WYOMING STATE HOSPITAL

Title 25 Provider Manual

April 1, 2021

Wyoming Department of Health

Overview

Thank you for your willingness to serve clients receiving services while under the care of the Wyoming State Hospital (WSH).

NOTE: Policies and procedure outlines in this manual are applicable ONLY in cases when the client receiving services under a Title 25 hold is not a current Wyoming Medicaid client.

If a client receiving services under a Title 25 hold has active Medicaid coverage, services should be delivered and billed with all supporting documentation to Wyoming Medicaid in accordance with all policies and procedures outlined in the applicable Wyoming Medicaid Provider Manuals:

- **CMS 1500 ICD-10 – For professional services**
- **Institutional Manual ICD-10 – For all facility based inpatient and/or outpatient services.**

For information on how to obtain Prior Authorization for inpatient services provided to Medicaid clients, please call WYhealth at1-888-545-1710.

Rule References

Providers must be familiar with all current rules and regulations governing the Title 25 Program. This provider manual is to assist providers with billing for services rendered; it does not contain all WSH rules and regulations. Any rule or statue citations in the text are only a reference tool. They are not a summary of the entire statute or rule. In the event that the manual conflicts with a statute or rule, the statute or rule prevails. Wyoming State Hospital 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

This provider manual is 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).

Title 25 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, Wyoming State Hospital is the state entity designated to review and reimburse for services in accordance with Title 25 of Wyoming Statute. The Division of Healthcare Financing (DHCF), who also directly administers the Medicaid Program, has been designated as the entity to receive and process medical claims for payment of eligible services.

This manual is intended to be a guide for providers when filing medical claims for services provided to clients under a Title 25 hold. The manual is to be read and interpreted in conjunction with State statutes and administrative procedures. This manual does not take precedence over State statutes or administrative procedures.

Contents

Chapter One – General Information

1.1 How the Title 25 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	**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
Five	**Third Party Liability (TPL)/Medicare** – Explains what TPL/Medicare is, how to bill it, and exceptions to it
Six	**Important Information –** This chapter contains important information such as claims review, coding, and fee schedule information.
Seven	**Title 25 Covered Services –** This chapter 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 Title 25 Program, the Wyoming State Hospital (WSH) 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

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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

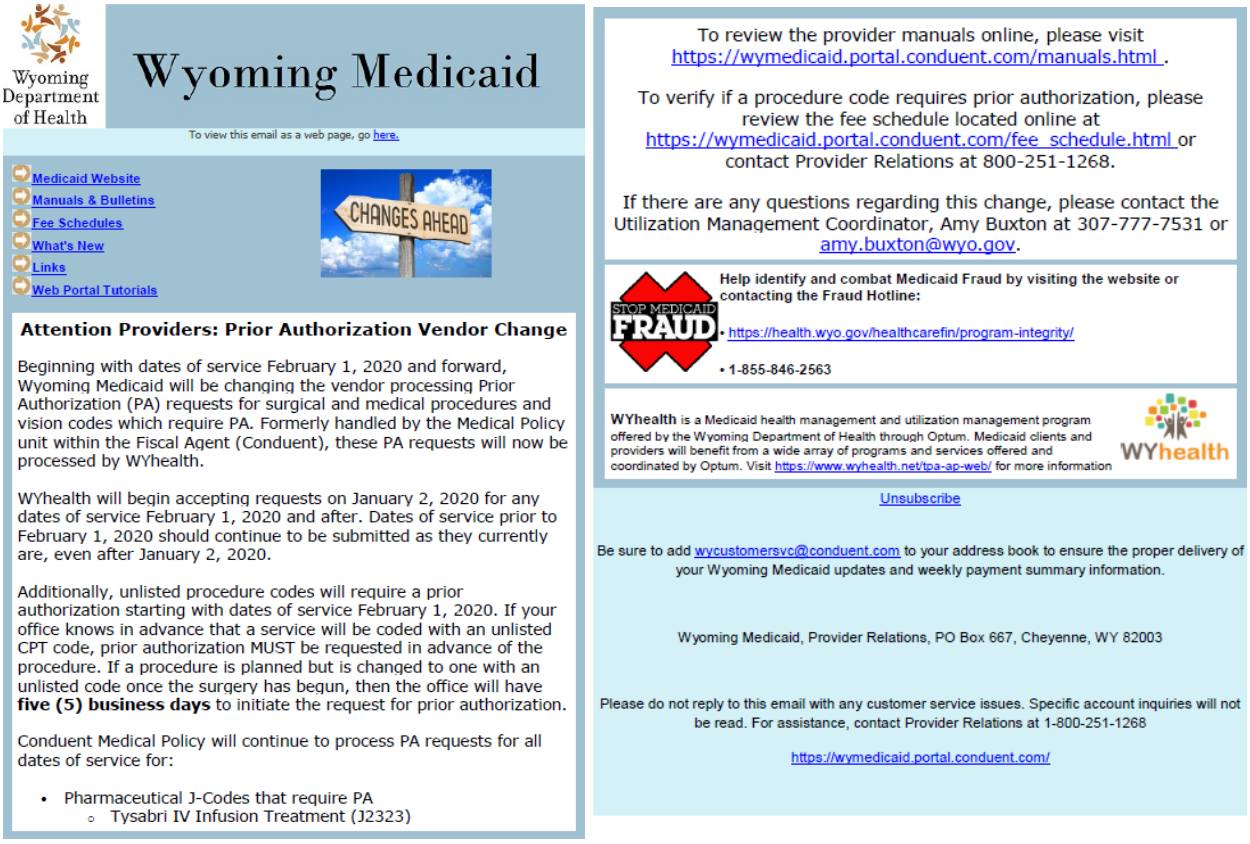
Remittance Advice Number: 123456
Amount of Check: 16,070.85
The RA banner notification will appear here when activated for the provider's taxonomy (provider type)

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

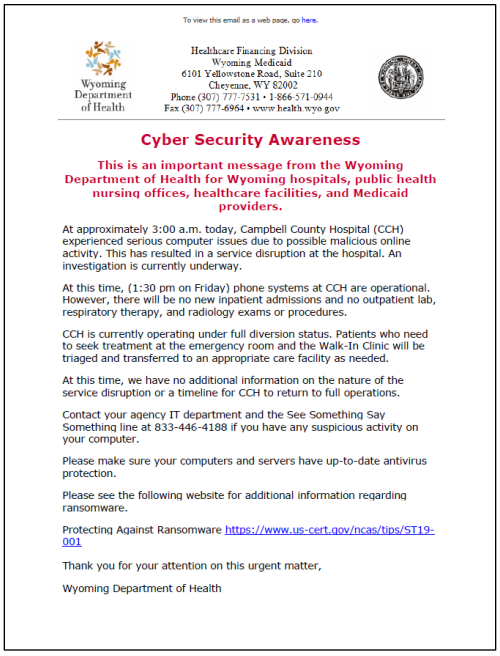
Please do not reply to this email with any customer service issues. Specific account inquiries will not be read. For assistance, contact Provider Relations at 1-800-251-1268

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.

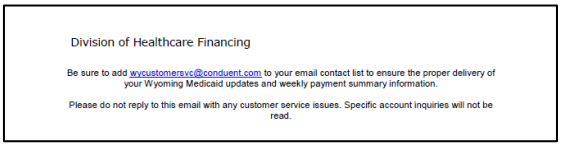
Please make sure your computers and servers have up-to-date antivirus protection.

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 Wyoming State Hospital administers the Title 25 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 for Title 25. They also answer provider inquiries regarding claim status, payments, client eligibility, and known third party insurance information.

NOTE: Neither the Wyoming State Hospital nor Conduent are responsible for the training of providers' billing staff, providing procedure or diagnosis codes, or coding training. Conduent may assist with billing but cannot advise providers on which codes to use.

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 • Prior Authorization requests for Dental Services
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: • 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	• 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 • 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)
HHS Technology Group	(877)299-0121 8-5 MST M_F	https://wyoming.dyp.cloud	• Online Provider Enrollment • Provider file updates • Provider enrollment questions • Banking Information/W9 additions and updates

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 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 and Title 25 questions
- Claim, prior authorization, and other forms for download
- Title 25 Program publications, such as provider handbooks and bulletins
- Payment Schedule
- Primary resource for all information related to Medicaid and Title 25
- 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**
- Prior Authorization Status Inquiry – Search any Prior Authorization to determine status. Used Prior Authorizations will not appear.
- Client Eligibility Inquiry – Search Wyoming Medicaid clients to determine eligibility for the current month.
    - Primary Insurance information will not be available through this function.

Chapter Three – Provider Responsibilities

3.1 Enrollment

Title 25 payments are made only to providers who are actively enrolled in the Medicaid Program.

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

3.2 Accepting Title 25 Clients

If a client receiving services under a Title 25 (T25) hold has active Medicaid coverage, services should be delivered and billed with all supporting documentation to Wyoming Medicaid in accordance with all policies and procedures outlined in the applicable Wyoming Medicaid Provider Manuals:

- CMS 1500 ICD-10 – For professional services
- Institutional Manual ICD-10 – For all facility based inpatient and/or outpatient services.

Clients receiving only T25 coverage do not require Prior Authorization (PA). Clients receiving T25coverage in addition to Wyoming Medicaid full coverage will require PA for service, as appropriate.

For information on how to submit Prior Authorization for inpatient services provided to Medicaid clients, contact WYhealth (2.1, Quick Reference).

3.2.1 Determining Residency for Purposes of County Liability

Pursuant to Wyoming Statute Title 25, the client's county of residence is responsible for the payment of all services provided to a client in the first 72 hours of the emergency detention (to include all weekends and legal holidays). Services cannot be billed to the Wyoming State Hospital until after expiration of the initial 72 hour detention period unless the client is a non-resident of the State. If the client is not a documented Wyoming resident, the Wyoming State Hospital will review claims for all applicable dates of service covered under the emergency detention.

A resident is defined by Wyo. Stat. § 25-10-101 (xv) as a United States citizen who has been a resident of and domiciled in Wyoming for not less than ninety (90) days and who has note claimed residency elsewhere for the purpose of obtaining medical or psychiatric services during that ninety (90) day period immediately preceding the date when services were provided. A resident also includes any alien who has resided continuously in Wyoming for at least ninety (90) days immediately prior to the date when services were provided as well as any active duty member, the spouse or minor child of any active duty member of the armed forces of the United States who is stationed in Wyoming.

A client who has not been in Wyoming County for at least 90 days, or doesn't otherwise meeting the definition of a resident should be considered to be a non-resident for purposes of Wyoming State Hospital payment liability.

3.2.2 Determining Primary Payer Resources (Wyo. Stat. § 25-10-112)

It is the provider's responsibility to determine all sources of healthcare coverage for any client.

For dates of service on or after April 1, 2017, Wyoming Medicaid is considered an allowable primary payer. All Title 25 services provided to Wyoming Medicaid clients after the expiration of the county's liability should be billed on paper (both UB and CMS1500 claims) with all supporting documentation to Wyoming Medicaid.

If inpatient psychiatric services are provided to a Medicaid enrolled client, they must be prior authorized in accordance with Wyoming Medicaid policy for payment. Please refer to billing requirements in the Medicaid Institutional Provider Manual.

The Wyoming State Hospital requires all providers to complete and submit the Title 25 Certification Form as evidence that all potential options for a primary payer source were identified and billed prior to submitting claims to the WSH for payment. The most current form can be found on the Medicaid website under the "Forms" section. The Title 25 Certification Form must be a fully executed attestation between the facility and the client, to include complete client demographic information, client/guardian or witness signature, and an authorized signature from a facility representative. Claims submitted with an incomplete Title 25 Certification Form will not be accepted or processed.

3.2.3 Determining Eligible Dates of Service

Pursuant to Wyoming Statute § 25-10-112, the client's county of residence is responsible for the payment of all services provided to a client in the first 72 hours of the emergency detention (to include all weekends and legal holidays). Services cannot be billed to the Wyoming State Hospital until after expiration of the initial emergency detention period unless the client is a non-resident. If the client is not a documented Wyoming resident, then the Wyoming State Hospital will review claims for all applicable dates of service covered under the emergency detention. If claims are received for services provided within the first 72 hours of the emergency detention, they will be returned to the provider.

The Wyoming State Hospital calculates the expiration of county financial responsibility exactly 72 hours after the time of the initial detention, as noted in the 3-81 document. The Wyoming State Hospital will exclude all weekends and legal holidays in this calculation. For example, if a client is detained at 8:00am on Friday morning, the 72 hour period would expire on the following Wednesday at 8:00am.

3.2.4 Submitting Required Title 25 Documentation

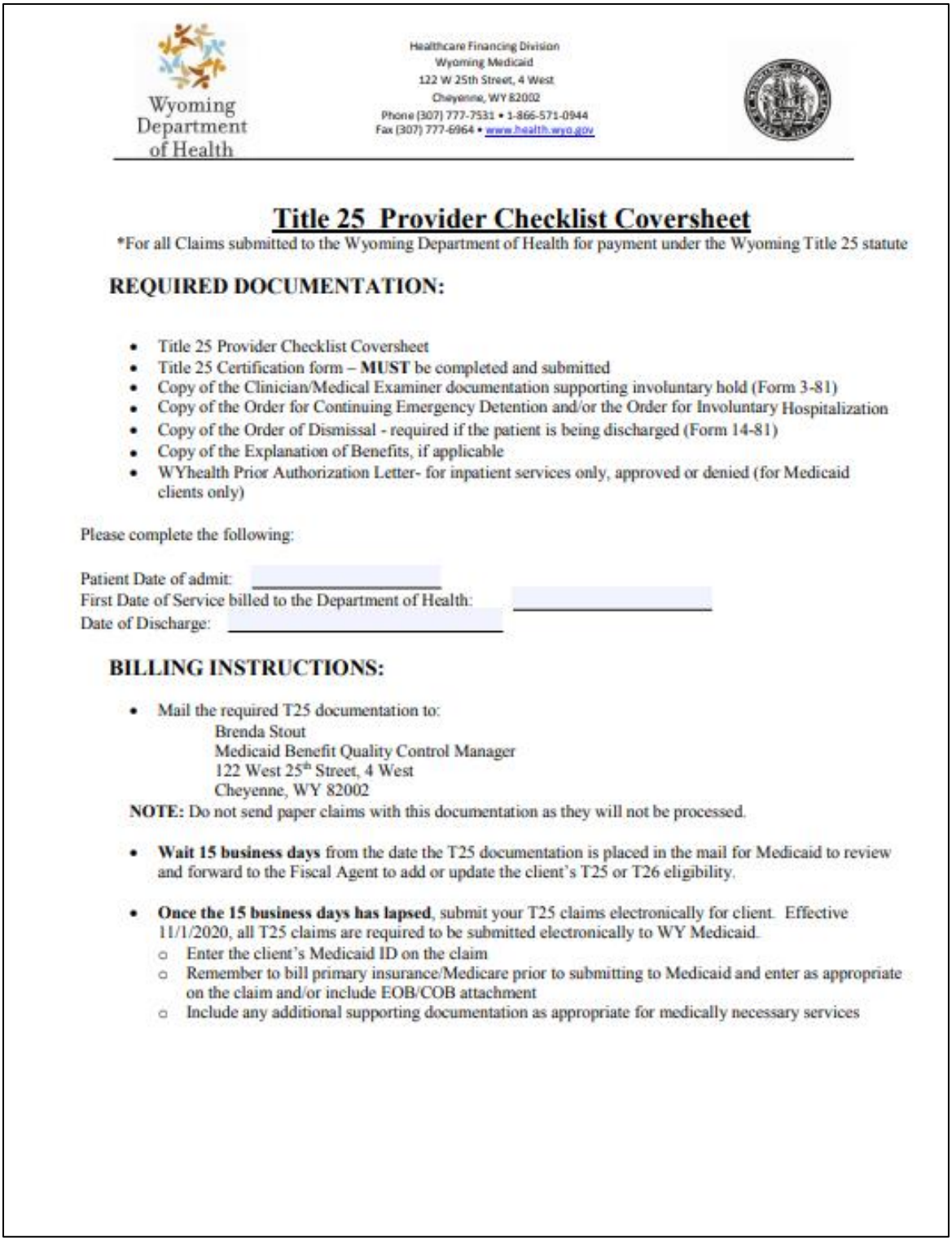
After determining the above information, the following Title 25 documentation must be sent via mail to the Medicaid Benefits Quality Control Manager:

Brenda Stout
Medicaid Benefits Quality Control Manager
122 West 25th St, 4 West
Cheyenne, WY 82002

- Title 25 Provider Checklist Coversheet (3.2.4.1)
- Title 25 Certification form (3.2.4.2) – MUST be completed and submitted
- Copy of the Clinician/Medical Examiner documentation supporting involuntary hold (Form 3- 81)
- Copy of the Order for Continuing Emergency Detention and/or the Order for Involuntary Hospitalization
- Copy of the Order of Dismissal – required if the patient is being discharged (Form 14- 81)
- Copy of the Explanation of Benefits, if applicable

When sending Title 25 documentation, **DO NOT** include paper claims as they will not be processed. Processing of this documentation can take 15 or more days. To determine if submitted documents have been processed, check client eligibility by calling the IVR or Provider Relations (2.1, Quick Reference). Claims must be submitted electronically (4.1, Electronic Billing) after this documentation is processed.

3.2.4.1 Title 25 Provider Checklist Coversheet



Wyoming Department of Health

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

Title 25 Provider Checklist Coversheet

*For all Claims submitted to the Wyoming Department of Health for payment under the Wyoming Title 25 statute

REQUIRED DOCUMENTATION:

- Title 25 Provider Checklist Coversheet
- Title 25 Certification form – **MUST** be completed and submitted
- Copy of the Clinician/Medical Examiner documentation supporting involuntary hold (Form 3-81)
- Copy of the Order for Continuing Emergency Detention and/or the Order for Involuntary Hospitalization
- Copy of the Order of Dismissal - required if the patient is being discharged (Form 14-81)
- Copy of the Explanation of Benefits, if applicable
- WYhealth Prior Authorization Letter- for inpatient services only, approved or denied (for Medicaid clients only)

Please complete the following:

Patient Date of admit: _____
First Date of Service billed to the Department of Health: _____
Date of Discharge: _____

BILLING INSTRUCTIONS:

- Mail the required T25 documentation to:
  Brenda Stout
  Medicaid Benefit Quality Control Manager
  122 West 25th Street, 4 West
  Cheyenne, WY 82002

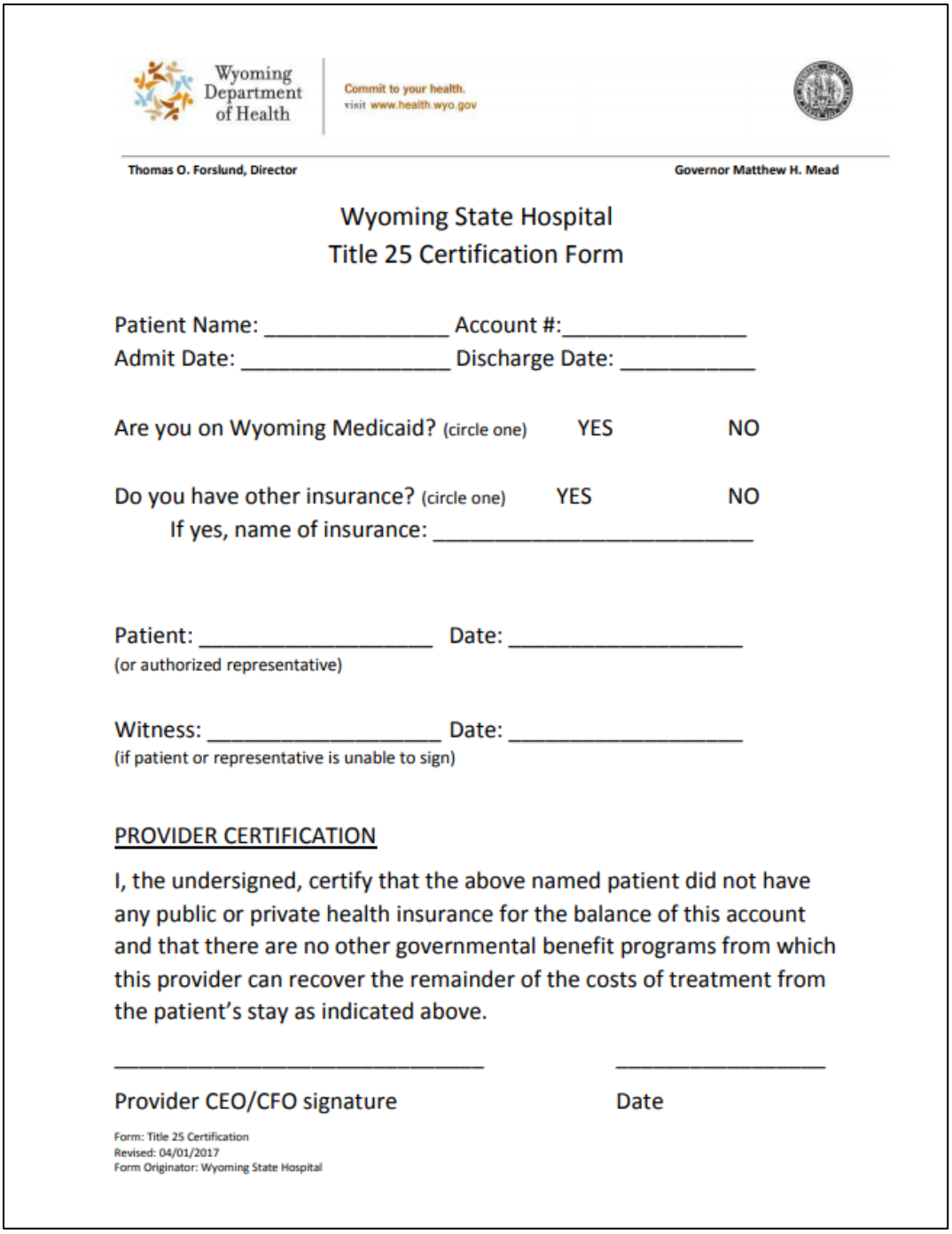
  NOTE: Do not send paper claims with this documentation as they will not be processed.

- **Wait 15 business days** from the date the T25 documentation is placed in the mail for Medicaid to review and forward to the Fiscal Agent to add or update the client's T25 or T26 eligibility.

- **Once the 15 business days has lapsed**, submit your T25 claims electronically for client. Effective 11/1/2020, all T25 claims are required to be submitted electronically to WY Medicaid.
  - Enter the client's Medicaid ID on the claim
  - Remember to bill primary insurance/Medicare prior to submitting to Medicaid and enter as appropriate on the claim and/or include EOB/COB attachment
  - Include any additional supporting documentation as appropriate for medically necessary services

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

3.2.4.2 Title 25 Certification Form



Wyoming Department of Health

Commit to your health.
visit www.health.wyo.gov

Thomas O. Forslund, Director — Governor Matthew H. Mead

Wyoming State Hospital
Title 25 Certification Form

Patient Name: _____ Account #:_____
Admit Date: _____ Discharge Date: _____

Are you on Wyoming Medicaid? (circle one) YES NO

Do you have other insurance? (circle one) YES NO
If yes, name of insurance: _____

Patient: _____ Date: _____
(or authorized representative)

Witness: _____ Date: _____
(if patient or representative is unable to sign)

PROVIDER CERTIFICATION

I, the undersigned, certify that the above named patient did not have any public or private health insurance for the balance of this account and that there are no other governmental benefit programs from which this provider can recover the remainder of the costs of treatment from the patient's stay as indicated above.

_____ _____
Provider CEO/CFO signature Date

Form: Title 25 Certification
Revised: 04/01/2017
Form Originator: Wyoming State Hospital

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

3.3 Wyoming State Hospital Payment is Payment in Full

As a condition of receiving payment from the WSH (see provider agreement), the provider must accept payment \as payment in full for a covered service. The provider shall not seek any additional payment from the client.

3.4 Record Keeping, Retention, and Access

3.4.1 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.

3.4.2 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.

3.4.3 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.

Chapter Four – Common Billing Information

4.1 Electronic Billing of Wyoming State Hospital Claims

Providers should submit bills only upon discharge of the client. No interim claims will be allowed.

As of November 1, 2020 all Title 25 claims must be submitted electronically. Claims should be submitted 15 days after submission of Required Title 25 Documentation, at the earliest. 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)).

4.2 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 Title 25 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.

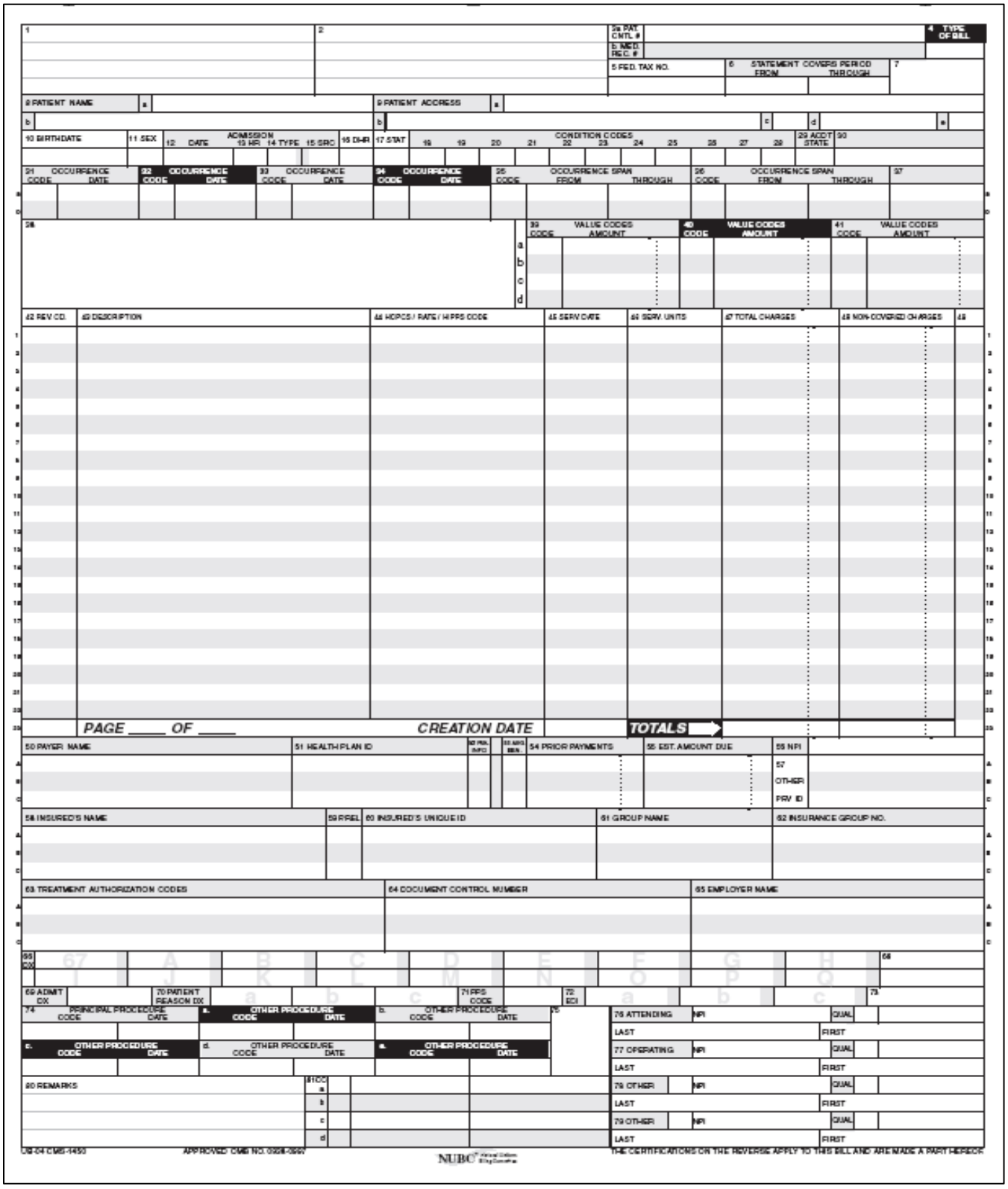
Billing errors detected after a claim is submitted cannot be corrected until after WSH has made payment or notified the provider of the denial. Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice (6.18, Resubmitting Versus Adjusting Claims).

NOTE: Claims are to be submitted only after service(s) have been rendered, not before. Inpatient claims are to be submitted upon client discharge only. No interim billing will be allowed for inpatient admissions.

4.3 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.

4.4 The UB-04 Claim Form



4.4.1 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: <u>Second Digit</u> <u>Third Digit</u> 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 4 Interim – Last claim (thru Care Level 1 Date is discharge date) 6 Intermediate Care Level 2 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. <u>Inpatient:</u> Enter the date of admission through the date of discharge. <u>Outpatient:</u> Enter the date or dates of services that are being billed on the claim.

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.

4.4.2 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.

4.5 Examples of Billing

4.5.1 Client has No Primary Payer Coverage

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	11 SEX	12 ADMISSION 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
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	1575 60	
0370	ANESTHESIA			4	1538 30	
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

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

67 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

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

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

80 REMARKS | 81CC a B3 282N00000X

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.

4.5.2 Client has Primary Medicare Coverage

Field	Value
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 / THROUGH	043015 / 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 CODE / AMOUNT	01 / 979 80
40 VALUE CODES CODE / AMOUNT	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	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	18	0612345678		

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

67 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 / 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	

76 ATTENDING NPI 1234567891 — LAST SAMPLE FIRST ATTENDING

77 OPERATING NPI 1234567891 — LAST SAMPLE FIRST ATTENDING

78 OTHER NPI — LAST FIRST

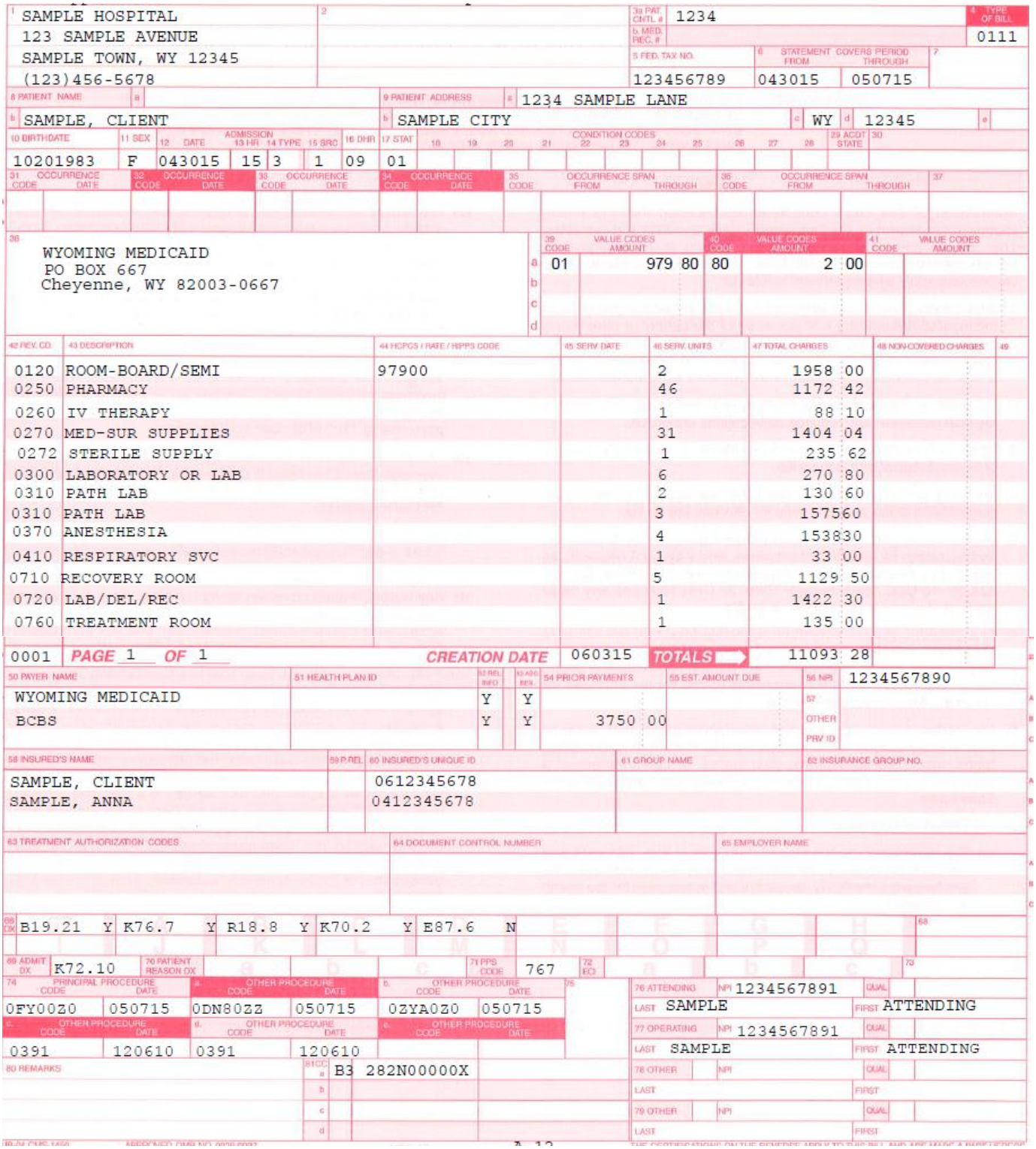
79 OTHER NPI — LAST FIRST

80 REMARKS

81CC a: B3 282N00000X

UB-04 CMS-1450

4.5.3 Client has Third Party Liability (TPL)



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

3a PAT. CNTL. # 1234
b. MED. REC. #
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	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
10201983	F	043015	15	3	1	09	01

CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

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

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

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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	57
WYOMING MEDICAID		Y	Y			1234567890	
BCBS		Y	Y	3750 00			OTHER PRV ID

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

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

67 DX: B19.21 Y | K76.7 Y | R18.8 Y | K70.2 Y | E87.6 N
A B C D E F G H I J K L M N O P Q 68

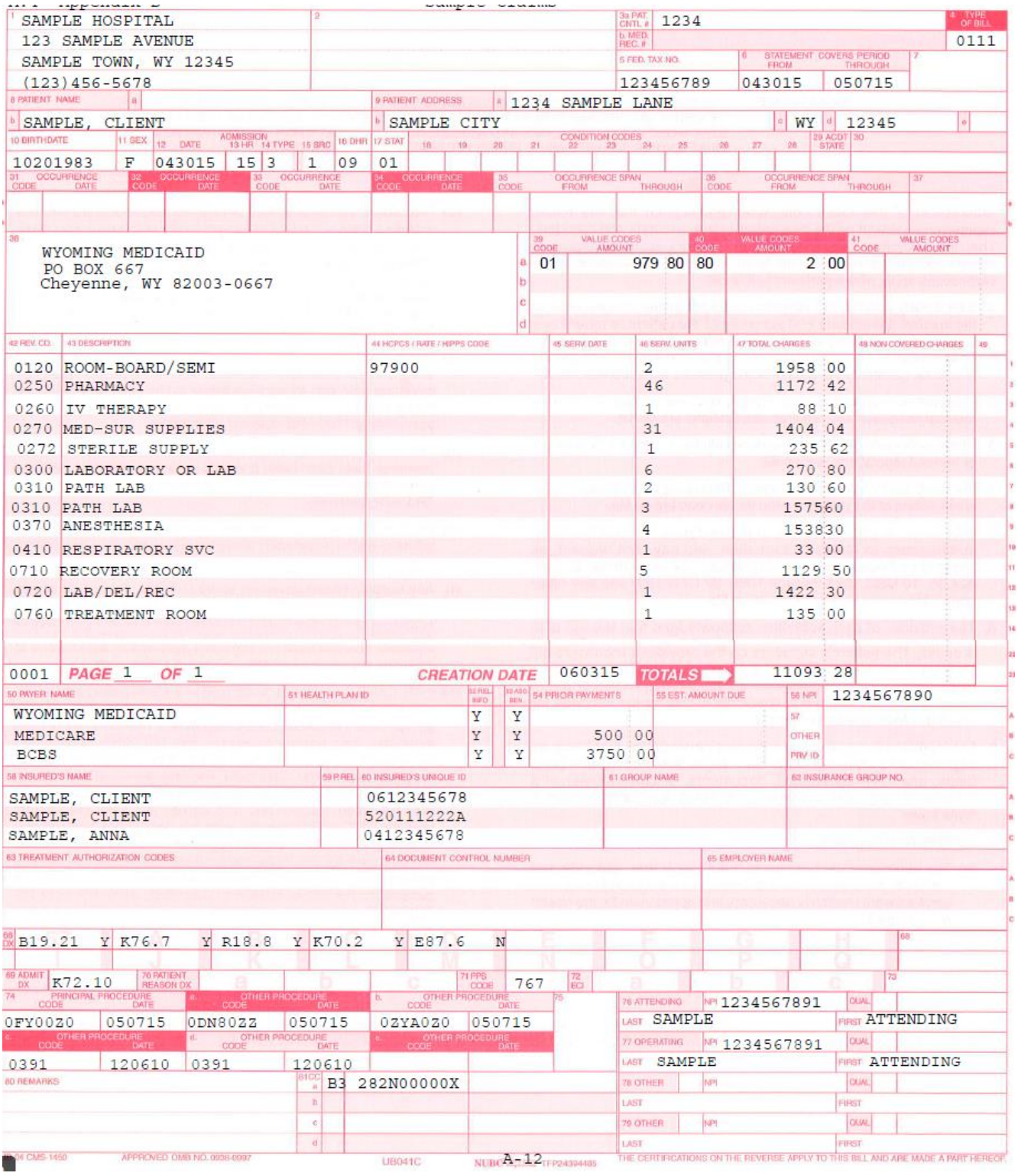
69 ADMIT DX: K72.10
70 PATIENT REASON DX
71 PPS CODE: 767
72 ECI
73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
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
b
c
d

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

4.5.4 Client has TPL and Medicare



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

3a PAT. CNTL. # 1234
b. MED. REC. # 0111
4 TYPE OF BILL
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

29 ACDT STATE

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

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

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a 01 979 80 | 80 2 00
b
c
d

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	57 OTHER / PRV ID
WYOMING MEDICAID		Y	Y			1234567890	
MEDICARE		Y	Y	500 00			
BCBS		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		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

67 ADMIT DX: K72.10 | 70 PATIENT REASON DX | 71 PPS CODE: 767 | 72 ECI | 73

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

75

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
b
c
d

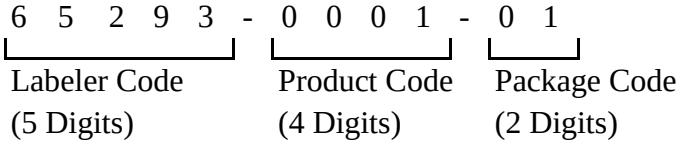
UB04 CMS-1450 APPROVED OMB NO. 0938-0997 | UB041C | NUBC | TFP24394485 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

A-12

4.6 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

4.6.1 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.

4.6.2 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.

4.6.3 Billing Requirements

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

4.6.4 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

4.6.5 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.

4.6.6 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).

4.6.7 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.

4.6.7.1 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		

4.6.7.2 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.

4.7 Reimbursement Methodologies

Reimbursement from the Wyoming State Hospital for covered services under Title 25 is based on a variety of payment methodologies depending on the services provided. In most cases reimbursement will mirror Medicaid' methodology and fee schedule, with the exception of the current per-diem reimbursement rate for Title 25 clients who do not have active Medicaid coverage.

Medicaid reimbursement methodologies are as below:

- 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)

4.8 Submitting Attachments for Electronic Claims

Title 25 Documentation is submitted via mail to the Medicaid Benefits Quality Control Manager and is not required to be attached to claims. However, claims may still require attached documentation; such as, primary payer EOBs, invoices, or any additional supporting documentation as appropriate for medically necessary services.

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 of the Institutional Provider Manual 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 (4.8.1, Attachment Cover Sheet) and mail it with the attachment to Claims (2.1, Quick Reference)

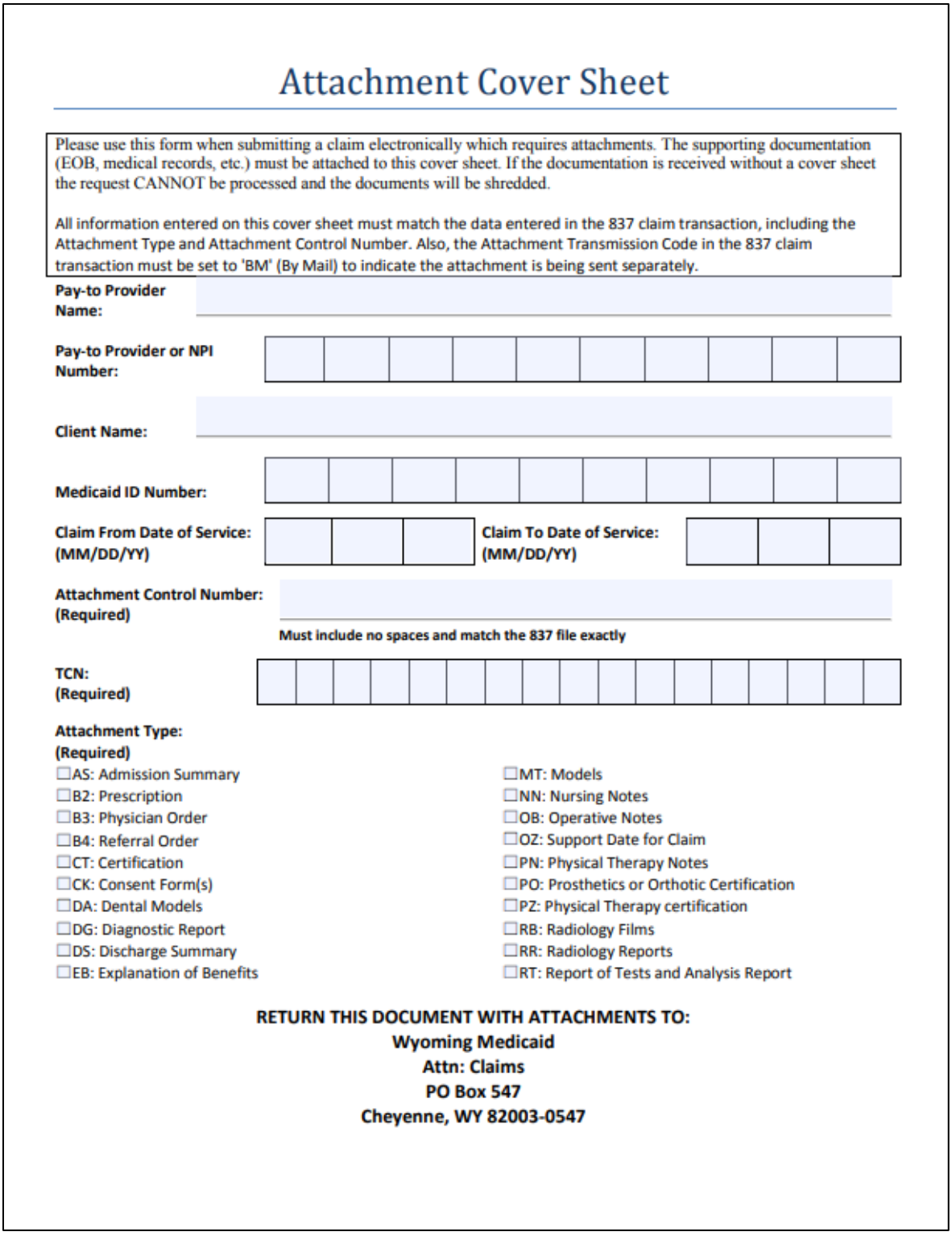
Steps for submitting paper attachments by **email**:

- 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 (4.8.1, 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.

4.8.1 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

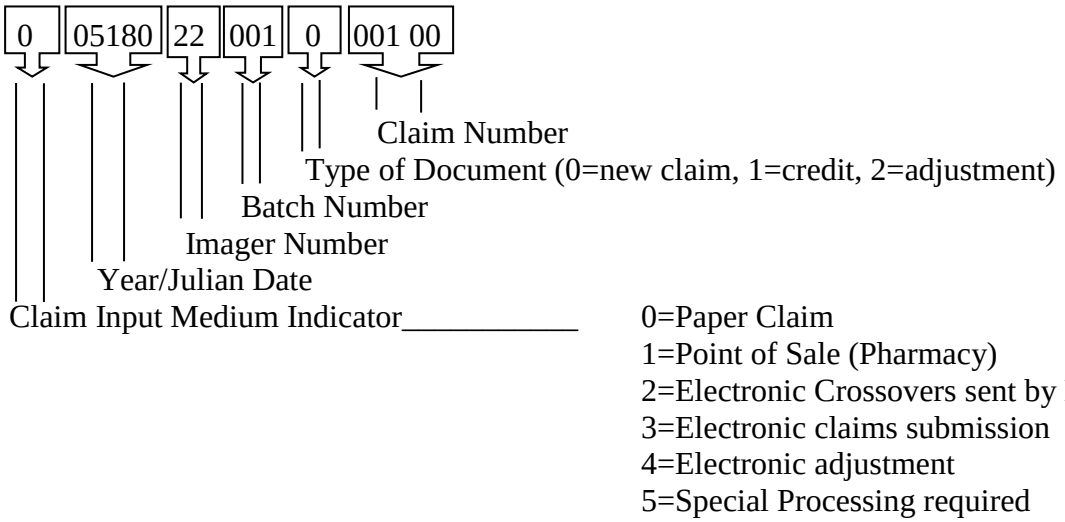
NOTE: Click the image above to be taken to a printable version of this form.

4.9 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.

4.9.1 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
```

4.9.2 How to Read the Remittance Advice

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

(TABLE)

4.9.3 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:

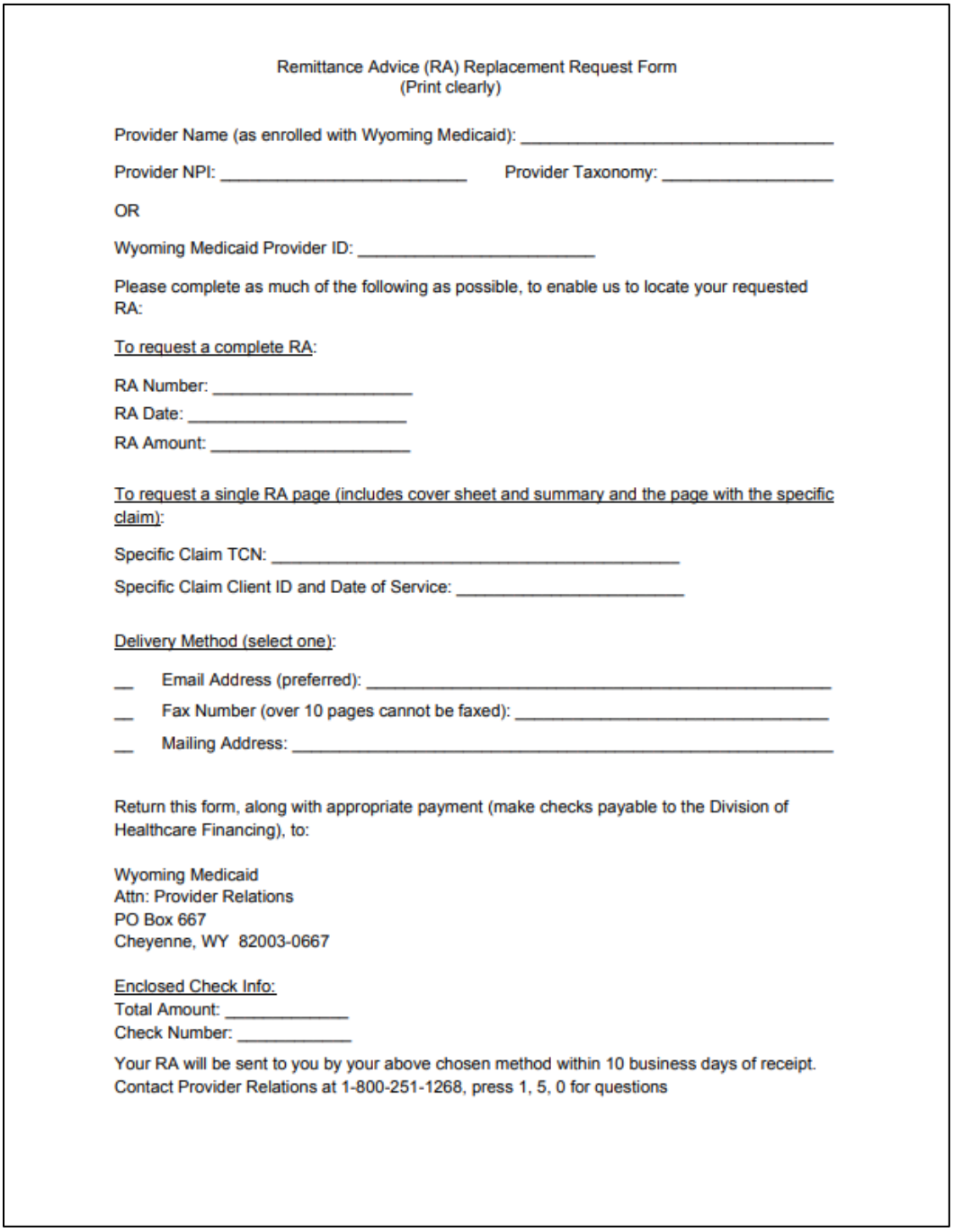
- Print the Remittance Advice (RA) replacement request form
- For replacement of a complete RA contact Provider Relations (2.1, Quick Reference) to obtain the RA number, date, and number of pages
- Replacements of a specific page of an RA (containing a requested specific claim/TCN) will be three (3)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

4.9.3.1 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.

4.9.4 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).

4.9.5 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 5 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 (5.2.1, Third Party Resources Information Sheet) should be used for reporting new insurance coverage or changes in insurance coverage on a client's policy.

4.10 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.

4.10.1 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.

4.10.2 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

4.10.2.1 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

4.10.3 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.

4.10.3.1 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.

4.10.3.2 When to Request a Void

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

4.10.3.3 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"

4.10.3.4 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.

4.10.3.5 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.

4.10.3.6 Adjusting a claim electronically via an 837 transaction

Wyoming Medicaid accepts claim adjustments electronically, refer to Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications, section 9.11 of the Institutional Manual for complete details.

4.11 Timely Filing

The Division of Healthcare Financing adheres strictly to its timely filing policy. The provider must submit a clean claim to the WSH 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.

4.11.1 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 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.

4.11.2 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.

4.11.2.1 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.

4.12 Billing Tips to Avoid Timely Filing Denials

- File claims soon after services are rendered
- Carefully review EOB codes on the Remittance Advice/835 transaction (work RAs/835s weekly)
- Resubmit the entire claim or denied line only after all corrections have been made
- Contact Provider Relations (2.1, Quick Reference):
    - With any questions regarding billing or denials
    - When payment has not been received within 30 days of submission, verify the status of the claim
    - When there are multiple denials on a claim, request a review of the denials prior to resubmission

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

Chapter Five – Third Party Liability

5.1 Definition of a Third Party Liability

5.1.1 Third Party Liability (TPL)

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)
- Indian Health Services
- Veteran's Administration
- Medicaid (Wyoming or another state)
- County of Residence

5.1.2 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
    - County of Residence
    - Medicaid (Wyoming or another state)
    - Indian Health Services
    - Veteran's Administration
    - Tricare

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).

The WSH is always 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.

5.1.3 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.

5.1.4 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.

5.1.5 Medicare Supplement Plans

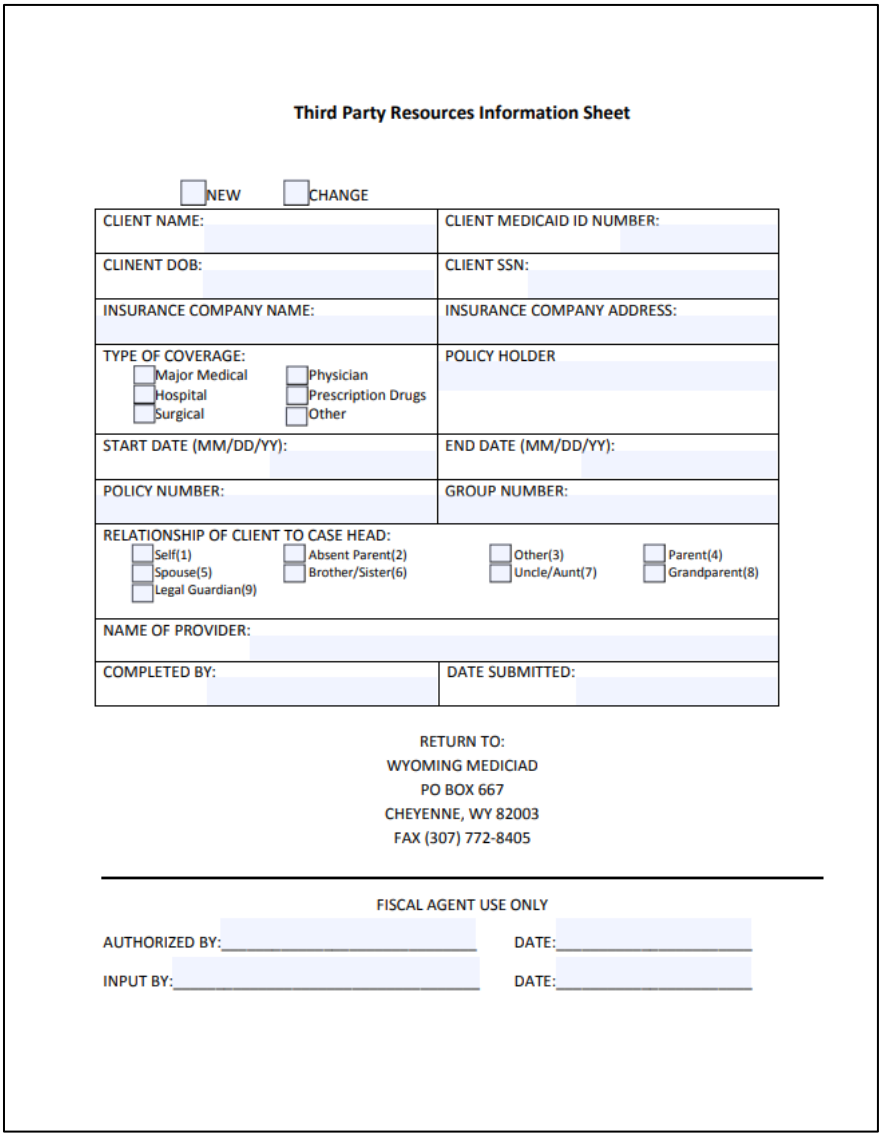
Medicare Supplement Plans are additional coverage to Medicare. Providers must verify whether or not a policy is a Medicare replacement or supplement policy. If the policy is a Medicare supplement policy, the supplement information should be entered as TPL on the claim. Please see section 4.6.4 for more information on submitting tertiary claims.

5.2 Provider's Responsibilities

Providers have an obligation to investigate and report the existence of other third-party liability information. The WSH uses the Title 25 Certification Form as documentation that providers have complied with all applicable statutes, rules, and guidelines for identifying and seeking payment from responsible primary payers. Providers play an integral and vital role as they have direct contact with the client. The contribution providers make to the WSH in the TPL arena is significant. Their cooperation is essential to the functioning of the Title 25 Program and to ensuring prompt payment.

At the time of client intake, the provider must obtain primary payer information from the client. At the same time, the provider should also ascertain if additional insurance resources exist and document findings on the Title 25 Certification Form. 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.

5.2.1 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).

5.2.2 Provider is not enrolled with TPL Carrier

The WSH will **not** accept a letter with a claim indicating that a provider does not participate with a specific health insurance company. The provider must work with the insurance company and/or client to have the claim submitted to the carrier.

5.2.3 Medicare Opt-Out

Providers may choose to opt-out of Medicare. However, the WSH 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.

5.3 Billing Requirements

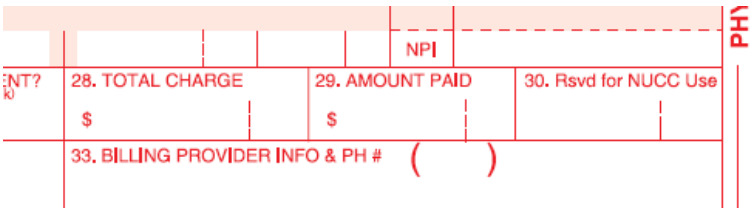
Providers should bill TPL/Medicare and receive payment to the fullest extent possible before billing the WSH. The provider must follow the rules of the primary insurance plan (such as obtaining prior authorization, obtaining medical necessity, obtaining a referral or staying in-network) or the related Title 25 claim will be denied. Follow specific plan coverage rules and policies. The WSH does not allow state 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.

The WSH 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.

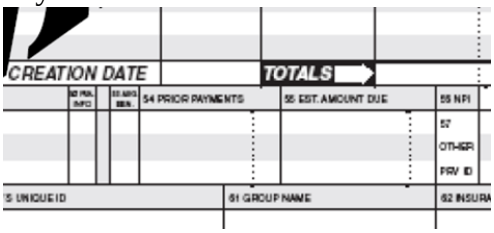
Once payment/denial is received by TPL/Medicare, the claim may then be billed to Medicaid as a secondary claim. If payment is received from the other payer, the provider should compare the amount received with Medicaid's maximum allowable fee for the same claim.

- 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:



- If payment is received from the other payer after the WSH already paid the claim, the WSH's payment must be refunded for either the amount of the WSH 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: The WSH will accept refunds from a provider at any time. Timely filing will not apply to adjustments where money is owed to the WSH (4.15, 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 (4.11, 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 the WSH with the Previous Attempts to Bill

Services Letter. A claim submitted to a third party payer will be considered "denied" if the claim is submitted and no response is received within the ninety (90) days of being properly submitted. If a claim is later paid after originally being denied, and payment was already received from the WSH or the county, payment must be returned to the payer

5.3.1 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.). The WSH will pay no more than the remaining patient responsibility (PR) after payment by the primary insurance.
- The WSH will reimburse the provider for the patient liability up to the allowable amount. A provider must include the contract write-off amount and the amount paid by the other insurance as the third party liability payment.
- TPL is applied to claims at the header level. The WSH 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 the WSH with the Previous Attempts to Bill Services Letter.

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

5.3.1.1 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 547
Cheyenne, WY 82003-0547

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.

5.3.2 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 Title 25 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.

5.3.3 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.

5.3.4 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.

Chapter Six – Important Information

6.1 Claims Review

The WSH is committed to paying claims as quickly as possible. Claims are processed using an automated claims adjudication system. 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 the WSH later discovers the service was incorrectly billed or paid, or the claim was erroneous in some other way, the WSH is required to recover any overpayment, regardless of whether the incorrect payment was the result of WSH, fiscal agent, provider error or other cause.

6.2 Coding

****IMPORTANT**

Standard use of medical coding conventions is required when billing the WSH. The following suggestions may help reduce coding errors and unnecessary claim denials:

- **Inpatient services – for inpatient days, use revenue code 0919 with the appropriate inpatient bill type**
- **Outpatient/ER/Observation services – claims should be completed in accordance with routine outpatient claim coding and the appropriate outpatient/ER/Observation bill type**
- **Professional services – should be billed on the CMS 1500 claim form in accordance with standard CPT/HCPCS coding guidelines**
- Use current CPT-4, HCPCS Level II, and ICD-10-CM 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, the WSH 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 requirements. 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. Send a written letter of reconsideration to Wyoming Medicaid, Medical Policy (2.1, Quick Reference Guide).

6.3 Importance of Fee Schedules

For eligible Title 25 clients, the maximum allowable per diem reimbursement rate for inpatient services provided is $677 per day. This rate is an all-inclusive rate for the facility. **For billing of all eligible inpatient days, use revenue code 0919 for payment of the per diem.**

All outpatient/ER/observation services will be priced and reimbursed according to Medicaid's OPPS methodology.

All professional services for eligible dates of service will be paid according to the Medicaid fee schedule rate in place on the claim date of service. 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. The WSH complies 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/indes.html.

Chapter Seven – Critical Access Hospital and General Hospital Inpatient

7.1 General Coverage Principals and Definitions

The WSH reimburses for inpatient psychiatric and medical hospital services when they are directly related to an emergency detention or involuntary hospitalization.

7.1.1 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.

7.1.2 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.

7.1.3 Psychiatric Hospital

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

7.1.4 Inpatient Services

Inpatient Services are those services for which the Title 25 client was determined to be mentally ill and admitted as an inpatient to the hospital facility, regardless of the length of stay.

- Inpatient hospital services are covered pursuant to written orders by a physician or staff under the supervision of a physician or other appropriate practitioner.

- 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.

7.1.5 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).
- Evidence of the following must be present:
    - "Mentally ill" (Wyo. Stat. § 25-10-101 (ix)) - means a physical, emotional, mental or behavioral disorder which causes a person to be dangerous to themselves or others and which requires treatment, but does not include addiction to drugs or alcohol, drug or alcohol intoxication or developmental disabilities, except when one (1) or more of those conditions co-occurs as a secondary diagnosis with a mental illness;
    - "Dangerous to themselves or others" (Wyo. Stat. § 25-10-101 (ii)) - means that, as a result of mental illness, a person:
        - Evidences a substantial probability of physical harm to themselves as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm; or
        - Evidences a substantial probability of physical harm to other individuals as manifested by a recent overt homicidal act, attempt or threat or other violent act, attempt or threat which places others in reasonable fear of serious physical harm to them; or
        - Evidences behavior manifested by recent acts or omissions that, due to mental illness, they are unable to satisfy basic needs for nourishment, essential medical care, shelter or safety so that a substantial probability exists that death, serious physical injury, serious physical debilitation, serious mental debilitation, destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition or serious physical disease will imminently ensue, unless the individual receives prompt and adequate treatment for this mental illness. No person, however, shall be deemed to be unable to satisfy their needs for nourishment, essential medical care, shelter or safety if they are able to satisfy those needs with the supervision and assistance of others who are willing and available.

7.2 Inpatient Billing Guidelines

7.2.1 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 WSH became liable for payment through the discharge date (if the entire admission was involuntary). If at any time during the inpatient stay, the client transitions from involuntary to voluntary, the WSH will not pay for voluntary days.
- 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 per diem reimbursement calculations.

Value codes and your 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.

7.2.2 Claim Coding

****IMPORTANT**

- 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.

  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 the per diem is based on the days of service, 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.
- **For billing of all eligible inpatient days, use revenue code 0919 for payment of the per diem.**
- **Inpatient services – for inpatient days, use revenue code 0919 with the appropriate inpatient bill type**
- **Outpatient/ER/Observation services – claims should be completed in accordance with routine outpatient claim coding (procedure and revenue codes) and the appropriate outpatient/ER/Observation bill type**
- **Professional services – should be billed on the CMS 1500 claim form in accordance with standard CPT/HCPCS coding guidelines**

7.3 Billing Examples

7.3.1 Standard Claims

Example 1 – Clients with no Medicaid eligibility, AND no approved PA, AND age 22-64:

Coverage Period	Revenue Code	Discharged
7/4/2020 – 8/27/2020	0919 – 54 Units	Yes

Example 2 Clients with Medicaid eligibility, AND an approved PA, AND 21 and under, or 65 and over:

Coverage Period	Revenue Code	PA Effective Dates	Discharged
8/31/2020 – 10/3/2020	0124 – 33 Units	8/31/2020 – 10/8/2020	Yes

7.3.2 Medicare Crossover Claims

When Medicare only covers part of the patient's stay:

Coverage Period	Revenue Code	PA Effective Dates	Discharged
8/19/2020 – 9/11/2020	0919 – 17 Units	8/31/2020 – 10/8/2020	Yes

Services not covered by Medicare should be billed using the following steps:

1. Bill to Medicare as normal
2. Receive denial from Medicaid
3. Bill to Medicaid as a straight Medicaid claim with the Medicare paid dates entered as non-covered using Value Code 82
    a. DO NOT include Medicare payment amounts on the claim
    b. The Medicare EOB should be attached to the claim as documentation
4. Receive denial from Medicaid

5. Appeal the denial with an explanation that Medicare did not cover the entire stay and that only the remaining portion is being billed

7.3.3 Claims requiring Prior Authorization

Services that require prior authorization (PA) must be billed with an approved PA number on the claim. However, the PA effective dates must match the coverage period of the claim. If the effective dates on the PA do not match, contact Optum (2.1 Quick Reference) for questions and corrections.

Example 1:

PA Information:

PA Effective Dates	PA Approved Dates	PA Denied Dates
1/8/2020 – 1/16/2020	1/8/2020 – 1/14/2020	1/15/2020

Claim Information

Coverage Period	Discharged	Non-Covered Days	Revenue Code
1/8/2020 – 1/16/2020	Transferred 1/16/2020	1 – 1/15/2020	0124 – 7 units

Chapter Eight – Covered Services – Ambulance

8.1 Ambulance Overview

The Wyoming State Hospital will reimburse for certain Title 25 transportation expenses incurred in order to transfer or discharge patients to another location. Before arranging patient transportation and submitting claims to the Wyoming State Hospital, a provider must first contact the Wyoming State Hospital to arrange for client transportation using the Wyoming State Hospital's transportation resources. If transportation cannot be provided, it is the provider's responsibility to arrange for the transportation of the client, as necessary and appropriate. Providers should call the Wyoming State Hospital at 307-789-3464 and ask for the Security Manager or the Admissions Coordinator.

After confirming that transportation is not able to be provided by the Wyoming State Hospital, the provider may enroll as a provider (if not already) and submit claims for reimbursement of transportation expenses, as outlined in this manual, for reimbursement of transportation expenses. Claims will be paid per department rules and at the corresponding Medicaid rates.

This applies to Title 25 clients who are not enrolled in Wyoming Medicaid.

8.2 Ambulance Services

Procedure Code Range: A0380-A0436

Ambulance providers are independent ambulances or hospital-based ambulances.

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

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

Each ambulance service provided to a client (transport) **must be medically necessary** for all ages to be covered by Medicaid.

8.3 Covered Services

****IMPORTANT**

8.3.1 Emergency Transportation

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

- A medical emergency exists in that the use of any other method of transportation could endanger the health of the patient; and

- The patient is transported to the nearest facility capable of meeting the patient's medical needs; and
- The destination is an acute care hospital or psychiatric hospital where the patient is admitted as inpatient or outpatient.

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

- Restraints are required to transport the patient (often when a psychiatric diagnosis is made); or
- The client is considered a threat to themselves or others.

8.3.2 Non-Emergency Transportation

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

- The client is determined to be an immediate danger to themselves or others at the time of transport and is being transported from a hospital or one psychiatric facility to another.
    - Trip report documentation must support the danger explicitly and must be attested to by a licensed clinical counsellor, physician, or psychiatrist (a nurses signature is not accepted)
    - **If a client is stabilized and can be transported safely by another mode of transport, an ambulance is not covered under Medicaid**
- Facility to facility transportation to obtain medically necessary care unavailable at the originating facility by ambulance if it would endanger the health or life of the client to be transported by any other method

8.3.3 Definition of Service Levels

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

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

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

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

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

1. At least three (3) separate administrations of one (1) or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids)

8.4 Disposable Supplies

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

8.5 Oxygen and Oxygen Supplies

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

8.6 Mileage

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

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

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

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

8.7 Non-Covered Services

Medicaid does not reimburse for the following ambulance services:

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

- When a client is pronounced dead after an ambulance is called but before transport
- Transportation of a family member or friend to visit a client or consult with the client's physician or other provider of medical services
- Transportation to pick up pharmaceuticals
- Air ambulance services to transport a client from a hospital capable of treating the client to another hospital because the client or family prefers a specific hospital or practitioner
- Transportation of a client in response to detention ordered by a court or law enforcement agency (if within the first 72 hours)
- Transportation based on a physician's standing orders
- Stand-by time
- Special attendants
- Specialty Care Transport (SCT)
- Paramedic Intercept (PI)
- When a client has been stabilized and can be transported by another mode of transportation
- When a client can be transported by a mode other than ambulance without endangering the client's health, regardless of whether other transportation is available
- If a client is an inpatient at a hospital, Medicaid does not pay separately for round trip ambulance transport for an outpatient service (e.g., x-ray or other procedure) at a different hospital. This type of transport is included in the Medicaid payment to the hospital for the inpatient stay.

8.8 Multiple Client Transportation

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

8.9 Usual and Customary Charge

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

8.10 Billing Requirements

The following are the procedure codes accepted for ambulance services:

Procedure Code	Description
GROUND/*Advanced Life Support (ALS)*	
A0390	ALS mileage (per mile)
A0398	ALS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0433	Advanced life support, level 2 (ALS 2)

Wyoming Medicaid does not require a separate trip report provided the request for service has been entered appropriately into the Wyoming Ambulance Trip Reporting System https://health.wyo.gov/publichealth/ems/ems-program-2/watrs/, and marked appropriately for Wyoming Medicaid to review.

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

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

The WATRS reporting requirements apply if:

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

Exceptions to submitting a trip report via WATRS:

- Transports that do not touch ground in Wyoming at any point

- An out of state ambulance service that only transports a patient from out of state to a Wyoming destination and is not required to be licensed in the state of Wyoming (provider has license in another state)

If submitting a paper trip report, the claim should be submitted through the usual electronic billing method, and the claim should indicate that an attachment will be coming and by what method: electronic or mail (6.15, Submitting Attachments for Electronic Claims).

The paper trip report must include the following:

- Documentation in the narrative to support the level of service billed (ALS/BLS, Emergent/Non-Emergent, and if air transport rotary/fixed wing)
- Documentation in the narrative to support the medical necessity of the transport
- Documentation in the narrative of the use and medical necessity of any supplies
- Documentation in the narrative of the use and medical necessity of any oxygen
- Documentation of the patient loaded miles (must match the number of units billed on the claim)

8.11 Community Emergency Medical Services (CEMS)

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

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

8.11.1 Enrollment

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

CEMS Group Enrollment

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

EMT or Paramedic Individual/Treating Enrollment

When completing the enrollment for individual EMTs and Paramedics, in the Taxonomy Category, use the drop down box and select "Transportation Services",

and select Taxonomy Description " 146N00000X - Emergency Medical Technician (EMT)" OR "146L00000X - Paramedic" as appropriate.

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

8.11.2 Covered Services

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

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

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

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

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

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

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

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

- Hospital discharge follow-up care
- Minor medical procedures

There is no WATRS documentation requirement for CEMS-C services as WATRS does not contain the ability for a provider to report care provided outside of a call for service. Documentation of services provided, physician's orders, and the plan of care shall be kept in the client's comprehensive medical record maintained by the ambulance agency and supplied to the Department upon request.

8.11.3 Billing Requirements

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

Chapter Nine – Covered Services – Non-Emergency Medical Transportation

9.1 NEMT Overview

The Wyoming State Hospital will reimburse for certain Title 25 transportation expenses incurred in order to transfer or discharge patients to another location. Before arranging patient transportation and submitting claims to the Wyoming State Hospital, a provider must first contact the Wyoming State Hospital to arrange for client transportation using the Wyoming State Hospital's transportation resources. If transportation cannot be provided, it is the provider's responsibility to arrange for the transportation of the client, as necessary and appropriate. Providers should call the Wyoming State Hospital at 307-789-3464 and ask for the Security Manager or the Admissions Coordinator.

After confirming that transportation is not able to be provided by the Wyoming State Hospital, the provider may enroll as a provider (if not already) and submit claims for reimbursement of transportation expenses, as outlined in this manual, for reimbursement of transportation expenses. Claims will be paid per department rules and at the corresponding Medicaid rates.

This applies to Title 25 clients who are not enrolled in Wyoming Medicaid.

9.2 Non-Emergency Medical Transportation (NEMT)

WSH 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.

WSH enrolls taxi providers (344600000X), non-taxi ride providers (347C00000X), and lodging providers (177F00000X) to provide covered services.

9.3 Covered Services

9.3.1 Taxi and Non-Taxi Rides

- Covered for adults and children
- Client must call in the ride to the Transportation Call Center (2.1, Quick Reference Guide)
- Transportation Call Center will verify client is covered for the ride and meets criteria
- Transportation Call Center will contact Ride Provider once the ride is approved
- Transportation Call Center will supply client ID for billing purposes to Ride provider
- A Prior Authorization (PA) number will be generated when a client requests a ride and a letter will be mailed to the provider with the PA number that will need to be used when submitting claims

9.4 Billing Information

9.4.1 Taxi Rides

Procedure Codes: A0100, S0215

- Taxi provider must receive authorization for the taxi ride from the Transportation Call Center
- Transportation Call Center will provide client ID and TAC number for billing purposes
- The TAC number will be entered as the client's account number on the claim when billing
- Bill procedure code A0100 – Base Rate – 1 unit for each one way trip
- Bill procedure code S0215 – mileage for each mile or part of a mile
- Mileage is always rounded up. Example: 5.2 miles would be billed as 6 miles
- Bill with the PA number associated with the ride
- Mileage without the client on board is not eligible for billing
- Wait time is not a covered service
- No show or late clients are not a covered service, however, they should be reported to the Transportation Call Center (2.1, Quick Reference Guide)
- All rides billed are subject to post payment review and as such records should be kept with detail including:
    - Authorization from Transportation Call Center
    - Prior Authorization number
    - Client information
    - Date and time of pick-up
    - Pick up address
    - Destination address
    - Total mileage
    - Total charge

NOTE: Providers cannot span bill for dates. All services (rides) must be billed on separate lines.

9.4.2 Non-Taxi Rides

Procedure Codes: A0110, A0080

- Ride Provider must receive authorization for the ride from the Transportation Call Center
- Bill with the PA number associated with the ride
- Transportation Call Center will provide client ID and TAC number for billing purposes
    - The TAC number will be entered as the client's account number on the claim when billing
- Bill procedure code A0110 – Base Rate – 1 unit for each one way trip

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

      NOTE: The first 15 miles are INCLUDED with the base rate and are not billed

- Mileage without the client on board is not eligible for billing
- Wait time is not a covered service
- No show or late clients are not a covered service, however, they should be reported to the Transportation Call Center (2.1, Quick Reference Guide)
- All rides billed are subject to post payment review and as such records should be kept with detail including:
    - Authorization from Transportation Call Center
    - Prior Authorization number
    - Client information
    - Date and time of pick up
    - Pick up address
    - Destination address
    - Total mileage
    - Total charge

NOTE: Providers cannot span bill for dates. All services (rides) must be billed on separate lines.

Appendix

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APPENDIX A – TITLE 25 MANUAL VERSION CONTROL TABLE

Revision Date	Change(s)
04/01/2021	**Chapter 2 – Getting Help When Needed** 2.1 *Quick Reference* – moved PAs for Dental services from Medical to Dental Services. Added HHS Tech Group. 2.3 *How to Get Help Online* – Added information of PA and Client Eligibility Inquiry functions
	Chapter 3 – Provider Responsibilities 3.1 *Enrollment* – Added HHS Tech as the enrollment vendor to submit applications to
	Chapter 8 – Covered Services – Ambulance NEW
	Chapter 9– Covered Services – Non-Emergency Medical Transportation NEW

APPENDIX B – Provider Notifications Log			
Active Date(s)	Notification Type	Title	Audience
2/22/21 3/1/21 3/8/21 3/15/21	Bulletin	Important Enrollment Vendor Transition Updates	All Providers
2/24/21	Bulletin	New Client Eligibility Inquiry Function Now Available	All Providers
3/3/21	Bulletin	2021 Q&A Sessions Coming Next Week	All Providers
3/4/21	RA Banner	Enrollment Vendor Transition Updates	All Providers
3/4/21	Bulletin	Important Reminder – Wyoming Medicaid Code Update Schedule	All Providers
3/17/21	Bulletin	Winter Storm Warming	All Providers
3/25/21	Bulletin	Important Enrollment Vendor Transition Clarification	All Providers

Bulletin – Important Enrollment Vendor Transition Updates

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

COMING SOON

Wyoming Medicaid would like to announce the transition of Medicaid provider enrollment and provider updates to our new vendor, HHS Technology Group. With this transition there will be a new provider portal specifically for providers to complete enrollments, re-enrollments, re-validations, make updates, and upload documents to their Medicaid provider file.

IMPORTANT UPDATE

If you are required to re-enroll soon but have not yet started the process please wait until you receive notification from the new vendor HHS Technology Group. You will still be required to complete your re-enrollment but can do so with no lapse in active status if completed with the new vendor once prompted to do so.

If you are currently completing the enrollment process all supplemental documents must be sent in electronically to avoid delays in processing. Documents can be sent to wyenrollment@conduent.com. All documents must be received by March 15th, any documents received after this date will be returned and the process will have to be restarted and completed with HHS Technology Group.

If you are a new provider, or have new providers within your organization that need to enroll and are not currently enrolled with Wyoming Medicaid, please enroll immediately. Wyoming Medicaid will not be enrolling any providers during the upcoming blackout

period while we transition to the new system.

If your email, phone, or mailing address have changed, do not delay. Please update this information now or we may not be able to contact you.

Provider updates can be sent in by:

- Mail –

  Fiscal Agent of Wyoming Medicaid
  PO Box 667
  Attn. Provider Relations
  Cheyenne, Wyoming 82003

- Fax – 307-772-8405 (attn. Provider relations)
- Email – wycustomersvc@conduent.com

For additional questions please contact Provider Relations 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**

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: 2/22/2021; 3/1/2021; 3/8/2021; 3/15/2021
- Deployment Time: 3:30 PM; 10:00 AM; 3:00 PM: 10:30 AM
- Audience: All Providers

Bulletin – New Client Eligibility Inquiry Function Now Available

Wyoming Department of Health

Wyoming Medicaid

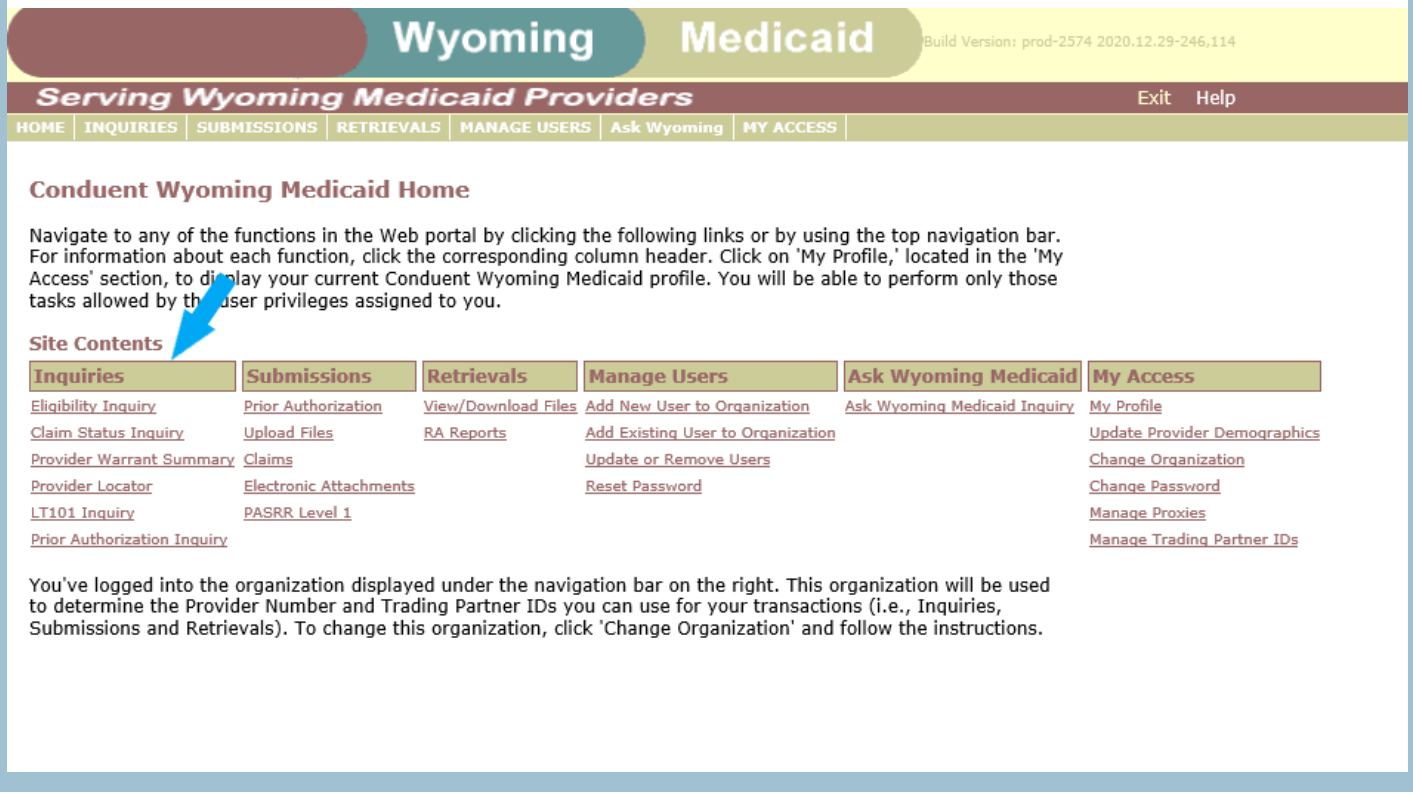
To view this email as a web page, go here.

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

Attention Providers!

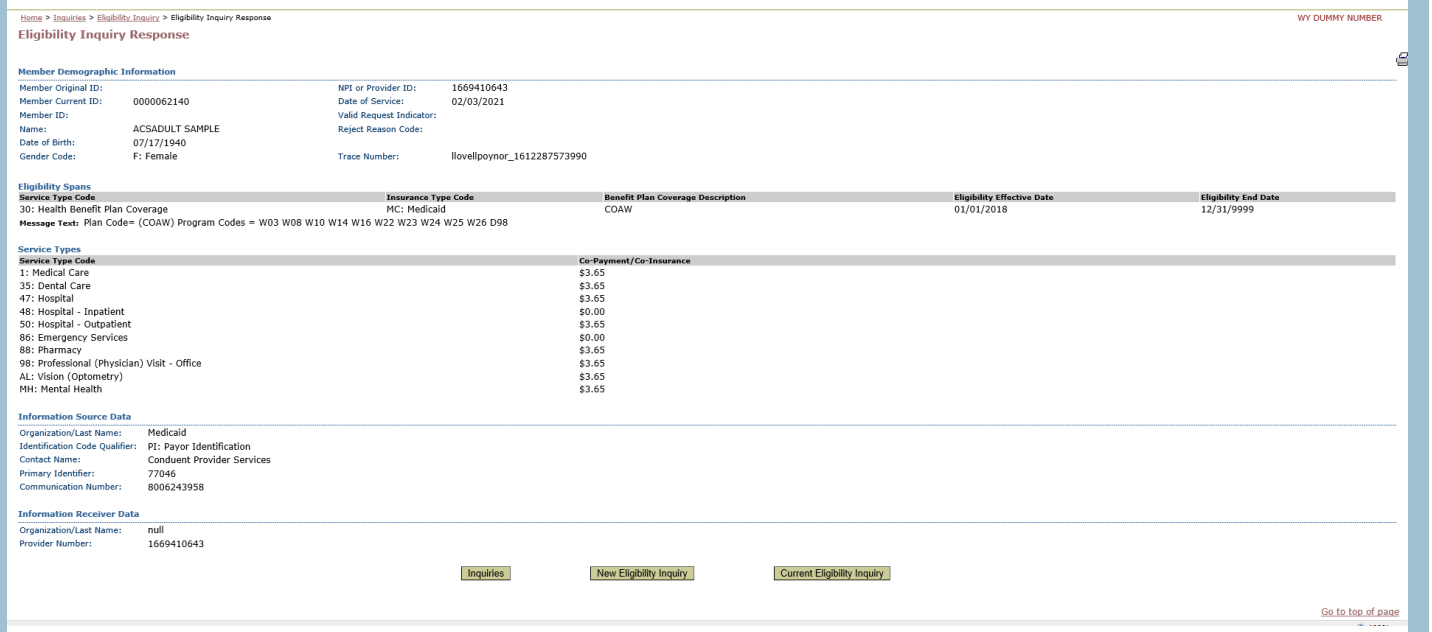
Wyoming Medicaid is happy to announce the option to check client eligibility is now available on the Provider Portal.

From the secured "Home" page, select "**Eligibility Inquiry** ".



Eligibility can be checked by entering the anticipated date of service, in addition to **ONE** of the below:

- **Member ID (10 digits)**
- **Last name, first name, gender, date of birth**
- **Last name, first name, SSN**
- **SSN, date of birth**



Home > Inquiries > Eligibility Inquiry > Eligibility Inquiry Response

WY DUMMY NUMBER

Eligibility Inquiry Response

Member Demographic Information

Member Original ID:		NPI or Provider ID:	1669410643
Member Current ID:	0000062140	Date of Service:	02/03/2021
Member ID:		Valid Request Indicator:	
Name:	ACSADULT SAMPLE	Reject Reason Code:	
Date of Birth:	07/17/1940		
Gender Code:	F: Female	Trace Number:	llovellpoynor_1612287573990

Eligibility Spans

Service Type Code	Insurance Type Code	Benefit Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	COAW	01/01/2018	12/31/9999

Message Text: Plan Code= (COAW) Program Codes = W03 W08 W10 W14 W16 W22 W23 W24 W25 W26 D98

Service Types

Service Type Code	Co-Payment/Co-Insurance
1: Medical Care	$3.65
35: Dental Care	$3.65
47: Hospital	$3.65
48: Hospital - Inpatient	$0.00
50: Hospital - Outpatient	$3.65
86: Emergency Services	$0.00
88: Pharmacy	$3.65
98: Professional (Physician) Visit - Office	$3.65
AL: Vision (Optometry)	$3.65
MH: Mental Health	$3.65

Information Source Data

Organization/Last Name:	Medicaid
Identification Code Qualifier:	PI: Payor Identification
Contact Name:	Conduent Provider Services
Primary Identifier:	77046
Communication Number:	8006243958

Information Receiver Data

Organization/Last Name:	null
Provider Number:	1669410643

Inquiries | New Eligibility Inquiry | Current Eligibility Inquiry

Go to top of page

The search will provide the following details:

- **Plan code**
- **Eligibility effective dates**
- **Copays**
- **Thresholds- where applicable**

NOTE: Keep in mind client eligibility is determined on a monthly basis, and should be checked for each date of service to ensure the client is still eligible.

Providers are urged to review the Eligibility Inquiry tutorial on the Wyoming Medicaid Provider website for more detail on utilizing this tool.

Client Eligibility Inquiry

For more information please contact Provider Relations 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

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: 2/24/2021
- Deployment Time: 3:00 PM
- Audience: All Providers

Bulletin – 2021 Q&A Session Coming Next Week

Wyoming Department of Health

Wyoming Medicaid

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Attention Providers – 2021 Provider Visits

The Provider Relations Field Representatives from the Fiscal Agent for Wyoming Medicaid will be hosting virtual Question & Answers sessions and offering virtual one-on-one visits for the 2021 season via Microsoft TEAMS.

Field Representatives will provide updates on new & important policy changes and will be available to answer questions in either setting. We do ask that specific claims questions be reserved for a scheduled one-on-one visit to best use everyone's time.

The Q&A sessions will be dedicated to specific provider types and will allow providers to ask any billing or policy questions they may have. Everyone is encouraged to attend a Q&A session to hear their peers' questions and participate in discussion, in addition to scheduling a one-on-one visit.

The Benefits Quality & Control Managers with the Wyoming Department of Health **strongly encourage** providers to attend the appropriate Q&A session and/or schedule an individual visit.

Medicaid requires all 2020 NEWLY enrolled providers (never billed Medicaid services previously) to receive training from a Field Representative, either in a Q&A session OR in an individual visit.

Invitations for Q&A Sessions

Invitations to attend Q&A sessions will be sent out to the specific provider types with

scheduling options.

To schedule a virtual one-on-one:

- Email or call the Provider Relations Field Representatives with questions:
  - WYFieldreps@conduent.com
  - Veronica Johnson 307-772-8421 (**DENTAL**)
  - Sherry Murphy between the hours of 8 AM -12 PM at 307-772-8412
  - Jessica Irons at 307-772-8441
- Or Call Provider Relations at 800-251-1268 (1.5.0).

Providers who register will be sent a Detail Report with their 2021 Year to Date claim numbers and top five denial reasons for the past six (6) months.

There will be a survey link at the end of the presentations and we would greatly appreciate feedback of our virtual workshops!

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**

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

Deployment Information:

- Deployment Date: 03/03/2021
- Deployment Time: 10:00 AM
- Audience: All Providers

RA Banner – Enrollment Vendor Transition Update

COMING SOON

WYOMING MEDICAID WOULD LIKE TO ANNOUNCE THE TRANSITION OF MEDICAID PROVIDER ENROLLMENT AND UPDATES TO OUR NEW VENDOR, HHS TECHNOLOGY GROUP. WITH THIS TRANSITION THERE WILL BE A NEW PROVIDER PORTAL SPECIFICALLY FOR COMPLETE ENROLLMENTS, RE-ENROLLMENTS, RE-VALIDATIONS, UPDATES, AND UPLOADING DOCUMENTS TO PROVIDER FILES.

IF YOU ARE CURRENTLY COMPLETING THE ENROLLMENT PROCESS, ALL SUPPLEMENTAL DOCUMENTS MUST BE SUBMITTED ELECTRONICALLY TO AVOID DELAYS IN PROCESSING. DOCUMENTS SHOULD BE SENT TO WYENROLLMENT@CONDUENT.COM. ALL DOCUMENTS MUST BE RECEIVED BY MARCH 15TH. ANY DOCUMENTS RECEIVED AFTER THIS DATE WILL BE RETURNED AND THE PROCESS NEED RE-STARTED WITH HHS TECHNOLOGY GROUP.

STARTING MONDAY MARCH 15TH A BLACKOUT WILL BEGAN AND ENROLLMENTS WILL NO LONGER BE ACCEPTED BY THE CURRENT VENDOR. PLEASE WAIT UNTIL YOU RECEIVE NOTIFICATION FROM THE NEW VENDOR, HHS TECHNOLOGY GROUP, TO PROCEED FURTHER.

CONTACT PROVIDER RELATIONS AT 1-800-251-1268 FOR ADDITIONAL QUESTIONS.

Deployment Information:

- Deployment Start Date: 3/4/2021
- Deployment End Date: 3/24/2021
- Audience: All Providers

Bulletin – Important Reminder – Diagnosis Code Update Schedule

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

Wyoming Department of Health

Wyoming Medicaid

Attention Providers - Important Reminder

Wyoming Medicaid Code Update Schedule

Wyoming Medicaid implements CMS driven code changes the following quarter. This includes HCPCS, CPT, and Diagnosis codes. As a reminder, it may be necessary to wait until the next quarter to bill in order to avoid denials.

Please contact Provider Relations at 1-800-251-1268 with questions.

Unsubscribe

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

Deployment Information:

- Deployment Date: 3/4/2021
- Deployment Time: 3:00 PM
- Audience: All Providers

Bulletin – Winter Storm Impacts

Wyoming Department of Health

Wyoming Medicaid

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

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IMPORTANT NOTICE

Attention Providers
Winter Storm Impacts

Due to the winter storm over the weekend of 3/13/21, the offices of the Fiscal Agent are temporarily closed, to be reopened when travel is safe. The call centers will remain available.

Due to the closure any paper documentation cannot be processed until offices re-open.

Regarding Provider Enrollment updates with any documents that are postmarked on or before March 18th will still be processed. These include but is not limited to:

- Enrollment Supplemental Documents
- W9's & Banking information
- Provider Updates such as licensures, address changes, email updates, linking and unlinking requests, etc.
- Attachments

Regarding attachments that cannot be processed and were initially sent in by mail, fax or email, we are requesting any claims that deny between 3/15/21-3/22/21 be resubmitted.

Additionally, if you have sent your claim attachments by mail or email you have the option to upload your attachment through the web portal to avoid denials.

Steps for submitting electronic attachments:

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://www.wpshealth.com/resources/files/med_b_837p_companion.pdf.

2. Log onto the Secured Provider Web Portal
3. Under the submissions menu select Electronic Attachments
4. Complete required information – Information must match the claim as submitted i.e. DOS, client information, provider information, and the name of the attachment must be identical to what was submitted in the in the electronic file (with no spaces).
5. Navigate to the location of the electronic attachment on the provider's computer
6. Click Upload

If you need further assistance with uploading your attachments please contact EDI Services at 1-800-672-4959.

Please be patient as we work to re-open offices.

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**

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

Deployment Information:

- Deployment Date: 3/17/2021
- Deployment Time: 3:30 PM
- Audience: All Providers

Bulletin – Important Enrollment Vendor Transition Clarification

Wyoming Department of Health

Wyoming Medicaid

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Attention Providers

Additional Provider Enrollment Transition Information

Wyoming Medicaid has begun the transition of Medicaid provider enrollment and provider updates to our new vendor, HHS Technology Group. However, Provider Enrollment transition information and services are currently still being provided by the fiscal agent, Conduent.

Conduent is still processing enrollments with documentation received postmarked for 3/18/2021 or earlier. Conduent will continue to process W9's until HHS Technology Group goes live. All enrollments with documents received by Conduent that are postmarked after 3/18/2021 will not be processed. These will need resubmitted to HHS Techonology.

With this transition there will be a separate online portal specifically for enrollment related services, which will go live April 9, 2021.

The HHS Technology Group owned provider portal, http://wyoming.dyp.cloud, will be used for:

- Enrollment
- Re-enrollment

- Re-validations
- Provider Updates
- Upload Files

HHS Technology has setup training sessions for all providers. These training sessions will provide details on how to enroll with the new vendor within their system. Please register for the best date.

Please be sure to wait until April 9, 2021 to contact HHS, Technology Group for your enrollment questions or concerns.

Conduent's Secured Provider Web Portal will still be used to for:

- Ask Wyoming Medicaid
- Claims Submission
- Claim Status Inquiry
- Prior Authorization Inquiry\
- RA Retrieval
- Prior Authorization
- LT101 Inquiry
- PASRR Level I
- Electronic Claim Attachments
- Provider Warrant Summary
- EDI Application

For billing questions contact Provider Relations at 1-800-251-1269 options 1, 5, 0.

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- **1-855-846-2563**

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WYhealth

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

Deployment Information:

- Deployment Date: 3/25/2021
- Deployment Time: 10:30 AM
- Audience: All Providers