LOC 9	DRG Processing-Refer to 3M for payment details
Bone Marrow Transplant	• Prior authorized transplant services; AND • ICD-10 surgical procedure code of 30230AZ to 30263Y1	LOC 10	DRG Processing-Refer to 3M for payment details

Inpatient Category	LOC Criterion	Discharge prior to 2/1/19	Discharge 2/1/19 and after
Lung Transplant	• Prior authorized transplant services; AND • ICD-10 surgical procedure code of 0BYK0Z0-0BYM0Z2	LOC 16	DRG Processing-Refer to 3M for payment details
Pancreas Transplant	• Prior authorized transplant services; AND • ICD-10 surgical procedure code of 0FYG0Z0-0FSG4ZZ	LOC 18	DRG Processing-Refer to 3M for payment details
Rehabilitation with ventilator	• Principal ICD-10 diagnosis codes: See List; AND • ICD-10 surgical procedure code: See List	LOC 30	LOC 30
Rehabilitation	• Principal ICD-10 diagnosis codes: See List; AND • ICD-10 surgical procedure code: See List	LOC 31	LOC 31
Maternity/Surgical	• Principal ICD-10 diagnosis codes: See List; AND • Major Surgery Procedure Code	LOC 32	DRG Processing-Refer to 3M for payment details
Maternity/Medical	• Principal ICD-10 diagnosis codes: See List	LOC 33	DRG Processing-Refer to 3M for payment details
NICU	• Revenue Code 0174	LOC 34	DRG Processing-Refer to 3M for payment details
ICU/CCU/Burn	• Revenue Code 0200-0205, 0207-0213, 0215-0219	LOC 35	DRG Processing-Refer to 3M for payment details
Surgery	• Revenue Code 0360-0369; AND • Major Surgery Procedure Code	LOC 36	DRG Processing-Refer to 3M for payment details

Inpatient Category	LOC Criterion	Discharge prior to 2/1/19	Discharge 2/1/19 and after
Psychiatric	• Prior authorized psychiatric services; AND • Principal ICD-10 diagnosis codes: See List	LOC 37	DRG Processing- Refer to 3M for payment details
Newborn Nursery	• Principal ICD-10 diagnosis codes See List • First date of service is < 29 days of age	LOC 38	DRG Processing- Refer to 3M for payment details
Routine	All remaining discharges	LOC 39	DRG Processing- Refer to 3M for payment details

- Valid diagnosis codes are required. All diagnosis codes will be validated against the current ICD coding book for the dates of service on the claim.
- For all inpatient and inpatient crossover claims where the recipient is less than or equal to 29 days, value code 54 (newborn birth weight in grams) must be populated.

  NOTE: Diagnosis codes must be valid for the date of discharge on the claim. Claims processing is based on codes and policy effective for the date of discharge.

- All inpatient claims must have complete and valid admit hour, admit type, admit source and discharge hour.
- Inpatient claims field 18-21 (Admit hour, admit type, admit source and discharge hour) must be complete and valid.
- As LOC is based on the principal diagnosis code, the claim will be reimbursed as a whole; however, each line item will be edited for validity. Any error on a line item may cause the whole claim to deny.

12.6.5.1 Level of Care Exceptions

- Less than 24-hour inpatient stays are subject to review. Admissions determined to be appropriate will receive a Level of Care per-diem rate, rather than the complete Level of Care amount.
- Patient transfers (both the transferring and the receiving hospital) will receive a Level of Care per-diem rate for each day of care provided to the client, with a maximum payment of the full Level of Care payment, unless the claim qualifies for a high cost outlier payment.
  - The transferring hospital should use a patient status of 02 or 05 to indicate a transfer. Medicaid does not reimburse for the date of discharge regardless of discharge time.

  - The receiving hospital should use an admit source of 04 to indicate the patient was transferred in. Medicaid will reimburse for admit date regardless of admit time.
  - Transfers do not include movement of a patient from one hospital unit to another within a hospital, even if the hospital's internal process includes a discharge and admission between the units. Example: A patient is treated in the acute care setting and later moved to the psychiatric unit of the same hospital – this is billed as one (1) complete stay, not two (2) claims.
- In the event that a claim's dates of service cross two (2) different hospital-specific or statewide rate (typically updated annually) for the same level of care, the rates in effect on the admission date will be used to calculate payment.
- High cost outlier cases will receive additional payment. High cost outlier cases are defined as those cases for which allowable submitted charges exceed Level of Care threshold.

12.6.6 Level of Care High Cost Outlier Reimbursement

When the total charges on a claim exceed the established outlier threshold for a given level of care, an increased payment may be calculated to compensate for the additional cost of care to the patient. In order to determine if additional payment will be made, the hospital will need a completed claim and their rates calculated for their specific hospital for the dates of service on the claim. If the hospital does not have hospital-specific rates, the state wide rates will be used.

- Information required for calculation
- Total Billed Charges
- Admission Date
- Level of Care (12.6.5, Level of Care Reimbursement for Inpatient Hospital Claims)
- Cost to Charge ratio (for the level of care and admission date)
- Outlier Threshold (for the level of care and admission date)
- Level of Care Payment (for the admission date)
- Capital Reimbursement

NOTE: This information can be found on the rate letter sent to the hospital by the Division of Healthcare Financing.

Steps:

1. Determine if the total billed charges are greater than the outlier threshold amount. If so, continue. If not – regular Level of care Methodology will be used to determine reimbursement (12.6.5, Level of Care Reimbursement for Inpatient Hospital Claims).

2. Multiply the cost to charge ratio by the total billed charges. Determine if this amount is greater than the outlier threshold amount. If so, continue. If not, regular level of care methodology will be used to determine reimbursement (12.6.5, Level of Care Reimbursement for Inpatient Hospital Claims).
3. Subtract the outlier threshold amount from the results in Step 2.
4. Multiply the result from Step 3 by .75.
5. Add the result of Step 4 to the level of care payment, and capital reimbursement to calculate the final reimbursement amount.

Example:

The hospital assumes hospital specific rates for a surgical level of care claim.

Total Billed Charges: $125,000.00
Admission Date: 10/29/15
Level of Care: 36 – Surgery

Cost to charge ratio (for the level of care and admission date): .3875
Outlier threshold (for the level of care and admission date): $12000.50
Level of care payment (for the admission date): $5500.00
Capital reimbursement: $277.87

Steps:

1. Determine if the total billed charges are greater than the outlier threshold amount. If so, continue. If not, regular level of care methodology will be used to determine reimbursement.

   $125,000.00 > $12,000.50 – YES

2. Multiply the cost to charge ratio by the total billed charges. Determine if this amount is greater than the outlier threshold amount. If so continue. If not, regular level of care methodology will be used to determine reimbursement.

   $125,000.00 X .3875 = $48,437.50 – YES

3. Subtract the outlier threshold amount from the results in Step 2.

   $48,437.50 - $12,000.50 = $36,437.00

4. Multiply the result from Step 3 by .75.

   $36,737.00 X .75 = $27,327.75

5. Add the result of Step 4 to the level of care payment, and capital reimbursement to calculate the final reimbursement amount.

   $27,327.75 + $5,500.00 + $277.87 = $33,105.62

Chapter Thirteen – Comprehensive Outpatient Rehabilitation Facility (CORF)

13.1 Comprehensive Outpatient Rehabilitation Facility (CORF)

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

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

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

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

13.1.1 Billing Requirements

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

Service Provided	Revenue Code	CPT or HCPCS Code
Respiratory Therapy	041X	
Physical Therapy	042X	
Occupational Therapy	043X	
Speech Language Pathology	044X	
Nursing Services	055X	HCPCS G0128
Immunizations	0636	

Service Provided	Revenue Code	CPT or HCPCS Code
Vaccine Administration	0771	CPT 90471
Behavioral Health Treatments/Services	090X, 091X	CPT 96152 Social & Psychological Services

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

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

Chapter Fourteen – End Stage Renal Disease (ESRD)

14.1 End Stage Renal Disease (ESRD)

Revenue Code: 082X, 083X, 084X, 085X or 088X

ESRDs may be a freestanding facility or a hospital based facility, which provides inpatient, outpatient and / or home dialysis.

Procedure Code: 90951 to 90970 – Other procedure codes are billable under this program but at least one (1) of these must be present to be considered a dialysis claim.

NOTE: For the purpose of this policy this chapter refers to freestanding clinics. If the facility is an IHS ESRD facility, refer to Chapter Eighteen – Indian Health Services (IHS).

14.2 Billing Requirements

- ESRD providers are responsible for the procurement, delivery and maintenance of the equipment and supplies.
- The facility may bill for all medically necessary services for home dialysis.
- Services provided outside the ESRD scope must be billed under other applicable programs and guidelines.
- Personal attendants are not covered.
- Claims should be billed with an appropriate bill type – see ESRD Coding Criteria table below.
- NDC numbers must be billed with all J-codes.
- Medicaid will reimburse ESRD services based on the services that Medicare includes in its composite rate for ESRD (as listed in the Medicare Benefit Policy Manual – Chapter 11 – End Stage Renal Disease (ESRD).
- For dates of service prior to 01/01/2021 Medicaid will reimburse ESRD services at 9% of billed charges resulting in a Medicare-like payment. For dates of service 01/01/2021 and forward, Medicaid will reimburse ESRD service at 8.88% of billed charges resulting in a Medicare-like payment.
- If billing for laboratory services, ESRD providers MUST have a valid CLIA on file.

14.3 ESRD Coding Criteria

14.3.1 Coding Criteria Table

Bill Type: **72X**

Taxonomy: **261QE0700X**

Type of Service	Coding Criteria	Date of Service Effective Date 01/01/2014
Dialysis	All claims must include a revenue code 082X, 083X, 084X, 085X, or 088X with a procedure code in the range 90951 to 90970	9 % of billed charges.
Lab	80000-89999 Must have valid CLIA on file	9 % of billed charges
All other services	36400-36420; 90658; 90732; 90740; 90747; A4206 to A4259; A4265; A4300 to A5200; G0008; G0010: J0120 to J9999; Q4081	9 % of billed charges.

14.3.2 ESRD Coding Additional Information

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

Chapter Fifteen – Federally Qualified Health Centers (FQHC)

15.1 Federally Qualified Health Centers (FQHC)

Revenue Code: **0520 – 0528 Medical**

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

An FQHC is a community-based organization that provides comprehensive primary and preventative care, including medical, dental and mental health/substance abuse services to persons of all ages, regardless of their ability to pay.

15.1.1 Covered Services

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

- Dental Professional
- Nurse Practitioner
- Nurse Midwife
- Physician
- Physician's Assistant
- Visiting Nurse

Medical visits can also consist of:

- Medical nutrition therapy
- Diabetes outpatient self-management training

Other health visits are a face to face encounter between a client and:

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

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

15.1.2 Reimbursement Guidelines

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes, but is not limited to:

- Therapeutic services
- Diagnostic Services

- Tests
- Supplies
- Lab
- Radiology

NOTE: For dental treatment refer to the Dental Manual.

Billing for Long Acting Reversible

- Billing for the LARC device will need to be completed on a CMS 1500 claim form/837P electronic claims transaction.
- Providers should bill their usual and customary charges for devices.
- The group provider will be reimbursed the lesser of the provider's billed amount or the Medicaid allowed amount.
- There should be correlating UB and CMS 1500 claims for the insertion and for the actual LARC device.
- Group providers should not submit a device claim when the encounter was for removal of a device only.

- **FQHC/RHC Facility Encounter Billing on the UB Form/837I Claims Transaction**
    - FQHC/RHC Facility NPI as the pay-to provider and enter an attending provider NPI
    - LARC Covered Services/CPT Codes

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

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

Revenue Code	Procedure Code	Amount
520	T1015	$220.00
517	11981	$0.00
517	99215	$0.00

- **Practitioner Group LARC Device Billing on the CMS 1500 Form/837P Claims Transaction**
    - Practitioner Group NPI as pay-to provider and enter the treating provider NPI (same as the attending on the encounter claim)
    - Date of service must be the same as the date on the encounter claim

- LARC Device Covered Services/CPT Codes

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

NOTE: All LARC device codes require an NDC

- **Device Billing Example:**

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

15.1.3 Billing Requirements

- Multiple encounters within the FQHC, on the same day, with different practitioners are still considered one (1) encounter UNLESS the client suffers illness or injury requiring treatment unrelated to the first encounter or if the clients have both a medical visit and other health visit, as defined above.
- Claims must be billed with revenue and procedures codes for both the encounter and detail line items.
- All services provided during the encounter must be billed on a separate line.
- Claims must have a minimum of two (2) line items, the first would be the encounter line and the second line item is detail (both must include a revenue and procedure code combination).
- Encounter lines will be billed with a 0520 revenue code paired with:
  - Procedure code T1015 for a general encounter.
  - Procedure codes 99381-99385 or 99391-99395 for EPSDT encounter.
  - Use modifier 32 to indicate a health check encounter that results in a referral to a specialist.
  - Bill the total usual and customary charges for the visit.
- Detail line items will be billed with:
  - Any appropriate outpatient revenue code paired with any appropriate procedure code (for questions regarding appropriate pairing of revenue codes and procedure codes, use the current version of the NUBC Official UB Data Specifications Manual).
  - Document each procedure that occurred during the encounter.
  - Include a detailed line item for the office visit or health check procedure code if appropriate.

  - Bill the detail line items at $0.00.
- Appropriate Bill Type(s)
  - 73X-77X
- Pay-to Provider's Taxonomy
  - 261QF0400X

15.1.3.1 Billing Examples

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

Revenue Code	Procedure Code	Amount
0520	T1015	$175.00
0517	99213	$0.00

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

Revenue Code	Procedure Code	Amount
0520	T1015	$220.00
0517	99381	$0.00
0300	87086	$0.00

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

Chapter Sixteen – Home Health

16.1 Home Health

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

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

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

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

16.1.1 Supervision

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

16.1.2 Criteria

- Service must be:
- Ordered by a physician.
- Documented in a signed and dated Plan of Care/Medicare 485 Form that is reviewed and revised as medically necessary by the attending physician at least once every 60 days.
- Medically necessary.
- Three (3) or fewer encounters per day for any combination of home health aide and skilled nursing services

  - An encounter is defined as all home health services provided in a single day that could be provided in a single visit to the client, regardless of how many actual visits to the client are actually completed. For example, shower, shampooing, nail care, and dressing CAN all be completed at the same time, so, even if the shower is in the morning and nail care is completed in the afternoon, this is one encounter. A separate encounter is not to be billed due to the convenience of the provider nor due to scheduling issues or conflicts. A separate encounter can be billed when services must be separated due to orders or medical necessity, such as wound dressings being changed multiple times per day, or medication being given in the morning or at bed time, or assistance with nutritional intake multiple times per day.
- Expected to last six months or less

16.2 Covered Services

- Skilled nursing services provided by a Registered Nurse (RN) for client's condition while in the acute phase.
- Home health aide services delegated and supervised by a Registered Nurse (RN).
  - Each Home Health Aide visit MUST include at least one (1) or more of the following:
    - Bath (bed, sponge, tub, shower, or shampooing hair).
    - Nail or skin care (applying lotion does not constitute personal care).
    - Oral hygiene.
    - Toileting and elimination.
    - Safe transfers / assisted ambulation.
    - Assist with dressing (not grooming alone).
    - Assisted range of motion / positioning.
    - Assisted nutrition or fluid intake (meal set-up or prep or feeding assist / supervision).

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

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

- Medical social services provided by a qualified licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW) -prepared person supervised by an MSW.

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

16.2.1 Limitations

The following services are not covered through home health:

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

16.2.2 Documentation Requirements

For all documentation of services provided:

- If the client is receiving home health services only, visit notes must state home health services and detail the specific services provided.
- If the client is receiving both home health services and waiver services, visit notes must state either home health services or waiver services as appropriate and detail the specific services provided.
- The Plan of Care/Medicare 485 Form must list all services the client is receiving, regardless of pay source. This includes waiver, private duty nursing, etc. and frequency of the services to portray a clear picture of all services the client is receiving.
- Adequate documentation justifying medical necessity must be kept. Any plans extending past 120 days (two (2) consecutive 60-day plan periods) will be reviewed.
- New clients ordered to home health care must have documentation of a face-to-face visit with the ordering practitioner within the 90 days preceding the

beginning of home health. This face-to-face visit can be in the hospital, clinic, nursing home, or other clinical setting.

- Home Health Agencies that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The agency must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

16.2.3 Billing Requirements

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

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

- Bill using appropriate revenue codes.
- Do not bill with procedure codes.
- Do not span bill. Each date of service must be billed on a separate line.
- Bill using appropriate units.
- Prior authorizations (PA) are required for all services and are reviewed by WYhealth (6.14 Prior Authorization)
- Prior authorization number must be placed on the claim
- Prior authorization requests must be submitted within 10 business days of the start of services.
- Plans of Care/Medicare 485 Form, Physician Orders, documentation of face-to-face visit, and documentation of non-homebound status for Medicare/Medicaid dual clients stating the client would not be eligible for services under the Medicare Home Health (2.1 Quick Reference)

Home Health Revenue Codes		
Revenue Code	**Description**	**Unit**
551	Skilled Nursing	Per visit
421	Physical Therapy	Per visit
441	Speech Therapy	Per visit
431	Occupational Therapy	Per visit
571	Home Health Aide	Per visit
561	Medical Social Worker	Per visit

NOTE: Do not place procedure codes on the claim.

16.2.3.1 Prior Authorization

- Prior authorizations requests must be submitted within 10 business days of the start of services
- Requests submitted without a signed and dated 485 or physician's detailed order will not be processed
- Requests must be submitted under the home health revenue codes above, not using HCPCS/CPT codes
- Requests for PRN visits must be submitted after the visit has occurred, but within 5 business days, as a separate episode, and with documentation of the medical necessity of the PRN visit including the clinical notes from that visit
- For facility discharges, be sure to upload the discharge summary from the facility and any applicable therapies (PT, OT, ST)
- For wound care related requests, be sure to include current detailed wound specific information including frequency of care, drainage, wound measurements
- For IV medication related requests, include current medication orders with frequency and duration, and how often administration is to be completed
- For Pediatric G-Tube Care: Clients age 20 and younger, when medically necessary, 1 SN visit per month for review of the placement and patency of the G-Tube will be approved. Other PRN visits will be reviewed according to the PRN visit requirements.
- Technical denials will be issued by WYhealth for the following:
    - No signed/dated 485 or physician's orders
    - Failure of the provider to respond to requests for additional information
    - Incorrectly submitted codes (such as using HCPCS or CPT codes instead of Revenue Codes)

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

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

16.2.3.2 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through WYhealth, including any additional clinical information that supports the request for services

- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Benefit Quality Control Manager, Brenda Stout (brenda.stout1@wyo.gov).
    - The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from WYhealth's system. The appeal will be reviewed in conjunction with the documentation uploaded into WYhealth's system

Chapter Seventeen – Hospice

17.1 Hospice

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

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

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

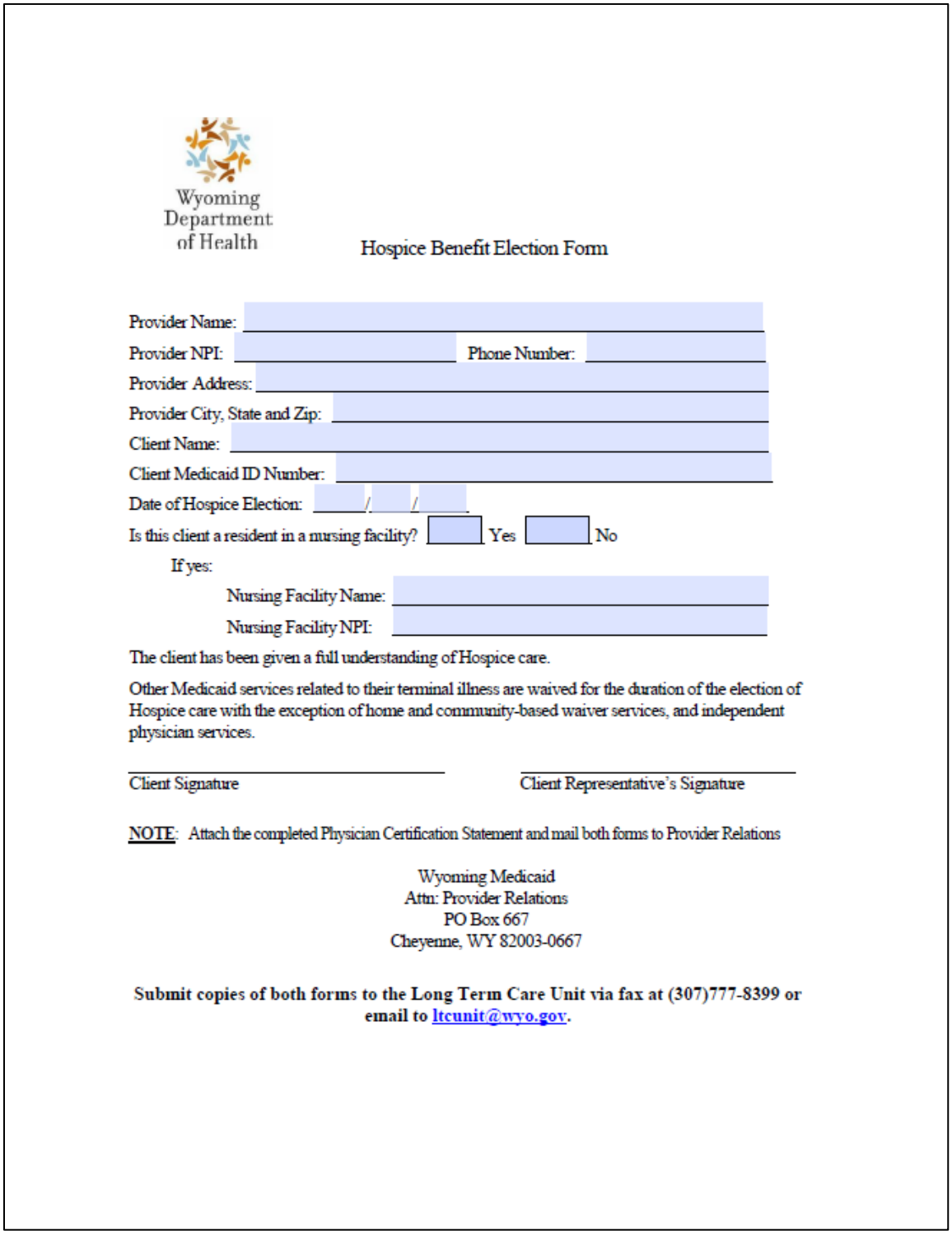
17.1.1 Electing Hospice Services

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 client lock-in, refer to (4.4, Client Lock-In).

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

The Hospice Benefit Election Form and physician certification of terminal illness must be mailed to Wyoming Medicaid Provider Relations (2.1, Quick Reference) and by fax or email to the Long Term Care Unit (2.1, Quick Reference).

17.1.1.1 Hospice Benefit Election Form



Wyoming Department of Health

Hospice Benefit Election Form

Provider Name: _____

Provider NPI: _____ Phone Number: _____

Provider Address: _____

Provider City, State and Zip: _____

Client Name: _____

Client Medicaid ID Number: _____

Date of Hospice Election: ____/____/____

Is this client a resident in a nursing facility? ☐ Yes ☐ No

If yes:

Nursing Facility Name: _____

Nursing Facility NPI: _____

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

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

_____ _____

Client Signature Client Representative's Signature

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

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

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

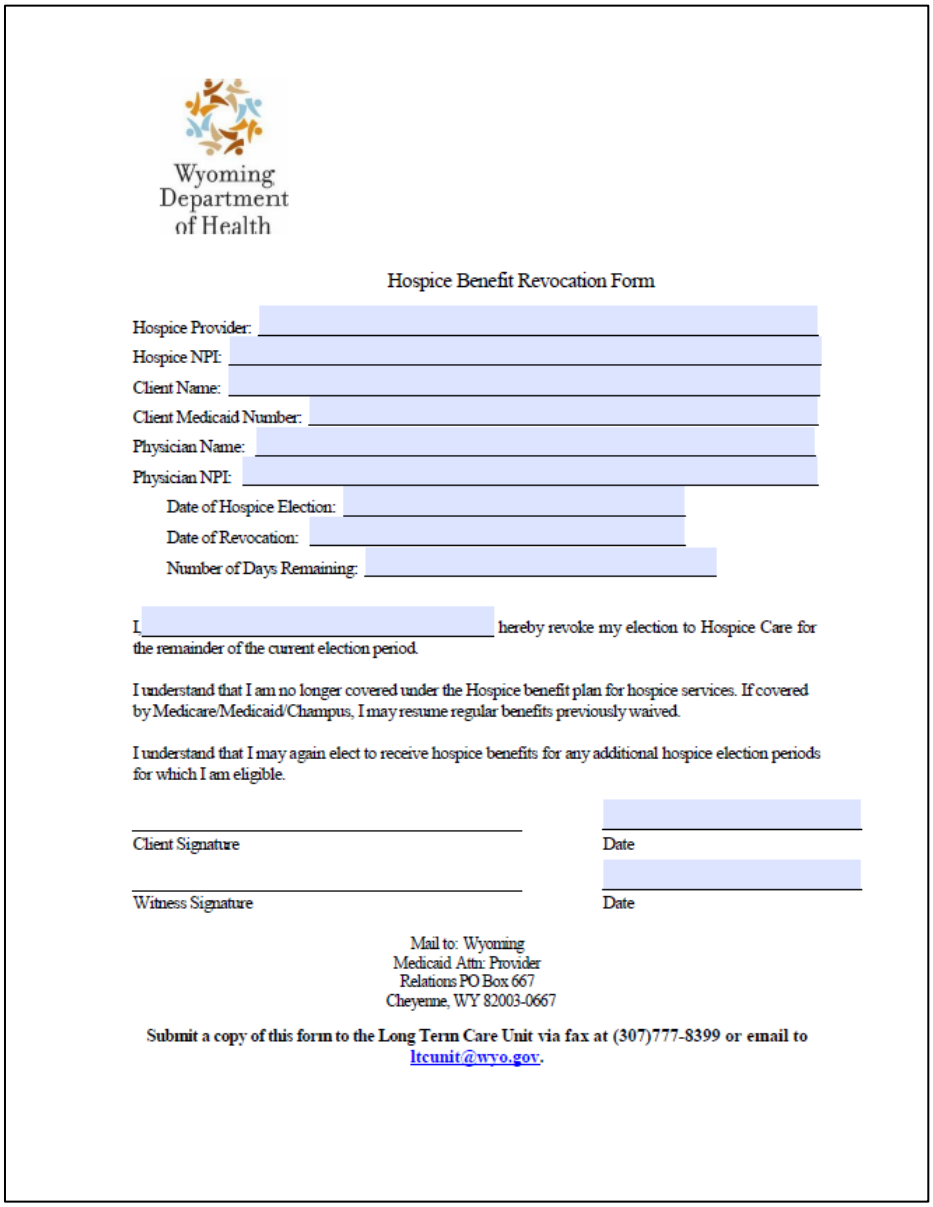
NOTE: Click the image above to be taken to a printable version of this form.

17.1.2 Hospice Benefit Revocation

When a client chooses to revoke his/her hospice election, a copy of the Hospice Revocation Form must be submitted to Wyoming Medicaid Provider Relations and the Long Term Care Unit (2.1, Quick Reference).. The hospice lock-in will be removed from the client's file and they will be able to receive services as applicable.

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

17.1.2.1 Hospice Benefit Revocation Form



Wyoming Department of Health

Hospice Benefit Revocation Form

Hospice Provider: _____

Hospice NPI: _____

Client Name: _____

Client Medicaid Number: _____

Physician Name: _____

Physician NPI: _____

Date of Hospice Election: _____

Date of Revocation: _____

Number of Days Remaining: _____

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

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

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

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

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

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

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

17.1.3 Covered Services

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

- A client is certified by a physician as being terminally ill – meaning that a physician has certified that if the illness runs its normal course, the client's life expectancy is six (6) months or less.
- The client has completed a Hospice Benefit Election Form (17.1.1.1 Hospice Benefit Election Form), which must be submitted to Medicaid along with the physician certification of terminal illness.

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

Revenue Code	Procedure Code	Description
0651		Routine home care
0651	G0162	Hospice last seven (7) days
0651	G0493	61 days and beyond – skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition
0651	G0494	61 days and beyond – skilled services of a licensed practical nurse (LPN for the observation and assessment of the patient's condition
0652		Continuous home care
0655		Inpatient respite care
0656		General inpatient care
0658		Nursing facility room and board
0659		Inpatient hospice room and board

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

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

Level of Care	Bill Type	Revenue Code
Routine Home Care	82X	0651
The hospice provider is to bill the routine home care rate for each day the client is under their care and another level of care is not reimbursed. The rate is a per diem rate. See billing information below table.		
Continuous Home Care	82X	0652
Continuous home care is to be provided by the hospice only during a period of crisis. Bill the continuous home care rate when continuous home care is provided. Reimbursement is for every hour or part of an hour of care furnished up to a maximum of 24 hours a day. A minimum of at least eight (8) hours a day must be provided. One (1) unit equals one (1) hour of service. The rate is an hourly rate.		
Inpatient Respite Care	81X	0655
Respite care is reimbursed to an approved inpatient facility for a maximum of five (5) consecutive days at a time including the date of admission but not counting the date of discharge. The rate is a per diem rate.		
General Inpatient Care	81X	0656
The hospice is to bill the general inpatient rate when general inpatient care is provided. If the client is discharged from general inpatient care as deceased, the general inpatient rate is billed for that day. If they are discharged to home, the appropriate home care rate is billed on a separate claim form. The rate is a per diem rate.		
Nursing Facility Hospice Room and Board	81X	0658
The hospice provider is to bill the nursing facility room and board component when the individual is a nursing facility resident. The hospice provider is responsible for paying the nursing facility. Use the provider number assigned to the hospice provider for nursing facility resident's room and board. The rate is a per diem rate.		
Inpatient Hospice Room and Board	81X	0659
The hospice provider is to bill the inpatient hospice room and board rate for each day a client is in the hospice facility receiving care or in the inpatient hospice facility receiving respite care. Revenue codes 0652, 0656, and 0658 cannot be billed with revenue code 0659. The rate is a per diem rate. There is no client copay.		

17.1.3.1 Billing Examples

Routine Home Care Payments

Revenue code: 0651

Procedure code: G0493 or G0494

Days 61 and beyond will be reimbursed at the lower "day 61 and beyond" rate

- Billing examples
    - Bill on one line: 0651, G0493 or G0494, appropriate service dates & units, and total charges OR
    - Bill on two lines (service dates on the claim must be different):
        - Line 1: 0651, no procedure code, appropriate service dates & units, and total charges.
        - Line 2: 0651, G0493 or G0494, appropriate service dates & units, and total charges.

Hospice client lifetime 60 day limit

- A client's hospice days will be calculated over a lifetime, meaning they will never reset.
- On 3/1/2016, Medicaid will reprocess any paid hospice claims with dates of service 1/1/2016 and forward to calculate the client's lifetime days.
- Once a client exceeds 60 days the provider must bill with the procedure code.
- Providers' responsibility to track the number of days for each client.
- EOB code: 567: Client exceeded 60 days or received 60 or less of routine home care & procedure code G0493 or G0494 was not billed or was billed with rev code 0651.

Service Intensity Add-On (SIA) Payment

Revenue code: 0651

Procedure code: G0162

This SIA service is reimbursable only when provided by a Registered Nurse or Social Worker in the last seven (7) days of the client's life.

- The SIA service is limited to a maximum of 4 hours per day.
- For claims to process to payment Medicaid must have the client's date of death on file and the dates of service are within the prior seven (7) days. Claims will be held as "in process" for 30 days pending the date of death and will deny after 30 days if no date of death is received.
- The SIA service is only billable in conjunction with routine home care (revenue code 0651).
    - A Medicaid hospice provider must have provided and received payment for the client's routine home care services within the last 2-years. To clarify, the claims history will go back to dates of service 1/1/16 and forward, but in the year 2018 will eventually review a full two (2) years from dates of service 1/1/16.

Billing Examples:

- Bill on one line: 0651, G0162 (SIA), appropriate service dates & units, and total charges; OR
- Bill on two lines (service dates on the claim must be different):
    - Line 1: 0651, no procedure code (60 or less days), appropriate service dates & units, and total charges.
    - Line 2: 0651, G0162 (SIA), appropriate service dates & units, and total charges.
- Bill on two lines (service dates on the claim must be different):
    - Line 1: 0651, G0493 or G0494 (exceeds 60 days), appropriate service dates & units, and total charges.

    - Line 2: 0651, G0162 (SIA), appropriate service dates & units, and total charges.
- Bill on three lines (service dates on the claim must be different):
    - Line 1: 0651, no procedure code (60 or less days), appropriate service dates & units, and total charges.
    - Line 2: 0651, G0493 or G0494 (exceeds 60 days), appropriate service dates & units, and total charges.
    - Line 3: 0651, G0162 (SIA), appropriate service dates & units, and total charges.

17.1.4 Nursing Facility Resident

For clients residing in the nursing facility, the hospice provider is responsible for billing the room and board charges, and reimbursing the nursing facility for their portion of the care. The hospice provider must request prior authorization to establish a rate for nursing home care (6.14, Prior Authorization).

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

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

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

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

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

The nursing home will not be able to submit any claims for a client who has elected hospice care. (19.2.2, Clients Under Hospice Care).

17.1.5 Reimbursement

In order for Medicaid to reimburse a hospice provider the following need to be completed as applicable:

- A physician certification statement of terminal illness certifying the client's medical prognosis is a life expectancy of six (6) months or less if the terminal illness runs its normal course sent to Provider Relations.
    - A copy must also be sent via fax or email to the Long Term Care Unit (2.1, Quick Reference).
- A Wyoming Medicaid Hospice Benefit Election Form (17.1.1.1 Hospice Benefit Election Form) has been completed. Only the WDH Medicaid Hospice Benefit Election Form will be accepted.
    - Clients who are eligible for both Medicare and Medicaid (dual eligible) must elect hospice under both programs.
    - A copy must also be sent via fax or email to Long Term Care Unit (2.1, Quick Reference).
- The hospice provider must request prior authorization to establish a rate for nursing home care when the client is residing in the nursing home (6.14, Prior Authorizations).
    - The prior authorization number must be entered on the claim.
- Providers billing revenue code 0659 will need to provide a certification as a licensed inpatient hospice facility.

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

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

17.1.6 Services Unrelated to the Terminal Illness

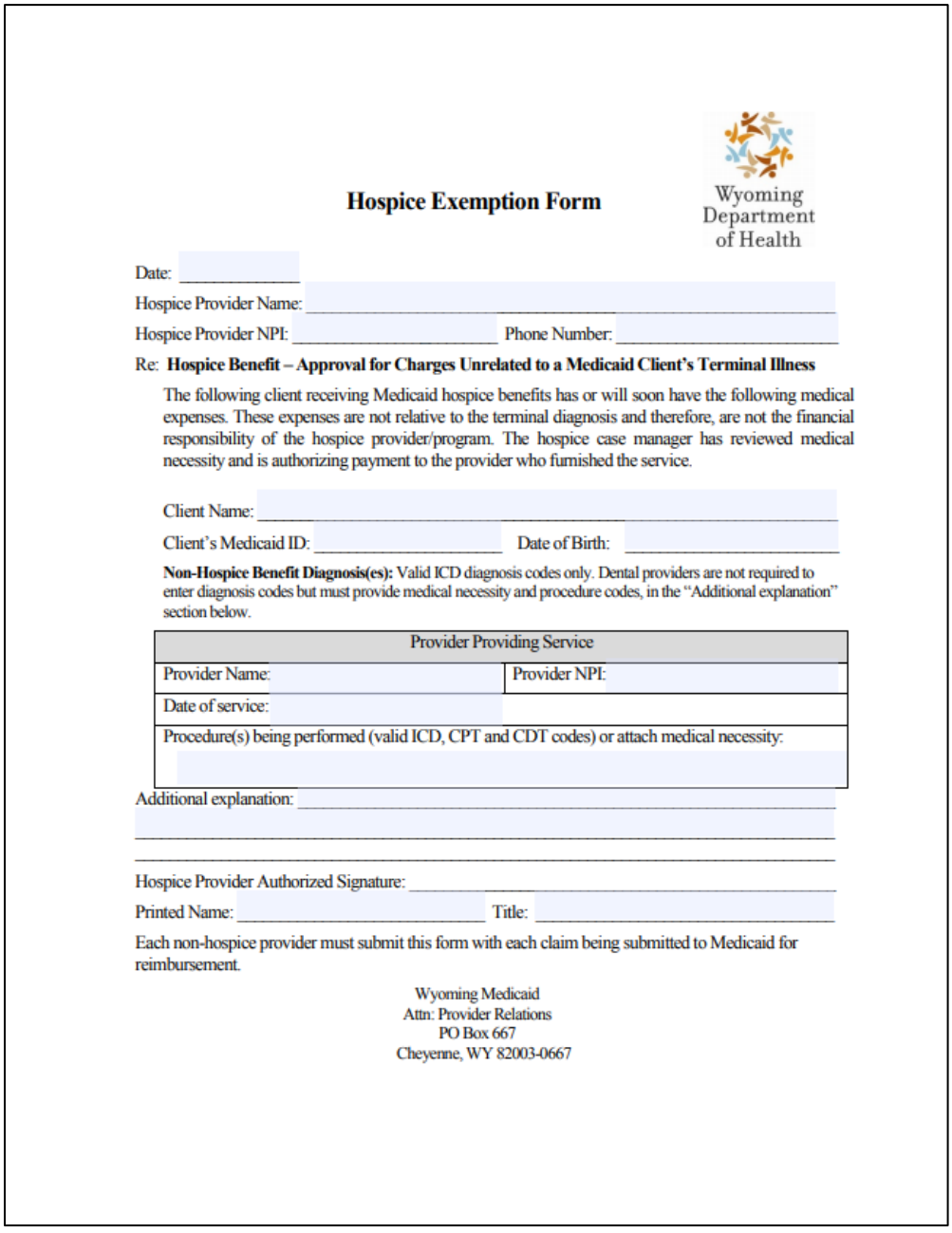
For services unrelated to the client's terminal illness, the hospice provider must provide the Hospice Exemption Form to the billing provider in order for the provider to be reimbursed. The service must be unrelated to the client's terminal illness to qualify.

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

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

NOTE: Providers may either upload the Hospice Benefit Election Form electronically or complete the Attachment Cover Sheet and mail the form (6.15, Submitting Attachments for Electronic Claims).

17.1.6.1 Hospice Exemption Form



Hospice Exemption Form

Wyoming Department of Health

Date: _____

Hospice Provider Name: _____

Hospice Provider NPI: _____ Phone Number: _____

Re: **Hospice Benefit – Approval for Charges Unrelated to a Medicaid Client's Terminal Illness**

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

Client Name: _____

Client's Medicaid ID: _____ Date of Birth: _____

Non-Hospice Benefit Diagnosis(es): Valid ICD diagnosis codes only. Dental providers are not required to enter diagnosis codes but must provide medical necessity and procedure codes, in the "Additional explanation" section below.

Provider Providing Service	
Provider Name:	Provider NPI:
Date of service:	
Procedure(s) being performed (valid ICD, CPT and CDT codes) or attach medical necessity:	

Additional explanation: _____

_____

_____

Hospice Provider Authorized Signature: _____

Printed Name: _____ Title: _____

Each non-hospice provider must submit this form with each claim being submitted to Medicaid for reimbursement.

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

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

Chapter Eighteen – Indian Health Services (IHS)

18.1 Indian Health Services – Including 638 Tribal Facilities

Appropriate Bill Type(s): **13X**

Pay-to Provider Taxonomy: **261QP0904X**

Indian Health Services (IHS), an agency of the US Public Health Services within the Department of Health and Human Services, is the principal Federal health care provider for Native American people.

Paramount to the goals of IHS is raising the Native Americans' health status to the highest possible level.

Indian Health Services provides comprehensive health care services, outpatient services including but not limited to: medical, vision, dental, and preventative services, etc.

18.1.1 Reimbursement

Indian Health Services are reimbursed through an encounter method.

An encounter is a face-to-face visit with an enrolled health care professional such as:

- Physician
- Physician's assistant
- Nurse practitioner
- Nurse midwife
- Psychologist
- Social worker
- Dental professional
- Physical, Occupational, Speech therapist, Dietitian and Chiropractor
- Mental Health Professional
- Home Health service provider

18.1.1.1 Encounter Rate

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes, but is not limited to:

- Therapeutic services
- Diagnostic services
- Tests
- Supplies

18.1.2 Billing Requirements

- Multiple encounters with one (1) or more professionals or multiple encounters with the same health professional on the same day in a single location should be billed as one (1) encounter, unless the patient suffers illness or injury which requires additional diagnosis or treatment.
- Starting April 1, 2017, claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.
- Each line (encounter and detail) must be billed with revenue and procedure codes
- All services provided during the encounter must be billed on a separate line.
- Encounter lines will be billed with the appropriate revenue code (see 18.1.3 for covered services) paired with:
    - Procedure code T1015 for general encounter.
    - Bill the current encounter rate per calendar year.
- Detail line items will be billed with:
    - Any appropriate outpatient revenue code paired with an appropriate procedure code (for questions regarding appropriate pairing of revenue codes and procedure codes, use the current version of the NUBC Official UB Data Specifications Manual).
    - Include a detail line for the office visit or health check procedure if appropriate.
    - Document each procedure that occurred during the encounter.
    - Bill the detail line items at $0.00
- Pharmacy claims do not require a procedure code but need to be billed with an eleven (11) digit National Drug Code (NDC) (see section 6.8 for NDC instructions)

Each revenue code encounter line with detail lines must be billed on a separate claim.

NOTE: Do not bill with the encounter revenue code on the detail line item. For the detail line, bill with any appropriate revenue code paired with an appropriate procedure code.

18.1.2.1 Billing Examples

Client comes to the clinic for complaint of cough and sees a physician. No additional tests or treatments are administered.

- **Claim #1 Date of Service 04/01/17**

Revenue Code	Procedure Code	Amount
0500	T1015	$391
0517	99213	$0.00

Client comes to the clinic for a medical appointment and a urine culture is run. The client then goes to the optometrist for an eye check.

- **Claim #1 Date of Service 03/17/17**

Revenue Code	Procedure Code	Amount
0500	T1015	$391
0517	99213	$0.00
0520	87086	$0.00

- **Claim #2 Date of Service 03/17/17**

Revenue Code	Procedure Code	Amount
0519	T1015	$391
0517	92012	$0.00

Client goes to Substance Abuse and Recovery Center and goes to individual therapy. The client then works with a Peer Specialist on goals related to the treatment plan.

- **Claim #1 Date of Service 03/16/17**

Revenue Code	Procedure Code	Amount
0914	T1015	$391
0517	H0047 (individual therapy)	$0.00

- **Claim #2 Date of Service 03/16/17**

Revenue Code	Procedure Code	Amount
0500	T1015	$391
0942	H2015 (peer specialist)	$0.00

NOTE: These are only examples and the appropriate encounter and non-encounter codes and procedure codes should be used.

18.1.3 Covered Services

Revenue Code	Description – within the IHS/638 Facility
0300	Laboratory
0400	Imaging/Radiology
0421	Physical Therapy
0431	Occupational Therapy
0441	Speech Therapy
0500	Medical Encounter
0512	Dental Encounter
0519	Optometric Encounter
0561	Medical Social Worker
0571	Home Health Aide
0771	VFC Administration

0779	Health Check Screening
0821	ESRD Encounter
0914	Psychiatric/Psychological Services – Individual Therapy
0915	Psychiatric/Psychological Services – Group Therapy
0987	Hospital Encounter (IHS physician at the hospital)

18.1.3.1 Laboratory

Revenue Code: 0300

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

- Services are ordered by physicians, dentists, or other providers licensed within the scope of their practice as defined by law.
- Services are provided in the facility.
- Providers must be Medicaid certified and must have a current Clinical Laboratory Improvement Amendments (CLIA) certification number.
- Providers may only bill for services they have performed. Medicaid does not pay for reference lab services.

NOTE: Non-covered services include routine handling charges, State fees, post-mortem examination and specimen collection fees for throat cultures or Pap Smears.

18.1.3.2 Imaging/Radiology

Revenue Code: 0400

Medicaid provides coverage of medically necessary radiology services which are directly related to the client's symptom or diagnosis when provided by independent radiologists, hospitals and practitioners. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

Radiology services must be ordered and provided by practitioners, dentists, or other providers licensed within the scope of their practice as defined by law. Radiology providers must be supervised by a practitioner licensed to practice within the state the services are provided.

18.1.3.3 Physical Therapy

Revenue Code: 0421

All services provided in the clinic by a physical therapist are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.4 Occupational Therapy

Revenue Code: 0431

All services provided in the clinic by the occupational therapist are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.5 Speech Therapy

Revenue Code: 0441

All services provided in the clinic by a speech therapist are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.6 Medical Encounters (within IHS Clinic)

Revenue Code: 0500

All professional services (including ancillary services and supplies) must be performed by or under the direct supervision of a licensed physician or doctor of osteopathy operating within the scope of his/her practice. This includes services rendered by a nurse practitioner, physical therapist, or other covered licensed health care professional performing services consistent with their scope of practice. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.7 Dental Encounters (within IHS Clinic)

Revenue Code: 0512

All professional services (including ancillary services and supplies) must be performed by or under the direct supervision of a licensed dentist operating within the scope of his/her practice. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.8 Optometric Encounters (within IHS Clinic)

Revenue Code: 0519

All professional services (including ancillary services and supplies) performed by a licensed optometrist practicing within the scope of his/her practice. Routine eye examinations are not covered for clients age 21 and older. Treatment of eye diseases or eye injury continues to be covered when billed with the appropriate diagnosis code. The reason for the visit must be documented in the medical record. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.9 Medical Social Worker

Revenue Code: 0561

Medical social services provided by a qualified licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW) -prepared person supervised by an MSW. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.10 VFC Administration

Revenue Code: 0771

All services provided during the visit are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.11 Comprehensive Health Screening (Health Checks)

Revenue Code: 0779

Indian Health Services is encouraged to participate in the Health Check (Well Child) program for Medicaid children under the age of 21. When an encounter meets the standards for a Health Check exam, use the Health Check encounter code(s) to assist the Medicaid program in tracking these services accurately. Individuals under age 21 are entitled to comprehensive health examinations. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

NOTE: This revenue code cannot be billed with any other revenue code on the same claim.

18.1.3.12 ESRD Encounter

Revenue Code: 0821

All services provided during the ESRD visit are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.13 Mental Health (Individual)

Revenue Code: 0914

All services provided during the encounter by the mental health professional are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.14 Mental Health (Group)

Revenue Code: 0914

All services provided during the encounter by the mental health professional are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.15 Hospital Visits by the Physician

Revenue Code: 0987

All services provided in the hospital by the physician will be billed together under this revenue code. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.16 Home Health Agency (Includes Therapies)

Revenue Codes: 0421, 0431, 0441, 0551, 0561 & 0571

When services are provided in the home, refer to Chapter 16, Home Health Services. Home health services cannot be paid the all-inclusive encounter rate because the services are not provided within the clinic.

Revenue Code	Description - provided in the client home
0421	Home Health - Physical Therapy
0431	Home Health - Occupational Therapy
0441	Home Health - Speech Therapy
0551	Home Health - Skilled Nursing
0561	Home Health - Medical Social Worker
0571	Home Health Aide

18.1.3.17 Non-Emergency Medical Transportation (NEMT)

Wyoming Medicaid provides non-emergency medical transportation (NEMT) services to clients who are in need of assistance traveling to and from medical appointments to enrolled providers to obtain covered services.

Wyoming Medicaid enrolls taxi providers (344600000X), non-taxi ride providers (347C00000X), and lodging providers (177F00000X) to provide covered services.

For the complete policy on travel services, please refer to the CMS 1500 Provider Manual, Chapter Twenty Three – Covered Services – Non-Emergency Medical Transportation.

Chapter Nineteen – Skilled Nursing Facility and Swing Bed Services

19.1 Skilled Nursing Facility (SNF) and Swing Bed Services

Skilled Nursing Facilities provide long term care to clients who are unable to live independently safely, including room and board, dietary needs, laundry services, nursing services, minor medical services, surgical supplies, over the counter medications, and the use of the equipment and facilities.

Swing Bed services are those long term care services provided in the hospital setting in place of transferring the client to the skilled nursing facility, and are subject to the same policy as those services provided in the skilled nursing facilities.

19.1.1 Covered Services

Services provided in the skilled nursing facility or swing beds are reimbursed based on a per diem payment that is all inclusive of the care for the patient for the day. This care includes but is not limited to:

- All general nursing services, including but not limited to:
  - Administration of oxygen and related medication
  - Hand feedings
  - Incontinency care
  - Tray service
- Therapy services, including:
  - Physical Therapy
  - Speech Therapy
  - Occupational Therapy

NOTE: If the facility is unable to provide therapy in the facility or chooses to send the client to an external therapist, the facility is responsible for the therapy charges as part of the Medicaid per diem.

- Medical supply and drug items stocked at nursing stations or on the floor in gross supply and distributed individually in small quantities, such as:
  - Alcohol
  - Applicators
  - Cotton balls
  - Band-Aids
  - Gloves
  - Ostomy supplies
  - Tongue depressors
- Oxygen and over-the-counter drugs, which includes insulin.
- Items which are used by individual patients but which are reusable and expected to be available, such as:
  - Ice bags
  - Bed rails
  - Canes

  - Crutches
  - Walkers
  - Wheelchairs
  - Traction equipment
  - Other durable medical equipment
- Laundry services for routine nursing facility requirements and clients personal clothing.
- Over the counter nutritional supplements used for tube feeding or oral feeding, even if written prescription items by a physician.

NOTE: When reviewing the fee schedule on the Wyoming Medicaid website, the Nursing Home indicator will either be indicated as "Y"- Yes, this item is allowed outside of the NH per diem or "N"- No, this item is not allowed outside of the NH per diem.

Incentive Indicator: N	Nursing Home Covered: Y
Referral Indicator: N	Hysterectomy Indicator: N
Dental Number: N	Sterilization Indicator: N/A
Dental Quadrant: N	Dental Surface: N
CLIA Certification Type: N/A	

19.1.1.1 Private Rooms

Medicaid reimburses for room and board for nursing home clients. Room and board in a semi-private room is included in the per diem – if a client wishes to stay in a private room within the nursing facility, the facility can bill Wyoming Medicaid as normal, and accept the reimbursed amount as payment in full for the private room, OR the responsible party for the nursing home client can pay the rate for the private room in full. The provider may not "balance bill" the client for the cost difference between a regular room and a private room within the facility.

19.1.2 Items Included in the Per Diem Rate

- ABD Pads
- Adhesive tape
- Aerosol, other types
- Air Mattresses, Air P.R. Mattresses
- Airway-Oral
- Alcohol Plaster
- Alcohol Sponges
- Alternating Pressure Pads
- Applicators, Cotton-tipped
- Applicators, Swab-eez
- Aquamatic K Pads (Water-Heated Pad)
- Arm Slings
- Asepto Syringes
- Baby Powder
- Bandages
- Bandages-Elastic or Cohesive
- Band-Aids
- Basins
- Bed Frame Equipment (for certain immobilized bed patients)
- Bed Rails
- Bedpans, All Types
- Beds; Manual, Electric, Clinitron
- Bedside tissues

- Bibs
- Blood Infusion Sets
- Bottle, Specimen
- Canes, All Types
- Cannula-Nasal
- Catheter-Indwelling
- Catheter Plugs
- Catheter Trays
- Catheter (any size)
- Colostomy Bags
- Combs
- Commodes, All Types
- Composite Pads
- Cotton Balls
- Crutches, All Types
- Decubitus Ulcer Pads/Dressings
- Denture Cleaner/Soak
- Denture Cups
- Deodorants
- Diapers
- Disposable Underpads
- Donuts
- Douche Bags
- Drain Tubing
- Drainage Bags
- Drainage Sets
- Drainage Tubes
- Dressing Tray
- Dressing, All Types
- Drugs (over the counter drugs as designated by the FDA)
- Enema Soap
- Enema Supplies
- Enema Unit
- Equipment and Supplies for Diabetic blood and urine testing
- Eye Pads
- Feeding Tubes
- Fingernail Clipping and Cleaning
- Flotation Mattress or Biowave mattress
- Flotation Pads and/or Turning Frames
- Foot Cradle, all types
- Gastric Feeding Unit, Including Bags
- Gauze Sponges
- Gloves, Unsterile and Sterile
- Gowns, Hospital
- Green Soap
- Hair Brushes
- Hair Care, Basic
- Hand Feeding
- Heat Cradle
- Heating Pads
- Heel Protector
- Hot Pack Machine
- Hydraulic Patient Lifts
- Hypothermia Blankets
- Ice Bags
- Incontinency Care
- Incontinency Pads and Pants
- Influenza Vaccine
- Infusion Arm Boards
- Infusion pumps, Enteral and Parenteral
- Inhalation Therapy Supplies
- Irrigation Bulbs
- Irrigations Trays
- I.V. Needles
- I.V. Trays
- Jelly, Lubricating
- Lines, Extra
- Lotion, Soap and Oil
- Massages (by facility personnel)
- Mattresses, All Types
- Medical Social Services
- Medicine Dropper
- Medicine Cups
- Nasal Catheter
- Nasal Catheter, Insertion and Tube
- Nasal Gastric Tubes
- Nasal Tube Feeding and feeding bags
- Nebulizer and Replacement kit
- Needles (various sizes)

- Needles – Hypodermic, Scalp Vein
- Non-Legend Nutritional Products
- Nursing Services (all) regardless of level including the administration of oxygen and restorate nursing care
- Nursing Supplies and Dressing
- Ostomy Supplies; Adhesive, Appliance, Belts, Fact Plates, Flanges, Gaskets, Irrigation sets, Night Drains, Protective Dressings, Skin Barriers, Tail Closures
- Over-the-Counter Drugs, including insulin
- Overhead Trapeze Equipment
- Oxygen, Gaseous and Liquid
- Oxygen Concentrators
- Oxygen Delivery Systems, Portable or Stationary
- Oxygen Mask
- Pads
- Pitcher
- Plastic Bib
- Pumps (Aspiration and Suction)
- Pumps for Alternating Pressure Pads
- Respiratory Equipment; Ambu Bags, Cannulas, Compressors, Humidifier, IPPS Machines and Circuits, Mouthpieces, Nebulizers, Suction Catheters, Suction Pumps, Tubing, Etc.
- Restraints
- Room and Board (Semi-private or private if necessitated by a medical or social condition)
- Sand Bags
- Scalpel
- Shampoo
- Shaves
- Shaving Cream
- Shaving Razors
- Sheepskin
- Side Rails
- Soap
- Special Diets
- Specimen Cups
- Sponges
- Steam Vaporizer
- Sterile Pads
- Sterile Saline for Irrigation
- Sterile Water for Irrigation
- Stomach Tubes
- Suction Catheter
- Suction machines
- Suction Tube
- Surgical Dressings (including sterile sponges)
- Surgical Pads
- Surgical Tape
- Suture Removal Kit
- Suture Trays
- Syringes (all sizes)
- Syringes, disposable
- Tape-for laboratory tests
- Tape (non-allergic or butterfly)
- Testing Sets and Refills (S&A)
- Therapy Services

NOTE: **Therapy Services** – If the facility is unable to provide therapy in the facility or chooses to send the client to an external therapist, the facility is responsible for the therapy charges as part of the Medicaid per diem.

- Toenail Clipping and Cleaning
- Tongue Depressors
- Toothbrushes
- Toothpaste
- Tracheostomy Sponges
- Transportation
- Trapeze Bars

- Tray Service
- Underpads
- Urinals, male and female
- Urinary Drainage Tube
- Urinary Tube and Bottle
- Urological Solutions
- Walkers, all types
- Water Circulating Pads
- Water Pitchers
- Wheelchairs: Amputee, Geriatric, Heavy Duty, Hemi, Lightweight, One Arm Drive, Reclining Roll-about, Semi-Reclining, Standard, Etc.

For the most current list of covered items review Attachment A in Chapter 7 of the State of Wyoming rules at: https://rules.wyo.gov/

NOTE: Certain drugs and pharmaceutical products may be dispensed by a long-term care facility and are included in the facility's per diem rate. Over-the-counter drugs, products, and medical supplies/equipment ordered by a physician for use by person residing in a nursing facility are included in the nursing facility's per diem rate and cannot be reimbursed separately, including insulin and diabetic supplies. This includes all over-the-counter drugs and products. Insulin and diabetic supplies are considered over-the-counter drugs and supplies.

Certain items are permitted to be billed outside of the per diem. These items include those that are customized or specialized for a specific client's use that would not be functional or beneficial to any other client such as:

- Ambulance services – when medically necessary
- Customized wheelchairs and seating systems
- Dental
- Hearing Aids
- Mental Health services
- Medical Services including
    - Laboratory, radiology, surgical procedures
- Orthotics
- Physician and other practitioner services, excluding Physical, Occupational and Speech Therapy
- Prosthetics

The fee schedule on the Medicaid website (2.1, Quick Reference) will document whether a specific procedure code is allowed outside of the per diem for a long term care resident. "Y" means it can be billed outside of the per diem. All charges must be billed by a provider outside of the nursing facility.

19.1.3 Nursing Facility / Swing Bed Transportation

The cost for non-ambulance patient transportation is included in the facilities per diem rate and includes:

- Patient returns home after discharge from facility
- Patient return to facility after discharge from hospital
- To/from appointments outside the facility
- Non-emergent transport to the hospital

For ambulance services, refer to the Ambulance Services section in the CMS-1500 Provider Manual.

The provider should make an effort to select the most efficient and cost effective mode of transportation for resident care which may include utilizing a facility owned vehicle or contracted outside service.

19.1.4 Prescription Drugs

Prescription drug services are handled through the pharmacy program, and all prescription drugs must be filled at an enrolled pharmacy. Skilled nursing facilities and swing bed units will not be reimbursed for the distribution of pharmacy drugs or products to clients, outside of the per diem. Please contact Change Healthcare for any pharmacy related questions (2.1, Quick Reference).

19.2 Patient Contributions

The Long Term Care Unit establishes the patient contribution upon admission to the nursing facility. Medicaid receives the initial patient contribution amount. Any adjustments made to the patient contribution must be reflected on the Patient Contribution Notice. The Long Term Care Unit will change or pro-rate the patient contribution as needed. They send the Patient Contribution Notice to the facility. The facility then submits an Adjustment Form along with the Patient contribution Notice to Medicaid to change the patient contribution.

A new Patient Contribution Notice is required for each calendar year, i.e., a Patient contribution Notice stating a change is for September forward is valid for September – December. For January a new Patient contribution Notice would be needed.

NOTE: Only paid claims can be adjusted. (6.17, Resubmitting Versus Adjusting Claims)

19.2.1 Multiple Facilities Billing and Patient Contribution

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

- Nursing Facility vs. Nursing Facility

Patient contribution is allocated across claims at 100% in the order the claims are received and processed. For example, if a client is a resident of two (2) facilities in the same month, the patient contribution would be taken from total amount paid from the first facility to bill and be paid until the patient contribution is satisfied. If payment to the first facility does not exhaust the client's patient contribution, the remaining patient contribution will be applied to the next facilities paid claim. This may mean that the provider who billed for the client for the second half of the month will be collecting the patient contribution and the provider billing for the first half of the month will receive a zero (0) patient contribution assignment.

- Nursing Facility vs. Hospice Services Provided with the Nursing Facility

Patient contribution is allocated across claims at 100% in the order the claims are received and processed. For example, if a client is a resident of a nursing facility and is receiving nursing facility hospice services in the same month, the patient contribution would be taken from total amount paid from the first provider (nursing facility or hospice provider) to bill and be paid until the patient contribution is satisfied. If payment to the first provider does not exhaust the client's patient contribution, the remaining patient contribution will be applied to the next provider's paid claim. This may mean that the provider who billed for the client for the second half of the month will be collecting the patient contribution and the provider billing for the first half of the month will receive a zero (0) patient contribution assignment. For subsequent months, the full patient contribution will be applied to the hospice claim.

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

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

19.2.2 Clients Under Hospice Care

For those clients receiving hospice care, no payment will be made to the skilled nursing facility or swing bed. Room and board is billed by the hospice and payment will be made to the hospice. The hospice is required to reimburse the nursing facility for the nursing facility's contracted rate (17.1.3, Nursing Facility Residents).

19.3 Evaluations That Must be Completed

The following two (2) evaluations must be completed prior to admission into skilled nursing or swing bed facilities:

- LT101
- PASRR -Pre Admission Screening and Resident Review

The following evaluation must be completed prior to admission into an ICF/ID:

- LT-MR-104

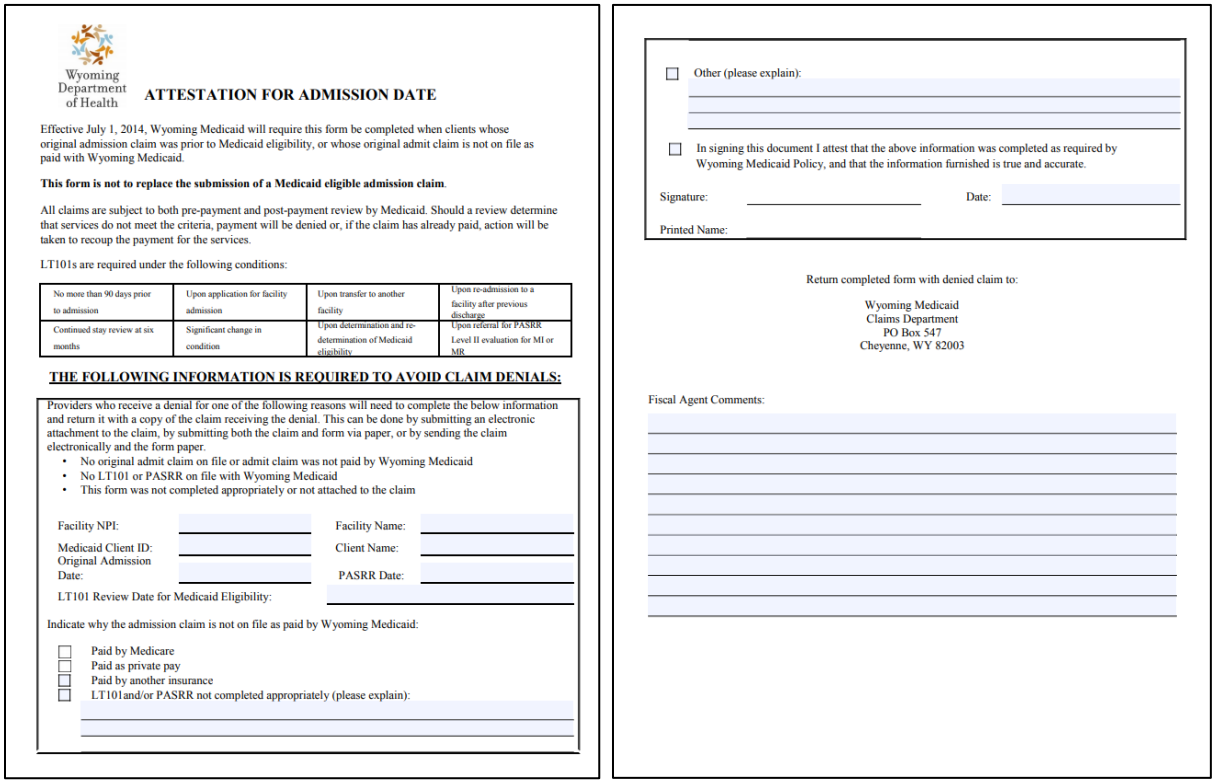
For all claims submitted after July 1, 2014 that are denied for one (1) of the following reasons, an Attestation for Admission Date Form (19.3.1, Attestation for Admission Date Form) must be completed and submitted with the claim form:

- Denied for no original admit claim on file with Wyoming Medicaid
- Denied for no LT101 or PASRR on file with Wyoming Medicaid
- Denied for no Attestation for Admission Date Form attached to the claim
- Denied for the Attestation for Admission Date Form not completed appropriately

This form can be attached to the claim form using one (1) of these methods:

- For electronic claim submissions
    - The attachment indicator must be a "Y" on the electronic claim submission, and the form can be uploaded electronically or submitted separate via paper. For a step by step tutorial on uploading the claim and attachment via the Secured Provider Web Portal, visit the Web Portal Tutorials section of the website and click on Institutional under the HIPAA 5010 Web Portal Tutorials, or view the WINASAP Tutorial under the WINASAP section of the website (2.1, Quick Reference).

19.3.1 Attestation for Admission Date Form



Wyoming Department of Health

ATTESTATION FOR ADMISSION DATE

Effective July 1, 2014, Wyoming Medicaid will require this form be completed when clients whose original admission claim was prior to Medicaid eligibility, or whose original admit claim is not on file as paid with Wyoming Medicaid.

This form is not to replace the submission of a Medicaid eligible admission claim.

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

LT101s are required under the following conditions:

No more than 90 days prior to admission	Upon application for facility admission	Upon transfer to another facility	Upon re-admission to a facility after previous discharge
Continued stay review at six months	Significant change in condition	Upon determination and re-determination of Medicaid eligibility	Upon referral for PASRR Level II evaluation for MI or MR

THE FOLLOWING INFORMATION IS REQUIRED TO AVOID CLAIM DENIALS:

Providers who receive a denial for one of the following reasons will need to complete the below information and return it with a copy of the claim receiving the denial. This can be done by submitting an electronic attachment to the claim, by submitting both the claim and form via paper, or by sending the claim electronically and the form paper.

- No original admit claim on file or admit claim was not paid by Wyoming Medicaid
- No LT101 or PASRR on file with Wyoming Medicaid
- This form was not completed appropriately or not attached to the claim

Facility NPI: _____ Facility Name: _____

Medicaid Client ID: _____ Client Name: _____

Original Admission Date: _____ PASRR Date: _____

LT101 Review Date for Medicaid Eligibility: _____

Indicate why the admission claim is not on file as paid by Wyoming Medicaid:

- ☐ Paid by Medicare
- ☐ Paid as private pay
- ☐ Paid by another insurance
- ☐ LT101and/or PASRR not completed appropriately (please explain):

☐ Other (please explain):

☐ In signing this document I attest that the above information was completed as required by Wyoming Medicaid Policy, and that the information furnished is true and accurate.

Signature: _____ Date: _____

Printed Name: _____

Return completed form with denied claim to:

Wyoming Medicaid
Claims Department
PO Box 547
Cheyenne, WY 82003

Fiscal Agent Comments:

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

19.3.1.1 Instructions for Completed the Attestation for Admission Date Form

- Read the form completely.
- Fill out all of the required information completely and accurately to ensure processing.
    - Facility NPI
    - Facility Name
    - Client Medicaid ID Number
    - Client Name
    - Original Admission Date (this is the date the client was first accepted into the nursing facility)
    - LT101 Review Date (the date of LT101 closest to the determination of Medicaid eligibility)
- Indicate why the admission claim is not on file as paid by Wyoming Medicaid by checking the appropriate box, or checking "Other" and providing explanation.
- Attest and complete remainder of form.

NOTE: For residents with a previous admit to the same skilled nursing facility, the previous stay must be billed through the date of discharge using the patient status code of "discharged". If not, future claims will deny for the client not being properly discharged. Claims in history can be adjusted and corrected to show the correct date of discharge.

19.3.2 LT101 (Medicaid Evaluation of Medical Necessity)

- The LT101 is a functional assessment performed by a Public Health Nurse under contract with the Division of Healthcare Financing. The LT 101 assesses how someone functions independently and captures the burden of care or how much assistance the client needs in performing Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and social and cognitive functioning. This determines whether an applicant or client meets nursing facility level of care for Medicaid nursing facility services, swing bed services, Home and Community Based Services (HCBS); Community Choices Waiver (CCW), or PACE (Program of All-Inclusive Care for the Elderly) services.
- LT101s are valid for 90 days after completion.
- The Secured Provider Web Portal provides office administrators for skilled nursing facilities, swing bed units, hospitals and other appropriate providers with the ability to review a client's LT101s that are on file with Wyoming Medicaid. This resource can be used to make sure that appropriate documents are in place with Wyoming Medicaid before billing is completed, to avoid denials of claims. (2.1, Quick Reference)
- Facilities must request an LT101 electronically through the Wyoming Department of Health Application Gateway: https://gateway.health.wyo.gov/. If the facility does not have access, please email the Assessment Coordinator of Long Term Care/Community Based Services Unit (CBSU), Sherry Mitchell at sherry.mitchell1@wyo.gov to request access. The WDH will not accept faxed LT101 requests.

NOTE: If corrections are needed after an LT101 has been submitted, contact Long Term Care, Sherry Mitchell at sherry.mitchell1@wyo.gov. Within the request, include what needs changed and why.

19.3.3 LT101s are Required Under the Following Conditions

- If there is not a valid LT101 on file. (LT101's are valid for 90 days)
- Prior to Admission
- No more than 90 days prior to admission
- Upon application for nursing facility admission. "Nursing Facility" includes hospital swing bed units. It does not include Medicare only Skilled Nursing Facilities that do not participate in Medicaid.

- Upon transfer to another nursing facility if the current LT101 on file is older than 90 days.
- Upon re-admission to a nursing facility after a previous discharge. "Discharge" does not include temporary absence from the facility for treatment in a hospital, home visit or a trial community stay, provided such a temporary absence is no longer than thirty consecutive days.
- Nursing facility residents shall receive continued stay reviews during the sixth (6th) month.
- Significant change in condition.
- Upon re-determination of Medicaid eligibility following a loss of eligibility for any reason.
- Medicaid shall not grant eligibility to a nursing facility resident unless the resident has an LT101 less than 90 days old.
- Upon referral for PASRR Level II evaluation for MI or MR or Categorical.

19.3.4 PASRR Pre-Admission Screening and Resident Review

PASRR process encompasses PASRR Level 1 and Level II (Pre Admission Screening).

PASRR Level I – The purpose of the Level I is to screen for potential diagnosis of mental illness or intellectual disabilities. Such a determination will result in a referral for a Level II.

Routine annual Level I screenings are no longer required by Medicaid. If the Level I does not result in a referral to Level II, it need never be performed again unless a significant change in the residents condition indicates that a Level II evaluation is advisable or if there is a transfer to another facility.

Mental status changes that result in a new diagnosis or that trigger a significant change to the total score on the Brief Interview for Mental Status (BIMS) or the Patient Health Questionnaire (PHQ9) on the Minimum Data Set (MDS) would result in a significant change of condition.

Please refer to http://pasrrassist.org/resources/mds-30/what-considered-significant-change-condition for more information on significant changes of condition.

PASRR Level II – The purpose of the Level II is to more accurately identify mental illness or intellectually disabled and assess whether the individual needs specialized services and nursing facility level of care.

NOTE: Dementia, including Alzheimer's disease and other dementias, is excluded from the definition of serious mental illness for PASRR purposes. An individual is considered to have dementia if he or she has a primary diagnosis of dementia as described in the DSM (current edition), or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above. A primary diagnosis of a serious mental

illness supersedes a secondary diagnosis of dementia and the individual must be referred for a Level II evaluation.

- Medicaid/Federal law requires all individuals, regardless of payment source, who apply as new admissions to Medicaid Facilities on or after January 1, 1989, must be screened prior to admission for mental illness and intellectual disabilities
    - Individuals for whom respite care is provided (under LTC HCBS Waiver or the DD HCBS Waiver) in a nursing facility must be treated like any other nursing facility admission, therefore, all PASRR and LT101 requirements apply prior to admission
- Any individual who's PASRR Level I screening indicates the presence or probability of mental illness or intellectual disabilities must be referred to the State. This authority has been delegated by contract to WYhealth. (2.1, Quick Reference)
- PASRR Level II must be determined prior to admission to be appropriate for nursing facility payment.
- If the individual is appropriate for nursing facility placement, the need for specialized services will be determined.
    - If an individual seeking admission to a nursing facility has Mental Illness or Intellectual Disabilities and is found to be inappropriate for nursing facility placement, the nursing facility may not admit the individual.
    - If an individual already residing a nursing facility has Mental Illness or Intellectual Disabilities and is found to be inappropriate for nursing facility placement, the provider must cooperatively arrange with the state for the resident's orderly discharge from the facility.
    - Adverse determinations carry the right of appeal for the resident.

NOTE: If corrections are needed after a PASRR has been submitted, contact Benefits Quality Control Manager, Amy Guimond. Within the request, outline the details (client id, name, DOB, PASRR determination date, etc.). Once approved, the PASRR will be deleted and can be re-entered.

NOTE: PASRR is not a requirement for CHOW (Change of Ownership) completion. However, the skilled nursing facility will want to ensure that the admitted residents that need a PASRR evaluation have one on file and all residents are evaluated as appropriate.

19.4 New Admission

A Level I screening is required prior to admission for all new nursing facility admissions, regardless of payment source.

- A re-admission following hospitalization or therapeutic home leave is not considered a new admission for PASRR purposes and does not require a Level I screening unless a new diagnosis indicates the presence of MI or MR.
- An individual with MI or MR who has a Level II in the past and is being readmitted following hospitalization or therapeutic home leave is not considered a new admission.

19.4.1 Transfer

A Level I is required upon transfer from one facility to another facility.

- In the case of a transfer of a resident with Intellectual Disabilities or Mental Illness from the nursing facility to a hospital or to another nursing facility the transferring nursing facility is responsible for ensuring that copies of the most recent PASRR Level I and II (if applicable) and Resident Assessment reports accompany the transferring resident.

19.4.2 Categorical Determinations that do Not Require a Level II Prior to Admission

Pursuant to Federal guidelines, the Division of Healthcare Financing has defined certain categories of conditions that automatically constitute appropriateness for nursing facility placement. The State may override the categorical determination and refer the individual for a Level II where appropriate.

- **Categorical 4 – Appropriate for nursing facility placement due to terminal illness** – Verified in writing by a physician. This constitutes a Level II determination of "appropriate specialized services not required".
- **Categorical 5 – Appropriate for nursing facility placement due to severe medical conditions** – This determination may only be applied to an individual with Mental Illness or Intellectual Disabilities who is comatose, ventilator dependent, functions at the brain stem level, OR has a diagnosis such as COPD, severe Parkinson's disease, amyotrophic lateral sclerosis, congestive heart failure (CHF), cardiovascular accident (CVA), Huntington's Disease, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end stage renal disease (ESRD), severe diabetic neuropathy or refractory anemia. The condition must result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. This constitutes a Level II determination of "appropriate, specialized services not required".
- **Categorical 6 – Convalescent care for an acute physical illness** – This determination applies only to an individual with Mental Illness or Intellectual Disabilities who has an acute physical illness which required hospitalization; **AND** does not meet all the criteria for an exempt hospital discharge (defined above). This categorical determination is limited to 120 days. When it becomes apparent the individual will require nursing facility placement longer than 120 days, the nursing facility must complete the Level II. A Level II

determination must be rendered before permanent nursing facility placement can be made.

- **Categorical 7 – Provisional placements** – Pending further assessment in cases of delirium, where an accurate diagnosis cannot be made until the delirium clears, or for respite of caregivers. This categorical determination is limited to 14 days. The nursing facility must complete the Level II. A Level II determination must be rendered before permanent nursing facility placement can be made.
- **Categorical 8 – Emergency placement** – For an individual with Mental Illness or Intellectual Disabilities for the individual's protection. This categorical determination is limited to seven (7) days, at which time the nursing facility must complete the Level II. The determination must be rendered before permanent nursing facility placement can be made.

19.5 Medicaid Reimbursement

Medicaid will not reimburse a nursing facility for services provided to any individual who has not been screened at Level I.

- Payment will commence as of the Level I date or admission date, whichever is later.
- No retroactive payment will be made.

Medicaid will not reimburse a nursing facility for services provided to any individual with MI or MR who is admitted prior to completion of a PASRR Level II.

- Payment will commence upon the date of determination of appropriate placement.
- No retroactive payment will be made.
- The nursing facility may be subject to withdrawal of Medicaid certification if such a person is admitted to the facility before a Level II determination is rendered.

Medicaid will not reimburse a nursing facility for services provided to any individual who has previously been found to be inappropriate for nursing facility placement due to the need for specialized services.

- Any individual who has received such a determination must be re-evaluated and determined to be appropriate before any placement will be allowed.

NOTE: Medicaid does not accept paper copies of the PASRR screening forms. All PASRR forms must be entered on the Secured Provider Web Portal (2.1, Quick Reference). Please contact your office administrator if you are in need of a log on ID to access the secure web portal. If you do not know

who your office administrator is contact EDI Services (2.1, Quick Reference) Refer to the Medicaid web site for instructions on how to enter the PASRR online.

19.6 Billing Requirements

19.6.1 Nursing Facility

Revenue Code: **0100 – Room & Board**

Appropriate Bill Type: **21X, 23X**

Pay-to Provider's Taxonomy: **31400000X, 315P00000X, 283Q00000X (State Hospital Only)**

19.6.2 Swing Bed

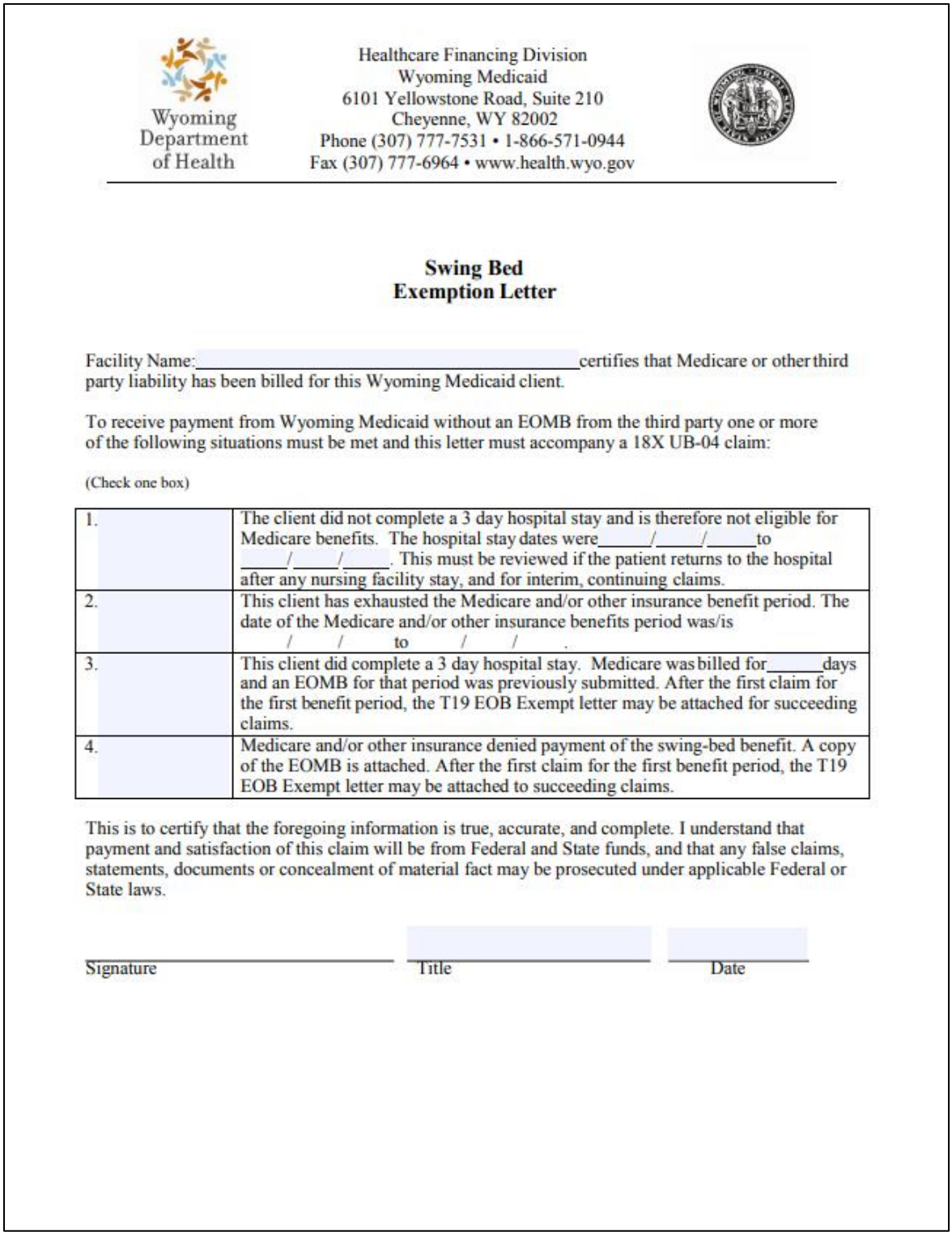
Revenue Code: **0100- Room & Board**

Appropriate Bill Type: **18X**

Pay-to Provider's Taxonomy: **275N00000X**

- Enter one (1) unit for each day the client was a resident
- Medicaid does not pay for the date of discharge
    - Reduce units by one (1) in order to reflect this
    - Patient status on the claim is something other than 30 (still a patient) (6.4.1 Instructions for Completing the UB-04 Claim Form)

19.6.2.1 Swing Bed Exemption Letter



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

Swing Bed
Exemption Letter

Facility Name:_____certifies that Medicare or other third party liability has been billed for this Wyoming Medicaid client.

To receive payment from Wyoming Medicaid without an EOMB from the third party one or more of the following situations must be met and this letter must accompany a 18X UB-04 claim:

(Check one box)

1.	The client did not complete a 3 day hospital stay and is therefore not eligible for Medicare benefits. The hospital stay dates were_____/_____/_____to _____/_____/_____. This must be reviewed if the patient returns to the hospital after any nursing facility stay, and for interim, continuing claims.
2.	This client has exhausted the Medicare and/or other insurance benefit period. The date of the Medicare and/or other insurance benefits period was/is / / to / / .
3.	This client did complete a 3 day hospital stay. Medicare was billed for_____days and an EOMB for that period was previously submitted. After the first claim for the first benefit period, the T19 EOB Exempt letter may be attached for succeeding claims.
4.	Medicare and/or other insurance denied payment of the swing-bed benefit. A copy of the EOMB is attached. After the first claim for the first benefit period, the T19 EOB Exempt letter may be attached to succeeding claims.

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature _____ Title _____ Date _____

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

19.6.3 Reserve Bed Days

Reserve bed days during a resident's temporary absence are not covered unless the resident is absent from the facility for less than 24 hours. In these instances the absence should be billed to Medicaid as a normal covered day.

For days the resident is absent from the facility for 24 hours or more, bill these as non-covered days, using value code 81. Value codes and accommodation units must total the number of days within the coverage period.

Example:

- Coverage period is from 1/1/18-1/30/18, with a patient status of 30 (still a patient)
- Client went to the hospital for care from 1/5/18-1/10/18
- Total coverage period is 30 days
- Total non-covered days is 5 days
- Claim would show:
    - Room and board days revenue code (0100) billed for 25 units
    - Value code 81 (non-covered days) for 5 units

A provider may bill a client or the client's responsible party for reserved bed days if the facility has informed them in writing of their financial responsibility, before services are rendered.

19.7 Census Requirements

Effective April 1, 2019, nursing facilities are no longer required to submit a census report to Wyoming Medicaid or their contractor.

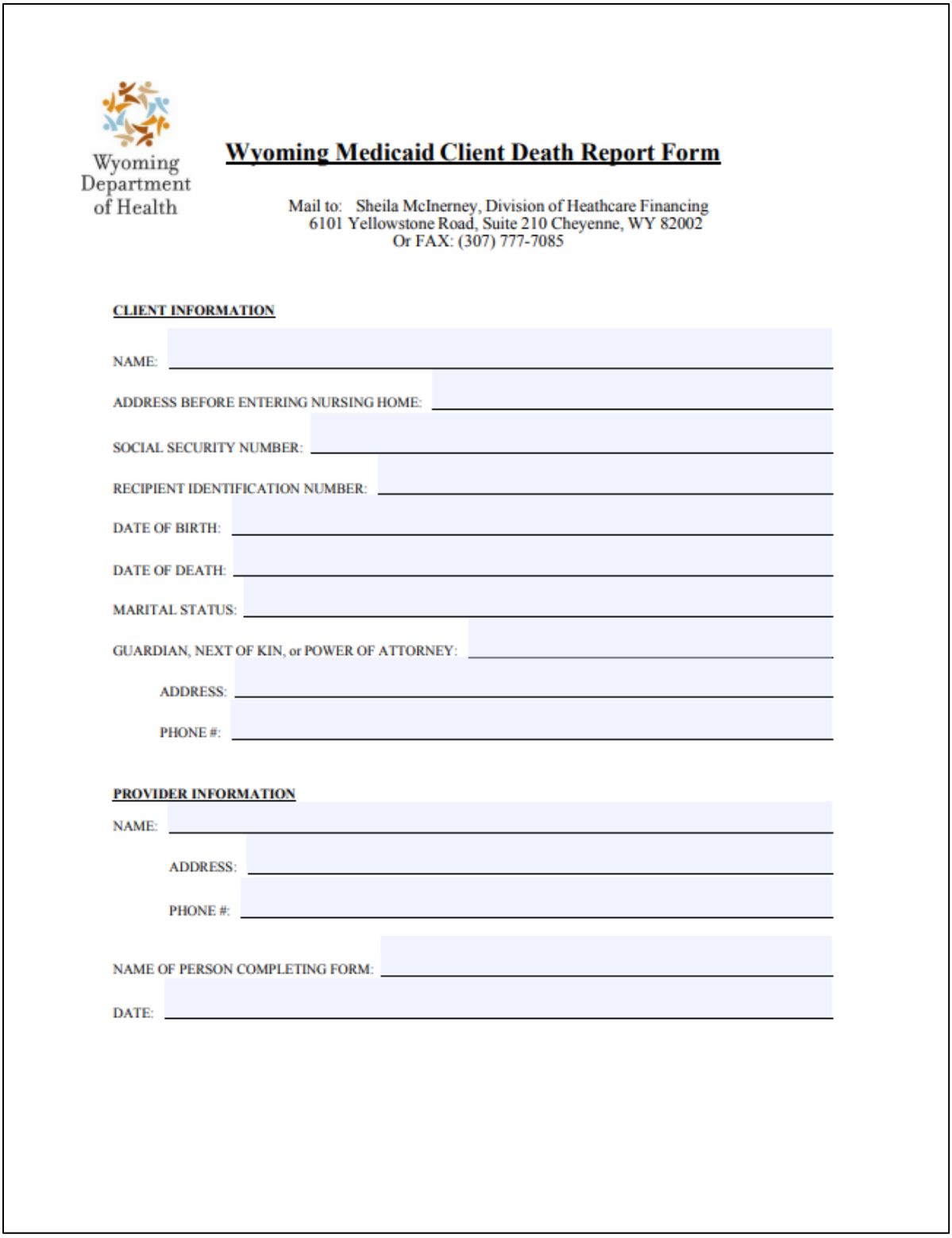
19.8 Wyoming Medicaid Client Death Reporting

Pursuant to Wyoming Department of Health, Division of Healthcare Financing (Wyoming Medicaid) rules, providers are required to notify the Department of Health, Division of Healthcare Financing of the death of any Wyoming Medicaid client in their facility within three (3) working days of the client’s death.

The Medicaid Client Death Report Form is located below for the providers’ use to report this information. Send or fax it promptly to:

Division of Healthcare Financing
122 West 25th St, 4th Floor West
Attn: Sheila McInerney
Cheyenne WY 82002

19.8.1 Medicaid Client Death Report Form



Wyoming Department of Health

Wyoming Medicaid Client Death Report Form

Mail to: Sheila McInerney, Division of Heathcare Financing
6101 Yellowstone Road, Suite 210 Cheyenne, WY 82002
Or FAX: (307) 777-7085

CLIENT INFORMATION

NAME: _____

ADDRESS BEFORE ENTERING NURSING HOME: _____

SOCIAL SECURITY NUMBER: _____

RECIPIENT IDENTIFICATION NUMBER: _____

DATE OF BIRTH: _____

DATE OF DEATH: _____

MARITAL STATUS: _____

GUARDIAN, NEXT OF KIN, or POWER OF ATTORNEY: _____

ADDRESS: _____

PHONE #: _____

PROVIDER INFORMATION

NAME: _____

ADDRESS: _____

PHONE #: _____

NAME OF PERSON COMPLETING FORM: _____

DATE: _____

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

19.9 Extraordinary Care

Revenue Code: **0101 – Room & Board (Prior Authorization is required)**

Appropriate Bill Type: **21X, 23X**

Pay-to Provider's Taxonomy: **31400000X, 315P00000X**

Extraordinary Care is for clients that require service beyond the average resident. They have an MDS Activities of Daily Living Sum score of ten (10) or more and require special or clinically complex care as recognized under the Medicare RUG-III classification system. Extraordinary Care requires a prior authorization from WYhealth (2.1, Quick Reference).

The extraordinary care client's cost and service requirements must clearly exceed supplies and services covered under a facility's per diem rate. The cost of clients' extraordinary care shall not be included in the annual cost reports.

Patient contribution amounts will be applied to claims for approved Extraordinary Care clients. Please refer to section 19.2 Patient Contributions for more information regarding patient contribution.

19.9.1 Criteria

Extraordinary care clients services are covered when the below criteria is met, the services are individualized, specific, and consistent with symptoms or confirmed diagnosis, and not in excess of the client's needs.

Medical conditions considered under extraordinary care criteria:

- Ventilator Dependence allows for automatic qualification without additional criteria being met.
- Tracheostomy requiring routine care that cannot be performed by the client because the submitted records provide documentation of cognitive or physical impairment that limits self-care of the tracheostomy with the potential to result in tracheostomy and related complications.
- Morbid Obesity (ICD 10 E66.01) documented BMI and extreme limitation in mobility as documented by recent PT/OT or MD evaluation of ambulation, ROM and deficiencies in ability to independently perform basic hygiene and other ADLs. Other limitations not addressed in these guidelines but documented by a medical professional will be considered.
- Psychiatric care for clients with significant behaviors that cannot otherwise be safely cared for in a standard nursing facility setting without increased staffing or special accommodations. This includes clients with significant physical aggression, delirium and/or psychosis.

  NOTE: Please see next section for additional information on psychiatric condition requirements.

- Other conditions where special care or clinically complex care is required will be evaluated on a case-by-case basis.

19.9.2 Documentation

- Completed Admission Certification Skilled Nursing Extraordinary Care form including clinical justification documentation. Form can be found at www.wyhealth.net.
- Completed Rate Request Form. (Part of Admission Certification Skilled Nursing Extraordinary Care Form)
- If the request is for behavioral health extraordinary care clients the documentation must include the following information:
    - A treatment plan that specifies both medical and behavioral strategy.
    - A stabilization plan to include both internal policies and plans for community based supports and if necessary transfer opportunities.
    - External resources, agreements, working partnerships for inpatient stabilization (if behavior escalates to a point where for their safety or those of the other patients or staff), with a written agreement to return client to resident location upon stabilization and recommendation plan in place.
    - List of primary care and psychiatric doctors.
    - Packet must include clinical justification and financial request as with any other extraordinary care client.

19.9.3 Additional Requirements

- Continued stay reviews must be completed at 15 days, 30 days, 90 days and yearly thereafter. If medical evaluation shows difference or change in services needed, notify WYhealth (2.1, Quick Reference).
- If a client has a change in services needed, the provider can submit new cost information for consideration of a rate adjustment. Incremental revenue of negotiated rates will offset against the applicable cost report. Notify Myers & Stauffer of changes for modification to reimbursement (800)336-7721.
- Include all costs for residents under extraordinary care negotiated rates; cost reports will be adjusted during rate setting.
- Forms can be found on the Medicaid website (2.1, Quick Reference).

19.9.4 Enhanced Psychiatric Conditions Considered Under Extraordinary Care Criteria

Adult recipients presenting with a Severe and Persistent Mental Illness (SPMI) with long term psychiatric and behavioral health needs, which exhibit challenging and difficult behaviors that is beyond traditional skilled nursing home care as recognized, may qualify under the Extraordinary Care Criteria. Extraordinary Care requires a prior authorization from WYhealth (2.1, Quick Reference).

Any requests for a behavioral health extraordinary care client must include the following prior to any review by the Division of Healthcare Financing:

- A treatment plan that specifies both medical and behavioral strategy
- A stabilization plan to include both internal policies and plans for community based supports and if necessary transfer opportunities
- External resources, agreements, working partnerships for inpatient stabilization (if behavior escalates to a point where for their safety or those of the other patients or staff), with a written agreement to return client to resident location upon stabilization and recommendation plan in place.
- List of primary care and psychiatric doctors
- Packet must include clinical justification and financial request as with any other extraordinary care client
- Other conditions where special care or clinically complex care is required will be evaluated on a case by case basis by WYhealth
- Criteria are subject to change

19.9.5 Specific Criteria

All criteria must be met:

- The client has an SPMI as defined by the following
    - The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders
    - Prior to admission (admission to hospital stabilization or nursing home), the Global Assessment of Functioning (GAF) score is 40 or lower
- The level of impairment is confirmed by a Level II Pre-Admission Screening and Resident Review (PASRR) evaluation (42 CFR 483.128). (19.3.4, PASRR Pre-Admission Screening and Resident Review)
- The client is currently in a psychiatric hospital; or has had one (1) or more past hospitalizations; or is exhibiting behaviors that place him or her at risk of psychiatric hospitalization
- The client exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care, including one (1) of the following:
    - Combative and assaulting behaviors (physical abuse toward staff, or self-abuse / self-injurious behaviors)
    - Sexually inappropriate behaviors (touching or grabbing others)
    - Other challenging and difficult behaviors related to the individual's psychiatric illness

    OR

- Exhibits the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements

19.9.6 Continued Eligibility Criteria

Continued stay is applicable when the client either:

- Exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care, including one (1) of the following:
    - Combative and assaulting behaviors (physical abuse toward staff, or self-abuse / self-injurious behaviors)
    - Sexually inappropriate behaviors (touching or grabbing others)
    - Other challenging and difficult behaviors related to the individual's psychiatric illness

OR

- Exhibits the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements

19.9.7 Discharge from Extraordinary Care Criteria

Discharge from extraordinary care criteria is contingent upon the following:

- The consistent absence of unsafe behaviors as outlined in Section 19.9.5 Specific Criteria within consistently structured enhanced care; and
- The anticipation that the client will not exhibit the unsafe behavior if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements

NOTE: These criteria must be closely observed and monitored during a continuous period of at least three (3) months (quarterly).

Additional determining criteria for discharge include the following:

- Monitoring of medication stability/consistency
- Treatment compliance
- Appropriate living arrangements upon discharge
- Arrangement of aftercare for continued services

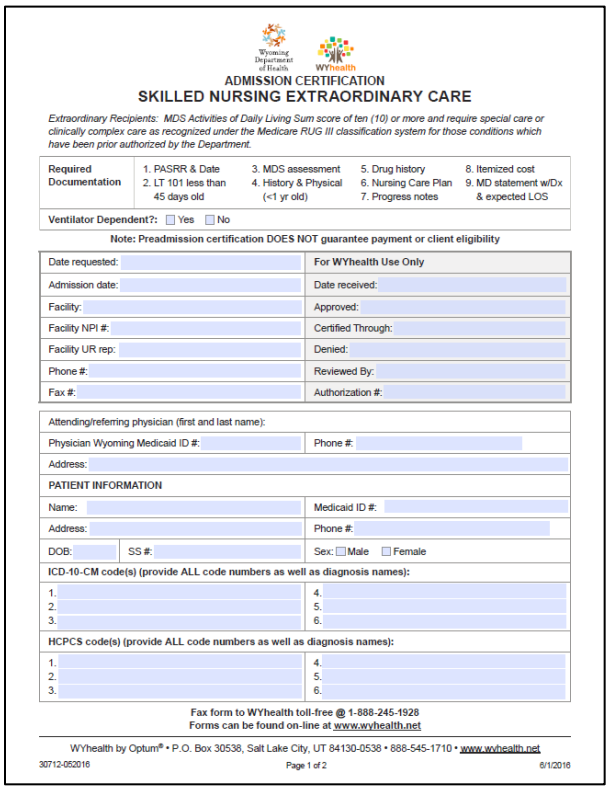
19.9.8 Documentation

- New Requests must contain a completed packet, required documentation and cost review. Prior Authorization (PA) is required for all Medicaid clients. (6.14 Prior Authorization)
- Extraordinary Care client packets can be faxed to WYhealth. (2.1, Quick Reference)
- Continued Stay Reviews must contain a completed Continued Stay Form (19.9.10 Continued Stay Skilled Nursing Extraordinary Care Form) and all

required documentation. Prior Authorization (PA) is required for all Medicaid clients.

- Annual Cost Reviews for extraordinary care clients rates will be done in conjunction with July 1 rate effective date reviews.
- Continued Stay Utilization Review must be completed at 15 days, 30 days, 90 days and yearly thereafter, or as needed if medical or psychiatric evaluation shows difference or change in services.
- If the client has a change in services needed, the provider can submit new cost information for consideration of a rate adjustment. Notify Myers & Stauffer of change for modification to reimbursement (800)336-7721.
- Include all costs for residents under extraordinary care negotiated rate; as incremental revenue of negotiated rate is offset against applicable cost repost.

19.9.9 Admission Certification Skilled Nursing Extraordinary Care Form



ADMISSION CERTIFICATION
SKILLED NURSING EXTRAORDINARY CARE

Extraordinary Recipients: MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

Required Documentation				
	1. PASRR & Date	3. MDS assessment	5. Drug history	8. Itemized cost
	2. LT 101 less than 45 days old	4. History & Physical (<1 yr old)	6. Nursing Care Plan 7. Progress notes	9. MD statement w/Dx & expected LOS

Ventilator Dependent?: ☐ Yes ☐ No

Note: Preadmission certification DOES NOT guarantee payment or client eligibility

Date requested:	**For WYhealth Use Only**
Admission date:	Date received:
Facility:	Approved:
Facility NPI #:	Certified Through:
Facility UR rep:	Denied:
Phone #:	Reviewed By:
Fax #:	Authorization #:

Attending/referring physician (first and last name):

Physician Wyoming Medicaid ID #:	Phone #:

Address:

PATIENT INFORMATION

Name:	Medicaid ID #:
Address:	Phone #:
DOB: SS #:	Sex: ☐ Male ☐ Female

ICD-10-CM code(s) (provide ALL code numbers as well as diagnosis names):

1.	4.
2.	5.
3.	6.

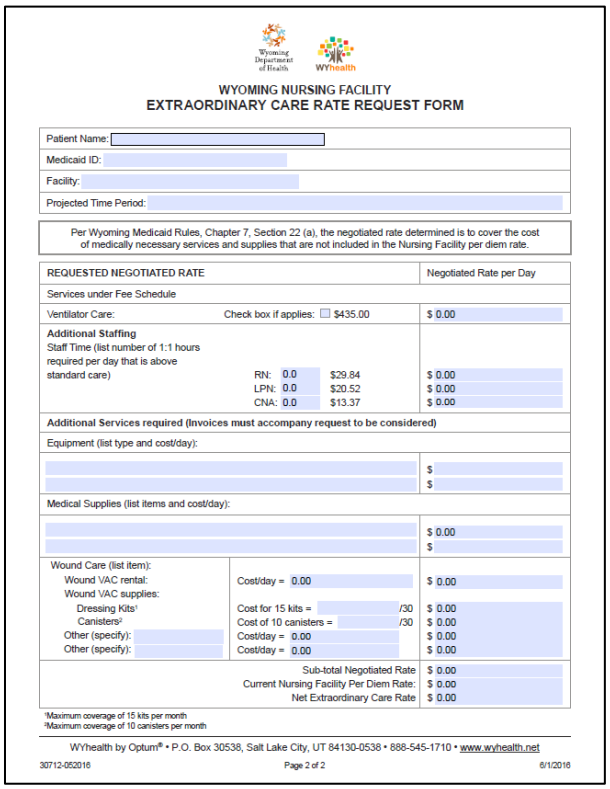
HCPCS code(s) (provide ALL code numbers as well as diagnosis names):

1.	4.
2.	5.
3.	6.

Fax form to WYhealth toll-free @ 1-888-245-1928
Forms can be found on-line at www.wyhealth.net

WYhealth by Optum® • P.O. Box 30538, Salt Lake City, UT 84130-0538 • 888-545-1710 • www.wyhealth.net

30712-052016 Page 1 of 2 6/1/2016



WYOMING NURSING FACILITY
EXTRAORDINARY CARE RATE REQUEST FORM

Patient Name:
Medicaid ID:
Facility:
Projected Time Period:

Per Wyoming Medicaid Rules, Chapter 7, Section 22 (a), the negotiated rate determined is to cover the cost of medically necessary services and supplies that are not included in the Nursing Facility per diem rate.

REQUESTED NEGOTIATED RATE			Negotiated Rate per Day
Services under Fee Schedule			
Ventilator Care:	Check box if applies: ☐ $435.00		$ 0.00
Additional Staffing Staff Time (list number of 1:1 hours required per day that is above standard care)	RN: 0.0	$29.84	$ 0.00
	LPN: 0.0	$20.52	$ 0.00
	CNA: 0.0	$13.37	$ 0.00
Additional Services required (Invoices must accompany request to be considered)			
Equipment (list type and cost/day):			
			$
			$
Medical Supplies (list items and cost/day):			
			$ 0.00
			$
Wound Care (list item):			
Wound VAC rental:	Cost/day = 0.00		$ 0.00
Wound VAC supplies:			
Dressing Kits[1]	Cost for 15 kits =	/30	$ 0.00
Canisters[2]	Cost of 10 canisters =	/30	$ 0.00
Other (specify):	Cost/day = 0.00		$ 0.00
Other (specify):	Cost/day = 0.00		$ 0.00
		Sub-total Negotiated Rate	$ 0.00
		Current Nursing Facility Per Diem Rate:	$ 0.00
		Net Extraordinary Care Rate	$ 0.00

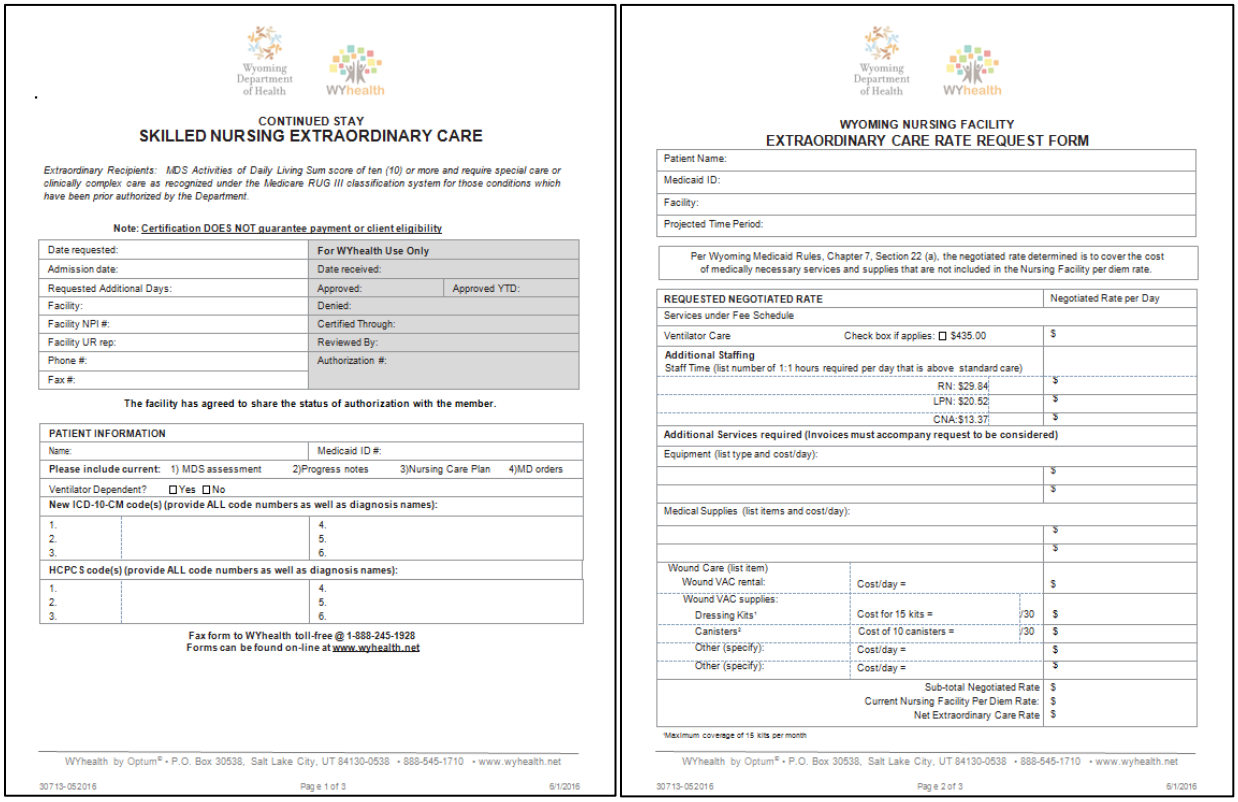
[1]Maximum coverage of 15 kits per month
[2]Maximum coverage of 10 canisters per month

WYhealth by Optum® • P.O. Box 30538, Salt Lake City, UT 84130-0538 • 888-545-1710 • www.wyhealth.net

30712-052016 Page 2 of 2 6/1/2016

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

19.9.10 Continued Stay Skilled Nursing Extraordinary Care Form



CONTINUED STAY
SKILLED NURSING EXTRAORDINARY CARE

Extraordinary Recipients: MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

Note: Certification DOES NOT guarantee payment or client eligibility

Date requested:	**For WYhealth Use Only**	
Admission date:	Date received:	
Requested Additional Days:	Approved:	Approved YTD:
Facility:	Denied:	
Facility NPI #:	Certified Through:	
Facility UR rep:	Reviewed By:	
Phone #:	Authorization #:	
Fax #:		

The facility has agreed to share the status of authorization with the member.

PATIENT INFORMATION			
Name:		Medicaid ID #:	
Please include current: 1) MDS assessment	2)Progress notes	3)Nursing Care Plan	4)MD orders
Ventilator Dependent? ☐Yes ☐No			
New ICD-10-CM code(s) (provide ALL code numbers as well as diagnosis names):			
1. 2. 3.		4. 5. 6.	
HCPCS code(s) (provide ALL code numbers as well as diagnosis names):			
1. 2. 3.		4. 5. 6.	

Fax form to WYhealth toll-free @ 1-888-245-1928
Forms can be found on-line at www.wyhealth.net

WYhealth by Optum® • P.O. Box 30538, Salt Lake City, UT 84130-0538 • 888-545-1710 • www.wyhealth.net

30713-052016 Page 1 of 3 6/1/2016

WYOMING NURSING FACILITY
EXTRAORDINARY CARE RATE REQUEST FORM

Patient Name:
Medicaid ID:
Facility:
Projected Time Period:

Per Wyoming Medicaid Rules, Chapter 7, Section 22 (a), the negotiated rate determined is to cover the cost of medically necessary services and supplies that are not included in the Nursing Facility per diem rate.

REQUESTED NEGOTIATED RATE			Negotiated Rate per Day
Services under Fee Schedule			
Ventilator Care	Check box if applies: ☐ $435.00		$
Additional Staffing Staff Time (list number of 1:1 hours required per day that is above standard care)			
	RN: $29.84		$
	LPN: $20.52		$
	CNA:$13.37		$
Additional Services required (Invoices must accompany request to be considered)			
Equipment (list type and cost/day):			
			$
			$
Medical Supplies (list items and cost/day):			
			$
			$
Wound Care (list item) Wound VAC rental:	Cost/day =		$
Wound VAC supplies: Dressing Kits[1]	Cost for 15 kits =	/30	$
Canisters[2]	Cost of 10 canisters =	/30	$
Other (specify):	Cost/day =		$
Other (specify):	Cost/day =		$
		Sub-total Negotiated Rate	$
		Current Nursing Facility Per Diem Rate:	$
		Net Extraordinary Care Rate	$

[1]Maximum coverage of 15 kits per month

WYhealth by Optum® • P.O. Box 30538, Salt Lake City, UT 84130-0538 • 888-545-1710 • www.wyhealth.net

30713-052016 Page 2 of 3 6/1/2016

NOTE: Maximum coverage of ten (10) canisters per month. Click the image above to be taken to a printable version of this form.

Chapter Twenty – Rural Health Clinics (RHC)

20.1 Rural Health Clinics (RHC)

Revenue Code: 0521

The purpose of an RHC program is to improve access to primary care in underserved rural areas. RHCs are required to use a team approach to provide outpatient primary care, and basic laboratory services.

20.1.1 Covered Services

A visit is a face-to-face encounter between a client and:

- Clinical psychologist
- Clinical social worker
- Nurse practitioner
- Nurse midwife
- Physician
- Physician's assistant
- Visiting nurse

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

20.1.2 Reimbursement Guidelines

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes, but is not limited to:

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

20.1.3 Billing Requirements

- The place of service must be the office, not the hospital, emergency room, home or nursing facility, etc.
- Multiple encounters within the same facility, on the same day, with different health professionals are still considered one (1) encounter UNLESS the

patient suffers illness or injury requiring additional diagnosis or treatment after the first encounter.

- Claims must be billed with revenue and procedure codes for both the encounter information and detailed line item information.
- Claims will have a minimum of two (2) line items, the first would be the encounter line and the second line item is detail (both must include a revenue code and a procedure code combination).

20.1.3.1 Encounter Line

The encounter line will be billed with Revenue Code 0521 paired with:

- Procedure code T1015 for general encounter.
- Procedure codes in the range of 99381-99385 or 99391-99395 for health check encounter.
    - Use modifier 32 to indicate a health check encounter that results in a referral to a specialist.
- Bill the total usual and customary charges for visit.

20.1.3.2 Detailed Line Items

Detailed line items will be billed with:

- Any appropriate outpatient revenue code paired with any appropriate procedure code.
- Document each procedure that occurred during the encounter.
- Include a detailed line item for the office visit or health check procedure code if appropriate.
- Bill the detail line items at $0.00
- For questions regarding appropriate pairings of revenue codes and procedure codes, refer to the NUBC Official WB Data Specifications Manual.

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

20.2 Billing Examples

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

Revenue Code	Procedure Code	Amount
0521	T1015	$175.00
0517	99213	$0.00

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

Revenue Code	Procedure Code	Amount
0521	T1015	$220.00
0517	99381	$0.00
0300	87086	$0.00

Chapter Twenty One – Psychiatric Residential Treatment Facility (PRTF)

21.1 Psychiatric Residential Treatment Facility (PRTF)

Appropriate Bill Type(s): 11X

Pay-to Provider's Taxonomy: 323P00000X

Psychiatric Residential Treatment Facility (PRTF) is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents under age 21, who have long-term illnesses and/or serious emotional disturbance(s) that are not likely to respond to short-term interventions and have failed to respond to community based intervention(s).

PRTFs provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality, pro-active treatment. In addition to diagnostic and treatment services, PRTFs should also provide instruction and support toward attainment of developmentally appropriate basic living skills/daily living activities that will enable children and adolescents to live in the community upon discharge.

The focus of a PRTF is on improvement of a client's symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; unless evidence shows family therapy would be detrimental to the client. Unless otherwise indicated, the program should facilitate family participation in the treatment planning, implementation of treatment planning, and timely, appropriate discharge planning, which includes assisting the family in accessing wrap-around services in the community.

Who should be admitted to a PRTF – A client may be appropriate for admission to a PRTF if he/she has a psychiatric condition which cannot be reversed with treatment in an outpatient treatment setting and the condition is characterized by severely distressing, disruptive and/or immobilizing symptoms which are persistent and pervasive.

Who should not be admitted to a PRTF – A client who is experiencing acute psychiatric behaviors is not appropriate to be admitted to a PRTF. PRTF services are not the entry point to accessing inpatient psychiatric services.

PRTF services must:

- Be provided under the direction of a physician.
- Provide active treatment.
- Be provided before the individual reaches age 21, per CFR 42§441.151, or if the individual was receiving services just prior to turning 21, the services must cease at the time the individual no longer requires services or the date at which the individual reaches age 22.

The PRTF must:

- Work closely with the appropriate school entity to ensure adherence to the youth's Individual Education Plan (IEP).
- Ensure a smooth transition back to the home school or develop an alternative transition plan for those youth who are not returning to their home school.
- Ensure that there is an adequate number of multi-disciplinary staff to carry out the goals and objectives of the facility and to ensure the delivery of individualized treatment to each resident as detailed in their treatment plan.

21.1.1 PRTF Physical Layout

A PRTF is a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis. A PRTF that is a part of a hospital or other facility must be a distinct, stand-alone unit/building separate from the hospital or other type of facility.

Clients who meet the PRTF level of care are not to be co-mingled with clients who are not at a PRTF level of care at any time. For example: a client in a facility's PRTF cannot co-mingle with another client (regardless of payment source) who may be in the facilities RTC unit (should they have both) during meals, schooling, therapies, or in living quarters.

21.1.2 Physical Separation

If more than one (1) type of program or facility is operated on the same piece of property, organizations should take steps to ensure that the programs or facilities can be easily identified as separate entities to those entering the property. Areas that providers are encouraged to consider include:

- **Documentation of Physical Separation –** the areas of the property occupied by the various programs should be clearly marked on campus maps and when buildings are shared, documentation of the parts of buildings occupied by different programs/facilities on floor plans should be clear and are readily available to surveyors or auditors.
- **Entrances and Signage –** when sharing a common property (i.e. same piece of land), the most ideal situation would be to have separate entrances, but when this is not feasible, the organization should use signage which clearly identifies and directs those entering the property or campus to the different facilities. Buildings should be clearly marked with signs that identify the programs or facilities that are located within them. For programs that must be open to the general public (outpatient clinic), there must not be physical barriers which prevent access or which would signal to those seeking services that the services would not be available to the general public (e.g. locked gate to the property).
- **Building Space –** Distinct buildings for each program or facility is best for maintaining separateness between programs and facilities. If building space is shared, physical separation of the programs/facilities must be managed within

the structure. Again, dividing the building space between programs in a manner that provides for clear and distinct separation of the programs and costs is the goal.

  - Programs that share a building must be clearly separated by floors, wings, or other building sections. Living areas must not be shared and beds from different programs should not be intermixed or commingled within the same building section. "Swing" beds or units that are variously used by one program or another depending on census are not acceptable. For example there cannot be beds that are sometimes utilized by an RTC and sometimes used by a PRTF.
  - When a building is occupied by more than one (1) program or facility, utilization of separate building entrance for each program is preferable. When this is not possible, separate entrances to each program from a common building lobby could be used. Again, signage within the building should clearly identify the specific program or facility areas.

- **Common Areas**
  - Recreational Areas: If a PRTF and an RTC, for example, are operated on the same property, each program should have separate recreational space for its residents. If there are also common recreational spaces used by both programs (i.e. gyms or other indoor or outdoor sporting and recreation areas), the use of these common areas should be scheduled by the different programs or facilities for separate use and the individuals receiving services from distinct programs should not use the facilities at the same time.
  - Dining Areas: If a PRTF and RTC, for example, are operated on the same property, each program should have separate dining space for its residents. If common dining room areas are used by different programs/facilities, they should be used at separately scheduled times and the individuals receiving services from distinct programs/facilities should not use the same dining area at the same time.
  - Treatment Areas: When an organization is providing both PRTF and outpatient services, for example, on the same campus or facility, separate areas must be used for treatment.

21.2 PRTF Requirements

Pursuant to 42 CFR § 483.352, the PRTF must meet all the requirements identified in subpart D, which include: State accreditation (§441.151), certification of need for the services (§441.152), the team certifying need for services (§441.153), active treatment (§441.154), components of an individual plan of care (§441.155), and the team involved in developing the individual plan of care (§441.156). The way a PRTF organizes itself is critical to its success in complying with federal regulations.

All PRTFs must be accredited by one (1) of the organizations identified in 42 CFR §441.151(a)(2)(ii):

- Joint Commission, or

- The Commission on Accreditation of Rehabilitation Facilities, or
- The Council on Accreditation of Services for Families and Children

Out of state PRTFs must be certified by The Center for Medicare and Medicaid Services (CMS), in conjunction with their state's licensing and survey agency as a PRTF, in order to enroll as a PRTF provider with Medicaid.

In state PRTFs must be certified as a PRTF by the Division of Healthcare Financing, in conjunction with the Office of Healthcare Licensing and Surveys and CMS, should they meet all the PRTF criteria.

21.3 Letter of Attestation

Each PRTF that provides inpatient psychiatric services to individuals under 21 must attest, in writing, that the facility is in compliance with CMS's standard governing the use of restraint and seclusion (42 CFR Subpart G-Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21). This attestation must be signed by the facility director, and is required for provider enrollment.

A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with Medicaid.

To download a copy of the Attestation Letter go to the Medicaid website under the Forms page.

21.4 Reporting of Serious Occurrences

The facility must report each serious occurrence to the Division of Healthcare Financing (State Medicaid Agency). Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in 42 CFR § 483.352, and resident's suicide attempt.

All PRFT incidents and serious occurrences must be submitted electronically; faxed forms are no longer accepted. The link to the online form can be found here:

https://health.wyo.gov/healthcarefin/medicaid/for-healthcare-providers/

42 CFR 483.374(b) states: In case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

42 CFR §483.374(c) states: "In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the CMS regional office. Staff must report the death of any resident to the CMS regional office by not later close of business the next business day after the resident's death.

Staff must document in the resident's record that the death was reported to the CMS regional office."

21.5 Covered Services

Services related to the client's treatment plan and provided by a PRTF are included in the PRTF per diem. This includes room and board and licensed treatment. A practitioner or facility that is outside of the PRTF may bill for covered ancillary services to Medicaid as long as they are an enrolled Wyoming Medicaid provider.

Facilities are required to send medications (either prescriptions or already filled) home with clients upon discharge.

Medicaid does not cover any educational services or room and board in a Residential Treatment Center (RTC). Medicaid may pay for medically necessary treatment or therapy to an RTC client when the provider is an enrolled Wyoming Medicaid provider.

21.6 Revenue Code

0919 – Psychiatric/psychological services (room and board)

21.6.1 Prior Authorizations

- Prior authorization requests must be submitted three (3) days prior to the client's planned admission.
- For prior authorizations requirements, review the WYhealth provider manual.
- For court ordered clients, a copy of the court order must be submitted as part of the prior authorization request. Court orders will be reviewed and must be in compliance with Wyoming Statute 14-3-429, 14-6-229 and 14-6-429.

21.7 PRTF Educational Services

Effective July 1, 2016, educational service payments will be authorized and made available by the Wyoming Department of Education for school services provided to all Wyoming Medicaid youth, regardless of court-order status.

There are several contingencies associated with the payment of educational services:

1. PRTF school programs must be certified by the Wyoming State Board of Education. To receive this certification, providers must make a formal application to the Wyoming Board of Education, undergo a formal on site survey, and be approved by the Board.
2. Educational service payment is contingent upon Medicaid's determination of medical necessity for the PRTF admission. Once a youth is determined to no longer meet medical necessity for the placement, education funding ceases.

3. PRTFs receiving payment for educational services are required to comply with various provisions detailed in statute, including, but not limited to the following:
    a. Comply with the federal Family Education Rights and Privacy Act;
    b. Not later than ten (10) days after discharge, transfer all records via a secure method to the resident school district or the district in which the student enrolls;
    c. Create an individualized learning plan for the student that is appropriate for the learning capabilities of the student, monitors and measures the student's progress toward meeting defined goals, facilitates necessary instructional support for the student, maintains the student's permanent education records, and fulfills the state education program rules and regulations.

The current prior authorization request process with Wyoming Medicaid is not changing, and educational days will be authorized based on current criteria used for PRTF placements.

Please contact the Wyoming Department of Education for questions regarding payment for educational services or the Wyoming State Board of Education regarding the PRTF school program certification process.

21.8 Therapeutic Leave Days

Medicaid reimbursement is available for reserving beds in a PRTF for therapeutic leaves of absence of Medicaid clients less than 21 years of age at the regular per diem rate when all of the following conditions are present:

- A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the client's habilitation plan.
- A physician's order for therapeutic leave must be maintained in the client's file at the facility.
- In a PRTF, the total length of time allotted for therapeutic leaves in any calendar year shall be 14 days per client. If the client is absent from the PRTF for more than 14 days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that client in that year.
- In no instance will Medicaid reimburse a PRTF for reserving beds for Medicaid clients when the facility has an occupancy rate of less than 90% (Based on licensed beds).

WYhealth must approve and prior authorize all therapeutic leave days. Approved therapeutic leave days should be billed as normal covered days. Therapeutic leave days that are not approved by WYhealth, when the client does leave the facility, must be billed as non-covered days.

Refer to the WYhealth Manuals at: https://www.wyhealth.net/tpa-ap-web/?page=defaultRoot or contact WYhealth (2.1, Quick Reference) for PRTF prior

authorization, PRTF referrals, admission criteria, continued stay review criteria, discharge planning, and other important PRTF information.

21.9 Onsite Compliance Review Process

21.9.1 Purpose and Goal

The purpose of an On-Site Compliance Review (OSCR) is to verify that the PRTF is in compliance with all applicable State and Federal requirements for mental health treatment, and to monitor the quality of treatment being provided to Wyoming Medicaid beneficiaries. This verification will include a review of adherence to all Federal and State guidelines restricting commingling should a level of care other than PRTF also be provided within the facility.

The goals of the OSCR are to:

- Access the program and services offered by the PRTF through direct observation, document review, and staff/resident interviews by experienced clinicians; and
- To provide clear, specific feedback regarding review findings to PRTF staff in order for services to be enhanced.

21.9.2 Review Team Composition

The review team will be comprised of at least two (2) but no more than five (5) Wyoming Medicaid staff and consultants. The participation of an appropriately credentialed child/adolescent psychiatrist is required. Optional team member may include any of the clinicians listed below:

- A registered nurse
- A licensed clinical social worker
- A licensed psychologist

Team members, in addition to the child/adolescent psychiatrist and Medicaid representative may be drawn from a variety of areas (i.e. Medicaid, contractor, Department of Family Services, private sector professionals) depending on availability, existing service contracts, and appropriated funding.

21.9.3 Pre-Review Notification

Written notification of an upcoming OSCR will be provided to the PRTF administrator 24 to 48 hours prior to the time the OSCR is scheduled to begin. The notification will include:

- The anticipated schedule for the OSCR
- The names of the participating team members
- A list of documents to be reviewed
- A list of clinical records to be reviewed

21.9.4 Overview of the OSCR Process

The OSCR is intended to monitor a PRTF's overall operations for compliance with legal requirements and for quality of clinical programs and services. The review inquires in to the PRTF's operations in three (3) domains:

- **Administration –** This area comprises the organizational structure and management of the facility. The facility's administrative functioning is evaluated through the review of such information as policy and procedure manuals, staff credentials, transfer agreements with hospitals, utilization review documents, incident reports, etc. The administrative area will account for 15% of the PRTF's overall compliance rating.
- **Program –** This area comprises the philosophy and structure of the facility's approach to treatment (what the facility believes constitutes good treatment and how they plan to carry it out). The facility's program is evaluated through the review of documents (e.g. policy and procedure manuals, unit rules/regulations, unit level systems, schedules of unit activities, staff training schedules and agendas, seclusion/restraint logs, etc.), the facility tour, and staff interviews. The program area will account for 35% of the PRTF's overall compliance rating.
- **Services –** This area comprises the manner in which a PRTF's program translates into treatment of individual residents. The team particularly looks at whether or not services are delivered in such a manner as to provide maximum benefit to each child. The facility's services are evaluated through the review of clinical records and resident interviews. The services area will account for 50% of the PRTF's overall compliance rating.

The frequency with which routine reviews are scheduled is dependent upon the status of the facility at the time of its last review. Generally, the higher the facility's rating, the longer the period of time between reviews. Refer to the PRTF Status Categories below for applicable time frames. Routine OSCRs will almost always be full scale reviews, with every aspect of the PRTF being evaluated. In most cases, a routine OSCR will be completed in two (2) to three (3) days.

Reviews are conducted utilizing the following Compliance Review Instruments (CRI) which can be viewed on the Wyoming Medicaid Provider website, UB Provider Manual within the PRTF section:

- Administrative Document Review
- Facility Tour
- Program Document Review
- Staff Interview
- Staff Record & Training Review
- Resident Record Review
- Resident Interviews

At the discretion of Wyoming Medicaid, an OSCR may be conducted at any time, and the OSCR may be conducted as a partial off-site (review of records) and partial on-site (facility tour and staff/resident interviews) compliance review.

Regardless of when the next OSCR may be due, an interim review may be scheduled at any time at the discretion of Wyoming Medicaid to address specific concerns. Interim reviews may be full-scale or partial, depending upon the focus or scope of Wyoming Medicaid's concerns. Interim reviews will typically be completed in one (1) to three (3) days.

21.9.4.1 General Outline of the OSCR Process

- **Entrance Interview –** At the beginning of the OSCR, the review team will meet with a small group (not to exceed six (6) people) of PRTF staff selected by the facility for an overview of the OSCR process. The group will typically consist of the PRTF Administrator, Medical Director, Risk Manager (where applicable), Clinical Director, and one (1) representative each from nursing, primary therapy and direct care staff. The entrance interview is the facility's opportunity to meet the review team and inform the team of any changes, improvements, etc. that have occurred since the last review or to ask questions about the current proceedings. The review team will take this opportunity to interview the PRTF team on areas such as EBP used, average length of stay, etc. This phase will typically take about an hour.
- **Tour of the Facility –** The review team will tour all units of the PRTF and talk informally with staff and/or residents. They will note the physical layout and appearance/atmosphere of the units, review posted information, and observe interactions between staff and residents.
- **Review of Administrative and Program Records –** A review team member, usually the team leader, will review documents requested in the pre-OSCR notification. Information requested may include (but is not limited to) records pertaining to staff credentials and training, policy and procedure manuals, transfer agreements with hospitals, utilization review, staff training schedules and/or agendas, seclusion/restraint logs, treatment outcome data, etc. In addition, the facility must provide the review team with a roster of all staff who provide direct services to resident. The roster should be organized according to discipline and each name should be accompanied by the staff member's signature. All documents requested should be ready for review at the beginning of the OSCR.
- **Review of Clinical Records –** Resident records will be reviewed by the team to assess compliance with PRTF treatment requirements identified by Wyoming Medicaid policy. Charts will be selected from the census list of Wyoming Medicaid residents and all clients discharged in the previous 120 days. The PRTF must provide the review team with an organization guide to the resident record, which clearly identifies where specific documents may be found within the record.
- **Staff Interviews –** Staff to be interviewed will be identified as early in the review process as possible. When interviewing staff, review team members

will want to know whether or not there are guiding treatment principles of which ALL STAFF (from psychiatrist to cafeteria worker to therapist to resident aide to facility administrator to maintenance worker) are aware and to which ALL STAFF adhere. The team is particularly interested in how well program guidelines are carried out in practice and whether or not staff work together collaboratively, functioning as a true team.

- **Resident Interviews –** Residents to be interviewed will be identified as early in the review process as possible. When interviewing residents, review team members will want to know whether or not residents feel they are active participants in their treatment, how knowledgeable they are about specific aspects of their treatment programs, and how they view the program and staff's ability to help them. Refer to Provider Manual Section 18.36 for CRI-Clinical Services Section B: Resident Interviews policy.
- **Review Team Conference –** At the conclusion of the above components, the review team will meet to compile all information acquired and prepare for the Exit Interview.
- **Exit Interview –** The review team will meet with the PRTF staff (the same representatives who were present at the Entrance Interview unless changes have been discussed with the review team leader) to present an overview of the team's findings. At this time, PRTF staff may ask questions, request examples of problems cited, etc. This phase typically will last one (1) hour or less.
- **Written Report –** Wyoming Medicaid will provide the PRTF with a written report of the review team's findings within 30 days after the close of the OSCR.

21.9.5 PRTF Status Categories

At the time of the exit interview, the PRTF will be informed of its status ruling if that can be clearly determined. Star ratings will be published in the Wyoming Medicaid PRTF newsletter and website, as well as shared with other Judicial and Child Placement Agencies throughout Wyoming. The rating categories are as follows:

Three Star (☆☆☆)Commendation: Program and services consistently exceed standards. No problems were cited by the review team. The next OSCR will be scheduled within the next three (3) years.

Two Star (☆☆) Approved: Program and services consistently meet standards the majority of the time. No significant health and/or safety concerns were cited by the review team. The next OSCR will be scheduled in one (1) to two (2) years. A corrective action (CAP) may be requested at the State's discretion for findings cited.

One Star (☆) Review: Overall program and services are of acceptable quality with one (1) or more specific areas of health and/or safety risk or other substandard quality directly impacting the quality and effectiveness of services delivered. A CAP must be submitted to all address findings cited. The next OSCR will be scheduled within the next six (6) to 12 months after the implementation of an approved CAP.

21.9.6 OSCR Rating

21.9.6.1 Probation

- Program and services are of substandard quality OR
- The facility is already on Review Status and failed to show improvement in a follow-up OSCR OR
- An isolated, non-recurring condition exists which could jeopardize the safety or well-being of residents.

A CAP must be submitted to address all problems cited in the review. The next OSCR will be scheduled within the next three (3) to six (6) months after implementation of an approved CAP. Details of required elements within the CAP are detailed further in this document.

A facility receiving this rating will be subject to the following actions taken by Wyoming Medicaid:

- A hold on new admissions
- Youth transfers will be considered
- Guardian notifications of rating will be initiated for all Wyoming Medicaid clients receiving services from the facility
- Notification of facility rating will be provided to the Facility's licensing and survey authority and the Facility's Board of Directors

21.9.6.2 Suspension

Program and services are of unacceptable quality OR an ongoing pattern of recurring conditions exist which jeopardize the lives or well-being of residents OR the facility received probation status in any two (2) OSCRs and failed to show sufficient improvement in the next follow-up OSCR. The next OSCR will be scheduled as soon as possible (no later than 30 days) after the implementation of an approved corrective action plan. The CAP must be submitted to Wyoming Medicaid for review and approval no later than seven (7) days from the close of the OSCR.

A facility receiving this rating will be subject to the following actions taken by Wyoming Medicaid:

- A hold on new admissions.
- Child transfers will be initiated.
- Guardian notifications of rating will be initiated for all Wyoming Medicaid clients receiving services from the facility.
- Notification of facility rating will be provided to the Facility's licensing and survey authority and the Facility's Board of Directors.
- A facility receiving two (2) suspension ratings during its course of enrollment with Wyoming Medicaid (does not need to be consecutive compliance reviews) will be dis-enrolled as a Wyoming Medicaid provider. Petitions for re-enrollment will be considered on a case by case basis, no sooner than 24-months after dis-enrollment. Dis-enrollment could be considered by Wyoming

Medicaid after one (1) suspension rating depending on the severity and scope of the findings.

21.9.6.3 Deferred

If the review team requires additional information or expert opinion in order to complete its determination, then the status ruling may be deferred. In cases of deferred status, Wyoming Medicaid must re-contact the PRTF within ten (10) days to:

- Request additional information or documentation, which must then be provided by the PRTF within ten (10) days of receiving the request; AND/OR
- Schedule a continuation of the OSCR, in which case additional team members may participate in further on-site review of the facility, OR
- Submit a final status ruling.

The ten (10) day request/submission response cycle will continue until a final status determination is made.

21.9.7 Corrective Action Plan

Any facility receiving a rating of Review, Probation or Suspension must submit a Corrective Action Plan (CAP). The CAP must be received by Wyoming Medicaid no later than ten (10) working days following the PRTF's receipt of its status ruling.

The CAP must address separately each concern cited in the OSCR report by:

- Proposing specific measureable actions that will be taken to correct each identified problem
- Specifying an implementation date for each corrective action
- Including supporting documentation as appropriate, e.g. policy or procedural changes, new or revised forms, copies of schedules of training or staffing, etc

Justifications or explanations for the cited problems have no place in the CAP. Although there may be good reasons for the existence of the problems, Wyoming Medicaid is interested only in the proposed solutions. The narrative of the CAP should be succinct and to-the-point. The following format is suggested for each separate element cited:

- Description of element
- Findings
- Plan of correction
- Implementation date
- Supporting documentation (attached to the CAP and referenced in the narrative response)

21.9.7.1 CAP Examples

- Description of element: Psychosocial assessment contains a developmental profile
- Findings: Developmental profiles were missing from two (2) of the charts reviewed, were inadequate or incomplete in two (2) others
- Plan of correction: Program Director will provide in-service training to therapy staff on developmental history-taking and documentation. Psychosocial assessments will be reviewed for completeness through record audits by Program Director
- Implementation Date: January 1, 2008
- Supporting documentation: Attachment A: Training Logs

The CAP will include the name and telephone number of a PRTF staff member who will work with Wyoming Medicaid towards approval of the CAP.

Wyoming Medicaid must approve/disapprove of the PRTF's proposed CAP within ten (10) days of its receipt by Wyoming Medicaid. The ten (10) day submission/ ten (10) day response cycle will continue until Wyoming Medicaid approves a CAP. The PRTF must implement the CAP within 30 days of its approval.

When notifying the PRTF of its CAP approval, Wyoming Medicaid will also inform the PRTF of the anticipated time of the next follow-up OSCR.

21.9.8 Appeals Process

If the PRTF disagrees with its status ruling or has a complaint regarding Wyoming Medicaid's response to its proposed CAP, it may appeal the review team's finding pursuant to the process outlined in Section 20 of Wyoming Medicaid Chapter 16 Rule. Wyoming Medicaid must receive the facility's appeal in writing within 20 days of the date of the final status determination. If the reconsideration is not favorable, in accordance with Section 21 of Wyoming Medicaid Chapter 16 Rule, providers may request an administrative hearing pursuant to Chapter 4.

21.9.9 OSCR Forms

21.9.9.1 A: Administrative Section: Document Review

1. The facility is COA, CARF, or JCAHO-accredited.
   - o Yes
   - o No

2. The facility's PRTF license is current.
   - o Yes
   - o No

3. The licenses of professional staff are current.
   - o Yes
   - o No

4. A roster of all staff, divided by discipline, who provide direct services to residents were provided with staff signatures.
   - o Yes
   - o No

5. The facility meets State-staffing requirements as outlined in 42 CFR, Part 441, Subpart D- Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs.
   - o Yes
   - o No

6. The facility has informed WDH of changes in PRTF administrator, Medical Director, or Clinical Director within 72 hours of the effective date of the change.
   - o Yes
   - o No

7. Records and documentation requested by WDH were provided at the time requested. An index or key was provided to locate required information.
   - o Yes
   - o No

8. The facility's policy and procedures are in accordance with WDH requirements.
   - o Yes
   - o No

9. The facility's policy and procedures for transfer, discharge, and provision of services are the same for all residents, regardless of payment source.
   - o Yes

- No

10. The facility does not accept new residents who have attained the age of 21 or maintain residents who have attained the age of 22.
    - Yes
    - No

11. The facility has a signed transfer agreement with one or more general hospitals to provide any needed diagnostic and medical services to residents (Facility to provide an example of a chart note/documentation as evidence of arrangement).
    - Yes
    - No

12. The facility has arrangements with community providers to provide specialized medical care to residents when needed (Facility to provide an example of a chart note/documentation as evidence of arrangement).
    - Yes
    - No

13. Personnel records verify that all licensed and provisionally licensed staff/providers who participate in treatment planning have a minimum one-years' experience in treating children and adolescents who are emotionally disturbed.
    - Yes
    - No

14. The facility has informed WDH in writing of the occurrence of any serious incidents as defined in Section 18.18 within one working day following their occurrence.
    - Yes
    - No

15. Records and documentation are maintained per the facility record retention policy.
    - Yes
    - No

16. The facility has a policy in place and a committee that meets regularly regarding policies on trauma informed care and bullying.
    - Yes
    - No

21.9.9.2 B: Facility Tour

1. The physical treatment environment is:

Category:	4	3	2	1
Attractive (clean, pleasant décor).				
Warm, child-friendly (pictures, plants, home-like atmosphere).				
Treatment-oriented (educational/motivational posters, treatment reminders).				

2. Program information (activity schedules, unit rules, requirements for level system) are posted in public spaces for resident reference.
   - 4
   - 3
   - 2
   - 1

3. Program information for residents (e.g., unit rules, behavior care plans, and other treatment information posted on units or given to children) is:

Category:	4	3	2	1
Clear, specific.				
In age-appropriate language.				
Worded respectfully.				
Expressed in positive terms.				

4. Staff's verbal communication with children is observed to be:

Category:	4	3	2	1
Clear, specific.				
In age-appropriate language.				
Respectful.				
Expressed in positive terms.				
Delivered in friendly voice tones.				
Reflects patients individualized behavior care plan.				

5. The physical arrangement of the units indicates a high level of staff/resident interaction (professional offices located on units or close to them, no unnecessary physical barriers between staff and residents).
   - 4
   - 3
   - 2
   - 1

6. Random checks of residents' behavior program documentation (point sheets or similar documents) indicate that compliance feedback is being provided in a timely manner.
   - o Yes
   - o No

7. Effective safety precautions are in place for monitoring reactive children. There is a sensory room or other physical space (or items such as a sensory chart) to help children de-escalate.
   - o Yes
   - o No
   - o Not applicable

8. Nighttime bed-monitoring procedures are established and documented. These are individualized to the needs of each resident.
   - o Yes
   - o No

9. Each unit has identified an appropriate place/procedure for responding to residents' physical/medical complaints.
   - o Yes
   - o No

10. Rules and schedules for the use of personal hygiene facilities provide adequately for the safety of residents.
    - o Yes
    - o No

11. Areas set aside for seclusion/restraint are clean, well-lighted/ventilated, and without doors.
    - o Yes
    - o No

12. All actions in each seclusion/restraint room can be continuously monitored.
    - o Yes
    - o No

13. The facility has adequate areas for indoor/outdoor recreation.
    - o 4
    - o 3
    - o 2
    - o 1

14. The facility provides an accredited school for residents.
    - o Yes
    - o No

15. There is a designated area for the provision of well-balanced meals. The menu is posted in public areas.
    - Yes
    - No

16. Areas designated for the provision of group therapy and community meetings are conducive to therapeutic interaction.
    - 4
    - 3
    - 2
    - 1

17. There is evidence of adequate facility security to minimize elopement risk.
    - 4
    - 3
    - 2
    - 1

18. Designated warm places where the residents can meet their families when they visit.
    - Yes
    - No

19. There is HIPAA compliant video conferencing availability with family for therapy sessions.
    - Yes
    - No

20. Evidence the facility follows their written policy/procedures was observed.
    - Yes
    - No

21.9.9.3 C: Program Section: Document Review

1. Behavior program used as a part of treatment is:

Category:	4	3	2	1
Clear, specific.				
Age-appropriate to the targeted group.				
Reasonable and workable in the normal course of treatment.				
Reflective of a trauma informed culture.				

2. Adequate staff in-service training is provided, as evidenced by:

Category:	Yes	No
Orientation and supervised on-the-job training is provided to new staff prior to their being assigned independent responsibilities.		
A minimum of 20 hours of in-service training (excluding training described in item 3 below) are received by each staff member per year.		
Training topics are appropriate to the needs of residential treatment staff.		
Trainers are qualified in the area of training they provide.		
Reflect a trauma-informed care approach to treatment.		

3. All direct care staff are trained and certified in a professionally recognized method of milieu management, de-escalating problem behaviors, applying physical restraints when necessary, and providing trauma-informed care.
   - o Yes
   - o No

4. There is documentation that adequate clinical supervision is provided. Therapists, nursing staff, and direct care staff receive a minimum of four (4) hours of clinical supervision per month, provided through a combination of individual supervision, group supervision, and participation in treatment team meetings. This requirement is not satisfied through training.
   - o 4
   - o 3
   - o 2
   - o 1

5. All occurrences of seclusion/restraint are documented in a facility-wide log and must be reported to the State through utilization review.
   - o Yes
   - o No
   - o Not applicable

6. An interdisciplinary team that looks specifically at patterns and/or trends (for staff, shifts, etc.) reviews all occurrences of seclusion/restraint monthly. The team will then develop an appropriate action plan to address these occurrences, as an on-going process.
   - o Yes
   - o No
   - o Not applicable

7. Incident reports (accidents, injuries, allegations of staff misconduct) are maintained according to policy. Documentation indicates that incidents have been handled appropriately by the PRTF staff and are reported as required.
   - o Yes
   - o No

8. Child abuse allegations are reported to proper authorities.
   - Yes
   - No

9. Standards have been developed for evaluating the effectiveness of the facility's program. The evaluation protocol includes, at a minimum:

Category:	Yes	No
A comparison of each resident's pre- and post-treatment functional status.		
There is a standardized process for discharge planning and development of an aftercare plan.		
A comparison of prescribed medications, pre- and post-treatment.		

10. The therapeutic curriculum used by the facility is trauma-informed and evidence-based for the population and age range being served.
    - Yes
    - No

11. Documentation indicates that the facility follows its policies and procedures in practice
    - Yes
    - No

21.9.9.4 D: Staff Interviews

1. Staff can explain ways the facility's culture and philosophy are trauma-informed.
   - 4
   - 3
   - 2
   - 1

2. Staff understands the facility's behavior program and can explain it.
   - 4
   - 3
   - 2
   - 1

3. Staff participates regularly in community meetings with residents on the treatment unit.
   - 4
   - 3
   - 2
   - 1

4. Staff reports receiving adequate clinical supervision. Staff can identify their primary supervisor and at least two (2) other people with supervisory training and/or experience to whom they can turn for information, support, and guidance. Staff perceives supervision as helpful to them in improving the quality of services they provide to residents.
   - 4
   - 3
   - 2
   - 1

5. Staff reports receiving adequate in-service training. Staff can summarize the salient points of at least one (1) training provided within the last year. Staff perceives the training they have received as relevant to their job responsibilities.
   - 4
   - 3
   - 2
   - 1

6. Staff perceives professional working relationships as cooperative and collaborative.
   - 4
   - 3
   - 2
   - 1

7. Staff communication is timely, accurate, and works for the benefit of the residents.
   - 4
   - 3
   - 2
   - 1

8. Staff perceives the facility's administration as supportive of the clinical program and responsive to its needs and problems.
   - 4
   - 3
   - 2
   - 1

9. Staff understands the proper use and documentation of special procedures (seclusion and restraint), when and how they should be used, which staff is authorized to apply them, and what other less restrictive techniques might be attempted to de-escalate difficult situations or behavior.
   - 4
   - 3

- 2
- 1

10. Staff is aware of the proper procedure for handling medical/physical complaints of residents.
    - 4
    - 3
    - 2
    - 1

11. Staff believes that treatment units are adequately staffed, and a policy is in place to ensure there is coverage for individual and family therapy when staff is on leave.
    - 4
    - 3
    - 2
    - 1

21.9.9.5 E: Resident Record Review

1. Resident Record:

Category:	Yes	No	Not Applicable
Well organized and legible with a key identifying the location of all required documents.			
Copies of documents verifying custody.			

2. Admission:

Category:	Yes	No
Documentation of MD recommendations and psychiatric evaluation for admission to PRTF within 30 days prior to admit.		
If admission is for a Sexually Acting Out or SO program, then a current and independent Psychosocial Assessment should be completed in advance and the findings should be reflected in the Psychiatric Recommendations.		
Parents or guardians were informed regarding medication policies (permission for medication changes, or any PRN changes), seclusion and restraint procedures, and requirements for family involvement.		

3. At admission, less restrictive treatment is not appropriate:

Category:	Yes	No
Resident failed to respond to less restrictive treatment.		
Symptom severity warrants residential treatment.		
Resident is being stepped-down from acute care or symptoms could not be controlled at lower level of care.		

4. Assessment:

Category:	Yes	No
Psychiatric evaluation completed within seven (7) days of admit		
Medical history and physical exam provided within seventy-two (72) hours of admission including medication history.		
Escalation risk/safety plan, trauma assessment, risk of sexual offense, and acting out behavior are addressed.		
Psychosocial assessment per LOC.		
Provisional discharge plan completed at intake.		

5. Assessment: Required Elements

Category:	4	3	2	1
A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).				
Documentation of presence or absence of any current medical conditions.				
A complete mental status exam, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.				
Documentation of efforts to obtain collateral information from previous treatment providers and parent/guardian.				
Adequate information in the record to make a careful diagnostic assessment or resolve differences in diagnostic impressions.				
There is evidence that initial coordination of care has occurred.				

6. Psychosocial assessment:

Category:	4	3	2	1
Includes developmental profile.				
Includes behavioral assessment.				
Includes details regarding onset of symptoms.				
Assesses potential family resources.				
Trauma Assessment				
Risk of sexual offense and acting out behavior.				
For patients 12 and older, a substance abuse screening occurs. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.				

7. Treatment Planning: Team Composition

Category:	Yes	No
Psychiatrist or PMH-MP/psychologist and physician separate PCP from psych.		
LCSW, LPC, LMFT, LAT, Provisionally Licensed Staff/Providers, and Licensed Psychologists.		

8. Treatment Planning: Time Lines Met

Category:	Yes	No	Not Applicable
Initial plan at intake.			
Comprehensive plan within fourteen (14) days.			
Reviews: once at end of first month of stay.			
Reviews: once monthly after first month of stay.			
Treatment plans are updated within 24 hours following seclusion or restraint.			

9. Treatment Planning: Required Elements

Category:	Yes	No
If trauma and/or sexual acting out behavior has been identified, it is reflected in the treatment plan goals and interventions.		
Both resident's strengths and problem areas are addressed.		
Both family's strengths and problem areas are addressed.		
The treatment plan is individualized and consistent with diagnosis.		
Short and long term goals are objective and measurable.		
Treatment plan addresses each diagnosis separately.		
Treatment modalities and clinicians responsible are identified. Realistic and obtainable goals are put in place for kids with self-harm history.		
Family therapy goals/objectives are explained.		
Discharge plan and estimated discharge date are identified.		
If a substance use disorder is identified, it is reflected in the treatment plan goals and interventions.		

10. Treatment Planning: Reviews

Category:	Yes	No	Not Applicable
Identify changes in treatment, if needed, to address goals where progress is minimal.			
The need for residential versus less-restrictive treatment is reassessed.			
The progress in relation to projected discharge date, as measured by meeting measurable goals/objectives, is assessed.			
Goals, measurable objectives, target dates for completion are incorporated into the treatment plan.			
Treatment successes are noted.			

11. Evidence that resident and parent/guardian actively participate in treatment goals.
    - Yes
    - No

12. Evidence that psychiatrist directs treatment through comprehensive notes and participation in staffing.
    - Yes
    - No

13. Evidence of interdisciplinary collaboration in planning.
    - Yes
    - No

14. Treatment Documentation: Required Elements

Category:	4	3	2	1
Summary of content/process is detailed enough to provide an accurate clinical picture to those outside the treatment team.				
Sessions clearly have therapeutic focus.				
Outcome of session and plan for time between sessions and next session.				
Documentation that goals of treatment are communicated with all direct care staff.				

15. Treatment Documentation for all modalities:

Category:	Yes	No
Therapist's name and signature is present on treatment documentation.		
Date/length of session.		

16. Individual Therapy: Required Elements

Category:	4	3	2	1
Progress towards treatment goals is identified.				
Progress in relation to discharge date and plan for future sessions is addressed at least monthly.				
If trauma has been identified, there is evidence it is being addressed.				
The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.				
Treatment modalities are evidence-based and appropriate for the diagnoses.				
Progress notes contain a level of detail sufficient for those not directly involved in treatment to have an accurate clinical picture.				
Mental status and depression assessment.				

17. Individual Therapy is provided a minimum of one hour per week.
    - Yes
    - No
18. Family Therapy: Required Elements

Category:	4	3	2	1
Resident's response to family.				
Documentation supports family therapy focus on addressing presenting problems prior to admission and preparing for a successful transition home.				
If family is not actively involved in treatment, therapeutic intervention is addressed.				
Evidence of alternative treatment interventions when there is minimal or no progress.				
If trauma has been identified, there is evidence it is being addressed.				

19. Family Therapy is provided a minimum of one hour per week.
    - Yes
    - No
20. Group Therapy: Required Elements

Category:	Yes	No
Activities are therapeutic in nature and relate to treatment goals.		
There is evidence of resident's participation in groups.		

21. Group therapy is provided a minimum of 3 hours in at least 3 sessions per week.
    - Yes
    - No
22. Therapeutic milieu is provided 24 hours per day seven days per week.
    - Yes
    - No
23. Medication

Category:	Yes	No	Not Applicable
All orders are in chart.			
Evidence of PRN orders routinely reviewed and updated (PRN follows WDH guidelines).			
There was informed consent for meds properly executed.			
The resident was assessed for side effects.			
Administration is timely and accurate (MAR).			
There is documentation of medical history.			
Reasons for, and response to, PRN medication use is documented in MAR.			
There is no evidence of chemical restraints being used.			

24. Medication Monitoring: Required Elements

Category:	Yes	No	Not Applicable
Rationale behind the medication plan is discussed.			
When medication does not appear to be therapeutically effective, there is an aggressive plan to address.			
Evidence the lab results were received and reviewed by the clinician.			
Evidence of progress documented by the physician/addictionologist at regular intervals, appropriate to the rendered service.			
Record of previous medication trials.			
Documentation of monitoring for boxed warnings for medication.			
Metabolic parameters obtained per best practice guidelines.			
Rule out diagnoses confirmed or eliminated.			
Record contains documentation of a differential diagnosis when medical conditions are present.			

25. There is evidence that frequency of client visits with psychiatrist is appropriate to the intensity of treatment and current risk issues.
    - Yes
    - No
26. Care of the Whole Person

Category:	Yes	No	Not Applicable
Residents have access to a primary care physician.			
Residents have access to dental/vision.			
PRTF is ensuring resident is current with EPSDT.			
PRTF is providing health care education (STDs, birth control, etc.)			
Biometrics changes are addressed by the psychiatrist and/or dietitian.			

27. Therapeutic Pass:

Category:	Yes	No	Not Applicable
Goals for pass are identified based on clinical need not programmatic standards.			
Evidence that goals were discussed with resident and family/guardian.			
Evidence of evaluation of the pass.			

28. Therapeutic Leave:

Category:	Yes	No
Authorized by physician's or PMHNP's orders.		
Not taken during 14-day assessment.		
Date/Time patient checked out/in is documented.		
Medication instructions given using non-medical language.		
Therapeutic goals for leave are discussed with resident and family/guardian.		
Required time of return is identified and documented.		
Name of person with whom leave will be spent with is documented.		
Resident's condition at check-out-in and mental status is documented.		
Name/signature of person with whom child is leaving/returning with is documented.		
There is documentation that goals were discussed with the child and their family.		
Name/signature of staff checking child out/in is documented.		
Medications provided/returned are noted and include number of doses.		
Outcome of leave is assessed by therapist within 72 hours of return.		
UDS completed upon return when clinically indicated.		

29. Prior to seclusion/restraint, the least restrictive effective intervention was used:

Category:	4	3	2	1
Prior to seclusion/restraint, were less restrictive attempts to de-escalate behavior utilized.				
Documentation of which less restrictive measures were used and how they failed.				

30. Seclusion/Restraint: Required Elements

Category:	Yes	No	Not Applicable
Seclusion/restraint initiated and ended only by a state approved professional.			
Personal seclusion/restraint administered by trained personnel.			
Seclusion/restraints only used for imminent threat.			

31. Seclusion/Restraint: Documentation

Category:	Yes	No	Not Applicable
Date/Time procedure started/ended.			
Names of staff involved in applying or monitoring seclusion/restraint.			
Was the precipitating event for the escalating behavior identified.			
Order obtained from state approved professional within one hour.			

Category:	Yes	No	Not Applicable
Orders for children under the age of 9 are no more than one hour, 9-17 year old children are two hours, and orders for 18-21 year olds are four hours.			
Order was renewed when original order expired and why a renewal was needed was documented.			
Clear criteria for ending seclusion/restraint was identified.			
Resident's health/comfort was assessed every 15 minutes.			
Vital signs were taken every hour.			
In-person assessment conducted by physician, PMHNP, or RN within 1 hour, regardless of length of procedure.			

32. Seclusion/Restraint: Assessment of Outcome

Category:	4	3	2	1
Resident's physical/psychological status.				
Resident's response to the restraint.				
Resulting complications.				
Seclusion/restraint ended at the earliest possible time.				

33. Seclusion/Restraint: Timelines

Category:	Yes	No
The treatment plan was modified within one working day of incident as indicated.		
Parents or guardian notified within 24 hours of the incident.		
The incident was processed with the resident by staff within 24 hours.		
Resulting complications.		

34. Provisional discharge/aftercare plan developed at intake and updated throughout treatment episode to reflect resident progress.
    - Yes
    - No

35. Provisional Aftercare Plan: Required Elements

Category:	Yes	No
Anticipated date of discharge.		
Recommendations for parents/caregivers.		
Educational summary and recommendations.		
Recommendations for mental health providers.		

36. Final Aftercare Plan: Required Elements

Category:	Yes	No
Person/agency to who resident will be released.		
Address where resident will reside.		
Documentation that coordination of care was attempted by PRTF therapist.		
Names, addresses, and phone numbers of follow-up mental health care providers was documented.		
Recommendations and briefing of safety plan with parents/caregivers.		
Follow up appointment with PCP, psychiatrist, and therapist including date, time, and provider name documented.		
Documentation of functional impairments preventing completion of activities of daily living and ongoing risk.		

37. Final Aftercare Plan: Timelines Met

Category:	Yes	No
Follow up therapy appointment within 7 days of discharge.		
Medication management appointment scheduled within 30 days of discharge.		

38. Final Discharge Summary: Required Elements

Category:	Yes	No
Dates of admission and discharge.		
Progress towards treatment goals.		
Summary of reason(s) for discharge.		

39. Parents/Guardians Received:

Category:	Yes	No
Minimum of one week supply of medications.		
Written prescription for 30-day supply of medications.		
Copy of aftercare plan.		

40. Documentation that educational summary and recommendations were mailed to the resident's school within 24 hours post-discharge.
    - Yes
    - No
41. Documentation that aftercare plan and discharge summary were mailed to follow-up mental health care providers within 2 weeks post-discharge.
    - Yes
    - No
42. Documentation indicates that the facility follows its policies and procedures in practice.
    - Yes
    - No

21.9.9.6 F: Resident Interviews

1. Residents can explain how they are encouraged to participate freely in community meetings. Residents perceive open, collaborative communication between themselves and staff.
   - 4
   - 3
   - 2
   - 1

2. Residents feel like they can safely bring concerns and challenges to staff without fear of consequences.
   - 4
   - 3
   - 2
   - 1

3. Residents participate in treatment team meetings. They are knowledgeable about their treatment goals and have helped to set them.
   - 4
   - 3
   - 2
   - 1
4. Residents understand their behavior program(s). They know what phase they are on and what is required to reach the next phase.
   - 4
   - 3
   - 2
   - 1

5. Residents report receiving timely feedback on their progress towards treatment goals.
   - 4
   - 3
   - 2
   - 1

6. Residents are knowledgeable about their medications: names, strengths, frequency of dosages, and which symptoms are targeted. They can explain possible side effects of their medications.
   - 4
   - 3
   - 2
   - 1

7. Residents are aware of the goals they need to meet before going home, targeted discharge date, and current discharge date.
   - 4
   - 3
   - 2
   - 1

8. If residents have been secluded or restrained, they understand why the seclusion/restraint was used and understood their release criteria at the time the procedure was in progress.
   - 4
   - 3
   - 2
   - 1
   - Not applicable

9. A staff member helped them to process the incident after its conclusion.
   - Yes
   - No
   - Not applicable

10. Resident could name their triggers and at least two coping skills they can try in the future when feeling upset or out of control.
    - 4
    - 3
    - 2
    - 1

11. Does the resident feel safe when others are out of control?
    - 4
    - 3
    - 2
    - 1

12. Residents believe that medical complaints are handled in a timely and appropriate manner.
    - 4
    - 3
    - 2
    - 1

13. Residents have a positive perception of the facility's program and how they are being treated. They perceive staff as genuinely interested in their welfare and capable of helping them.
    - 4
    - 3

- 2
- 1

14. Residents feel they are making progress in their treatment and can explain why.
    - 4
    - 3
    - 2
    - 1

15. Resident feels the facility is warm, safe, and comfortable.
    - 4
    - 3
    - 2
    - 1

16. Resident feels satisfied with how the facility reacts with their family and they are able to contact their family regularly.
    - 4
    - 3
    - 2
    - 1

17. Residents understand the grievance policy and how to submit a complaint if they have a grievance.
    - 4
    - 3
    - 2
    - 1

Appendix

Page left blank intentionally.

APPENDIX A – INSTITUTIONAL 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 & added DOS indicators to threshold info.
	Chapter 3 – Provider Responsibilities 3.1.1 *Ordering, Referring, and Prescribing Providers (ORP)* – added note concerning Chiropractors 3.5 *Medicaid Payment is Payment in Full* – added DOS specifier to Chiropractic and Dietitian thresholds
	Chapter 6 – Common Billing Information 6.10.1 *Under Age 21* – added BH services and DOS specifier to Chiropractic & Dietitian thresholds 6.10.2 *Ages 21 and Older* – added codes H0046 and S9480 to table, added DOS specifier to Chiropractic & Dietitian thresholds, added under age 21 to BH 6.10.3 *Authorization of Medical Necessity* – Added DOS specifier to AOMN requirements 6.10.5 *Prior Authorization Once Thresholds are Met* – Added Board certified Behavior Analyst to providers who can make requests. 6.24.1 *Covered Services* – changed language to indicate Originating Sites list is comprehensive of all approved sites & removed the client's home as an allowed site 6.24.2 *Non-Covered Services* – Added statement concerning clients using personal equipment 6.24.4 *Billing Requirements* – Added NOTE concerning clients using personal equipment
	Chapter 11 – Outpatient Services 11.4.2.2 *Limitations* – replaced all instances of "mental retardation" with "intellectual disabilities"
	Chapter 14 – End State Renal Disease (ESRD) 14.2 *Billing Requirements* – Added rate reduction for 2021
	Chapter 16 – Home Health 16.2.3.1 *Prior Authorization* – Added paragraphs w/ PA denial explanations and appeal information.
	Chapter 19 – Skilled Nursing Facility and Swing Bed Services 19.3.4 *PASRR Pre-Admission Screening and Resident Review* – replaced all instances of "mental retardation" with intellectual disabilities 19.4.1 *Transfer* – replaced all instances of "mental retardation" with "intellectual disabilities" 19.4.2 *Categorical Determinations that do Not Require a Level II Prior to Admission* – replaced all instances of "mental retardation" with intellectual disabilities

APPENDIX B – Provider Notifications Log			
Active Date(s)	Notification Type	Title	Audience
10/13/20	Bulletin	HH & DME Prior Authorization Requirement Reinstatement	332B00000X, 251E00000X, 364SP0808X
11/2/20	Bulletin	Medicaid Behavioral Health Rate, Coding, and Threshold Changes	261QR1300X, 261QF0400X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X, 2084P0800X, 2080N0001X, 208100000X, 363A00000X, 207Q00000X, 207R00000X, 364SP0808X, 363LP0200X, 363L00000X, 363LA2200X, 363LF0000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 261QM0801X, 261QR0405X, 101Y00000X, 251E00000X, 332B00000X, 261Q00000X, 261QP0904X
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
11/13/20	Bulletin	LT101 & Nursing Home Claims Reprocessing	314000000X & 275N00000X
11/19/20	RA Banner	Wyoming Medicaid Enrollment Vendor Transition	All Providers
11/20/20	Bulletin	CARES Act Funding for Mental Health & Substance Abuse Services	261Q00000X, 261QP0904X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 364SP0808X, 2084N0400X, 2084P0800X, 261QF0400X, 261QR1300X
12/7/20	Bulletin	URGENT! DECEMBER PAYMENT DATE CHANGES – MEDICAID	All Providers
12/10/20	Bulletin	Telehealth Updates for Originating Sites	261Q00000X, 261QP0904X, 251E00000X, 282NR1301X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 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, 261QF0400X, 261QR0401X, 261QR1300X
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

Bulletin – Home Health & DME Prior Authorization Requirement Reinstatement

Wyoming Department of Health

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

Attention Home Health Providers

Effective December 1st, 2020, prior authorizations will be reinstated for home health services. The revenue codes are listed below with some general guidelines for submitting requests to WYhealth.

Revenue Code	Description	Unit	HCPCS Code
0421	PHYSICAL THERAPY - VISIT CHARGE	Per Visit	G0151
0431	OCCUPATIONAL THERAPY - VISIT CHARGE	Per Visit	G0156
0441	SPEECH THERAPY - VISIT CHARGE	Per Visit	G0153
0551	SKILLED NURSING - VISIT CHARGE	Per Visit	G0154
0561	MEDICAL SOCIAL SERVICES - VISIT CHARGES	Per Visit	G0155
0571	HOME HEALTH AIDE - VISIT CHARGE	Per Visit	G0156

Guidelines

- For Dates of Service 12/1/2020 and forward, Prior Authorization (PA)requests are required and must be submitted no more than 10 business days after the start of services
  - Dates of service during the COVID-19 pandemic from 3/17/20 to 11/30/20 do not require a PA.
- Requests submitted without a signed and dated 485 form or physician's detailed order will be issued a technical denial
- While claims will be billed with ONLY the revenue code, PA requests must be submitted with the associated HCPCS code for processing.

- Requests for As-Needed (PRN) visits must be submitted after the visit has occurred, but within 5 business days, as a separate episode. Requests must include documentation of the medical necessity of the PRN visit, including the clinical notes from that visit
- For facility discharges, upload the discharge summary from the facility and any applicable therapies (Physical Therapy (PT), Occupational Therapy(OT), Speech Therapy(ST))
- For wound care related requests, include current detailed wound specific information including frequency of care, drainage, and wound measurements
- For IV medication related requests, include current medication orders with frequency and duration, and how often administration is to be completed
- For Pediatric G-Tube Care: Clients age 20 and younger, when medically necessary, 1 Skilled Nursing (SN) visit per month for review of the placement and patency of the G-Tube will be approved. Other PRN visits will be reviewed according to the PRN visit requirements.
- Technical denials will be issued by WYhealth for the following:
    - No signed/dated 485 form or physician's orders
    - Failure of the provider to respond to requests for additional information
    - Incorrectly submitted codes (such as using HCPCS or CPT codes instead of Revenue Codes)
- In order to bill for services, the approved prior authorization number must be included on the claim to avoid delays and denials.

To receive training on iExchange for home health prior authorizations, please email WYhealth Provider Relations: wyhealth@optum.com or register for iExchange, https://www.medecision.com/sign-up-today . Follow the steps and complete all required fields for easy registration. Select "WYhealth" as the health plan for access. Please watch for email communications to come from Medecision regarding your iExchange log-in credentials. Please make sure you check your spam folder. Wyoming Medicaid is still allowing telehealth services for home health care for state plan only Medicaid home health providers, not waiver providers, at this time. Please follow the telehealth policy in the CMS 1500 Provider Manual, https:/wymedicaid.portal.conduent.com, using the GT modifier to identify the claims.

Call WYhealth at (888)-545-1710 with questions or concerns.

Attention Durable Medical Equipment Providers

Effective December 1st, 2020, prior authorizations will be reinstated for enteral nutrition. The procedure codes are listed below with some general guidelines for submitting requests to WYhealth.

Enteral Nutrition Codes: B4100, B4102, B4103, B4104 – B4162 (require prior authorization)

Procedure Code	Procedure Code Description	PA Requirement	NDC Requirement
B4100	FOOD THICKENER	Yes	No
B4102	ENTERAL FORMULA, FOR ADULTS	Yes	No
B4103	ENTERAL FORMULA, FOR PEDIATRICS	Yes	No
B4104	ADDITIVE FOR ENTERAL FORMULA	Yes	No
B4149	ENTERAL FORMULA, BLENDERIZED NAT FOODS	Yes	No
B4150	ENTERAL FORMULAE; CATEGORY I	Yes	No
B4151	ENTERAL FORMULA; CATEGORY I	Yes	No
B4152	ENTERAL FORMULA; CATEGORY II	Yes	No
B4153	ENTERAL FORMULA; CATEGORY III	Yes	No
B4154	ENTERAL FORMULA; CATEGORY IV	Yes	No
B4155	ENTERAL FORMULA; CATEGORY V	Yes	No
B4156	ENTERAL FORMULA; CATEGORY VI	Yes	No
B4157	ENTERAL FORMULA; NUTRITIONALLY COMPLETE	Yes	No
B4158	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No
B4159	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No
B4160	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No
B4161	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No
B4162	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No

If enteral nutrition is taken orally, use modifier BO on the claim (the modifier also needs to be part of the request during the prior authorization process).

Enteral nutrition may be covered for the following reasons:

1. When ordered by a physician who has seen the client within 60 days prior for oral nutrition and within 180 days prior for nasogastric, jejunostomy, or gastrostomy tube to ordering the therapy and has documented that the client cannot receive adequate nutrition by dietary adjustments and/or oral supplements. The face-to-face visit requirement is for first time prescriptions and annually thereafter. The face-to-face visit can be completed via telehealth. If an individual goes to a new DME provider, this is considered a first time prescription. Enteral therapy may be given by:
    A. Nasogastric
    B. Jejunostomy
    C. Gastrostomy tube
    D. Orally

2. Enteral Nutrition Therapy is considered reasonable and necessary for clients with:
    A. Functioning gastrointestinal tracts who, due to pathology or non-function of the structures that normally permit food to reach the digestive tract, cannot maintain weight, strength, and overall health status

3. Oral enteral nutrition therapy is covered if the patient has a diagnosed medical condition such as, but not limited to:
    A. A mechanical inability to chew or swallow solid or pureed or blenderized foods;
    B. A malabsorption inability due to disease of infection;
    C. Weaning from Total Parenteral Nutrition or feeding tube;
    D. A significant weight lost over the past six (6) months or, for children under age 21, has experienced significantly less than expected weight; or
    E. If patient receives less that 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, a nutritionist, speech-language pathologist or a physician must write a detailed plan to decrease dependence on the supplement.

4. Enteral nutrition therapy is not covered:
    A. For clients whose nutritional deficiencies are due to a lack of appetite or cognitive problem; or
    B. For healthy newborns; or
    C. For individuals living in a nursing facility or residential facilities as this should be part of the per diem or room and board; or
    D. For clients whose need is nutritional rather than medical or is related to an unwillingness to consume solid or pureed foods; or
    E. As a convenient alternative to preparing or consuming regular foods; or
    F. Because of an inability to afford regular foods or supplements.

Documentation :

For all requests for authorization of enteral nutritional products, documentation must include the following:

A. Specific enteral product requested
B. Average number of calories to be obtained per day from the enteral nutritional product
C. Average number or calories to be obtained per day for other sources
D. Medical condition that requires an enteral nutrition product
E. Type of food preparation that have been tried (mechanically chopped, pureed or blenderized)
F. Documentation if a swallowing study or swallowing evaluation has been completed with a history of aspiration
G. Medical document to support the clinical need of the prescribed product
H. Written order

Documentation of medical necessity must be kept on file by the provider and made available upon request.

If you have not been trained on iExchange for DME prior authorizations, please email WYhealth Provider Relations: wyhealth@optum.com or register for iExchange, https://www.medecision.com/sign-up-today. Follow the steps and complete all required fields for easy registration. Select "WYhealth" as the health plan for access. Please watch for email communications to come from Medecision regarding your iExchange log-in credentials. Please make sure you check your spam folder.

Wyoming Medicaid is still allowing telehealth services for physician, NP or PA visits for DME. Please follow the telehealth policy in the CMS 1500 Provider Manual, https:/wymedicaid.portal.conduent.com, using the GT modifier to identify the claims.

Call WYhealth at (888)-545-1710 with questions or concerns.

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: 10/13/20
- Deployment Time: 10:00 AM

- Audience: HH & DME providers
    - Taxonomies: 332B00000X, 251E00000X, 364SP0808X

Bulletin – Medicaid Behavioral Health Rate, Coding, and Threshold Changes

Wyoming Department of Health

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

Attention Behavioral Health Providers – Thresholds for Children and Group Therapy Changes

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 Biennium 2021-2022 Budget Reduction Plan, https://health.wyo.gov/wp-content/uploads/2020/08/WDH_2021-2022-Budget-Reduction-Plan_8.26.2020.pdf .

Behavioral Health Threshold Limits for Clients Under 21

Starting January 1, 2021, clients under the age 21 receiving behavioral health services and Applied Behavioral Analysis treatment will be subject to a threshold of 30 visits per calendar year. Once the threshold is reached, the provider will need to submit a Prior Authorization (PA) request for additional medically necessary services. The policy is similar to the adult population with behavioral health services but has the following differences.

- For clients ages 21 and older, all services, including the initial 30, must be rehabilitative in nature.
- For clients ages 20 and younger, all services, including the initial 30, must be medically necessary, but may fall outside the rehabilitative category.

Prior Authorization Process and Requirements

Prior Authorizations will be processed by the vendor WYhealth. Requests must be submitted electronically via the iExchange portal.

If you have not been trained on iExchange for behavioral health prior authorizations, please email WYhealth Provider Relations: wyhealth@optum.com or register for iExchange, https://www.medecision.com/sign-up-today . Follow the steps and complete all required fields for easy registration. Select “WYhealth” as the health plan for access. Please watch for email communications to come from Medecision

regarding your iExchange log-in credentials. Make sure you check your spam folder if you have not added Medecision to your contacts.

The following must be submitted with your request to WYhealth in order for a determination to be made:

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

To verify a Medicaid client's thresholds and eligibility, please use the IVR.

- Call the Provider Relations IVR at 1(800)251-1268
  - To obtain client eligibility, etc. – press 1
  - Select how you bill Medicaid and enter your Provider Information
    - Press 1 for 10 digit NPI, IVR repeats, if correct – press 1
    - Press 2 for 9 digit Provider ID, IVR repeats, if correct – press 1
  - Client eligibility – press 1
  - Enter the client information
    - For Client ID – press 1
      - Enter 10 digit client ID, IVR repeats, if correct – press 1
    - For SSN – press 2
      - Enter SSN, IVR repeats, if correct – press 1
      - Enter DOB (mm/dd/yyyy)
  - Enter DOS (mm/dd/yyyy)
  - For DOS this client is eligible for xx(xx) benefit plan(s)
  - To continue – press 3,
  - Check service usage for Authorization Of Medical Necessity – press 2
    - Choose the threshold type or choose to listen to all threshold information

Prior authorization (PA) inquiry and print functionality is now available on the Wyoming Medicaid secure provider portal. 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 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.

Reminders

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

- "Medical necessity" or "Medically necessary" means a determination that a health service is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected to relieve pain or to improve and preserve health and be essential to life. The service must be:
    - Consistent with the diagnosis and treatment of the client's condition;
    - In accordance with the standards of good medical practice among the providers' peer group;
    - Required to meet the medical needs of the client and undertaken for reasons other than the convenience of the client and the provider; and,
    - Performed in the most cost effective and appropriate setting required by the client's condition.
- Maintenance (Habilitative) Services – Services that help clients keep, learn, or reach developmental milestones or improve skills and functioning for daily living that they have not yet acquired. Examples would include therapy for a child who is not walking or talking at the expected age.
- Restorative (Rehabilitative) Services – Services that help clients keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the client was sick, hurt, or suddenly disabled.
    - Federal Medicaid Law defines rehabilitative services as: "Any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice

under State law, for maximum reduction of physical or mental disability and restoration of an individual to his best possible functional level" [42 C.F.R. §440.130].

Changes to Coding and Rate Reductions

Group Therapy

Starting January 1st, 2021, the new Group Psychotherapy HCPCS code will be **H0046** – Mental Health Services, not otherwise specified, per session. This code, H0046, will be added so that H2019 will only be used for Individual Therapy. Please note that if you use the Current Procedural Terminology (CPT) codes such as 90853 – Group Medical Psychotherapy, you can continue to use them. Group therapy will be limited to two sessions per day and the sessions will not be allowed to be billed consecutively. For example, a group therapy session form 10-12 p.m. and then another one from 12-2p.m. will not be allowed. There must be a minimum of 1 hour between the two group sessions.

Intensive Outpatient Program Services

Starting January 1st, 2021, there will be a new code **S9480** – Intensive Outpatient Psychiatric Services, per diem. The new code is for Intensive Outpatient Program services provided at a Community Mental Health Centers and Substance Abuse Treatment Centers.

Please remember to use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service. Claims that are submitted for payment may be reviewed through our utilization management vendor. Appropriate changes will be made to the CMS 1500 provider manual for January 1, 2021.

Rate Reductions

Due to significantly reduced state revenues, the Wyoming Department of Health (WDH), Division of Healthcare Financing will be reducing provider rates by 2.5%. With these changes, the behavioral health codes will be aligning the reimbursement rates. This means that the current rates for HCPCS codes will match the rates for the CPT procedure codes that are equivalent. This was part of the final recommendation for the 2016-2017 Behavioral Health Cost Study. It stated that payments and units differed from the same therapy services based on the use of HCPCS or CPT codes. The change to align comparable CPT/HCPCS codes to the fee schedules will also take place January 1st, 2021.

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: 11/2/2020
- Deployment Time: 10:30 AM
- Audience: BH Providers
    - Taxonomies: 261QR1300X, 261QF0400X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X, 2084P0800X, 2080N0001X, 208100000X, 363A00000X, 207Q00000X, 207R00000X, 364SP0808X, 363LP0200X, 363L00000X, 363LA2200X, 363LF0000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 261QM0801X, 261QR0405X, 101Y00000X, 251E00000X, 332B00000X, 261Q00000X, 261QP0904X

Bulletin – Medicaid Budget Reduction Changes

To view this email as a web page, go here.

Wyoming Department of Health

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%

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 Department of Health

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

Bulletin – LT101 & Nursing Home Claims Reprocessing

Wyoming Department of Health

Wyoming Medicaid

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

IMPORTANT NOTICE

Attention Long Term Care/Nursing Home Providers

Conduent has identified and resolved issues that may have caused Nursing Home (314000000X), Inpatient, and Inpatient Crossover/Swingbed (275N00000X) claims to be denied in error or paid with patient contribution with errors.

If ALL of the below conditions apply:

Your provider type is one of the taxonomies above,
You received EOB 368, 369, 370, 372, 373, 375, 376, 377, 378, 379, 380, 382, and/or 579
The client admit date is 3/1/20 or later, AND
The LT101 referral date, PASRR Level I date, and Level II dates were completed within 30 days of the admit date on the claim

Your action is required! Please resubmit any denied claims to Wyoming Medicaid.

Additionally, the COVID-19 exception that waived co-pays, when diagnosis codes U07.1 and B97.29 were present on a claim, has been applied to patient contribution for Nursing Homes. This caused claims to be paid with an incorrect patient contribution amount of $0.00. The

exception is being corrected for claims submitted after 11/5/20.

Your action is required! Claims processed prior to 11/5/20 with either dx code present need to be resubmitted or adjusted, as appropriate, to correctly apply patient contribution.

We apologize for any inconvenience this may have caused.

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/

Deployment Information:

- Deployment Date: 11/13/20
- Deployment Time: 10:00 AM
- Audience: LT101 & NH Providers
    - Taxonomies: 314000000X & 275N00000X

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

Deployment Information:

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

Bulletin – CARES Act Funding for Mental Health & Substance Abuse Services

To view this email as a web page, go here.

Wyoming Department of Health

Wyoming Medicaid

Attention Behavioral Health Providers

The Wyoming Department of Health (WDH), together with Governor Mark Gordon, is providing enhanced CARES Act funding for mental health and substance abuse services for Wyoming residents requiring services resulting from the COVID-19 pandemic.

Please visit the following link for more information:
https://health.wyo.gov/publichealth/infectious-disease-epidemiology-unit/disease/novel-coronavirus/covid-19-mental-health-and-substance-abuse-provider-funding/

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: 11/20/20
- Deployment Time: 10:30 AM
- Audience: Behavioral Health Providers
  - Taxonomies: 261Q00000X, 261QP0904X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 364SP0808X, 2084N0400X, 2084P0800X, 261QF0400X, 261QR1300X

Bulletin – URGENT! DECEMBER PAYMENT DATE CHANGES – MEDICAID

To view this email as a web page, go here.

Wyoming Department of Health

Wyoming Medicaid

Attention Providers and Billers!

Important Medicaid Payment Date Changes for December

2020 DECEMBER CHANGES IN MEDICAID'S PAYMENT SCHEDULE
********************READ NOTES BELOW*** ******************

WEEK OF	WYOMING MEDICAID PAYMENT DATES	STATE AUDITOR'S PAYMENT DATES	EFT TRANSMIT DATES *(Banks have up to 3 business days to post to accounts)*	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

Bulletin – Telehealth Updates for Originating Sites

Wyoming Department of Health

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

IMPORTANT NOTICE

Attention Telehealth Providers

Effective January 1, 2021, providers are not allowed to bill Q3014 for the originating site when the originating site is the client's home. This also applies when the client uses their personal telephone or computer while at an authorized originating site or when the client is at any location that is not listed below.

Claims that are submitted for payment may be reviewed through our utilization management vendor for appropriate use of telehealth codes.

The originating sites will be updated in the January 1, 2021 quarterly CMS 1500 Provider Manual update to show as follows.

Originating Sites (Spoke Site)

The Originating Site or Spoke site is the location of an eligible Medicaid client at the time the service is being furnished via the site's telecommunications system.

Authorized originating sites are:

- Hospitals
- Office of a physician or other practitioner (this includes medical clinics)
- Office of a psychologist or neuropsychologist
- Community mental health or substance abuse treatment center (CMHC/SATC)
- Office of an advanced practice nurse (APN) with specialty of psych/mental health
- Office of a Licensed Mental Health Professional (LCSW, LPC, LMFT, LAT)

- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Skilled nursing facility (SNF)
- Indian Health Services Clinic (IHS)
- Hospital-based or Critical Access Hospital-based renal dialysis centers (including satellites). Independent Renal Dialysis Facilities are not eligible originating sites
- Developmental Center
- Family Planning Clinics
- Public Health Offices

Please refer to the CMS 1500 Provider Manual section 6.24, for additional telehealth policy information. If you have any questions about this policy update, please call Provider Relation at 1-800-251-1268.

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

Deployment Information

- Deployment Date: 12/10/2020
- Deployment Time: 3:00 PM
- Audience: Telehealth Originating Site Providers
    - Taxonomy: 261Q00000X, 261QP0904X, 251E00000X, 282NR1301X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X,

103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 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, 261QF0400X, 261QR0401X, 261QR1300X

Bulletin – Kid Care CHIP Medical & Outpatient Claims Reprocessing

To view this email as a web page, go here.

Wyoming Department of Health

Wyoming Medicaid

Attention Providers & Billers!

Kid Care CHIP Co-Payments Not Applied to Medical and Outpatient Claims

Provider Impact:

- Claims submitted and **paid** for children on the KIDC benefit plan only between the dates of 10/1/2020 and 11/19/2020 did not have co-payments applied
- 681 claims have been identified

Provider Action:

- No action is required to be taken by the provider or billing staff

Next Steps:

- Medicaid will adjust these paid claims on behalf of the providers and billers the week of 12/14/2020
- On 12/17/2020, these claim adjustments will begin appearing on Medicaid remittance advices (RAs) and 835 transactions

Contact provider Relations for questions and provide the adjusted TCN number for the best assistance in this matter. Provider Relations can be called at 1-800-251-1268 and following the below directions:

- Press 1
- Enter NPI or Provider ID
- Press 5 (listen to all the options)
- Press 0 to be transferred to an agent

We apologize for any inconvenience this may cause. Thank you for your patience.

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: 12/16/2020
- Deployment Time: 3:00 PM
- Audience: All Providers

State Letter – Vaccine Partner Update December 2020

To view this email as a web page, go here.

Wyoming Department of Health

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,

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

SP/ts

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