

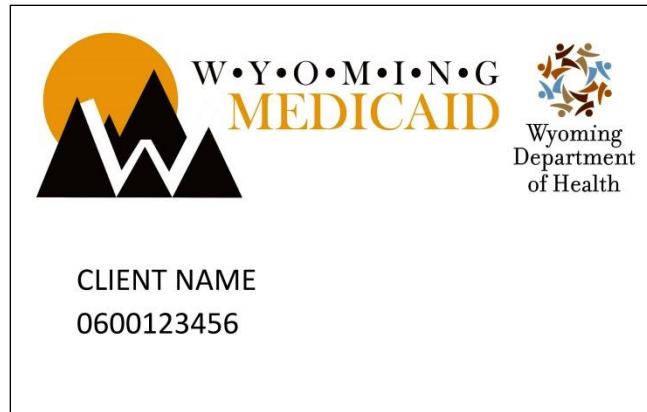
DIVISION OF HEALTHCARE FINANCING

Tribal Provider Manual

January 1, 2021



Wyoming
Department
of Health



Overview

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

Rule References

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

Importance of Fee Schedules and Provider's Responsibility

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

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

Getting Questions Answered

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

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

AUTHORITY

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

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

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1.1 How the Tribal Manual is Organized

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

Chapter	Description
Two	Getting Help When Needed – Quick Reference guide, telephone numbers and addresses and web sites for help and training
Three	Provider Responsibilities – Obligations and rights as a Medicaid provider. The topics covered include enrollment changes, civil rights, group practices, provider-patient relationship, and record keeping requirements.
Four	Utilization Review – Fraud and abuse definitions, the review process, and rights and responsibilities.
Five	Client Eligibility – How to verify eligibility when a client presents their Medicaid card
Six	Institutional/UB Common Billing Information – Basic claim information, completing the claim form, authorization for medical necessity requirements, co-pays, prior authorizations, timely filing, consent forms, NDC, working the Medicaid remittance advice (RA) and completing adjustments
Seven	CMS-1500 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
Eight	Dental 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
Nine	Third Party Liability (TPL)/Medicare – Explains what TPL/Medicare is, how to bill it and exceptions to it.
Ten	Electronic Data Interchange (EDI) – Explains the advantages of exchanging documents electronically. Secured Provider Web Portal registration process
Eleven	Wyoming Specific HIPAA 5010 Electronic Specifications – This chapter covers the Wyoming Specific requirements pertaining to electronic billing, Wyoming payer number and electronic adjustments/voids
Twelve	Important Information – This chapter covers important billing information such as coding, definitions of supervision and face-to-face visit requirements.
Thirteen	Important Information – Billing Indian Health Services – This chapter covers additional important billing information including claims review, definitions of physician supervision, and coding.
Fourteen through Twenty Eight	Covered Services – These chapters are alphabetical by professional service and provides information such as: definitions, procedure code ranges, documentation requirements, covered and non-covered services, and billing examples.
Appendices	Appendices – Provides key information in an at-a-glance format. This includes the Provider Manual Version Control Table, and last quarters Provider Notifications.

1.2 Updating the Manual

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

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

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

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

All bulletins and updates are published to the Medicaid website ([2.1, Quick Reference](#)).

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

1.2.1 RA Banner Notices Samples

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

Sample RA Banner:

ICD-10 IMPLEMENTATION OCTOBER 1, 2015

EXPECT:

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

TROUBLESHOOTING TIPS PRIOR TO CALLING THE CALL CENTERS:

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

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

Sample RA Payment Summary (weekly email notification):

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

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

Sent: Thursday, May 28, 2015 5:17 AM

To: Provider Email Name

Subject: Remittance Advice Payment Summary

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

Dear Provider Name,

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

RA PAYMENT SUMMARY

To: Provider Name

NPI Number: 1234567890

Provider ID: 111111111

Remittance Advice Number: 123456

Amount of Check: 16,070.85


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

1.2.2 Medicaid Bulletin Notification Sample

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

Sample bulletin email notification (HTML format)


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



Wyoming Medicaid

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

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



Attention Providers: Prior Authorization Vendor Change

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

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

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

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

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

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

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

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

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

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

[Unsubscribe](#)

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

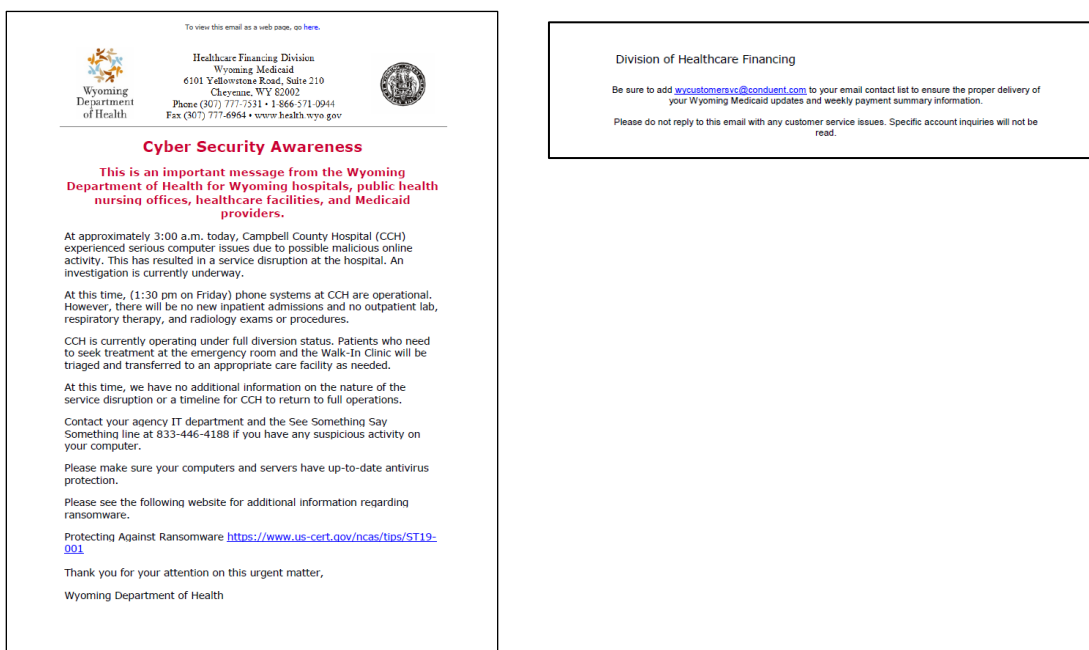
Wyoming Medicaid, Provider Relations, PO Box 667, Cheyenne, WY 82003

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

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

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

Sample WDH email notification (HTML format)



1.3 State Agency Responsibilities

The Division of Healthcare Financing administers the Medicaid Program for the Department of Health. They are responsible for financial management, developing policy, establishing benefit limitations, payment methodologies and fees, and performing utilization review.

1.4 Fiscal Agent Responsibilities

Conduent is the fiscal agent for Medicaid. They process all claims and adjustments, with the exception of pharmacy. They also answer provider inquiries regarding claim status, payments, client eligibility, known third party insurance information and provider training visits to train and assist the provider office staff on Medicaid billing procedures or to resolve claims payment issues.

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

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2.1 Quick Reference

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

Getting Help When Needed

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

Getting Help When Needed

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

Getting Help When Needed

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Stop Medicaid Fraud	Tel (855)846-2563	https://health.wyo.gov/healthcarefin/program-integrity/	<ul style="list-style-type: none"> Information and education regarding fraud, waste, and abuse in the Wyoming Medicaid program To report fraud, waste and abuse
DHCF Pharmacy Program 122 West 25th St, 4th Floor West Cheyenne, WY 82002	Tel (307)777-7531 Fax (307)777-6964	N/A	General questions
Change Healthcare	Tel (877)209-1264 (Pharmacy Help Desk) Tel (877)207-1126 (PA Help Desk)	http://www.wymedicaid.org/	<ul style="list-style-type: none"> Pharmacy prior authorization Enrollment Pharmacy manuals FAQs
Customer Service Center (CSC) , Wyoming Department of Health 3001 E. Pershing Blvd, Suite 125 Cheyenne, WY 82001	Tel (855)294-2127 TTY/TDD 1-855-329-5205 (Clients Only, CSC cannot speak to providers) 7am-6pm MST M-F Fax (855)329-5205	https://www.wesystem.wyo.gov	<ul style="list-style-type: none"> Client Medicaid applications Eligibility questions regarding: <ul style="list-style-type: none"> Family and Children's programs Tuberculosis Assistance Program Medicare Savings Programs Employed Individuals with Disabilities
Wyoming Department of Health Long Term Care Unit (LTC)	Tel (855)203-2936 8-5pm MST M-F Fax (307)777-8399	N/A	<ul style="list-style-type: none"> Nursing home program eligibility questions Patient Contribution Waiver Programs Inpatient Hospital Hospice Home Health
Wyoming Medicaid	N/A	https://wymedicaid.portal.consumer.com	<ul style="list-style-type: none"> Provider manuals HIPAA electronic transaction data exchange Fee schedules On-line Provider Enrollment Frequently asked questions (FAQs) Forms (e.g., Claim Adjustment/Void Request Form) Contacts What's new Remittance Advice Retrieval EDI enrollment form Trading Partner Agreement Secured Provider Web Portal Training Tutorials
Magellan Healthcare, Inc.	Tel (307)459-6162 8-5pm MST M-F (855)883-8740 After Hours	https://www.magellanofwyoming.com/	<ul style="list-style-type: none"> Care Management entity Services that require PA with dates of service 10/1/2020 and forward (listed in 6.13, Prior Authorization)

2.2 How to Call for Help

The fiscal agent maintains a well-trained call center that is dedicated to assisting providers. These individuals are prepared to answer inquiries regarding client eligibility, service limitations, third party coverage, electronic transaction questions, and provider payment issues

2.3 How to Write for Help

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

Reasons to write vs. calling:

- **Appeals** – Include the claim that is believed to have been denied or paid erroneously, all documentation previously submitted with the claim, explanation for request, documentation supporting the request.
- **Written documentation of answers** – Include all documentation to support the provider request.
- **Rate change requests** – Include request and any documentation supporting the provider request.
- **Requesting a service to be covered by Wyoming Medicaid** – Include request and any documentation supporting the provider request

To expedite the handling of written inquiries, we recommend providers use a Provider Inquiry Form ([2.3.1, Provider Inquiry Form](#)). Providers may copy the form in this manual. Provider Relations will respond to the provider inquiry within ten business days of receipt.

2.3.1 Provider Inquiry Form

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

Mail completed form to:

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

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

2.4 How to Get a Provider Training Visit

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

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

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

2.5 How to Get Help Online

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

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

The Medicaid Secured Provider Web Portal delivers the following services:

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

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

2.6 Training Seminars/Presentations

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

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3.1 Enrollment/Re-Enrollment

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

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

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

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

Provider Responsibilities

Categorical Risk Level	Screening Requirements
<ul style="list-style-type: none"> Comprehensive outpatient rehabilitation facilities (CORF) Hospice organizations Independent Clinical Laboratories Independent diagnostic testing facilities Physical therapists enrolling as individuals or as group practices Portable x-ray suppliers Revalidating home health agencies Revalidating DMEPOS suppliers 	
<p>HIGH</p> <p>Includes:</p> <ul style="list-style-type: none"> Prospective (newly enrolling) home health agencies Prospective (newly enrolling) DMEPOS suppliers Prosthetic/orthotic (newly enrolling) suppliers Individual practitioners suspected of identity theft, placed on previous payment suspension, previously excluded by the OIG, and/or previously had billing privileges denied or revoked within the last ten (10) years 	<p>Performs the “limited” and “moderate” screening requirements listed above.</p> <p>Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a five (5) percent or greater direct or indirect ownership interest in the provider or supplier.</p> <p>Conducts a fingerprint-based criminal history record check of the FBI’s Integrated Automated Fingerprint Identification System on all individuals who maintain a five (5) percent or greater direct or indirect ownership interest in the provider or supplier</p> <p>Categorical Risk Adjustment: CMS adjusts the screening level from limited or moderate to high if any of the following occur:</p> <ul style="list-style-type: none"> Exclusion from Medicare by the OIG Had billing privileges revoked by a Medicare contractor within the previous ten (10) years and is attempting to establish additional Medicare billing privilege by— <ul style="list-style-type: none"> Enrolling as a new provider or supplier Billing privileges for a new practice location Has been terminated or is otherwise precluded from billing Medicaid Has been excluded from any Federal health care program <p>Has been subject to a final adverse action as defined in §424.502 within the previous ten (10) years</p>

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

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

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

The application fee is required for the following:

- New enrollments
- Enrollments for new locations

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

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

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

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

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

3.1.1 Ordering, Referring, and Prescribing Providers (ORP)

Wyoming Medicaid requires that ordering, referring, or prescribing (ORP) providers be documented on claims. All ORP provider and attending provider must be enrolled with Wyoming Medicaid. This applies to all in state and out-of-state providers, even if they do not submit claims to Wyoming Medicaid.

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

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

Taxonomies always required to include an ORP/attending NPI	
Taxonomy	Taxonomy Description
332S00000X	Hearing Aid Equipment
332B00000X	Durable Medical Equipment (DME) & Supplies
335E00000X	Prosthetic/Orthotic Supplier
291U00000X	Clinical Medical Laboratory
261QA1903X	Ambulatory Surgical Center (ASC)
261QE0700X	End-Stage Renal Disease (ESRD) Treatment
261QF0400X	Federally Qualified Health Center (FQHC)
261QR0208X	Radiology, Mobile
261QR0401X	Comprehensive Outpatient Rehabilitation Facility (CORF)
261QR1300X	Rural Health Clinic (RHC)
225X00000X	Occupational Therapist
225I00000X	Physical Therapist
235Z00000X	Speech Therapist
251E00000X	Home Health
251G00000X	Hospice Care, Community Based
261Q00000X	Development Centers (Clinics/Centers)
261QP0904X	Public Health, Federal/Health Programs Operated by IHS
282N00000X	General Acute Care Hospital
282NR1301X	Critical Access Hospital (CAH)
283Q00000X	Psychiatric Hospital
283X00000X	Rehabilitation Hospital
323P00000X	Psychiatric Residential Treatment Facility
111N00000X	Chiropractors
231H00000X	Audiologist
133V00000X	Dietitians

3.1.2 Enrollment Termination

3.1.2.1 License/Certification

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

3.1.2.2 Contact Information

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

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

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

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

3.1.2.3 Inactivity

Providers who do not submit a claim within **fifteen (15) months** may be terminated due to inactivity and a new enrollment will be required.

3.1.2.4 Re-enrollment

Providers are required to complete an enrollment application, undergo a screening process and sign a Provider Agreement at least every five (5) years. Prior to any re-enrollment termination, providers will be notified in advance that a re-enrollment is required to remain active. If a re-enrollment is completed and approved prior to the set termination date, the provider will remain active with no lapse in their enrollment period.

3.1.3 Discontinuing Participation in the Medicaid Program

The provider may discontinue participation in the Medicaid Program at any time. Thirty (30) days written notice of voluntary termination is requested.

Notices should be address to Provider Relations, attention Enrollment Services ([2.1, Quick Reference](#)).

3.2 Accepting Medicaid Clients

3.2.1 Compliance Requirements

All providers of care and suppliers of services participating in the Medicaid Program must comply with the requirements of Title VI of the Civil Rights Act of 1964, which requires that services be furnished to clients without regard to race, color, or national origin.

Section 504 of the Rehabilitation Act provides that no individual with a disability shall, solely by reason of the handicap:

- Be excluded from participation;
- Be denied the benefits; or
- Be subjected to discrimination under any program or activity receiving federal assistance.

Each Medicaid provider, as a condition of participation, is responsible for making provision(s) for such individuals with a disability in their program activities.

As an agent of the Federal government in the distribution of funds, the Division of Healthcare Financing is responsible for monitoring the compliance of individual provider and, in the event a discrimination complaint is lodged, is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

3.2.2 Provider-Patient Relationship

The relationship established between the client and the provider is both a medical and a financial one. If a client presents himself or herself as a Medicaid client, the provider must determine whether the provider is missing to accept the client as a Medicaid patient **before** treatment is rendered.

Providers must verify eligibility each month as programs and plans are re-determined on a varying basis, and a client eligible one (1) month may not necessarily be eligible the next month.

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

Provider Responsibilities

It is the providers' responsibility to determine all sources of coverage for any client. If the client is insured by an entity other than Medicaid, and Medicaid is unaware of the insurance, the provider must submit a Third Party Resources Information Sheet ([9.2.1, Third Party Resources Information Sheet](#)) to Medicaid. The provider may not discriminate based on whether or not a client is insured.

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

When and what must be billed to a Medicaid client.

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

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

Full Coverage Plan – Plan covers the full range of medical, dental, hospital, and pharmacy services and may cover additional nursing home or waiver services.

Limited Coverage Plan – Plan with services limited to a specific category or type of coverage.

Specific Financial Agreement – Specific written agreement between a provider and a client, outlining the specific services and financial charges for a specific date of service, with the client agreeing to the financial responsibility for the charges

3.2.2.1 Medicare/Medicaid Dual Eligible Clients

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

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

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

3.2.2.2 Accepting a Client as Medicaid after Billing the Client

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

- Prior to submitting the claim to Medicaid, the provider must refund the entire amount previously collected from the client to him or her for the services rendered; and
- The twelve (12) month timely filing deadline will not be waived ([6.20, Timely Filing](#)).

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

- Prior to billing Medicaid, the provider must refund the entire amount previously collected from the client to him or her for the services rendered; and
- The 12 month (365 days) timely filing deadline will be waived ([6.20, Timely Filing](#)).

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

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

3.2.2.3 Mutual Agreements between the Provider & Client

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

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

3.2.3 Missed Appointments

Appointments missed by Medicaid clients **cannot** be billed to Medicaid. However, if a provider's policy is to bill **all** patients for missed appointments, then the provider may bill Medicaid clients directly.

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

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

NOTE: For clients who miss dental appointments, Wyoming Medicaid has a tracking process. Refer to [section 28.1](#) for specifics.

3.3 Medicare Covered Services

Claims for services rendered to clients eligible for both Medicare and Medicaid which are furnished by an out-of-state provider must be filed with the Medicare intermediary or carrier in the state in which the provider is located.

Questions concerning a client's Medicare eligibility should be directed to the Social Security Administration ([2.1, Quick Reference](#)).

3.4 Medical Necessity

The Medicaid Program is designed to assist eligible clients in obtaining medical care within the guidelines specified by policy. Medicaid will pay only for medical services that are medically necessary and are sponsored under program directives. Medically necessary means the service is required to:

- Diagnose
- Treat
- Cure
- Prevent an illness which has been diagnosed or is reasonably suspected to:
 - Relieve pain
 - Improve and preserve health
 - Be essential for life

Additionally, the service must be:

- Consistent with the diagnosis and treatment of the patient's condition
- In accordance with standards of good medical practice
- Required to meet the medical needs of the patient and undertaken for reasons other than the convenience of the patient or their physician
- Performed in the least costly setting required by the patient's condition

Documentation, which substantiates that the client's condition meets the coverage criteria, must be on file with the provider.

All claims are subject to both pre-payment and post-payment review for medical necessity by Medicaid. Should a review determine that services do not meet all the criteria listed above, payment will be denied or, if the claim has already been paid, action will be taken to recoup the payment for those services.

3.5 Medicaid Payment is Payment in Full

As a condition of becoming a Medicaid provider (see provider agreement), the provider must accept payment from Medicaid as payment in full for a covered service.

The provider may never bill a Medicaid client:

- When the provider bills Medicaid for a covered service, and Medicaid denied the providers claim due to billing errors such as wrong procedure and diagnosis code(s), lack of prior authorization, invalid consent forms, missing attachments, or an incorrectly filled out claim form
- When Medicare or another third party payer has paid up to or exceeded what Medicaid would have paid
- For the difference in the providers' charges and the amount Medicaid has paid (balance billing)

The provider may bill a Medicaid client:

- If the provider has not billed Medicaid, the service provided is not covered by Medicaid, and, prior to providing services, the provider informed the client in writing that the service is non-covered and he/she is responsible for the charges
- If a provider does not accept a patient as a Medicaid client (because they cannot produce a Medicaid ID card or because they did not inform the provider they are eligible)
- If the client is not Medicaid eligible at the time the provider provides the services or is on a plan that does not cover those particular services. Refer to the table above for guidance
- If the client has reached the threshold on physical therapy, occupational therapy, speech therapy, behavioral health services, chiropractic services and dietitian services with dates of service prior to 01/01/2021, prescriptions, and/or office/outpatient hospital visits and has been notified that the services are not medically necessary in writing by the provider ([6.10 Service Thresholds](#))

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

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

3.6 Medicaid ID Card

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

3.7 Verification of Client Age

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

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

3.8 Verification Options

One (1) Medicaid ID Card is issued to each client. Their eligibility information is updated every month. The presentation of a card is not verification of eligibility. It is each provider's responsibility to ensure that their patient is eligible for the services rendered. A client may state that they are covered by Medicaid, but not have any proof of eligibility. This can occur if the client is newly eligible or if their card was lost. Providers have several options when checking patient eligibility.

3.8.1 Free Services

The following is a list of free services offered by Medicaid for verifying client eligibility:

- Contact Provider Relations. There is a limit of three (3) verifications per call but not limit on the number of calls.
- Fax a list of identifying information to Provider Relations for verification. Send a list of beneficiaries for verification and receive a response within ten (10) business days.
- Call the Interactive Voice Response (IVR) System. IVR is available 24 hours a day seven (7) days a week. The IVR System allows 30 minutes per phone call. ([2.1. Quick Reference](#))
- Use the Ask Wyoming Medicaid feature of the Secured Provider Web Portal ([2.1. Quick Reference](#))

3.8.2 Fee for Service

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

3.9 Freedom of Choice

Any eligible non-restricted client may select any provider of health services in Wyoming who participates in the Medicaid Program, unless Medicaid specifically restricts their choice through provider lock-in or an approved Freedom of Choice

waiver. However, payments can be made only to health service providers who are enrolled in the Medicaid Program.

3.10 Out-of-State Service Limitations

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

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

Colorado

Craig

Idaho

Montpelier

Pocatello

Idaho Falls

Montana

Billings

Bozeman

Nebraska

Kimball

Scottsbluff

South Dakota

Deadwood

Custer

Rapid City

Spearfish

Belle Fourche

Utah

Salt Lake City

Ogden

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

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

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

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

- **Emergency Care** – When a client is traveling and an emergency arises due to accident or illness.
- **Other Care** – When a client is referred by a Wyoming physician to a provider outside the WMSA for services not available within the WMSA
 - The referral must be documented in the provider's records. Prior authorization is **not** required unless the specific service is identified as requiring prior authorization ([6.14, Prior Authorization](#))
- Children in out-of-state placement

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

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

3.11 Record Keeping, Retention, and Access

3.11.1 Requirements

The Provider Agreement requires that the medical and financial records fully disclose the extent of services provided to Medicaid clients. The following elements are not limited to, but include:

- The record must be typed or legibly written
- The record must identify the client on each page
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record. For any drugs administered, the NDC on the product must be recorded, as well as the lot number and expiration date.
- The record must indicate the observed medical condition of the client, the progress at each visit, any change in diagnosis or treatment, and the client's response to treatment. Progress notes must be written for every service, including, but not limited to: office, clinic, nursing home, or hospital visits billed to Medicaid.
- Total treatment minutes of the client, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented separately, to include beginning time and ending time for services billed.

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

3.11.2 Retention of Records

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

3.11.3 Access to Records

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

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

3.11.4 Audits

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

Audits may include, but are not limited to:

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

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

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

Medicaid is authorized to examine all provider records in that:

- All eligible clients have granted Medicaid access to all personal medical records developed while receiving Medicaid benefits
- All providers who have, at any time, participated in the Medicaid Program, by signing the Provider Agreement, have authorized the State and their designated agents to access the provider's financial and medical records

- Provider's refusal to grant the State and its' representatives access to examine records or to provide copies of records when requested may result in:
 - Immediate suspension of all Medicaid payments
 - All Medicaid payments made to the provider during the six (6) year record retention period for which records supporting such payments are not produced, shall be repaid to the Division of Healthcare Financing after written requests for such repayment is made
 - Suspension of all Medicaid payments furnished after the requested date of service
 - Reimbursement will not be reinstated until adequate records are produced or are being maintained
 - Prosecution under applicable State and Federal Laws.

3.12 Tamper Resistant RX Pads

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

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

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

- May also contain any of the features listed within category two, recommendations provided by the NCPDP, or that meets the standards set forth in this category.
- 3. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all written prescriptions must contain:
 - Security features and descriptions listed on the FRONT of the prescription blank.
 - May also contain any of the features listed within category three (3), recommendations provided by the NCPDP, or that meets the standards set forth in this category.
- Computer Printed Prescriptions: As of October 1, 2008 prescriptions must contain all three (3) of the following characteristics:
 1. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement all prescriber's computer generated prescriptions must contain:
 - Same as Written Prescription for this category
 2. One (1) or more industry-recognized features designed to prevent the erasure or modification of information printed on the prescription by the prescriber. In order to meet this requirement all computer generated prescriptions must contain:
 - Same as Written Prescription for this category
 3. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all prescriber's computer generated prescriptions must contain:
 - Security features and descriptions listed on the FRONT or BACK of the prescription blank.
 - May also contain any of the features listed within category three (3), recommendations provided by the NCPDP, or that meets the standards set forth in this category.

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

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

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4.1 Utilization Review

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

- Review of claims submitted for payment (pre and post payment reviews)
- Reviews of medical records and documents related to covered services
- Audit of medical records and client interviews
- Review of client Explanation of Medical Benefits (EOMB) responses
- Operation of the Surveillance/Utilization Review (SUR) process
- Provider screening and monitoring
- Program compliance and enforcement

4.2 Complaint Referral

The Program Integrity Unit reviews complaints regarding inappropriate use of services from providers and clients. No action is taken without a complete investigation. To file a complaint, please submit the details in writing and attach supporting documentation to:

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

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

4.3 Release of Medical Records

Every effort is made to ensure the confidentiality of records in accordance with Federal Regulations and Wyoming Medicaid Rules. Medical records must be released to the agency or its designee. The signed Provider Agreement allows the Division of Healthcare Financing, or its designated agents, access to all medical and financial records. In addition, each client agrees to the release of medical records to the Division of Healthcare Financing when the accept Medicaid benefits.

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

4.4 Client Lock-In

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

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

A participating Medicaid provider who is not designated as the client's primary practitioner may provide and be reimbursed for services rendered to lock-in clients only under the following circumstances:

- In a medical emergency where a delay in treatment may cause death or result in lasting injury or harm to the client
- As a physician covering for the designated physician or on referral from the designated primary physician

In cases where lock-in restrictions are indicated, it is the responsibility of each provider to determine whether they may bill for services provided to a lock-in client. Contact Provider Relations in circumstances where coverage of a lock-in client is unclear ([2.1, Quick Reference](#)).

4.5 Pharmacy Lock-In

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

When a pharmacy is chosen to be a client's designated Lock-In provider, notification is sent to that pharmacy with all important client identifying information. If a Lock-In client attempts to fill a prescription at a pharmacy other than their Lock-In pharmacy, the claim will be denied with an electronic response of "NON-MATCHED PHARMACY NUMBER-Pharmacy Lock-In."

Pharmacies have the right to refuse Lock-In provider status for any client. The client may be counseled to contact the Medicaid Pharmacy Case Manager at (307)777-8773 in order to obtain a new provider designation form to complete.

Expectations of a Medicaid designated Lock-In pharmacy:

- Medicaid pharmacy providers should be aware of the Pharmacy Lock-In Program and the criteria for client lock-in status as stated above. The entire pharmacy staff should be notified of current Lock-In clients.
- Review and monitor all drug interactions, allergies duplicate therapy, and seeking of medications from multiple prescribers. Be aware that the client is locked-in when "refill too soon" or "therapeutic duplication" edits occur. Cash payment for controlled substances should serve as an alert and require further review.
 - Gather additional information, which may include, but is not limited to, asking the client for more information and/or contacting the prescriber. Document the finding and outcomes. The Wyoming Board of Pharmacy will be contacted when early refills and cash payment are allowed without appropriate clinical care and documentation.

When doctor shopping for controlled substances is suspected, please contact the Medicaid Pharmacy Case Manager at (307)777-8773. The Wyoming Online Prescription Database (WORx) is online with 24/7 access for practitioners and pharmacists. The WORx program is managed by the Wyoming Board of Pharmacy at <https://worxpdp.com/> and can be used to view client profiles with all scheduled II through IV prescriptions the client has received. The Wyoming Board of Pharmacy may be reached at (307)634-9636 to answer questions about WORx.

EMERGENCY LOCK-IN PRESCRIPTIONS

If the dispensing pharmacist feels that in his or her professional judgment, a prescription should be filled and they are not the Lock-In provider, they may submit a hand-billed claim to Change Healthcare for review ([2.1, Quick Reference](#)). Overrides may be approved for true emergencies (auto accidents, sudden illness, etc.).

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

- Pharmacy Case Manager (307)777-8773 or
- Fax referrals to (307)777-6964.
 - Referral forms may be found on the Pharmacy website ([2.1, Quick Reference](#)).

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

4.6 Hospice Lock-In

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

4.7 Fraud and Abuse

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

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

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

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

4.8 Provider Responsibilities

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



4.9 Referral of Suspected Fraud and Abuse

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

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

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

4.9.1 Report of Suspected Abuse of the Medicaid Healthcare System Form

 <p>Wyoming Department of Health</p>	<p>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</p>	
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NAME(s) OF Wyoming Medicaid CLIENT/PROVIDER: _____

ADDRESS OF Wyoming Medicaid CLIENT/PROVIDER: _____

TELEPHONE NUMBER OF Wyoming Medicaid CLIENT/ PROVIDER: _____

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

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

Signature of Person Reporting Abuse _____ Date _____

ADDRESS: _____ Telephone # _____

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

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

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

4.10 Sanctions

The Division of Healthcare Financing (DHCF) may invoke administrative sanctions against a Medicaid provider when a credible allegation of fraud, abuse, waste, and/or non-compliance with Provider Agreement and/or Medicaid Rules exists, or who is under sanction by another regulatory entity (i.e. Medicare, licensing boards, OIC, or other Medicaid designated agents).

Providers who have had sanctions levied against them may be subject to prohibitions or additional requirements as defined by Medicaid Rules ([2.1, Quick Reference](#)).

4.11 Adverse Actions

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

Chapter Five – Client Eligibility

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5.1 What is Medicaid?

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

5.2 Who is Eligible?

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

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

NOTE: Incarcerated persons are automatically ineligible for Wyoming Medicaid. If a client becomes incarcerated while on Medicaid, all benefits will be suspended and Providers should pursue alternate payment sources.

5.2.1 Children

- Newborns are automatically eligible if the mother is Medicaid eligible at the time of birth.
- Low Income Children are eligible if family income is at or below 133% of the federal poverty level (FPL) or 154% of the FPL, dependent on the age of the child.
- Presumptive Eligibility (PE) for Children allows temporary coverage for a child who meets eligibility criteria for the full Children's Medicaid program.
 - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.
- Foster Care Children in Department of Family Services (DFS) custody, including some who enter subsidized adoption or who age out of foster care until they are age 26.
- PE for Former Foster Youth allows temporary coverage for a person who meets eligibility criteria for the full Former Foster Youth Medicaid.
 - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.

5.2.2 Pregnant Women

- Pregnant Women are eligible if family income is at or below 154% of the FPL. Women with income less than or equal to the MAGI conversion of the 1996 Family Care Standard must cooperate with child support to be eligible.
- Presumptive Eligibility (PE) for Pregnant Women allows temporary outpatient coverage for a pregnant woman who meets eligibility criteria for the full Pregnant Woman Medicaid program.
 - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.

5.2.3 Family MAGI Adult

- Family MAGI Adults (caretaker relatives with a dependent child) are eligible if family income is at or below the MAGI conversion of the 1996 Family Care Standard.
- PE for Caretaker Relatives allows temporary coverage for the parent or caretaker relative of a Medicaid eligible child who meets eligibility criteria for the full Family MAGI Medicaid program.
 - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.

5.2.4 Aged, Blind or Disabled

5.2.4.1 Supplemental Security Income (SSI) and SSI Related

- **SSI** – A person receiving SSI automatically qualifies for Medicaid.
- **SSI Related** – A person no longer receiving SSI payment may be eligible using SSI criteria.

5.2.4.2 Institution

All categories are income eligible up to 300% of the SSI Standard.

- Nursing Home
- Inpatient Hospital Care
- Hospice
- ICF ID – Wyoming Life Resource Center
- INPAT-PSYCH – WY State Hospital – clients are 65 years and older.

5.2.4.3 Home and Community Based Waiver

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

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

5.2.5 Other

5.2.5.1 Special Groups

- **Breast and Cervical Cancer (BCC) Treatment Program** – Uninsured women diagnosed with breast or cervical cancer are income eligible at or below 250% of the FPL.
- Presumptive Eligibility (PE) for BCC allows temporary coverage for a woman who meets eligibility criteria for the full BCC Medicaid program.
 - PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.
- **Tuberculosis (TB) Program** – Individuals diagnosed with tuberculosis are eligible based on the SSI Standard.
- **Program for All Inclusive Care for the Elderly (PACE)** – Individuals over the age of 55 assessed to be in need of nursing home level of care, with income less than or equal to 300% of the SSI Standard, receive all services coordinated through the PACE provider. This program is currently available in Laramie County only.
- **Kid Care CHIP** – To be eligible for this program the following criteria must be met:
 - A United States citizen, a lawful qualified non-citizen (refugee or asylum) or a lawful, permanent alien who has lived in the United States for at least 5 consecutive years;
 - A Wyoming resident;
 - **Less than 19 years of age (not past the month of their 19th birthday);**
 - Not eligible for or already enrolled in Medicaid
 - Not currently covered by health insurance nor has had health insurance during the last 30 days, except as provided for under section 4.7;
 - Not eligible to receive health insurance benefits under Wyoming's state employee benefit plan;
 - Not residing in a public correctional institution.
 - Financially eligible based on a MAGI income eligibility determination.

5.2.5.2 Employed Individuals with Disabilities (EID)

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

5.2.5.3 Medicare Savings Programs

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

5.2.5.4 Non-Citizens with Medical Emergencies (ALEN)

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

5.3 Maternal and Child Health (MCH)

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

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

Public Health Division
122 West 25th St, 3rd Floor West
Attn: Maternal & Child Health
Cheyenne, WY 82002

(800)438-5795 or Fax (307)777-7215

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

5.4 Eligibility Determination

5.4.1 Applying for Medicaid

- Persons applying for Medicaid or Kid Care CHIP may complete the Streamlined Application. The application may be mailed to the Wyoming Department of Health (WDH). Applicants may also apply online at https://www.wesystem.wyo.gov/AVANCE_ONLINE_APP/Landing.action or by telephone at 1-855-294-2127.
- Presumptive Eligibility (PE) applicants may also apply through a qualified provider or qualified hospital for the PE programs.

5.4.2 Determination

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

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

Medicaid assumes no financial responsibility for services rendered prior to the effective date of a client's eligibility as determined by the WDH or the SSA. However, the effective date of eligibility as determined by the WDH may be retroactive up to 90 days prior to the month in which the application is filed, as long as the client meets eligibility criteria during each month of the retroactive period. If the SSA deems the client eligible, the period of original entitlement could precede the application date beyond the 90 day retroactive eligibility period and/or the 12 month (365 days) timely filing deadline for Medicaid claims ([6.20, Timely Filing](#)). This situation could arise for the following reasons:

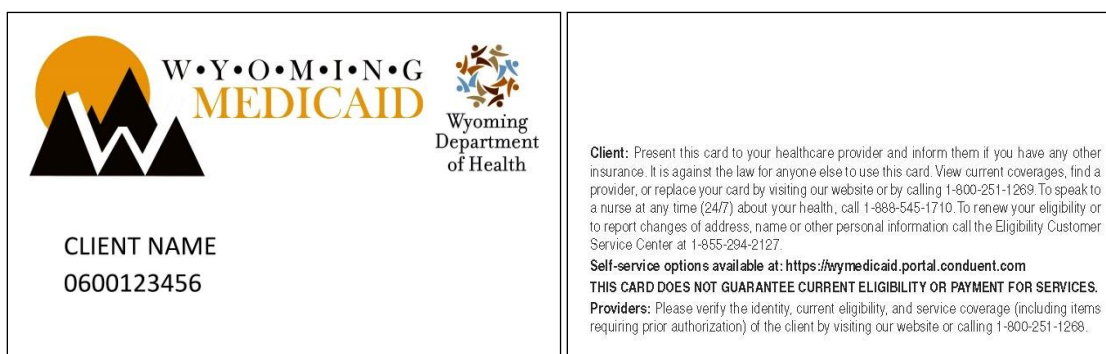
- Administrative Law Judge decisions or reversals
- Delays encountered in processing applications or receiving necessary client information concerning income or resources

5.5 Client Identification Cards

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

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

Sample Medicaid ID card:



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

5.6 Other Types of Eligibility Identification

5.6.1 Medicaid Approval Notice

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

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

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6.1 Electronic Billing

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

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

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

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

Mail requests to:

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

A new exemption request must be submitted for each calendar year. Wyoming Medicaid has free software or applications available for provider to bill electronically ([Chapter 10, Electronic Data Interchange \(EDI\)](#)).

6.2 Basic Paper Claim Information

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

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

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

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

Claims that do not follow Medicaid provider billing policies and procedures may be returned unprocessed with a letter or may be processed incorrectly. When a claim is returned, the provider may correct the claim and return it to Medicaid for processing.

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

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

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

6.3 Authorized Signatures

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

6.4 The UB-04 Claim Form

1		2		3 PAY CMT. # 5 NCD REC. #		4 TYPE OF BILL	
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		9 PATIENT ADDRESS					
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 NR 14 TYPE 15 SRC	
16 DNR		17 STAT		18		19	
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89							

6.4.1 Instructions for Completing the UB-04 Claim Form

Field	Item Description	Required Outpatient	Required Inpatient	Action																								
1	Provider Name and Address and Telephone	X	X	Enter the name of the provider submitting the bill, complete mailing address and telephone number.																								
2	Pay-To Name and Address	X	X	Enter the Pay-To Name and Address if different from 1.																								
3a	Patient Control Number	X	X	(Optional) Enter the providers account number for the client. Any alpha/numeric character will be accepted and referenced on the R.A. No special characters are allowed.																								
3b	Medical Record Number																											
4	Type of Bill First Digit 1 Hospital 2 Skilled Nursing 3 Home Health 7 Clinic (ESRD,FQHC,RHC, or CORF) 8 Special Facility (Hospital, CAH)	X	X	Enter the three (3) digit code indicating the specific type of bill. The code sequence is as follows: <table><tr><td><u>Second Digit</u></td><td><u>Third Digit</u></td></tr><tr><td>1 Inpatient</td><td>0 Non-payment/Zero Claim</td></tr><tr><td>2 ESRD</td><td>1 Admit through discharge</td></tr><tr><td>3 Outpatient</td><td>Claim</td></tr><tr><td>4 Other</td><td>2 Interim – 1st Claim</td></tr><tr><td>5 Intermediate</td><td>3 Interim – Continuing claim</td></tr><tr><td>Care Level 1</td><td>4 Interim – Last claim (thru</td></tr><tr><td>6 Intermediate</td><td>Date is discharge date)</td></tr><tr><td>Care Level 2</td><td></td></tr><tr><td>7 Subacute Inpatient</td><td></td></tr><tr><td>8 Swing bed</td><td></td></tr><tr><td>Medicare/Medicaid</td><td></td></tr></table>	<u>Second Digit</u>	<u>Third Digit</u>	1 Inpatient	0 Non-payment/Zero Claim	2 ESRD	1 Admit through discharge	3 Outpatient	Claim	4 Other	2 Interim – 1 st Claim	5 Intermediate	3 Interim – Continuing claim	Care Level 1	4 Interim – Last claim (thru	6 Intermediate	Date is discharge date)	Care Level 2		7 Subacute Inpatient		8 Swing bed		Medicare/Medicaid	
<u>Second Digit</u>	<u>Third Digit</u>																											
1 Inpatient	0 Non-payment/Zero Claim																											
2 ESRD	1 Admit through discharge																											
3 Outpatient	Claim																											
4 Other	2 Interim – 1 st Claim																											
5 Intermediate	3 Interim – Continuing claim																											
Care Level 1	4 Interim – Last claim (thru																											
6 Intermediate	Date is discharge date)																											
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.																								

Common Billing Information – Institutional/UB

Field	Item Description	Required Outpatient	Required Inpatient	Action
				<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. <u>Outpatient/Inpatient Combined:</u> 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: <u>Code Description</u> 01 Home or self-care

Common Billing Information – Institutional/UB

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

Common Billing Information – Institutional/UB

Field	Item Description	Required Outpatient	Required Inpatient	Action
41	Amounts			
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.
54	Prior Payments	Situational	Situational	Enter if applicable.
55	Estimated Amount Due	X	X	Enter remaining total if 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.

Common Billing Information – Institutional/UB

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

6.4.2 Appropriate Bill Type and Provider Taxonomy Table

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

6.5 Medicare Crossovers

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

6.5.1 General Information

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

6.5.2 Billing Information

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

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

6.6 Examples of Billing

6.6.1 Client has Medicaid Coverage Only

1 SAMPLE HOSPITAL 123 SAMPLE AVENUE SAMPLE TOWN, WY 12345 (123)456-5678		2		3a PAT CNTRL # 1234 b. MED REC # 5 FED. TAX NO. 123456789		4 TYPE OF BILL 0111	
8 PATIENT NAME SAMPLE, CLIENT		9 PATIENT ADDRESS 1234 SAMPLE LANE		c. WY d. 12345			
10 BIRTH DATE 10201983		11 SEX F		12 DATE 043015		13 ADMISSION 13 HR 14 TYPE 15 BRD 1 09 01	
16 DHR 01		17 STAT 01		18-21		22-25	
26-29		30		31-34		35-38	
39-42		43		44		45	
46-49		50		51		52	
53-56		57		58		59	
60-63		64		65		66	
67-70		71		72		73	
74-77		78		79		80	
81-84		85		86		87	
88-91		92		93		94	
95-98		99		100		101	
102-105		106		107		108	
109-112		113		114		115	
116-119		120		121		122	
123-126		127		128		129	
130-133		134		135		136	
137-140		141		142		143	
144-147		148		149		150	
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158-161		162		163		164	
165-168		169		170		171	
172-175		176		177		178	
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186-189		190		191		192	
193-196		197		198		199	
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207-210		211		212		213	
214-217		218		219		220	
221-224		225		226		227	
228-231		232		233		234	
235-238		239		240		241	
242-245		246		247		248	
249-252		253		254		255	
256-259		260		261		262	
263-266		267		268		269	
270-273		274		275		276	
277-280		281		282		283	
284-287		288		289		290	
291-294		295		296		297	
298-301		302		303		304	
305-308		309		310		311	
312-315		316		317		318	
319-322		323		324		325	
326-329		330		331		332	
333-336		337		338		339	
340-343		344		345		346	
347-350		351		352		353	
354-357		358		359		360	
361-364		365		366		367	
368-371		372		373		374	
375-378		379		380		381	
382-385		386		387		388	
389-392		393		394		395	
396-399		400		401		402	
403-406		407		408		409	
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417-420		421		422		423	
424-427		428		429		430	
431-434		435		436		437	
438-441		442		443		444	
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452-455		456		457		458	
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466-469		470		471		472	
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529-532		533		534		535	
536-539		540		541		542	
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557-560		561		562		563	
564-567		568		569		570	
571-574		575		576		577	
578-581		582		583		584	
585-588		589		590		591	
592-595		596		597		598	
599-602		603		604		605	
606-609		610		611		612	
613-616		617		618		619	
620-623		624		625		626	
627-630		631		632		633	
634-637		638		639		640	
641-644		645		646		647	
648-651		652		653		654	
655-658		659		660		661	
662-665		666		667		668	
669-672		673		674		675	
676-679		680		681		682	
683-686		687		688		689	
690-693		694		695		696	
697-700		701		702		703	
704-707		708		709		710	
711-714		715		716		717	
718-721		722		723		724	
725-728		729		730		731	
732-735		736		737		738	
739-742		743		744		745	
746-749		750		751		752	
753-756		757		758		759	
760-763		764		765		766	
767-770		771		772		773	
774-777		778		779		780	
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802-805		806		807		808	
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816-819		820		821		822	
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830-833		834		835		836	
837-840		841		842		843	
844-847		848		849		850	
851-854		855		856		857	
858-861		862		863		864	
865-868		869		870		871	
872-875		876		877		878	
879-882		883		884		885	
886-889		890		891		892	
893-896		897		898		899	
900-903		904		905		906	
907-910		911		912		913	
914-917		918		919		920	
921-924		925		926		927	
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935-938		939		940		941	
942-945		946		947		948	
949-952		953		954		955	
956-959		960		961		962	
963-966		967		968		969	
970-973		974		975		976	
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984-987		988		989		990	
991-994		995		996		997	
998-1001		1002		1003		1004	
1005-1008		1009		1010		1011	
1012-1015		1016		1017		1018	
1019-1022		1023		1024		1025	
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1068-1071		1072		1073		1074	
1075-1078		1079		1080		1081	
1082-1085		1086		1087		1088	
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1096-1099		1100		1101		1102	
1103-1106		1107		1108		1109	
1110-1113		1114		1115		1116	
1117-1120		1121		1122		1123	
1124-1127		1128		1129		1130	
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1159-1162		1163		1164		1165	
1166-1169		1170		1171		1172	
1173-1176		1177		1178		1179	
1180-1183		1184		1185		1186	
1187-1190		1191		1192		1193	
1194-1197		1198		1199		1200	
1201-1204		1205		1206		1207	
1208-1211		1212		1213		1214	
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Common Billing Information – Institutional/UB

6.6.2 Client has Medicaid and Medicare

1 SAMPLE HOSPITAL 123 SAMPLE AVENUE SAMPLE TOWN, WY 12345 (123)456-5678										34 PAY CONT. # 1234 5 MED. REC. # 5 FED. TAX NO. 123456789 6 STATEMENT COVERS PERIOD FROM 043015 THROUGH 050715										4 TYPE OF BILL 0111									
8 PATIENT NAME SAMPLE, CLIENT										9 PATIENT ADDRESS 1234 SAMPLE LANE										10 WY 12345									
10 BIRTH DATE 10201983 11 SEX F 12 DATE 043015 13 HR 15 14 TYPE 3 15 BRD 1 16 DHR 09 17 STAT 01										18 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE																			
31 OCCURRENCE CODE DATE 32 OCCURRENCE CODE DATE 33 OCCURRENCE CODE DATE 34 OCCURRENCE CODE DATE 35 OCCURRENCE CODE DATE										36 OCCURRENCE SPAN FROM THROUGH 37 OCCURRENCE SPAN FROM THROUGH																			
38 WYOMING MEDICAID PO BOX 667 Cheyenne, WY 82003-0667										39 CODE 01 40 VALUE CODES AMOUNT 979 80 80 41 CODE 2 42 VALUE CODES AMOUNT 00																			
43 DESCRIPTION										44 HCPCS / RATE / HPPS CODE										45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NOW 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 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 WYOMING MEDICAID										51 HEALTH PLAN ID										52 PRIOR PAYMENTS 53 EST. AMOUNT DUE 54 NR 1234567890									
MEDICARE																				3750 00									
56 INSURED'S NAME SAMPLE, CLIENT										57 R. REL 18 58 INSURED'S UNIQUE ID 0612345678										59 GROUP NAME 60 INSURANCE GROUP NO.									
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME									
66 B19.21 Y K76.7 Y R18.8 Y K70.2 Y E87.6 N																													
68 ADMIT DX K72.10 69 PATIENT REASON DX										70 PPS CODE 767										71 72 73									
74 PRINCIPAL PROCEDURE CODE 0FY0020 050715 75 OTHER PROCEDURE CODE 0DN8022 050715 76 OTHER PROCEDURE CODE 0ZYA020 050715										77 ATTENDING NPI 1234567891 78 LAST SAMPLE 79 FIRST ATTENDING										80 QUAL									
74 OTHER PROCEDURE CODE 0391 120610 75 OTHER PROCEDURE CODE 0391 120610										77 OPERATING NPI 1234567891 78 LAST SAMPLE 79 FIRST ATTENDING										80 QUAL									
80 REMARKS										81 B3 282N00000X										82 83 84 85 86 87 88 89 90									

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

6.6.3 Client has Medicaid and Third Party Liability (TPL)

1 SAMPLE HOSPITAL 123 SAMPLE AVENUE SAMPLE TOWN, WY 12345 (123)456-5678										3 30 PAY CNTR # 1234 31 MED REC # 5 FED. TAX NO. 123456789 6 STATEMENT COVERS PERIOD FROM 043015 THROUGH 050715										4 TYPE OF BILL 0111																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
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NOTE: If the client has both Medicare and TPL in addition to Medicaid, attach the TPL EOB and the Medicare EOMB to the claim. If the client has TPL and Medicaid but no Medicare, attach the TPL EOB to the claim.

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Revision: January 1, 2021

6.7 Provider Preventable Conditions (PPC)

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

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

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

6.7.1 Providers Included in the PPC Review

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

6.7.2 Present on Admission (POA) Indicator

Wyoming Medicaid requires POA indicators on all inpatient hospital for all hospital types participating in Wyoming Medicaid. Wyoming Medicaid has adopted

Medicare’s list of exempt ICD-10 diagnosis codes. The list of diagnosis codes exempt from the POA requirement can be found at:

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

Wyoming’s Health Care-Acquired Condition Inpatient Payment Adjustment Process.

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

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

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

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

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

6.8 Value Codes

Most frequently used value codes by Wyoming Medicaid providers:

Value code 54

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

Value Code 80 and 81

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

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

6.9 National Drug Code (NDC) Billing Requirement

Medicaid requires provider 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.

6	5	2	9	3	-	0	0	0	1	-	0	1
-----						-----					-----	
Labeler Code						Product Code					Package Code	
(5 Digits)						(4 Digits)					(2 Digits)	

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

6.9.1 Converting 10-Digit NDCs 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 three (3) common 10 digit NDC formats converted to 11 digits.

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

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

6.9.2 Documenting and Billing the Appropriate NDC

A drug may have multiple manufacturers so it is vital to use the NDC of the administered drug and not another manufacturer's product, even if the chemical name is the same. It is important that providers develop a process to capture the NDC when the drug is administered, before the packaging is thrown away. It is not permissible to bill Medicaid with any NDC other than the one (1) administered. Providers should not pre-program their billing systems to automatically utilize a certain NDC for a procedure code that does not accurately reflect the product that was administered to the client.

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

6.9.3 Billing Requirements

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

6.9.4 Submitting One NDC per Procedure Code

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

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

6.9.5 Submitting Multiple NDCs per Procedure Code

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

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

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

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

6.9.6 OPPTS Packages Services (Critical Access and General Hospitals only)

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

6.9.7 UB-04 Billing Instructions

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

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

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

6.9.7.1 UB-04 One NDC per Procedure Code

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

6.9.7.2 UB-04 Two NDCs per Procedure Code

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

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

6.10 Service Thresholds

6.10.1 Under Age 21

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

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

6.10.2 Ages 21 and older

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

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

OFFICE AND OUTPATIENT HOSPITAL VISITS		
Codes	Service Threshold	Does not apply to:
Procedure Codes: 99281-99285 99201-99215 Revenue Codes: 0450-0459 0510-0519	12 combined visits per calendar year	<ul style="list-style-type: none"> • Clients Under Age 21 • Emergency Visits • Family Planning Services • Medicare Paid Crossovers

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

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, BEHAVIORAL HEALTH VISITS, CHIROPRACTIC VISITS AND DIETITIAN		
Codes	Service Threshold	Does not apply to:
<p>Procedure codes: 90785; 90791; 90792; 90832-90834; 90836- 90839; 90845-90849; 90853; 90857; 92507- 92508; 92526; 92609; 96105-96146; 97010- 97039; 97110-97150; 97161-97546; 97802- 97804; 98940-98942; (all modalities on same date of service count as 1 visit)</p> <p>HCPCS Level II codes: G9012; H0004; H0031; H0038; H0046, H2010; H2014; H2017; H2019; S9480, T1017 (all modalities on same date of service count as 1 visit)</p> <p>Revenue codes: 0421-0449 (each unit counts as 1 visit)</p>	<p>20 physical therapy visits per calendar year</p> <p>20 occupational therapy visits per calendar year</p> <p>30 speech therapy visits per calendar year</p> <p>Behavioral Health Visits:</p> <ul style="list-style-type: none"> 2020 dates of service and prior - threshold of 30 visits per calendar year applies to clients 21 and over only 2021 dates of service and forward - threshold applies to all clients <p>Chiropractic Visits:</p> <ul style="list-style-type: none"> 2020 dates of service and prior - 20 chiropractic visits per calendar year 2021 dates of service and forward – Chiropractic services are not covered <p>Dietitian Visits:</p> <ul style="list-style-type: none"> 2020 dates of service and prior - 20 dietitian visits per calendar year 2021 dates of service and forward - no threshold on visits 	<ul style="list-style-type: none"> Medicare Paid Crossovers Inpatient and ER behavioral health services

6.10.3 Authorization of Medical Necessity

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

- Dietitian visits
- Chiropractic visits

Authorizations of Medical Necessity must be submitted on the Authorization of Medical Necessity form and cite specific medical necessity. See section [6.10.3.1, Authorization of Medical Necessity Request Form](#) below.


The form must be mailed to:

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

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

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

6.10.3.1 Authorization of Medical Necessity Request Form



Wyoming
Department
of Health

Authorization of Medical Necessity

1) Pay to (Group) NPI:	2) Pay to (Group) Name:	3) Service Type (Select one):
4) Taxonomy Code:	5) Contact Email:	<input type="checkbox"/> Chiropractic Services
6) Treating/Rendering NPI:	7) Treating/Rendering Name:	<input type="checkbox"/> Dietician Services
8) Client ID:	9) Client Name:	10) Frequency: # visits _____
11) Request Year:	12) Begin Date:	per <input type="checkbox"/> Week <input type="checkbox"/> Month
13) ICD-10 Diagnosis Code(s) up to 4: <small>1) 2) 3) 4)</small>	14) End Date:	15) Date of Condition Onset:
16a) Describe injury, illness, surgery or triggering event that initiated the need for service:		
16b) Describe need for medically necessary service. Include progress to date to include treatment methods, goals, level of improvement, and dates of treatment:		
16c) Describe anticipated length of additional treatment:		
<small>In signing and dating this document you are attesting that this form was completed to the best of your knowledge and belief, that all information and data in the Authorization of Medical Necessity are true, accurate and complete, and contains no false or erroneous information.</small> 17) TREATING Provider Signature: _____ 18) Date: _____		<p style="font-size: 1.2em; margin: 0;">FISCAL AGENT USE ONLY</p>

Submit form to ATTN Medical Policy:
 MAIL: Wyoming Medicaid, PO Box 667, Cheyenne, WY 82003 | FAX: 307-772-8405 | EMAIL: WYMedPol@conduent.com

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

6.10.3.2 Instructions for Completing the Authorization of Medical Necessity Request Form

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

*16c	Describe anticipated length of additional treatment:	Describe the anticipated progress and length needed for the additional treatment
*17	Treating Provider signature:	The provider who is requesting the services must sign the form attesting to validity of request. Stamped, copied, and typed signatures will not be accepted.
*18	Signature Date:	The provider who is requesting the services must date the signature applied.

6.10.4 Office and Outpatient Hospital Visits Once Threshold is Met

Procedure Code Range: 99281 – 99285, 99201 – 99215

Revenue Code Ranges: 0450 – 0459 & 0510 – 0519

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

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

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

6.10.5 Prior Authorization Once Thresholds are Met

Once the threshold has been reached, or once the provider is aware the threshold will be met and the client is nearing the threshold, a Prior Authorization may be requested through WYhealth ([2.1, Quick Reference](#)) for the following services:

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

Requests can be made by:

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

6.11 Reimbursement Methodologies

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

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

6.11.1 Invoice Charges

- Invoice must be dated within 12 months (365 days) prior to the date of service being billed – if the invoice is older, a letter must be included explaining the age of the invoice (i.e. product purchased in large quantity previously, and is still in stock)
- All discounts will be taken on the invoice.
- The discounted pricing or codes cannot be marked out.
- A packing slip, price quote, purchase order, delivery ticket, etc. may be used only if the provider no longer has access to the invoice, and is unable to obtain a replacement from the supplier/manufacturer, and a letter with explanation is included.
- Items must be clearly marked (i.e. how many calories are in a can of formula, items in a case, milligrams, ounces, etc.)

6.12 Co-Payment Schedule

\$3.65 Co-Payment Schedule		
Procedure and Revenue Code(s)	Description	Exceptions
T1015 and 0521 Revenue Code	Rural Health Clinic encounters	Co-payment requirements do not apply to: <ul style="list-style-type: none"> • Clients under age 21 <ul style="list-style-type: none"> ○ Medicaid eligibility for children is under 21 ○ Kid Care CHIP eligibility is under 19 NOTE: Co-pays Apply to KIDC Benefit Plan (Kid Care CHIP Plans B & C)
T1015 and 0520 Revenue Code	Federally Qualified Health Center encounters	
0450-0459 and 0510-0519	Outpatient hospital visits (non –emergency)	

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

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

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

6.13 How to Bill for Newborns

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

6.14 Prior Authorization

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

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

Agency Name	Phone	Services Requiring PA
Division of Healthcare Financing (DHCF)	Contact case manager Case manager will contact the DHCF	<ul style="list-style-type: none">• Community Choice Waiver (CCW)• Out-of-State Home Health• Out-of-State Placement for LTC Facilities• Comprehensive Developmental Disability Waivers• Support Developmental Disability Waivers
Change Healthcare	(877)207-1126	<ul style="list-style-type: none">• Pharmacy

Common Billing Information – Institutional/UB

Agency Name	Phone	Services Requiring PA
Magellan	Tel (307)549-6162 8-5pm MST M-F (855)883-8740 (after hours) http://www.magellanofwyoming.com/	Care Management Entity services that include: <ul style="list-style-type: none"> • Family Care Coordination • Family Peer Support Partner • Youth Peer Support Partner • Youth and Family Training & Support • Respite services
Medical Policy	(800)251-1268 Option 1, 1, 4, 3	<ul style="list-style-type: none"> • Belimumab Injections • Botox, Dysport, and Myobloc Injections • Dental Implants & fixed bridges • Hospice Services: Limited to clients residing in a nursing home • Ilaris/Cankinumab • Ocrevus/Ocrelizumab • Oral & Maxillofacial Surgeries • Pralatrexate • Reslizumab (CINQAIR) IV Infusion Treatment • Severe Malocclusion • Specialized Denture Services • Synvisc & Hylagen Injections • Tysabri IV Infusion Treatment
WYhealth (Utilization and Care Management)	(888)545-1710	<ul style="list-style-type: none"> • Acute Psych • Cochlear Implant – 1x/5yrs • Durable Medical Equipment (DME) • Extended Psych • Extraordinary Care • Gastric Bypass • Genetic Testing • Home Health • MedaCube • Prosthetic and Orthotic Supplies (POS) • PRTF – Psychiatric Residential Treatment Facility • PT/OT/ST/BH once threshold has been met • Surgeries (within range 10000- 99999) that requires prior authorization • Transplants • Vagus Nerve Stimulator • Vision – Lenses, Contacts, & Scleral Shells • Unlisted Codes

NOTE: Services with a threshold that not listed here require an Authorization of Medical Necessity (AOMN) to be submitted to Medical Policy ([6.8.3, Authorization of Medical Necessity](#)).

6.14.1 Requesting an Emergency Prior Authorization

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

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


6.14.2 Requesting Prior Authorization from Medical Policy

This section only applies to providers requesting PA for certain surgeries and hospice services (limited to clients residing in a nursing home). For all other types of PA requests, contact the appropriate authorizing agencies listed above for their written PA procedures.

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

- Medicaid Prior Authorization Form ([6.14.2.1, Medicaid Prior Authorization Form](#)): A hardcopy form for requesting a PA by mail, email, or fax. For a copy of the form and instructions on how to complete it, refer to the following sections.
- X12N 278 Prior Authorization Request and Response. A standard electronic file format used to transmit PA requests and receive responses. For additional information, refer to [Chapter 10, Electronic Data Interchange \(EDI\)](#) and [Chapter 11, Wyoming Specific HIPAA 5010 Electronic Specifications](#); or
- Web-Based Entry (Limited to Medical Policy PA requests). A web-based option for entering PA requests and receiving responses via Medicaid Secured Provider Web Portal. For direction on entering a PA request through the Secured Provider Web Portal, view the Web Portal Tutorial found on the website ([2.1, Quick Reference](#)). For additional information, refer to [Chapter 10, Electronic Data Interchange \(EDI\)](#) and [Chapter 11, Wyoming Specific HIPAA 5010 Electronic Specifications](#).

6.14.2.1 Medicaid Prior Authorization Form



Wyoming
Department
of Health

Prior Authorization Request
To Avoid Delays – Please fill out Completely

☐ ADD
☐ MODIFY
☐ CANCEL

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

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

Rev. 7/2014

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

6.14.2.2 Instructions for Completing the Medicaid Prior Authorization Form

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

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

6.14.3 Prior Authorization Status Inquiry

Once a PA status is determined, providers will be able to view their determinations on the Provider Portal, including the 10-digit PA number. The complete 10-digit PA number must be entered in box 23 of the CMS-1500 02-12 claim form. For placement in an electronic X12N 837 Professional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.

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

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

To view a PA status:

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

6.15 Submitting Attachments for Electronic Claims

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

Steps for submitting electronic attachments:

- The fiscal agent has created a process that allows providers to submit electronic attachments for electronic claims. Providers need only follow these steps:
 1. Mark the attachment indicator on the electronic claim. For more information on the attachment indicator, consult the provider software vendor or clearinghouse, or the X12N 837 Professional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf
 2. Log onto the [Secured Provider Web Portal](#).
 3. Under the submissions menu select Electronic Attachments.
 4. Complete required information – Information must match the claim as submitted i.e. DOS, client information, provider information, and the name of the attachment must be identical to what was submitted in the in the electronic file (with no spaces).
 5. Navigate to the location of the electronic attachment on the provider's computer.
 6. Click Upload.
 7. For support and additional information, refer to [Chapter 10](#) and [Chapter 11](#) or contact EDI Services ([2.1, Quick Reference](#)).

NOTE: Providers may not attach a document to many claims at one time. Attachments must be added per claim. If the attachment is not received within 30 days of the electronic claim submission, the claim will deny and it will be necessary to resubmit it with the proper attachment..

Steps for submitting paper attachments by mail:

- The fiscal agent has created a process that allows providers to submit paper attachments for electronic claims. Providers need only follow these two (2) simple steps:
 1. Mark the attachment indicator on the electronic claim and indicate by mail as the submission method. For more information on the attachment indicator, consult the provider software vendor or clearinghouse, or the X12N 837 Professional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.
 - The data entered on the form must match the claim exactly in DOS, client information, provider information, etc.
 2. Complete the Attachment Cover Sheet ([6.15.1, Attachment Cover Sheet](#)) and mail it with the attachment to Claims ([2.1, Quick Reference](#)).

Steps for submitting paper attachments by email:

- The fiscal agent has created a process that allows providers to submit paper attachments for electronic claims. Provider need only follow these two (2) simple steps:
 1. Mark the attachment indicator on the electronic claim and indicate by mail as the submission method. For more information on the attachment indicator, consult the provider software vendor or clearinghouse, or the X12N 837 Professional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.
 - The data entered on the form must match the claim exactly in DOS, client information, provider information, etc.
 2. Complete the Attachment Cover Sheet ([6.15.1, Attachment Cover Sheet](#)) and email it with the attachment to wycustomersvc@conduent.com ([2.1, Quick Reference](#)).
 - All emails must come secured and cannot exceed 25 pages.

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

6.15.1 Attachment Cover Sheet

Attachment Cover Sheet																					
<p>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.</p> <p>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.</p>																					
Pay-to Provider Name:	<input style="width: 90%;" type="text"/>																				
Pay-to Provider or NPI Number:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> </tr> </table>																				
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Attachment Control Number: (Required)	<input style="width: 90%;" type="text"/>																				
Must include no spaces and match the 837 file exactly																					
TCN: (Required)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> </tr> </table>																				
Attachment Type: (Required)																					
<input type="checkbox"/> AS: Admission Summary <input type="checkbox"/> B2: Prescription <input type="checkbox"/> B3: Physician Order <input type="checkbox"/> B4: Referral Order <input type="checkbox"/> CT: Certification <input type="checkbox"/> CK: Consent Form(s) <input type="checkbox"/> DA: Dental Models <input type="checkbox"/> DG: Diagnostic Report <input type="checkbox"/> DS: Discharge Summary <input type="checkbox"/> EB: Explanation of Benefits	<input type="checkbox"/> MT: Models <input type="checkbox"/> NN: Nursing Notes <input type="checkbox"/> OB: Operative Notes <input type="checkbox"/> OZ: Support Date for Claim <input type="checkbox"/> PN: Physical Therapy Notes <input type="checkbox"/> PO: Prosthetics or Orthotic Certification <input type="checkbox"/> PZ: Physical Therapy certification <input type="checkbox"/> RB: Radiology Films <input type="checkbox"/> RR: Radiology Reports <input type="checkbox"/> RT: Report of Tests and Analysis Report																				
RETURN THIS DOCUMENT WITH ATTACHMENTS TO: Wyoming Medicaid Attn: Claims PO Box 547 Cheyenne, WY 82003-0547																					

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

6.16 Sterilization, Hysterectomy, and Abortion Consent Forms

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

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

6.16.1 Sterilization Consent Form and Guidelines

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

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

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

FEDERAL GUIDELINES

The waiting period between consent and sterilization must not exceed 180 days and must be at least 30 days, except in cases of premature delivery and emergency abdominal surgery. The day the client signs the consent form and the surgical dates are not included in the 30-day requirement. For example, a client signs the consent form on July 1. To determine when the waiting period is completed, count 30-days beginning on July 2. The last day of the waiting period would be July 31; therefore, surgery may be performed on August 1.

In the event of premature delivery, the consent form must be completed and signed by the client at least 72-hours prior to the sterilization, and at least 30-days prior to the expected date of delivery.

In the event of emergency abdominal surgery, the client must complete and sign the consent form at least 72-hours prior to sterilization.

The consent form supplied by the surgeon must be attached to every claim for sterilization related procedures; i.e., ambulatory surgical center clinic, physician, anesthesiologist, inpatient or outpatient hospital. Any claim for a sterilization related procedure which does not have a signed and dated, valid consent form will be denied.

All blanks on the consent form must be completed with the requested information. The consent form must be signed and dated by the client, the interpreter (if one is necessary), the person who obtained the consent, and the physician who will perform the sterilization.

The physician statement on the consent form must be signed and dated by the physician who will perform the sterilization, on the date of the sterilization or after the sterilization procedure was performed. The date on the sterilization claim form must be identical to the date and type of operation given in the physician's statement.

6.16.1.1 Sterilization Consent Form

Sterilization Consent Form	
<p>NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.</p>	
<p>CONSENT TO STERILIZATION</p> <p>I have asked for and received information about sterilization from 1 _____ . When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or EqualityCare that I am now getting or for which I may become eligible.</p> <p>I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.</p> <p>I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.</p> <p>I understand that I will be sterilized by an operation known as a 2 _____ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.</p> <p>I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.</p> <p>I am at least 21 years or age and was born on 3 _____ Month Day Year</p> <p>4 I, _____, hereby consent of my own free will to be sterilized by 5 _____ (doctor) by a method called 6 _____. My consent expires 180 days from the date of my signature below.</p> <p>I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.</p> <p>I have received a copy of this form.</p> <p>7 _____ 8 Date: _____ Signature Month Day Year</p> <p>9 You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check) ____ American Indian or Alaska Native ____ Black (not of Hispanic origin) ____ Asian or Pacific Islander ____ Hispanic ____ White (not of Hispanic origin)</p> <p>INTERPRETER'S STATEMENT</p> <p>If an interpreter is provided to assist the individual to be sterilized:</p> <p>I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in 10 _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.</p> <p>11 _____ 12 _____ Signature of Interpreter Date</p>	<p>STATEMENT OF PERSON OBTAINING CONSENT</p> <p>Before 13 _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation 14 _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.</p> <p>I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.</p> <p>I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.</p> <p>To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.</p> <p>15 _____ 16 _____ Signature of person obtaining consent Date</p> <p>17 _____ Facility</p> <p>18 _____ Address</p> <p>PHYSICIAN'S STATEMENT</p> <p>Shortly before I performed a sterilization operation upon 19 _____ (name of individual to be sterilized) on 20 _____ (date of sterilization operation)</p> <p>I explained to him/her the nature of the sterilization operation 21 _____ (specify type of operation) the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.</p> <p>I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.</p> <p>I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.</p> <p>To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.</p> <p>Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.</p> <p>(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.</p> <p>(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):</p> <p><input type="checkbox"/> Premature delivery Individual's expected date of delivery: 22 _____ (Date)</p> <p><input type="checkbox"/> Emergency abdominal surgery: (describe circumstances): _____</p> <p>23 _____ 24 _____ Physician Date</p>

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

6.16.1.2 Instructions for Completing the Sterilization Consent Form

Important tips for completing the Sterilization Consent Form:

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

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

Section	Field #	Action
		<ul style="list-style-type: none">• If premature delivery is checked, the provider must write in the expected date of delivery here.• If emergency abdominal surgery is checked, describe circumstances here.
	23	• Physician performing the sterilization signs here
	24	Physician performing the sterilization dates signature here

6.16.2 Hysterectomy Acknowledgment of Consent

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

NOTE: For instructions on attaching documents to claims, refer to [Section 6.15](#).

6.16.2.1 Hysterectomy Acknowledgement Consent Form

<p style="text-align: center;">HYSTERECTOMY ACKNOWLEDGMENT OF CONSENT</p> <p>Complete PART A if consent is obtained PRIOR to surgery</p> <p>It is anticipated that _____ will perform a hysterectomy on me. I understand that there are medical indications for this surgery. It has been explained to me and I understand that this hysterectomy will render me permanently incapable of bearing children.</p> <p>Diagnosis: _____</p> <p>Signature of Patient: _____ Date: _____</p> <p>Signature of Person Explaining Hysterectomy: _____ Date: _____</p> <p>=====</p> <p>Complete PART B if consent is obtained AFTER surgery</p> <p>On _____ (Date) _____ (Physician)</p> <p>performed a hysterectomy on me. I understand that there were medical indications for this surgery. Prior to the procedure the doctor again explained to me that this surgery would render me permanently incapable of bearing children.</p> <p>Diagnosis: _____</p> <p>Signature of Patient: _____ Date: _____</p> <p>Signature of Person Explaining Hysterectomy: _____ Date: _____</p> <p>=====</p> <p>COMPLETE PART C IF NO CONSENT IS OBTAINED</p> <p>Diagnosis: _____</p> <p>Check which is applicable:</p> <p><input type="checkbox"/> Other reason for sterility: _____</p> <p><input type="checkbox"/> Previous tubal _____ Date: _____</p> <p><input type="checkbox"/> Emergency situation (describe)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____ Physician Signature Date</p> <p style="text-align: right;">HCF-03</p>	
--	--

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

6.16.2.2 Instructions for Completing the Hysterectomy Acknowledgment of Consent Form

Section	Field #	Action
Part A	1	Enter the name of the physician performing the surgery.
	2	Enter the narrative diagnosis for the client's condition.
	3	The client receiving the surgery signs here and dates.
	4	The person explaining the surgery signs here and dates.
Part B	5	Enter the date and the physician's name that performed the hysterectomy.
	6	Enter the narrative diagnosis for the client's condition.
	7	The client receiving the surgery signs here and dates.
	8	The person explaining the surgery signs here and dates.
Part C	9	Enter the narrative diagnosis for the client's condition.
	10	Check applicable box: <ul style="list-style-type: none"> • If other reason for sterility is checked, the provider must write what was done. • If previous tubal is checked, the provider must enter the date of the tubal. • If emergency situation is checked, the provider must enter the description.
	11	<ul style="list-style-type: none"> • The physician who performed the hysterectomy signs here and dates.

6.16.3 Abortion Certification Guidelines

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

6.16.3.1 Abortion Certification Form

ABORTION CERTIFICATION FORM

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

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

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

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

3. Patient Name: _____

4. Address: _____

5. Physician Signature: _____ Date _____

6. Address: _____

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

6.16.3.2 Instructions for Completing the Abortion Certification Form

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

6.17 Remittance Advice

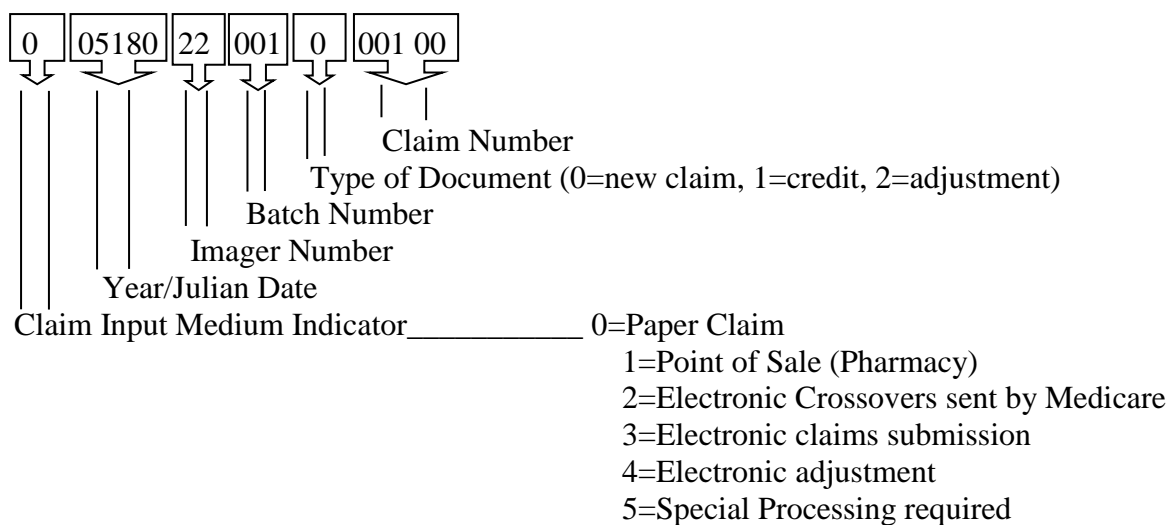
After claims have been processed weekly, Medicaid distributes a Medicaid proprietary Remittance Advice (RA) to providers. The RA plays an important communication role between providers and Medicaid. It explains the outcome of claims submitted for payment. Aside from providing a record of transactions, the RA assists providers in resolving potential errors. As of April 1 2020, all providers will receive electronic remittance advices. No paper remittance advices shall be mailed from the Agency after March 31, 2020. Any provider currently receiving paper checks should begin the process with the State Auditor's Office to move to electronic funds transfer. Any new providers requesting paper checks shall only be granted in temporary, extenuating circumstances.

The RA is organized in the following manner:

- The first page or cover page is important and should not be over looked as it may include an RA Banner notification from Wyoming Medicaid ([1.2, RA Banner Notices/Samples](#))
- Claims are grouped by disposition category.
 - Claim Status PAID group contains all the paid claims.
 - Claim Status DENIED group reports denied claims.
 - Claim Status PENDED group reports claims pending for review. Do not resubmit these claims. All claims in pending status are reported each payment cycle until paid or denied. Claims can be in a pending status for up to 30 days.
 - Claim Status ADJUSTED group reports adjusted claims.
- All paid, denied, and pending 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

Common Billing Information – Institutional/UB

system. The digits and groups of digits in the TCN have specific meanings, as explained below:



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

Common Billing Information – Institutional/UB

6.17.1 Sample Institutional Remittance Advice

WYOMING DEPARTMENT OF HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
R E M I T T A N C E A D V I C E

RUN DATE 00/00/00

TO: SAMPLE PROVIDER R.A. NO.: 0101010 DATE PAID: 00/00/00 PROVIDER NUMBER: 123456789/1234567890 PAGE: 1

TRANS-CONTROL NUMBER	PROC/MOD	REV	UNITS	BILLED AMT.	OTHER INS.	PAID BY MCAID	COPAY AMT	WRITE OFF	DIS 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 M01
	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
PENDEDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	-----	0.00	0.00
AMOUNT OF CHECK:					0.00

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

690 SERVICE ON SAME DAY AS INPATIENT PROCEDURE CODE

3

661 INPATIENT PROCEDURES AND INPATIENT SEPARATE PROCEDURES NOT PAID

6.17.2 How to Read the Remittance Advice

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

FIELD NAME	HEADER DESCRIPTION
To	Provider Name
R.A. Number	Remittance Advice Number assigned.
Date Paid	Payment date.
Provider Number	Medicaid provider number/NPI number
Page	Page Number
Last, MI, and First	The client's name as found on the Medicaid ID Card.
Recip ID	The client's Medicaid ID Number.
Patient Acct #	The patient account number reported by the provider on the claim.
Trans Control Number	Transaction Control Number: The unique identifying number assigned to each claim submitted.
Billed Amt.	Total amount billed on the claim
Mcare Paid	Amount paid by Medicare
Copay Amt.	The amount due from the client for their co-payment.
Other Ins.	Amount paid by other insurance.
Deductible	Medicare deductible amount.
Coins Amt.	Medicare coinsurance amount.
Mcaid Paid	The amount paid by Medicaid
Write off	Difference between Medicaid paid amount and the provider's billed amount.
Header EOB(s)	Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA
Li	The line item number of the claim.
Svc date	The date of service.
Proc / Mods	The procedure code and applicable modifier.
Units	The number of units submitted.
Billed Amt.	Total amount billed on the line.
Mcare Paid	Amount paid by Medicare
Copay Amt.	The amount due from the client for their co-payment.
Other Ins.	Amount paid by other insurance.
Deductible	Medicare deductible amount.
Coins Amt.	Medicare coinsurance amount.
Mcaid Paid	The amount paid by Medicaid
Write off	Difference between Medicaid paid amount and the provider's billed amount.
Treating Provider	The treating provider's NPI number.
S	How the system priced each claim. For example, claims priced manually have a distinct code. Claims paid according to the Medicaid fee schedule have another code. Below is a table which describes these pricing source codes:

	A= Anesthesia B= Billed Charge C= Percent-of-Charges D= Inpatient Per Diem Rate E= EAC Priced Plus Dispensing Fee F= Fee Schedule G= FMAC Priced Plus Dispensing Fee H= Encounter Rate I= Institutional Care Rate J= Calculated Medicaid Crossover K= Denied L= Maximum Suspend Ceiling M= Manually Priced N= Provider Charge Rate O= Relative Value Units TC P= Prior Authorization Rate Q= DRG HCAC Pricing Reduction P= Prior Authorization Rate Q= DRG HCAC Pricing Reduction	R= Relative Value Unit Rate S= Relative Value Unit PC T= Fee Schedule TC U= Priced by NDC V= RBRVS W= Drug Standard Rate X= Medicare Coinsurance and Deductible Y= Fee Schedule PC Z= Fee Plus Injection 1= LOC Per Diem 2= LOC Outlier Applied 3= Maximum Fee For Emergency 4= Pricing Using Procedure 5= APC Priced 6= APC Bundled 7= DRG Standard Rate with Outlier 8= DRG Transfer 9= DRG Transfer with Outlier
Plan	The Medicaid and State Healthcare Benefit Plan the client is eligible for (Section A.3).	
Line EOB(s)	Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA	

6.17.3 Remittance Advice Replacement Request Policy

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

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

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

RAs less than 24 weeks old can be obtained from the Secured Provider Web Portal, once a provider has registered for access ([10.5.2.1, Secured Provider Web Portal Registration Process](#)).

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

6.17.3.1 Remittance Advice (RA) Replacement Request Form

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

Provider Name (as enrolled with Wyoming Medicaid): _____

Provider NPI: _____ Provider Taxonomy: _____

OR

Wyoming Medicaid Provider ID: _____

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

To request a complete RA:

RA Number: _____

RA Date: _____

RA Amount: _____

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

Specific Claim TCN: _____

Specific Claim Client ID and Date of Service: _____

Delivery Method (select one):

☐ Email Address (preferred): _____

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

☐ Mailing Address: _____

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

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

Enclosed Check Info:

Total Amount: _____

Check Number: _____

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

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

6.17.4 Obtain an RA from the Web

Providers have the ability to view and download their last 24 weeks of RAs from the Medicaid website, refer to [Chapter 10, Electronic Data Interchange \(EDI\)](#).

6.17.5 When a Client Has Other Insurance

If the client has other insurance coverage reflected in Medicaid records, payment may be denied unless providers report the coverage on the claim. Medicaid is always the payer of last resort. For exceptions and additional information regarding Third Party Liability, refer to [Chapter 9](#) of this manual. To assist providers in filing with the other carrier, the following information is provided on the RA directly below the denied claim:

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

The information is specific to the individual client. The Third Party Resources Information Sheet ([9.2.1, Third Party Resources Information Sheet](#)) should be used for reporting new insurance coverage or changes in insurance coverage on a client's policy.

6.18 Resubmitting Versus Adjusting Claims

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

Action	Description	Timely Filing Limitation
VOID	Claim has paid; however, the provider would like to completely cancel the claim as if it was never billed.	May be completed any time after the claim has been paid.
ADJUST	Claim has paid, even if paid \$0.00; however, the provider would like to make a correction or change to this paid claim.	Must be completed within 6 months (180 days) after the claim has paid UNLESS the result will be a lower payment being made to the provider, then no time limit.
RESUBMIT	Claim has denied entirely or a single line has denied. The provider may resubmit on a separate claim.	One (1) year (365 days) from the date of service.

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

The deadlines for resubmitting and adjusting claims are different:

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

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

6.18.2 Resubmitting a Claim

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

How to Resubmit:

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

6.18.2.1 When to Resubmit to Medicaid

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

6.18.3 Adjusting or Voiding Paid Claims

When a provider identifies an error on a paid claim, the provider must submit an [Adjustment/Void Request Form](#). If the incorrect payment was the result of a keying error (paper claim submission), by the fiscal agent contact Provider Relations to have the claim corrected ([2.1, Quick Reference](#)).

Denied claims cannot be adjusted.

When adjustments are made to previously paid claims, Medicaid reverses the original payment and processes a replacement claim. The result of the adjustment appears on the RA/835 transaction as two (2) transactions. The reversal of the original payment will appear as a credit (negative) transaction. The replacement claim will appear as a debit (positive) transaction and may or may not appear on the same RA/835 transaction as the credit transaction. The replacement (debit) claim will have almost the same TCN as the credit transaction, except the 12th digit will be a two (2), indicating an adjustment, whereas the credit will have a one (1) in the 12th digit indicating a credit.

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

6.18.3.1 When to Request an Adjustment

- When a claim was overpaid or underpaid.
- When a claim was paid, but the information on the claim was incorrect (such as client ID, date of service, procedure code, diagnoses, units, etc.)
- When Medicaid pays a claim and the provider subsequently receives payment from a third party payer, the provider must adjust the paid claim to reflect the TPL amount paid.
 - If an adjustment is submitted stating that TPL paid on the claim, but the TPL paid amount is not indicated on the adjustment or an EOB is not sent in with the claim, Medicaid will list the TPL amount as either the billed or reimbursement amount from the adjusted claim (whichever is greater). It will be up to the provider to adjust again, with the corrected information.
 - Attach a corrected claim showing the insurance payment and attach a copy of the insurance EOB if the payment is less than 40% of the total claim charge.
 - For the complete policy regarding Third Party Liability, refer to [Chapter 9](#).

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

6.18.3.2 When to Request a Void

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

6.18.3.3 How to Request an Adjustment/Void

To request an adjustment, use the Adjustment/Void Request Form ([6.18.3.2 Adjustment/Void Request Form](#)). The requirements for adjusting/voiding a claim are as follows:

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

6.18.3.4 Adjustment/Void Request Form

Adjustment/void Request Form	
EXHIBIT 6.9	
ADJUSTMENT/VOID REQUEST FORM	
SECTION A: CHECK BOX 1a), 1b) OR 2)	
<input type="checkbox"/> 1a) CLAIM ADJUSTMENT: Attach a copy of the claim with corrections made in BLUE ink. DO NOT USE HIGHLIGHTER <input type="checkbox"/> 1b) VOID CLAIM: Attach a copy of the claim or Remittance Advice. Complete Sections B and C. If attaching a check, the check should be payable to Division of Healthcare Financing (DHCF) .	<input type="checkbox"/> 2) CANCELLATION OF THE ENTIRE REMITTANCE ADVICE. Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances. Complete Section C only. Attach RA. If manual check attach the check from the DHCF or if EFT make check payable to the DHCF for the entire remit amount.
SECTION B	
TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:	
1. 17-DIGIT TCN:	2. PAYMENT DATE:
<input style="width: 100px; height: 20px; border: 1px solid black;" type="text"/>	
3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER:	4. PROVIDER NAME:
<input style="width: 100px; height: 20px; border: 1px solid black;" type="text"/>	
5. 10-DIGIT CLIENT NUMBER:	6. 10-DIGIT PA NUMBER:
<input style="width: 100px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 100px; height: 20px; border: 1px solid black;" type="text"/>
7. REASON FOR ADJUSTMENT OR VOID:	
SECTION C: SIGNATURE AND DATE REQUIRED	
PROVIDER SIGNATURE: _____ DATE: _____	
RETURN ALL REQUESTS TO: WYOMING MEDICAID ATTN: CLAIMS PO BOX 547 CHEYENNE, WY 82003-0547	
REMARKS/STATUS: _____ (FOR INTERNAL USE ONLY)	
CASH CONTROL NUMBER: _____	
ADJUSTED BY: _____ DATE: _____	

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

6.18.3.5 How to Complete the Adjustment/Void Request Form

Section	Field #	Field Name	Action
A	1a, 1b	Claim Adjustment	Mark this box if any adjustments need to be made to a claim. Attach a copy of the claim with corrections made in BLUE ink (do not use red ink or highlighter) or the RA. Attach all supporting documentation required to process the claim, i.e. EOB, EOMB, consent forms, invoice, etc.
		Void Claim	Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the Remittance Advice.
			Sections B and C must be completed.
B	1	17-digit TCN	Enter the 17-digit transaction control number assigned to each claim from the Remittance Advice.
	2	Payment Date	Enter the Payment Date
	3	Nine (9) digit Provider or ten (10) digit NPI Number	Enter provider’s nine (9)-digit Medicaid provider number or ten (10)-digit NPI number, if applicable.
	4	Provider Name	Enter the provider name.
	5	Ten (10) digit Client Number	Enter the client’s ten (10)-digit Medicaid ID number.
	6	Ten (10) digit PA Number	Enter the ten (10)-digit Prior Authorization number, if applicable.
	7	Reason for Adjustment or Void	Enter the specific reason and any pertinent information that may assist the fiscal agent.
C		Provider Signature and Date	Signature of the provider or the providers’ authorized representative and the date.

6.18.3.6 Adjusting a claim electronically via an 837 transaction

Wyoming Medicaid accepts claim adjustments electronically, refer to Chapter 11, Wyoming Specific HIPAA 5010 Electronic Specifications ([11.11, 835 Institutional Claims Transaction](#)), for complete details.

6.19 Credit Balances

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

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

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

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

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

6.20 Timely Filing

The Division of Healthcare Financing adheres strictly to its timely filing policy. The provider must submit a clean claim to Medicaid within 12 months (365 days) of the date of service. A clean claim is an error free, correctly completed claim, with all required attachments, that will process and approve to pay within the twelve month (365 days) time period. Submit claims immediately after providing services so that, when a claim is denied, there is time to correct any errors and resubmit. Claims are to be submitted only after the service(s) have been rendered, and not before. For deliverable items (i.e. dentures, DME, glasses, hearing aids, etc.) the date of service must be the date of delivery, not the order date.

6.20.1 Exceptions to the Twelve Month (365 days) Limit

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

Exceptions Beyond the Control of the Provider	
When the Situation is:	The Time Limit is:
Medicare Crossover	A Claim must be submitted within 12 months (365 days) of the date of service or within 6 months (180 days) from the payment date on the Explanation of Medicare Benefits (EOMB), whichever is later
Client is determined to be eligible on appeal, reconsideration, or court decision (retroactive eligibility)	Claims must be submitted within 6 months (180 days) of the date of the determination of retroactive eligibility. The client must provide a copy of the dated letter to the provider to document retroactive eligibility. If a claim exceeds timely filing and the provider elects to accept the client as a Medicaid client and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be a SSI award notice or a notice from WDH.

Exceptions Beyond the Control of the Provider	
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.

6.20.2 Appeal of Timely Filing

A provider may appeal a denial for timely filing **ONLY** under the following circumstances:

- The claim was originally filed within 12 months (365 days) of the date of service and is on file with Wyoming Medicaid; and
- The provider made at least one (1) attempt to resubmit the corrected claim within 12 months (365 days) of the date of service; and
- The provider must document in their appeal letter all claims information and what corrections they made to the claim (all claims history, including TCNs) as well as all contact with or assistance received from Provider Relations (dates, times, call reference number, who was spoken with, etc.) or
- A Medicaid computer or policy problem beyond the provider's control prevented the provider from finalizing the claim within 12 months (365 days) of the date of service

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

6.20.2.1 How to Appeal

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

- Documentation of previous claim submission (TCNs, documentation of the corrections made to the subsequent claims);

- Documentation of contact with Provider Relations;
- An explanation of the problem; and
- A clean copy of the claim, along with any required attachments and required information on the attachments. A clean claim is an error free, correctly completed claim, with all required attachments, that will process and pay.

6.21 Important Information Regarding Retroactive Eligibility Decisions

The client is responsible for notifying the provider of the retroactive eligibility determination and supplying a copy of the notice.

A provider is responsible for billing Medicaid only if:

- They agreed to accept the patient as a Medicaid client pending Medicaid eligibility; or
- After being informed of retroactive eligibility, they elect to bill Medicaid for services previously provided under a private agreement. In this case, any money paid by the client for the services being billed to Medicaid would need to be refunded prior to a claim being submitted to Medicaid.

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

In the event of retroactive eligibility, claims must be submitted within 6 months (180 days) of the date of determination of retroactive eligibility.

NOTE: Inpatient Hospital Certification: A hospital may seek admission certification for a client found retroactively eligible for Medicaid benefits after the date of admission for services that require admission certification. The hospital must request admission certification within 30 days after the hospital receives notice of eligibility. To obtain certification, contact WYhealth ([2.1, Quick Reference](#)).

6.22 Client Fails to Notify Provider of Eligibility

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

- Any money paid by the client for the service being billed to Wyoming Medicaid must be refunded prior to billing Medicaid;

- The client can no longer be billed for the service; and
- Timely filing criterion is in effect.

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

6.23 Billing Tips to Avoid Timely Filing Denials

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

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

6.24 Telehealth

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

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

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

include Community Mental Health Centers and Substance Abuse Treatment Centers. A single pay to provider can bill both the originating site (spoke site) and the distant site provider (hub site) when applicable. See below for billing and documentation requirements.

6.24.1 Covered Services

Originating Sites (Spoke Site)

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

Authorized originating sites are:

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

Distant Site Providers (Hub Site)

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

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

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

- Board Certified Behavior Analyst
- Speech Therapist

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

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

6.24.2 Non-Covered Services

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

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

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

6.24.3 Documentation Requirements

- Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented and monitored.
- Providers need to develop and document evaluation processes and patient outcomes related to the telehealth program, visits, provider access, and patient satisfaction.

- All service providers are required to develop and maintain written documentation in the form of progress notes the same as is originated during an in-person visit or consultation with the exception that the mode of communication (i.e. teleconference) should be noted.
- Documentation must be maintained at the hub and spoke locations to substantiate the services provided. Documentation must indicate that the services were rendered via telehealth and must clearly identify the location of the hub and spoke sites.

6.24.4 Billing Requirements

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

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

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

- Additional services provided at the originating site on the same date as the telehealth service may be billed and reimbursed separately according to published policies and the national correct coding initiative guidelines.
- For ESRD-related services, at least one (1) face-to-face, "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a qualified provider.
- Care Management Entity/Children's Mental Health Waiver service providers (CME providers) are to use Place of Service code 02-Telehealth per their

provider agreement with Magellan Healthcare. CME providers are NOT to use the “GT” modifier or “Q3014-Telehealth Originating Site Facility Fee” codes for virtual services.

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

6.24.4.1 Billing Examples

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

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

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

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

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

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

6.24.5 Telehealth Consent

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

- Verbally
- Email
- Text Message

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

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7.1 Electronic Billing

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

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

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

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

Mail requests to:

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

A new exemption request must be submitted for each calendar year. Wyoming Medicaid has free software or applications available for provider to bill electronically ([Chapter 10, Electronic Data Interchange \(EDI\)](#)).

7.2 Basic Paper Claim Information

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

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

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

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

Claims that do not follow Medicaid provider billing policies and procedures may be returned unprocessed with a letter or may be processed incorrectly. When a claim is returned, the provider may correct the claim and return it to Medicaid for processing.

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

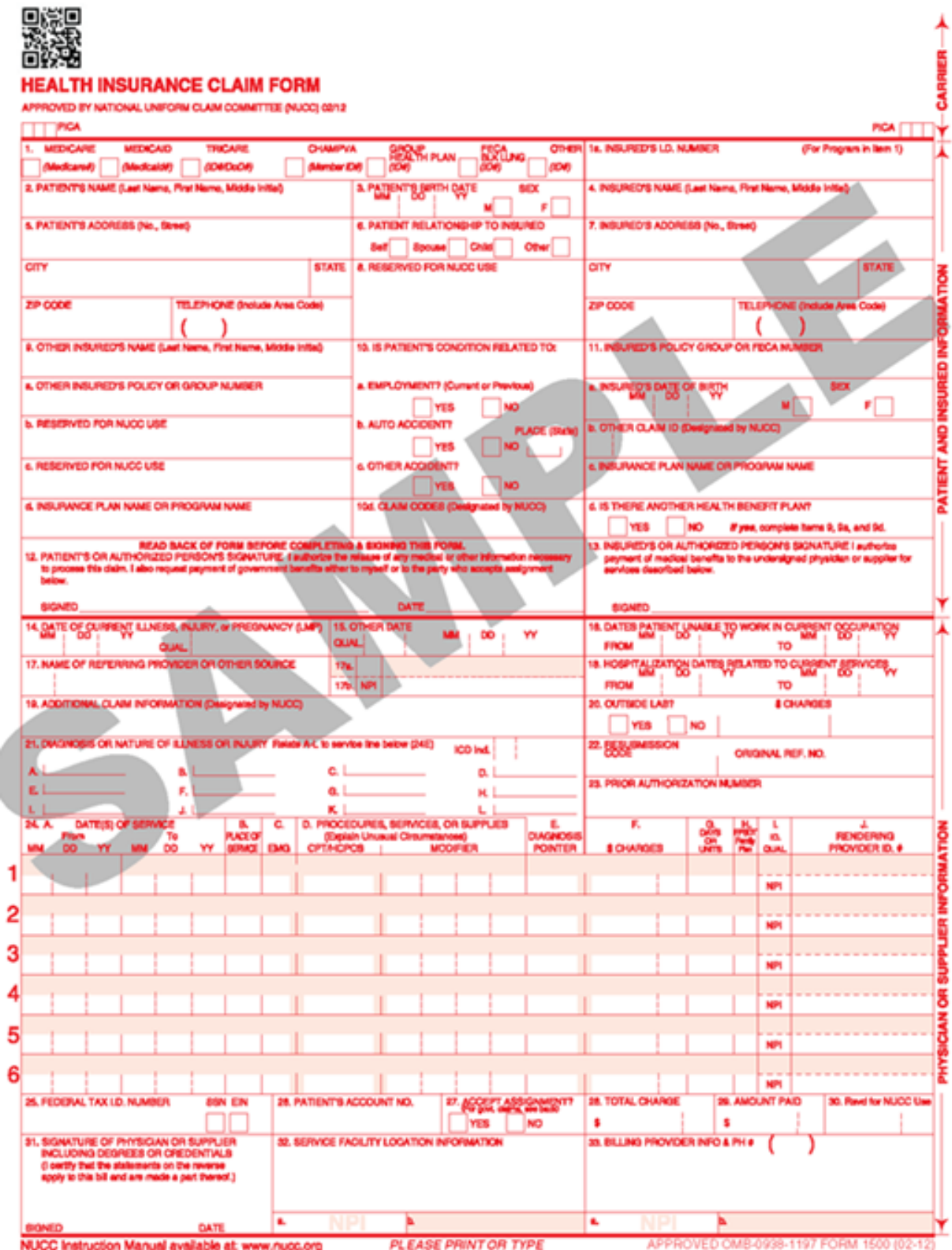
Billing errors detected after a claim is submitted cannot be corrected until after Medicaid has made payment or notified the provider of the denial. Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice ([7.18, Resubmitting Versus Adjusting Claims](#)).

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

7.3 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.

7.4 The CMS-1500 Claim Form



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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE ☐ **MEDICAID** ☐ **TRICARE** ☐ **CHAMPVA** ☐ **GROUP HEALTH PLAN** ☐ **FECA (B/L/LUNG)** ☐ **OTHER** ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **3. PATIENT'S BIRTH DATE** MM DD YY **SEX** M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **5. PATIENT'S ADDRESS** (No., Street) **6. PATIENT RELATIONSHIP TO INSURED** Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street) **8. RESERVED FOR NUCC USE** **9. OTHER INSURED'S NAME** (Last Name, First Name, Middle Initial) **10. IS PATIENT'S CONDITION RELATED TO:**

11. INSURED'S POLICY GROUP OR FECA NUMBER **12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) **13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY **15. OTHER DATE** MM DD YY **16. INSURED'S DATE OF BIRTH** MM DD YY **17. NAME OF REFERRING PROVIDER OR OTHER SOURCE** **18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **20. OUTSIDE LAB?** ☐ YES ☐ NO **21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** (Please A-L to service line below (24E)) **22. SUBMISSION CODE** **23. PRIOR AUTHORIZATION NUMBER**

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY **B. PLACE OF SERVICE** (EMG) **C. PROCEDURES, SERVICES, OR SUPPLIES** (Explain Unusual Circumstances) **D. DIAGNOSIS** **E. CHARGES** **F. CHARGES** **G. CHARGES** **H. CHARGES** **I. CHARGES** **J. CHARGES**

25. FEDERAL TAX I.D. NUMBER **26. PATIENT'S ACCOUNT NO.** **27. ACCEPT ASSIGNMENT?** YES ☐ NO ☐ **28. TOTAL CHARGE** \$ **29. AMOUNT PAID** \$ **30. BILLING PROVIDER INFO & PH #** ()

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **32. SERVICE FACILITY LOCATION INFORMATION** **33. BILLING PROVIDER INFO & PH #** ()

34. SIGNATURE OF PHYSICIAN OR SUPPLIER **35. DATE**

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMS-0998-1197 FORM 1500 (02-12)

7.4.1 Instructions for Completing the CMS-1500 Claim Form

Claim Item	Title	Required	Conditionally Required	Action/Description
1	Insurance Type	X		Place an "X" in the "Medicaid" box.
1a	Insured's ID Number	X		Enter the clients' ten (10) digit Medicaid ID number that appears on the Medicaid Identification card.
2	Patient's Name	X		Enter the client's last name, first name, and middle initial.
3	Patient's Date of Birth/Sex			Information that will identify the patient and distinguishes persons with similar names
4	Insured's Name		X	Enter the insured's full last name, first name, and middle initial. Insured's name identifies who holds the policy if different than Patient information.
5	Patient's Address			This refers to patient's permanent residence.
6	Patient's Relationship to Insured		X	If the client is covered by other insurance, mark the appropriate box to show relationship.
7	Insured's Address		X	Enter the address of the insured.
8	Patient Status			Indicates patient's marital and employment status
Instruct ions for 9a-d	Other Insurance Information		X	If item number 11d is marked, complete fields 9 and 9a-d.
9	Other Insured's Name		X	When additional group health coverage exists, enter other insured's full last name, first name and middle initial of the enrollee if different from item number 2.
9a	Other Insured's Policy or Group Name		X	Enter the policy or group number of the other insured.
9b	Reserved for NUCC Use			
9c	Reserved for NUCC Use			
9d	Insurance Plan or Program Name		X	Enter the other insured's insurance plan or program name.
10a-c	Is Patient's Condition Related to?		X	When appropriate, enter an X in the correct box to indicate whether one or more the services described in Item Number 24 are for a condition or injury the occurred on the job or as a result of an auto accident.

Common Billing Information – CMS-1500

Claim Item	Title	Required	Conditionally Required	Action/Description
10d	Reserved for Local Use			
11	Insured's Policy, group or FECA Number		X	Enter the insured's policy or group number as it appears on the ID card. Only complete if Item Number 4 is completed.
11a	Insured's Date of Birth, Sex		X	Enter the 8- digit date of birth (MM/DD/CCYY) and an X to indicate the sex of the insured.
11b	Insured's Employer's Name or School Name		X	Enter the Name of the insured's employer or school.
11c	Insurance Plan Name or Program Name		X	Enter the insurance plan or program name of the insured.
11d	Is there another Health Benefit Plan?		X	When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a-d.
12	Patient's or Authorized Person's Signature			Indicates there is an authorization on file for the release of any medical or other information necessary to process the claim.
13	Payment Authorization Signature			Indicates that there is a signature on file authorizing payment of medical benefits
14	Date of current illness, injury or pregnancy	X		Enter the date of illness, injury or pregnancy.
15	If Patient has had Same or Similar Illness			A patient having had same or similar illness would indicate that the patient had a previously related condition.
16	Date Patient Unable to Work in Current Occupation			Time span the patient is or was unable to work.
17	Name of Referring Physician			Enter the name and credentials of the professional who referred, ordered or supervised the service on the claim.
17a	17a Other ID #	X		Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right.

Common Billing Information – CMS-1500

Claim Item	Title	Required	Conditionally Required	Action/Description
17b	NPI #	X		Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.
18	Hospitalization Dates Related to Current Service			The hospitalization dates related to current services would refer to an inpatient stay and indicates admission and discharge dates.
19	Reserved for Local Use			
20	Outside lab? \$ Charges			Indicates that services have been rendered by an independent provider as indicated in Item Number 32 and related Costs.
21	ICD Indicator Diagnosis or Nature of Illness or Injury	X		Enter the ICD-9 or ICD-10 indicator Enter the patient's diagnosis/condition. List up to twelve ICD-PCM codes. Use the highest level of specificity. Do not provide a description in this field.
22	Medicaid Resubmission Code			The code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim
23	Prior Authorization		X	Enter the ten (10)-digit Prior Authorization number from the approval letter, if applicable. Claims for these services are subject to service limits and the 12 month (365 days) filing limit.
24	Claim Line Detail			Supplemental information is to be placed in the shaded sections of 24A through 24G as required by individual payers. Medicaid requires information such as NDC and taxonomy in the shaded areas as defined in each Item Number
24A	Dates of Service	X		Enter date(s) of service, from and to. If one (1) date of service, only enter that date under "from". Leave "to" blank or reenter "from" date. Enter as MM/DD/YY. NDC qualifier and NDC code will be placed in the shaded area. For detailed information on billing with the corresponding NDC codes, refer to the NDC entry information following this instruction table.
24B	Place of Service	X		Enter the two (2)-digit Place of Service (POS) code for each procedure performed.

Common Billing Information – CMS-1500

Claim Item	Title	Required	Conditionally Required	Action/Description
24C	EMG	X		This field is used to identify if the service was an emergency. Provider must maintain documentation supporting an emergency indicator. Enter Y for “YES” or leave blank or enter N for “NO” in the bottom, un-shaded area of the field. This field is situational, but required when the service is deemed an emergency
24D	Procedures, Services, or Supplies	X		Enter the CPT or HCPCS codes and modifiers from the appropriate code set in effect on the date of service.
24E	Diagnosis Pointer	X		Enter the Diagnosis Code Reference Letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. Do Not enter any diagnosis codes in this box.
24F	\$ Charges	X		Enter the charge for each listed service.
24G	Days or Units	X		Enter the units of services rendered for each detail line. A unit of service is the number of times a procedure is performed. If only one (1) service is performed, the numeral 1 must be entered.
24H	EPSDT/Family Plan		X	Identifies certain services that may be covered under some state plans
24I	ID Qualifier		X	If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area (Chapter 11, Wyoming Specific HIPAA 5010).
24J	Rendering Provider ID #		X	The individual rendering the service is reported in 24J. Enter the taxonomy code in the shaded area of the field. Enter the NPI number in the un-shaded area of the field. Report the Identification Number in Items 24I and 24J only when different from the data in Items 33a and 33b.
25	Federal Tax ID Number			Refers to the unique identifier assigned by a federal or state agency.
26	Patient’s Account Number			The patient’s account number refers to the identifier assigned by the provider (optional).

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

7.4.2 Place of Service

Place of Service	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system.
03	School	A facility whose primary purpose is education

Place of Service	Place of Service Name	Place of Service Description
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	N/A
11	Office	Location, Other than a Hospital, Skilled Nursing Facility, Military treatment Facility, Community Health Center, State or Local Public Health Clinic, or Intermediate Care Facility, where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a Hospital or other Facility, where the patient receives care in a private session

Place of Service	Place of Service Name	Place of Service Description
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24-hours a day, seven (7) days a week, with the capacity to deliver or arrange for services including some healthcare and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and / or behavioral services, custodial service, and minimal services (e.g., medication administration)
15	Mobile Unit	A facility / unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and / or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in-health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment-Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a Hospital, which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require Hospitalization or Institutionalization
23	Emergency Room – Hospital	A portion of a Hospital where emergency diagnosis and treatment of illness or injury is provided

Common Billing Information – CMS-1500

Place of Service	Place of Service Name	Place of Service Description
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis
25	Birth Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants
26	Military Treatment Facility	A medical facility operated by one (1) or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Services (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled, nursing care and related services to patients who require medical, nursing, or rehabilitation services but does not provide the level of care of treatment available on a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

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

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

7.5 Medicare Crossovers

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

7.5.1 General Information

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

7.5.2 Billing Information

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

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

7.6 Examples of Billing

7.6.1 Client has Medicaid Coverage Only or Medicaid and Medicare Coverage

HEALTH INSURANCE CLAIM FORM									
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12									
<div> <div> </div> <div> <div>1. MEDICARE</div> <div>2. MEDICAID</div> <div>3. TRICARE</div> <div>4. CHAMPVA</div> <div>5. GROUP HEALTH PLAN</div> <div>6. FECA</div> <div>7. OTHER</div> </div> </div>									
<div> <div> <div>1a. INSURED'S I.D. NUMBER</div> <div>0600XXXXXX</div> </div> <div> <div>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</div> <div>SAMPLE CLIENT</div> </div> </div>									
<div> <div> <div>3. PATIENT'S BIRTH DATE</div> <div>09 01 1976</div> </div> <div> <div>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div></div> </div> </div>									
<div> <div> <div>5. PATIENT'S ADDRESS (No., Street)</div> <div>123 THIS STREET</div> </div> <div> <div>6. PATIENT'S RELATIONSHIP TO INSURED</div> <div>Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></div> </div> </div>									
<div> <div> <div>7. INSURED'S ADDRESS (No., Street)</div> <div></div> </div> <div> <div>8. RESERVED FOR NUCC USE</div> <div></div> </div> </div>									
<div> <div> <div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div></div> </div> <div> <div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div> <div>a. EMPLOYMENT? (Current or Previous)</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div> </div> </div> </div>									
<div> <div> <div>11. INSURED'S POLICY GROUP OR FECA NUMBER</div> <div></div> </div> <div> <div>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</div> <div>JOHN SMITH MD</div> </div> </div>									
<div> <div> <div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</div> <div></div> </div> <div> <div>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)</div> <div>09 30 2015</div> </div> </div>									
<div> <div> <div>15. OTHER DATE</div> <div></div> </div> <div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div></div> </div> </div>									
<div> <div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div> <div>JOHN SMITH MD</div> </div> <div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</div> <div></div> </div> </div>									
<div> <div> <div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</div> <div></div> </div> <div> <div>20. OUTSIDE LAB?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div> </div>									
<div> <div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</div> <div>A. ICD-10: 200.121</div> </div> <div> <div>22. RESUBMISSION CODE</div> <div></div> </div> </div>									
<div> <div> <div>23. PRIOR AUTHORIZATION NUMBER</div> <div></div> </div> <div> <div>24. A. DATE(S) OF SERVICE</div> <div>10 01 15</div> </div> </div>									
<div> <div> <div>25. FEDERAL TAX I.D. NUMBER</div> <div>000000000</div> </div> <div> <div>26. PATIENT'S ACCOUNT NO.</div> <div>200345</div> </div> </div>									
<div> <div> <div>27. ACCEPT ASSIGNMENT?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div> <div> <div>28. TOTAL CHARGE</div> <div>\$ 100.00</div> </div> </div>									
<div> <div> <div>29. AMOUNT PAID</div> <div>\$ 100.00</div> </div> <div> <div>30. Rsvd for NUCC Use</div> <div></div> </div> </div>									
<div> <div> <div>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</div> <div>JOHN DOE MD 10/6/15</div> </div> <div> <div>32. SERVICE FACILITY LOCATION INFORMATION</div> <div>THIS TOWN MEDICAL OFFICE 123 MEDICAL DRIVE THIS TOWN, WY 82009</div> </div> </div>									
<div> <div> <div>33. BILLING PROVIDER INFO & PH #</div> <div>THE PEDIATRIC OFFICE 456 PROVIDER DRIVE THIS TOWN, WY 82003</div> </div> <div> <div>34. BILLING PROVIDER INFO & PH #</div> <div></div> </div> </div>									

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

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Revision: January 1, 2021

7.7 National Drug Code (NDC) Billing Requirement

Medicaid requires provider 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/manufacture under Federal Drug Administration (FDA) regulations. It is comprised of three (3) segments configured in a 5-4-2 format.

6 5 2 9 3	-	0 0 0 1	-	0 1
└──────────┘		└──────────┘		└───┘
Labeler Code		Product Code		Package Code
(5 Digits)		(4 Digits)		(2 Digits)

- **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.

7.7.1 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 three (3) 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.

7.7.2 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 (1) 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.

7.7.3 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 code information such as dates of service, CPT/HCPCS code, modifier(s), charges, and units.

7.7.4 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.

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

7.7.5 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.

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.

7.7.6 Medicare Crossover Claims

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

7.7.7 CMS-1500 02-12 Billing Instructions

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

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

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

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

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

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

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

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

7.8 Service Thresholds

7.8.1 Under Age 21

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

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

7.8.2 Ages 21 and older

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

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

OFFICE AND OUTPATIENT HOSPITAL VISITS		
Codes	Service Threshold	Does not apply to:
Procedure Codes: 99281-99285 99201-99215 Revenue Codes: 0450-0459 0510-0519	12 combined visits per calendar year	<ul style="list-style-type: none">• Clients Under Age 21• Emergency Visits• Family Planning Services• Medicare Paid Crossovers

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

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, BEHAVIORAL HEALTH VISITS, CHIROPRACTIC VISITS AND DIETITIAN		
Codes	Service Threshold	Does not apply to:
<p>Procedure codes: 90785; 90791; 90792; 90832-90834; 90836- 90839; 90845-90849; 90853; 90857; 92507- 92508; 92526; 92609; 96105-96146; 97010- 97039; 97110-97150; 97161-97546; 97802- 97804; 98940-98942; (all modalities on same date of service count as 1 visit)</p> <p>HCPCS Level II codes: G9012; H0004; H0031; H0038; H0046, H2010; H2014; H2017; H2019; S9480, T1017 (all modalities on same date of service count as 1 visit)</p> <p>Revenue codes: 0421-0449 (each unit counts as 1 visit)</p>	<p>20 physical therapy visits per calendar year</p> <p>20 occupational therapy visits per calendar year</p> <p>30 speech therapy visits per calendar year</p> <p>Behavioral Health Visits:</p> <ul style="list-style-type: none"> • 2020 dates of service and prior - threshold of 30 visits per calendar year applies to clients 21 and over only • 2021 dates of service and forward - threshold applies to all clients <p>Chiropractic Visits:</p> <ul style="list-style-type: none"> • 2020 dates of service and prior - 20 chiropractic visits per calendar year • 2021 dates of service and forward – Chiropractic services are not covered <p>Dietitian Visits:</p> <ul style="list-style-type: none"> • 2020 dates of service and prior - 20 dietitian visits per calendar year • 2021 dates of service and forward - no threshold on visits 	<ul style="list-style-type: none"> • Medicare Paid Crossovers • Inpatient and ER behavioral health services

7.8.3 Authorization of Medical Necessity

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

- Dietitian visits
- Chiropractic visits

Authorizations of Medical Necessity must be submitted on the Authorization of Medical Necessity form and cite specific medical necessity. See section [7.8.3.1, Authorization of Medical Necessity Request Form](#) below.


The form must be mailed to:

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

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

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

7.8.3.1 Authorization of Medical Necessity Request Form

 <p>Wyoming Department of Health</p>			<h2>Authorization of Medical Necessity</h2>		
1) Pay to (Group) NPI:		2) Pay to (Group) Name:		3) Service Type (Select one):	
4) Taxonomy Code:		5) Contact Email:		<input type="checkbox"/> Chiropractic Services <input type="checkbox"/> Dietician Services	
6) Treating/Rendering NPI:		7) Treating/Rendering Name:			
8) Client ID:		9) Client Name:		10) Frequency:	
11) Request Year:		12) Begin Date:		# visits _____ per <input type="checkbox"/> Week <input type="checkbox"/> Month	
13) ICD-10 Diagnosis Code(s) up to 4:		14) End Date:		15) Date of Condition Onset:	
1) 2) 3) 4)					
16a) Describe injury, illness, surgery or triggering event that initiated the need for service:					
16b) Describe need for medically necessary service. Include progress to date to include treatment methods, goals, level of improvement, and dates of treatment:					
16c) Describe anticipated length of additional treatment:					
<small>In signing and dating this document you are attesting that this form was completed to the best of your knowledge and belief, that all information and data in the Authorization of Medical Necessity are true, accurate and complete, and contains no false or erroneous information.</small>				FISCAL AGENT USE ONLY	
17) TREATING Provider Signature: _____					
18) Date: _____					
<small>Submit form to ATTN Medical Policy: MAIL: Wyoming Medicaid, PO Box 667, Cheyenne, WY 82003 FAX: 307-772-8405 EMAIL: WYMedPol@conduent.com</small>					

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

7.8.3.2 Instructions for Completing the Authorization of Medical Necessity Request Form

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

*16c	Describe anticipated length of additional treatment:	Describe the anticipated progress and length needed for the additional treatment
*17	Treating Provider signature:	The provider who is requesting the services must sign the form attesting to validity of request. Stamped, copied, and typed signatures will not be accepted.
*18	Signature Date:	The provider who is requesting the services must date the signature applied.

7.8.4 Office and Outpatient Hospital Visits Once Threshold is Met

Procedure Code Range: 99281 – 99285, 99201 – 99215

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

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

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

7.8.5 Prior Authorization Once Thresholds are Met

Once the threshold has been reached, or once the provider is aware the threshold will be met and the client is nearing the threshold, a Prior Authorization may be requested through WYhealth ([2.1, Quick Reference](#)) for the following services:

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

Requests can be made by:

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

7.9 Reimbursement Methodologies

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

- Medicaid fee schedule
- By report pricing
- Billed charges
- Invoice charges
- Negotiated rates
- Per diem
- Resource Based Relative Value Scale (RBRVS)

7.9.1 Invoice Charges

- Invoice must be dated within 12 months (365 days) prior to the date of service being billed – if the invoice is older, a letter must be included explaining the age of the invoice (i.e. product purchased in large quantity previously, and is still in stock)
- All discounts will be taken on the invoice.
- The discounted pricing or codes cannot be marked out.
- A packing slip, price quote, purchase order, delivery ticket, etc. may be used only if the provider no longer has access to the invoice, and is unable to obtain a replacement from the supplier/manufacturer, and a letter with explanation is included.
- Items must be clearly marked (i.e. how many calories are in a can of formula, items in a case, milligrams, ounces, etc.)

7.10 Usual and Customary Charges

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

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

7.11 Co-Payment Schedule

\$2.45 Co-Payment Schedule		
Procedure and Revenue Code(s)	Description	Exceptions
99201 – 99215	Office Visits only when the place of service code is 11	Co-payment requirements do not apply to: <ul style="list-style-type: none"> • Clients under age 21 <ul style="list-style-type: none"> ○ Medicaid eligibility for children is under 21 ○ Kid Care CHIP eligibility for children is under 19 NOTE: Co-Pays Apply to KIDC Benefit Plan (Kid Care CHIP Plans B & C) <ul style="list-style-type: none"> • Nursing Facility Residents • Pregnant Women
99341 -99350	Home Visits	
92002, 92004, 92014	Eye Examinations	
90804 – 90815	Medical psychotherapy – co-payment only applies when the place of service code is 11	

\$2.45 Co-Payment Schedule		
Procedure and Revenue Code(s)	Description	Exceptions
		<ul style="list-style-type: none"> • Family planning services • Emergency services • Hospice services • Medicare Crossovers • Members of a Federally recognized tribe

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

7.12 How to Bill for Newborns

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

7.13 Prior Authorization

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

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

Agency Name	Phone	Services Requiring PA
Division of Healthcare Financing (DHCF)	<p>Contact case manager</p> <p>Case manager will contact the DHCF</p>	<ul style="list-style-type: none"> • Community Choice Waiver (CCW) • Out-of-State Home Health • Out-of-State Placement for LTC Facilities • Comprehensive Developmental Disability Waivers • Support Developmental Disability Waivers

Common Billing Information – CMS-1500

Agency Name	Phone	Services Requiring PA
Change Healthcare	(877)207-1126	<ul style="list-style-type: none"> Pharmacy
Magellan	Tel (307)549-6162 8-5pm MST M-F (855)883-8740 (after hours) http://www.magellanofwyoming.com/	Care Management Entity services that include: <ul style="list-style-type: none"> Family Care Coordination Family Peer Support Partner Youth Peer Support Partner Youth and Family Training & Support Respite services
Medical Policy	(800)251-1268 Option 1, 1, 4, 3	<ul style="list-style-type: none"> Belimumab Injections Botox, Dysport, and Myobloc Injections Dental Implants & fixed bridges Hospice Services: Limited to clients residing in a nursing home Ilaris/Cankinumab Ocrevus/Ocrelizumab Oral & Maxillofacial Surgeries Pralatrexate Reslizumab (CINQAIR) IV Infusion Treatment Severe Malocclusion Specialized Denture Services Synvisc & Hylagen Injections Tysabri IV Infusion Treatment
WYhealth (Utilization and Care Management)	(888)545-1710	<ul style="list-style-type: none"> Acute Psych Cochlear Implant – 1x/5yrs Durable Medical Equipment (DME) Extended Psych Extraordinary Care Gastric Bypass Genetic Testing Home Health MedaCube Prosthetic and Orthotic Supplies (POS) PRTF – Psychiatric Residential Treatment Facility PT/OT/ST/BH once threshold has been met Surgeries (within rage 10000- 99999) that requires prior authorization Transplants Vagus Nerve Stimulator Vision – Lenses, Contacts, & Scleral Shells Unlisted Codes

NOTE: Services with a threshold that not listed here require an Authorization of Medical Necessity (AOMN) to be submitted to Medical Policy ([6.8.3, Authorization of Medical Necessity](#)).

7.13.1 Requesting an Emergency Prior Authorization

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

NOTE: Contact the other appropriate authorizing agencies for their pending/emergency PA procedures ([7.13, Prior Authorization](#)).


7.13.2 Requesting Prior Authorization from Medical Policy

This section only applies to providers requesting PA for certain surgeries and hospice services (limited to clients residing in a nursing home). For all other types of PA requests, contact the appropriate authorizing agencies listed above for their written PA procedures.

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

- Medicaid Prior Authorization Form ([7.13.2.1, Medicaid Prior Authorization Form](#)): A hardcopy form for requesting a PA by mail, email, or fax. For a copy of the form and instructions on how to complete it, refer to the following sections.
- X12N 278 Prior Authorization Request and Response. A standard electronic file format used to transmit PA requests and receive responses. For additional information, refer to [Chapter 10, Electronic Data Interchange \(EDI\)](#) and [Chapter 11, Wyoming Specific HIPAA 5010 Electronic Specifications](#); or
- Web-Based Entry (Limited to Medical Policy PA requests). A web-based option for entering PA requests and receiving responses via Medicaid Secured Provider Web Portal. For direction on entering a PA request through the Secured Provider Web Portal, view the Web Portal Tutorial found on the website ([2.1, Quick Reference](#)). For additional information, refer to [Chapter 10, Electronic Data Interchange \(EDI\)](#) and [Chapter 11, Wyoming Specific HIPAA 5010 Electronic Specifications](#).

7.13.2.1 Medicaid Prior Authorization Form



Wyoming
Department
of Health

Prior Authorization Request
To Avoid Delays – Please fill out Completely

☐ ADD
☐ MODIFY
☐ CANCEL

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

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

Rev. 7/2014

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

7.13.2.2 Instructions for Completing the Medicaid Prior Authorization Form

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

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

7.13.3 Prior Authorization Status Inquiry

Once a PA status is determined, providers will be able to view their determinations on the Provider Portal, including the 10-digit PA number. The complete 10-digit PA number must be entered in box 23 of the CMS-1500 02-12 claim form. For placement in an electronic X12N 837 Professional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.

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

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

To view a PA status:

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

7.14 Billing of Deliverables

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

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



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

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

- Print the “Order vs Delivery Date Exception Form,” ([7.14.1, Order vs Delivery Date Exception Form](#)).
- Complete the form and fax or mail it to the address at the bottom of the form
- Once the form is signed by the State, it will be returned to the provider and must be a part of the client’s permanent clinical record
- The provider may then bill the claim using the order date as the date of service

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

7.14.1 Order vs Delivery Date Exception Form

ORDER VS DELIVERY DATE BILLING ATTESTATION FORM

PROVIDER NAME: _____ NPI: _____

PROVIDER RETURN EMAIL: _____

CLIENT NAME: _____ MEDICAID ID#: _____

PROCEDURE CODE & DESCRIPTION: _____

ORDER DATE: _____ DELIVERY DATE: _____

DENTAL PROVIDERS

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

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

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

VISION PROVIDERS

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

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

☐ CLIENT DID NOT RETURN FOR GLASSES AND WHEN THE GLASSES WERE MAILED THEY WERE RETURNED TO OUR OFFICE DUE TO: _____

DME PROVIDERS

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

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

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

PROVIDER'S SIGNATURE

DATE

☐ APPROVED ☐ DENIED

STATE PROGRAM MANAGER, TITLE

DATE

THIS FORM MUST BE COMPLETED AND EMAILED TO: Lindsay.convers1@wyo.gov

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

7.15 Submitting Attachments for Electronic Claims

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

Steps for submitting electronic attachments:

- The fiscal agent has created a process that allows providers to submit electronic attachments for electronic claims. Providers need only follow these steps:
 1. Mark the attachment indicator on the electronic claim. For more information on the attachment indicator, consult the provider software vendor or clearinghouse, or the X12N 837 Professional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf
 2. Log onto the [Secured Provider Web Portal](#).
 3. Under the submissions menu select Electronic Attachments.
 4. Complete required information – Information must match the claim as submitted i.e. DOS, client information, provider information, and the name of the attachment must be identical to what was submitted in the in the electronic file (with no spaces).
 5. Navigate to the location of the electronic attachment on the provider's computer.
 6. Click Upload.
 7. For support and additional information, refer to [Chapter 10](#) and [Chapter 11](#) 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 ([7.15.1, Attachment Cover Sheet](#)) and mail it with the attachment to Claims ([2.1, Quick Reference](#)).

Steps for submitting paper attachments by email:

- The fiscal agent has created a process that allows providers to submit paper attachments for electronic claims. Provider need only follow these two (2) simple steps:
 1. Mark the attachment indicator on the electronic claim and indicate by mail as the submission method. For more information on the attachment indicator, consult the provider software vendor or clearinghouse, or the X12N 837 Professional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.
 - The data entered on the form must match the claim exactly in DOS, client information, provider information, etc.
 2. Complete the Attachment Cover Sheet ([7.15.1, Attachment Cover Sheet](#)) and email it with the attachment to wycustomersvc@conduent.com ([2.1, Quick Reference](#)).
 - All emails must come secured and cannot exceed 25 pages.

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

7.15.1 Attachment Cover Sheet

Attachment Cover Sheet																					
<p>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.</p> <p>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.</p>																					
Pay-to Provider Name:	<input style="width: 90%;" type="text"/>																				
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Must include no spaces and match the 837 file exactly																					
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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.

7.16 Sterilization, Hysterectomy, and Abortion Consent Forms

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

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

7.16.1 Sterilization Consent Form and Guidelines

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

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

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

FEDERAL GUIDELINES

The waiting period between consent and sterilization must not exceed 180 days and must be at least 30 days, except in cases of premature delivery and emergency abdominal surgery. The day the client signs the consent form and the surgical dates are not included in the 30-day requirement. For example, a client signs the consent form on July 1. To determine when the waiting period is completed, count 30-days beginning on July 2. The last day of the waiting period would be July 31; therefore, surgery may be performed on August 1.

In the event of premature delivery, the consent form must be completed and signed by the client at least 72-hours prior to the sterilization, and at least 30-days prior to the expected date of delivery.

In the event of emergency abdominal surgery, the client must complete and sign the consent form at least 72-hours prior to sterilization.

The consent form supplied by the surgeon must be attached to every claim for sterilization related procedures; i.e., ambulatory surgical center clinic, physician, anesthesiologist, inpatient or outpatient hospital. Any claim for a sterilization related procedure which does not have a signed and dated, valid consent form will be denied.

All blanks on the consent form must be completed with the requested information. The consent form must be signed and dated by the client, the interpreter (if one is necessary), the person who obtained the consent, and the physician who will perform the sterilization.

The physician statement on the consent form must be signed and dated by the physician who will perform the sterilization, on the date of the sterilization or after the sterilization procedure was performed. The date on the sterilization claim form must be identical to the date and type of operation given in the physician's statement.

7.16.1.1 Sterilization Consent Form

Sterilization Consent Form	
<p>NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.</p>	
<p>CONSENT TO STERILIZATION I have asked for and received information about sterilization from 1 _____ . When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or EqualityCare that I am now getting or for which I may become eligible.</p> <p>I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.</p> <p>I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.</p> <p>I understand that I will be sterilized by an operation known as a 2 _____ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.</p> <p>I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.</p> <p>I am at least 21 years or age and was born on 3 _____ Month Day Year</p> <p>4 I, _____, hereby consent of my own free will to be sterilized by 5 _____ (doctor) by a method called 6 _____. My consent expires 180 days from the date of my signature below.</p> <p>I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.</p> <p>I have received a copy of this form.</p> <p>7 _____ 8 Date: _____ Signature Month Day Year</p> <p>9 You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black (not of Hispanic origin) <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> White (not of Hispanic origin)</p> <p>INTERPRETER'S STATEMENT If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in 10 _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.</p> <p>11 _____ 12 _____ Signature of Interpreter Date</p>	<p>STATEMENT OF PERSON OBTAINING CONSENT Before 13 _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation 14 _____ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.</p> <p>I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.</p> <p>I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.</p> <p>To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.</p> <p>15 _____ 16 _____ Signature of person obtaining consent Date</p> <p>17 _____ Facility</p> <p>18 _____ Address</p> <p>PHYSICIAN'S STATEMENT Shortly before I performed a sterilization operation upon 19 _____ (name of individual to be sterilized) on 20 _____, (date of sterilization operation)</p> <p>I explained to him/her the nature of the sterilization operation 21 _____ (specify type of operation) the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.</p> <p>I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.</p> <p>I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.</p> <p>To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.</p> <p>Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.</p> <p>(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.</p> <p>(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):</p> <p><input type="checkbox"/> Premature delivery Individual's expected date of delivery: 22 _____ (Date)</p> <p><input type="checkbox"/> Emergency abdominal surgery: (describe circumstances): _____</p> <p>23 _____ 24 _____ Physician Date</p>

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

7.16.1.2 Instructions for Completing the Sterilization Consent Form

Important tips for completing the Sterilization Consent Form:

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

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

Section	Field #	Action
		<ul style="list-style-type: none"> • If premature delivery is checked, the provider must write in the expected date of delivery here. • If emergency abdominal surgery is checked, describe circumstances here.
	23	• Physician performing the sterilization signs here
	24	Physician performing the sterilization dates signature here

7.16.2 Hysterectomy Acknowledgment of Consent

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

NOTE: For instructions on attaching documents to claims, refer to [Section 7.15](#).

7.16.2.1 Hysterectomy Acknowledgement Consent Form

HYSTERECTOMY ACKNOWLEDGMENT OF CONSENT

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

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

Diagnosis:

Signature of Patient: _____ Date: _____

Signature of Person Explaining Hysterectomy: _____ Date: _____

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

On _____
(Date) (Physician)

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

Diagnosis: _____

Signature of Patient: _____ Date: _____

Signature of Person Explaining Hysterectomy: _____ Date: _____

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

Diagnosis: _____

Check which is applicable:

[] Other reason for sterility: _____

[] Previous tubal Date:

[] Emergency situation (describe)

Physician Signature
Date

HCF-03

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

7.16.2.2 Instructions for Completing the Hysterectomy Acknowledgment of Consent Form

Section	Field #	Action
Part A	1	Enter the name of the physician performing the surgery.
	2	Enter the narrative diagnosis for the client's condition.
	3	The client receiving the surgery signs here and dates.
	4	The person explaining the surgery signs here and dates.
Part B	5	Enter the date and the physician's name that performed the hysterectomy.
	6	Enter the narrative diagnosis for the client's condition.
	7	The client receiving the surgery signs here and dates.
	8	The person explaining the surgery signs here and dates.
Part C	9	Enter the narrative diagnosis for the client's condition.
	10	Check applicable box: <ul style="list-style-type: none">• If other reason for sterility is checked, the provider must write what was done.• If previous tubal is checked, the provider must enter the date of the tubal.• If emergency situation is checked, the provider must enter the description.
	11	<ul style="list-style-type: none">• The physician who performed the hysterectomy signs here and dates.

7.16.3 Abortion Certification Guidelines

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

7.16.3.1 Abortion Certification Form

ABORTION CERTIFICATION FORM

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

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

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

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

3. Patient Name: _____

4. Address: _____

5. Physician Signature: _____ Date _____

6. Address: _____

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

7.16.3.2 Instructions for Completing the Abortion Certification Form

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

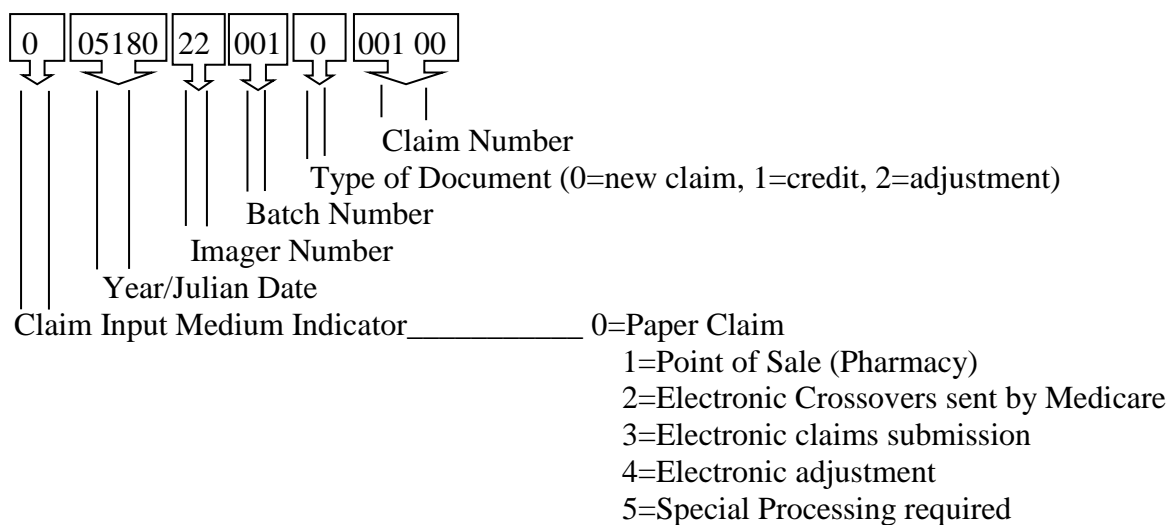
7.17 Remittance Advice

After claims have been processed weekly, Medicaid distributes a Medicaid proprietary Remittance Advice (RA) to providers. The RA plays an important communication role between providers and Medicaid. It explains the outcome of claims submitted for payment. Aside from providing a record of transactions, the RA assists providers in resolving potential errors. As of April 1 2020, all providers will receive electronic remittance advices. No paper remittance advices shall be mailed from the Agency after March 31, 2020. Any provider currently receiving paper checks should begin the process with the State Auditor's Office to move to electronic funds transfer. Any new providers requesting paper checks shall only be granted in temporary, extenuating circumstances.

The RA is organized in the following manner:

- The first page or cover page is important and should not be over looked as it may include an RA Banner notification from Wyoming Medicaid ([1.2, RA Banner Notices/Samples](#))
- Claims are grouped by disposition category.
 - Claim Status PAID group contains all the paid claims.
 - Claim Status DENIED group reports denied claims.
 - Claim Status PENDED group reports claims pending for review. Do not resubmit these claims. All claims in pending status are reported each payment cycle until paid or denied. Claims can be in a pending status for up to 30 days.
 - Claim Status ADJUSTED group reports adjusted claims.
- All paid, denied, and pending claims and claim adjustments are itemized within each group in alphabetic order by client last name.
- A unique Transaction Control Number (TCN) is assigned to each claim. TCNs allow each claim to be tracked throughout the Medicaid claims processing

system. The digits and groups of digits in the TCN have specific meanings, as explained below:



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

Common Billing Information – CMS-1500

7.17.1 Sample Professional Remittance Advice

WYOMING DEPARTMENT OF HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 00/00/00

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

TO: SAMPLE PROVIDER R.A. NO.: 0101010 DATE PAID: 00/00/00 PROVIDER NUMBER: 123456789/1234567890 PAGE: 1
TRANS-CONTROL-NUMBER BILLED MCARE COPAY OTHER DEDUCT- COINS MCAID WRITE TREATING
LI SVC-DATE PROC/MODS UNITS AMT. PAID AMT. INS. IBLE AMT. PAID OFF PROVIDER S PLAN
* * * CLAIM TYPE: HCFA 1500 * * * CLAIM STATUS: DENIED

ORIGINAL CLAIMS:

* BRADY TOM RECIP ID: 0000012345 PATIENT ACCT #: 00000
0-03000-22-000-0006-10 80.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
HEADER EOB(S): 300 147

01 04/28/15 42830 1 80.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 1234567890 K LTCS

* MANNING PEYTON RECIP ID: 0800000001 PATIENT ACCT #: 00001
0-03000-22-000-0006-12 80.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
HEADER EOB(S): 300 147

01 05/02/15 69436 1 80.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 1234567890 K NH

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:

147 THE TREATING PROVIDER TYPE IS NOT VALID WITH THE PROCEDURE CODE. 4
300 THE PROVIDER NUMBER CANNOT BE BILLED ON THIS CLAIM TYPE. VERIFY THE PROVIDER IS 4

USING THE CORRECT PROVIDER NUMBER FOR THIS CLAIM TYPE AND RESUBMIT.

7.17.2 How to Read the Remittance Advice

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

FIELD NAME	HEADER DESCRIPTION
To	Provider Name
R.A. Number	Remittance Advice Number assigned.
Date Paid	Payment date.
Provider Number	Medicaid provider number/NPI number
Page	Page Number
Last, MI, and First	The client's name as found on the Medicaid ID Card.
Recip ID	The client's Medicaid ID Number.
Patient Acct #	The patient account number reported by the provider on the claim.
Trans Control Number	Transaction Control Number: The unique identifying number assigned to each claim submitted.
Billed Amt.	Total amount billed on the claim
Mcare Paid	Amount paid by Medicare
Copay Amt.	The amount due from the client for their co-payment.
Other Ins.	Amount paid by other insurance.
Deductible	Medicare deductible amount.
Coins Amt.	Medicare coinsurance amount.
Mcaid Paid	The amount paid by Medicaid
Write off	Difference between Medicaid paid amount and the providers' billed amount.
Header EOB(s)	Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA
Li	The line item number of the claim.
Svc date	The date of service.
Proc / Mods	The procedure code and applicable modifier.
Units	The number of units submitted.
Billed Amt.	Total amount billed on the line.
Mcare Paid	Amount paid by Medicare
Copay Amt.	The amount due from the client for their co-payment.
Other Ins.	Amount paid by other insurance.
Deductible	Medicare deductible amount.
Coins Amt.	Medicare coinsurance amount.
Mcaid Paid	The amount paid by Medicaid
Write off	Difference between Medicaid paid amount and the providers' billed amount.
Treating Provider	The treating provider's NPI number.
S	How the system priced each claim. For example, claims priced manually have a distinct code. Claims paid according to the Medicaid fee schedule have another code. Below is a table which describes these pricing source codes:

FIELD NAME	HEADER DESCRIPTION	
	A= Anesthesia B= Billed Charge C= Percent-of-Charges D= Inpatient Per Diem Rate E= EAC Priced Plus Dispensing Fee F= Fee Schedule G= FMAC Priced Plus Dispensing Fee H= Encounter Rate I= Institutional Care Rate J= Calculated Medicaid Crossover K= Denied L= Maximum Suspend Ceiling M= Manually Priced N= Provider Charge Rate O= Relative Value Units TC P= Prior Authorization Rate Q= DRG HCAC Pricing Reduction P= Prior Authorization Rate Q= DRG HCAC Pricing Reduction	R= Relative Value Unit Rate S= Relative Value Unit PC T= Fee Schedule TC U= Priced by NDC V= RBRVS W= Drug Standard Rate X= Medicare Coinsurance and Deductible Y= Fee Schedule PC Z= Fee Plus Injection 1= LOC Per Diem 2= LOC Outlier Applied 3= Maximum Fee For Emergency 4= Pricing Using Procedure 5= APC Priced 6= APC Bundled 7= DRG Standard Rate with Outlier 8= DRG Transfer 9= DRG Transfer with Outlier
Plan	The Medicaid and State Healthcare Benefit Plan the client is eligible for (Section A.3).	
Line EOB(s)	Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA	

7.17.3 Remittance Advice Replacement Request Policy

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

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

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

RAs less than 24 weeks old can be obtained from the Secured Provider Web Portal, once a provider has registered for access ([10.5.2.1, 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

7.17.3.1 Remittance Advice (RA) Replacement Request Form

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

Provider Name (as enrolled with Wyoming Medicaid): _____

Provider NPI: _____ Provider Taxonomy: _____

OR

Wyoming Medicaid Provider ID: _____

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

To request a complete RA:

RA Number: _____

RA Date: _____

RA Amount: _____

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

Specific Claim TCN: _____

Specific Claim Client ID and Date of Service: _____

Delivery Method (select one):

☐ Email Address (preferred): _____

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

☐ Mailing Address: _____

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

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

Enclosed Check Info:

Total Amount: _____

Check Number: _____

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

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

7.17.4 Obtain an RA from the Web

Providers have the ability to view and download their last 24 weeks of RAs from the Medicaid website, refer to [Chapter 10, Electronic Data Interchange \(EDI\)](#).

7.17.5 When a Client Has Other Insurance

If the client has other insurance coverage reflected in Medicaid records, payment may be denied unless providers report the coverage on the claim. Medicaid is always the payer of last resort. For exceptions and additional information regarding Third Party Liability, refer to [Chapter 9](#) of this manual. To assist providers in filing with the other carrier, the following information is provided on the RA directly below the denied claim:

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

The information is specific to the individual client. The Third Party Resources Information Sheet ([9.2.1, Third Party Resources Information Sheet](#)) should be used for reporting new insurance coverage or changes in insurance coverage on a client's policy.

7.18 Resubmitting Versus Adjusting Claims

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

Action	Description	Timely Filing Limitation
VOID	Claim has paid; however, the provider would like to completely cancel the claim as if it was never billed.	May be completed any time after the claim has been paid.
ADJUST	Claim has paid, even if paid \$0.00; however, the provider would like to make a correction or change to this paid claim.	Must be completed within 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.

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

The deadlines for resubmitting and adjusting claims are different:

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

7.18.2 Resubmitting a Claim

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

How to Resubmit:

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

7.18.2.1 When to Resubmit to Medicaid

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

7.18.3 Adjusting or Voiding Paid Claims

When a provider identifies an error on a paid claim, the provider must submit an [Adjustment/Void Request Form](#). If the incorrect payment was the result of a keying error (paper claim submission), by the fiscal agent contact Provider Relations to have the claim corrected ([2.1, Quick Reference](#)).

Denied claims cannot be adjusted.

When adjustments are made to previously paid claims, Medicaid reverses the original payment and processes a replacement claim. The result of the adjustment appears on the RA/835 transaction as two (2) transactions. The reversal of the original payment will appear as a credit (negative) transaction. The replacement claim will appear as a debit (positive) transaction and may or may not appear on the same RA/835 transaction as the credit transaction. The replacement (debit) claim will have almost the same TCN as the credit transaction, except the 12th digit will be a two (2), indicating an adjustment, whereas the credit will have a one (1) in the 12th digit indicating a credit.

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

7.18.3.1 When to Request an Adjustment

- When a claim was overpaid or underpaid.
- When a claim was paid, but the information on the claim was incorrect (such as client ID, date of service, procedure code, diagnoses, units, etc.)
- When Medicaid pays a claim and the provider subsequently receives payment from a third party payer, the provider must adjust the paid claim to reflect the TPL amount paid.
 - If an adjustment is submitted stating that TPL paid on the claim, but the TPL paid amount is not indicated on the adjustment or an EOB is not sent in with the claim, Medicaid will list the TPL amount as either the billed or reimbursement amount from the adjusted claim (whichever is greater). It will be up to the provider to adjust again, with the corrected information.
 - Attach a corrected claim showing the insurance payment and attach a copy of the insurance EOB if the payment is less than 40% of the total claim charge.
 - For the complete policy regarding Third Party Liability, refer to [Chapter 9](#).

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

7.18.3.2 When to Request a Void

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

7.18.3.3 How to Request an Adjustment/Void

To request an adjustment, use the Adjustment/Void Request Form ([7.18.3.1, 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.”

7.18.3.4 Adjustment/Void Request Form

Adjustment/void Request Form	
EXHIBIT 6.9	
ADJUSTMENT/VOID REQUEST FORM	
SECTION A: CHECK BOX 1a), 1b) OR 2)	
<input type="checkbox"/> 1a) CLAIM ADJUSTMENT: Attach a copy of the claim with corrections made in BLUE ink . DO NOT USE HIGHLIGHTER <input type="checkbox"/> 1b) VOID CLAIM: Attach a copy of the claim or Remittance Advice. Complete Sections B and C. If attaching a check, the check should be payable to Division of Healthcare Financing (DHCF) .	<input type="checkbox"/> 2) CANCELLATION OF THE ENTIRE REMITTANCE ADVICE. Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances. Complete Section C only. Attach RA. If manual check attach the check from the DHCF or if EFT make check payable to the DHCF for the entire remit amount.
SECTION B	
TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:	
1. 17-DIGIT TCN: <div style="border: 1px solid black; width: 100px; height: 15px; margin: 5px 0;"></div>	2. PAYMENT DATE: <div style="border: 1px solid black; width: 100px; height: 15px; margin: 5px 0;"></div>
3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER: <div style="border: 1px solid black; width: 100px; height: 15px; margin: 5px 0;"></div>	4. PROVIDER NAME: <div style="border: 1px solid black; width: 100px; height: 15px; margin: 5px 0;"></div>
5. 10-DIGIT CLIENT NUMBER: <div style="border: 1px solid black; width: 100px; height: 15px; margin: 5px 0;"></div>	6. 10-DIGIT PA NUMBER: <div style="border: 1px solid black; width: 100px; height: 15px; margin: 5px 0;"></div>
7. REASON FOR ADJUSTMENT OR VOID: <div style="border: 1px solid black; width: 100%; height: 15px; margin: 5px 0;"></div>	
SECTION C: SIGNATURE AND DATE REQUIRED	
PROVIDER SIGNATURE: _____ DATE: _____ <div style="text-align: center;"> RETURN ALL REQUESTS TO: WYOMING MEDICAID ATTN: CLAIMS PO BOX 547 CHEYENNE, WY 82003-0547 </div>	
REMARKS/STATUS: _____ (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.

7.18.3.5 How to Complete the Adjustment/Void Request Form

Section	Field #	Field Name	Action
A	1a, 1b	Claim Adjustment	Mark this box if any adjustments need to be made to a claim. Attach a copy of the claim with corrections made in BLUE ink (do not use red ink or highlighter) or the RA. Attach all supporting documentation required to process the claim, i.e. EOB, EOMB, consent forms, invoice, etc.
		Void Claim	Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the Remittance Advice.
			Sections B and C must be completed.
B	1	17-digit TCN	Enter the 17-digit transaction control number assigned to each claim from the Remittance Advice.
	2	Payment Date	Enter the Payment Date
	3	Nine (9) digit Provider or ten (10) digit NPI Number	Enter provider’s nine (9)-digit Medicaid provider number or ten (10)-digit NPI number, if applicable.
	4	Provider Name	Enter the provider name.
	5	Ten (10) digit Client Number	Enter the client’s ten (10)-digit Medicaid ID number.
	6	Ten (10) digit PA Number	Enter the ten (10)-digit Prior Authorization number, if applicable.
	7	Reason for Adjustment or Void	Enter the specific reason and any pertinent information that may assist the fiscal agent.
C		Provider Signature and Date	Signature of the provider or the providers’ authorized representative and the date.

7.18.3.6 Adjusting a claim electronically via an 837 transaction

Wyoming Medicaid accepts claim adjustments electronically, refer to Chapter 11, Wyoming Specific HIPAA 5010 Electronic Specifications ([11.10, 837 Professional Claims Transaction](#)) for complete details.

7.19 Credit Balances

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

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

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

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

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

7.20 Timely Filing

The Division of Healthcare Financing adheres strictly to its timely filing policy. The provider must submit a clean claim to Medicaid within 12 months (365 days) of the date of service. A clean claim is an error free, correctly completed claim, with all required attachments, that will process and approve to pay within the twelve month (365 days) time period. Submit claims immediately after providing services so that, when a claim is denied, there is time to correct any errors and resubmit. Claims are to be submitted only after the service(s) have been rendered, and not before. For deliverable items (i.e. dentures, DME, glasses, hearing aids, etc.) the date of service must be the date of delivery, not the order date.

7.20.1 Exceptions to the Twelve Month (365 days) Limit

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

Exceptions Beyond the Control of the Provider	
When the Situation is:	The Time Limit is:
Medicare Crossover	A Claim must be submitted within 12 months (365 days) of the date of service or within 6 months (180 days) from the payment date on the Explanation of Medicare Benefits (EOMB), whichever is later
Client is determined to be eligible on appeal, reconsideration, or court decision (retroactive eligibility)	Claims must be submitted within 6 months (180 days) of the date of the determination of retroactive eligibility. The client must provide a copy of the dated letter to the provider to document retroactive eligibility. If a claim exceeds timely filing and the provider elects to accept the client as a Medicaid client and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be a SSI award notice or a notice from WDH.

Exceptions Beyond the Control of the Provider	
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.

7.20.2 Appeal of Timely Filing

A provider may appeal a denial for timely filing **ONLY** under the following circumstances:

- The claim was originally filed within 12 months (365 days) of the date of service and is on file with Wyoming Medicaid; and
- The provider made at least one (1) attempt to resubmit the corrected claim within 12 months (365 days) of the date of service; and
- The provider must document in their appeal letter all claims information and what corrections they made to the claim (all claims history, including TCNs) as well as all contact with or assistance received from Provider Relations (dates, times, call reference number, who was spoken with, etc.) or
- A Medicaid computer or policy problem beyond the provider's control 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.

7.20.2.1 How to Appeal

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

- Documentation of previous claim submission (TCNs, documentation of the corrections made to the subsequent claims);

- Documentation of contact with Provider Relations;
- An explanation of the problem; and
- A clean copy of the claim, along with any required attachments and required information on the attachments. A clean claim is an error free, correctly completed claim, with all required attachments, that will process and pay.

7.21 Important Information Regarding Retroactive Eligibility Decisions

The client is responsible for notifying the provider of the retroactive eligibility determination and supplying a copy of the notice.

A provider is responsible for billing Medicaid only if:

- They agreed to accept the patient as a Medicaid client pending Medicaid eligibility; or
- After being informed of retroactive eligibility, they elect to bill Medicaid for services previously provided under a private agreement. In this case, any money paid by the client for the services being billed to Medicaid would need to be refunded prior to a claim being submitted to Medicaid.

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

In the event of retroactive eligibility, claims must be submitted within 6 months (180 days) of the date of determination of retroactive eligibility.

NOTE: Inpatient Hospital Certification: A hospital may seek admission certification for a client found retroactively eligible for Medicaid benefits after the date of admission for services that require admission certification. The hospital must request admission certification within 30 days after the hospital receives notice of eligibility. To obtain certification, contact WYhealth ([2.1, Quick Reference](#)).

7.22 Client Fails to Notify Provider of Eligibility

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

- Any money paid by the client for the service being billed to Wyoming Medicaid must be refunded prior to billing Medicaid;

- The client can no longer be billed for the service; and
- Timely filing criterion is in effect.

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

7.23 Billing Tips to Avoid Timely Filing Denials

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

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

7.24 Telehealth

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

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

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

include Community Mental Health Centers and Substance Abuse Treatment Centers. A single pay to provider can bill both the originating site (spoke site) and the distant site provider (hub site) when applicable. See below for billing and documentation requirements.

7.24.1 Covered Services

Originating Sites (Spoke Site)

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

Authorized originating sites are:

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

Distant Site Providers (Hub Site)

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

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

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

- Board Certified Behavior Analyst
- Speech Therapist

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

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

7.24.2 Non-Covered Services

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

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

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

7.24.3 Documentation Requirements

- Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented and monitored.
- Providers need to develop and document evaluation processes and patient outcomes related to the telehealth program, visits, provider access, and patient satisfaction.

- All service providers are required to develop and maintain written documentation in the form of progress notes the same as is originated during an in-person visit or consultation with the exception that the mode of communication (i.e. teleconference) should be noted.
- Documentation must be maintained at the hub and spoke locations to substantiate the services provided. Documentation must indicate that the services were rendered via telehealth and must clearly identify the location of the hub and spoke sites.

7.24.4 Billing Requirements

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

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

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

- Additional services provided at the originating site on the same date as the telehealth service may be billed and reimbursed separately according to published policies and the national correct coding initiative guidelines.
- For ESRD-related services, at least one (1) face-to-face, "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a qualified provider.
- Care Management Entity/Children's Mental Health Waiver service providers (CME providers) are to use Place of Service code 02-Telehealth per their

provider agreement with Magellan Healthcare. CME providers are NOT to use the “GT” modifier or “Q3014-Telehealth Originating Site Facility Fee” codes for virtual services.

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

7.24.4.1 Billing Examples

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

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

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

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

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

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

7.24.5 Telehealth Consent

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

- Verbally
- Email
- Text Message

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

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8.1 Electronic Billing

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

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

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

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

Mail requests to:

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

A new exemption request must be submitted for each calendar year. Wyoming Medicaid has free software or applications available for provider to bill electronically ([Chapter 10, Electronic Data Interchange \(EDI\)](#)).

8.2 Basic Paper Claim Information

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

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

Billing errors detected after a claim is submitted cannot be corrected until after Medicaid has made payment or notified the provider of the denial. Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice ([8.12, Resubmitting Versus Adjusting Claims](#)).

Common Billing Information - Dental

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

8.3 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.

8.4 The Dental Claim Form

ADA American Dental Association® Dental Claim Form											
HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX											
2. Predetermination/Preauthorization Number											
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION											
3. Company/Plan Name, Address, City, State, Zip Code											
OTHER COVERAGE (Mark applicable box and complete items 5-11, if none, leave blank.)											
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)											
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)											
6. Date of Birth (MM/DD/YYYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#)											
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other											
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code											
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)											
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code											
13. Date of Birth (MM/DD/YYYY) 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#)											
16. Plan/Group Number 17. Employer Name											
PATIENT INFORMATION											
18. Relationship to Policyholder/Subscriber in #13 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other 19. Reserved For Future Use											
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code											
21. Date of Birth (MM/DD/YYYY) 22. Gender <input type="checkbox"/> M <input type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist)											
RECORD OF SERVICES PROVIDED											
24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30a. Diag. Pointer	30b. Cx	30. Description	31. Fee		
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
33. Missing Teeth Information: (Place an "X" on each missing tooth.)					34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)					35a. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12
13	14	15	16	17	18	19	20	21	22	23	24
25	26	27	28	29	30	31	32	33	34	35	36
34a. Diagnosis Code(s)										35b. Total Fee	
35. Remarks											
AUTHORIZATIONS											
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental provider has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.											
X. Patient/Guardian Signature _____ Date _____											
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.											
X. Subscriber Signature _____ Date _____											
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)											
48. Name, Address, City, State, Zip Code											
49. NPI 50. License Number 51. SSN or TIN											
52. Phone Number () - 53a. Additional Provider ID											
ANCILLARY CLAIM/TREATMENT INFORMATION											
38. Place of Treatment: <input type="checkbox"/> In-office, <input type="checkbox"/> Off-site, <input type="checkbox"/> Hospital (Use "Place of Service Codes for Professional Claims")											
39. Enclosures (Y or N) <input type="checkbox"/>											
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)											
41. Date Appliance Placed (MM/DD/YYYY)											
42. Months of Treatment Remaining 43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)											
44. Date of Prior Placement (MM/DD/YYYY)											
45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident											
46. Date of Accident (MM/DD/YYYY) 47. Auto Accident State											
TREATING DENTIST AND TREATMENT LOCATION INFORMATION											
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.											
X. Signed (Treating Dentist) _____ Date _____											
54. NPI 55. License Number											
56. Address, City, State, Zip Code 57. Provider Specialty Code											
58. Phone Number () - 59. Additional Provider ID											
©2012 American Dental Association J430 (Same as ADA Dental Claim Form - J431, J432, J433, J434, J435D)											
To reorder call 800.947.4746 or go online at adacatalog.org											

8.4.1 Instructions for Completing the Dental Claim Form

Claim Item	Title	Required	Action
1	Type of transaction	X	Mark “Statement of Actual Services.”
2	Predetermination/ Prior Authorization	X	(When applicable) Enter Prior Authorization number here.
3	Insurance Company/ Dental Benefit Plan		
4	Other dental or medical coverage	X	(When applicable) Mark appropriate box. If no, skip to box 18. If yes, complete boxes 5-11
5	Subscriber name	X	(When applicable) Enter policyholder’s name.
6	Date of birth	X	(When applicable) Enter policyholder’s date of birth
7	Gender	X	(When applicable) Enter policyholder’s gender
8	Subscriber identifier	X	(When applicable) Enter policyholder’s social security number or policy number
9	Plan/Group number	X	(When applicable) Enter policyholder’s plan/group number
10	Relationship to primary subscriber	X	(When applicable) Mark appropriate box
11	Other carrier name and address	X	(When applicable) Enter carrier name and address
12	Policyholder/ Subscriber Information	X	(When applicable) Enter the primary subscriber’s name, address, city, state, and zip code
13	Date of Birth	X	(When applicable) Enter the primary subscriber’s date of birth (MMDDCCYY)
14	Gender	X	(When applicable) Enter the primary subscriber’s gender
15	Subscriber Identifier	X	(When applicable) Enter the primary subscriber’s SSN or ID#
16	Plan/Group Number	X	(When applicable) Enter the primary subscriber’s plan/group number
17	Employer Name	X	(When applicable) Enter the primary subscriber’s employer name
18	Patient information- relationship to primary subscriber	X	Mark applicable box

Common Billing Information - Dental

Claim Item	Title	Required	Action
19	Reserved for Future Use		No entry required
20	Name and address of patient	X	Enter name and address of patient
21	Patient date of birth	X	Enter patient's date of birth
22	Gender		No entry required
23	Patient ID/account number	X	Enter the patients 10 digit client ID number
24	Procedure Date	X	Enter date services were rendered
25	Area of oral cavity		(When applicable) Enter quadrant or arch. <ul style="list-style-type: none"> • UR- Upper Right • UL – Upper Left • LL- Lower Left, • LR – Lower Right • UA – Upper Arch • LA – Lower Arch
26	Tooth system		No entry required
27	Tooth numbers (s) or letter(s)	X	(When applicable) Enter tooth number (s) or letter (s). For supernumerary teeth – add an S after the tooth code (e.g. supernumerary tooth A becomes AS) (15+50=65)
28	Tooth surface	X	(When applicable) Enter tooth surface: <ul style="list-style-type: none"> • B – Buccal surface • D – Distal surface • F – Facial surface • I – Incisal surface • L – Lingual surface • M – Mesial surface • O – Occlusal surface
29	Procedure code	X	Enter appropriate CDT –code
29a	Diagnosis Pointer		No entry required
29b	Qty		Enter the units of service
30	Description		No entry required
31	Fee	X	Enter usual and customary charges for the procedure
31a	Other Fees	X	(When applicable) Enter the amount paid by

Common Billing Information - Dental

Claim Item	Title	Required	Action
			another dental plan. Do not enter prior Medicaid payments. This box is reserved for third party coverage only. If this amount is more than 40% of the total claim, providers do not need to attach an EOB
32	Total fee	X	Add together all of the fees listed in item 31 and enter the total amount in this field
33	Missing teeth information		No entry required
34	Diagnosis List Qualifier		No entry required
34a	Diagnosis Codes		No entry required
35	Remarks		No entry required – Notes in this box will not be reviewed by Medicaid
36	Patient/Guardian Signature	X	No entry required
37	Subscriber signature		No entry required
38	Place of treatment	X	Office=11 Hospital=21 Other=99
39	Number of enclosures		No entry required
40	Is treatment for orthodontics		No entry required
41	Date appliance placed		No entry required
42	Months of treatment remaining		No entry required
43	Replacement of prosthesis		No entry required
44	Date prior placement		No entry required
45	Treatment resulting		No entry required
46	Date of accident		No entry required
47	Auto accident state		No entry required
48	Name, address, city, state, zip of billing dentist or dental entity	X	Enter the name, address, city, state, and zip code of the billing dentist or dental entity
49	NPI	X	(When applicable) Enter Group/Pay-To NPI number
50	License number		No entry required
51	SSN or TIN		No entry required

Common Billing Information - Dental

Claim Item	Title	Required	Action
52	Phone number		No entry required
52a	Additional Provider ID		No entry required
53	Treating dentist signature	X	Sign and date the claim. All claims must be signed and dated. Providers have the choice of using a handwritten signature, a facsimile signature, a typed signature, initials, or an authorized signature. However, providers are responsible for ensuring that the signature on the claim is that of authorized individual. Providers are responsible for all claims billed using their Medicaid Provider number.
54	Treating dentist's NPI number	X	If a group practice, enter the treating provider's NPI number
55	License number		No entry required
56	Address, city, state, zip code	X	Enter the address, city, state, and zip code of treatment location
56a	Provider specialty code		(When applicable) Enter taxonomy code
57	Phone number		No entry required
58	Additional Provider ID		No entry required

8.5 Examples of Billing

8.5.1 Client has Medicaid Only

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																															
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX																															
2. Predetermination/Preauthorization Number																															
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																															
3. Company/Plan Name, Address, City, State, Zip Code Wyoming Medicaid PO Box 667 Cheyenne, WY 82003																															
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																															
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, Jane 123 This Town This Town, WY 82009																															
13. Date of Birth (MM/DD/CCYY) 01/01/2001						14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#) 0600XXXXXX																							
16. Plan/Group Number						17. Employer Name																									
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																															
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)																															
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																															
6. Date of Birth (MM/DD/CCYY)				7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)																									
9. Plan/Group Number				10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																											
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																															
PATIENT INFORMATION																															
18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other																															
19. Reserved For Future Use																															
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																															
21. Date of Birth (MM/DD/CCYY)				22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)																									
RECORD OF SERVICES PROVIDED																															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
1	11/01/2014																														
2	11/01/2014																														
3																															
4																															
5																															
6																															
7																															
8																															
9																															
10																															
33. Missing Teeth Information (Place an "X" on each missing tooth)												34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)										31a. Other Fee(s)									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____										32. Total Fee					
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A") B _____ D _____										104.00					
35. Remarks																															
AUTHORIZATIONS																ANCILLARY CLAIM/TREATMENT INFORMATION															
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental entity has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X SIGNATURE ON FILE 11/01/2014 Patient/Guardian Signature Date																38. Place of Treatment <input checked="" type="checkbox"/> 11 (e.g. 11=office; 22=OP Hospital) 39. Enclosures (Y or N) <input type="checkbox"/>															
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X SIGNATURE ON FILE 11/01/2014 Subscriber Signature Date																40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)															
																42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)															
																45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident															
																46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State															
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)																TREATING DENTIST AND TREATMENT LOCATION INFORMATION															
48. Name, Address, City, State, Zip Code Dental Office 123 That Town This Town, WY 82009																53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X TREATING DENTIST 11/01/2014 Signed (Treating Dentist) Date															
49. NPI				50. License Number				51. SSN or TIN				54. NPI 1112224440								55. License Number 9999											
52. Phone Number (307) 555-5555																56. Address, City, State, Zip Code 123 That Town This Town, WY 82009															
52a. Additional Provider ID																57. Phone Number (307) 555-5555															
58. Additional Provider ID																58a. Provider Specialty Code 122300000X															

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

To reorder call 800.947.4746
 or go online at adacatalog.org

8.5.2 Client has Medicaid and Third Party Liability (TPL)

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																									
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX																									
2. Predetermination/Preauthorization Number																									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																									
3. Company/Plan Name, Address, City, State, Zip Code Wyoming Medicaid PO Box 667 Cheyenne, WY 82003																									
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																									
4. Dental? <input checked="" type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)																									
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) Parent																									
6. Date of Birth (MM/DD/CCYY) 01/01/1960		7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#) XXX-XX-XXXX																					
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Dependent <input type="checkbox"/> Other																							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code Other Dental Plan 124 That Town This Town, WY 82001																									
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																									
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, Jane 123 This Town This Town, WY 82009																									
13. Date of Birth (MM/DD/CCYY) 01/01/2001				14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#) 0600XXXXXX																			
16. Plan/Group Number				17. Employer Name																					
PATIENT INFORMATION																									
18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other																									
19. Reserved For Future Use																									
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																									
21. Date of Birth (MM/DD/CCYY)				22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)																			
RECORD OF SERVICES PROVIDED																									
	24. Procedure Date (MM/DD/CCYY)		25. Area of Oral Cavity		26. Tooth System		27. Tooth Number(s) or Letter(s)		28. Tooth Surface		29. Procedure Code		29a. Diag. Pointer		29b. Qty		30. Description		31. Fee						
1	11/01/2014				JP						D0150				1		COMP ORAL EVAL - NEW ESTAB PAT		60.00						
2	11/01/2014				JP						D0274				1		BITE WING FOUR FILMS		44.00						
3																									
4																									
5																									
6																									
7																									
8																									
9																									
10																									
33. Missing Teeth Information (Place an "X" on each missing tooth.)												34. Diagnosis Code List Qualifier				(ICD-9 = B; ICD-10 = AB)				31a. Other Fee(s)					
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16												34a. Diagnosis Code(s)				A. C.				50.00					
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17												(Primary diagnosis in "A")				B. D.				32. Total Fee					
35. Remarks																				104.00					
AUTHORIZATIONS												ANCILLARY CLAIM/TREATMENT INFORMATION													
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.												38. Place of Treatment <input type="checkbox"/> 11 (e.g. 11=office; 22=QIP Hospital) (Use "Place of Service Codes for Professional Claims")										39. Enclosures (Y or N) <input type="checkbox"/>			
X SIGNATURE ON FILE 11/01/2014 Patient/Guardian Signature Date												40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										41. Date Appliance Placed (MM/DD/CCYY)			
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.												42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		44. Date of Prior Placement (MM/DD/CCYY)	
X SIGNATURE ON FILE 11/01/2014 Subscriber Signature Date												45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident										46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)												TREATING DENTIST AND TREATMENT LOCATION INFORMATION													
48. Name, Address, City, State, Zip Code Dental Office 123 That Town This Town, WY 82009												53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. <input checked="" type="checkbox"/> TREATING DENTIST 11/01/2014 Signed (Treating Dentist) Date													
49. NPI 1112223330				50. License Number 5555				51. SSN or TIN				54. NPI 1112223330				55. License Number 9999									
52. Phone Number (307) 555 - 5555												56. Address, City, State, Zip Code 123 That Town This Town, WY 82009										58a. Provider Specialty Code 122300000X			
52a. Additional Provider ID												57. Phone Number (307) 555 - 5555										58. Additional Provider ID			

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

To reorder call 800.947.4746
 or go online at adacatalog.org

8.6 Reimbursement Methodologies

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

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

8.6.1 Invoice Charges

- Invoice must be dated within 12 months (365 days) prior to the date of service being billed – if the invoice is older, a letter must be included explaining the age of the invoice (i.e. product purchased in large quantity previously, and is still in stock)
- All discounts will be taken on the invoice.
- The discounted pricing or codes cannot be marked out.
- A packing slip, price quote, purchase order, delivery ticket, etc. may be used only if the provider no longer has access to the invoice, and is unable to obtain a replacement from the supplier/manufacturer, and a letter with explanation is included.
- Items must be clearly marked (i.e. how many calories are in a can of formula, items in a case, milligrams, ounces, etc.)

8.7 Usual and Customary Charges

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

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

8.8 Prior Authorization

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

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


Services Requiring PA	PA Requirements
Cone Beam CT Capture and Interpretation	See Chapter 28 – Covered Services
Specialized Denture Services	See Chapter 28 – Covered Services
Implant Services and Fixed Prosthesis (Bridges)	See Chapter 28 – Covered Services
Oral and Maxillofacial Surgery	See Chapter 28 – Covered Services
Orthodontics/Severe Malocclusion Program	See Chapter 28 – Covered Services

8.8.1 Requesting Prior Authorization

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

Providers must complete a Medicaid Prior Authorization Form ([8.8.1.1, Medicaid Prior Authorization Form](#)) for all requests.

8.8.1.1 Medicaid Prior Authorization Form



Wyoming
Department
of Health

Prior Authorization Request
To Avoid Delays – Please fill out Completely

☐ ADD
☐ MODIFY
☐ CANCEL

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

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

Rev. 7/2014

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

8.8.1.2 Instructions for Completing the Medicaid Prior Authorization Form

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

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

8.8.2 Prior Authorization Status Inquiry

Once a PA status is determined, providers will be able to view their determinations on the Provider Portal, including the 10-digit PA number. The complete 10-digit PA number must be entered in box 23 of the CMS-1500 02-12 claim form. For placement in an electronic X12N 837 Professional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.

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

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

To view a PA status:

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

8.9 Billing of Deliverables

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

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



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

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

- Print the “Order vs Delivery Date Exception Form,” ([8.9.1, Order vs Delivery Date Exception Form](#)).
- Complete the form and fax or mail it to the address at the bottom of the form
- Once the form is signed by the State, it will be returned to the provider and must be a part of the client’s permanent clinical record
- The provider may then bill the claim using the order date as the date of service

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

8.9.1 Order vs Delivery Date Exception Form

ORDER VS DELIVERY DATE BILLING ATTESTATION FORM

PROVIDER NAME: _____ NPI: _____

PROVIDER RETURN EMAIL: _____

CLIENT NAME: _____ MEDICAID ID#: _____

PROCEDURE CODE & DESCRIPTION: _____

ORDER DATE: _____ DELIVERY DATE: _____

DENTAL PROVIDERS

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

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

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

VISION PROVIDERS

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

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

☐ CLIENT DID NOT RETURN FOR GLASSES AND WHEN THE GLASSES WERE MAILED THEY WERE RETURNED TO OUR OFFICE DUE TO: _____

DME PROVIDERS

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

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

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

PROVIDER'S SIGNATURE

DATE

☐ APPROVED ☐ DENIED

STATE PROGRAM MANAGER, TITLE

DATE

THIS FORM MUST BE COMPLETED AND EMAILED TO: Lindsay.convers1@wyo.gov

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

8.10 Submitting Attachments for Electronic Claims

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

Steps for submitting electronic attachments:

- The fiscal agent has created a process that allows providers to submit electronic attachments for electronic claims. Providers need only follow these steps:
 1. Mark the attachment indicator on the electronic claim. For more information on the attachment indicator, consult the provider software vendor or clearinghouse, or the X12N 837 Professional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf
 2. Log onto the [Secured Provider Web Portal](#).
 3. Under the submissions menu select Electronic Attachments.
 4. Complete required information – Information must match the claim as submitted i.e. DOS, client information, provider information, and the name of the attachment must be identical to what was submitted in the in the electronic file (with no spaces).
 5. Navigate to the location of the electronic attachment on the provider's computer.
 6. Click Upload.
 7. For support and additional information, refer to [Chapter 10](#) and [Chapter 11](#) 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 ([8.10.1, Attachment Cover Sheet](#)) and mail it with the attachment to Claims ([2.1, Quick Reference](#)).

Steps for submitting paper attachments by email:

- The fiscal agent has created a process that allows providers to submit paper attachments for electronic claims. Provider need only follow these two (2) simple steps:
 1. Mark the attachment indicator on the electronic claim and indicate by mail as the submission method. For more information on the attachment indicator, consult the provider software vendor or clearinghouse, or the X12N 837 Professional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at https://wpshealth.com/resources/files/med_b_837p_companion.pdf.
 - The data entered on the form must match the claim exactly in DOS, client information, provider information, etc.
 2. Complete the Attachment Cover Sheet ([8.10.1, Attachment Cover Sheet](#)) and email it with the attachment to wycustomersvc@conduent.com ([2.1, Quick Reference](#)).
 - All emails must come secured and cannot exceed 25 pages.

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

8.10.1 Attachment Cover Sheet

Attachment Cover Sheet

Please use this form when submitting a claim electronically which requires attachments. The supporting documentation (EOB, medical records, etc.) must be attached to this cover sheet. If the documentation is received without a cover sheet the request CANNOT be processed and the documents will be shredded.

All information entered on this cover sheet must match the data entered in the 837 claim transaction, including the Attachment Type and Attachment Control Number. Also, the Attachment Transmission Code in the 837 claim transaction must be set to 'BM' (By Mail) to indicate the attachment is being sent separately.

Pay-to Provider Name:

Pay-to Provider or NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Client Name:

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Claim From Date of Service:

--	--	--

Claim To Date of Service:

--	--	--

(MM/DD/YY) (MM/DD/YY)

Attachment Control Number:
(Required)

Must include no spaces and match the 837 file exactly

TCN:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(Required)

Attachment Type:
(Required)

<input type="checkbox"/> AS: Admission Summary	<input type="checkbox"/> MT: Models
<input type="checkbox"/> B2: Prescription	<input type="checkbox"/> NN: Nursing Notes
<input type="checkbox"/> B3: Physician Order	<input type="checkbox"/> OB: Operative Notes
<input type="checkbox"/> B4: Referral Order	<input type="checkbox"/> OZ: Support Date for Claim
<input type="checkbox"/> CT: Certification	<input type="checkbox"/> PN: Physical Therapy Notes
<input type="checkbox"/> CK: Consent Form(s)	<input type="checkbox"/> PO: Prosthetics or Orthotic Certification
<input type="checkbox"/> DA: Dental Models	<input type="checkbox"/> PZ: Physical Therapy certification
<input type="checkbox"/> DG: Diagnostic Report	<input type="checkbox"/> RB: Radiology Films
<input type="checkbox"/> DS: Discharge Summary	<input type="checkbox"/> RR: Radiology Reports
<input type="checkbox"/> EB: Explanation of Benefits	<input type="checkbox"/> 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.

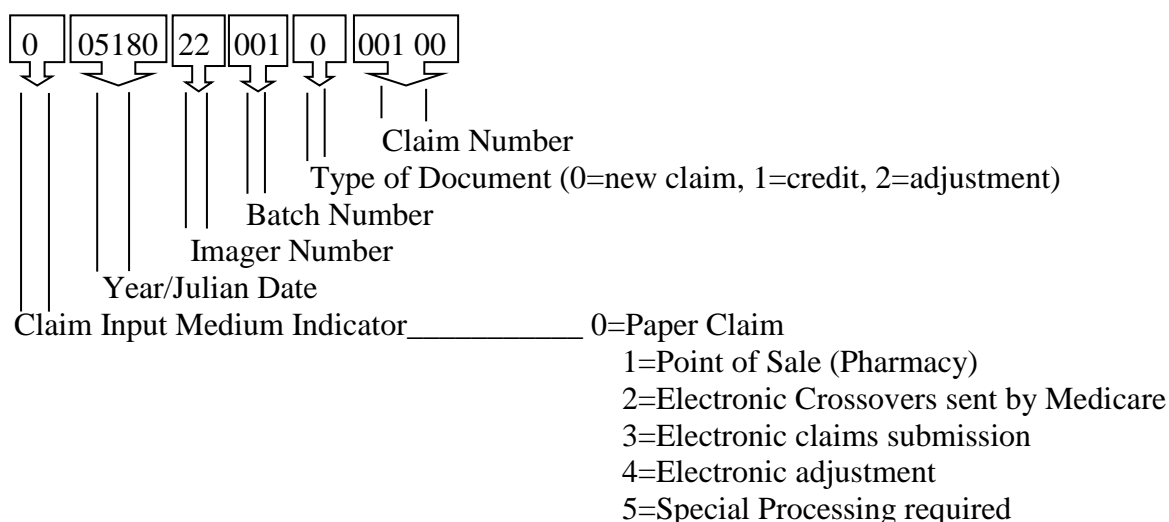
8.11 Remittance Advice (RA)

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 ([1.2.1, RA Banner Notices/Samples](#))
- Claims are grouped by disposition category.
 - Claim Status PAID group contains all the paid claims.
 - Claim Status DENIED group reports denied claims.
 - Claim Status PENDED group reports claims pended for review. Do not resubmit these claims. All claims in pended status are reported each payment cycle until paid or denied. Claims can be in a pended status for up to 30 days.
 - Claim Status ADJUSTED group reports adjusted claims.
- All paid, denied, and pended claims and claim adjustments are itemized within each group in alphabetic order by client last name.
- A unique Transaction Control Number (TCN) is assigned to each claim. TCNs allow each claim to be tracked throughout the Medicaid claims processing system. The digits and groups of digits in the TCN have specific meanings, as explained below:



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

Common Billing Information - Dental

8.11.1 Sample Dental Remittance Advice

WYOMING DEPARTMENT OF HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 00/00/00

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

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

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

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

REMITTANCE ADVICE

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

REMITTANCE T O T A L S

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

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

88 ONLY ONE PROPHYLAXIS (ADULT OR CHILD) PER SIX MONTHS WITHOUT DOCUMENTATION OF MEDICAL NECESSITY.	1
97 THE RECIPIENT IS NOT COVERED FOR THE TYPE OF SERVICE BILLED.	1

8.11.2 How to Read the Remittance Advice (RA)

Each claim processed during the weekly cycle is listed on the RA with the following information

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

8.11.3 Remittance Advice (RA) 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 RA, complete the following steps:

- Print the 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 ([10.5.2.1, 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

8.11.3.1 Remittance Advice 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 image above to be taken to a printable version of this form.

8.11.4 Obtain an RA from the Web

Providers have the ability to view and download their last 24 weeks of RAs from the Medicaid website, refer to [Chapter 10, Electronic Data Interchange \(EDI\)](#).

8.11.5 When a Client Has Other Insurance

If the client has other insurance coverage reflected in Medicaid records, payment may be denied unless providers report the coverage on the claim. Medicaid is always the payer of last resort. For exceptions and additional information regarding Third Party Liability, refer to [Chapter 9](#) of this manual. To assist providers in filing with the other carrier, the following information is provided on the RA directly below the denied claim:

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

The information is specific to the individual client. The Third Party Resources Information Sheet ([9.2.1, Third Party Resources Information Sheet](#)) should be used for reporting new insurance coverage or changes in insurance coverage on a client's policy.

8.12 Resubmitting Versus Adjusting Claims

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

Action	Description	Timely Filing Limitation
VOID	Claim has paid; however, the provider would like to completely cancel the claim as if it was never billed.	May be completed any time after the claim has been paid.
ADJUST	Claim has paid, even if paid \$0.00; however, the provider would like to make a correction or change to this paid claim.	Must be completed within 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.

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

The deadlines for resubmitting and adjusting claims are different:

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

8.12.2 Resubmitting a Claim

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

How to Resubmit:

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

8.12.2.1 When to Resubmit to Medicaid

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

8.12.3 Adjusting or Voiding Paid Claims

When a provider identifies an error on a paid claim, the provider must submit an [Adjustment/Void Request Form](#). If the incorrect payment was the result of a keying error (paper claim submission), by the fiscal agent contact Provider Relations to have the claim corrected ([2.1, Quick Reference](#)).

Denied claims cannot be adjusted.

When adjustments are made to previously paid claims, Medicaid reverses the original payment and processes a replacement claim. The result of the adjustment appears on the RA/835 transaction as two (2) transactions. The reversal of the original payment will appear as a credit (negative) transaction. The replacement claim will appear as a debit (positive) transaction and may or may not appear on the same RA/835 transaction as the credit transaction. The replacement (debit) claim will have almost the same TCN as the credit transaction, except the 12th digit will be a two (2), indicating an adjustment, whereas the credit will have a one (1) in the 12th digit indicating a credit.

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

8.12.3.1 When to Request an Adjustment

- When a claim was overpaid or underpaid.
- When a claim was paid, but the information on the claim was incorrect (such as client ID, date of service, procedure code, diagnoses, units, etc.)
- When Medicaid pays a claim and the provider subsequently receives payment from a third party payer, the provider must adjust the paid claim to reflect the TPL amount paid.
 - If an adjustment is submitted stating that TPL paid on the claim, but the TPL paid amount is not indicated on the adjustment or an EOB is not sent in with the claim, Medicaid will list the TPL amount as either the billed or reimbursement amount from the adjusted claim (whichever is greater). It will be up to the provider to adjust again, with the corrected information.
 - Attach a corrected claim showing the insurance payment and attach a copy of the insurance EOB if the payment is less than 40% of the total claim charge.
 - For the complete policy regarding Third Party Liability, refer to [Chapter 9](#).

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

8.12.3.2 When to Request a Void

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

8.12.3.3 How to Request an Adjustment/Void

To request an adjustment, use the Adjustment/Void Request Form ([8.12.3.2 Adjustment/Void Request Form](#)). The requirements for adjusting/voiding a claim are as follows:

- An adjustment/void can only be processed if the claim has been paid by Medicaid.
- Medicaid must receive individual claim adjustment requests within 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.”

8.12.3.4 Adjustment/Void Request Form

Adjustment/void Request Form	
EXHIBIT 6.9	
ADJUSTMENT/VOID REQUEST FORM	
SECTION A: CHECK BOX 1a), 1b) OR 2)	
<input type="checkbox"/> 1a) CLAIM ADJUSTMENT: Attach a copy of the claim with corrections made in BLUE ink . DO NOT USE HIGHLIGHTER <input type="checkbox"/> 1b) VOID CLAIM: Attach a copy of the claim or Remittance Advice. Complete Sections B and C. If attaching a check, the check should be payable to Division of Healthcare Financing (DHCF) .	<input type="checkbox"/> 2) CANCELLATION OF THE ENTIRE REMITTANCE ADVICE. Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances. Complete Section C only. Attach RA. If manual check attach the check from the DHCF or if EFT make check payable to the DHCF for the entire remit amount.
SECTION B	
TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:	
1. 17-DIGIT TCN:	2. PAYMENT DATE:
<div style="border: 1px solid black; width: 150px; height: 15px; margin: 0 auto;"></div>	
3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER:	4. PROVIDER NAME:
<div style="border: 1px solid black; width: 100px; height: 15px; margin: 0 auto;"></div>	
5. 10-DIGIT CLIENT NUMBER:	6. 10-DIGIT PA NUMBER:
<div style="border: 1px solid black; width: 100px; height: 15px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 100px; height: 15px; margin: 0 auto;"></div>
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.

8.12.3.5 How to Complete the Adjustment/Void Request Form

Section	Field #	Field Name	Action
A	1a, 1b	Claim Adjustment	Mark this box if any adjustments need to be made to a claim. Attach a copy of the claim with corrections made in BLUE ink (do not use red ink or highlighter) or the RA. Attach all supporting documentation required to process the claim, i.e. EOB, EOMB, consent forms, invoice, etc.
		Void Claim	Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the Remittance Advice.
		Sections B and C must be completed.	
B	1	17-digit TCN	Enter the 17-digit transaction control number assigned to each claim from the Remittance Advice.
	2	Payment Date	Enter the Payment Date
	3	Nine (9) digit Provider or ten (10) digit NPI Number	Enter provider’s nine (9)-digit Medicaid provider number or ten (10)-digit NPI number, if applicable.
	4	Provider Name	Enter the provider name.
	5	Ten (10) digit Client Number	Enter the client’s ten (10)-digit Medicaid ID number.
	6	Ten (10) digit PA Number	Enter the ten (10)-digit Prior Authorization number, if applicable.
	7	Reason for Adjustment or Void	Enter the specific reason and any pertinent information that may assist the fiscal agent.
C		Provider Signature and Date	Signature of the provider or the providers’ authorized representative and the date.

8.12.3.6 Adjusting a claim electronically via an 837 transaction

Wyoming Medicaid accepts claim adjustments electronically, refer to Chapter 11, Wyoming Specific HIPAA 5010 Electronic Specifications ([11.12, 837 Dental Claims Transaction](#)), for complete details.

8.13 Credit Balances

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

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

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

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

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

8.14 Timely Filing

The Division of Healthcare Financing adheres strictly to its timely filing policy. The provider must submit a clean claim to Medicaid within 12 months (365 days) of the date of service. A clean claim is an error free, correctly completed claim, with all required attachments, that will process and approve to pay within the twelve month (365 days) time period. Submit claims immediately after providing services so that, when a claim is denied, there is time to correct any errors and resubmit. Claims are to be submitted only after the service(s) have been rendered, and not before. For deliverable items (i.e. dentures, DME, glasses, hearing aids, etc.) the date of service must be the date of delivery, not the order date.

8.14.1 Exceptions to the Twelve Month (365 days) Limit

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

Exceptions Beyond the Control of the Provider	
When the Situation is:	The Time Limit is:
Medicare Crossover	A Claim must be submitted within 12 months (365 days) of the date of service or within 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.

Exceptions Beyond the Control of the Provider	
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.

8.14.2 Appeal of Timely Filing

A provider may appeal a denial for timely filing **ONLY** under the following circumstances:

- The claim was originally filed within 12 months (365 days) of the date of service and is on file with Wyoming Medicaid; and
- The provider made at least one (1) attempt to resubmit the corrected claim within 12 months (365 days) of the date of service; and
- The provider must document in their appeal letter all claims information and what corrections they made to the claim (all claims history, including TCNs) as well as all contact with or assistance received from Provider Relations (dates, times, call reference number, who was spoken with, etc.) or
- A Medicaid computer or policy problem beyond the provider's control prevented the provider from finalizing the claim within 12 months (365 days) of the date of service

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

8.14.2.1 How to Appeal

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

- Documentation of previous claim submission (TCNs, documentation of the corrections made to the subsequent claims);

- Documentation of contact with Provider Relations;
- An explanation of the problem; and
- A clean copy of the claim, along with any required attachments and required information on the attachments. A clean claim is an error free, correctly completed claim, with all required attachments, that will process and pay.

8.15 Important Information Regarding Retroactive Eligibility Decisions

The client is responsible for notifying the provider of the retroactive eligibility determination and supplying a copy of the notice.

A provider is responsible for billing Medicaid only if:

- They agreed to accept the patient as a Medicaid client pending Medicaid eligibility; or
- After being informed of retroactive eligibility, they elect to bill Medicaid for services previously provided under a private agreement. In this case, any money paid by the client for the services being billed to Medicaid would need to be refunded prior to a claim being submitted to Medicaid.

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

In the event of retroactive eligibility, claims must be submitted within 6 months (180 days) of the date of determination of retroactive eligibility.

NOTE: Inpatient Hospital Certification: A hospital may seek admission certification for a client found retroactively eligible for Medicaid benefits after the date of admission for services that require admission certification. The hospital must request admission certification within 30 days after the hospital receives notice of eligibility. To obtain certification, contact WYhealth ([2.1, Quick Reference](#)).

8.16 Client Fails to Notify Provider of Eligibility

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

- Any money paid by the client for the service being billed to Wyoming Medicaid must be refunded prior to billing Medicaid;

- The client can no longer be billed for the service; and
- Timely filing criterion is in effect.

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

8.17 Billing Tips to Avoid Timely Filing Denials

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

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

Chapter Nine – Third Party Liability

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9.1 Definition of a Third Party Liability

9.1.1 Third Party Liability (TPL)

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

In simple terms, TPL is often referred to as other insurance, other health insurance, medical coverage, or other insurance coverage. Other insurance is considered a third-party resource for the client. Third-party resources may include but are not limited to:

- Health insurance (including Medicare)
- Vision coverage
- Dental coverage
- Casualty coverage resulting from an accidental injury or personal injury
- Payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more clients.

9.1.2 Third Party Payer

Third Party Payer is defined as a person, entity, agency, insurer, or government program that may be liable to pay, or that pays pursuant to a client's right of recovery arising from an illness, injury, or disability for which Medicaid funds were paid or are obligated to be paid on behalf of the client. Third party payers include, but are not limited to:

- Medicare
- Medicare Replacement (Advantage or Risk Plans)
- Medicare Supplemental Insurance
- Insurance Companies
- Other
 - Disability Insurance
 - Workers' Compensation
 - Spouse or parent who is obligated by law or by court order to pay all or part of such costs (absent parent)
 - Client's estate
 - Title 25

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

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

9.1.3 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.

9.1.4 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.

9.1.5 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 [sections 6.6.2-6.6.4](#) for more information on submitting tertiary claims.

9.1.6 Disability Insurance Payments

If the disability insurance carrier pays for health care items and services, the payments must be assigned to Wyoming Medicaid. The client may choose to receive a cash benefit. If the payments from the disability insurance carrier are related to a medical event that required submission of claims for payment, the reimbursement from the disability carrier is considered a third party payment. If the disability policy does not meet any of these, payments made to the Wyoming Medicaid client may be treated as income for Medicaid eligibility purposes.

9.1.7 Long-Term Care Insurance

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

income. The funds will be included in calculation of the client's patient contribution to the nursing facility.

9.1.8 Exceptions

The only exceptions to this policy are referenced below:

- Children's Special Health (CSH) – Medical claims are sent to Wyoming Medicaid's MMIS fiscal agent
- Indian Health Services (IHS) – 100% federally funded program
- Ryan White Foundation – 100% federally funded program
- Wyoming Division of Victim Services/Wyoming Crime Victim Compensation Program
- Policyholder is an absent parent
 - Upon billing Medicaid, providers are required to certify if a third party has been billed prior to submission. The provider must also certify that they have waited 30 days from the date of service before billing Medicaid and has not received payment from the third party
- Services are for preventative pediatric care (Early and Periodic Screening, Diagnosis, and Treatment/EPSDT), prenatal care.
- Wyoming Medicaid will deny claims for prenatal services for Wyoming Medicaid clients with health insurance coverage other than Wyoming Medicaid. If the provider of service(s) does not bill the liable third party, the claim will be denied. Providers will receive claim denial information on their remittance advices along with the claims billing addresses for the liable third parties. Providers will be required to bill the liable third parties.

NOTE: Inpatient labor and delivery services and post-partum care must be cost avoided or billed to the primary health insurance.

- The probable existence of third-party liability cannot be established at the time the claim is filed.
- Home and community based (HCBS) waiver services, as most insurance companies do not cover these types of services

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

9.2 Provider's Responsibilities

Providers have an obligation to investigate and report the existence of other third-party liability information. Providers play an integral and vital role as they have direct contact with the client. The contribution providers make to Medicaid in the TPL arena is significant. Their cooperation is essential to the functioning of the Medicaid Program and to ensuring prompt payment.

At the time of client intake, the provider must obtain Medicaid billing information from the client. At the same time, the provider should also ascertain if additional insurance resources exist. When a TPL/Medicare has been reported to the provider, these resources must be identified on the claim in order for claims to be processed properly. Other insurance information may be reported to Medicaid using the Third Party Resources Information Sheet. Claims should not be submitted prior to billing TPL/Medicare.

9.2.1 Third Party Resources Information Sheet

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

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

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

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

9.2.2 Provider is not enrolled with TPL Carrier

Medicaid will **no** longer accept a letter with a claim indicating that a provider does not participate with a specific health insurance company. The provider must work with the insurance company and/or client to have the claim submitted to the carrier. Providers cannot refuse to accept Medicaid clients who have other insurance if their office does not bill other insurance. However, a provider may limit the number of Medicaid clients s/he is willing to admit into his/her practice. The provider may not discriminate in establishing a limit. If a provider chooses to opt-out of participation with a health insurance or governmental insurance, Medicaid will not pay for services covered by, but not billed to, the health insurance or governmental insurance.

9.2.3 Medicare Opt-Out

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

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

9.3 Billing Requirements

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

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

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

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:

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

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

CREATION DATE		TOTALS	
50 PAID AMT	51 AMT PAID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
56 UNQUEID		57 GROUP NAME	
		58 INSURA	

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

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

Third Party Liability

- If the TPL payer paid less than 40% of the total billed charges, included the appropriate claim reason and remark codes or attach an explanation of benefits (EOB) with the electronic claim (Electronic Attachments).
- If payment is received from the other payer after Medicaid already paid the claim, Medicaid's payment must be refunded for either the amount of the Medicaid payment or the amount of the insurance payment, whichever is less. A copy of the EOB from the other payer must be included with the refund showing the reimbursement amount.

NOTE: Medicaid will accept refunds from a provider at any time. Timely filing will not apply to adjustments where money is owed to Medicaid ([6.20 Timely Filing](#)).

- If a denial is obtained from the third party payer/Medicare that a service is not covered, attach the denial to the claim ([6.15, Submitting Attachments for Electronic Claims](#)). The denial will be accepted for one (1) calendar year or benefit plan year, as appropriate, but will still need to be attached with each claim.
- If verbal denial is obtained from a third party payer, type a letter of explanation on official office letterhead. The letter must include:
 - Date of verbal denial
 - Payer's name and contact person's name and phone number
 - Date of Service
 - Client's name and Medicaid ID number
 - Reason for denial
- If the third party payer/Medicare sends a request to the provider for additional information, the provider must respond. If the provider complies with the request for additional information and, after ninety (90) days from the date of the original claim, the provider has not received payment or denial, the provider may submit the claim to Medicaid with the Previous Attempts to Bill Services Letter.

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

- In situations involving litigation or other extended delays in obtaining benefits from other sources, Medicaid should be billed as soon as possible to avoid timely filing. If the provider believes there may be casualty insurance, contact TPL Unit ([2.1, Quick Reference](#)). TPL will investigate the responsibility of the other party. Medicaid does not require providers to bill a third party when liability has not been established. However, the provider cannot bill the casualty carrier and Medicaid at the same time. The provider must choose to bill Medicaid or the casualty carrier (estate). Medicaid will seek recovery of

payments from liable third parties. If providers bill the casualty carrier (estate) and Medicaid, this may result in duplicate payments.

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

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).

9.3.1 How TPL is Applied

The amount paid to providers by primary insurance payers is often less than the original amount billed, for the following reasons:

Reductions resulting from a contractual agreement between the payer and the provider (contractual write-off); and,

Reductions reflecting patient responsibility (copay, coinsurance, deductible, etc.). Wyoming Medicaid will pay no more than the remaining patient responsibility (PR) after payment by the primary insurance.

Wyoming Medicaid will reimburse the provider for the patient liability up to the Medicaid Allowable Amount. For preferred provider agreements or preferred patient care agreements, do not bill Medicaid for the difference between the payment received from the third party based on such agreement and the providers billed charges.

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

Example:

- The total claim billed to Medicaid is for \$100.00, with a Medicaid allowable for the total claim of \$50.00. TPL has paid \$25.00 for only the second line of

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the claim. The claim will be processed as follows: Medicaid allowable (\$50.00) minus the TPL paid amount (\$25.00) = \$25.00 Medicaid Payment.

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

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

9.3.1.1 Previous Attempts to Bill Services Letter

The form is titled "Previous Attempts to Bill Services Letter" and is from the Wyoming Department of Health. It is addressed to "Wyoming Medicaid,". The body of the letter states: "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." The letter concludes with "Thank you." and a signature line for the "Authorized Representative of [redacted] (Billing Facility)". Below the signature line are fields for "Name of insurance company billed:", "Date billing attempts made:", "Policyholder's name:", and "Policyholder's policy number:". There is also a "Comments:" section with multiple lines for text entry. At the bottom, the form is dated and includes the text "Wyoming Medicaid", "Adm. Claims", "PO Box 667", "Cheyenne, WY 82003-0667".

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 [redacted] (Billing Facility)

Name of insurance company billed: [redacted]

Date billing attempts made: [redacted]

Policyholder's name: [redacted]

Policyholder's policy number: [redacted]

Comments: [redacted]

Wyoming Medicaid
Adm. Claims
PO Box 667
Cheyenne, WY 82003-0667

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

9.3.2 Acceptable Proof of Payment or Denial

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

9.3.3 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.

9.3.4 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.

9.3.5 TPL and Copays

A client with private health insurance primary to Wyoming Medicaid is required to pay the Wyoming Medicaid copay. Submit the claim to Wyoming Medicaid in the usual manner, reporting the insurance payment on the claim with the balance due. If the Wyoming Medicaid allowable covers all or part of the balance billed, Wyoming

Medicaid will pay up to the maximum Wyoming Medicaid allowable amount, minus any applicable Wyoming Medicaid copay. Wyoming Medicaid will deduct the copay from its payment amount to the provider and report it as the copay amount on the provider's RA. **Remember, Wyoming Medicaid is only responsible for the client's liability amount or patient responsibility amount up to its maximum allowable amount.**

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

9.3.6 Primary Insurance Recoup after Medicaid Payment

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

9.4 Medicare Pricing

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

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

9.4.1 Medicaid Covered Services

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

Example:

- Procedure Code 99239
 - Medicaid Allowable - \$97.67
 - Medicare Paid - \$83.13
 - Medicare assigned Coinsurance and Deductible - \$21.21
 - First payment method option: (Medicaid Allowable) \$97.67 – (Medicare Payment) \$83.13 = \$14.54
 - Second payment method option: Coinsurance and deductible = \$21.21

- Medicaid will pay the lesser of the Medicaid payment methodology or the coinsurance and deductible
 - This procedure code would pay \$14.54 since it is less than \$21.21

NOTE: If the method for Medicaid covered services results in a Medicaid payment of \$0 and the claim contains lines billed for physician-administered pharmaceuticals, the line will pay out at \$0.01.

9.4.2 Medicaid Non-Covered Services

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

Example:

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

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

9.4.3 Coinsurance and Deductible

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

For clients on other plans who are dual eligible, coinsurance and deductible amounts remaining after Medicare payment cannot be billed to the client if the claim was

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billed to Wyoming Medicaid, regardless of payment amount (including claims that Medicaid pays at \$0.00).

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

Chapter Ten – Electronic Data Interchange (EDI)

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10.1 What is Electronic Data Interchange (EDI)?

In its simplest form, EDI is the electronic exchange of information between two (2) business concerns (trading partners), in a specific, predetermined format. The exchange occurs in basic units called transactions, which typically relate to standard business documents, such as healthcare claims or remittance advices.

10.2 Benefits

Several immediate advantages can be realized by exchanging documents electronically:

- **Speed** – Information moving between computers moves more rapidly, and with little or no human intervention. Sending an electronic message across the country takes minutes or less. Mailing the same document will usually take a minimum of one (1) day.
- **Accuracy** – Information that passes directly between computers without having to be re-entered eliminates the chance of data entry errors.
- **Reduction in Labor Costs** – In a paper-based system, labor costs are higher due to data entry, document storage and retrieval, document matching, etc. As stated above, EDI only requires the data to be keyed once, thus lowering labor costs.

10.3 Standard Transaction Formats

In October 2000, under the authority of the Health Insurance Portability and Accountability Act (HIPAA), the Department of Health and Human Services (DHHS) adopted a series of standard EDI transaction formats developed by the Accredited Standards Committee (ASC) X12N. These HIPAA-compliant formats cover a wide range of business needs in the healthcare industry from eligibility verification to claims submission. The specific transaction formats adopted by DHHS are listed below.

- X12N 270/271 Eligibility Benefit Inquiry and Response
- X12N 276/277 Claims Status Request and Response
- X12N 278 Request for Prior Authorization and Response
- X12N 277CA Implementation Guide Error Reporting
- X12N 835 Claim Payment/Remittance Advice
- X12N 837 Dental, Professional and Institutional Claims
- X12N 999 Functional Acknowledgement

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

10.4 Sending and Receiving Transactions

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

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

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

10.5 EDI Services

10.5.1 Getting Started

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

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

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

10.5.2 Web Portal

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

10.5.2.1 Secured Provider Web Portal Registration Process

- Go to the Medicaid website: <https://wymedicaid.portal.conduent.com>.
- Select Provider.
- Select Provider Portal from the left hand menu.
- Under “New Providers” select Web Portal to register.
- Enter the following information from the EDI Welcome Letter:
 - Provider ID: Trading Partner/Submitter ID.
 - Trading Partner ID: Trading Partner/Submitter ID.
 - EIN/SSN: The Providers tax-id as entered on the EDI application.
 - Trading Partner Password: Password/User ID – Must be entered exactly as shown on the welcome letter.
- Select Continue
 - Confirm that the information that the provider has entered is correct. If it is, choose Continue, if not re-enter information.
- Additional Trading Partner IDs:
 - If the provider needs to enter additional Trading Partner IDs enter the ID and the Trading Partner password on this page.
 - If the provider does not have any additional Trading Partner IDs select continue.

10.5.2.2 Creating an Office Administrator

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

1. Select “Create a new user”
 - a. Enter a unique user ID, last name, first name, email address and phone number for the person that the provider wants to be the office administrator.
 - b. Confirm the information entered is correct.

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

10.5.2.3 Creating Additional Users

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

10.5.3 WINASAP

WINASAP allows all Trading Partners to submit claims 24-hours a day, seven (7) days a week from any computer with a dial up modem over an analog phone line that the provider has installed the software on. WINASAP5010 software can be downloaded from the Conduent EDI Solutions website ([2.1, Quick Reference](#)) or the provider can call EDI Services ([2.1, Quick Reference](#)) and request a CD to be mailed to the provider.

Requirements:

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

10.5.3.1 WINASAP Start-up

1. Download program from the Conduent EDI Solutions website or install the program from the CD the provider requested.
 - a. When the welcome screen appears click next
 - b. Read and accept the terms of the Software License Agreement
 - c. Enter User Information
 - d. Choose Destination Location

- e. Confirm provider current settings and choose Next
 - f. Check Yes, launch the program file and Finish.
 2. Creating a WINASAP login
 - a. The user ID auto fills as ADMIN
 - b. Tab to password and type ASAP
 - i. The user ID and password are the same for everyone using WINASAP, we suggest that the provider does not change them
 - c. After successfully logging in choose ok
 3. Steps that must be completed
 - a. The screen will automatically open the first (1st) time the provider runs the program that says Open Payer
 - i. Select Wyoming Medicaid and choose OK
 - ii. Choose File and Trading Partner – Enter the following
 - iii. Primary Identification: Enter the provider Trading Partner ID from the EDI Welcome Letter
 - iv. Secondary Identification – Re-enter the provider Trading Partner ID (primary and secondary identification will be the same)
 - b. Trading Partner Name:
 - i. Entity Type: select person or non-person.
 1. Choose person if the provider is an individual such as; a waiver provider, physician, therapist, or nurse practitioner
 2. Choose non-person if the provider is a facility such as; a hospital, pharmacy or nursing home.
 - c. Enter the providers last name, first name and middle initial (optional) OR the organization name
 - i. Contact Information:
 1. Contact Name: provider Name
 2. Telephone Number: Enter provider phone number
 3. Fax Number: Enter provider fax number (optional)
 4. Email: Enter provider email address
 4. The following criteria must be completed:
 - a. WINASAP5010 Communications:
 - i. Host Telephone Number: This phone number is listed as the Submission Telephone Number on the EDI Welcome Letter. Enter it with no spaces, dashes, commas, or other punctuation marks.
 - ii. User ID Number: Enter providers Password/User ID exactly as it appears.
 - iii. User Name: Enter providers User Name exactly as it appears.
 - iv. Choose Save

10.6 Additional Information Sources

For more information regarding EDI, please refer to the following websites:

- Centers for Medicare and Medicaid Services: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html>. This is the official HIPAA website of the Centers for Medicare & Medicaid service.
- Washington Publishing Co.: http://www.wpc-edi.com/hipaa/HIPAA_40.asp. This website is the official source of the implementation guides for each of the ASC X12 N transactions.

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

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

10.7 Scheduled Web Portal Downtime

Scheduled Web Portal Downtime			
What is Impacted	Functionality Impact	Why	Downtimes
Entire website (Provider/Client) Static web pages <ul style="list-style-type: none">https://wymedicaid.portal.conduent.com	Website not available	Regular scheduled maintenance	<ul style="list-style-type: none">4 a.m. – 4:30 a.m. MST Saturdays3 p.m. – 6 p.m. MST Sundays
Secured Provider Web Portal <ul style="list-style-type: none">https://wymedicaid.portal.conduent.com/provider_home.html	Verification of claims submission will not be available	Regular scheduled maintenance	<ul style="list-style-type: none">10 p.m. – 12 a.m. (midnight) Sundays

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11.1 Wyoming Specific HIPAA 5010 Electronic Specifications

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

11.2 Transaction Definitions

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

Acknowledgement Transaction Definitions

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

11.3 Transmission Methods and Procedures

11.3.1 Asynchronous Dial-up

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

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

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

11.3.1.1 Communication Protocols

The EDI Clearinghouse currently supports the following communication options:

- XMODEM
- YMODEM
- ZMODEM
- KERMIT

11.3.1.2 Teleprocessing Requirements

The general specifications for communication with EDI Clearinghouse are:

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

11.3.1.3 Teleprocessing Settings

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

11.3.1.4 Transmission Procedures

SUBMITTER	HOST
Dials Host 1(800) 334-2832 or (800) 334-4650	Answers call, negotiates a common baud rate, and sends to the Trading Partner:
Prompt: “Please enter provider Logon=>”	
Enters User Name (From the EDI Welcome Letter) <CR>	Receives User Name and sends prompt to the Trading Partner:

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

11.3.2 Web Portal

The trading partner must be an authenticated portal user who is a provider. Only active providers are authorized to access files via the web. Provider must have completed the web registration process. ([10.5.2.1, Secured Provider Web Portal Registration Process](#))

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

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

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

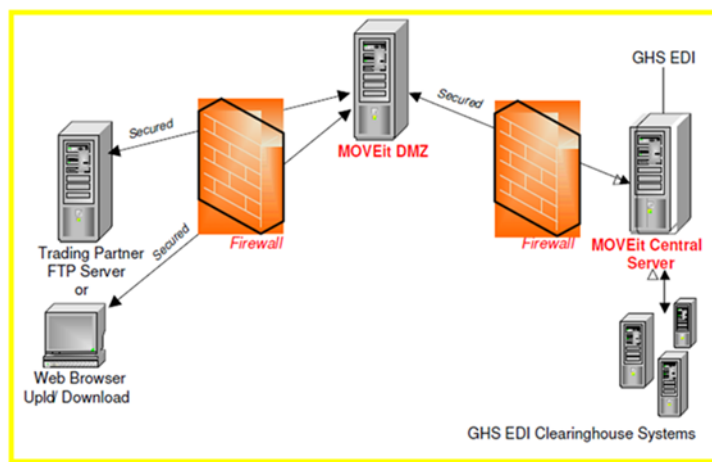
Transaction files can be uploaded and downloaded through the Secured Provider Web Portal at <https://wymedicaid.portal.conduent.com>.

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

11.3.3 Managed File Transfer (MOVEit)

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

Diagram 3. MOVEit Managed File Transfer



11.4 Acknowledgement and Error Reports

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

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

11.4.1 Confirmation Report

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

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

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

The Confirmation Report includes the following information:

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

11.4.2 Interchange Level Errors and TA1 Rejection Report

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

The TA1 reports the syntactical analysis of the interchange header and trailer. The TA1 allows EDI Clearinghouse to notify the trading partner that a valid X12N transaction envelope was received; or if problems were encountered with the interchange control structure or the trading partner relationship.

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

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

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

11.4.3 999 Implementation Acknowledgements

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

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

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

11.4.3.1 Batch and Real-Time Usage

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

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

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

11.4.4 Data Retrieval Method

Secured Web Portal

The web portal allows all trading partners to retrieve data via the internet 24-hours a day, seven (7) days a week. Each provider has the option of retrieving the transaction responses and reports themselves or allowing billing agents and clearinghouses to

retrieve on their behalf. The trading partner will access the Secured Provider Web Portal system using the user ID and password provided upon completion of the enrollment process ([10.5.2.1, Secured Provider Web Portal Registration Process](#)). Contact EDI Services for more information ([2.1, Quick Reference](#)).

11.5 Testing

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

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

If a production HIPAA 5010 file is submitted while in test mode the file will fail with a TA1 error ([11.4.2, Interchange Level Errors and TA1 Rejection Report](#)).

11.5.1 Testing Requirements

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

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

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

Each test transmission is validated to ensure no format errors are present. Testing is conducted to verify the integrity of the format not the integrity of the data. However, in order to simulate a true production environment, we request that test files contain

realistic healthcare transaction data. The number of test transmissions required depends on the number of format errors in a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to Wyoming Specific HIPAA 5010 Specifications or HIPAA mandated changes.

11.6 270/271 Eligibility Request and Response

Health Care Eligibility Benefit Inquiry Request and Response for Wyoming Medicaid

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

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

11.6.1 ISA Interchange Control Header

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

11.6.2 GS Functional Group Header

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

11.6.3 Access Methods Supported by Wyoming Medicaid

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

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

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

11.6.4 270 Eligibility Request

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

11.6.5 271 Eligibility Response

No Wyoming specific requirements.

11.7 276/277 Claim Request and Response

Health Care Claim Status Request and Response for Wyoming Medicaid

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

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

11.7.1 ISA Interchange Control Header

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

11.7.2 GS Function Group Header

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

11.7.3 276 Claim Status Report

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

11.7.4 277 Claim Status Response

No Wyoming specific requirements.

11.8 278 Request for Review and Response**Health Care Services Request for Review/Response for Wyoming Medicaid**

This section is for use along with the ANSI ASC X12 Health Care Prior Authorization Request and Response 278. It should not be considered a replacement for the TR3's, but rather used as an additional source of information. This section

contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

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

11.8.1 ISA Interchange Control Header

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

11.8.2 GS Function Group Header

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

11.8.3 278 Prior Authorization Request – Data Clarifications Inbound

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

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

11.9 835 Claim Payment/Advice

Health Care Claim Payment Advice for Wyoming Medicaid

11.9.1 Payment/Advice

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 107	1000B	REF	01	If the provider does not have an NPI then REF01 will contain “PQ” (Payee Identification) and REF02 will contain the Wyoming Medicaid Provider ID.

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

11.10 837 Professional Claims Transactions

Wyoming Medical Professional Claims

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

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

11.10.1 ISA Interchange Control Header

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

11.10.2 GS Functional Group Header

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

11.10.3 837 Professional

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 72	Header	BHT	06	Wyoming Medicaid only accepts the CH code.
Page 80	1000B	NM1	03	Enter Wyoming Medicaid.
Page 80	1000B	NM1	09	Enter 77046.
Page 83	2000A	PRV	03	If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.
Page 115	2000B	HL	04	Enter 0. The subscriber is always the patient; therefore, the dependent level will not be utilized.
Page 116-117	2000B	SBR	01	Enter P (Primary-Payer Responsibility Sequence Number code) Client has only Medicaid Coverage.
Page 123	2010BA	NM1	09	Enter the ten (10) digit Wyoming Medicaid Client ID.
Page 134	2010BB	NM1	03	Enter Wyoming Medicaid.
Page 134	2010BB	NM1	08	Enter PI (Payer Identification).
Page 134	2010BB	NM1	09	Enter 77046.
Page 140	2010BB	REF	01	If 'XX' is used to pass the NPI number in 2010AA, NM109, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then submit 'G2' (Provider Commercial Number) in 2010BB REF01, and submit the Wyoming Medicaid Provider Number in the 2010BB REF02.
Page 140-141	2010BB	REF	02	If 'XX' is used to pass the NPI number in 2010AA, NM109, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then submit 'G2' (Provider Commercial Number) in 2010BB REF01 and submit the Wyoming Medicaid Provider number in 2010BB REF02.

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TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 161	2300	CLM	05:3	Void/Adjustment (Frequency Type Code) should be six (6) (Adjustment) only if paid date was within the last six (6) months (180 days) (12 month (365 days) timely filing will be waived), or seven (7) (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.
Page 262-263	2310A	REF	01	If 'XX' is used to pass the NPI Number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 262-263	2310A	REF	02	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in the REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 269-270	2310B	REF	01	If 'XX' is used to pass the NPI number in NM10, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 269-270	2310B	REF	02	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted the enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 300	2320	SBR	09	Do not use code MC.
Page 427	2410	LIN	03	Enter the 11 digit National Drug Code (NDC). NDC's less than 11-digits will cause the service line to be denied by Wyoming Medicaid. Do not enter hyphens or spaces within the NDC.

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
				NOTE: Only the first iteration of Loop 2410 will be used for claims processing. If two (2) or more NDCs need to be reported for the same procedure code on the same claim, the procedure code must be repeated on a separate service line with the first iteration of Loop 2410 used to report each unique NDC. For more information consult the Wyoming Medicaid website (https://wymedicaid.portal.conduent.com).
Page 436	2420A	PRV	03	If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.
Page 437	2420A	REF	01	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 471	2420 F	REF	01	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 472	2420F	REF	02	If 'XX' is used to pass the NPI number is NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and Wyoming Medicaid Provider ID in REF02.

11.11 837 Institutional Claims Transactions

Wyoming Medicaid Institutional Claims

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

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

11.11.1 ISA Interchange Control header

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

11.11.2 GS Functional Group Header

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

11.11.3 837 Institutional

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

11.12837 Dental Claims Transactions

Wyoming Medicaid Dental Claims

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

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

11.12.1 ISA Interchange Control Header

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

11.12.2 GS Functional Group Header

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

11.12.3 Dental

TR3Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 75	1000B	NM1	03	Enter Wyoming Medicaid
Page 75	1000B	NM1	09	Enter 77046
Page 125	2010BB	NM1	03	Enter Wyoming Medicaid
Page 125	2010BB	NM1	08	Enter PI (Payer Identification)
Page 125	2010BB	NM1	09	Enter 77046
Page 126	2010BB	N3	01	Enter PO Box 547
Page 127	2010BB	N4	01	Enter Cheyenne
Page 128	2010BB	N4	02	Enter WY
Page 128	2010BB	N4	03	Enter 82003

Page 149	2300	CLM	05:3	Void/Adjustment (Frequency Type Code) should be six (6) (Adjustment) only if paid date was within the last six (6) months (180 days) (12 month (365 days) timely filing will be waived), or seven (7) (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.
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12.1 Claims Review

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

12.2 Coding

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

- Use current CPT-4, HCPCS Level II, and ICD-10 coding books.

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

- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend coding classes offered by certified coding specialists.
- Use the correct unit of measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II coding books. One (1) unit may equal “one (1) visit” or “15 minutes.” Always check the long version of the code description.
- Effective April 1, 2011, the National Correct Coding Initiative (NCCI) methodologies were incorporated into Medicaid’s claim processing system in order to comply with Federal legislation. The methodologies apply to both CPT Level I and HCPCS Level II codes.
- Coding denials cannot be billed to the patient but can be reconsidered per Wyoming Medicaid Rules, Chapter 16. Send a written letter of reconsideration to Wyoming Medicaid, Medical Policy ([2.1, Quick Reference](#)).

12.3 Importance of Fee Schedules

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

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

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

12.4 Interpretation Services

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

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

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

12.5 340B Attestation

Wyoming Medicaid 340B Attestation Form

Completion Instructions and Provisions

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

Covered Entity Information

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

"Pay To" Provider Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ NPI: _____

Wyoming Medicaid Provider ID: _____

340B Carve In Information

1. Has the provider listed above been designated as a 340B Covered Entity by HRSA? ☒ Yes ☐ No
2. Does this provider use drug products purchased under Section 340B of the Public Health Service Act for Wyoming Medicaid client (carve in)? ☐ Yes ☒ No
3. Carve In Effective Date. This should be a date on or after April 1, 2017 which reflects the beginning of the quarter in which the provider began carving in all Wyoming Medicaid clients to the 340B program.
☐ January 1, 20__ (Q1) ☐ April 1, 20__ (Q2) ☐ July 1, 20__ (Q3) ☐ October 1, 20__ (Q4)

Contact Information for 340B Program

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

Contact Name: _____ Email: _____ @ _____

Phone: _____ Ext. _____

Signature and Date

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

_____ Signature	_____ Date
_____ Name of Signator (please print)	_____ Phone Number

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

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

12.6 Dental Specific Important Information

12.6.1 Claims Review

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

12.6.2 Coding

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

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

12.6.3 Importance of Fee Schedules and Provider's Responsibility

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

12.6.4 Master Fee Schedule

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



12.6.5 By Report or Manually Priced Codes

Certain dental codes are manually priced or by report. By report dental codes are noted on the fee schedule by MP and will be paid at 70% of billed charge for dates of service prior to January 1, 2021. For January 1, 2021 and forward dates of services, by report dental codes will be paid at 68.25% of billed charges. Retrospective reviews may reveal inappropriate codes being billed or paid. After review by the Division of Healthcare Financing and the Department of Oral Health, if it is determined that the billing was inappropriate, federal regulations require that Medicaid recover any overpayment. Documentation should always support billing.

12.6.6 Dental Provider Client Acceptance Form Requirement

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

12.6.6.1 Dental Provider Client Acceptance Form

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

Dental Provider Client Acceptance Form

Billing Provider Name:

Provider NPI Number:

Provider Address:

Provider Phone:

Person completing form:

Date form completed:

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

<hr style="border: none; border-top: 1px solid black;"/> <div>Dentist Signature</div>	<hr style="border: none; border-top: 1px solid black;"/> <div>Date</div>
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A provider's form must be received by the Division of Healthcare Financing by July 15th of each year. A provider is responsible for completing a new form if their policy on accepting Medicaid clients changes during the year.

Return this form to:

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

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

12.6.7 Supernumerary Teeth

For Alphabetic tooth codes, add an S after the tooth code (e.g. supernumerary tooth A becomes AS)

For Numeric tooth codes, add 50 to the tooth codes value (e.g. supernumerary tooth 15 becomes $15+50 = 65$)

12.6.8 Dental Services Performed in an IHS/Tribal Clinic

Dental services that are performed in a tribal health clinic must be billed on the most current ADA claim form/837D. The encounter rate includes ALL services provided during the encounter regardless of actual charges, or is considered to be an all-inclusive rate. The first billed line item should be procedure code T1015, with the encounter rate. Additional lines should be billed with appropriate covered CDT codes showing each service provided and billed with a zero (0) dollar amount. All charges must be submitted on one (1) claim. If any codes on the claim deny due to being non-covered, the entire claim will deny. The provider is responsible for only billing Medicaid for covered dental services for the client.

Chapter Thirteen – Billing Indian Health Services/638 Tribal Facility Encounter Services

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13.1 Indian Health Services/638 Tribal Facilities

Appropriate Bill Type(s): 13X

Pay to Provider Taxonomy: 261QP0904X

Indian Health Services (IHS), an agency of the US Public Health Services within the Department of Health and Human Services, is the principal Federal health care provider for American Indians/Alaskan Natives.

A Tribal 638 Facility is a facility or location owned and operated by a federally recognized American Indian Tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic and rehabilitation services to tribal members.

Paramount is raising the health status of the American Indian/Alaskan Native health status to the highest possible level.

The facilities provide comprehensive health services, outpatient services including but not limited to: medical, vision, dental and preventative services, etc.

13.1.1 Reimbursement

Indian Health Services are reimbursed through an encounter method.

An encounter is a face-to-face visit with an enrolled health care professional such as:

- Physician
- Physician's assistant
- Nurse practitioner
- Nurse midwife
- Psychologist
- Social worker
- Dental professional
- Physical, Occupational and/or Speech therapist
- Dietitian
- Chiropractor
- Home health service provider

13.1.2 Encounter Rate

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

- Therapeutic services
- Diagnostic services
- Tests
- Supplies

Payment for multiple encounters on the same date of service will be allowed only if the services are categorically different and/or are provided for distinct and separate diagnoses. Different categories of allowable services shall include but are not limited to practitioner services, mental/behavioral health, optometric services, dental services, physical therapy, occupational therapy, speech therapy, medical social worker, laboratory, radiology, VFC Administration and Health Check Screening.

13.2 Billing Requirements

To receive the all-inclusive encounter rate, services must be provided within the “four 4 walls” of the clinic. Services billed at the encounter rate include:

Revenue Code	Description – within the IHS/638 Facility
0300	Laboratory
0400	Imaging/Radiology
0421	Physical Therapy
0431	Occupational Therapy
0441	Speech Therapy
0500	Medical Encounter
0512	Dental Encounter
0519	Optometric Encounter
0561	Medical Social Worker
0571	Home Health Aide
0771	VFC Administration
0779	Health Check Screening
0821	ESRD Encounter
0914	Psychiatric/Psychological Services – Individual Therapy
0915	Psychiatric/Psychological Services – Group Therapy
0987	Hospital Encounter (IHS physician at the hospital)

All claims for the services above must:

- Have a minimum of two (2) line items, the 1st would be the encounter line and the 2nd, 3rd, 4th, etc. line items are the detail.
- Both lines must have a revenue and procedure code combination.
- **Encounter lines** will be billed with one of the above encounter revenue codes paired with:
 - Procedure code T1015 for general encounter.
 - Bill the encounter line at the encounter rate
- **Detail line items** will be billed with:
 - An appropriate outpatient revenue code (excluding the encounter revenue codes) paired with an appropriate procedure code (for

questions regarding appropriate pairing of revenue codes and procedure codes, use the current version of the NUBC Official UB Data Specifications Manual).

- Document each procedure that occurred during the visit.
- Include a detailed line item for each office visit or health check procedure code if appropriate.
- Bill the detail line items at \$0.00

NOTE: Multiple encounters on the same day must be billed on separate claims. For multiple encounters to pay the diagnosis or treatment of the patient must be different than the 1st encounter.

13.2.1 Billing Examples

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

1st Claim

Date of Service	Revenue Code	Procedure Code	Amount
07/01/2017	0500	T1015	\$391.00
07/01/2017	0517	99213	\$0.00

2nd Claim

Date of Service	Revenue Code	Amount	NDC
07/01/2017	0259	\$391.00	00000-0000-00

The client is a child who has come to the facility for an office visit with complaints of trouble urinating.

1st Claim

Date of Service	Revenue Code	Procedure Code	Amount
07/02/2017	0500	T1015	\$391.00
07/02/2017	0517	99213	\$0.00

A client younger than 21, comes in and attends multiple appointments while they are there. They see a physician for leg pain, the physical therapist for therapy, dentist for a routine oral evaluation and a counselor for individual therapy.

1st claim for physician encounter

Date of Service	Revenue Code	Procedure Code	Amount
07/03/2017	0500	T1015	\$391.00
07/03/2017	0517	99213	\$0.00

2nd claim for physical therapy encounter

Date of Service	Revenue Code	Procedure Code	Amount
07/03/2017	0421	T1015	\$391.00
07/03/2017	0429	97110	\$0.00

3rd claim for dentist encounter

Date of Service	Revenue Code	Procedure Code	Amount
07/03/2017	0512	T1015	\$391.00
07/03/2017	0510	D0120	\$0.00
07/03/2017	0517	D1110	\$0.00

4th claim for behavioral health encounter

Date of Service	Revenue Code	Procedure Code	Amount
07/03/2017	0914	T1015	\$391.00
07/03/2017	0919	90832	\$0.00

Chapter Fourteen – Covered Services - Audiology

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14.1 Audiology Services

Encounter Revenue Code: 0529

Procedure Code Range: V5000-V5275 and 92550-92700

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

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

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

14.2 Requirements

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

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

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

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

14.3 Reporting Standards

The audiologist's report for Medicaid clients must contain the following information:

- The client's name, date of birth, and Medicaid ID number;
- Results of the audiometric tests at 500, 1,000, 2,000, and 3,000 hertz for the right and left ears, and the word recognition or speech discrimination scores obtained at levels which insure pb max;
- The report shall include the audiologist's name, address, license number, and signature of the audiologist completing the audiological evaluation, including the date performed; and
- A written summary from the licensed audiologist regarding the results of the evaluation indicating whether a hearing instrument is required, the type of

hearing instrument (e.g., in-the-ear, behind-the-ear, body amplifier, etc.), and whether monaural or binaural aids are requested.

A copy must be sent to the referring practitioner for the client's permanent record.

If binaural aids are requested, all of the following criteria must be met:

- Two-frequency average at 1 KHZ and 2 KHZ must be greater than 40 decibels in both ears;
- Two-frequency average at 1 KHZ and 2 KHZ must be less than 90 decibels in both ears;
- Two-frequency average at 1 KHZ and 2 KHZ must have an interaural difference of less than 15 decibels;
- Interaural word recognition or speech discrimination score must have a difference of not greater than 20%;
- Demonstrated successful use of a monaural hearing aid for at least six (6) months; and
- Documented need to understand speech with a high level of comprehension based on an educational or vocational need

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

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

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

14.4 Billing Procedures

- Providers must bill for services using the procedure codes set forth and according to the definitions contained in the HCPCS Level II and CPT coding book. It is essential for providers to have the most current HCPCS and CPT editions for proper billing.
- Providers are responsible for billing services provided within the scope of their practice and licensure.
- The date of service is the date the hearing aid is delivered or the date that the repairs are completed.

- A copy of the invoice must be attached to the claim. No other attachments are required ([6.15, Submitting Attachments for Electronic Claims](#)).

14.5 Reimbursement

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

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

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

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

NOTE: These fees are subject to change. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedule on the website ([2.1, Quick Reference](#)).

14.6 Hearing Aid Repair

The following guidelines apply to the repair of hearing aids:

- Repairs covered under warranty are not billable to Medicaid.
- V5014 is used to bill for repairs that are not covered under warranty.
- Re-dispensing fee may be applicable. When re-dispensing the hearing aid after the repair, use the RP modifier with the appropriate dispensing code.
- Claims must have an invoice attached.
- Claims are reimbursed at invoice plus shipping only

NOTE: Cleaning and checking the functionality of a hearing aid cannot be billed as hearing aid repairs.

14.7 Hearing Aid Insurance

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

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

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Covered Services – Behavioral Health

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15.1 Behavioral Health Services

Encounter Revenue Codes: 0500, 0914, and 0915

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

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

- **"Medical necessity" or "Medically necessary"** means a determination that a health service is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected to relieve pain or to improve and preserve health and be essential to life. The service must be:
 - Consistent with the diagnosis and treatment of the client's condition;
 - In accordance with the standards of good medical practice among the providers' peer group;
 - Required to meet the medical needs of the client and undertaken for reasons other than the convenience of the client and the provider; and,
 - Performed in the most cost effective and appropriate setting required by the client's condition.
- **Maintenance (Habilitative) Services** – Services that help clients keep, learn, or reach developmental milestones or improve skills and functioning for daily living that they have not yet acquired. Examples would include therapy for a child who is not walking or talking at the expected age.
- **Restorative (Rehabilitative) Services** – Services that help clients keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the client was sick, hurt, or suddenly disabled.
 - **Federal Medicaid Law** defines rehabilitative services as:
"Any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to his best possible functional level" [42 C.F.R. §440.130].
- **Patients in Controlled/Baseline State** – Patients in this group may well be symptomatic, but symptoms are controlled such that they can be reasonably treated with Outpatient (OP) Services with no immediate concern for patient safety.

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

15.1.1 Rehabilitative Services

- **What are Rehabilitative services?** “Rehabilitative” means to restore ability
 - An ability was once present, but was lost; or, was present and not exercised, and ability is restored through rehabilitative services
 - Similar to other rehabilitative therapies, such as occupational therapy, skills are incrementally introduced and practiced to reach achievable and measurable goals so that rehabilitative services are no longer necessary
- **Medicaid rehabilitative service providers** are required to:
 - Be familiar with and consult the Wyoming Medicaid mental health and/or substance abuse treatment rehabilitative services policy found in the CMS 1500 Provider Manual, Bulletins, and RA Banners.
 - Specify the type, frequency and duration of service in written treatment (rehabilitative) plan with a key focus on ensuring that all services are being directed toward specific and measurable rehabilitation goals which are developed with the client and their family and/or guardian
 - Avoid billing Medicaid for provision of services that are "intrinsic elements" of another federal, state, or local program other than Medicaid.
 - Rehabilitative services should not automatically be a part of an agency's day programming and are considered an individualized service based on each client's unique treatment needs

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

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

15.2 Eligible Providers

Individual and/or Group Providers		
Licensed Professional Counselor (LPC) 101YP2500X	Shall be enrolled as an individual or in one (1) of the following groups:	
	<ul style="list-style-type: none"> • Psychiatry • CMHC • SATC • Developmental Center 	<ul style="list-style-type: none"> • Psychologist • Neuropsychologist • Physician
Licensed Addictions Therapist (LAT) 101YA0400X	Shall be enrolled as an individual or in one (1) of the following groups:	
	<ul style="list-style-type: none"> • Psychiatry • CMHC • SATC • Developmental Center 	<ul style="list-style-type: none"> • Psychologist • Neuropsychologist • Physician
Neuropsychologist 103G00000X	Shall be enrolled as an individual or in one (1) of the following groups:	
	<ul style="list-style-type: none"> • CMHC • Physician 	<ul style="list-style-type: none"> • SATC
Clinical Psychologist 103TC0700X	Shall be enrolled as an individual or in one (1) of the following groups:	
	<ul style="list-style-type: none"> • CMHC • Physician 	<ul style="list-style-type: none"> • SATC • LAT

Covered Services – Behavioral Health

Individual and/or Group Providers		
Licensed Clinical Social Worker (LCSW) 1041C0700X	Shall be enrolled as an individual or in one (1) of the following groups:	
	<ul style="list-style-type: none"> • Psychiatry • CMHC • SATC • Developmental Center 	<ul style="list-style-type: none"> • Psychologist • Neuropsychologist • Physician
Licensed Marriage and Family Therapist (LMFT) 106H00000X	Shall be enrolled as an individual or in one (1) of the following groups:	
	<ul style="list-style-type: none"> • Psychiatry • CMHC • SATC • Developmental Center 	<ul style="list-style-type: none"> • Psychologist • Neuropsychologist • Physician

Only Enrolled Under Supervision		
Certified Mental Health Worker (CMHW) 101Y00000X	Shall be under the supervision of a Qualified Clinical Supervisor and employer; AND Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • Psychologist • CMHC 	<ul style="list-style-type: none"> • Neuropsychologist • SATC
Certified Addictions Practitioner (CAP) 101YA0400X	Shall be under the supervision of a Licensed Professional and Employer; AND Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • Psychologist • CMHC 	<ul style="list-style-type: none"> • Neuropsychologist • SATC
Certified Social Worker (CSW) 1041C0700X	Shall be under the supervision of a Qualified Clinical Supervisor and employer; AND Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • Psychologist • CMHC 	<ul style="list-style-type: none"> • Neuropsychologist • SATC
Community Health Worker – Individual Rehabilitative Services Worker (IRS) 172V00000X	Shall be under the supervision of a Licensed Professional and Employer; AND Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • CMHC 	<ul style="list-style-type: none"> • SATC
Certified Addictions Practitioner Assistant (CAPA) 172V00000X	Shall be under the supervision of a Licensed Professional and Employer; AND Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • CMHC 	<ul style="list-style-type: none"> • SATC

Covered Services – Behavioral Health

Providers MUST be enrolled in a group		
Provisional Professional Counselor (PPC) 101Y00000X	Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • CMHC • Psychiatry • Neuropsychologist • LPC • LAT • Developmental Center 	<ul style="list-style-type: none"> • SATC • Psychologist • Physician • LCSW • LMFT
Provisional Licensed Addictions Therapist (PLAT) 101YA0400X	Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • CMHC • Psychiatry • Neuropsychologist • LPC • LAT • Developmental Center 	<ul style="list-style-type: none"> • SATC • Psychologist • Physician • LCSW • LMFT
Master of Social Worker (MSW) with Provisional License (PCSW) 1041C0700X	Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • CMHC • Psychiatry • Neuropsychologist • LPC • LAT • Developmental Center 	<ul style="list-style-type: none"> • SATC • Psychologist • Physician • LCSW • LMFT
Provisional Marriage and Family Therapist (PMFT) 106H00000X	Shall be enrolled in one (1) of the following groups:	
	<ul style="list-style-type: none"> • CMHC • Psychiatry • Neuropsychologist • LPC • LAT • Developmental Center 	<ul style="list-style-type: none"> • SATC • Psychologist • Physician • LCSW • LMFT
Registered Nurse (RN) 163W00000X	Shall only be enrolled in one (1) of the following groups:	
	• CMHC	• SATC
Licensed Practical Nurse (LPN) 164W00000X	Shall only be enrolled in one (1) of the following groups:	
	• CMHC	• SATC
Case Manager 171M00000X	Shall only be enrolled in one (1) of the following groups:	
	• CMHC	• SATC
Certified Peer Specialist 175T00000X	Shall only be enrolled in one (1) of the following groups:	
	• CMHC	• SATC

15.3 Requirements for Community Mental Health Centers (CMHC) and Substance Abuse Centers

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

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

15.3.1 Provider's Role

Each Medicaid provider shall:

- Be certified under state law to perform the specific services.
- Certify that each covered service provided is medically necessary, rehabilitative and is in accordance with accepted norms of mental health and substance use practice.
- Providers are required to maintain records of the nature and scope of the care furnished to Wyoming Medicaid clients.

15.3.2 Responsibilities of Mental Health/Substance Abuse Providers

- Each client shall be referred by a licensed practitioner who attests to medical necessity as indicated by the practitioner's signature, date on the clinical assessment, and on the initial and subsequent treatment plans which prescribe rehabilitative, targeted case management, or ESPDT mental health services.
- Licensed practitioners who are eligible to refer and to sign for medical necessity are persons who have a current license from the State of Wyoming to practice as a:
 - Licensed Professional Counselor
 - Licensed Addictions Therapist
 - Licensed Psychologist
 - Licensed Clinical Social Worker
 - Licensed Marriage and Family Therapist
 - Licensed Physician
 - Licensed Psychiatric Nurse (Masters)
 - Licensed Advanced Practitioner of Nursing (Specialty area of psychiatric/mental health nursing)

- For a licensed practitioner to be authorized to refer and to sign for medical necessity, the agreement between the licensed practitioner and the provider by which the practitioner's responsibilities under the Medicaid Mental Health Rehabilitative Option, Targeted Case Management Option, and EPSDT mental health services are specified.
- Any licensed practitioner under contract with, or employed by, a provider shall be required to submit Medicaid claims through the provider and to indicate the provider as payee. All individuals providing services must have their own provider number.
- Prior to the providers' billing Medicaid for Mental Health Rehabilitative Option, Targeted Case Management Option and EPSDT mental health services a licensed practitioner shall sign, date and add their credentials to the client's clinical assessment, written treatment plan and clinical notes.
- Licensed practitioners who sign for services that are not medically necessary and rehabilitative in nature are subject to formal sanctions through Wyoming Medicaid and/or referral to the relevant licensing board.

15.3.3 Qualification for Participating Provider and Staff

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

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

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

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

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

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

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

- Be employed or under contract with the Behavioral Health Division certified Medicaid provider. Self-identify as a person in recovery from mental illness and/or substance use disorder.
- Be twenty-one years of age or older.
- Be credentialed by the Behavioral Health Division as a peer specialist, and
- Be under the direct supervision of the primary therapist for that client.

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

- Be employed or under contract with the Behavioral Health Division certified mental health or substance use treatment center and enrolled as a Medicaid provider, and
- Be a mental health or substance use treatment professional, a mental health or substance use treatment counselor, a mental health or substance use treatment assistant as pursuant to Wyoming Medicaid Rules, Chapter 13- Mental Health Services, or
- Be a registered nurse (R.N.), licensed in the State of Wyoming, who has at least two years of clinical experience after the awarding of the R.N.
- Knowledgeable of the community and have the ability to work with other agencies

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

15.3.4 Quality Assurance

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

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

15.3.5 Psychiatric Services

- **Psychiatric Services** – Medicaid covers medically necessary psychiatric and mental health services when provided by the following practitioners:
 - Psychiatrists or Physicians; or
 - APN/PMHNP (Advance Practice Nurse/Psychiatric Mental Health Nurse Practitioner).
- **APN/PMHNP Services** – Medicaid covers medically necessary psychiatric services when provided by an APN/PMHNP.
 - The APN/PMHNP must have completed a nursing education program and national certification that prepares the nurse as a specialist in Psychiatric/Mental Health and is recognized by the State Board of Nursing in that specialty area of advance practice.

15.3.5.1 Psychologists

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

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

15.3.5.2 Licensed Mental Health Professionals

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

provider, and the individual treating providers NPI as the rendering provider at the line level.

15.3.5.3 Provisional Licensed Mental Health Professionals

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

15.3.5.4 Supervision

Supervision is defined as the ready availability of the psychiatrist/physician, psychologist or LMHPs for consultation and direction of the activities of the mental health professionals in the office. Contact with the supervising practitioner (physician /psychiatrist, psychologist, or LMHPs) by telecommunication is sufficient to show ready availability, if such contact provides quality care. The supervising practitioner maintains final responsibility for the care of the client and the performance of the mental health professional in their office.

15.3.5.5 Reimbursement for Behavioral Health Residents and Student Interns

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

15.3.6 Behavioral Health Providers Eligible for Medicare Enrollment

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

Taxonomy Codes Eligible for Medicare Enrollment	
Taxonomy	Description
2084P0800X	Psychiatrist
103TC0700X	Licensed Psychologist

Taxonomy Codes Eligible for Medicare Enrollment	
Taxonomy	Description
1041C0700X	Licensed Clinical Social Worker (LCSW)
364SP0808X	Advanced Practice Nurse Practitioner (APRN)

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

15.4 Covered Services

- **Adult Psychosocial Rehabilitation or Day Treatment** (Community Mental Health and Substance Abuse Treatment Centers only) focuses both on the process of recovery as well as the development of skills clients can use to cope with mental health symptoms. Skills addressed may include:
 - Emotional skills, such as coping with stress, managing anxiety, dealing constructively with anger and other strong emotions, coping with depression, managing symptoms, dealing with frustration and disappointment and similar skills.
 - Behavioral skills, such as managing overt expression of symptoms like delusions and hallucinations, appropriate social and interpersonal interactions, proper use of medications, extinguishing aggressive/assaultive behavior.
 - Daily living and self-care, such as personal care and hygiene, money management, home care, daily structure, use of free time, shopping, food selection and preparation and similar skills.
 - Cognitive skills, such as problem solving, concentration and attention, planning and setting, understanding illness and symptoms, decision making, reframing, and similar skills.
 - Community integration skills, which focus on the maintenance or development of socially valued, age appropriate activities.
 - And similar treatment to implement each enrolled client's treatment plan.
 - Excludes the following services; academic education, recreational activities, meals and snacks, and vocational services and training.

NOTE: HQ modifier for group sessions is not needed on this code.

- **Agency/Based Individual/Family Therapy:** Contact within the provider's office or agency with the client and/or collaterals for the purpose of developing and implementing the treatment plan for an individual or family. This service is targeted at reducing or eliminating specific symptoms or behaviors which are related to a client's mental health or substance abuse disorder as specified in the treatment plan.

- **Peer Specialist Services** (Community Mental Health and Substance Abuse Treatment Centers only): Contact with enrolled clients (and collaterals as necessary) for the purpose of:
 - To teach and support the restoration and exercise of skills needed for management of symptoms **AND**
 - For utilization of natural resources within the community **AND**
 - Implementing the portion of the client's treatment plan that promotes the client to direct their own recovery and advocacy process **OR**
 - Training to parents on how best to manage their child's mental health and/or substance abuse disorder to prevent out-of-home placement

The skills and knowledge is provided to assist the client and/or parent to design and have ownership of their individualized plan of care. Services are person centered and provided from the perspective of an individual who has their own recovery experience from mental illness and/or substance use and is trained to promote hope and recovery, assist meeting the goals of the client's treatment plan and to provide Peer Specialist services. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a client's mental health and/or substance use disorder(s) as identified in the treatment plan. Services provided to family members must be for the direct benefit of the Medicaid client. This service is 15 minutes per unit.

- **Children's Psychosocial Rehabilitation** (Community Mental Health and Substance Abuse Treatment Centers only): This service is designed to address the emotional and behavioral symptoms of youth diagnosed with childhood disorder including: ADHD, Oppositional Defiant Disorder, Depression, Disruptive Behavior Disorder, and other related children's disorders. Within this service there are group and individual modalities and a primary focus on behaviors that enhance a youth's functioning in the home, school, and community. Youth will acquire skills such as conflict resolution, anger management, positive peer interaction and positive self-esteem. Treatment interventions include group therapy, activity based therapy, psycho-educational instruction, behavior modification, skill development, and similar treatment to implement each enrolled client's treatment plan. The day treatment program may include a parent group designed to teach parents the intervention strategies used in the program.
- **Clinical Assessment:** Contact with the enrolled client and/or collaterals as necessary, for the purpose of completing an evaluation of the client's mental health and substance use disorder(s) to determine treatment needs and establish a treatment plan. This service may include psychological testing if indicated, and establishing DSM (current edition) diagnosis.
- **Community-Based Individual/Family Therapy:** Contact outside of the provider's office or agency, with the client and/or collaterals for the purpose of developing and implementing the treatment plan for an individual or family. This service is targeted at reducing or eliminating specific symptoms or behaviors which are related to a client's mental health or substance abuse disorder as specified in the treatment plan.

- **Comprehensive Medication Services** (Community Mental Health and Substance Abuse Treatment Centers only): Assistance to clients by licensed and duly authorized medical personnel such as a licensed professional counselor, registered nurse, or licensed practical nurse, acting within the scope of their licensure, regarding day-to-day management of the recipient's medication regime. This service may include education of clients regarding compliance with the prescribed regime, filling pill boxes, locating pharmacy services, and assistance managing symptoms that don't require a prescriber's immediate attention. This service is separate and distinct from the medication management performed by physicians, physician's assistants and advanced practitioners of nursing who have prescriptive authority. This service is 15 minutes per unit.
- **Group Therapy:** Contact with two or more unrelated clients and/or collaterals as necessary, for the purpose of implementing each client's treatment plan. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a recipient's mental health and/or substance abuse disorder(s) as identified in the treatment plan.
- **Individual Rehabilitative Services** (Community Mental Health and Substance Abuse Treatment Centers only): Contact with the enrolled client for the purpose of implementing that portion of the client's treatment plan targeted to developing and restoring basic skills necessary to function independently in the home and the community in an age-appropriate manner. As well as for the purpose of restoring those skills necessary to enable and maintain independent living in the community in an age-appropriate manner, including learning skills in use of necessary community resources. Individual rehabilitative services assist with the restoration of a recipient to his or her optimal functional level. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a recipient's mental health and/or substance use disorder(s) as identified in the treatment plan. Services provided to family members must be for direct benefit of the Medicaid recipient. This service is 15 minutes per unit.
- **Intensive Individual Rehabilitative Services** (Community Mental Health and Substance Abuse Treatment Centers only): The short-term use of two skill trainers with one client in order to provide effective management of particularly acute behaviors that are violent, aggressive, or self-harmful. Skill trainers who provide Intensive Individual Rehabilitative Services shall have been trained in non-violent behavioral management techniques.
- **Substance Use Intensive Outpatient Treatment Services** (Community Mental Health and Substance Abuse Treatment Centers only): Direct contact with two or more enrolled clients (and collaterals as necessary) for the purpose of providing a preplanned and structured program of group treatment which may include education about role functioning, illness and medications; group therapy and problem solving, and similar treatment to implement each enrolled client's treatment plan.

- **Psychiatrist Services:** These mental health and substance abuse treatment services are covered by Medicaid when it is determined to be medically necessary and rehabilitative in nature.

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

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

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

Targeted case management activities include the following:

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

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

15.4.2 EPSDT Mental Health Services or Ongoing Case Management

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

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

Ongoing case management activities include the following:

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

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

15.4.3 Limitations to Mental Health/Substance Abuse Services

- Medicaid Mental Health Rehabilitative Targeted Case Management Option and EPSDT mental health services are limited to those clients that meet the criteria and have a primary diagnosis of a mental/substance use disorder in the most current edition of the Diagnostic and Statistical Manual Disorders (DSM) or ICD equivalent.
- Specifically excluded from eligibility for Rehabilitative Option, Targeted Case Management Option and EPSDT mental health services are the following diagnoses resulting from clinical assessment:
 - Sole DSM diagnosis of intellectual disabilities

- Sole DSM diagnosis of any Z code and services provided for a Z code diagnosis (exception for young children)
- Sole DSM diagnosis of other unknown and unspecified cause of morbidity and mortality
- Sole DSM diagnosis of specific learning disorders
- Habilitative services are not covered for clients twenty-one (21) years of age or older.

15.4.4 Collateral Contact

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

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

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

15.4.4.1 Collateral Visits

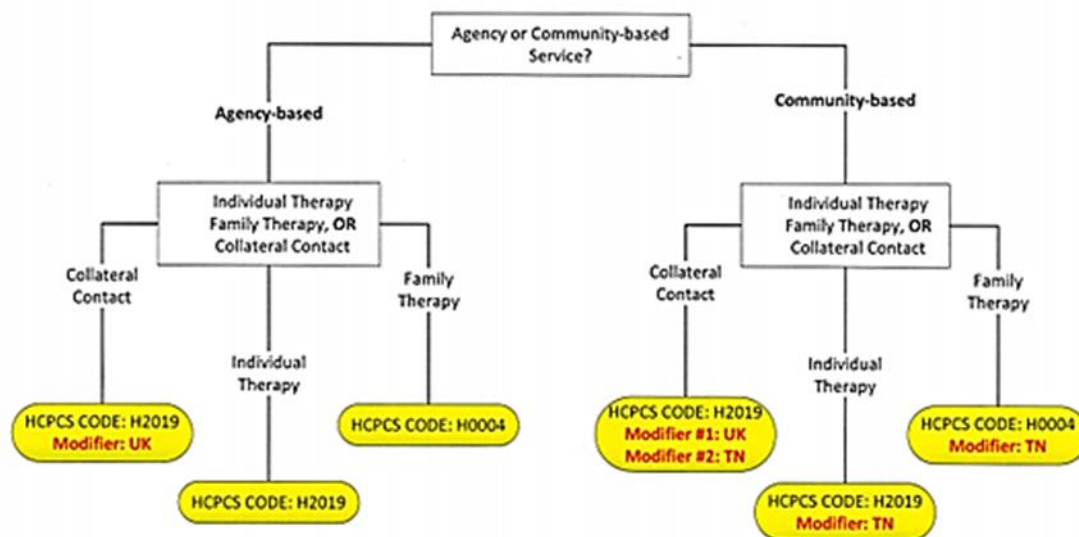
- A collateral can attend a session with the therapist with or without the client present.
- Generally, unlike patients, collaterals do not have the right to access clinical records unless they are a parent or legal guardian.
- Collaterals are not responsible for the fees of the sessions they attend, unless they have been responsible for the fees all along, as is often the case when the collateral is the parent of a minor patient.

- Collaterals are not patients of the provider. The provider does not have the same responsibility for collaterals as they have for their clients.
- Information about the collateral may be entered into the clinical records with a varied range of details, depending on the clinician, the situation, the relationships between the patient and the collateral and the communication between the therapist, client and collateral.
- Clinicians who work with children often treat them in the context of their family. Sometimes family members are included in sessions as collaterals.
- If a clinician thinks it is appropriate, he/she may offer a referral to the collateral for a follow up with another mental health professional.
- Child or adult abuse and similar reporting laws apply to collateral visits.
- In many situations, the patient is not mandated to sign an 'Authorization to Release Information' to the collateral for information shared during the visit if both collateral and patient are present in the room at the same time.

15.4.5 Community-Based Services

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

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



15.5 Covered Service Codes

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

Covered Services – Behavioral Health

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
G9012	Ongoing Case Management (≤ 20 years)	Per 15 minutes	GT, HQ, HL, UK	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Case Manager, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
T1017	Adult Case Management Targeted Case Management (≥ 21 years)	Per 15 minutes	GT, HQ, HL, UK	CMHC, SATC	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Case Manager, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
H0004	Family Therapy	Per 15 minutes	GT, HQ, HL, TN, UK	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
H0031	Clinical Assessment - Mental Health Assessment by non-physician Note: If the clinical assessment takes multiple	Per session	GT, UK, HL	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN,	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with

Covered Services – Behavioral Health

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
	days to complete, it should be billed on the day of completion per CMS and AAPC guidelines.			Taxonomies beginning with 20 (Physicians)	20 (Physicians)
H0038	Certified Peer Specialist	Per 15 minutes	UK	CMHC, SATC	Peer Specialist
H0038+HQ	Certified Peer Specialist with a group	Per 15 minutes	HQ, UK	CMHC, SATC	Peer Specialist
H0046	Group Therapy – Mental health services, not otherwise specified	Per session	GT, TN, UK, HL	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
H2010	Comprehensive Medication Therapy	Per 15 minutes		CMHC, SATC	LPC, RN, LPN, APRN
H2014	Individual Rehabilitative Service - Skills Training and Development	Per 15 minutes	HQ, HL	CMHC, SATC	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, LPN, Case Manager, IRS worker
H2017	Psychosocial Rehabilitation Services	Per 15 minutes	HL	CMHC, SATC	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Case Manager, Psychiatrist, APRN

Covered Services – Behavioral Health

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

Covered Services – Behavioral Health

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

Covered Services – Behavioral Health

CPT Code	Description	1 Unit Equals	Pay-to Providers Taxonomies Allowed	Treating Provider Taxonomies Allowed
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians).	Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians)
90834	Psychotherapy, 45 minutes with patient and/or family member	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
90836	Psychotherapy, 45-minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, APRN, , Taxonomies beginning with 20 (Physicians)	Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians)
90837	Psychotherapy, 60 minutes with patient and/or family member	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)

Covered Services – Behavioral Health

CPT Code	Description	1 Unit Equals	Pay-to Providers Taxonomies Allowed	Treating Provider Taxonomies Allowed
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management services (list separately in addition to the code for primary procedure)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, APRN, , Taxonomies beginning with 20 (Physicians)	Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians)
90845	Psychoanalysis	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
90846	Family Medical Psychotherapy (without the patient present)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LPC, LCSW, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians),	LPC, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
90847	Family Psychotherapy	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	LPC, PPC, LCSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)

Covered Services – Behavioral Health

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

NOTE: Interpretations or explanation of results of psychiatric services to family members or other responsible persons is included in the fee for psychotherapy. The following matrix indicates the CPT-4 codes specific to psychological services. Please refer to the most current version of the CPT book.

Covered Services – Behavioral Health

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

Community Mental Health Centers & Substance Abuse Treatment Centers Only		
Taxonomy	Provider Types	Allowed Codes
101Y00000X	Provisional Professional Counselor (PPC), Certified Mental Health Worker	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90832, 90834, 90837, 90845, 90847, 90849, 90853
101YA0400X	Licensed Addictions Therapist (LAT), Provisionally Licensed Addictions Therapist (PLAT), Certified Addictions Practitioner (CAP)	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90832, 90834, 90837, 90845, 90847, 90849, 90853
101YP2500X	Licensed Professional Counselor (LPC)	G9012, H0004, H0031, H0046, H2010, H2014, H2017, H2019, S9480, T1017, 90791, 90785, 90832, 90834, 90837, 90846, 90847, 90849, 90853
103G00000X	Neuropsychologist	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90792, 90832-90834, 90836-90839, 90845-90847, 90849, 90853, 96101-96103, 96105, 96110-96111, 96116, 96118-96120, 96125
103TC0700X	Clinical Psychologist	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90792, 90832-90834, 90836-90839, 90845-90847, 90849, 90853, 96105-96146
1041C0700X	Licensed Clinical Social Worker (LCSW)\	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90832, 90834, 90837, 90845, 90847, 90849, 90853
106H00000X	Marriage and Family Therapist (MFT), Provisionally Licensed Marriage and Family Therapist (PMFT)	G9012, H0004, H0031, H0046, H2014, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90832, 90834, 90837, 90845, 90849, 90853

Covered Services – Behavioral Health

Community Mental Health Centers & Substance Abuse Treatment Centers Only		
Taxonomy	Provider Types	Allowed Codes
163W00000X	RN	G9012, H0004, H0031, H0046, H2010, H2014, H2017, H2019, S9480, T1017
164W00000X	LPN	G9012, H2010, H2014
171M00000X	Case Manager	G9012, H2014, H2017, T1017
175T00000X	Certified Peer Specialist	H0038
172V00000X	Community Health Worker – Individual Rehabilitative Services Worker (IRS), Certified Addictions Practitioner Assistant (CAPA)	H2014
Taxonomies beginning with 20	Physicians	G9012, H0004, H0031, H0046, H2019, S9480, T1017, 90785, 90791, 90792, 90832- 90834, 90836-90839, 90845 90846, 90847, 90849, 90853, 96105-96146
2084P0800X	Psychiatry and Neurology, Psychiatry	G9012, H0004, H0031, H0046, H2017, H2019, S9480, T1017, T2011, 90785, 90791, 90792, 90832-90834, 90836-90839, 90845-90847, 90849, 90853, 96105-96146
364SP0808X	Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health	G9012, H0004, H0031, H0046, H2010, H2017, S9480, T1017, T2011, 90785, 90791, 90792, 90832-90834, 90836-90839, 90845-90847, 90849, 90853, 96105-96146

15.6 Non-Covered Services

- Hospital liaison services that include institutional discharge functions that are Medicaid reimbursable to the institution
- Consultation to other persons and agencies about non-clients, public education, public relations activities, speaking engagements and education
- Clinical services not provided through face-to-face contact with the client, other than collateral contacts necessary to develop/implement the prescribed plan of treatment
- Residential room, board, and care
- Substance use and mental health prevention services
- Recreation and socialization services
- Vocational services and training
- Appointments not kept
- Day care

- Psychological testing done for the sole purpose of educational diagnosis or school placement
- Remedial or other formal education
- Travel time
- Record keeping time
- Time spent writing test reports with the exception of three hours allowed for report writing by a licensed psychologist for the purpose of compiling a formal report of test findings and time spent completing reports, forms and correspondence covered under case management services
- Time spent in consultation with other persons or organizations on behalf of a client unless:
 - The consultation is a face-to-face contact with collateral in order to implement the treatment plan of a client receiving Rehabilitative Option services. OR
 - The consultation is a face-to-face or telephone contact in order to implement the treatment plan of a client receiving EPSDT Mental Health Services. OR
 - The consultation is a face-to-face or telephone contact in order to implement the treatment plan of a client receiving Targeted Case Management Services. OR
 - The consultation is a face-to-face or telephone contact in order to implement the treatment plan of a client receiving Applied Behavior Analysis treatment.
- Groups such as Alcoholics Anonymous, Narcotics Anonymous, and other self-help groups
- Driving while under the influence (DUI) classes
- Services provided by a school psychologist

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

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

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

15.7 Applied Behavioral Analysis Treatment

Applied Behavior Analysis (ABA) treatments are allowable to children between the ages of 0-20 years of age with a diagnosis of Autism Spectrum Disorder. ABAs are individualized treatments based in behavioral sciences that focus on increasing

positive behaviors and decreasing negative or interfering behaviors to improve a variety of well-defined skills. ABA is a highly structured program that includes incidental teaching, intentional environmental modifications, and reinforcement techniques to produce socially significant improvement in human behavior. ABA strategies include reinforcement, shaping, chaining of behaviors, and other behavioral strategies to build specific targeted functional skills that are important for everyday life.

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

15.7.1 Applied Behavior Analysis Providers

ABA Providers must follow the requirements set by the Board of Certified Behavior Analysts as per <https://www.bacb.com/become-credentialed/> in order to provide applied behavior analysis treatment services to Wyoming Medicaid clients.

Covered Services – Behavioral Health

Name	Abbreviation and Requirements http://bacb.com/credentials/
Board Certified Behavior Analysts – Doctoral 103K00000X	BCBA-D Be actively certified as a BCBA in Good Standing Have earned a degree from a doctoral program accredited by the Association for Behavior Analysis International or; A certificant whose doctoral training was primarily behavior-analytic in nature, but was not obtained from an ABAI-accredited doctoral program, may qualify for the designation by demonstrating that his or her doctoral degree met the following criteria: (a.) The degree was conferred by an acceptable accredited institution; AND (b.) The applicant conducted a behavior-analytic dissertation, including at least 1 experiment; AND (c.) The applicant passed at least 2 behavior analytic courses as part of the doctoral program of study; AND (d.) The applicant met all BCBA coursework requirements prior to receiving the doctoral degree.
Board Certified Behavior Analysts 103K00000X	BCBA Option 1 requires an acceptable graduate degree from an accredited university, completion of acceptable graduate coursework in behavior analysis, and a defined period of supervised practical experience to apply for the BCBA examination. Option 2 requires an acceptable graduate degree from an accredited university, completion of acceptable graduate coursework in behavior analysis that includes research and teaching, and supervised practical experience to apply for BCBA examination. Option 3 requires an acceptable doctoral degree that was conferred at least 10 years ago and at least 10 years post-doctoral practical experience to apply for the BCBA examination.
Board Certified Assistant Behavior Analyst 106E00000X	BCaBA 1. Degree Applicant must possess a minimum of a bachelor's degree from an acceptable accredited institution. The bachelor's degree may be in any discipline. 2. Coursework Course work must come from an acceptable institution and cover the required content outlined in the BACB's Fourth Edition Task List and Course Content Allocation documents. 3. Experience Applicants must complete experience that fully complies with all of the current Experience Standards. 4. Examination Applicants must take and pass the BCaBA examination.
Registered Behavior Technician 106S00000X	RBT 1. Age and Education RBT applicants must be at least 18 years of age and have demonstrated completion of high school or equivalent/higher. 2. Training Requirement The 40-hour RBT training is not provided by the BACB but, rather, is developed and conducted by BACB certificants. 3. The RBT Competency Assessment The RBT Competency Assessment is the basis for the initial and annual assessment requirements for the RBT credential. 4. Criminal Background Registry Check To the extent permitted by law, a criminal background check and abuse registry check shall be conducted on each RBT applicant no more than 45 days prior to submitting an application. 5. RBT Examination

Covered Services – Behavioral Health

All candidates who complete an RBT application on or after December 14, 2015 will need to take and pass an examination before credential is awarded.

15.7.2 Covered Services

Adaptive Behavior Assessment and Treatment Procedure Codes						
Essential Elements applied Behavior Analysis Services		General Description	Descriptor	Code	Time/Units	Attended By and Provider Type(s)
Assessment Codes	Development of individualized treatment plan by supervising behavior analyst/QHP	Assessment for treatment plan development	Behavior identification assessment, administered by a qualified healthcare professional, each 15 minutes of the other qualified healthcare professional's or Board Certified Behavior Analyst's (QHP/BCBA) time face-to-face with patient and/or guardian/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	97151	Per 15 Min (48 Max Units/Day)	Functional analysis of severe maladaptive behaviors in specialized settings
	Assessment may include: <ul style="list-style-type: none"> Review of file information about client's medical status, prior assessments, prior treatments Stakeholder interviews and rating scales Review of assessments by other professionals Direct observation and measurement of client's behavior in structured and unstructured situations Determination of baseline levels of adaptive and maladaptive behaviors Functional behavior analysis 		Behavior identification supporting assessment, administered by one technician under the direction of a QHP/BCBA, face-to-face with the patient, each 15 minute.	97152	Per 15 Min	Client & RBT (106S00000X) or BCaBA (106E00000X) (BCBA or BCBA-D may substitute for the technician)
		Functional analysis of severe maladaptive behaviors in specialized settings	Behavior identification supporting assessment. Each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: <ul style="list-style-type: none"> administered by the QHP/BCBA who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized to the patient's behavior. 	0362T	Per 15 Min	Client & RBT (106S00000X) or BCaBA (106E00000X) (BCBA or BCBA-D may substitute for the technician)
Treatment Codes	Implementation and management of treatment plan by supervising behavior analyst/BCBA. Includes: <ul style="list-style-type: none"> Training technicians to 	Direct treatment	Adaptive behavior treatment by protocol, administered by technician under the direction of a QHP/BCBA, face-to-face with one patient, each 15 minutes.	97153	Per 15 Min (32 Max Units/Day)	Client & RBT (106S00000X) or BCaBA (106E00000X) (BCBA or BCBA-D may substitute for the technician)

Covered Services – Behavioral Health

Adaptive Behavior Assessment and Treatment Procedure Codes						
Essential Elements applied Behavior Analysis Services		General Description	Descriptor	Code	Time/Units	Attended By and Provider Type(s)
	a) carry out treatment protocols accurately, frequently, and consistently; b) record data on treatment targets; c) record notes; d) summarize and graph data. • Training family members and other caregivers to implement selected aspects of treatment plan. • Ongoing supervision of technician and caregiver implementation. • Ongoing, frequent review and analysis of direct observational data on treatment targets. • Modification of treatment targets and protocols based on data. • Training technicians, family members, and other caregivers to implement revised protocols.	Direct treatment of severe maladaptive behavior in specialized settings	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: <ul style="list-style-type: none"> administered by the QHP/BCBA who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized, to the patient's behavior. 	0373T	Per 15 Min	Client & 2 or more RBTs (106S00000X) or BCaBAs (106E00000X) (BCBA or BCBA-D may substitute for the technician)
		Direct treatment by QHP	Adaptive behavior treatment with protocol modification, administered the QHP/BCBA, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	97155	Per 15 Min (16 Max Units/Day)	Client & BCBA or BCBA-D (103K00000X); may include a RBT, BCaBA and/or Caregiver
		Group Treatment	Group adaptive behavior treatment by protocol, administered by technician under the direction of a QHP/BCBA, face-to-face with two or more patients, each 15 minutes.	97154	Per 15 Min (32 Max Units/Day)	2 or more Clients & RBT (106S00000X) or BCaBA (106E00000X) (BCBA or BCBA-D may substitute for the technician)
				97158	Per 15 Min (32 Max Units/Day)	2 or more Clients & BCBA or BCBA-D (103K00000X)
		Family Training	Multiple-family group adaptive behavior treatment guidance, administered by QHP/BCBA (without the patient present), face-to-face with multiple sets of guardian/caregivers, each 15 minutes.	97156	Per 15 Min (4 Max Units/Day)	Caregiver & BCBA or BCBA-D (103K00000X)
			Multiple-family group adaptive behavior treatment guidance, administered by QHP/BCBA (without the patient present), face-to-face with multiple sets of guardian/caregivers, each 15 minutes.	97157	Per 15 Min (4 Max Units/Day)	Caregivers of 2 or more Clients & BCBA or BCBA-D (103K00000X)

Definitions:

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

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

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

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

15.7.3 ABA Supervision of Technicians

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

When a QHP/BCBA is directing the activities of a technician in person (**face-to-face contact with the patient**) for purposes such as checking procedural integrity and problem solving and/or modifying a treatment protocol that is not effective, the QHP/BCBA would bill for this time using the adaptive behavior treatment with protocol modification code. There is no separate code for QHP/BCBA supervision of

technicians without the patient present. This type of supervision is included in the codes used to bill according to a technician's time, and is typically considered to be 10–15 minutes of QHP/BCBA time for each hour that a technician spends face to face with a patient.

NOTE: The CPT Editorial Panel regards supervision as primarily a human resources function (e.g., providing performance feedback, resolving employee conflicts, approving vacation, conducting annual evaluations). The CPT Editorial Panel considers these activities practice expenses, and therefore does not publish codes to allow professionals to bill for supervision as a separate health procedure.

15.8 Limitations for Behavioral Health Services

Report writing is not a covered service by Medicaid for any provider type except for psychologist and neuropsychologist. New CPT codes for these provider types went into effect January 1, 2019 for billing Wyoming Medicaid.

Span billing is not allowed for fee for service behavioral health services. Each date of service must be billed on its own separate line.

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

- Services are not medically necessary.
- Treatment whose purpose is vocationally or recreationally based.
- Diagnosis or treatment in a school-based setting by a provider employed by the school district.

The following conditions are subject to limitations and will not be covered outside of those limitations:

- Clients age 21 and over are limited to restorative/rehabilitative services only. Restorative/rehabilitative services are services that assist an individual in regaining or improving skills or strength.
- Maintenance therapy can be provided for clients age 20 and under.

15.8.1 Prior Authorization Once Thresholds are Met

Medicaid clients with dates of service in excess of thirty (30) per calendar year will require a prior authorization which can be obtained through WYhealth ([6.10 Service Thresholds](#)).

The following must be submitted with your request to WYhealth in order for a determination to be made:

- Clinical Assessment

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

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

15.8.1.1 Appeals Process

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

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

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through WYhealth, including any additional clinical information that supports the request for services
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Behavioral Health Program Manager, Brenda Stout (Brenda.stout1@wyo.gov).
 - The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from WYhealth's system. The appeal will be reviewed in conjunction with the documentation uploaded into WYhealth's system.

15.9 Documentation Requirements for All Behavioral Health Providers (Including ABA Providers)

15.9.1 Provider Agreement

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

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

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

15.9.2 Documentation of Services

Documentation of the services must contain the following:

- Name of the client
- Identify the covered services provided and the procedure code billed to Medicaid
- Identify the date, length of time (start and end times in standard or military format), and location of the service
- Identify all persons involved
- Be legible and contain documentation that accurately describes the services rendered to the client and progress towards identified goals
- Full signature, including licensure or certification of the treating provider involved

- Providers shall not sign for a service prior to the service being completed
- No overlapping behavioral health services except for codes 97153 and 97155

NOTE: When providing behavioral health services to a Medicaid client, the documentation kept must be accurate with the date and times the services were rendered ([3.11 Record Keeping, Retention and Access, 15.9 Documentation Requirements for All Behavioral Health Providers](#)). Behavioral health services cannot overlap date and time for a client. For example, a client being seen for group therapy on February 28th from 11:00 to 12:00 cannot also be seen for targeted case management on February 28th from 11:00 to 12:00. These are overlapping services and cannot be billed to Medicaid. Proper documentation of services is important to differentiate the times of services being rendered, as times cannot be billed on a CMS 1500 claim.

15.9.3 Client Records

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

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

15.9.3.1 Requirements

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

- There shall be a separate clinical note made in each client's clinical record for every treatment contact that is to be billed to Medicaid. More frequent documentation is acceptable and encouraged
 - A separate progress note in the clinical record for each face-to-face contact with the client and with others who are collaterals to implement the client's treatment plan. Progress notes shall include:
 - The name of the Medical reimbursable service rendered and procedure code billed to Medicaid
 - The date, length of time (time in and time out in standard or military time format) and location of the contact
 - Persons involved (in lieu of or in addition to the client)
 - Summary of client condition, issues addressed, and client progress in meeting treatment goals
 - Signature, date and credentials of treating staff member

- A separate progress note for Psychosocial Rehabilitation shall document:
 - The date and length of time (time in and time out in standard or military time format) of each day's contact
 - A separate progress note describing therapeutic activities provided, the procedure code billed to Medicaid, and client's progress in achieving the treatment goal(s) to be accomplished through psychosocial rehabilitation
 - Signature, date and credentials of treating staff member
 - Co-signature of the primary therapist on progress notes for services provided by non-licensed, certified staff, or qualified case managers
- Individual Rehabilitative Services (IRS), a separate progress note shall document each contact to be billed, including:
 - The date and length of time (time in and time out in standard or military time format) of each day's contact
 - Activities of the skill trainer and activities of the client
 - Any significant client behavior observed
 - The date and signature of the skill trainer
 - The location of service and the procedure code billed to Medicaid
 - The signature, date and credentials of the primary therapist
- Peer Specialist Services, a separate progress note shall document for each contact to be billed, including:
 - The date and length of time (time in and time out in standard or military time format) of each day's contact
 - Activities of the skill trainer and activities of the client
 - Any significant client behavior observed
 - The date and signature of the skill trainer
 - The location of service and the procedure code billed to Medicaid
 - The signature, date and credentials of the primary therapist
- Ongoing Case Management Services and Targeted Case Management Services, a separate progress note shall document each contact to be billed, including:
 - The date and length of time (time in and time out in standard or military time format) of each day's contact
 - The date and signature of the case manager
 - Type and description of each service and the procedure code billed to Medicaid
- Each note shall show length of service, time in and time out in standard or military format.
- The provider shall adhere to clinical records standards defined in Section 3.5.
- The provider shall maintain an individual ledger account for each Medicaid client who receives services. The ledger account shall indicate, at a minimum:

- The length of contact rounded to the nearest 15- minute unit, per billing instructions. If seven (7) minutes or less of the next fifteen (15) minute unit is utilized, the unit must be rounded down. However, if eight (8) or more minutes of the next fifteen (15) minute unit are utilized, the units can be rounded up. Date ranges are not acceptable.
- The date and type of each treatment contact.
- The appropriate Medicaid charge.
- Date that other third-party payers were billed and the result of the billing. Services noted on the individual ledger account and billed to Medicaid shall be substantiated by the clinical record documentation.

15.9.3.2 Clinical Records Content Requirement

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

- Documentation of client consent to treatment at the agency. If an adult client is under guardianship, consent shall be obtained from the guardian. In the case of minors, consent shall be obtained from a parent or the guardian. Wyoming Medicaid shall not reimburse for services delivered before a valid consent is signed.
- A client fee agreement, signed by the client or guardian. For Medicaid, this agreement shall include authorization to bill Medicaid, and other insurance if applicable, using the following statement, “I authorize the release of any treatment information necessary to process Medicaid/insurance claims.”
- A specific fee agreement for any Medicaid non-covered service, and the fee that an enrolled client agrees to pay.
- Documentation that each client has been informed of his or her client rights.
- A clinical assessment/clinical intake form completed prior to the provision of treatment services which shall include at a minimum:
 - The specific symptoms/behaviors of a mental/substance use disorder which constitute the presenting problem.
 - History of the mental/substance use disorder and previous treatment.
 - Family and social data relevant to the mental/substance use disorder.
 - Medical data, including a list of all medications being used, major physical illnesses, and substance use (if not the presenting problem).
 - Mental status findings.
 - A diagnostic interpretation.
 - A DSM (current edition) diagnosis
 - The clinical assessment must be updated annually at a minimum.
- A diagnostic interpretation or a treatment plan shall be completed prior to or within five (5) working days of the third face-to-face contact with a licensed mental health professional.
- Properly executed release of information, as applicable, and chart documentation of information received or released as a result of the written client consent.

- Testing, correspondence, and like documents or copies.
- For clients receiving ten or more therapeutic contacts, a discharge summary is required and must:
 - Include each type of Medicaid service provided, detailing the client's progress in achieving treatment goal(s) and plans for follow-up
 - Be completed within 90 days of the last contact with the client
 - Document the reason for case closure within clinical records

15.9.4 Treatment Plans

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

Treatment plans must also:

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

15.9.5 Billing Requirements

In order to obtain Medicaid reimbursement for services, the following standards must be observed.

- The services must be medically necessary and follow generally accepted standards of care.
- Bill using the appropriate code set.

- The service must be a service covered by Medicaid.
- Claims must be filed according to Medicaid billing instructions

15.9.6 Time and Frequency

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

15.9.7 Pre-Admission Screening and Resident Review (PASRR) Assessments

15.9.7.1 Billing Requirements

- Submit PASRR Level II claims to the Medicaid Program.
- PASRR Level II assessments should be sent to WYhealth ([2.1, Quick Reference](#)).

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

Chapter Sixteen – Covered Services – Care Management Entity/Children’s Mental Health Waiver

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These services cannot be paid at the all-inclusive rate. A separate enrollment would need to be completed to be paid the fee for service rate for these services. Youth must also qualify to receive these services.

16.1 Care Management Entity (CME)/Children’s Mental Health Waiver (CMHW) Services as Administered by Magellan Healthcare, Inc.

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

All youth applying for CME enrollment must meet clinical eligibility requirements which include completion of the Early Childhood Service Intensity Instrument (ECSII) for children 4-5 or, completion of the Child & Adolescent Service Intensity Instrument (CASII) for youth 6-20 and a Level of Care assessment by a Qualified Mental Health Professional that indicates clinical eligibility for enrollment.

16.1.1 Enrollment

CME providers must have a current provider agreement with Magellan Healthcare and maintain current enrollment with Medicaid as a CME provider under taxonomy 251S00000X. Details about enrollment with Magellan Healthcare are found at <https://www.magellanofwyoming.com/become-a-provider/>.

16.1.2 CME/CMHW Services

16.1 Service	Procedure Code
Family Care Coordination	T1016
Family Peer Support Partner	H0038+UK
Youth Peer Support Partner	H0038
Youth and Family Training and Support (for CMHW youth only)	T1027
Respite	T2027

Please refer to the CME provider agreement and/or the Medicaid C04 benefit plan fee schedule for current service reimbursement rates.

16.1.1 Claim Submission Requirements

For CME/CMHW services with dates of service October 1, 2020 and forward, CME network provider must submit claims for services that are authorized by the CME

directly to Wyoming Medicaid. The CME will continue to review and authorize CME service plans of care and will transmit the authorization information to Medicaid to apply to claims submitted by CME network providers.

For dates of service prior to October 1, 2020, network provider should continue to submit claims information to the CME as usual.

16.2 Early Child and Child and Adolescent Service Intensity Instrument

Children and youth enrolling with the CME/CMHW must have either an Early Childhood Intensity Instrument (ECSII) or Child and Adolescent Intensity Instrument (CASII) evaluation by a qualified evaluator as part of the clinical eligibility determination process for enrollment into the CME/CMHW program.

16.2.1 Enrollment Requirements for ECSII/CASII Evaluators

In order to enroll with Wyoming Medicaid as an ECSII or CASII evaluator (taxonomy 174400000X) to perform evaluations as an Independent Assessor (IA), one must:

- Be certified by the CMHW/CME Program Manager, as having met the evaluator training and certification guidelines
- Certification is demonstrated by a certificate of good standing which is issued by the CMHW/CME Program Manager to qualified evaluators
- Agree to be listed on a public facing roster for selection by youth and families seeking an evaluation
- Meet ongoing recertification requirements as specified in policy
- Once the evaluator has been certified, an online enrollment for Wyoming Medicaid must be completed. Online enrollments are located on the website <https://wymedicaid.portal.conduent.com>, under Provider Enrollment.

16.2.2 ECSII/CASII Eligibility Add Form

For clients who are not currently eligible for Wyoming Medicaid, the evaluator performing the ECSII or CASII assessment will need to complete an ECSII/CASII Eligibility Add Form (One Day Add Form) and submit to Magellan Healthcare per their instructions. The form is available on the CME, Magellan Healthcare Inc., website: <http://magellanofwyoming.com>, under the Provider Hub, Independent Assessors section.

- Completed ECSII/CASII Eligibility Add Form and the High Fidelity Wraparound Application will be sent to Magellan Healthcare. The CMHW/CME Program Manager will provide the evaluator with the client’s Medicaid ID number and the date of service for billing after the online add is successfully processed.

16.2.3 High Fidelity Wraparound Application

All clients who are applying for the CME/CMHW must complete the High Fidelity Wraparound Application. This application must be completed whether the client is currently eligible for Wyoming Medicaid benefits or not. Applications can be found on the Magellan Healthcare website <http://magellanofwyoming.com> under Applications.

16.2.4 Covered Services

Procedure code: H0002

- Early Childhood Service Intensity Instrument (ECSII) for children ages 4-5
 - Client must have a DSM Axis 1 or ICD diagnosis that meets the States’ diagnostic criteria
 - Assessment completed within 12 months of application or annual assessment
- Child & Adolescent Service Intensity Instrument (CASII) for youth ages 6-20
 - Completed by an IA, outside of the High Fidelity Team
 - Initial CASII must be completed within 6 months of application
 - Annual re-evaluation is required

ECSII/CASII Evaluation Procedure Code				
Procedure Code	Modifier	1 Unit Equals	Procedure Quantity	Description
H0002		1 Evaluation	1 Max Unit	Evaluation Only

NOTE: The same evaluator may perform two-consecutive ECSII/CASII evaluations with the same client. The third evaluation that is used to determine ongoing eligibility needs to be completed by a different evaluator than the one who performed the previous two assessments.

Chapter Seventeen – Covered Services – Chiropractic Services

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17.1 Coverage Indications

Effective for dates of service 01/01/2021 and forward, all Chiropractic services will no longer be covered.

Encounter Revenue Code: 0529

For dates of service prior to 01/01/2021, coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of the hands. Manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine, however, no additional payment is available for use of the device, nor does Medicaid recognize an extra charge for the device itself.

The word "correction" may be used in lieu of "treatment." The following terms, or combination of, may be used to describe manual manipulation as defined above:

- Spine or spinal adjustment by manual means
- Spine or spinal manipulation
- Manual adjustment
- Vertebral manipulation or adjustment

17.2 Covered CPT Codes

99201-99205, 99211-99215

- These office visit codes are subject to a \$2.45 co-pay for adults >21 years of age.
- A full schedule of co-pays and exceptions is located in [Chapter 6](#)

98940, 98941, 98942

70100 -77086 Diagnostic Radiology codes

- Refer to Chapter 25 ([25.13, Radiology Services](#)) for additional information regarding radiology services.

17.3 Definitions

- **Acute:** A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in or arrest of the progression of the patient's condition.
- **Maintenance therapy:** Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care,

and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. Maintenance therapy is not a Wyoming Medicaid covered service.

17.4 Medical Necessity

ALL of the following criteria must be met to substantiate medical necessity:

1. The client has a neuromusculoskeletal disorder.
2. The medical necessity for treatment is clearly documented.
3. Improvement is documented within the initial two (2) weeks of chiropractic care.

The service will NOT be considered medically necessary if:

1. No improvement is documented within the initial two (2) weeks unless the treatment is modified.
2. No improvement is documented within 30-days despite modification of chiropractic treatment.
3. The maximum therapeutic benefit has been achieved.
4. The chiropractic manipulation is being performed in asymptomatic person or persons without an identifiable clinical condition.
5. The chiropractic care is occurring in persons whose condition is neither regressing nor improving.

17.5 Documentation Requirements

1. History as stated above.
2. Description of the present illness including:
 - Mechanism of trauma.
 - Quality and character of symptoms/problem.
 - Onset, duration, intensity, frequency, location, and radiation of symptoms.
 - Aggravating or relieving factors.
 - Prior interventions, treatments, medications, secondary complaints.
 - Symptoms causing client to seek treatment.

NOTE: These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro), and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but

in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement in the client's file/chart that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination.
4. Diagnosis (ICD-10 diagnosis codes will be required for dates of service 10/1/2015 and after): The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.
5. Treatment Plan: The treatment plan should include the following:
 - Recommended level of care (duration and frequency of visits).
 - Specific treatment goals.
 - Objective measures to evaluate treatment effectiveness.
6. Date of the initial treatment.

Chapter Eighteen – Covered Services – Dietitian

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18.1 Dietitian Services

18.1.1 Medical Nutrition Therapy (MNT)

18.1.1.1 Covered CPT Codes

97802 – Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes – Maximum allow 4 units per day.

97803 – Medical nutrition therapy; re-assessment and intervention, individual, face - to-face with the patient, each 15 minutes – Maximum allow 4 units per day.

97804 – Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes – Maximum 2 units per day.

18.1.1.2 Documentation Requirements

For Medical Nutrition Therapy, the following elements must be in the documentation:

1. Date of MNT visit along with Beginning and Ending Time of visit;
2. ICD-10 code – defines type of visit/counseling;
 - Subjective Data:
 - Client's reason for visit
 - Primary care physician
 - History
 - i. Past and present medical
 - ii. Nutrition including food patterns and intake
 - iii. Weight
 - iv. Medication
 - v. Exercise
3. Objective Data:
 - Laboratory results (if available)
 - Height
 - Weight
 - BMI
 - Calorie Needs
 - Drug/Nutrient Interactions
4. Individual Assessment of Diet/Intake:
 - Laboratory results (if available)
 - Height
 - Weight
 - BMI
 - Calorie Needs
 - Drug/Nutrient Interactions
5. Plan:

- Individualized dietary instruction that incorporates diet therapy counseling and education handouts for nutrition related problem.
 - Plan for follow-up.
 - Documentation of referral for identified needs.
 - Send a letter to the client's physician describing dietary instruction provided and progress. A copy of the letter should be placed in the client's medical record.
6. Date and legible identity of provider:
- All entries must be signed and dated by the provider.

18.1.2 Diabetes Prevention Program (DPP)

The Diabetes Prevention Program is intended to help prevent Type 2 Diabetes through a yearlong plan of care. A client is considered eligible for these services if they have a diagnosis of prediabetes.

18.1.2.1 Covered Services

DPP services may be used only one time per client. The clinical intervention consists of a minimum of 16 core dietitian sessions throughout a six (6) month period to facilitate weight control. After completing the initial core sessions, less intensive monthly follow-up visits maybe be utilized to ensure that beneficiaries maintain healthy behaviors.

Plan of Care:

First 6 Months of DPP Initial Core Sessions:

- Sessions 1-4: G9873 – One (1) Expanded Model (EM) Core Session.
- Sessions 5-8: G9874 – Four (4) EM Core Sessions.
- Sessions 9-16: G9875 – Nine (9) EM Core Sessions.

NOTE: Session one (1) cannot be performed via telehealth. Sessions 2-16 can be provided via telehealth. For billing purposes use the telehealth modifier, GT, to indicate this.

Second 6 Months of DPP Maintenance:

- Months 7-9:
 - G9876 – Two (2) EM Core Maintenance Sessions.
 - Utilized when DPP criteria is NOT achieved
 - G9878 – Two (2) EM Core Maintenance Sessions.
 - Utilized when DPP criteria IS achieved.
- Months 10-12:
 - G9877 – Two (2) EM Core Maintenance Sessions.
 - Utilized when DPP criteria is NOT achieved
 - G9879 – Two (2) EM Core Maintenance Sessions.
 - Utilized when DPP criteria IS achieved.

NOTE: These sessions can all be provided via telehealth. For billing purposes use the telehealth modifier, GT, to indicate these services.

Second and Subsequent Years of DPP:

- Months 13-15: G9882 – Two (2) EM Ongoing Maintenance Sessions.
- Months 16-18: G9883 – Two (2) EM Ongoing Maintenance Sessions.
- Months 19-21: G9884 – Two (2) EM Ongoing Maintenance Sessions.
- Months 22-24: G9885 – Two (2) EM Ongoing Maintenance Sessions.

NOTE: These sessions can all be provided via telehealth. For billing purposes use the telehealth modifier, GT, to indicate these services.

18.1.2.2 Billing Requirements

DPP services and non-DPP services must be billed on separate claim forms; however, multiple services for the same client may be submitted on the same claim. The Telehealth Modifier should be billed with any G-code that is associated with a session that was furnished as a virtual make-up session.

18.1.2.3 Documentation Requirements

Each HCPCS G-code should be listed with the corresponding session date of service and rendering dietitian National Provider Identifier (NPI).

Diabetes Prevention Program providers must maintain the following electronic or paper records for 10 years following the last day of a DPP client's receipt of services. Certain circumstances may require extension.

- Upon first session providers must record:
- The provider name and NPI
 - Client information, including but not limited to
 - Name
 - Wyoming Medicaid Client Identification Number
 - Age
 - Evidence that each client meets eligibility requirements
- Upon each additional session providers must record:
 - Session type
 - Core OR
 - Core Maintenance OR
 - Ongoing Maintenance.
 - Regularly Schedule session OR
 - Make-up session.
 - NPI of the provider furnishing the session
 - Date and place of the session
 - Curriculum topic
 - The client's weight (only required for regularly scheduled sessions)
- When Applicable, DPP provider records must indicate when a client has

- Attended core sessions
 - Achieved 5% weight loss
 - Attended core maintenance session and maintained minimum weight loss
 - Attended two ongoing maintenance sessions and maintained required minimum weight loss
 - Achieved at least 9% weight loss
- DPP providers must keep records of certain client engagement incentives provided to clients in compliance with 42 CFR 424.210.

18.2 Limitations

- Dietitian services must be ordered by a physician or nurse practitioner.
- For Medicaid clients, for dates of service prior to 01/01/2021, dates of service in excess of twenty (20) per calendar year will require authorization of medical necessity ([6.10, Service Thresholds](#)).

Chapter Nineteen – Covered Services – End Stage Renal Disease

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19.1 End Stage Renal Disease (ESRD)

Encounter Revenue Code: **082X, 083X, 084X, 085X or 088X**

ESRDs may be a freestanding facility or a hospital based facility, which provides inpatient, outpatient and / or home dialysis.

Procedure Code: **90951 to 90970**

Other procedure codes are billable under this program but at least one (1) of these must be present to be considered a dialysis claim.

NOTE: For the purpose of this policy this chapter refers to freestanding clinics.

19.2 Billing Requirements

- ESRD providers are responsible for the procurement, delivery and maintenance of the equipment and supplies.
- The facility may bill for all medically necessary services for home dialysis.
- Services provided outside the ESRD scope must be billed under other applicable programs and guidelines.
- Personal attendants are not covered.
- Claims should be billed with an appropriate bill type – see ESRD Coding Criteria table below.
- NDC numbers must be billed with all J-codes.
- Medicaid will reimburse ESRD services based on the services that Medicare includes in its composite rate for ESRD (as listed in the Medicare Benefit Policy Manual – Chapter 11 – End Stage Renal Disease (ESRD)).
- Medicaid will reimburse ESRD services at 9% of billed charges resulting in a Medicare-like payment.
- If billing for laboratory services, ESRD providers **MUST** have a valid CLIA on file.

19.3 ESRD Coding Criteria

Bill Type: 72X

Taxonomy: 261QE0700X

Type of Service	Coding Criteria	Date of Service Effective Date 01/01/2014
Dialysis	All claims must include a revenue code 082X, 083X, 084X, 085X, or 088X with a procedure code in the range 90951 to 90970	9 % of billed charges.
Lab	80000-89999 Must have valid CLIA on file	9 % of billed charges
All other services	36400-36420; 90658; 90732; 90740; 90747; A4206 to A4259; A4265; A4300 to A5200; G0008; G0010; J0120 to J9999; Q4081	9 % of billed charges.

19.3.1 ESRD Coding Additional Information

- The above criterion does not apply to Medicare crossover claims, claims for any other bill type, or for denied lines.
- Claims or claim lines that are billed with a CPT code not on the coding criteria list will be denied.
- Codes within the above ranges that aren't normally covered by Medicaid will not be covered for ESRD claims either.

Chapter Twenty – Covered Services – Family Planning

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20.1 Family Planning Clinics

Encounter Revenue Code: 0500

Family planning clinics provide services that are prescribed to clients of childbearing age for the purpose of enabling them to freely determine the number and spacing of their children.

20.2 Covered Services

The following services are covered by Medicaid:

- Appropriate office visits according to CPT guidelines
- Contraceptive supplies and devices as prescribed by a healthcare provider (limited to a three (3) month supply)
- Insertion or removal of implantable capsules are allowed with appropriate E&M procedure code
- Insertion or removal of intrauterine devices (IUD's) are allowed with an appropriate E&M procedure code
- Pap smears
- Pregnancy tests

20.3 Non-Covered Services

The following services are **not** covered by Medicaid:

- Reversal of Sterilizations
- Artificial insemination
- Fertility testing
- Infertility counseling

NOTE: Pregnant by Choice/Family Planning Waiver has specific covered and non-covered services ([26.1, Pregnant By Choice/Family Planning Waiver](#)).

Chapter Twenty One – Covered Services – Health Check

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21.1 Health Check – EPSDT

Encounter Revenue Code: 0779

The Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT):

- Brings comprehensive healthcare to children from birth up to and including 20-years of age who are eligible for Medicaid
- Has a preventive health philosophy of discovering and treating health problems before they become disabling and far more costly to treat in terms of both human and financial resources
- Examines all aspects of a child's well-being and corrects any problems that are discovered
- Is administered by the Division of Healthcare Financing (DHCF), Medicaid

NOTE: Preventative Medicine codes are not appropriate to bill for clients aged 21 and over. Providers should instead use the appropriate Evaluation & Management code for visits with adult clients.

EPSDT is a statewide program that provides children with comprehensive health screenings, diagnostic services, and treatment of any health problem detected. Defining each word of the program title will help explain the concept of EPSDT.

Procedure Code Range: 99381-99394

Early – Well Child Screens will be performed as soon as possible in the child's life (in case of a family already receiving assistance) or as soon as a child's eligibility for Medicaid is established.

Periodic – Means Well Child Screens will be performed at intervals established by medical, dental, and other healthcare experts. Periodic screens assure diseases or disabilities are detected in the early stages. Types of procedures performed will depend on age and health history of the child.

Screening – The use of examination procedures for early detection and treatment of diseases of abnormalities. Referrals are made for those in need of specialized care.

Diagnosis – The determination of the nature or cause of physical or mental disease (abnormality). A diagnosis is made through the combined use of a health history, physical, developmental and psychological evaluations, laboratory tests, and x-rays. Practitioners who complete EPSDT examinations may diagnosis and treat health problems uncovered by the screen or may refer the child to other appropriate sources for care.

Treatment – Care provided by practitioners enrolled with Medicaid to prevent, correct, or ameliorate disease or abnormalities detected by screening and diagnostic procedures. Practitioners may screen, diagnose, and treat during one (1) office visit.

21.1 Periodicity Schedule

The periodicity schedule contains an easy reference table for Well Child Screens defined by the age of the child. Refer to the Well Child Screen Requirements table for all ages.

Key: ✓ = to be performed ✕ = to be performed for clients at risk s = subjective, by history o = objective, by a standard testing method s/o = objective at 12, 15, and 18 years old, subjective, by history for all other years.

21.2 Reimbursement

If an abnormality or abnormalities is/are encountered or a pre-existing problem is addressed in the process of performing preventative medicine E&M service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem oriented E&M service, then the appropriate office/outpatient code 99201-99215 should also be reported. Modifier 25 must be added to the office/outpatient code to indicate that a significant, separate identifiable E&M service was provided by the same physician on the same day as the preventative service. The appropriate preventative medicine service is additionally reported.

Covered Services – Health Check

Well Child Screen Requirements For Ages Birth through 21 Years Old				
	Newborn – 12 months	15 months to 4 years	5-10 years	11-21 years
History				
Initial/Interval	✓	✓	✓	✓
Measurements				
Height & Weight	✓	✓	✓	✓
Head circumference	✓	✓ (up to 24 mo.)		
Blood Pressure		✓ (start at 3 yrs)	✓	✓
Sensory Screening				
Vision	s	s	o	o
Hearing	s	s	o	s/o
Developmental / Behavioral Assessment				
	✓	✓	✓	✓
Immunizations				
Health Check Immunizations	✓	✓	✓	✓
Procedures				
Lead Screening	(9-12 mo)	(24 mo)		
Tuberculin Test	✗ (12 mo)	✗	✗	✗
Topical Fluoride Varnish	✓ (6–12mo)	✓ (15 m-3 yrs)		
Cholesterol Screening		✗ (24 mo-4 yrs)	✗	✗
STD Screening				✗
Pelvic Exam				✗
Anticipatory Guidance				
Injury Prevention	✓	✓	✓	✓
Violence Prevention	✓	✓	✓	✓
Sleep Positioning Counseling	✓ (up to 6 mo)			
Nutrition Counseling	✓	✓	✓	✓
Dental				
	✓ (12 mo)	✓	✓	✓

All abnormalities detected during the Health Check exam should be referred to the appropriate specialist, including but not limited to a vision, dental and /or hearing specialist as necessary. The appropriate way to indicate that the provider has referred the child is to add Modifier 32 to the preventative service code.

If any insignificant or trivial problem/abnormality is encountered while performing the preventative medicine E&M services, and does not require additional work, the office/outpatient code should not be reported.

It is of utmost importance that the appropriate CPT, modifier, and diagnosis codes are reported. For the provider's convenience, the codes, modifiers, and diagnosis codes

Covered Services – Health Check

for EPSDT-Health Check and the most current fee schedule for the above mentioned codes are attached. Fees are subject to change without notice.

- At a minimum, these screenings must include, but are not limited to:
- Comprehensive health and developmental history
- Comprehensive unclothed physical examination
- Dental screening
- Appropriate vision testing
- Appropriate hearing testing
- Appropriate laboratory test(s) (Blood Lead Level testing is required at 12 and 24 months for all children)
- The most current copy of the immunization schedule may be found at <http://www.cdc.gov/vaccines/schedules/index.html>.

Diagnosis Codes to be used when Billing for EPSDT – Well Child Checks		
Diagnosis Code	Description	
Z76.1	Health Supervision of Foundling.	
Z76.2	Other Healthy Infant or Child Receiving Care.	
Z00.121, Z00.129	Routine Infant or Child Health Check.	
Topical Fluoride		
Procedure Code	Modifier	Description
99188	32	Topical Fluoride Varnish.
Preventative Medicine Services		
Procedure Code	Modifier	Description
99381/99391	32	Comprehensive Preventative Medicine Age 0 through 11 Months.
99382/99392	32	Early Childhood Age 1-4 Years.
99383/99393	32	Late Childhood Age 5-11 Years.
99384/99394	32	Adolescent Age 12-17 Years.
99385/99395	32	Age 18-20 Years.
Modifier		
32	Mandated Services – Referral.	

Evaluation and Management Services – New Patient		
Procedure Code	Modifier	Description
99201	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: <ul style="list-style-type: none"> • A problem focused history. • A problem focused exam. • Straight forward medical decision making.
99202	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: <ul style="list-style-type: none"> • An expanded focused history.

Covered Services – Health Check

Evaluation and Management Services – New Patient		
Procedure Code	Modifier	Description
		<ul style="list-style-type: none"> • An expanded focused exam. • Straight forward medical decision making.
99203	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: <ul style="list-style-type: none"> • A detailed history. • A detailed exam • Medical decision making of low complexity.
99204	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: <ul style="list-style-type: none"> • A comprehensive history. • A comprehensive exam. • Medical decision making of moderate complexity.
99211	25	Office or other outpatient visit for the E&M of an established patient that may not require the presence of a physician. Usually the presenting problems are minimal. Typically five (5) minutes are spent performing or supervising these services.
99212	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: <ul style="list-style-type: none"> • A problem focused history. • A problem focused exam. • Straight forward medical decision making.
99213	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: <ul style="list-style-type: none"> • An expanded problem focused history. • An expanded problem focused exam. • Straightforward medical decision making.
99214	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: <ul style="list-style-type: none"> • A detailed history. • A detailed exam. • Medical decision making of low complexity.
99215	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: <ul style="list-style-type: none"> • A comprehensive history. • A comprehensive exam. • Medical decision making of high complexity.

NOTE: Please refer to the current CPT for additional information regarding preventative services.

21.3 Detailed Information for Well Child Screens

- In some instances, Well Child Screens may not be completed at the suggested age (example: immunizations); the healthcare professional must follow recommended practices to ensure the child becomes current.
- Results may indicate further testing or referrals are needed. Healthcare professionals should complete tests or make referrals according to standard procedures and practices.
- Well Child Screens must be completed when there is no acute diagnosis applicable (i.e. otitis media).
- Results may show that a high risk factor is present based on the child's environment, history, or test results. Healthcare professionals should proceed with required/recommended tests. Evaluation methods used may be different from what is indicated on the Well Child Screen Requirements table (example: a tuberculin test performed on a child who is nine (9) months of age because the child's sibling had an active case of diagnosed tuberculosis).

The following information contains additional guidelines to be used when performing Well Child Screens.

21.3.1 Initial/Interval History

The initial/interval history should be obtained from a parent or other responsible adult who is familiar with the child's health history. This must include, but is not limited to:

- Family history
- Details of birth, prenatal, neonatal periods
- Nutritional status
- Growth and development
- Childhood illness
- Hospitalizations
- Immunization history

NOTE: If a health history has been obtained previously, then update it each visit.

21.3.2 Assessments

Appropriate Developmental Screening –The following screening tools are recommended for children age birth to six (6) years:

1. Prescreening Developmental Questionnaire
2. Denver Developmental Screening Test
3. Battelle Screening Test

Providers should administer a developmental screen appropriate to the age of the child during each Well Child Screen

- A complete physical examination including an oral inspection
- Accurate measurements of height and weight (all measurements should be plotted on the National Center for Health Statistics Growth Charts)
- Screening for iron deficiency at the appropriate ages and/or intervals
- Children five (5) years of age and older should have a general developmental assessment including gross-motor and fine-motor skills, social-emotional skills, and cognitive and self-help skills development
- Results of development screens need to be considered in combination with other information gained through the history, physical examination, observations of behavior, and reports of observations by the parents/caregivers.
- Any abnormalities detected during a Well Child Screen outside of the attending physician's scope of practice should be referred to the appropriate specialist, including vision, dental, and hearing specialists as necessary. All services provided must be medically necessary and provided in the most cost-effective manner
- Nutritional Screen – Providers should assess the nutritional status at each Well Child Screen through the following activities:
 - Inquire about dietary practices to identify unusual eating habits. Unusual eating habits include pica behavior, extended use of bottle feedings, or diets deficient or excessive in one (1) or more nutrients;

NOTE: Children with nutritional problems may be referred to a licensed nutritionist or dietitian for further assessment, counseling, or education as needed.

21.3.3 Comprehensive Unclothed Physical Examination

Each comprehensive unclothed physical examination should include the following:

- Height measurement
- Weight measurement
- Standard body systems evaluation
- Observation for any signs of abuse
- Observation of any physical abnormality

During each Well Child Screen, providers need to assess the child's growth. All measurements should be plotted on the National Center for Health Statistics (NCHS) Growth Chart.

Growth assessments should be documented in the medical record and any abnormality should be addressed as abnormal:

- If a child's height and/or weight is below the 5th percentile or above the 95th percentile; or
- If weight for height is below the 10th percentile or above the 90th percentile (using the weight for height graph).

21.3.4 Head Circumference

An Occipital Frontal Head Circumference (OFHC) should be measured on each child four (4) years and younger at each Well Child Screen. This measurement should be plotted on the NCHS Growth Chart. OFHC should be reported abnormal if:

- It is below the 5th percentile or above the 95th percentile;
- Size of the head is not following a normal growth curve; or
- Head is grossly disproportionate to the child's length.

Deviations in the shape of the head may warrant further evaluation and follow-up.

21.3.5 Blood Pressure

- All children three (3) years and older must have a blood pressure reading at each Well Child Screen.
- Measurements should be taken in a quiet environment, with the correct size cuff, and with the fourth (4th) and fifth (5th) phase Korotkoff sound noted for the diastolic pressure.
- Blood pressure is considered abnormal if the systolic and/or diastolic or both are above the 95th percentile. Any child with a blood pressure reading above the 95th percentile should have it repeated in 7-14 days. If the blood pressure is still elevated, the child should be rechecked again in 7-14 days. If blood pressure is elevated on the third visit, the child should receive appropriate medical evaluation and follow-up, as recommended by the American Academy of Pediatrics.

21.3.6 Vision Screen

A vision screen appropriate to the age of the child should be conducted at each Well Child Screen. Further evaluations and proper follow up should be recommended if the following conditions are present:

- Infants and children who show evidence of infection, squinting, enlarged or lazy cornea, crossed eyes, amblyopia, cataract, excessive blinking, or other eye abnormality;
- An infant or child who scored abnormal on the fixation test, papillary light reflex test, alternate cover test, or the corneal light reflect test in either eye;
- Three (3) to nine (9) year old children who demonstrate a visual acuity of less than 20/40 in either eye or who demonstrate a one (1) line difference in visual acuity between the two (2) eyes within the passing range; or
- Children ten (10) years and older whose vision is 20/30 or worsen in either eye or who demonstrate a one (1) line difference in visual acuity between the two (2) eyes within the passing range.

21.3.7 Topical Fluoride Varnish

Physicians can apply a topical fluoride varnish for patients who are at a moderate to high risk for dental caries:

- This application should be done in conjunction with EPSDT well child visits.
- Physician offices may bill the CPT code 99188 on the CMS-1500 form.
- Fluoride varnish application can be done up to three (3) times a year on children ages six (6) months (or when the first teeth erupt) through age three (3) years.
- The American Academy of Pediatric Dentistry recommends the establishment of dental home no later than 12 months of age.

21.3.8 Hearing Screen

A hearing screen appropriate to the age of the child should be conducted at each Well Child Screen. Further evaluations and proper follow up should be recommended if one (1) of the following conditions is present:

- Infants and children who are positive on one (1) or more of the Eight (8) Hi-Risk register items:
 - Visible congenital or traumatic deformity of the ear
- Congenital, such as atresia (no ear canal) or abnormally small ear canals
- Traumatic deformity, collapsed canals or a deformed ear that might contraindicate presence of mold or aid
- History of active drainage from the ear within previous 90 days
- History of sudden or rapidly progressive hearing loss within the previous 90 days possibly due to viral attack, trauma, etc. should be seen by a medical doctor immediately
- Acute or chronic dizziness indicates possible problems with semi-circular canals (balance)
- Unilateral hearing loss of sudden or recent onset within the previous 90 days. Could be caused by mumps, virus, head trauma, Meniere's disease, and various vascular disorders
- Audiometric air-bone gap equal to or greater than 15 decibels (dB) at 500Hz, 1000Hz, 2000Hz and 3,000Hz. Conductive or middle ear pathology can cause a difference of greater than 15dB between the air conduction test results and results by bone conduction
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal
- Pain or discomfort simply indicates there is something wrong and should be seen by a medical doctor
- Infants and children whose medical, physical, or developmental history indicates possible hearing loss
- Positive family history of hearing loss
- Viral or other non-bacterial transplacental infection

- Defects of ear, nose or throat system; malformed, low-set to absent pinnae; cleft lip or palate
- Birth weight under 1500 grams
- Unconjugated bilirubin over 24 mg/100 ml or over infant's weight in decagrams
- Bacterial meningitis
- Sever asphyxia with arterial flow less than 7.25, coma, seizures or need for continuous assisted ventilation
- Children found positive when tested with pure tone screening

21.3.9 Laboratory Tests

Providers who conduct Well Child Screens must use their medical judgment when determining the applicability of performing specific laboratory tests and/or analyses. The following are basic laboratory tests that should be performed when a child reaches the required age.

21.3.9.1 Hematocrit and Hemoglobin

Hematocrit or Hemoglobin is completed at the following ages:

- Newborns (for high risk infants)
- Two (2) months (for high risk infants)
- 8-12 months
- 18-24 months
- Three to four (3-4) years
- 11-12 years

21.3.9.2 Blood Lead Level

- A venous blood lead level determination must be performed on children at 12 and 24 months of age
- Children who have a history of pica behavior, an environment suspect of lead exposure, or whose history/physical examination findings are suspicious should have a blood lead level follow-up
- Lead poisoning is an elevated venous blood lead level that is greater than or equal to 10 micrograms per deciliter (ug/dl)
- If an elevated blood level is discovered, a child should be re-screened every three (3) to four (4) months until lead levels are within normal limits. In addition, a venipuncture blood lead level should be performed annually through at least age six (6)

Beginning at six (6) months of age and at each visit thereafter until six (6) years of age providers must discuss with parent(s)/caregiver(s) about childhood lead poisoning interventions and assess the child's risk for exposure. A verbal interview or written questionnaire, such as the following may identify those children at high risk for lead

exposure. Blood lead testing should be carried out on those children identified as high risk by this or a similar questionnaire:

- Does your child live in or regularly visit an old house built before 1950? Is your child's day care center / preschool / babysitter's home built before 1978? Does the house have peeling or chipping paint?
- Does your child live in a house built before 1978 with recent, ongoing, or planned renovation or remodeling (within the last six (6) months)?
- Do any of your children or their playmates have or had lead poisoning?
- Does your child frequently come in contact with an adult who works with lead? Examples are construction, welding, pottery, or other trades practiced in your community.
- Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead?
- Do you give your child any home or folk remedies that may contain lead?
- Does your child live near a heavily traveled major highway where the soil and dust may be contaminated with lead?
- Does your home's plumbing have lead pipes or copper with lead solder joints?

Ask any additional questions specific to situations existing in the provider's community. Risk is determined from responses to a verbal or written questionnaire risk assessment. A subsequent verbal risk assessment can change a child's risk category. Any information suggesting increased lead exposure for previously low risk children must be followed up with a blood lead test. Medicaid will pay for samples to be taken from the home and sent to state laboratory for testing.

If answers to all questions are negative, a child is considered low risk for high doses of lead exposure. Practitioners will need to determine whether to perform additional blood lead level test beyond those required at 12 and 24 months of age.

If the answers to any questions are positive, a child is considered high risk for high doses of lead exposure. Practitioners are required to perform a venous blood lead level on children determined to be high risk. Tests need to be repeated every three (3) to four (4) months until lead levels are within normal limits. Tests should continue to be completed if the child is still considered high risk.

21.3.9.3 Tuberculin Screening

Tuberculin testing should be completed as indicated on the Well Child Screen Requirements table or more often on clients in high-risk populations (Asian refugees, Indian children, migrant children, etc.), or if historical findings, physical examinations or other risk factors so indicate.

21.3.9.4 Urinalysis

Urinalysis using a multiple dipstick method should be completed on all children at two (2) years and 13-15 years.

- Because of heightened incidence of bacteriuria in girls, they should have additional tests around three (3) years, five (5) years and eight (8) years
- Children who have had previous urinary tract infections should be re-screened more frequently
- If test results are positive but the history and physical examination are negative, the child should be tested again in seven (7) days
- If the results are positive a second time or if there are supportive findings in the history and physical examination from the first (1st) positive test, further follow-up is required
- If a male child has a urinary tract infection, a referral for further testing should be completed immediately

21.3.9.5 Other

Other laboratory tests (i.e., chest x-ray, Pap smear, sickle cell testing, etc.) should be completed if medically necessary.

21.3.10 Immunizations

- The immunization status of each child should be assessed at each Well Child Screen.
- Assessing the immunization status of a child includes interviewing parents/caretakers, reviewing immunization history/records, and reviewing known high risk factors to which the child may be exposed.
- Immunizations needed by children at their Well Child Screen should be given on-site, provided there are not existing contradictions.
- Immunizations are to be given according to the Advisory Committee on Immunization Practices (ACIP).
- Arrangements should be made with the parents/responsible adult for the completion of immunizations.
- If immunizations have not been completed at the recommended age, the healthcare professional should set up a schedule to ensure the child becomes current.

NOTE: The Recommended Immunization Schedule can be found at <http://www.cdc.gov/vaccines/schedules/index.html>.

21.3.11 Dental Screen

Oral inspections are included in Well Child Screens. Results should be included in the child's Initial/Interval History. Although an oral inspection is part of Well Child Screens, it does not substitute for an examination through a direct referral to a dentist. A child should be referred to the dentist as follows:

- When the first tooth erupts and at least yearly thereafter

- If an oral inspection reveals cavities, infection, or the child has or is developing a handicapping malocclusion or significant abnormality

NOTE: Refer back to Topical Fluoride ([21.3.7, Topical Fluoride Varnish](#)).

21.3.12 Speech and Language Screens

Speech and language screens identify delays in development of children.

Referrals for further speech and hearing evaluations may be appropriate if one (1) or more of the following exists:

- Child is not talking at all by the age of 18 months
- Suspected hearing impairment
- Child is embarrassed or disturbed by his/her own speech
- Voice is monotone, extremely loud, largely inaudible, or of poor quality
- There is noticeable hyper-nasality or lack of nasal resonance
- There is undue parental concern
- Where speech is not understandable at three (3) years of age, a referral may be appropriate, as the condition may be caused by an unsuspected hearing impairment or a variety of undiagnosed conditions

21.3.13 Discussion and Counseling

Parents should have the opportunity to ask questions, to have them answered and to have sufficient time allotted for unhurried discussions. Practitioners should discuss and interpret examination results in accordance with the parents' level of understanding.

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These services are not within the four “4” walls and cannot be reimbursed at the encounter rate. A separate enrollment is required to bill these services. These services also require a prior authorization.

22.1 Home Health

Home Health services are intended to be a temporary transitional program to assist clients with care required after an acute health incident or an institutionalized stay. Home Health services are to provide medical support and education to the client and any caregiver regarding the client's new medical needs. Home Health is never intended to be a long term solution. For clients with long term needs, Home Health is available initially while the client and any caregiver is educated about the new medical needs and determines what the long term solution will be for meeting the needs of the client. Long term solutions may include additional or alternate care givers, waiver programs, higher levels of care such as nursing facilities, and the client providing for his or her own needs as he or she is able.

Long Term custodial care services are not covered under the home health state plan benefit. Long term custodial care is defined as care that has moved beyond the acute state (has become clinically stable) and is expected to be needed for the rest of the client's life.

Medicare certified or State Licensed Home Health agencies can provide Home Health services. These agencies may be independent or based in a hospital, nursing home, Senior Center, or Public Health agency. Agencies that are not Medicare certified must continue to meet the Conditions of Participation for Medicare and will need to be licensed by the Division of Healthcare Licensing and Survey.

Home Health agencies are unable to bill for the sale or rental of Durable Medical Equipment unless they are separately enrolled as a DME provider. For specific billing instructions refer to the DME General and DME Covered Services Provider Manuals on the Medicaid website ([2.1, Quick Reference](#)).

NOTE: All claims are subject to post payment review, ensuring Home Health policy has been adhered to.

22.1.1 Supervision

Supervision is defined as: The Registered Nurse (RN) shall be immediately available to the home health aide for consultation in person or by telephone. The supervising RN must make a supervisory visit to the home at least every 60 days. The supervisory visit is not a Medicaid billable service.

22.1.2 Criteria

Service must be:

- Ordered by a physician
- Documented in a signed and dated Plan of Care/Medicare 485 Form that is reviewed and revised as medically necessary by the attending physician at least once every 60 days
- Medically necessary
- Three (3) or fewer encounters per day for any combination of home health aide and skilled nursing services
 - An encounter is defined as all home health services provided in a single day that could be provided in a single visit to the client, regardless of how many actual visits to the client are actually completed. For example, shower, shampooing, nail care, and dressing CAN all be completed at the same time, so, even if the shower is in the morning and nail care is completed in the afternoon, this is one encounter. A separate encounter is not to be billed due to the convenience of the provider nor due to scheduling issues or conflicts. A separate encounter can be billed when services must be separated due to orders or medical necessity, such as wound dressings being changed multiple times per day, or medication being given in the morning or at bed time, or assistance with nutritional intake multiple times per day.
- Expected to last six months or less

22.2 Covered Services

- Skilled nursing services provided by a Registered Nurse (RN) for client's condition while in the acute phase.
- Home health aide services delegated and supervised by a Registered Nurse (RN).
 - Each Home Health Aide visit MUST include at least one (1) or more of the following:
 - Bath (bed, sponge, tub, shower, or shampooing hair).
 - Nail or skin care (applying lotion does not constitute personal care).
 - Oral hygiene.
 - Toileting and elimination.
 - Safe transfers / assisted ambulation.
 - Assist with dressing (not grooming alone).
 - Assisted range of motion / positioning.
 - Assisted nutrition or fluid intake (meal set-up or prep or feeding assist / supervision).

NOTE: Home Health Aid services must be related to the client's skilled need (SN, PT, OT, ST). Without a related skilled need, HHA services are not covered.

- Physical therapy services provided by a qualified licensed physical therapist.
- Speech therapy services provided by a qualified licensed therapist.
- Occupational therapy services provided by a qualified registered or certified therapist.
- Medical social services provided by a qualified licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW) -prepared person supervised by an MSW.

NOTE: MSW services are not to be used in place of appropriate behavioral health referrals to community resources. Regular therapy is not appropriate under the MSW benefit. MSW services are to be used to assist the client in coordination with and accessing community resources to meet their needs.

22.2.1 Limitations

The following services are not covered through home health:

- Long term custodial care
- Homemaker services
- Respite care
- Home delivered meals
- Services for clients who are hospital patients or residents of skilled nursing facilities
- Services for clients that are inappropriate in the client's home setting
- Services for clients that are extensive or for long periods and/or are not cost effective
- Services for clients where the desired outcome could be better and faster accomplished in another setting
- Services for clients where the client must be compliant to achieve measured success and the client is not compliant

22.2.2 Documentation Requirements

For all documentation of services provided:

- If the client is receiving home health services only, visit notes must state home health services and detail the specific services provided.
- If the client is receiving both home health services and waiver services, visit notes must state either home health services or waiver services as appropriate and detail the specific services provided.

- The Plan of Care/Medicare 485 Form must list all services the client is receiving, regardless of pay source. This includes waiver, private duty nursing, etc. and frequency of the services to portray a clear picture of all services the client is receiving.
- Adequate documentation justifying medical necessity must be kept. Any plans extending past 120 days (two (2) consecutive 60-day plan periods) will be reviewed.
- New clients ordered to home health care must have documentation of a face-to-face visit with the ordering practitioner within the 90 days preceding the beginning of home health. This face-to-face visit can be in the hospital, clinic, nursing home, or other clinical setting.
- Home Health Agencies that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The agency must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

22.2.3 Billing Requirements

Appropriate Bill Type(s): 33X, 32X

Pay-to Provider's Taxonomy: 251E00000X

- Bill using appropriate revenue codes.
- Do not bill with procedure codes.
- Do not span bill. Each date of service must be billed on a separate line.
- Bill using appropriate units.
- Prior authorizations (PA) are required for all services and are reviewed by WYhealth ([6.14 Prior Authorization](#))
- Prior authorization number must be placed on the claim
- Prior authorization requests must be submitted within 10 business days of the start of services.
- Plans of Care/Medicare 485 Form, Physician Orders, documentation of face-to-face visit, and documentation of non-homebound status for Medicare/Medicaid dual clients stating the client would not be eligible for services under the Medicare Home Health ([2.1 Quick Reference](#))

Home Health Revenue Codes		
Revenue Code	Description	Unit
551	Skilled Nursing	Per visit
421	Physical Therapy	Per visit
441	Speech Therapy	Per visit
431	Occupational Therapy	Per visit
571	Home Health Aide	Per visit
561	Medical Social Worker	Per visit

NOTE: Do not place procedure codes on the claim.

22.2.3.1 Prior Authorization

- Prior authorization requests must be submitted within 10 business days of the start of services
- Requests submitted without a signed and dated 485 or physician's detailed order will not be processed
- Requests must be submitted under the home health revenue codes above, not using HCPCS/CPT codes
- Requests for PRN visits must be submitted after the visit has occurred, but within 5 business days, as a separate episode, and with documentation of the medical necessity of the PRN visit including the clinical notes from that visit
- For facility discharges, be sure to upload the discharge summary from the facility and any applicable therapies (PT, OT, ST)
- For wound care related requests, be sure to include current detailed wound specific information including frequency of care, drainage, wound measurements
- For IV medication related requests, include current medication orders with frequency and duration, and how often administration is to be completed
- For Pediatric G-Tube Care: Clients age 20 and younger, when medically necessary, 1 SN visit per month for review of the placement and patency of the G-Tube will be approved. Other PRN visits will be reviewed according to the PRN visit requirements.
- Technical denials will be issued by WYhealth for the following:
 - No signed/dated 485 or physician's orders
 - Failure of the provider to respond to requests for additional information
 - Incorrectly submitted codes (such as using HCPCS or CPT codes instead of Revenue Codes)

Prior Authorization requests can be denied for two basic reasons: Administrative reasons such as incomplete or missing forms and documentation, etc.; or the client does not meet the established criteria for coverage of the item.

Following a denial for administrative reasons, the provider may send additional information in order to request that the decision be reconsidered. If the information is received within thirty (30) days of the denial, with a clearly articulated request for reconsideration, it will be handled as such. If the information is received more than thirty days after the denial, it will be a new Prior Authorization request. As such, a new Prior Authorization form must be submitted, and all information to be considered must accompany it.

22.2.3.2 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through WYhealth, including any additional clinical information that supports the request for services
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Benefit Quality Control Manager, Brenda Stout (brenda.stout1@wyo.gov).
 - The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from WYhealth's system. The appeal will be reviewed in conjunction with the documentation uploaded into WYhealth's system

Chapter Twenty Three – Covered Services – Laboratory Services

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23.1 Laboratory Services

Encounter Revenue Code: 0300

Procedure Code Range: 36415, G0027, G0306, G0307, G0477, 80000-89999

Medicaid covers tests provided by independent (non-hospital) clinical laboratories when the following requirements are met:

- Services are ordered by physicians, dentists, or other providers licensed within the scope of their practice as defined by law.
- Services are provided in an office or other similar facility, but not in a hospital outpatient department or clinic.
- Providers of lab services must be Medicaid certified.
- Providers of lab services must have a current Clinical Laboratory Improvement Amendments (CLIA) certification number.
- **Providers may bill Medicaid only for those lab services they have performed themselves. Medicaid does not allow pass-through billing.**
- Wyoming Medicaid will only cover medically necessary tests. Tests derived through court order will not be reimbursed by Wyoming Medicaid.

NOTE: Non-covered services include routine handling charges, State fees, post-mortem examination, and specimen collection fees for throat culture or Pap Smears.

23.2 CLIA Requirements

The type of CLIA certificate required to cover specific codes is listed in the table below. These codes are identified by Center for Medicare and Medicaid Services (CMS) as requiring CLIA certification; however, Medicaid may not cover all of the codes listed. Refer to the fee schedule located on Medicaid website ([2.1, Quick Reference](#)) for actual coverage and fees. Content is subject to change at any time, without notice.

NOTE: Codes within the below table are NOT Wyoming Medicaid specific. It is the provider's responsibility to ensure the codes being billed are covered by Wyoming Medicaid.

Covered Services – Laboratory Services

CLIA CERTIFICATE TYPE	ALLOWED TO BILL						
REGISTRATION, COMPLIANCE, OR ACCREDITATION (LABORATORY) (1)	G0103	G0123	G0124	G0141	G0143	G0144	G0145
	G0147	G0148	G0306	G0307	G0328	17311	17312
	17313	17314	17315	78110	78111	78120	78121
	78122	78130	78191	78270	78271	78272	
	0001U-0083U						
	80000-89999 (UNLESS OTHERWISE SPECIFIED ELSEWHERE IN THIS TABLE)						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE LABORATORY (CLIA TYPE 1) SECTION AND ALL CODES FOR PPMP (CLIA TYPE 4) SECTION AND WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
PROVIDER- PERFORMED MICROSCOPY PROCEDURES (PPMP) (4)	81000	81001	81015	81020	89055	89190	G0027
	Q0111	Q0112	Q0113	Q0114	Q0115		
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE PPMP (CLIA TYPE 4) SECTION AND ALL CODES FOR WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
WAIVER (2)	80305	81002	81025	82044 QW	82150 QW	82270	82272
	82274 QW	82962	83026	83036 QW	84830	85013	85025 QW
	85651	86618 QW	86780 QW	87502 QW	87631 QW	87633 QW	87634 QW
	87651 QW						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE WAIVER (CLIA TYPE 2) SECTION AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
NO CERTIFICATION	PROVIDERS WITHOUT A CLIA MAY BILL ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (SEE BELOW)						

NOTE: The QW modifier is used to bypass CLIA requirements. A QW next to a laboratory code signifies that the QW modifier should be used.

CODES EXCLUDED FROM CLIA REQUIREMENTS									
80500	80502	81050	82075	83013	83014	83987	86077	86078	86079
86910	86960	88125	88240	88241	88304	88305	88311	88312	88313
88314	88329	88720	88738	88741	89049	89220			

For updated Medicare CLIA information visit: http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Categorization_of_Tests.html

23.3 Genetic Testing

Procedure Codes: 81200-81599; 96040

Prior Authorization is required for all genetic testing codes ([7.13, Prior Authorization](#)). Prior authorization documentation must document all of the following:

- There is reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists
- Test results will influence decisions concerning disease treatment or prevention
- Genetic testing of children might confirm current symptomatology or predict adult onset diseases and findings might result in medical benefit to the child or as the child reaches adulthood
- Referral is made by a genetic specialist (codes 81223 and 81224) or a specialist in the field of the condition to be tested; and
- All other methods of testing and diagnosis have met without success to determine the client's condition such that medically appropriate treatment cannot be determined and rendered without the genetic testing
- Counseling is provided by healthcare professional with education and training in genetic issues relevant to the genetic tests under consideration.
- Counselor is free of commercial bias and discloses all (potential and real) financial and intellectual conflicts of interest.
- Process involves individual or family and is comprised of ALL of the following:
 - Calculation and communication of genetic risks after obtaining 3-generation family history
 - Discussion of natural history of condition in question, including role of heredity
 - Discussion of possible impacts of testing (eg, psychological, social, limitations of nondiscrimination statutes)
 - Discussion of possible test outcomes (ie, positive, negative, variant of uncertain significance)
 - Explanation of potential benefits, risks, and limitations of testing
 - Explanation of purpose of evaluation (eg, to confirm, diagnose, or exclude genetic condition)
 - Identification of medical management issues, including available prevention, surveillance, and treatment options and their implications
 - Obtaining informed consent for genetic test
- **Codes 81420, 81507** - Mother must be documented as high-risk to include:
 - advanced maternal age >35 (at EDC)
 - previous "birth" of embryo/fetus/child with aneuploidy
 - parent with known balanced translocation
 - screen positive on standard genetic screening test (FTCS, multiple marker screen of one type or another, etc)
 - ultrasound finding on embryo/fetus consistent with increased risk of aneuploidy
- **Code 81519** - All of the following conditions must be met and documented in the prior authorization request:
 - The test will be performed within 6 months of the diagnosis

- Node negative (micrometastases less than 2mm in size are considered node negative)
 - Hormone receptor positive (ER-positive or PR-positive)
 - Tumor size 0.6-1.0 cm with moderate/poor differentiation or unfavorable features (ie, angiolymphatic invasion, high nuclear grade, high histologic grade) OR tumor size >1 cm
 - Unilateral disease
 - Her-2 negative
 - Patient will be treated with adjuvant endocrine therapy
 - The test result will help the patient make decisions about chemotherapy when chemotherapy is a therapeutic option
- **Code 81599** - All of the following conditions must be met and documented in the prior authorization request:
 - Patient must be post-menopausal
 - Pathology reveals invasive carcinoma of the breast that is estrogen receptive (ER) positive, Her2-negative
 - Lymph node-negative or has 1-3 positive lymph nodes
 - Patient has no evidence of distant metastasis
 - Test result will be used to determine treatment choice between endocrine therapy alone, vs. endocrine therapy plus chemotherapy

NOTE: The test should not be ordered if the physician does not intend to act upon the test result.

23.3.1 BRCA Testing and Counseling

The U.S. Preventive Services Task Force (USPSTF) recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for evaluation for BRCA testing (81211-81217 and 81162-81167). Medicaid covers BRCA testing when the following criteria are met:

- Personal and/or family history of breast cancer, especially if associated with young age of onset; OR
- Multiple tumors; OR
- Triple-negative (i.e., estrogen receptor, progesterone receptor, and human epidermal growth factor receptor 2-negative) or medullary histology; OR
- History of ovarian cancer; AND
- 18 years or older; AND
- Documentation indicates a genetic counseling visit pre or post testing.

Chapter Twenty Four – Covered Services – Non-Emergency Medical Transportation

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These services are not within the four “4” walls and cannot be reimbursed at the encounter rate. A separate enrollment and provider number is required to bill these services.

24.1 Non-Emergency Medical Transportation (NEMT)

Wyoming Medicaid provides non-emergency medical transportation (NEMT) services to clients who are in need of assistance traveling to and from medical appointments to enrolled providers to obtain covered services.

Wyoming Medicaid enrolls taxi providers (344600000X), non-taxi ride providers (347C00000X), and lodging providers (177F00000X) to provide covered services.

24.1.1 Covered services

24.1.1.1 Taxi and non-taxi rides

- Covered for adults and children
- Client must call in the ride to the Transportation Call Center (800-595-0011)
 - Transportation Call Center will verify client is covered for the ride and meets criteria
 - Client is given Transportation Authorization Confirmation (TAC) number once travel is confirmed. This number is given to the transportation provider as proof of approval.
- Transportation Call Center will contact Taxi Provider once the ride is approved
 - For shuttle services, the client would contact the transportation provider and provide the TAC for proof of approval.
- 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

24.1.1.2 Lodging

- Covered for clients 20 years of age and younger
- Client must be inpatient or outpatient at a medical facility that is enrolled with Wyoming Medicaid
- Client must call in the transportation request to the Transportation Call Center and indicate that they are staying with an enrolled lodging provider
- Client must live more than 400 miles round trip from medical facility
 - Exceptions may be granted for special circumstances (several appointments over several days; very early appointments; need for direct medical supervision during outpatient recovery; etc. The client

must contact Transportation Call Center (800-595-0011) to request exceptions)

24.2 Billing Information

24.2.1 Non-Taxi Rides (Shuttle Services)

Procedure Codes: **A0110, A0080**

- Ride Provider must receive authorization for the 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 with the PA number associated with the ride
- Bill procedure code A0110 – Base Rate – 1 unit for each one way trip
- Bill procedure code A0080 – mileage for each mile or part of a mile above 15 miles
 - Mileage is always rounded up
 - Example – A trip of 23.2 miles would be billed with code A0110 as the base rate (1 unit) and A0080 for the mileage (9 units: 23.2 miles - 15 base miles = 8.2 miles, round up to 9 miles = 9 units)

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 (800-595-0011)
- 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.

24.2.2 Lodging

Procedure Code: A0180

- Client must call in transportation to the Transportation Call Center (800-595-0011) and indicate they are staying with an enrolled lodging provider and provide the TAC number to the lodging provider for billing purposes
 - The TAC number will be entered as the client's account number on the claim when billing
- Client must provide client ID of child to the lodging provider for billing purposes
- Bill procedure code A0180 for each night of lodging – child client must be inpatient in medical facility or outpatient and staying at lodging provider
- All lodging claims are subject to post payment review and as such records should be kept with detail including:
 - Client information
 - Medical facility client was patient of
 - Inpatient/outpatient status
 - Dates of stay
 - Total nights
 - Total charge
- The client's family will need a copy of receipt/documentation to receive their per diem for the stay



24.3 Travel Request Form

Wyoming Medicaid – Travel Request Form

Section 1 – Client Information			
Client Name:	Medicaid ID Number:	Preferred Contact: Phone: ___ Email: ___ N/A ___	
Full Physical Address: Address: City: State: Zip: ___	Have you received travel reimbursement before? Yes ___ No ___		
Full Mailing Address (if different from physical address): Address: City: State: Zip: ___	Person Requesting (receives payment for travel): Yes ___ No ___		
Additional Person of Contact (if no personal email or phone): Name: Phone: Email: ___	Is the client aged 20 years or younger? Yes ___ No ___		
Section 2 – Travel Information			
Date of Travel (leaving/returning): Leaving: ___ Returning: ___	Appointment Date/Time: Date: ___ Time: ___		
Name of Doctor/Office Visiting: ___	Doctor's Address: Address: City: State: Zip: ___		
Section 3 – Client 20 years or younger (if client is 21 years and older, please see section 4)			
Please check yes if all statements below apply:			
Client is under age of 21: Yes ___ No ___			
Total mileage will be over 400 miles round trip *or* 150 miles round trip with multiple appointments on consecutive days: Yes ___ No ___			
Client is inpatient at the facility: Yes ___ No ___			
Are you staying overnight for the client's appointment(s)? Yes ___ No ___		Lodging for appointment: Ronald McDonald House of Aurora ___ Hotel ___ Brent's Place ___ Other ___	
Section 4 – Client 21 years or older (Travel Reimbursement Only)			
Please indicate travel type: If taxi/shuttle, please specify: ___			
Personal car ___	T1 Shuttle (Cheyenne Only) ___	Eastern Shoshone Tribal Health ___	Sheridan Bus (Sheridan only) ___
Driven by family/friend ___	Ark Regional Services ___	Northern Arapaho Tribal Health ___	
Taxi/Bus/Shuttle ___	Best Home Health & Hospice ___	Wind River Family/Community Health Care ___	
Section 5 – Additional Information			
Are you receiving any assistance from sources other than Medicaid? Yes ___ No ___		If "Yes", please explain: ___	
Print Name: _____ Signature: _____ Date: _____			
Please mail completed form to: Wyoming Medicaid (Attn: Transportation Services) P.O. Box 567 Cheyenne, WY 82003			
Internal Use Only			
Received: _____		TAC: _____	

Covered Services – Non-Emergency Medical Transportation



(800) 595-0011

Wyoming Medicaid – Travel Request Form

Section 1:

- Please fill out all information fully. To be approved for reimbursement, full verification of identification is required.
- If you haven't requested travel assistance before, please complete the included Vendor Management Form and W9, and return with travel request form.
- If you do not have an active phone or email for contact, please include the number of a friend, family member, or guardian who we would be able to leave a message with for you (in case of errors on claim form, questions about dates or provider, etc.)

Section 2:

- If there are multiple travel dates, please include a sheet of paper indicating the extra dates in question with your form, along with the appropriate appointment dates and times.
- Client is required to be active with Wyoming Medicaid on date(s) of service.
- Doctor you are seeing is required to be enrolled and active with Wyoming Medicaid on the date(s) of service.
- If you are requesting emergency funds or airline travel assistance, please call Transportation Services at (800) 595-0011 for assistance. These requests cannot be mailed with a request form.

Sections 3-4:

- Please note that only clients under the age of 21 will be eligible for lodging assistance.
- If staying with facility enrolled with Medicaid, facility must be active on date of service.

Internal Use Only

Received _____ TAC _____

NOTE: This form is available to IHS clients that do not have access to a phone. The form can be found on the Medicaid Website. Click image above to be taken to a printable version of this form.

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25.1 Practitioner Services

Practitioners Include:

- Physicians (MD/DO)
- Locum Tenens
- Nurse Practitioners
- Physician's Assistants
- Mental Health Providers
- Ordering, Rendering and Prescribing Providers

25.2 Covered Services

- Abortion
- Anesthesia Services
- Dermatology
- Diabetic Training
- Family Planning
- Hysterectomies
- Imaging Services
- Immunizations
- Injections
- Interpretation Services
- Laboratory Services
- Locum Tenens
- Maternity Care
- Medical Supplies
- Practitioner Visits
- Pregnant By Choice/Family Planning Waiver
- Preventive Medicine
- Psychiatric Services
- Public Health Services
- Screening, Brief Intervention, Referral and Treatment (SBIRT)
- Sterilization
- Surgical Services
- Transplant Policy
- Vision Service

NOTE: Many unlisted procedure codes require prior authorization ([7.13, Prior Authorization](#)). For planned services, authorization must be obtained prior to the date of service. For procedures that are planned and altered during surgery, prior authorization must be requested within three (3) business

days. Please contact WYhealth or review the WYhealth Provider Manual for specifics ([2.1 Quick Reference](#)).

25.3 Dermatology

Encounter Revenue Code: 0500

Medicaid covers medically necessary services rendered in the treatment of dermatological illnesses.

25.3.1 Covered Services

- Acne surgery due to disfigurement requires prior authorization ([7.13, Prior Authorization](#))
- Removal of lesions suspected to be precancerous.
- Removal of a benign lesion, ganglion cyst, skin tag, keloid, or wart, may be covered when medically necessary.

25.3.2 Benign Lesion Removal and Destruction of Benign or Premalignant Lesions

Procedure Code:	11200 (Removal of Skin Tags)
Procedure Code:	11310 (Removal / Shave Lesion)
Procedure Code Range:	11400-11446 (Removal)
Procedure Code Range:	17106-17111 (Destruction)

25.3.3 Covered Services

Benign skin lesions include seborrheic keratosis, sebaceous (epidermoid) cysts, skin tags, milia (keratin-filled cysts), nevi (moles) acquired hyperkeratosis (keratoderma), papillomas, hemangiomas and viral warts.

25.3.4 Billing Requirements

Wyoming Medicaid considers **removal of benign skin lesions** as medically necessary, and not cosmetic, when **any** of the following is met and is clearly documented in the medical record, operative report or pathology report:

- The lesion is symptomatic as documented by any of the following:
 - Intense itching
 - Burning
 - Irritation
 - Pain
 - Tenderness
 - Chronic, recurrent or persistent bleeding.
 - Physical evidence of inflammation (e.g., purulence, oozing, edema, erythema, etc.)

- The lesion demonstrates a significant change in size or color.
- The lesion obstructs an orifice or clinically restricts vision.
- There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesional appearance, change in appearance and/or non-response to conventional treatment.
- The lesion is likely to turn malignant as documented by medical peer-reviewed literature or medical textbooks.
- A prior biopsy suggests the possibility of lesional malignancy.
- The lesion is an anatomical region subjected to recurrent physical trauma that has in fact occurred and objective evidence of such injury or the potential for such injury is documented.

Wyoming Medicaid considers **destruction of benign or malignant skin lesions** as medically necessary, and not cosmetic, when any of the following is met and is clearly documented in the medical record, operative report or pathology report.

- An over-the-counter (OTC) product has been tried and was ineffective (when applicable)
- Lesion causes symptoms of such a severity that the patient's normal bodily functions/activities of daily living are impeded (e.g., palmar or plantar warts)
- Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding;
- Warts showing evidence of spread from one (1) body area to another, particularly in immunosuppressed patients.
- Lesions are condyloma acuminata or molluscum contagiosum.
- Cervical dysplasia or pregnancy associated with genital warts.
- Port wine stains and other hemangiomas when lesions are located on the face and neck.
 - Progress notes and photos documenting improvement must be kept in the patient record and available upon request.

NOTE: Wyoming Medicaid does not consider removal of skin lesions to improve appearance as medically necessary. Removal of certain benign skin lesions that do not pose a threat to health or function are considered cosmetic, and as such, are not medically necessary. In the absence of any of the above indications, removal of seborrheic keratoses, sebaceous cysts, nevi (moles) or skin tags is considered cosmetic. Wart removal can be requested for 3 units at a time.

25.3.5 Documentation Requirements

One (1) or more of the above conditions, clearly documented in the medical record, operative report or pathology report are required.

25.4 Diabetic Training

Encounter Revenue Code: 0942

Procedure Code Range: G0108-G0109

Physicians, public health nurses, and nurse practitioners managing a client's diabetic condition are responsible for ordering diabetic training sessions. Certified Diabetic Educators (CDE) or dietitians may furnish outpatient diabetes self-management training.

25.4.1 Covered Services

Individual and group diabetes self-management training sessions are covered. Curriculum will be developed by individual providers and may include, but is not limited to:

- Medication education
- Dietetic/nutrition counseling
- Weight management
- Glucometer education
- Exercise education
- Foot/skin care
- Individual plan of care services received by the client

25.4.2 Billing Requirements

- HCPCS Level II codes, G0108 (individual session) and G0109 (group session) should be used
- Do not bill a separate office visit on the same date of service
- Billing is to be done under the physician, nurse practitioner, or hospital's provider number

25.4.3 Documentation Requirements

- Documentation should reflect an overview of relative curriculum and any services received by the client
- The Diabetic Education Certificate is not required to be submitted with each claim

25.5 Family Planning Services

Encounter Revenue Code: 0500

Family planning services are to assist clients of childbearing age with learning the choices available to them to freely determine the number and spacing of their children.

Family planning services include the following:

- Initial visit
- Initial physical examination
- Comprehensive history
- Laboratory services
- Medical counseling
- Annual visits
- Routine visits

25.5.1 Covered Services

- Sterilization procedures are covered only when all Medicaid guidelines have been met ([7.16.1.1, Sterilization Consent Form](#)).
- Contraceptives
- Cervical caps
- Male/female condom
- Contraceptive injections
- Creams
- Diaphragms
- Foams
- Insertion/removal of implantable contraceptives (Norplant and Implanon)
- Insertion/removal of IUDs
- Oral contraceptives when prescribed by a physician or nurse practitioner and dispensed a participating pharmacy
- Spermicides
- Sponges

NOTE: Pregnant by Choice/Family Planning Waiver has specific covered and non-covered services. The plan information can be found in [Section 26.1](#).

25.6 Public Health Services – Home Visits

Revenue Code: 0529

Procedure Code Range: 99341-99350

- Public health clinic services are physician and mid-level practitioner services provided in a clinic designated by the Department of Health as a public health clinic.
- Services must be provided directly by a physician or by a public health nurse under a physician's immediate supervision (i.e., the physician has seen the client and ordered the service).

Home visits are evaluation and management services provided by a practitioner in a private residence. These visits must be medically necessary. These home visits must be medical in nature.

25.6.1 Documentation

The following documentation must be included in the client's medical record:

- Documentation of practitioner order and treatment plan of care
- Documentation of observed medical condition, progress at each visit, any change in treatment, and the client's response to treatment
- Documentation of coordination of care between office and home visit

25.7 Immunizations

Encounter Revenue Code: **0771** (if given by the physician, nurse practitioner, nurse, or physician's assistant, this cannot be billed separate from the medical encounter)

Procedure Code Range: **90477-90756, 99460, 99461, & 99471-99474**

Vaccines For Children (VFC) Program

Providers must enroll with the VFC program to receive and distribute VFC vaccines. The VFC program makes available, at no cost to providers, selected vaccines for eligible children 18 years old and under. Medicaid will therefore pay only for the administration of these vaccines (oral or injection). VFC covered vaccines may change from year to year. For more information on the VFC program current VFC covered vaccines or how to enroll as a VFC provider contact the Wyoming Immunization Program at (307)777-7952.

25.7.1 Billing Procedures: VFC Supplied or Private Stock

Use the following guidelines when submitting claims to Medicaid:

- Providers must use a VFC provided vaccine when available and client appropriate. If the vaccine is supplied by VFC, bill the appropriate procedure code and use the SL modifier. Codes 90477-90748 identify the vaccine product only. To report the administration of vaccine/toxoid, the appropriate administration code (see table below) must be reported in addition to the vaccine/toxoid code. Reimbursement will be made for the administration only.
- When Medicaid is the secondary payer, the provider must submit the claim according to Medicaid guidelines. Bill other potential payers before billing Medicaid.
- Providers are reminded that use of any vaccine or immunization solely for the purpose of travel is not covered by Medicaid.
- According to VFC policy, providers may not impose a charge for the administration of the vaccine that is higher than the maximum fee established

by the Centers for Medicaid and Medicare Services (CMS) regional cap of \$21.72 per dose.

- A previous policy from our office indicated that additional units could be billed for each antigen in the combination vaccination. Separate codes are available for combination vaccines. It is inappropriate to code each component of a combination vaccine separately.
- Codes 90477-90748 identify the vaccine product only. To receive reimbursement for administration they must be reported in addition to an immunization administration code from the tables below.
- When a vaccine is privately obtained due to lack of availability through the VFC program, it will be reimbursed at 100% of purchase invoice. **DO NOT USE** the SL modifier in this instance. This policy applies exclusively to situation where the VFC Program has issued a notice of vaccine shortage and has specified which vaccines are affected.
- For vaccines administered to adults over 18 years of age, or for vaccines/toxoids not supplied by VFC, report the appropriate CPT code and administration fee. **DO NOT USE** the SL modifier. Medicaid will reimburse for the vaccine/toxoid and the administration.
- When the vaccine/toxoid product code does not contain the SL modifier, a manufacturers' invoice must be attached to the claim. The vaccine/toxoid will be reimbursed at 100% of the invoice cost. **Exception:**
 - For procedure codes 90656, 90660, 90703, 90707, and 90714, an invoice is only required for those clients age 18 years and younger. Those claims for clients 19 years and older will be reimbursed at a flat rate of \$15.00 for these codes.
 - For procedure code 90658, an invoice is only required for those clients age 18 years and younger. Those claims for clients 19 years and older will be reimbursed at a flat rate of \$20.00 for this code.
 - For procedure code 90715 an invoice is only required for those clients age 18 years and younger. Those claims for clients 19 years and older will be reimbursed at a flat rate of \$30.00 for this code.

25.7.2 Other Immunizations

Other immunizations include, but are not limited to:

- Synagis can only be billed via pharmacy. The provider will only bill for the services that they provided i.e. E & M and administration. The providers will need to work with a pharmacy to provide the medication.
- Please see instructions for Synagis on the following Pharmacy site under prior authorization: <http://www.wymedicaid.org/>.
- Additional Vaccines, Toxoids
 - CPT-4 codes for vaccines are to be used to bill for the vaccine product itself and are reported in addition to the immunization administration codes (90471, 90472) unless the VFC program supplied the vaccine.

- Separate codes are available for combination vaccines. It is inappropriate to code each component of a combination vaccine separately.

NOTE: The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedule on the website ([2.1, Quick Reference](#)).

25.8 Injections

Reimbursement for J-codes and therapeutic injections include the cost of the administration fee. This cost is already calculated into the fee for each code.

NOTE: Therapeutic injections may not be billed with a J-code ([7.7, National Drug Code \(NDC\) Billing Requirement](#)).

If multiple drugs are included in a single injection, separate codes may be billed for the drugs, however, the administration fee should be included with only one (1) code.

For an accurate listing of codes, refer to the fee schedule on the Medicaid website ([2.1, Quick Reference](#)).

25.8.1 Belimuab (Benlysta®)

Procedure Code: J0490

25.8.1.1 Covered Services

Belimumab is covered and considered medically necessary if the below requirements are met.

25.8.1.2 Billing Requirements

Prior authorization requirements ([7.13, Prior Authorization](#)):

Wyoming Medicaid considers Belimumab medically necessary when all of the following is met and is clearly documented in the medical record, operative report, or pathology report:

- The patient is 5 years of age or older for intravenous infusion administration
- The patient is 18 years of age or older for subcutaneous injection administration.
- The patient has a diagnosis of active systemic lupus erythematosus (SLE) disease.
- The patient has positive autoantibody test results [positive antinuclear antibody (ANA >1:80) and/or anti-dsDNA (>30 IU/mL)].

- **ONE (1) of the following:**
 - The patient is currently on a standard of care SLE treatment regimen comprised of at least one (1) of the following: corticosteroids, hydroxychloroquine, chloroquine, nonsteroidal anti-inflammatory drugs (NSAIDS), aspirin, and/or immunosuppressives (azathioprine, methotrexate, cyclosporine, oral cyclophosphamide, or mycophenolate).
 - The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the standard of care drug classes listed above.
- The patient does NOT have severe active lupus nephritis [proteinuria >6 g/24-hour or equivalent or serum creatinine >2.5 mg/dL OR required hemodialysis or high-dose prednisone >100 mg/day] within the past 90-days.
- The patient does NOT have severe active central nervous system lupus [e.g. seizures, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis, CNS vasculitis requiring therapeutic intervention] within the past 60 days.
- The patient has NOT been treated with intravenous cyclophosphamide in the previous six (6) months.
- The patient is NOT currently using another biologic agent.
- The patient is NOT currently being treated for a chronic infection.
- The dose for intravenous administration is within the FDA labeled dosage of 10 mg/kg intravenously at two (2) week intervals for the first three (3) doses and at four (4) week intervals thereafter.
- The dose for subcutaneous administration is within the FDA labeled dosage of 200 mg once weekly.

NOTE: Length of Approval: 12 months.

25.8.2 Botox®

Procedure Code Range: J0585

25.8.2.1 Covered Services

OnabotulinumtoxinA [Botox] is covered for the treatment of the following conditions and are considered medically necessary when specific criterion is met.

25.8.2.2 Billing Requirements

Prior authorization requirements ([7.13, Prior Authorization](#)):

Wyoming Medicaid considers Botulinum toxin A (onabotulinumtoxinA [Botox®]) appropriate for the treatment of the following conditions and meet medical necessity criteria where it is stated:

- Incontinence with inadequate response to or intolerance of anticholinergic medications PLUS one of the following:
 - Overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency
 - At least 3 urinary urgency incontinence episodes
 - At least 24 micturitions in 3 days' time
 - Total dose: 100 units, as 0.5 mL (5 Units) injections across 20 sites into the detrusor
 - To qualify for re-treatment, ALL of the following must apply:
 - At least 12 weeks must have passed since the prior treatment
 - Post-void residual urine volume must have been less than 200 mL
 - Patients must have reported at least 2 urinary incontinence episodes over 3 days
 - Urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)]
 - Total dose: 200 Units, as 1 mL (~6.7 Units) injections across 30 sites into the detrusor
 - To qualify for re-treatment, ALL of the following must apply:
 - At least 12 weeks must have passed since the prior treatment
 - Post-void residual urine volume must have been less than 200 mL
 - Patients must have reported at least 2 urinary incontinence episodes over 3 days with no more than 1 incontinence-free day.
- Upper and lower limb spasticity, excluding spasticity caused by cerebral palsy
 - Patient must be 2 years of age or older
 - Upper Limb:
 - Adult total dose: Select dose based on muscles affected, severity of muscle activity, prior response to treatment, and adverse event history; Electromyographic guidance recommended
 - Patient is at least 6-weeks post-stroke
 - Pediatric total dose: 3 Units/kg to 6 Units/kg (maximum 200 Units) divided among affected muscles
 - Lower Limb:
 - Adult total dose: 300 Units to 300 Units divided across ankle and toe muscles
 - Pediatric total dose: 4 Units/kg to 8 Units/kg (maximum 300 Units) divided among affected muscles
- Cervical dystonia
 - Patient is 16 years or older

- Base dosing on the patient's head and neck position, localization of pain, muscle hypertrophy, patient response, and adverse event history; use lower initial dose in botulinum toxin naïve patients
- Severe axillary hyperhidrosis with ALL of the following:
 - Patient is 18 years or older
 - Inadequate management by topical agents
 - Total dose: 50 units per axilla
- Blepharospasm associated with dystonia with ALL of the following:
 - Patient is 12 years or older
 - Includes benign essential blepharospasm or VII nerve disorders
 - Total dose: 1.25 Units-2.5 Units into each of 3 sites per affected eye
- Strabismus
 - Patient is 12 years or older
 - Total dose: The dose is based on prism diopter correction or previous response to treatment with Botox®
 - For vertical muscles, and for horizontal strabismus of less than 20 prism diopters: 1.25 Units-2.25 Units in any one muscle
 - For horizontal strabismus of 20 prism diopters to 50 prism diopters: 2.5 Units-5 Units in any one muscle
 - For persistent VI nerve palsy of one month or longer duration: 1.25 Units-2.5 Units in the medial rectus muscle
- Migraine headaches prevention is considered medically appropriate if the headaches are chronic with ANY ONE (1) the following criteria met:
 - Initial six (6) month trial for migraine headaches with ALL the following:
 - Occur 15-days or more per month
 - Lasting 4 hours a day or longer
 - Experienced for three (3) months or more
 - Symptoms persist despite adequate trials of a minimum of **two (2) agents** from different classes used in the treatment of chronic migraines (e.g. **Angiotensin-converting enzyme inhibitors/angiotensin II receptor blockers, anti-depressants, anti-epileptics, beta blockers and calcium channel blockers**), unless the individual has contraindications to such medications.
 - Continuation of therapy after six (6) month trial for the prevention of migraines requires frequency reduced by at least seven (7) days per month.

NOTE: When initiating treatment, the lowest recommended dose should be used. In treating adult patients for one or more indications, the maximum cumulative dose should not exceed 400 Units, in a 3 month interval. In pediatric patients, the total dose should not exceed the lower of 10 Units/kg body weight or 340 Units, in a 3 month interval.

NOTE: Botox® can only be requested one (1) session at a time, with medical necessity provided for each session.

Botox should not be administered and will not be approved if the patient has either of the following contraindications:

- Hypersensitivity to any botulinum toxin
- Infection at proposed injection site
- Intra-detrusor injections: when the client has a urinary tract infection or urinary retention

25.8.2.3 Non-Covered Services

- Prophylaxis of episodic migraine (<14 headache days per month)
- Treatment of hyperhidrosis in body areas other than axillary

25.8.3 Dysport®

Procedure Code Range: J0586

25.8.3.1 Covered Services

Abobotulinum toxin A [Dysport®] (Botulinum toxin type A) for the treatment of the following conditions and are considered medically necessary when specific criteria is met.

25.8.3.2 Billing Requirements

Prior authorization requirements ([7.13, Prior Authorization](#)):

Wyoming Medicaid considers Botulinum toxin A (abobotulinumtoxinA [Dysport®]) appropriate for the treatment of the following conditions and meet medical necessity criteria where it is stated:

- Cervical dystonia associated with ALL of the following
 - with or without a history of prior treatment with botulinum toxin
- Spasticity in adults
- Lower limb spasticity in pediatric patients with ALL of the following;
 - Patient is 2 years of age or older

NOTE: Dysport® can only be requested one (1) session at a time, with medical necessity provided for each session.

Dysport should not be administered and will not be approved if the patient has either of the following contraindications:

- Hypersensitivity to any botulinum toxin products, cow's milk protein, or any other components in the formulation
- Infection at the proposed injection site(s)

25.8.4 Myobloc®

Procedure Code Range: J0587

25.8.4.1 Covered Services

Botulinum toxin type B (fimabotulintoxinB [Myobloc®]) for the treatment of the following conditions and are considered medically necessary when specific criteria is met.

25.8.4.2 Billing Requirements

Prior authorization requirements ([7.13, Prior Authorization](#)):

Wyoming Medicaid considers Botulinum toxin B (fimabotulintoxinB [Myobloc®]) appropriate for the treatment of the following conditions and meet medical necessity criteria where it is stated:

- Cervical dystonia with ALL of the following:
 - Moderate or greater severity
 - At least 2 muscles involved
 - Absent of neck contractures (or other causes of decreased neck range of motion)
 - Absent history of other neuromuscular disorder
- Chronic Sialorrhea in adults

NOTE: Myobloc® can only be requested one (1) session at a time, with medical necessity provided for each session.

Myobloc should not be administered and will not be approved if the patient has either of the following contraindications:

- Hypersensitivity to any botulinum toxin products, cow's milk protein, or any other components in the formulation
- Infection at the proposed injection site(s)

25.8.5 Ocrelizumab (Ocrevus)

Procedure Code: J2350 - ONLY NDC Approved 50242.0150.01

25.8.5.1 Covered Services

Ocrelizumab (Ocrevus) is used for the treatment of clients with relapsing or primary progressive forms of multiple sclerosis and considered medically necessary if the prior authorization criteria are met.

25.8.5.2 Billing Requirements

Prior Authorization (PA) Requirements ([7.13, Prior Authorization](#)):

Quantity Limits and PA issuance:

- Products comes as 300 mg/10 ml, single dose vial
- A single PA will be provided in 600 mg increments.
 - Client receives initial does of 300 mg (IV), with a second 300 mg dose two weeks later.
 - Subsequent dose is 600 mg every six (6) months

INITIAL PA APPROVAL

- Ocrelizumab for the treatment of relapsing or primary progressive forms of multiple sclerosis is considered medically necessary if ALL of the following criteria are met:
 - Individual is 18 years of age and older
 - Individual must have clear, documented indication for therapy
 - Individual must be screened for and is without active hepatitis B viral infection prior to initial dose
 - Further diagnosis of ANY ONE of the following:
 - Primary Progressive MS (PPMS)
 - Indications: For PPMS – This is the only agent that is FDA approved.
 - Relapsing Form of MS (RMS)
 - Patient has had adequate trials with **two** drugs from Wyoming Medicaid's preferred Drug list; **Avonex, Betaseron, Rebif, Copaxone, or Gilenya** and the preferred drugs were ineffective or caused intolerable adverse side effects. An adequate trial is eight weeks of therapy where a member was compliant and adherent to the regimen.

RENEWAL PA CRITERIA

- Ocrelizumab is considered medically necessary for renewal only when ALL of the following criteria are met:
 - Documents adherence to the regimen, with no adverse side effects warranting discontinuation of therapy.

- Absence of unacceptable toxicity from the agent, e.g., severe upper respiratory tract infections, lower respiratory tract infections, skin infections, herpes-related infections, bronchospasm, pharyngeal or laryngeal edema, hypotension, headache, dyspnea, pyrexia, tachycardia.
- Absence of active hepatitis B infection
- Evidence of ANY ONE of the following:
 - Diagnosis of primary progressive multiple sclerosis (PPMS) shows maintenance of baseline or reduction of confirmed disability progression
 - Diagnosis of relapsing forms of multiple sclerosis (RMS) show relative reduction in annual relapse rate (ARR) to baseline

Reason(s) for denial of PA request

- Unclear indication
- Active hepatitis B virus infection
- History of life-threatening infusion reaction
- Client with Relapsing-Remitting Multiple Sclerosis (RRMS) has not completed adequate trials with two (2) preferred drugs

25.8.6 Hyaluronic Acid Derivatives Injections

Procedure Code: J7321-J7326

25.8.6.1 Covered Services

Hyaluronic Acid Derivatives are injected directly into the knee joint to improve lubrication and reduce the pain associated with osteoarthritis of the knee. Hyaluronic Acid Derivatives are subject to prior authorization as well as step therapy. When prior authorization criteria is met and approval given, step therapy must still be followed. The FDA has not approved intra-articular hyaluronan for joints other than the knee.

25.8.6.2 Limitations

- **Euflexxa®** – Is injected into the affected knee, 20 mg once (1) weekly for three (3) weeks, a total of three (3) injections.
- **Synvisc One®** – Is injected into the affected knee, 48 mg for one (1) dose only.
- **Synvisc** – Is injected into the affected knee, 16 mg once weekly for three (3) weeks, a total of three (3) injections.
- **Hyalgan®** – Is injected into the affected knee, 20 mg once (1) weekly for a total of five (5) injections.
- **Orthovisc** – Is injected into the affected knee, 30 mg once (1) weekly for three (3) or four (4) injections.
- **Supartz®** – Is injected into the affected knee, 25 mg once (1) weekly for a total of five (5) injections.

- **Gel-One®** – Is injected into the affected knee, 30 mg, for one (1) dose only.

25.8.6.3 Billing Requirements

Prior authorization requirements ([7.13, Prior Authorization](#)):

Wyoming Medicaid considers Hyaluronic Acid Derivatives injections as medically necessary when all of the following is met and is clearly documented in the medical record, operative report or pathology report. ALL of the following criteria must be met for approval of coverage:

- Documented diagnosis of symptomatic osteoarthritis of the knee
- Pain interferes with functional activities such as ambulation and prolonged standing.
- Trial of conservative nonpharmacologic treatment, (education, physical therapy, weight loss if appropriate) has not resulted in functional improvement. **Medical records documenting these therapies must be submitted.**
- Trial of pharmacotherapy (NSAIDs, COX II Inhibitors, acetaminophen) has not resulted in functional improvement.
- Prior therapy with at least one (1) intra-articular corticosteroid injection.

Repeat doses of any viscosupplement will be approved only when the following criteria are met:

- At least six (6) months has elapsed since the previous injection or completion of the prior series of injections.
- Medical records must document significant improvement in pain and functional capacity of the knee joint.

25.8.7 Reslizumab (CINQAIR)

Procedure Code: J2786 - ONLY NDC Approved 59310.0610.31

25.8.7.1 Covered Services

Reslizumab is the treatment for severe asthma and is covered when the following conditions in the billing requirements section are met.

25.8.7.2 Limitations:

- One infusion every 4 weeks when documented improvement is present

25.8.7.3 Billing Requirements

Prior authorization (PA) requirements ([7.13, Prior Authorization](#)):

- Client must be 18 years and older on the date of prior authorization request

- Must be an add on maintenance treatment for patients with severe asthma and an eosinophilic phenotype
- The patient does NOT have any one (1) of the following:
 - Other eosinophilic conditions
 - Known hypersensitivity to Reslizumab or any of its excipients
 - Acute asthma symptoms
 - Acute exacerbations
 - Acute bronchospasms
 - Status asthmaticus
- Individuals must be clear from pre-existing helminth infection prior to initial dose.
- Blood eosinophil count of >400 cells/mcL within 3 to 4 weeks of dosing (other symptoms of eosinophil phenotype may be considered on an individual basis)
- Severe asthma that is inadequately controlled despite standard of care (medium to high dose inhaled corticosteroids with long acting beta agonists)
 - Symptoms at least >2 days a week
 - Decreased forced expiratory volume in 1 second (FEV1) by 20% or more from baseline
 - Decreased peak expiratory flow rate (PEFR) by 30% or more from baseline
 - Short acting beta agonist use for symptom control at least > 2 days a week
 - Severe interference with daily activities – well documented
- At least 1 asthma exacerbation requiring use of oral (systemic) corticosteroids over the last 12 months.
- Compromised lung function

25.8.8 Tysabri®

Procedure Code: J2323

25.8.8.1 Covered Services

Tysabri® is a monotherapy treatment for relapsing forms of Multiple Sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.

Tysabri® is a treatment for inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn's Disease (CD).

NOTE: Tysabri® increases the risk of Progressive Multifocal Leukoencephalopathy (PML), an opportunistic viral infection of the brain that usually leads to death or severe disability.

25.8.8.2 Documentation Requirements

Multiple Sclerosis and Crohn's Disease Prior Authorization (PA) Requirements (7.13, Prior Authorization):

- Physician's prescription
- Must document an inadequate response to, or inability to tolerate an appropriate trial with at least one (1) of the following interferon agents:
 - Betaseron
 - Avonex
 - Rebif
 - Copaxone
 - This documentation **must** include information that states when the drug(s) was started and discontinued, and the reason the drug(s) was discontinued.
- Documentation must state the date the treating provider and patient were enrolled in the Touch Program, and both must meet all eligibility requirements of that program. As of 11/18/2015, the first infusion can be documented with Initial Notice of Patient Authorization.

25.8.8.3 Billing Requirements

MS specific PA requirements (7.13, Prior Authorization):

- Tysabri® must be prescribed by a neurologist enrolled in the Touch Program.
- Both the provider administering the Tysabri® and the patient receiving the Tysabri® must be enrolled in the Touch Program.
- Medicaid will only authorize Tysabri® for clients that have a diagnosis of MS.
- For continued PA the neurologist must submit documentation to show improvement or stabilization.
- Length of PA: 12 months
- Dosage: 300 mg IV infusion every four (4) weeks.
- Must be billed using the NDC number and the appropriate J-code.

NOTE: Medicaid will not cover Tysabri® when used in conjunction with other medications for the treatment of progressive MS.

CD PA requirements (7.13, Prior Authorization):

- Tysabri® must be prescribed by a neurologist enrolled in the Touch Program.
- Both the provider administering the Tysabri® and the patient receiving the Tysabri® must be enrolled in the Touch Program.
- Patient is NOT currently taking immunosuppressant (e.g., e.g., 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or inhibitors of TNF- α

- For continued PA the neurologist must submit documentation to show improvement or stabilization.
- Length of PA: 12 months
- Dosage: 300 mg IV infusion every four (4) weeks.
- Must be billed using the NDC number and the appropriate J-code.

25.9 Genetic Testing

Procedure Codes: 81200-81599; 96040

Prior Authorization ([7.13, Prior Authorization](#)): is required for all genetic testing codes. Prior authorization documentation must document the following:

25.9.1 Covered Services

Medicaid covers genetic testing under the following conditions:

- There is reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists; and
- Test results will influence decisions concerning disease treatment or prevention (in ways that not knowing the test results would not); and
- Genetic testing of children might confirm current symptomatology or predict adult onset diseases and findings might result in medical benefit to the child or as the child reaches adulthood; and
- Referral is made by a genetic specialist (codes 81223 and 81224) or a specialist in the field of the condition to be tested; and
- All other methods of testing and diagnosis have met without success to determine the client's condition such that medically appropriate treatment can be determined and rendered without the genetic testing.
- Counseling is provided by healthcare professional with education and training in genetic issues relevant to the genetic tests under consideration.
- Counselor is free of commercial bias and discloses all (potential and real) financial and intellectual conflicts of interest.
- Process involves individual or family and is comprised of ALL of the following:
 - Calculation and communication of genetic risks after obtaining 3-generation family history
 - Discussion of natural history of condition in question, including role of heredity
 - Discussion of possible impacts of testing (eg, psychological, social, limitations of nondiscrimination statutes)
 - Discussion of possible test outcomes (ie, positive, negative, variant of uncertain significance)
 - Explanation of potential benefits, risks, and limitations of testing
 - Explanation of purpose of evaluation (eg, to confirm, diagnose, or exclude genetic condition)

- Identification of medical management issues, including available prevention, surveillance, and treatment options and their implications
 - Obtaining informed consent for genetic test
- **Codes 81420, 81507** - Mother must be documented as high-risk to include:
 - advanced maternal age >35 (at EDC)
 - previous "birth" of embryo/fetus/child with aneuploidy
 - parent with known balanced translocation
 - screen positive on standard genetic screening test (FTCS, multiple marker screen of one type or another, etc)
 - ultrasound finding on embryo/fetus consistent with increased risk of aneuploidy
- **Code 81519** - All of the following conditions must be met and documented in the prior authorization request:
 - The test will be performed within 6 months of the diagnosis
 - Node negative (micrometastases less than 2mm in size are considered node negative)
 - Hormone receptor positive (ER-positive or PR-positive)
 - Tumor size 0.6-1.0 cm with moderate/poor differentiation or unfavorable features (ie, angiolymphatic invasion, high nuclear grade, high histologic grade) OR tumor size >1 cm
 - Unilateral disease
 - Her-2 negative
 - Patient will be treated with adjuvant endocrine therapy
 - The test result will help the patient make decisions about chemotherapy when chemotherapy is a therapeutic option

25.9.1.1 BRCA Testing and Counseling

The U.S. Preventive Services Task Force (USPSTF) recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for evaluation for BRCA testing (81211-81217 and 81211-81217). Medicaid covers BRCA testing when the following criteria are met:

- Personal and/or family history of breast cancer, especially if associated with young age of onset; or
- Multiple tumors; or
- Triple-negative (i.e., estrogen receptor, progesterone receptor, and human epidermal growth factor receptor 2-negative) or medullary histology; or
- History of ovarian cancer; and
- 18 years or older; and
- Documentation indicates a genetic counseling visit pre or post testing

25.9.1.2 Billing Requirements

Enrolled laboratories should bill Medicaid directly for genetic testing, refer to [Section 23.1](#).

The following billing procedures must be followed when the physician agrees to act as a third party agent for a non-enrolled laboratory:

The following documents must be attached to the claim ([7.15, Submitting Attachments for Electronic Claims](#)):

- The physician's letter justifying the genetic testing must be attached to the claim. The letter must document the necessity for the genetic testing by meeting the covered service conditions mentioned above.
- Manufacturer's invoice
 - Reimbursement will be invoice plus 15% for dates of service prior to 01/01/2021 and 12.13% for 01/01/2021 and forward dates of service.
- No prior authorization is required.

NOTE: Post payment claim review will be conducted.

25.10 Maternity Care

Encounter Revenue Code: 0500

Procedure Code Range: 59000-59898, 0500F

Maternity services include antepartum, delivery & postpartum care of a pregnant woman, according to guidelines set forth in the current edition of the CPT-4 book.

25.10.1 Obstetric Care Reporting

Procedure Code: 0500F

All pregnancies should be reported using this code. When a woman has her first obstetric visit, bill 0500F using the first visit's date as the date of service, even if the provider plans to bill using a global maternity code. This should be reported as soon as possible after the first obstetrical care visit in order for Wyoming Medicaid to be notified of the client's pregnancy. 0500F should only be reported once per pregnancy.

24.1.1 Billing Requirements

25.10.1.1 Non-Global Services for Routine Obstetric Care

Use the following billing procedures when a patient is seen by a different physician or a different physician group for their antepartum care:

- If the total antepartum visits with the patient is 1-3, bill the appropriate E&M (Evaluation and Management) code for each visit.

- Bill only one (1) of the following two (2) antepartum procedure codes (depending on the total number of antepartum visits):
 - **59425** – Antepartum care only; four (4) to six (6) visits. This code would be used in the case where the patient was only seen for four (4) to six (6) visits and then quit seeing that provider. The provider would not be providing services of delivery or postpartum care. If the provider saw the patient at least four (4) times and no more than six (6) times, this is the correct code the provider would submit.
 - **59426** – Antepartum care only; seven (7) or more visits. This code would be used for the patient who was seen for seven (7) or more antepartum visits, but the provider did not provide services for delivery or postpartum care.
- Bill procedure code 59430 for postpartum care only (separate procedure). This code is to be used when the provider did not provide the service of the delivery, but they may have provided the antepartum care.

NOTE: It is not appropriate to separately report the antepartum, delivery and postpartum care when provided by the same physician or same physician group. However, any other visits or services provided within the antepartum period, other than those listed above, should be coded and reported separately. The date of service is the date of delivery.

25.10.1.2 Patient has Other Medical Conditions, or a Complicated Pregnancy

Use the following billing procedures when the patient has other medical conditions, or a complicated pregnancy:

- If the provider needs to treat the patient for additional services due to complication of pregnancy, use the proper CPT and ICD codes to reflect the complication.
- If the provider attempts to bill a separate E&M visit and only code the encounter as a normal pregnancy code, the claim will be denied and considered unbundling of the Global Maternity package.

These codes cover attendance at delivery when requested by the provider delivering and initial stabilization of newborn. These codes may be reported in addition to the CPT-4 code for history and examination, but not in addition to the newborn resuscitation code.

When billing for a twin delivery, modifier 22 should be added to the appropriate global or delivery code and documentation must accompany the claim. Assisting providers should bill for just the delivery with appropriate modifiers. Providers cannot bill two (2) separate delivery codes for the delivery of twins except, when one (1) twin is delivered vaginally and the other by cesarean.

Pregnancies that terminate in abortion/miscarriage in any trimester must bill with the appropriate CPT-4 code and documentation is required. Prenatal visits and additional services may be billed in addition to the abortion code.

NOTE: When billing for an assistant surgeon at a delivery, use the procedure code for delivery only with an 80 or AS modifier as appropriate. Refer to [Section 6.16.1, Sterilization Consent Form and Guidelines](#) for more information if the client is considering sterilization.

25.10.1.3 Elective Inductions and Medical Necessity

Induction of labor for medical reasons is appropriate when there may be health risks to the woman or baby if the pregnancy were to continue. Some indications for inducing labor include:

- High blood pressure caused by the pregnancy
- Maternal health problems affecting the pregnancy
- Infection in the uterus
- Water has broken too early
- Fetal growth problems

Documentation, which substantiates that the patient's condition meets the coverage criteria, must be on file with the provider.

All claims are subject to both pre-payment and post-payment review for medical necessity by Medicaid. Should a review determine that services do not meet all the criteria listed above, payment will be denied or, if the claim has already been paid, action will be taken to recoup the payment for those services.

Induction is not a covered service unless it meets the guidelines listed above. Inductions without medical necessity will be subject to post pay reviews and possible recoupment of payments to both the physician and hospital.

25.10.1.4 Obstetrical Ultrasound

Procedure Code Range: 76801-76828

Acceptable Modifiers: TC, 22, 26 and 52

Medicaid covers obstetrical ultrasounds during pregnancy when medical necessity is established for one (1) or more of the following conditions:

- Establish date of conception
- Discrepancy in size versus fetal age
- Early diagnosis of ectopic or molar pregnancy
- Fetal Postmaturity Syndrome
- Guide for amniocentesis
- Placental localization associated with abnormal vaginal bleeding (placenta previa)
- Polyhydramnios or Oligohydramnios

- Suspected congenital anomaly
- Suspected multiple births
- Other conditions related directly to the medical diagnosis or treatment of the mother and/or fetus.

NOTE: Maintain all records and/or other documentation that substantiates medical necessity for OB ultrasound services performed for Medicaid clients as documentation may be requested for post-payment review purposes.

Medicaid will not reimburse obstetrical ultrasounds during pregnancy for any of the following reasons:

- Determining gender
- Baby pictures
- Elective

Post-payment review will be conducted on obstetrical ultrasound claims after payment is made to the provider in order to ensure claims meet the Medicaid policies contained in this manual.

25.11 Practitioner Visits

Encounter Revenue Code: 0500

Procedure Code Range: 99201-99443

Practitioner services are provided in inpatient and outpatient settings and include:

- Consultation services
- Emergency department services
- Home visits
- Hospital services
- Nursing facilities
- Office visits
- Telephone services

NOTE: Practitioner services provided to a client between ages 22 and 64 at an Institution for Mental Disease (IMD) are **a non-covered service** pursuant to federal Medicaid regulation. This includes Medicare crossover claims for dual eligible clients. An IMD is defined as a hospital, nursing facility, or other institution of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases.

25.11.1 New Client

Procedure Code Range: 99201-99205

Medicaid considers a new client to be a client who is new to the practitioner and whose medical and administrative records need to be established. A new client visit should be submitted once per client lifetime per provider. An exception may be allowed when a client has been absent for a period of three (3) years, or more.

25.11.2 Established Client**Procedure Code Range: 99211-99215**

Medicaid considers an established client to be a client that has been seen by the practitioner and whose medical and administrative records have been established.

25.11.3 After Hours Services

Medicaid reimburses physicians and practitioners who see clients in their offices rather than the emergency room, when appropriate. The following codes are only to be used when the client is seen in the physician/practitioner's office. The following codes may be billed in addition to Evaluation and Management codes.

Physician/Practitioner's After Hours Billing Codes	
CPT-4 Code	Description
99050	Services provided in the office times other than regularly scheduled office hours, or days when the office is normally closed (e.g. holidays, Saturday, or Sunday) in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

NOTE: Do not use these codes for seeing clients in the emergency room.

25.12 Preventive Medicine

Encounter Revenue Code: **0500** (in most cases)

Procedure Code Range: **99381-99385**

25.12.1 Covered Services

For specific information on preventive health services for clients under age 21, refer to [Section 21.1, Health Check – EPSDT](#).

Preventive health services for clients over 21 are:

- Cancer screening services

- Screening mammographies are limited to a baseline mammography between ages 35 and 39; one (1) screening mammography per year after age 45. All mammograms require a referral.
- Annual gynecological exam including a Pap smear. One (1) per year following the onset of menses. This should be billed using an extended office visit procedure code. The actual Lab Cytology code is billed by the lab where the test is read and not by the provider who obtains the specimen.

25.13 Radiology Services

Encounter Revenue Code: 0400

Procedure Code Range: 70010-79999

Radiology services are ordered and provided by practitioners, dentists, or other providers licensed within the scope of their practice as defined by law. Radiology providers must be supervised by a practitioner licensed to practice medicine within the state the services are provided. Imaging providers must meet state facility licensing requirements. Facilities must also meet any additional federal or state requirements that apply to specific tests (e.g., mammography). All facilities providing screening and diagnostic mammography services are required to have a certificate issued by the Federal Food and Drug Administration (FDA).

25.13.1 Covered Services

Medicaid provides coverage of medically necessary radiology services, which are directly related to the client's symptom or diagnosis when provided by independent radiologists, hospitals and practitioners.

25.13.2 Billing Requirements

For most radiology services and some other tests, the fee schedules indicate different fees, whether the practitioner provided only the technical component (performed the test), only the professional component (interpreted the test), or both components (also known as the global service). Practitioners must bill only for the services they provide ([2.1, Quick Reference](#)).

- Technical components of imaging services must be performed by appropriately licensed staff (e.g., x-ray technician) operating within the scope of their practice as defined by state law and under the supervision of a practitioner.
- Multiple procedures performed on the same day must be billed with two (2) units to avoid duplicate denial of service.

Modifier	Description	Reimbursement
26	Professional Component	30% of allowed fee
TC	Technical Component	70% of allowed fee

25.13.3 Limitations

- Screening mammographies are limited to a baseline mammography between ages 35 and 39; one (1) screening mammography per year after age 45. All mammograms require a referral by a practitioner
- X-rays performed as a screening mechanism or based on standing orders
- Separate consultations or procedures unless ordered by the attending practitioner

25.14 Screening, Brief Intervention, Referral and Treatment (SBIRT)

Encounter Revenue Code: 0500 or 0914

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance abuse use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. The goal of SBIRT is to make screening for substance abuse a routine part of medical care.

- **Screening** is a quick, simple way to identify patients who need further assessment of treatment for substance use disorders. It does not establish definitive information about diagnosis and possible treatment needs.
- **Brief intervention** is a single session or multiple sessions of motivational discussion focused on increasing insight and awareness regarding substance use and motivation toward behavior change. Brief intervention can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at-risk as well as a vehicle for engaging those in need of more extensive levels of care.
- **Brief treatment** is a distinct level of care and is inherently different from both brief intervention and specialist treatment. Brief treatment is provided to those seeking or already engaged in treatment, who acknowledges problems related to substance use. Brief treatment in relation to traditional or specialist treatment has increased intensity and is of shorter duration. It consists of a limited number of highly focused and structured clinical sessions with the purpose of eliminating hazardous and/or harmful substance use.
- **Referral** to specialized treatment is provided to those identified as needing more extensive treatment than offered by the SBIRT program. The effectiveness of the referral process to specialty treatment is a strong measure of SBIRT success and involves a proactive and collaborative effort between SBIRT providers and those providing specialty treatments to ensure access to the appropriate level of care.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community's specialized

treatment program with a network of early intervention and referral activities that are conducted in medical and social service settings.

25.14.1 Covered Services and Billing Codes

Acceptable billing providers for SBIRT include:

- Physician – All 20X taxonomy types
- Public Health Clinic – 251K00000X
- FQHC – 261QF0400X
- RHC – 261QR1300X
- IHS – 261QP0904X
- Nurse Practitioners – 363L
- Advanced Practitioner of Psych/Mental Health Nursing – 364SP0808X
- Certified Nurse Midwives – 367A00000X
- Nurse Anesthetists – 357500000X

Medicaid covers SBIRT services for clients 18 years of age and older.

- **H0049** – Alcohol and/or drug screening, per screening. WY SBIRT Screening Tool – ASSIST – The Mental Health and Substance Abuse Services Division has chosen the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) developed by the World health organization (WHO) The ASSIST screening tool can be accessed through their web site at: http://www.who.int/substance_abuse/activities/assist/en/
- **H0050** – Alcohol and/or drug services, brief intervention, per 15 minute units – Maximum of four (4) units.

NOTE: Providers are to bill these codes in addition to the code they will bill for the primary focus of the visit. Screening and brief intervention are not stand alone services, rather they may be part of a medical visit with another problem focus. For example, a patient presents for migraine headaches and is given the ASSIST (H0049 – screening). The ASSIST tool indicates the need for brief intervention (H0050 – brief intervention). The physician would bill the most appropriate code for their services related to the initial complaint of migraine headache, in addition to the appropriate SBIRT codes.

25.14.2 Limitations

SBIRT will not be covered for clients with services limited to emergency services only.

25.15 Vision Services

Encounter Revenue Code: 0519

Vision and dispensing services are benefits for client's ages 0-20. Limited office visits for the treatment of an eye injury or eye disease is available for clients 21 & older. A licensed ophthalmologist, optometrist, or optician, within the Scope of the Practice Act within their respective profession, may provide vision services and dispensing services.

Vision services for clients 21 and older are only reimbursable for the treatment of eye disease or eye injury based on the appropriate ICD diagnosis code and client records must support billing of any vision services. Routine eye exams and/or glasses are not a covered benefit for clients 21 and older.

NOTE: Wyoming Medicaid will pay the deductible and/or coinsurance due on Medicare crossover claims for post-surgical contact lenses and/or eyeglasses, up to the Medicaid allowable.

25.15.1 Eye and Office Examinations

Procedure Code Range: 92002-92014, 99201-99215, 92018-92060, 92081-92226, 92230-92287, J7999

25.15.1.1 Covered Services

For clients under the age of 21 years:

- Eye exams determine visual acuity and refraction, binocular vision, and eye health.
 - **92002-92004** - New patient eye exams are a covered benefit for clients who are new to the provider's practice.
 - **92012-92014** - Established patient eye exams are a covered benefit once in a 365 day period unless there is medical necessity to support an additional exam.
- Office visits for the treatment of eye disease or eye injury.
 - **99201-99215** – May be billed by ophthalmologists for office exams.
 - **Documentation:** Eye care provider records must reflect medical necessity and include interpretation and report, as appropriate, of the procedure.
- **92018-92060, 92081-92226, 92230-92287** - Special Ophthalmological Services should be performed only when medically necessary. 99283 requires a prior authorization.

For clients 21 years and older:

- Eye exams to diagnose an eye disease or eye injury.

- **92002-92004** - New patient eye exams are a covered benefit for clients who are new to the provider's practice.
- **92012-92014** - Established, patient eye exams are a covered benefit once in a 365 day period unless there is medical necessity to support an additional exam.

NOTE: Routine eye exam are not covered for adult clients. Do not bill for routine eye exams for clients 21 years and older. Exam codes may pay, and then upon audit, be taken back as Medicaid abuse recovery. These codes are not limited by diagnosis at this time and should only be billed when medical necessity can be documented to show an eye disease or injury.

- Office visits as for the treatment of eye disease or eye injury.
 - **99201-99215** - Ophthalmologists may bill these codes for office exams
 - **Documentation:** Eye care provider records must reflect medical necessity and include interpretation and report, as appropriate, of the procedure.
- **92018-92060, 92081-92226, 92230-92287** - Special ophthalmological services should be performed only when medically necessary and will be subject to post-payment review of the client's records. 92283 will require a prior authorization.

25.15.1.2 Non Covered Services

Exam codes should not be billed for routine eye exams for clients over 21 years old.

25.15.2 Eyeglasses/Materials

Procedure Code Range: V2020, V2100-V2499, V2627, V2784

25.15.2.1 Covered Services

For Clients under the age of 21 years:

- One (1) pair of eyeglasses is covered per 365 days
- **V2020** – Standard frames are covered up to \$73.49. The provider may not “balance bill” the client for frames that cost more than the allowable amount.

NOTE: Balancing billing example – When the client selects \$120 frames and Medicaid allows up to \$73.49 then the optometrist should either, mutually agree in writing with the client that the client is responsible for the payment of the frames (\$120), or, the provider may bill Medicaid for \$73.49 and accept this payment as payment in full for the frames.

- Covered eye glass lenses – only 2 units of any type of lens (V2100-V2499) are to be billed per pair of eye glasses:
 - **V2100-V2121 (V2199)** requires prior authorization) - Single lenses
 - **V2200-V2221 (V2299)** requires prior authorization) – Bifocal lenses
 - **V2300-V2321 (V2399)** requires prior authorization) – Trifocal lenses
 - **V2410-V2430 (V2499)** requires prior authorization) – Variable lenses
 - **V2782-V2783** (requires prior authorization) – High Index Aspheric lenses
 - Aspheric lenses will only be covered when medically necessary.
 - **V2784** – Polycarbonate lens (billed as an add on to a standard C-39 lens)

NOTE: Only two (2) units of any lenses can be billed on the same DOS and must be ordered as pairs. If the lens on one (1) side is aspheric or high index, then the matching lens should also be aspheric or high index, even if it does not meet the threshold.

- **V2700-V2783** are considered add-ons to eye glasses and require a prior authorization (PA) prior to the glasses being ordered. These services are only covered by Medicaid when they are deemed medically necessary to treat a vision condition. When requesting a PA, providers should describe, in detail, the medical condition that the add-on is needed to treat.
 - Providers should not request a PA or bill for add-ons if the doctor has not prescribed the add-on as a medically necessary procedure. The client can be billed for these add-ons when not medically necessary and are chosen as an option. The provider must have a written statement that these services are not covered by Medicaid and the client understands financial responsibility.
- Medicaid will allow one (1) replacement of lenses and frames within the 12 month period if:
 - There is a change in the prescription for the lenses, use the existing frames if possible.
 - Eyeglasses are lost or broken beyond repair – This will require documentation stating it was not due to blatant abuse or neglect

NOTE: The provider will need to submit an electronic claim and attach necessary documentation of the medical necessity to substantiate why the replacement glasses are needed. The claim will then be review and processed if criteria is met. ([7.15 Submitting Attachments for Electronic Claims](#))

- Repair of eyeglasses may be billed upon expiration of the warranty

- **V2623, V2629** (Prosthetic eyes) **V2627** (Scleral cover shell) –requires a prior authorization ([7.13, Prior Authorization](#)).

25.15.2.2 Non Covered Services

- Reimbursement for dispensing of frames, frame parts, and/or lenses is not allowed in addition to reimbursement for dispensing of total eyeglasses
- Clients 21 years of age and older are not covered for eyeglasses

25.15.2.3 Reimbursement

- Obtain eligibility information from Medicaid prior to placing order for eyewear
- Verify with client and Provider Relations (1-800-251-1268) if the benefit has been used in the past year
- Deliver glasses in a reasonable amount of time (typically within one to two weeks)
- Verify client eligibility for the date of delivery
- Bill Medicaid on the delivery date of the glasses. The date of delivery must be used as the date of service on a claim.
- If the client does not return to receive their glasses, the glasses should be mailed to the client and the mail date used as the date of service.

NOTE: If the client is not eligible on the delivery date or does not return for the delivery, the provider may submit an “Order vs Delivery Date Exception Form” for authorization to bill on the order date. ([7.14.1 Order Vs Delivery Date Exception Form](#))

25.15.3 Contact Lenses

Procedure Code Range: V2500-V2599, 92072

Contact lenses are covered for correction of pathological conditions when useful vision cannot be obtained with regular lenses.

25.15.3.1 Covered Services

For Clients under the age of 21 years:

- **V2500-V2599** – Contact lenses require prior authorization (PA) and documentation provided must show medical necessity and state why the client’s vision cannot be corrected with eyeglasses. (6.14 Prior Authorizations)
- Contact lenses will be reimbursed at the cost of invoice, plus shipping and handling, plus 15% for dates of service prior to 01/01/2021. For dates of service 01/01/2021 and forward contact lenses will be reimbursed at invoice

cost, plus shipping and handling, plus 12.13%. ([7.15, Submitting Attachments for Electronic Claims](#)).

- **92072** – Fitting of contact lens does not require PA, however, should only be billed when PA has been obtained for the lens.

25.15.3.2 Non-Covered Services

Contact lenses are not covered for clients 21 and older.

25.15.4 Vision Therapy

Procedure Code Range: 92065 & 99070

Vision therapy is a sequence of activities individually prescribed and monitored by the doctor to develop efficient visual skills and processing. It is prescribed after a comprehensive eye examination has been performed and has indicated that vision therapy is an appropriate treatment option. The vision therapy program is based on the results of standardized tests, the needs of the patient, and the patient's signs and symptoms.

Research has demonstrated vision therapy can be an effective treatment option for individuals under the age of 21 or individuals with Acquired Brain Injury:

- Ocular motility dysfunctions (eye movement disorders)
- Non-strabismic binocular disorders (inefficient eye teaming)
- Strabismus (misalignment of the eyes)
- Amblyopia (poorly developed vision)
- Accommodative disorders (focusing problems)
- Visual information processing disorders, including visual-motor integration and integration with other sensory modalities

25.15.4.1 Covered Services

- **92065** – Vision Therapy can be billed for clients under the age of 21 and clients with Acquired Brain Injury, that are eligible for the Comprehensive or Support Developmental Disability Waiver plans, with a qualifying medical diagnosis (See tables below)
- When administered in the office under the guidance of a practitioner.
- It requires a number of office visits and depending on the severity of the diagnosed conditions
- The length of the program typically ranges from several weeks to several months
- Activities paralleling in-office techniques are typically taught to the patient to be practiced at home to reinforce the developing visual skills
- Vision therapy visits are capped at 32 per 365-days for treatment of ICD diagnosis
 - Additional visits or exceptions to these diagnosis codes will be considered on a case by case basis only

- **99070** - Vision Therapy training aids will be reimbursed at cost of invoice. Invoices must be submitted with documentation of medical necessity to Medial Policy ([2.1, Quick Reference](#)) for consideration ([7.15, Submitting Attachments for Electronic Claims](#))

Diagnosis Codes for Clients under 21 years old	
Diagnosis Codes	Description
Amblyopia	
H53.031, H53.032, H53.033	Strabismic amblyopia
H53.011, H53.012, H53.013	Deprivation amblyopia
H53.021, H53.022, H53.023	Refractive amblyopia
Strabismus (Concomitant)	
H50.11, H50.012	Monocular esotropia
H50.05	Alternating esotropia
H50.11, H50.112	Monocular exotropia
H50.15	Alternating exotropia
H50.311, H50.312	Intermittent esotropia, monocular
H50.32	Intermittent esotropia, alternating
H50.331, H50.332	Intermittent exotropia, monocular
H50.34	Intermittent exotropia, alternating
H50.43	Accommodative component in esotropia
Non-strabismic disorder of binocular eye movements	
H51.11	Convergence insufficiency
H51.12	Convergence excess
H51.8	Anomalies of divergence
Ocular Motor Dysfunction	
H55.81	Deficiencies of saccadic eye movements
H55.89	Deficiencies of smooth pursuit movements
Heterophoria	
H50.51	Esophoria
H50.52	Exophoria
General Binocular Vision Disorder	
H53.30	General Binocular Vision Disorder
Nystagmus	
H55.01	Nystagmus

Diagnosis Codes for Clients with Acquired Brain Injury	
Diagnosis Codes	Description
I69.998	Disturbances of vision
S06 Family of Codes	Late effect injury intracranial injury without mention of skull fracture.

Chapter Twenty Six – Covered Services – Pregnant by Choice

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26.1 Pregnant by Choice/Family Planning Waiver

Pregnant by Choice provides family planning service to women who have received Medicaid benefits through the Pregnant Women Program. This program extends family planning options to women who would typically lose their Medicaid benefits up to two (2) months postpartum.

26.1.1 Covered Services

- Initial physical exam and health history, including client education and counseling related to reproductive health and family planning options, including a pap smear and testing for sexually transmitted diseases
- Annual follow up exam for reproductive health/family planning purposes, including a pap smear and testing for sexually transmitted diseases where indicated
- Brief and intermediate follow up office visits related to family planning
- Necessary family planning/reproductive health-related laboratory procedures and diagnostic tests
- Contraceptive management including drugs, devices and supplies
- Insertion, implantation or injection of contraceptive drugs or devices
- Removal of contraceptive devices
- Sterilization services and related laboratory services (when properly completed sterilization consent form has been submitted)
- Medications required as part of a procedure done for family planning purposes
- Services must be provided by an enrolled Medicaid provider

26.1.2 Non-Covered Services

- Services are limited to approved family planning methods and products approved by the Food and Drug Administration (FDA)
- Sterilization reversals, infertility services, treatments or abortions

26.1.3 Eligibility Criteria

- The client must be transitioning from the Pregnant Women Program
- Is not eligible for another Medicaid program
- Does not have health insurance including Medicare
- Is a Wyoming resident
- Is a US Citizen.
- Her age is 19 through 44 years
- She is not pregnant

26.1.4 Enrollment Process

- The Customer Service Center, Wyoming Department of Health (WDH) must be notified of the pregnancy and birth of the baby
- The Customer Service Center, WDH will send a review form and a Pregnant by Choice Questionnaire to women eligible for the Pregnant Women Program while in the two (2) month postpartum period to determine if they are interested in the program
- If a mother allows her Medicaid benefits to lapse after the two (2) month postpartum period she will not be eligible for the Pregnant by Choice Program
- Eligibility is determined yearly

26.2 Pregnant by Choice Covered Codes

Pregnant By Choice Covered Codes	
Covered Diagnosis Codes	Diagnosis Code Description
Z30.011	General counseling on prescription of oral contraceptives
Z30.013, Z30.014, Z30.018, Z30.019	General counseling on initiation of other contraceptive
Z30.012	Encounter for emergency contraceptive counseling and prescription
Z30.02	Natrl Family pln – avoid preg
Z30.09	Other general counseling and advice on contraception
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.432	Encounter for removal of intrauterine contraceptive device
Z30.433	Encounter for removal & insertion of IUD
Z30.2	Sterilization
Z30.40	Contraceptive surveillance, unspecified
Z30.41	Surveillance of contraceptive pill
Z30.431	Surveillance of intrauterine contraceptive device
Z30.49	Surveillance of implantable sub dermal contraceptive
Z30.42, Z30.49	Surveillance of other contraceptive method
Z30.019, Z30.49	Surveillance of previously prescribed contraceptive methods
Z30.8	Other specified contraceptive management
Z32.02	Pregnancy examination or test, negative result
Z32.01	Pregnancy examination or test, positive result
Z11.3	Screening examination for venereal disease
Pregnant By Choice Covered Codes	
Covered Procedures	Procedure Code Description
99201-99203	Office/Outpatient New
99211-99213	Office/Outpatient Established
11976	Removal, implantable contraceptive capsules
11980	Implant hormone pellet(s)

Covered Services – Pregnant by Choice

Pregnant By Choice Covered Codes	
Covered Procedures	Procedure Code Description
11981	Implant hormone pellet(s)
11982	Remove drug implant device
11983	Remove/insert drug implant
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of Intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
58600	Division of fallopian tube
58615	Occlude fallopian tube(s)
58670	Laparoscopy tubal cautery
58671	Laparoscopy tubal block
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
80048	Basic metabolic panel (calcium, total)
80076	Hepatic function panel
81000-81015	Urinalysis
81025	Urine pregnancy test
82465	Cholesterol
82947-82948	Glucose
84703	Gonadotropin, Chorionic (HCG)
85013	Blood count
85014-85018	Blood smear exam
86592	Syphilis Test
86593	Syphilis test non-trep quant
86689	HTLV or HIV antibody, confirmatory test (EG, Western Blot)
86701	HIV – 1 – Antibody
86702	HIV – 2 – Antibody
86703	HIV – 1 and HIV – 2, single assay – antibody
87070-87081	Culture, bacterial
87110	Culture, Chlamydia
87205-87207	Smear, primary source
87209	Smear complex stain
87210	Smear wet mount saline/ink
87270	Infectious agent antigen detection Chlamydia
87274	Infectious agent antigen detection Herpes Simplex virus type 1
87320	Infectious agent antigen detection multiple step method; Chlamydia Trachomatis
87340	Infectious agent antigen detection Hepatitis B surface antigen (HBSAG)
87490	Infectious agent detection by Nucleic Acid (DNA or RNA); Chlamydia Trachomatis, direct probe technique
87491	Infectious agent detection by Nucleic Acid (DNA or RNA); Chlamydia

Covered Services – Pregnant by Choice

Pregnant By Choice Covered Codes	
Covered Procedures	Procedure Code Description
	Trachomatis, amplified probe technique
87590	N.Gonorrhoeae DNA dir prob
87591	Infectious agent detection by Nucleic Acid (DNA or RNA); Neisseria Gonorrhoeae, amplified probe technique
88141-88143	Cytopathology
88164-88167	Cytopathology
88175	Cytopath C/V auto fluid redo
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom, male, each
A4268	Contraceptive supply, condom, female, each
J0696	Injection, Ceftriaxone sodium, Per 250MG
J1050	Injection, medroxyprogesterone acetate, contraceptive 150 MG (Depo-Provera)
J7296	KYLEENA, 19.5 MG
J7300	Intrauterine copper contraceptive
J7301	Skyla 13.5MG
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive patch
J7307	Etonogestrel (Contraceptive) implant system, including implant and supplies
S4993	Contraceptive pills for birth control
T1015	Clinic encounter, per visit
58600	Ligation or transaction of fallopian tube(s) abdominal or bignal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by devices (EG, Bank, Clip, Falope Ring) Vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (EG, Bank, Clip or Falope ring)
00851	Laparoscopy; tubal ligation/transaction

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27.1 Therapy Services

Physical Therapy – The treatment of physical dysfunction or injury by the use of therapeutic exercise and the application of modalities intended to restore or facilitate normal function or development; also called physiotherapy.

Occupational Therapy – Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Speech Therapy – Services that are necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presences of a communication disability.

Restorative (Rehabilitative) Services – Services that help patients keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the client was sick, hurt or suddenly disabled.

Maintenance (Habilitative) Services – Services that help patients keep, learn, or improve skills and functioning for daily living. Examples would include therapy for a child who isn't walking or talking at the expected age.

Time and Frequency are required on all documentation and must be specific so time in and time out must be reflected on the document in standard or military format. Time can be a unit of 15 minutes depending on the Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) Level II code used to bill the service. For example, if the code is a fifteen (15) minute unit, then follow the guidelines for rounding to the nearest unit. If seven (7) minutes or less of the next 15 minute unit is utilized, the unit must be rounded down. However, if eight (8) or more minutes of the next 15 minute unit are utilized, the units can be rounded up.

27.2 Physical and Occupational Therapy

27.2.1 Covered Services

Services must be directly and specifically related to an active treatment plan. Independent physical therapy services are only covered in an office or home setting.

- **Physical Therapy & Occupational Therapy** – Services may only be provided following physical debilitation due to acute physical trauma or physical illness. All therapy must be physically rehabilitative and provided under the following conditions:

- Prescribed during an inpatient stay continuing on an outpatient basis, OR
 - As a direct result of outpatient surgery or injury
- **Manual Therapy Techniques** – When a practitioner or physical therapist applies physical therapy and/or rehabilitation techniques to improve the client's functioning
- **Occupational Therapy** interventions may include:
 - Evaluations/re-evaluations required to assess individual functional status
 - Interventions that develop, improve, or restore underlying impairments

27.2.2 Limitations

Reimbursement includes all expendable medical supplies normally used at the time therapy services are provided. Additional medical supplies/equipment provided to a client as part of the therapy services for home use will be reimbursed separately through the Medical Supplies Program.

- For Medicaid clients, dates of service in excess of twenty (20) per calendar year, providers will need to contact WYhealth for prior authorization
 - Physical therapy visits and occupational therapy visits are counted separately ([6.10 Service Thresholds](#))
 - Authorizations for acute conditions can be authorized up to 8 visits at a time
 - Authorizations for Habilitative therapy for children can be authorized for up to 180 days at a time
- Visits made more than once daily are generally not considered reasonable
- There should be a decreasing frequency of visits as the client improves
- Clients age 21 and over are limited to restorative services only. Restorative services are services that assist an individual in regaining or improving skills or strength
- Maintenance therapy can be provided for clients 20 and under

27.2.3 Documentation

The practitioners and licensed physical therapist's treatment plan must contain the following:

- Diagnosis and date of onset of the client's condition
- Client's rehabilitation potential
- Modalities
- Frequency
- Duration (interpreted as estimated length of time until the client is discharged from physical therapy)
- Practitioner signature and date of review
- Physical therapist's notes and documented measurable progress and anticipated goals

- Initial orders certifying the medical necessity for therapy
- Practitioner's renewal orders (at least every 180 days) certifying the medical necessity of continued therapy and any changes. The ordering practitioner must certify that:
 - The services are medically necessary
 - A well-documented treatment plan is established and reviewed by the practitioner at least every 180 days
 - Outpatient physical therapy services are furnished while the client is under their care
- Total treatment minutes of the client, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented, to include beginning time and ending time for services billed

Practitioners and licensed physical therapist's progress notes must be completed for each date of service and contain the following:

- Identification of the client on each page of the treatment record
- Identification of the type of therapy being documented on each entry (i.e., 97530 vs. 97110)
- Date and time(s) spent in each therapy session; total treatment minutes of the client, including those minutes of active treatment reported under timed codes and those minutes represented by the untimed codes, must be documented, to include beginning time and ending time for each service billed
- Description of therapy activities, client reaction to treatment and progress being made to stated goals/outcomes
- Full signature or counter signature of the licensed therapist, professional title and date that entry was made and the signature of the therapy assistant and date the entry was made. Licensed therapist must sign progress notes of assistants within 30 days

27.3 Speech Therapy

Speech (pathology) therapy services are those services necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presences of a communication disability.

27.3.1 Covered Services

Speech therapy services provided to Medicaid clients must be restorative for clients 21 and over. Maintenance therapy can be provided for clients 20 and under. The client must have a diagnosis of a speech disorder resulting from injury, trauma or a medically based illness. There must be an expectation that the client's condition will improve significantly.

To be considered medically necessary, the services must meet all the following conditions:

- Be considered under standards of medical practice to be a specific and effective treatment for the client's condition
- Be of such a level of complexity and sophistication, or the condition of the client must be such that the services required can be performed safely and effectively only by a qualified therapist or under a therapist's supervision
- Be provided with the expectation that the client's condition will improve significantly
- The amount, frequency and duration of services must be reasonable

In order for speech therapy services to be covered, the services must be related directly to an active written treatment plan established by a practitioner and must be medically necessary to the treatment of the client's illness or injury.

In addition to the above criteria, restorative therapy criteria will also include the following:

- If an individual's expected restoration potential would be insignificant in relation to the extent and duration of services required to achieve such potential, the speech therapy services would not be considered medically necessary
- If at any point during the treatment it is determined that services provided are not significantly improving the client's condition, they may be considered not medically necessary and discontinued

27.3.2 Limitations

The following conditions do not meet the medical necessity guidelines, and therefore will not be covered:

- For dates of service in excess of thirty (30) per calendar year providers will need to obtain prior authorization ([6.10 Service Thresholds](#))
- Clients age 21 and over are limited to restorative services only. Restorative services are services that assist an individual in regaining or improving skills or strength
- Maintenance therapy can be provided for clients age 20 and under
- Self-correcting disorders (e.g., natural dysfluency or articulation errors that are self-correcting)
- Services that are primarily educational in nature and encountered in school settings (e.g., psychosocial speech delay, behavioral problems, attention disorders, conceptual handicap, intellectual disabilities, developmental delays, stammering and stuttering)
- Services that are not medically necessary
- Treatment of dialect and accent reduction
- Treatment whose purpose is vocationally or recreationally based
- Diagnosis or treatment in a school-based setting

Maintenance therapy consists of drills, techniques, and exercises that preserve the present level of function so as to prevent regression of the function and begins when therapeutic goals of treatment have been achieved and no further functional progress is apparent or expected.

NOTE: In cases where the client receives both occupational and speech therapy, treatments should not be duplicated and separate treatment plans and goals should be provided.

27.3.3 Documentation

The practitioners and licensed speech therapist's treatment plan must contain the following:

- Diagnosis and date of onset of the client's condition
- Client's rehabilitation potential
- Modalities
- Frequency
- Duration (interpreted as estimated length of time until the client is discharged from speech therapy)
- Practitioner signature and date of review
- Speech therapist's notes and documented measurable progress and anticipated goals
- Initial orders certifying the medical necessity for therapy
- Practitioner's renewal orders (at least every 180 days) certifying the medical necessity of continued therapy and any changes. The ordering practitioner must certify that:
 - The services are medically necessary
 - A well-documented treatment plan is established and reviewed by the practitioner at least every 180 days
 - Outpatient speech therapy services are furnished while the client is under their care
- Total treatment minutes of the client, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented, to include beginning time and ending time for services billed

Practitioners and licensed speech therapist's progress notes must be completed for each date of service and contain the following:

- Identification of the client on each page of the treatment record
- Identification of the type of therapy being documented on each entry (i.e., 97530 vs. 97110)
- Date and time(s) spent in each therapy session; total treatment minutes of the client, including those minutes of active treatment reported under timed codes and those minutes represented by the untimed codes, must be documented, to include beginning time and ending time for each service billed

- Description of therapy activities, client reaction to treatment and progress being made to stated goals/outcomes
- Full signature or counter signature of the licensed therapist, professional title and date that entry was made and the signature of the therapy assistant and date the entry was made. Licensed therapist must sign progress notes of assistants within 30 days

27.3.4 Prior Authorization Once Threshold is Met

For Medicaid clients, for dates of service in excess of thirty (30) per calendar year for each service, providers will need to contact WYhealth for prior authorization ([6.10 Service Thresholds](#)).

Prior Authorization requests can be denied for two basic reasons: Administrative reasons such as incomplete or missing forms and documentation, etc.; or the client does not meet the established criteria for coverage of the item.

Following a denial for administrative reasons, the provider may send additional information in order to request that the decision be reconsidered. If the information is received within thirty (30) days of the denial, with a clearly articulated request for reconsideration, it will be handled as such. If the information is received more than thirty days after the denial, it will be a new Prior Authorization request. As such, a new Prior Authorization form must be submitted, and all information to be considered must accompany it.

27.4 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through WYhealth, including any additional clinical information that supports the request for services
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Benefit Quality Control Manager, Brenda Stout (brenda.stout1@wyo.gov).
 - The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from WYhealth's system. The appeal will be reviewed in conjunction with the documentation uploaded into WYhealth's system.

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28.1 No Show Appointments/Broken Appointments

Dental Code Range: D9986

Appointments canceled or missed by Medicaid clients cannot be billed to Medicaid. Medicaid recognizes the concern of missed/broken appointments and for tracking purposes only has created code D9986. Providers will not be reimbursed for this code. When submitting a claim to Medicaid for missed/broken appointments an amount of \$0.00 should be entered in box 31 (fee) of the claim form. This line will show as a denial on the Remittance Advice. If a provider's policy is to bill all patients for missed appointments/broken appointments, the provider may bill Medicaid clients.

28.2 Examinations

28.2.1 Examinations for Children (Ages 0-20)

Dental Code Range: D0120-D0180

- **D0120** – Routine periodic oral evaluations, **reimbursable** once every six (6) months
- **D0140** – Limited oral evaluations, **reimbursable** twice every 12 months
- **D0145** – Oral evaluation for patients 0-3 years of age – **reimbursable** once every six (6) months but not in addition to D0120 or D0150
- **D0150** – Comprehensive oral evaluations, **reimbursable** once every 12 months, and may replace a D0120
- **D0160 and D0170** – Detailed and extensive oral evaluations, **reimbursable** as needed
- **D0180** – Comprehensive periodontal evaluations are **reimbursable** once every 12 months, ages 19-20 years. Not to be billed with any other exam codes (D0120-D0170)
- **D0412** – Blood Glucose Test is a covered service for client of any age once every six (6) months

28.1.1 Examinations for Adults (Ages 21 and Over)

Dental Code Range: D0120-D0191

- **D0120 or D0150** – Oral evaluations, **reimbursable** once every six (6) months
- **D0140** – Limited oral evaluations, **reimbursable** twice every 12 months
- **D0191** – Assessment of a patient, **reimbursable** to clients on the Nursing Home (NH) plan once every 12 months only if the client has not been to a dentist within the last year

- **D0412** - If the provider and/or client would like all of the 3rd molars removed at time of surgery, only teeth that are documented to be symptomatic should be billed to Medicaid

28.3 Radiographs and Diagnostic Imaging

Dental Code Range: D0210-D0330

Diagnostic radiological procedures, performed in accordance with current American Dental Association (ADA) guidelines, are to be limited to those instances in which a dentist anticipates that the information is likely to contribute materially to the proper diagnosis, treatment, and prevention of disease. **Routine use of periapical radiographs for primary anterior teeth is not considered appropriate unless there is clearly documented medical need.**

- **D0210** – Intraoral complete series* – **reimbursable** every five (5) years for clients of any age.
- **D0330** – Panoramic film* – **reimbursable** every five (5) years for clients five (5) years and older.
- **D0270, D0272, or D0274** – Bitewing x-rays –**reimbursable** once every year for clients of any age.
- **D0220** – Intraoral first film
- **D0230** – Each additional film after the first (as needed).

NOTE: A maximum of seven (7) periapicals are allowed per visit.

- **D0367** – Cone Beam CT Capture and Interpretation with Field of view of Both Jaws – **reimbursable** when providers are performing an implant, exposure of un-erupted tooth for the purpose of orthodontic bonding, jaw surgery **for clients age 0-20**, or a request has been made by a Cleft Palate team for diagnostic purposes related to a client's cleft palate/lip treatment. A Prior Authorization will be required for this code ([8.8, Prior Authorization](#)).
- **D0210 or D0330** is reimbursable once every five (5) years.

NOTE: When making referrals, the referring dentist should send the dentist/specialist a copy of the current radiographs to prevent unnecessary duplication of services, expenditure and radiation exposure. Medicaid will only reimburse one (1) provider per date of service for radiographs.

28.4 Preventive Dental Care

28.4.1 Preventative Dental Care for Children

Dental Code Range: D1110 - D1354

- **D1110** – Prophylaxis-Adult (ages 12 - 20) **reimbursable** every six (6) months
- **D1120** – Prophylaxis-Child (ages 0-11) **reimbursable** every six (6) months
- **D1206** – Topical application of fluoride varnish (office procedure) – **reimbursable** every six (6) months, for ages 0-14
- **D1208** – Topical application of fluoride (office procedure), **reimbursable** every six (6) months, for ages 0-14.
- **D1310** – Nutritional Counseling **reimbursable** every six (6) months for ages 0-3.
- **D1330** – Oral Hygiene Instruction **reimbursable** one (1) time for any client age 4-20 for different treating providers.
- **D1351** – The application of sealants for permanent molar teeth and primary second (2nd) molars. Sealants are allowed once per tooth per 18 months. Medicaid will not pay for a sealant and a filling on the same tooth on the same date of service.
Allowed Tooth Numbers: 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32, A, J, K and T
- **D1352** – Preventive resin restoration in a moderate to high caries risk patient – permanent tooth are allowed once per tooth per 18 months. Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin, includes placement of a sealant in any radiating non-carious fissures or pits. D1351 sealant should not be billed on the same tooth on the same date of service. When there are separate restorations on each surface, D1352 may be billed multiple times per tooth and requires a tooth number along with quadrant. Records must clearly indicate each restoration is treatment for a separate surface of decay and not one continuous restoration.
- **D1354** - Interim Caries Arresting Medicament (Silver Diamine Fluoride) is allowed once per tooth per 18 months. D1351, D1352, or any other restorative procedure (D2000-D2999) cannot be billed on the same tooth on the same date of service. Records must indicate tooth number and surface applied to. When billing, a tooth number is required but not a surface. Wyoming Medicaid will perform post-payment review of this code monthly to review for high utilization and appropriateness. Clinical records must support billing for each tooth and outcomes of the treatment at follow-up visits.

28.4.2 Preventative Dental Care for Adults

Dental Code Range: D1110

- **D1110** – Prophylaxis, reimbursable once every six (6) months.

NOTE: When an adult client (21 years and older) is scheduled for a D1110, but the client is in need of a D4341, scaling and root planing, these procedures are the financial responsibility of the client. Providers may bill the client for this service as long as the client is informed, in writing, prior to the procedure that they are financially responsible.

28.5 Periodontal Treatment

28.5.1 Periodontal Treatment for Children

Dental Code Range: D4210-D4999

Scaling, root planing and curettage can be billed once per quadrant and are considered one (1) procedure regardless of the number of visits it takes to complete. Periodontal treatment is allowed once in a 24month period when indicated with a diagnosis of periodontitis. This includes scaling and root planing or a full mouth debridement. D4910, Periodontal Maintenance is reimbursable every three (3) months for clients who have had scaling and root planing. Clear evidence of bone loss must be present on the current radiographs to support the diagnosis of periodontitis. There must be current six (6) point periodontal charting inclusive of a periodontal prognosis. Gingivectomies can be billed once per quadrant, per lifetime. Minor scaling procedures will be considered part of a prophylaxis.

- **D4346** – Scaling in presence of generalized moderate or severe gingival inflammation- full mouth, after oral evaluation. This procedure is allowed once every 24 months, AND the client cannot have had D4341, D4342 or D4355 within the last 12 months. This procedure is intended to treat gingival inflammation.
- **D4355** – Full mouth debridement is allowed once every 24 months, AND the client cannot have had D1110 or D4346 within the last 12 months. This procedure is intended to debride the mouth so that further examination can be done to determine stage of periodontal disease.

28.5.2 Periodontal Treatment for Adults

Dental Code Range: D4346 and D4355

Scaling and full mouth debridement are the only covered periodontal treatment services covered for adult clients (ages 21 and older).

28.6 Prosthetics Removable

28.6.1 Prosthetics Removable for Children

Dental Code Range: D5110-D5899

There are no limits on the fabrication of denture and/or partial services for clients under the age of 21 years old.

- **D5110-D5140** – Complete dentures (including routine post-delivery care) placed immediately must be of structure and quality to be considered the final prosthesis.
- **D5211-D5281** – Partial dentures (including routine post-delivery care)
- **D5410-D5422** – Denture/partial adjustments
 - For dates of service prior to January 1, 2021 this service is limited to two (2) per 12 month period.
 - For dates of service January 1, 2021 and forward this service is limited to two (2) per arch per 12 month period.
- **D5510-D5721** – Other services include the repair of a broken denture base, repair or replacement of broken clasps, replacement of teeth.
- **D5730-D5761** – Denture/partial relines
 - For dates of service prior to January 1, 2021 this service is limited to two (2) per 12 month period.
 - For dates of service January 1, 2021 and forward this service is limited to once every three (3) years.
- **D5810-D5821** – Interim complete/partial dentures
- **D5850-D5851** – Tissue conditioning, this service is limited to once per lifetime, per arch.
- **D5860-D5866** – Specialized denture services require Prior Authorization (PA) (6.8.1, Requesting Prior Authorization).

NOTE: In the event a client is not satisfied with the denture/partial, the client must return to the provider who made the appliance to allow the provider the opportunity to work with the client to fit it properly. If a client has returned to the provider more than three (3) times and is still not able to wear the appliance, a client may contact Dental Services for guidance on how to proceed with the dispute. A client should not proceed to a different provider to have adjustments done.

Contact Dental Services ([2.1, Quick Reference](#)) for denture benefit availability.

28.6.2 Prosthetics Removable for Adults

Dental Code Range: D5410-D5761

Relines and repairs to existing removable appliances are covered.

- **D5410-D5422** – Denture/partial adjustments

- For dates of service prior to January 1, 2021 this service is limited to two (2) per 12 month period.
- For dates of service January 1, 2021 and forward this service is limited to two (2) per arch per 12 month period.
- **D5510-D5721** – Other services include the repair of a broken denture base, repair or replacement of broken clasps, replacement of teeth.
- **D5730-D5761** – Denture/partial relines
 - For dates of service prior to January 1, 2021 this service is limited to two (2) per 12 month period.
 - For dates of service January 1, 2021 and forward this service is limited to once every three (3) years.

In the event a client is not satisfied with the denture/partial, the client must return to the provider who made the appliance to allow the provider the opportunity to work with the client to fit it properly. If a client has returned to the provider more than three (3) times and is still not able to wear the appliance, a client may contact Dental Services for guidance on how to proceed with the dispute. **A client should not proceed to a different provider to have adjustments done.**

Contact Dental Services ([2.1, Quick Reference](#)) for denture benefit availability.

28.7 Extractions

28.7.1 Extractions for Children

Dental Code Range: D7111-D7250

- Extractions are reimbursable for those teeth that demonstrate radiographically, pathologic, pulpal involvement, periapical infection, periodontally involved teeth of the class IV category, and large carious lesions that the eligible client wants extracted even though they have been informed of alternate treatment remedies. Current radiographs and other clinical documentation of teeth that are extracted must be maintained in the patient record.
- Incision and drainage is reimbursable when an emergency extraction cannot be performed due to health reasons or in the case of gingival infections, pericoronal or lateral abscess due to periodontal pathology.

28.7.2 Extractions for Adults

Dental Code Range: D7111-D7510

- Extractions are reimbursable for those teeth that demonstrate radiographically, pathologic, pulpal involvement, periapical infection, periodontally involved teeth of the class IV category, and large carious lesions that **the eligible client wants extracted even though they have been informed of alternate treatment remedies.** Current radiographs and other clinical documentation of teeth that are extracted must be maintained in the patient record.

- **D5710-** Incision and drainage is reimbursable when an emergency extraction cannot be performed due to health reasons or in the case of gingival infection, pericoronal or lateral abscess due to periodontal pathology.

28.8 Oral and Maxillofacial Surgery

Oral surgery procedures that are not covered using a CDT procedure code should be billed using a CPT code on a CMS-1500 Claim Form. It is the provider's responsibility to check covered medical services prior to rendering services. For use of the CPT codes refer to the [CMS-1500 Provider Manual](#) and obtain Prior Authorization ([7.14, Prior Authorization](#)) as required.

28.8.1 Oral and Maxillofacial Surgery for Children


Dental Code Range: D7111-D7999

Reimbursement of oral surgical procedures includes routine preoperative and postoperative care, sutures, suture and/or wire removal, and local anesthetics.

Impacted third molars or supernumerary teeth are covered only when they are symptomatic; that is, causing pain, infected, preventing proper alignment of permanent teeth or proper development of the arch. Reimbursement for prophylactic extractions of third molars is not a covered service.

Orthognathic surgery is only covered when required to complete treatment for severe malocclusion. The client must be approved for orthodontic treatment through the Medicaid Severe Malocclusion program to be considered for corrective jaw surgery. The following oral surgery codes require an approval prior to performing the services, from Medicaid, in the form of a Prior Authorization (PA): D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, and D7950. Prior Authorizations will not be issued after a procedure is completed. Providers must obtain a PA prior to rendering services and at the time of the Severe Malocclusion request ([8.8.1, Requesting Prior Authorization](#)). Requests for Oral and Maxillofacial surgery must include the Consideration for Oral Surgery Form, shown below. If the provider and/or client would like all of the 3rd molars removed at time of surgery, only teeth that are documented to be symptomatic should be billed to Medicaid.

28.8.1.1 Consideration for Oral Surgery Form



**CONSIDERATION FOR ORAL SURGERY
RELATED TO ORTHODONTIC APPROVAL**

ORAL SURGEON NAME:

NPI: DATE OF CONSULTATION:

CLIENT NAME: MEDICAID ID#:

REFERRING DENTIST NAME:

CONDITION REFERRED FOR:

WERE XRAYS AND/OR RECORDS SENT WITH THIS REFERRAL? ☐ YES ☐ NO

BASED ON YOUR EXAMINATION AND REVIEW OF THE RECORDS, PLEASE PROVIDE YOUR TREATMENT PLAN FOR THIS CLIENT RELATED TO THEIR SURGERY/ORTHODONTIC NEEDS. PROCEDURE CODES, FEES, AND TIMELINES SHOULD BE INCLUDED IN YOUR RECOMMENDATIONS.

ARE THERE ANY ALTERNATIVE RECOMMENDATIONS FOR THIS CLIENT?

DID THE CLIENT REPORT ANY OF THE FOLLOWING CONDITIONS:

<input type="checkbox"/> JAW PAIN	<input type="checkbox"/> JOINT PAIN	<input type="checkbox"/> FACIAL PAIN
<input type="checkbox"/> HEADACHES	<input type="checkbox"/> EAR PAIN	<input type="checkbox"/> GRIND TEETH
<input type="checkbox"/> JOINT POP	<input type="checkbox"/> LOCKED JAW	<input type="checkbox"/> LIMITED MOUTH OPENING
<input type="checkbox"/> PROBLEMS WITH MASTICATION		
<input type="checkbox"/> STRESS RELATED TO THEIR APPEARANCE		

DENTIST'S SIGNATURE DATE

RETURN THIS FORM WITH ANY SUPPORTING DOCUMENTATION TO THE ADDRESS BELOW

Wyoming Medicaid
Attn: Medical Policy
PO Box 667
Cheyenne, WY 82003-0067
WYMedPol@conduent.com

NOTE: Click the images above to be taken to a printable version of this form.

28.8.2 Oral and Maxillofacial Surgery for Adults

Dental Code Range: D7111-D7140, D7210-D7241, D7250, D7410-D7411, D7510

Reimbursement of oral surgery procedures includes routine preoperative and post-operative care, sutures, suture and/or wire removal, and local anesthetics.

Impacted third molars or supernumerary teeth are covered only when they are symptomatic; that is, causing pain, infected, preventing proper alignment of permanent teeth or proper development of the arch. Reimbursement for prophylactic extractions of third molars is not a covered service. If the provider and/or client would like all of the 3rd molars removed at time of surgery, only teeth that are documented to be symptomatic should be billed to Medicaid.

28.9 Anesthesia

Dental Code Range: D9222-D9223, D9239-D9243 and D9248

- **D9222-D9223, D9239-D9243, and D9248** are reimbursable. Dentists may only administer parenteral sedation and general anesthesia if they meet the requirements of the Wyoming State Board of Dental Examiners or the licensing board in the state they practice and it is within their scope of practice.
- Sedation and general anesthesia shall not be billed routinely, but limited to those patients requiring dental care who would not be expected to tolerate treatment or become unmanageable in the usual office setting due to medical, emotional or developmental limitations, and/or extent of treatments needs that are documented.
- The administration of intravenous (IV) or intramuscular (IM) sedation is subject to the same requirements as general anesthesia.

28.10 Dental Services Performed in an FQHC/RHC

Dental services that are performed in an FQHC/RHC must be billed on the most current ADA claim form/837D. Dental services will receive an encounter rate that is established by Wyoming Medicaid and includes ALL services provided during the encounter and is considered to be an all-inclusive rate.

28.10.1 Dental (Other Than Orthodontics) Claims

- D9999 – Must be billed as line one as the encounter rate
- Additional detail lines must be billed with appropriate covered CDT codes showing each service provided and billed with a zero (0) dollar amount.
- All charges for the same visit must be submitted on one (1) claim.

Covered Services – Dental Services

Example:

Child is seen for an exam, x-ray, and prophylaxis. Bill as follows:

Line	Procedure Code	Date	Amount	NPI
1	D9999	1/5/2019	Fee encounter rate	Treating Provider NPI
2	D1120	1/5/2019	\$0.00	Treating Provider NPI
3	D0240	1/5/2019	\$0.00	Treating Provider NPI
4	D1120	1/5/2019	\$0.00	Treating Provider NPI

NOTE: If any codes on the claim deny due to being non-covered, the entire claim will deny. The provider is responsible for checking eligibility and frequency limitations and only billing Medicaid for covered dental services for that client.

Refer to the [Dental Fee Schedule](#) for age limitation.

Services provided outside the clinic, including inpatient services, should be billed under the clinic's fee-for service provider number.

Multiple encounters with one (1) or more health professional that take place on the same day at the same office location constitute a single visit except when the patient, after the first encounter, suffers illness or injury requiring a distinctly separate diagnosis or treatment.

28.11 Services Covered for Children Only

28.11.1 Restorative Treatment

Dental Code Range: D2140-D2394 and D2510-D2664

Restorative treatment is limited to those services essential to restore and maintain adequate dental health. Pins and special preparations are reimbursed separately from the restoration. Temporary restorations are reimbursable only as a result of palliative or emergency treatment. When more than one (1) surface is involved, and one (1) continuous filling is used, select the appropriate code from the range of D2140-D2394. When there are separate fillings on each surface, the one (1) surface codes (D2140 and D2391) are to be used. Records must clearly indicate each filling is treatment for a separate surface of decay.

Inlays and Onlays are a covered service but paid at the same rate as amalgam and composite fillings.

NOTE: D2140-D2394 and D2510-D2664 are allowed once per tooth, per surface, every 18 months.

28.11.2 Crowns

Dental Code Range: D2710-D2934

- **D2929-D2933** – Prefabricated metal or tooth colored (plastic/composite/stainless/zirconia) materials for the fabrication of an **interim** crown on a primary or permanent tooth to protect until exfoliation or a permanent crown can be placed. Treatment of severely decayed primary posterior teeth is reimbursable for those teeth that are not near exfoliation
- **D2710-D2794** – **The dentist may place a permanent crown when determined appropriate for clients between the ages of 14-20 OR prior to the age of 14 if the permanent tooth has had a root canal therapy.** Primary molars, with no permanent tooth but visible by x-ray, may have permanent crowns placed if decay or marked attrition is present.

NOTE: For clients under the age of 14, a pre-treatment request may be submitted prior to the treatment, if the tooth has not been treated with a root canal therapy and the dentist substantiates the need for a permanent crown prior to the age of 14 to preserve the integrity of the tooth structure. Send this request to Wyoming Medicaid Attn: Dental Services.

- **D2910-D2920** – Re-cementation of crowns, inlays, or onlays is covered, as needed.

28.11.3 Labial Veneers

Dental Code Range: D2961-D2962

Labial veneers may be used instead of full crowns for anterior permanent teeth that are severely fractured or carious, having continuous loss of fillings. Only CDT codes D2961 or D2962 will be reimbursed. Documentation to justify the need for services must be included in the patient's record.

28.11.4 Endodontics

Dental Code Range: D3110-D3330

The fee for endodontic treatment will include all necessary radiographs during treatment, including preoperative and postoperative radiographs. Root canal therapy for permanent teeth includes, extirpation, treatment, filling of root canals and all necessary radiographs, including a post-treatment radiograph. Emergency endodontic procedures, i.e., open tooth to drain, may be performed prior to root canal therapy. Endodontic treatment will only be reimbursed for situations where adequate bone viability can be documented. A radiograph demonstrating the completed endodontic treatment is required to be a part of the clinical procedure and must be included in the patient's permanent clinical record. Pulpal therapy for primary teeth is reimbursable for those teeth only not near exfoliation.

NOTE: A pulpotomy is not to be billed in conjunction with root canal therapy when performed on the same date or as an emergency endodontic procedure. Additionally, a provider may not bill for a pulpotomy and a root canal therapy on the same tooth. The provider may only bill for the pulpotomy or the root canal therapy.

28.11.5 Apicoectomy

Dental Code Range: D3410-D3426

Preoperative and postoperative radiographs are required as part of the clinical record for apicoectomies. A retrograde filling may be placed when necessary and billed separately.

28.11.6 Implant Services and Fixed Prosthesis

Dental Code Range: D6010-D6199 and D6205-D6999

The client must be between the ages of 17-20 and be eligible for Medicaid for permanent tooth replacement to be considered. Temporary replacement of a lost tooth may be provided to a client to maintain space prior to the age of 17 by using the appropriate code.

The tooth/teeth to be replaced must be documented and must have been lost due to one (1) of the following.

- Be congenitally missing
- Loss due to trauma
- Loss due to abnormal pathology not related to periodontal disease or carious lesions

The requesting dentist is responsible for determining if the client is an appropriate candidate for an implant or bridge based on completion of growth and neighboring teeth. Documentation of bone density, bone height and completion of skeletal growth must be in the patient record.

Fixed bridges and cast partials are covered only for the replacement of permanent teeth. A fixed bridge is not a reimbursable service when done in conjunction with a removable appliance in the same arch.

When a provider is requesting an implant the length of treatment must be considered based on the client's age. Typically when a client turns 19 years old, eligibility ends and restorative treatment for the previously placed implant will not be a covered service. Prior-authorizations (PAs) are only valid for client's who are eligible for Medicaid benefits at the time of service.

NOTE: If the tooth/teeth to be replaced were not lost due to the above conditions, Wyoming Medicaid will not pay for an implant or fixed bridge. The


requesting dentist must also consider the condition of neighboring teeth when requesting prior authorization. If the neighboring teeth are free of decay and/or large restorations, an implant can be indicated. If the neighboring teeth are in need of restorations, a fixed bridge should be indicated.

The client must be free of gingivitis and/or periodontal disease and must have proven adequate home care. The request will not be approved without a documented home care status included. The client must also be tobacco free; if the client is currently using tobacco products they must be referred to the Wyoming Quit line (800)784-8669 and display abstinence for six (6) months.

NOTE: Replacement of a missing tooth will only be reimbursed once per lifetime. If Wyoming Medicaid has paid for any type of permanent tooth replacement to replace the tooth/teeth, then an implant or fixed bridge will not be approved.

All implant codes and fixed prosthesis require an approval, prior to performing the services, in the form of a Prior Authorization (PA). Prior Authorizations ([8.8.1, Requesting Prior Authorization](#)) will not be issued after a procedure is complete. The provider must obtain a PA prior to rendering services. Prior Authorizations must also include a Tooth Replacement (Implant) Request Form, shown below.

28.11.6.1 Tooth Replacement (Implant) Request Form



TOOTH REPLACEMENT (IMPLANT) REQUEST PRIOR AUTHORIZATION ATTACHMENT

CLIENT NAME: _____ CLIENT ID: _____

CLIENT DOB: ____/____/____ CLIENT CURRENT PHONE #: (____) ____-____
Month Day Year

REQUESTING DENTIST: _____

REQUESTING DENTIST'S PHONE #: (____) ____-____ NPI: _____

1. TOOTH NUMBER(S) TO BE REPLACED _____
2. CONDITION OF NEIGHBORING TEETH _____
3. WAS THE TOOTH/TEETH TO BE REPLACED LOST DUE TO:

☐ CONGENITALLY MISSING
☐ LOSS DUE TO TRAUMA (DATE OF ACCIDENT _____)
☐ LOSS DUE TO ABNORMAL PATHOLOGY NOT RELATED TO PERIODONTAL DISEASE OR CARIOUS LESIONS

DESCRIBE CIRCUMSTANCES: _____

4. TREATMENT BEING REQUESTED- INCLUDE CODES _____

5. DOES THIS CLIENT CURRENTLY HAVE ANY TYPE OF REPLACEMENT IN PLACE? ☐ YES ☐ NO

6. IF YES, WHAT IS CURRENTLY IN PLACE? _____

7. IS THIS CLIENT FREE OF GINGIVITIS? ☐ YES ☐ NO PERIODONTAL DISEASE ☐ YES ☐ NO

8. IS THIS CLIENT FREE OF TOBACCO USE? ☐ YES ☐ NO

9. IF NO, HAS THIS CLIENT BEEN REFERRED TO THE WYOMING QUIT LINE (1-800-784-8669)? _____

SIGNATURE OF PROVIDER _____ DATE _____

THIS FORM IS TO BE INCLUDED WITH A PRIOR AUTHORIZATION REQUEST FORM.

A COMPLETE COPY OF THE CLIENT'S CLINICAL RECORDS MUST BE INCLUDED WITH THIS REQUEST FORM. THE PROVIDER SHOULD ALSO PROVIDE ANY ADDITIONAL DOCUMENTATION TO SUBSTANTIATE THIS REQUEST INCLUDING ORAL HYGIENE REPORTS AND PROGRESS NOTES. PLEASE SEND THIS REQUEST TO THE ADDRESS BELOW.

Wyoming Medicaid
 Attn: Medical Policy
 PO Box 667
 Cheyenne, WY 82003-0067
WYMedPol@conduent.com

NOTE: Click the images above to be taken to a printable version of this form.

28.11.7 Biopsy of Oral Tissue – Soft

Dental Code Range: D7286

Removal of oral soft tissue lesions is allowed as needed to restore oral cavity to normal function and/or to check for pathology.

28.11.8 Occlusal Orthotic Device

Dental Code Range: D7880 (By Report), D9944 and D9945

- **D7880** - An occlusal splint may be provided to a client if the client has been diagnosed with Temporomandibular Joint Dysfunction (TMJ). A report of TMJ diagnosis and complete treatment plan including any physical therapy, and/or drugs used to treat symptoms must be submitted with the claim. This must be billed on the delivery date.
- **D9944** - Occlusal guard-hard, full arch. Prior authorization required with documented medical necessity. Prior authorizations will not be issued after impressions have been taken. The provider must obtain a PA prior to rendering services. This must be billed on the delivery date.
- **D9945** - Occlusal guard-soft, full arch. Prior authorization required with documented medical necessity. Prior authorizations will not be issued after impressions have been taken. The provider must obtain a PA prior to rendering services. This must be billed on the delivery date.

28.11.9 Nitrous Oxide/Analgesia

Dental Code Range: D9230

Nitrous Oxide is a covered benefit for any client age 0-19. Nitrous will only be reimbursed in conjunction with extractions or restorative procedures. Supporting documentation of why the client required the use of nitrous must be part of the patient's record and be available upon request. **It is the provider's responsibility to verify the client's eligibility prior to services rendered. When checking eligibility the provider must verify that the client is under the age of 20 years old.**

28.11.10 Behavior Management

Dental Code Range: D9920

Behavior Management, is a covered benefit for clients under ten (10) years old and/or disabled clients under 21 with a recognized mental or physical disability i.e. Autism, Down Syndrome, Paralysis, **who exhibit behavior(s) that require additional time for a procedure to be completed; supporting documentation must be a part of the patient's record and a report of specific behavior that warranted behavior management must be attached to the claim form.** This procedure is reimbursable at one (1) unit per visit and a maximum of three (3) units per 12 months.

28.11.11 Other Drugs and Medications

Dental Code Range: D9630

D9630 can be billed for clients if there is a documented need for additional medications. Antibiotics, antimicrobials and fluoride gels or rinses are the only medications that will be considered. This code should not be billed for pre-med prophylactic antibiotics given in office. Wyoming Medicaid will only cover D9630 for clients who need medications to treat the following diagnosed conditions:

- Rampant caries
- Cervical decay
- Gingivitis/Periodontitis
- Severe sensitivity

The report of specific drugs given in the office and for the treatment of what condition must be attached to the claim form. The following must be present on the report:

- Client name
- Date of service
- Diagnosed condition
- Medication given
- Doctor or hygienist signature

28.11.12 Space Maintenance

Dental Code Range: D1510, D1516, D1517 and D1575

- **D1510, D1516, D1517 and D1575**- Space maintainers must be billed using a quadrant in box 25 (area of oral cavity) of the claim form. Use UA, UR, UL, LA, LR or LL to indicate which area of the oral cavity the space maintainer was placed.
- **D1551** – Re-cementation of bilateral space maintainer, maxillary, is covered as needed
- **D1552** - Re-cementation of bilateral space maintainer, mandibular, is covered as needed
- **D1553** – Re-cementation of unilateral space maintainer, per quadrant, is covered as needed.

28.11.13 Tobacco Counseling

Dental Code Range: D1320

This code is **reimbursable** once (1) per 12 month period.

28.11.14 Orthodontics

Dental Code Range: D8000-D8999

Medicaid eligible clients under the age of 19 may receive treatment for severe malocclusion. Medicaid only reimburses codes D8000-D8999 to enrolled orthodontists who have obtained a Prior Authorization (PA) for treatment in the Wyoming Severe Malocclusion Program (SMP) prior to treatment.


Severe malocclusion is defined as malocclusion that is detrimental to the child's physical well-being, i.e. the ability to chew food in a compatible manner for digestion and/or breathing, or for correction of speech pathology.

28.11.14.1 Referral to the Severe Malocclusion Program

When a client is provided services at their general dentist for a check-up appointment, and the client appears to meet the set criteria of the Severe Malocclusion Program, the client may be referred to an enrolled orthodontist. It is up to the provider to know the criteria for the Severe Malocclusion Program and only refer appropriate clients to participating orthodontists.

- If the client does not appear to meet the Severe Malocclusion Program, there is a parent handout available on the website to assist in explaining why the client does not meet the criteria. ([2.1, Quick Reference](#))
- No referral form is needed for ages 12-18 for D8660.
- Orthodontists may also provide consultations to walk in clients ages 12-18 with no referral.
- If a provider finds it medically necessary for a child under the age of 12 to be part of the Severe Malocclusion Program, a Referral to Severe Malocclusion Program – Under 12 Form ([28.11.14.1.1, Referral to Severe malocclusion Program – Under 12 Form](#)) should be sent to the Medicaid Program Manager. A PA will be required for these clients for the consultation (D8660).
 - The form must be filled out completely and the child should not be provided services by the orthodontist until a PA is issued.

28.11.14.1.1 Referral to Severe Malocclusion Program – Under 12 Form

 Wyoming Department of Health	<u>SEVERE MALOCCLUSION PROGRAM - REFERRAL</u>
	CLIENTS LESS THAN 12 YEARS OF AGE

I would like to refer _____ for an
(name of client)
orthodontic examination to _____
(name of orthodontist).

Pay-to Provider NPI: _____ Treating Providers NPI: _____
Client Date of Birth: _____ / _____ / 20____ Client Medicaid ID: _____
Month Day Year

Parent/Legal Guardian: _____
Address, City, Zip: _____
Phone: (____) _____ - _____

Dentist's Reason for Ref. (must contain medically necessary reason to evaluate before the age of 12):

Dentist's Signature: _____
Dentist's Name (Printed): _____
Address: _____
(Street/P.O. Box, City, State, Zip Code)
Telephone: _____ Date: _____
NPI: _____ Provider ID: _____

Send completed referral to:

Wyoming Medicaid
Attn: Medical Policy
PO Box 667
Cheyenne, WY 82003-0067
WYMedPol@conduent.com

NOTE: Click the image above to be taken to a printable version of this form.

28.11.14.2 Submitting Records for Approval/Denial

The orthodontist will need to do the following prior to rendering services to a new client for consultation (D8660):

- Verify client eligibility prior to rendering services to the client.
- Verify age appropriateness.
- Verify the code/service has not been billed previously. (One (1) lifetime benefit)

The orthodontist may collect records on a new client. The records should include the Severe Malocclusion Request Form ([28.11.14.2.1, Severe Malocclusion Request Form](#)), color photos, and x-rays of the client. These, along with the Medicaid Prior Authorization Request Form ([8.8.1.1, Medicaid Prior Authorization Form](#)), should be submitted to Wyoming Medicaid at:

Wyoming Medicaid
Attn: Medical Policy
PO Box 667
Cheyenne, WY 82003-0067
WYMedPol@conduent.com

- Each case will be reviewed, and based on qualifying criteria, will be forwarded to the State Orthodontic Consultant for review; OR
- The case will be administratively denied and a letter will be mailed to the client and the orthodontist with the reason why it was denied.

Orthodontic cases will be forwarded to the State Dental Consultant if they meet at least one (1) of the following criteria;

- Cleft palate deformities with a recommendation from the Cleft Palate Team.
- Impacted anterior teeth – Considered when it is demonstrated that the tooth or teeth is or are impacted (soft or hard); not indicated for extraction and treatment planned to be brought into occlusion. Arch space must be available for correction.
- Deep Impinging Overbite – Considered when the lower incisors are destroying the soft tissue of the palate and there is tissue laceration and/or clinical attachment loss.
 - Color Photographic documentation will be required.
- Anterior Crossbite – Considered when clinical attachment loss and recession of the gingival margin are present.
 - Color Photographic documentation will be required.
- Severe Traumatic Deviation.
 - Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology.

- Congenitally missing teeth are not considered a Severe Traumatic Deviation. Missing teeth should be indicated on Part 2 (Diagnostic Information) of the Severe Malocclusion Request Form ([28.11.14.2.1, Severe Malocclusion Request Form](#)).
- A narrative should be written on Part 2 (Diagnostic Information) of the Severe Malocclusion Request Form ([28.11.14.2.1, Severe Malocclusion Request Form](#)) explaining what the deviation is.
- A minimum HLD index score of 30 is required to qualify for the program. All cases will be reviewed by the Orthodontic Consultant and the Medicaid Program Manager and if special circumstances apply, a lower score may be approved.

Cases that are forwarded on to the Orthodontic Consultant will be sent with all attached x-rays, color photos, and the completed Severe Malocclusion Request Form ([28.11.14.2.1, Severe Malocclusion Request Form](#)) from the orthodontist.

- After the consultant reviews the case, he/she will document his/her recommendation and return the entire case back to the Medicaid Program.
- If the case is approved, Medicaid will issue a Prior Authorization (PA) to the provider, for treatment to be started.
- If denied, the orthodontist will be sent a denial letter with an explanation.

Cases that are recommended for surgical intervention in conjunction with orthodontic treatment will require a consultation with an oral surgeon prior to approval/denial of orthodontic treatment and/or orthognathic surgery.

- An oral surgeon consultation form ([28.8.1.1, Consideration for Oral Surgery Form](#)) will be included with this letter to the orthodontist.
- The referring orthodontist should send this form along with any x-rays with the client to the oral surgeon.
- The oral surgeon will be responsible for completing this form and returning it to the Medicaid Medical Policy team.
- The Medicaid Medical Policy team will add this to the client's file and re-submit the case to the orthodontic consultant for consideration.
- If approved, the orthodontist and the oral surgeon will each be issued a PA for their portions of the treatment.
- If denied, the orthodontist, the oral surgeon, and the client will be sent a denial letter.

NOTE: A PA is only valid if the client is eligible for Medicaid on the date of service.

Cases that are submitted to the program as transfers from other states may be evaluated and approved with the intent of completing treatment that was already started. The requesting orthodontist should indicate on their request how much time is expected to complete the treatment. When approved, the State Orthodontic Consultant

will also evaluate the length of time needed to complete the case. A PA will be issued for the D8670 and the number of units determined to complete the case will be approved. If the client does not have orthodontic bands/brackets on one of the arches, D8080/D8090 may be authorized for a partial payment, if the requesting orthodontist anticipates banding this arch.

An orthodontist may request reconsideration of a denied application.


- The orthodontist must write a request letter stating the reason for the request. Any additional supporting documentation should be sent to Medical Policy for re-consideration.
- Medical Policy will forward this on to the orthodontic consultant for reconsideration. The request will only be sent back to the orthodontic consultant if the orthodontist has provided new evidence supporting the request. The orthodontic consultant will then provide a new review of the request.
- Requests for reconsideration that do not have any new information to support the request will be denied by Medical Policy and a letter will be sent to the orthodontist with an explanation.
- If reconsideration is approved, a [Prior Authorization Approval](#) letter will be sent to the provider informing them that the client has been approved for treatment.
- The provider must also indicate on their claim form in box 30, that the client has entered the retention phase.

The following codes will be reimbursed to enrolled orthodontists who have obtained a PA for the client:

- **D8660** – Pre-Orthodontic Consultation, once per lifetime per client
 - A PA is only required for this code for children under the age of 12 if the provider finds it medically necessary for a child to be part of the Severe Malocclusion Program early for Interceptive treatment.
- **D8080** – Comprehensive Orthodontic Treatment (ages 12-14), once per lifetime per client.
- **D8090** – Comprehensive Orthodontic Treatment (ages 15-18), once per lifetime per client.
- **D8670** – Periodic Orthodontic Treatment, maximum of eight (8) payments; Maximum of one (1) payment per three (3) month period.
- **D8680** – Orthodontic Retention and Removal
 - This may be authorized for clients who have moved here from another state and are unable to or do not plan to continue treatment.
- **D8703** – Maxillary replacement of Lost/Broken Retainer, once per lifetime per client.
- **D8704** – Mandibular replacement of Lost/Broken Retainer, once per lifetime per client.
- **D8060** – Interceptive Orthodontic Treatment

- This will only be authorized for clients who are ages 6-11 and meet the interceptive treatment criteria ([28.11.14.1.1, Referral to Severe malocclusion Program – Under 12 Form](#)).
- **D8690** – Final Balance Payment
 - This code to be billed for client's who lose eligibility during treatment. A Prior Authorization is required.

28.11.14.2.1 Severe Malocclusion Request Form

 WYOMING MEDICAID SEVERE MALOCCLUSION TREATMENT REQUEST FORM				
CLIENT NAME	CLIENT ID	CLIENT DATE OF BIRTH	EXAM DATE	LOCATION
PROVIDER GROUP NAME	GROUP NPI	TREATING PROVIDER NAME	TREATING NPI	FEE
PART 1. TREATMENT REQUESTED				
FULL TREATMENT <input type="checkbox"/>		INTERCEPTIVE TREATMENT <input type="checkbox"/>		TRANSFER CASE <input type="checkbox"/>
REQUIRES MAXILLO-FACIAL SURGERY?		# OF MONTHS:		
YES <input type="checkbox"/> NO <input type="checkbox"/>				
EXPLAIN:				
PART 2. DIAGNOSTIC INFORMATION				
STAGE OF DENTITION:		PRIMARY <input type="checkbox"/> PERMANENT <input type="checkbox"/> MIXED <input type="checkbox"/>		
SKELETAL CLASSIFICATION		Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 <input type="checkbox"/>		
POSTERIOR CROSSBITE		YES <input type="checkbox"/> NO <input type="checkbox"/>		
TEETH INVOLVED:				
MISSING TEETH (indicate related teeth)				
ECTOPIC ERUPTION (EXCLUDING 3RDs):		YES <input type="checkbox"/> NO <input type="checkbox"/>		
MISSING		YES <input type="checkbox"/> NO <input type="checkbox"/>		
IMPACTED		YES <input type="checkbox"/> NO <input type="checkbox"/>		
ANKYLOSED		YES <input type="checkbox"/> NO <input type="checkbox"/>		
SUPERNUMERARY		YES <input type="checkbox"/> NO <input type="checkbox"/>		
SEVERE TRAUMATIC DEVIATION (explain):		YES <input type="checkbox"/> NO <input type="checkbox"/>		
PART 3. BRIEF INITIAL OPINIONS				
ORAL HYGIENE:		GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/>		
RESTORATIONS COMPLETE:		YES <input type="checkbox"/> NO <input type="checkbox"/>		
(if no- please explain plan)				
PART 4. HLD INDEX (see instructions for scoring guidelines)				
CLEFT PALATE DEFORMITIES: indicate with an X				HLD SCORE
IMPACTED ANTERIOR TEETH: indicate with an X				
DEEP IMPINGING OVERBITE: indicate with an X only if tissue destruction				
ANTERIOR CROSSBITE: indicate with an X only if tissue destruction				
SEVERE TRAUMATIC DEVIATION: must document in Part 2- score 15 pts				
OVERJET IN mm				x1+
OVERBITE IN mm				x1+
MANDIBULAR PROTRUSION IN mm				x5+
OPENBITE IN mm				x4+
ECTOPIC ERUPTION: count each tooth				x3+
ANTERIOR CROWDING (score 1 pt for max and 1 pt for mand -- the max # of pts for this is 10)				x5+
POSTERIOR UNILATERAL CROSSBITE: 4 points				
TOTAL POINTS				
Treatment Narrative (provide any additional information that will substantiate your request for treatment):				
PLEASE NOTE: the HLD scoring is a guideline for your use and reference for the program consultant. You will still be required to send in photographs and supporting radiographs. The program will make the final decision regarding medical necessity and scoring criteria.				
MAIL COMPLETE REQUEST ALONG WITH PA FORM TO: WYOMING MEDICAID, ATTN: MEDICAL POLICY, PO BOX 667, CHEYENNE, WY 82003-0067 WYMEDPOL@conduent.com				
I certify that I am the Performing Provider and that the medical necessity information is true, accurate, and complete, to the best of my knowledge.				
I certify that I performed the above noted examination on this client.				
PERFORMING PROVIDER SIGNATURE		PRINT NAME		DATE

NOTE: Click the images above to be taken to a printable version of this form.

28.11.14.3 Billing Instructions for Severe Malocclusion Program (SMP)

The Severe Malocclusion Program will issue a Prior Authorization (PA) to each provider for each client. The PA will authorize the specific treatment for the client. The provider is only permitted to bill for services authorized within the PA. It is the responsibility of the provider to check client eligibility for each date of service. To check eligibility, call the IVR at (800)251-1270 or Dental Services at (888)863-5806.

- **D8660** – Pre-orthodontic treatment visit. This code will be paid once per lifetime per client unless the client has been placed on a hold by the State to monitor growth or oral hygiene progress. The State can issue a PA for a 2nd

consultation at a time determined appropriate by the State Orthodontic Consultant and program manager.

- PA is only required for this code for children under the age of 12 if the provider finds it medically necessary for a child to be part of the Severe Malocclusion Program or if the client is having a 2nd consultation.
 - The provider may not bill any other services with this visit. The fee indicated includes exam, records, all photos, diagnostic casts, and x-rays.
 - Providers who offer this service as part of a free consultation to all of their patients should not bill Medicaid for this service. If a client is screened with no records for application consideration and the client returns on a 2nd visit to have records taken, the provider can bill for this service at that visit.
- **D8080 (age 12-14) or D8090 (age 15-20)** – Comprehensive orthodontic treatment. The provider may not bill any other services with this visit. The fee indicated includes exam, banding, retention, and all photos during the treatment phase. This code will only be paid once per lifetime per client.
 - If the client has a primary insurance, the D8080 or D8090 must be billed to the primary insurance before billing Medicaid. A primary EOB must be attached when submitting the claim.
 - If the primary insurance does not cover orthodontic services, the EOB that states orthodontics are not covered must be attached to all claims submitted throughout treatment.
 - If the primary insurance covers orthodontic treatment, the primary insurance must be billed before each claim can be submitted (including D8670, quarterly payments) and the EOB must be attached to all claims submitted. When the maximum benefit from the primary insurance is met, attach a copy of the final EOB to each subsequent claim.
 - Providers must bill Medicaid for their full treatment amount for D8080 or D8090.
- **D8670** – Periodic orthodontic treatment visit (as part of the PA) reimburses per quarter (maximum of four (4) quarters per year for not more than 24 months).
 - When billing for periodic treatment visits, the claim should contain the actual date of service for each time the client was seen during the quarter. These dates of service should be on separate lines of the claim with the fee for each line showing \$0.00. The last line should have the last date of service for the quarter with the fee of \$300.00. The client must be seen within the quarter for the provider to bill this code. The provider will be paid the quarterly payment as long as the client is seen within the quarter and the provider has not exceeded eight (8) payments in the authorized treatment time period (typically 24 months).

- Due to the federal government's match to this program, tracking of each time a client is seen in the office for orthodontic adjustments is required to be reported.
- Once orthodontic bands are removed and the retention phase has begun, the provider may continue to bill D8670 (quarterly payments) until the total amount of the PA has been paid. Once the total has been paid to the provider, the provider may no longer bill for any orthodontic services without a new PA.
 - When bands are removed and the retention phase begins, the client must be seen at least once per quarter in order for the provider to bill the D8670 (quarterly payments).
- When the client enters retention, the provider is responsible for sending in a final photo of the client to Medicaid to be included in the client's State records.
 - Billing Example:
Client comes to provider's office for periodic treatment visits on 1/2/15, 2/2/15, and 3/2/15. The provider should bill as follows:
Line 1: 1/2/2015 D8670 \$0.00
Line 2: 2/2/2015 D8670 \$0.00
Line 3: 3/2/2015 D8670 \$300.00
- **D8690** - If the client becomes ineligible for Medicaid at any time during treatment, the provider will be paid the balance of the original Prior Authorization (PA). Providers must request this payment by submitting a final claim. The final claim must contain the following:
 - Date of service must be the last day the client was seen during the last month of eligibility.
 - Example: Client was seen 1/2/19, 2/2/19, 2/19/19 and 3/2/19. Client's eligibility ended 2/28/19. The final date of service should be 2/19/19.
 - Procedure code must be D8690, Orthodontic Treatment. Indicate in box 30 (Description), "PA balance for Orthodontic Treatment".
 - A separate PA number for this code will be required to bill.
 - Fee must be the total balance due from the original Prior Authorization (PA).
- **D8680** – Orthodontic Retention and Removal (removal of appliances and/or bands and construction and placement of retainers) reimburses \$600.00. **This code is to be billed by providers who are accepting orthodontic clients from other states who will not be continuing treatment.** This code will only be paid once per lifetime per client.
- **D8703** – Maxillary replacement of lost or broken retainer reimburses \$150.00.
- **D8704** – Mandibular replacement of lost or broken retainer reimburses \$150.00.

NOTE: When billing either D8703 or D8704, indicate in box 25 (area of oral cavity) on the claim form, UA for upper retainer or LA for

lower retainer. These codes will only be paid once per lifetime per client.

- **D8060** – Interceptive orthodontic treatment for transitional dentition (6-11 years). The provider may not bill any other services with this visit and the fee indicated includes exam, banding, retention, all photos, and follow-up visits. This code will be paid once per lifetime.

28.11.14.4 Wyoming Medicaid Interceptive Criteria

- Interceptive orthodontic treatment may be approved for ages 6-11 and will only be billable by enrolled orthodontists.
- Interceptive orthodontic treatment may be authorized for mixed dentitions where early intervention could result in avoiding a future crippling malocclusion, or reducing the need for complex comprehensive appliance therapy.
- The goal of the interceptive treatment is to reduce the severity of the malformation/malocclusion, mitigate its cause, and to prevent subsequent occlusal conditions that could cause a worsening malocclusion.
- Interceptive treatment will be evaluated on a case-by-case basis and may be authorized by the program only if there is clear evidence of immediate need for treatment based on the established criteria.
- A client with a pre-qualifying condition may not display sufficient need to have the orthodontic service approved immediately. The State Orthodontic Consultant will review each case for timing and will discuss the plan with the requesting orthodontist if there is need. It is imperative that the treatment request form provide adequate documentation of immediate need and treatment planning.
- It will be the provider's responsibility to inform the parent/guardian that if interceptive treatment is approved their child may not be eligible for full comprehensive treatment later, depending on the severity of their condition.
- The provider has full responsibility for maintaining documentation to justify the services provided and billed to Medicaid.
- Cases that are denied can be resubmitted at appropriate intervals as determined by the client's orthodontist and the State Orthodontic Consultant.
- Space maintenance appliances (D1510, D1515) are billable separately from D8060 Interceptive Orthodontic Treatment if necessary prior to Interceptive Treatment.
- Diagnostic Criteria for Interceptive Orthodontic Treatment (D8060) is as follows:
 - Cleft and other craniofacial anomalies.
 - Overjet of more than 10mm.
 - Anterior crossbite-class III mandibular prognathism or reverse overjet.
 - Anterior openbite greater than 3mm.

- Impeded eruption of teeth due to crowding, displacement, presence of supernumerary teeth, retained primary teeth, (and) any pathologic cause, or impacted anterior teeth.
- HLD (Handicapping Labio-Lingual Deviation) index scoring will be collected for documentation purposes, but will not be part of the qualifying criteria for this program.

28.11.15 Dental Services Performed in an FQHC/RHC

Dental services that are performed in an FQHC/RHC must be billed on the most current ADA claim form/837D. Dental services will receive an encounter rate that is established by Wyoming Medicaid and includes ALL services provided during the encounter and is considered to be an all-inclusive rate.

28.11.15.1 Dental Orthodontic Services

Dental Code Range: D8000-D8999

Providers must obtain a prior authorization (PA) before beginning any orthodontic treatment ([28.11.14, Orthodontics](#)). Providers will only be allowed to bill for procedure codes that are listed on their PA.

Wyoming Medicaid has a set rate of \$1200 for an approved interceptive case and \$3600 for an approved Comprehensive case. Facilities will be paid their full encounter rate during each quarterly billing cycle, up to these established maximums. When claims paid reaches these set amounts, the provider is expected to continue orthodontic treatment until complete, but no further payments will be made to the provider.

- D8999 – Must be billed on line one with the encounter rate
- Additional detail lines must be billed with appropriate covered CDT codes showing each service provided and billed with a zero (0) dollar amount.
- All charges for the same visit must be submitted on one (1) claim.
- Prior authorization (PA) numbers must be on all claims for the client's orthodontic visits.
- Provider may bill Medicaid for the initial banding and then quarterly (including all of the dates the child was seen for orthodontic adjustments during the quarter). The facility will not bill each time the child is in the facility for orthodontic treatment, only once per quarter.
- Actual dates of service must be included on the quarterly claim.
- No other dental codes may be billed on an orthodontic claim. Only codes in the D8000-D8999 range can be on the claim.

Example:

Child is banded on 1/5/2019 and returns on 2/12/2019, 3/20/2019 and 4/30/2019 for adjustments. Bill as follows

Claim number 1:

Line	Procedure Code	Date	Amount	NPI
1	D8999	1/5/2019	Fee encounter rate	Treating Provider NPI
2	D8080	1/5/2019	\$0.00	Treating Provider NPI

Claim number 2:

Line	Procedure Code	Date	Amount	NPI
1	D8999	1/5/2019	Fee encounter rate	Treating Provider NPI
2	D8080	1/5/2019	\$0.00	Treating Provider NPI

(This claim will not be submitted until the last date of service on the quarter, 4/30/2019)

NOTE: If any codes on the claim deny due to being non-covered, the entire claim will deny. The provider is responsible for checking eligibility and frequency limitations and only billing Medicaid for covered dental services for the client.

28.11.15.2 End of Treatment

At the conclusion of orthodontic treatment, the provider must provide the client with retainers. The removal and retention visits are not reimbursable in addition to the PA amount. The established PA amount includes these procedures.

28.11.15.3 Discontinued Treatment

If the client discontinues treatment (does not return, removes their own braces, or requests removal early), the provider stops billing Wyoming Medicaid. No further payments can be made to the provider if services have discontinued. Wyoming Medicaid can only pay claims for actual dates of service the provider saw the client in the facility. This also applies to the provider removing appliances early for non-compliance.

28.11.15.4 Resuming Treatment

If the client returns at a later date to resume treatment and the PA is not expired, the facility may resume treatment but can only be reimbursed for the remaining amount on the PA.

28.11.16 Health Check – EPSDT

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program was enacted by Congress mandating states provide eligible children under the age of 21

with well-child screening, diagnostic and medically necessary treatment services through their Medicaid programs. Services provided under EPSDT include periodic screening to include dental, vision and hearing, as well as any medically necessary treatment. As part of the requirements for providing EPSDT services under the federal Medicaid program the state is required to publish a periodicity schedule which meets reasonable standards of dental care. The periodicity instructions and table that the state has chosen are listed below. The EPSDT program in Wyoming is referred to as Health Check.

28.11.16.1 Suggested Procedures for Health Check Dental Services

- Birth to 12 months
 - **Clinical Oral Examination** – First examination at the eruption of the first tooth and no later than 12 months. Repeat every six (6) months or as indicated by the child's risk status/susceptibility to disease. Includes pathology and injuries. A provider must request, in writing, authorization to see a child more often than every six (6) months based on risk status and medical necessity.
 - **Assess Oral Growth And Development** – By clinical examination.
 - **Caries Risk Assessment** – Must be repeated regularly and frequently to maximize effectiveness.
 - **Radiographic Assessment** – As allowed by the child's cooperation and frequency limitations.
 - **Prophylaxis & Topical Fluoride** – Must be repeated regularly and frequently to maximize effectiveness and as allowed by the child's cooperation and frequency limitations.
 - **Fluoride Supplementation** – Considered when systemic fluoride exposure is suboptimal. Up to at least 16 years.
 - **Anticipatory Guidance/Counseling** – Appropriate discussion and counseling should be an integral part of each visit for care.
 - **Oral Hygiene Counseling** – Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
 - **Dietary Counseling** – At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
 - **Injury Prevention Counseling** – Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouth guards.
 - **Counseling For Nonnutritive Habits** – At first, discuss the need for additional sucking; digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
- 12 to 24 months

- Repeat birth – 12 month procedures every six (6) months or as indicated.
- Two (2) to six (6) years
 - Repeat birth – 12 month procedures every six (6) months.
 - **Assessment And Treatment Of Developing Malocclusion** – Discuss possible future malocclusions with parent and refer if early interceptive treatment is medically necessary.
 - **Assessment For Pit And Fissure Sealants** – For caries-susceptible first primary molars and permanent molars with deep pits and fissures; placed as soon as possible after eruption.
- Six (6) to 12 years
 - Repeat two (2) – six (6) year procedures every six (6) months.
 - **Substance Abuse Counseling** – As appropriate/needed.
 - **Counseling For Intraoral/Perioral Piercing** – as needed.
- 12 years and older
 - Repeat six (6) –12 year procedures every six (6) months.
 - **Assessment and/or Removal of Third Molars** – as needed.
 - Transition to adult dental care

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APPENDIX A – CMS 1500 MANUAL VERSION CONTROL TABLE

Revision Date	Change(s)
01/01/2021	Chapter 2 – Getting Help When Needed 2.1 Quick Reference Guide – updated CSC address and URL and added DOS specifier to threshold info.
	Chapter 3 – Provider Responsibilities 3.1.1 Ordering, Referring, and Prescribing Providers (ORP) – added note concerning Chiropractors. 3.5 Medicaid Payment is Payment in Full – added DOS specifier to Chiropractic & Dietitian thresholds
	Chapter 6 – Institutional/UB Common Billing Information 6.10.1 Under Age 21 – added BH services and DOS specifier to Chiropractic and Dietitian thresholds 6.10.2 Ages 21 and Older – added codes H0046 and S9480 to table, added DOS specifier to Chiropractic & Dietitian thresholds, added under age 21 to BH 6.10.3 Authorization of Medical Necessity – added DOS specifier to AOMN requirement 6.10.5 Prior Authorization Once Thresholds are Met – Added Board Certified Behavior Analyst to provider who can make requests. 6.24.1 Covered Services – changed language to indicate Originating Sites list is comprehensive of all approved sites & removed the client’s home as an allowed site 6.24.2 Non-Covered Services – Added statement concerning clients using personal equipment 6.24.4 Billing Requirements – Added NOTE concerning clients using personal equipment
	Chapter 7 – CMS-1500 Common Billing Information 7.8.1 Under Age 21 – added BH services and DOS specifier to Chiropractic and Dietitian thresholds 7.8.2 Ages 21 and Older – added codes H0046 and S9480 to table, added DOS specifier to Chiropractic & Dietitian thresholds, added under age 21 to BH 7.8.3 Authorization of Medical Necessity – added DOS specifier to AOMN requirements 7.8.5 Prior Authorization Once Thresholds are Met – Added Board Certified Behavior Analyst to provider who can make requests. 7.24.1 Covered Services – changed language to indicate Originating Sites list is comprehensive of all approved sites & removed the client’s home as an allowed site 7.24.2 Non-Covered Services – Added statement concerning clients using personal equipment 7.24.4 Billing Requirements – Added NOTE concerning clients using personal equipment
	Chapter 12 – Important Information 12.6.5 By Report or Manually Priced Codes – Added rate reduction for 2021.
	Chapter 14 – Covered Services – Audiology 14.5 Reimbursement – Added to match CMS
	Chapter 15 – Covered Services – Behavioral Health 15.4.3 Limitations to Mental Health/Substance Abuse Services – changed “mental retardation” to “intellectual disabilities” 15.5 Covered Service Codes – <ul style="list-style-type: none"> Table 1: Removed H2019+HQ & added H0046 & S9480 Table 4: <ul style="list-style-type: none"> Added H0046 & S9480 to taxonomies 101Y00000X-163W00000X & Taxonomies beginning with 20-364SP0808X Removed H2019+ HQ from taxonomies beginning with 20. Added codes 90847, 90849, 90853 to taxonomy 1041C0700X Removed CSW from H00321, 90791, 90832, 90834, 90837, 90845, 90847, 90849, 90853, and 1041C0700X

	<p>15.7.2 <i>Covered Services</i> – Added Max unites per day to codes 97151, 97153-97158</p> <p>15.8.1 <i>Prior Authorization Once Thresholds are Met</i> – removed “ages 21 and over” and added documentation requirements.</p>
	<p>Chapter 17 – Covered Services – Chiropractic Services</p> <p>17.1 <i>Coverage Indications</i> – Added clarifier that Chiropractic Services have ended as of 01/01/2021.</p>
	<p>Chapter 18 – Covered Services – Dietitian Services</p> <p>18.2 <i>Limitations</i> – added DOS clarifier to threshold limitations</p>
	<p>Chapter 22 – Home Health</p> <p>22.2.3.1 <i>Prior Authorization</i> – Added paragraphs w/ PA denial explanations and appeal information.</p>
	<p>Chapter 25 – Covered Services – Practitioner Services</p> <p>25.10.1.2 <i>Patient has Other Medical Conditions or a Complicated Pregnancy</i> – corrected to include information after bullet points.</p> <p>25.9.1.2 <i>Billing Requirements</i> – Added rate reduction for 2021</p> <p>25.15.3.1 <i>Covered Services</i> – Added rate reduction for 2021</p>
	<p>Chapter 27 – Covered Services – Therapy Services</p> <p>27.3.2 <i>Limitations</i> – changed “mental retardation” to “intellectual disabilities”</p> <p>27.3.4 <i>Prior Authorization Once Threshold is Met</i> – Added to match CMS</p> <p>27.4 <i>Appeals Process</i> – added to match CMS</p>
	<p>Chapter 28 – Covered Services – Dental Services</p> <p>28.6.1 <i>Prosthetics Removable for Children</i> – Added 2021 denture reline/adjustment frequency policy change</p> <p>28.6.2 <i>Prosthetics Removable for Adults</i> – Added 2021 denture reline/adjustment frequency policy change</p>

APPENDIX B – Provider Notifications Log

Active Date(s)	Notification Type	Title	Audience
10/13/20	Bulletin	HH & DME Prior Authorization Requirement Reinstatement	332B00000X, 251E00000X, 364SP0808X
11/2/20	Bulletin	Medicaid Behavioral Health Rate, Coding, and Threshold Changes	261QR1300X, 261QF0400X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X, 2084P0800X, 2080N0001X, 208100000X, 363A00000X, 207Q00000X, 207R00000X, 364SP0808X, 363LP0200X, 363L00000X, 363LA2200X, 363LF0000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 261QM0801X, 261QR0405X, 101Y00000X, 251E00000X, 332B00000X, 261Q00000X, 261QP0904X
11/2/20	Bulletin	Medicaid Budget Reduction Changes	341600000X, 231H00000X, 332S00000X, 111N00000X, 1223G0001X, 122300000X, 1223X0400X, 1223P0221X, 1223P0300X, 1223S0112X, 1223E0200X, 251K00000X, 251S00000X, 261Q00000X, 261QA0005X, 322D00000X, 133V00000X, 332B00000X, 335E00000X, 251E00000X, 282N00000X, 282NR1301X, 275N00000X, 283Q00000X, 283X00000X, 171R00000X, 291U00000X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 314000000X, 367A00000X, 367500000X, 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X, 364SP0808X, 207KA0200X, 207L00000X, 207SG0201X, 207N00000X, 2085R0202X, 207P00000X, 207Q00000X, 207R00000X, 207RC0000X, 207RE0101X, 207RG0100X, 207RG0300X, 207RX0202X, 207RN0300X, 207RP1001X, 207RR0500X, 207T00000X, 204D00000X, 207V00000X,

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			207VG0400X, 207VX0000X, 207W00000X, 207Y00000X, 207ZP0105X, 2080N0001X, 208100000X, 363A00000X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X, 2084P0800X, 208600000X, 207X00000X, 2086S0120X, 2082S0099X, 208G00000X, 2086S0129X, 208800000X, 213E00000X, 323P00000X, 261QA1903X, 261QE0700X, 261QR0208X, 261QR0401X, 225X00000X, 225100000X, 235Z00000X, 177F00000X, 344600000X, 347C00000X, 152W00000X, 156FX1800X
11/13/202	Bulletin	2020 1099 & W-9 Update Reminder	All Providers
11/19/20	RA Banner	Wyoming Medicaid Enrollment Vendor Transition	All Providers
11/20/20	Bulletin	CARES Act Funding for Mental Health & Substance Abuse Services	261Q00000X, 261QP0904X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 364SP0808X, 2084N0400X, 2084P0800X, 261QF0400X, 261QR1300X
12/10/20	Bulletin	Telehealth Updates for Originating Sites	261Q00000X, 261QP0904X, 251E00000X, 282NR1301X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 367A00000X, 367500000X, 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X, 364SP0808X, 207KA0200X, 207L00000X, 207SG0201X, 207N00000X, 2085R0202X, 207P00000X, 207Q00000X, 207R00000X, 207RC0000X, 207RE0101X, 207RG0100X, 207RG0300X, 207RX0202X, 207RN0300X, 207RP1001X, 207RR0500X, 207T00000X, 204D00000X, 207V00000X, 207VG0400X, 207VX0000X, 207W00000X, 207Y00000X, 207ZP0105X, 2080N0001X, 208100000X, 363A00000X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X, 2084P0800X, 261QF0400X, 261QR0401X,

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			261QR1300X
12/16/20	Bulletin	Kid Care CHIP Medical & Outpatient Claims Reprocessing	All Providers
12/21/20	State Letter	Vaccine Partner Update December 2020	All Providers
12/23/20	Bulletin	Update to Denture Adjustment and Relines Frequency Policy	Taxonomies beginning with 12

Bulletin – Home Health & DME Prior Authorization Requirement Reinstatement



Division of Healthcare Financing
Wyoming Medicaid
122 West 25th St., 4th Floor West
Cheyenne, WY 82002
Phone (307) 777-7531 • 1-866-571-0944



Attention Home Health Providers

Effective December 1st, 2020, prior authorizations will be reinstated for home health services. The revenue codes are listed below with some general guidelines for submitting requests to WYhealth.

Revenue Code	Description	Unit	HCPSC Code
0421	PHYSICAL THERAPY - VISIT CHARGE	Per Visit	G0151
0431	OCCUPATIONAL THERAPY - VISIT CHARGE	Per Visit	G0156
0441	SPEECH THERAPY - VISIT CHARGE	Per Visit	G0153
0551	SKILLED NURSING - VISIT CHARGE	Per Visit	G0154
0561	MEDICAL SOCIAL SERVICES - VISIT CHARGES	Per Visit	G0155
0571	HOME HEALTH AIDE - VISIT CHARGE	Per Visit	G0156

Guidelines

- For Dates of Service 12/1/2020 and forward, Prior Authorization (PA) requests are required and must be submitted no more than 10 business days after the start of services
 - Dates of service during the COVID-19 pandemic from 3/17/20 to 11/30/20 do not require a PA.
- Requests submitted without a signed and dated 485 form or physician's detailed order will be issued a technical denial
- While claims will be billed with ONLY the revenue code, PA requests must be submitted with the associated HCPSC code for processing.

- Requests for As-Needed (PRN) visits must be submitted after the visit has occurred, but within 5 business days, as a separate episode. Requests must include documentation of the medical necessity of the PRN visit, including the clinical notes from that visit
- For facility discharges, upload the discharge summary from the facility and any applicable therapies (Physical Therapy (PT), Occupational Therapy(OT), Speech Therapy(ST))
- For wound care related requests, include current detailed wound specific information including frequency of care, drainage, and wound measurements
- For IV medication related requests, include current medication orders with frequency and duration, and how often administration is to be completed
- For Pediatric G-Tube Care: Clients age 20 and younger, when medically necessary, 1 Skilled Nursing (SN) visit per month for review of the placement and patency of the G-Tube will be approved. Other PRN visits will be reviewed according to the PRN visit requirements.
- Technical denials will be issued by WYhealth for the following:
 - No signed/dated 485 form or physician's orders
 - Failure of the provider to respond to requests for additional information
 - Incorrectly submitted codes (such as using HCPCS or CPT codes instead of Revenue Codes)
- In order to bill for services, the approved prior authorization number must be included on the claim to avoid delays and denials.

To receive training on iExchange for home health prior authorizations, please email WYhealth Provider Relations: wyhealth@optum.com or register for iExchange, <https://www.medecision.com/sign-up-today>. Follow the steps and complete all required fields for easy registration. Select "WYhealth" as the health plan for access. Please watch for email communications to come from Medecision regarding your iExchange log-in credentials. Please make sure you check your spam folder. Wyoming Medicaid is still allowing telehealth services for home health care for state plan only Medicaid home health providers, not waiver providers, at this time. Please follow the telehealth policy in the CMS 1500 Provider Manual, <https://wymedicaid.portal.conduent.com>, using the GT modifier to identify the claims.

Call WYhealth at (888)-545-1710 with questions or concerns.

Attention Durable Medical Equipment Providers

Effective December 1st, 2020, prior authorizations will be reinstated for enteral nutrition. The procedure codes are listed below with some general guidelines for submitting requests to WYhealth.

Enteral Nutrition Codes: B4100, B4102, B4103, B4104 – B4162 (require prior authorization)

Procedure Code	Procedure Code Description	PA Requirement	NDC Requirement
B4100	FOOD THICKENER	Yes	No
B4102	ENTERAL FORMULA, FOR ADULTS	Yes	No
B4103	ENTERAL FORMULA, FOR PEDIATRICS	Yes	No
B4104	ADDITIVE FOR ENTERAL FORMULA	Yes	No
B4149	ENTERAL FORMULA, BLENDERIZED NAT FOODS	Yes	No
B4150	ENTERAL FORMULAE; CATEGORY I	Yes	No
B4151	ENTERAL FORMULA; CATEGORY I	Yes	No
B4152	ENTERAL FORMULA; CATEGORY II	Yes	No
B4153	ENTERAL FORMULA; CATEGORY III	Yes	No
B4154	ENTERAL FORMULA; CATEGORY IV	Yes	No
B4155	ENTERAL FORMULA; CATEGORY V	Yes	No
B4156	ENTERAL FORMULA; CATEGORY VI	Yes	No
B4157	ENTERAL FORMULA; NUTRITIONALLY COMPLETE	Yes	No
B4158	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No
B4159	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No
B4160	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No
B4161	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No
B4162	ENTERAL FORMULA; FOR PEDIATRICS	Yes	No

If enteral nutrition is taken orally, use modifier BO on the claim (the modifier also needs to be part of the request during the prior authorization process).

Enteral nutrition may be covered for the following reasons:

1. When ordered by a physician who has seen the client within 60 days prior for oral nutrition and within 180 days prior for nasogastric, jejunostomy, or gastrostomy tube to ordering the therapy and has documented that the client cannot receive adequate nutrition by dietary adjustments and/or oral supplements. The face-to-face visit requirement is for first time prescriptions and annually thereafter. The face-to-face visit can be completed via telehealth. If an individual goes to a new DME provider, this is considered a first time prescription. Enteral therapy may be given by:
 - A. Nasogastric
 - B. Jejunostomy
 - C. Gastrostomy tube
 - D. Orally
2. Enteral Nutrition Therapy is considered reasonable and necessary for clients with:
 - A. Functioning gastrointestinal tracts who, due to pathology or non-function of the structures that normally permit food to reach the digestive tract, cannot maintain weight, strength, and overall health status
3. Oral enteral nutrition therapy is covered if the patient has a diagnosed medical condition such as, but not limited to:
 - A. A mechanical inability to chew or swallow solid or pureed or blenderized foods;
 - B. A malabsorption inability due to disease of infection;
 - C. Weaning from Total Parenteral Nutrition or feeding tube;
 - D. A significant weight lost over the past six (6) months or, for children under age 21, has experienced significantly less than expected weight; or
 - E. If patient receives less than 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, a nutritionist, speech-language pathologist or a physician must write a detailed plan to decrease dependence on the supplement.
4. Enteral nutrition therapy is not covered:
 - A. For clients whose nutritional deficiencies are due to a lack of appetite or cognitive problem; or
 - B. For healthy newborns; or
 - C. For individuals living in a nursing facility or residential facilities as this should be part of the per diem or room and board; or
 - D. For clients whose need is nutritional rather than medical or is related to an unwillingness to consume solid or pureed foods; or

Documentation :

For all requests for authorization of enteral nutritional products, documentation must include the following:

- A. Specific enteral product requested
- B. Average number of calories to be obtained per day from the enteral nutritional product
- C. Average number or calories to be obtained per day for other sources
- D. Medical condition that requires an enteral nutrition product
- E. Type of food preparation that have been tried (mechanically chopped, pureed or blenderized)
- F. Documentation if a swallowing study or swallowing evaluation has been completed with a history of aspiration
- G. Medical document to support the clinical need of the prescribed product
- H. Written order

Documentation of medical necessity must be kept on file by the provider and made available upon request.

If you have not been trained on iExchange for DME prior authorizations, please email WYhealth Provider Relations: wyhealth@optum.com or register for iExchange, <https://www.medecision.com/sign-up-today>. Follow the steps and complete all required fields for easy registration. Select “WYhealth” as the health plan for access. Please watch for email communications to come from Medecision regarding your iExchange log-in credentials. Please make sure you check your spam folder.

Wyoming Medicaid is still allowing telehealth services for physician, NP or PA visits for DME. Please follow the telehealth policy in the CMS 1500 Provider Manual, <https://wymedicaid.portal.conduent.com>, using the GT modifier to identify the claims.

Call WYhealth at (888)-545-1710 with questions or concerns.

[Unsubscribe](#)

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Wyoming Medicaid, Provider Relations, PO Box 667, Cheyenne, WY 82003

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<https://wymedicaid.portal.conduent.com/>

Deployment Information:

- Deployment Date: 10/13/20

- Deployment Time: 10:00 AM
- Audience: HH & DME provide
 - Taxonomies: 332B00000X, 251E00000X, 364SP0808X

Bulletin – Medicaid Behavioral Health Rate, Coding, and Threshold Changes



Division of Healthcare Financing
Wyoming Medicaid
122 West 25th St., 4th Floor West
Cheyenne, WY 82002
Phone (307) 777-7531 • 1-866-571-0944
Fax (307) 777-6964 • www.health.wyo.gov



Attention Behavioral Health Providers – Thresholds for Children and Group Therapy Changes

The Wyoming Department of Health is in the process of implementing a variety of budget reductions due to declining state revenues. On August 26, 2020, Director Ceballos provided general information on these budget reductions as outlined in the Biennium 2021-2022 Budget Reduction Plan, https://health.wyo.gov/wp-content/uploads/2020/08/WDH_2021-2022-Budget-Reduction-Plan_8.26.2020.pdf.

Behavioral Health Threshold Limits for Clients Under 21

Starting January 1, 2021, clients under the age 21 receiving behavioral health services and Applied Behavioral Analysis treatment will be subject to a threshold of 30 visits per calendar year. Once the threshold is reached, the provider will need to submit a Prior Authorization (PA) request for additional medically necessary services. The policy is similar to the adult population with behavioral health services but has the following differences.

- For clients ages 21 and older, all services, including the initial 30, must be rehabilitative in nature.
- For clients ages 20 and younger, all services, including the initial 30, must be medically necessary, but may fall outside the rehabilitative category.

Prior Authorization Process and Requirements

Prior Authorizations will be processed by the vendor WYhealth. Requests must be submitted electronically via the iExchange portal.

If you have not been trained on iExchange for behavioral health prior authorizations, please email WYhealth Provider Relations: wyhealth@optum.com or register for iExchange, <https://www.medecision.com/sign-up-today>. Follow the steps and complete all required fields for easy registration. Select "WYhealth" as the health

regarding your iExchange log-in credentials. Make sure you check your spam folder

if you have not added Medecision to your contacts.

The following must be submitted with your request to WYhealth in order for a determination to be made:

- Clinical assessment
 - A psychological evaluation or psychosocial assessment that describes the patient's history, need for treatment, etc.
- A copy of the most recent treatment plan (must be reviewed every 90 days)
- Progress notes (demonstrating some indication that the client is working towards goals noted in the treatment plan, and that the service being provided is *rehabilitative* in nature – meaning the services are helping the client keep, get back, or improve skills/functioning for daily living that have been lost or impaired due to his/her mental health issues.

To verify a Medicaid client's thresholds and eligibility, please use the IVR.

- Call the Provider Relations IVR at 1(800)251-1268
 - To obtain client eligibility, etc. – press 1
 - Select how you bill Medicaid and enter your Provider Information
 - Press 1 for 10 digit NPI, IVR repeats, if correct – press 1
 - Press 2 for 9 digit Provider ID, IVR repeats, if correct – press 1
 - Client eligibility – press 1
 - Enter the client information
 - For Client ID – press 1
 - Enter 10 digit client ID, IVR repeats, if correct – press 1
 - For SSN – press 2
 - Enter SSN, IVR repeats, if correct – press 1
 - Enter DOB (mm/dd/yyyy)
 - Enter DOS (mm/dd/yyyy)
 - For DOS this client is eligible for xx(xx) benefit plan(s)
 - To continue – press 3,
 - Check service usage for Authorization Of Medical Necessity – press 2
 - Choose the threshold type or choose to listen to all threshold information

Prior authorization (PA) inquiry and print functionality is now available on the Wyoming Medicaid secure provider portal. To view a PA status:

1. Log into the Medicaid Secure Provider Portal.
 - a. From the secured Home page, select Prior Authorization Inquiry listed at the bottom of the Inquiries column
 - b. Search the PA using Provider Medicaid ID, Client ID, and/or PA

- i. Make sure to complete all required fields
- ii. From and To Dates of Service fields are limited to a 6 month span.
- iii. If searching by Client ID and no Client ID is entered, the results will show all PAs for the provider
- c. Click Submit.
- d. Click the PA number (Auth Num) to view the PA detail page.
 - i. From the detail page there is the option to print a paper copy.

Reminders

Wyoming Medicaid covers medically necessary therapy services, including mental health and substance abuse (behavioral health) treatment services via the federal authority guidelines granted by the Centers for Medicare and Medicaid Services (CMS) and specified in the Code of Federal Regulation's (CFR) rehabilitative services option section. All Medicaid clients who meet the service eligibility requirements and have a need for particular rehabilitative option services are entitled to receive them.

- "Medical necessity" or "Medically necessary" means a determination that a health service is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected to relieve pain or to improve and preserve health and be essential to life. The service must be:
 - Consistent with the diagnosis and treatment of the client's condition;
 - In accordance with the standards of good medical practice among the providers' peer group;
 - Required to meet the medical needs of the client and undertaken for reasons other than the convenience of the client and the provider; and,
 - Performed in the most cost effective and appropriate setting required by the client's condition.
- Maintenance (Habilitative) Services – Services that help clients keep, learn, or reach developmental milestones or improve skills and functioning for daily living that they have not yet acquired. Examples would include therapy for a child who is not walking or talking at the expected age.
- Restorative (Rehabilitative) Services – Services that help clients keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the client was sick, hurt, or suddenly disabled.
 - Federal Medicaid Law defines rehabilitative services as: "Any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to his best possible functional level" [42

Changes to Coding and Rate Reductions

Group Therapy

Starting January 1st, 2021, the new Group Psychotherapy HCPCS code will be **H0046** – Mental Health Services, not otherwise specified, per session. This code, H0046, will be added so that H2019 will only be used for Individual Therapy. Please note that if you use the Current Procedural Terminology (CPT) codes such as 90853 – Group Medical Psychotherapy, you can continue to use them. Group therapy will be limited to two sessions per day and the sessions will not be allowed to be billed consecutively. For example, a group therapy session from 10-12 p.m. and then another one from 12-2p.m. will not be allowed. There must be a minimum of 1 hour between the two group sessions.

Intensive Outpatient Program Services

Starting January 1st, 2021, there will be a new code **S9480** – Intensive Outpatient Psychiatric Services, per diem. The new code is for Intensive Outpatient Program services provided at a Community Mental Health Centers and Substance Abuse Treatment Centers.

Please remember to use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service. Claims that are submitted for payment may be reviewed through our utilization management vendor. Appropriate changes will be made to the CMS 1500 provider manual for January 1, 2021.

Rate Reductions

Due to significantly reduced state revenues, the Wyoming Department of Health (WDH), Division of Healthcare Financing will be reducing provider rates by 2.5%. With these changes, the behavioral health codes will be aligning the reimbursement rates. This means that the current rates for HCPCS codes will match the rates for the CPT procedure codes that are equivalent. This was part of the final recommendation for the 2016-2017 Behavioral Health Cost Study. It stated that payments and units differed from the same therapy services based on the use of HCPCS or CPT codes. The change to align comparable CPT/HCPCS codes to the fee schedules will also take place January 1st, 2021.

Be sure to add wycustomersvc@conduent.com to your email contact list to ensure the proper delivery of your Wyoming Medicaid updates and weekly payment summary information.

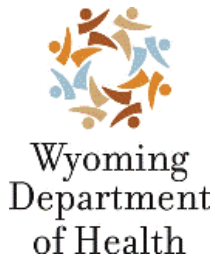
Please do not reply to this email with any customer service issues. Specific account inquiries will not be read.

Deployment Information:

- Deployment Date: 11/2/2020
- Deployment Time: 10:30 AM
- Audience: BH Providers
 - Taxonomies: 261QR1300X, 261QF0400X, 208D00000X, 208000000X,
2083P0901X, 2084N0400X, 2084P0800X, 2080N0001X, 208100000X,
363A00000X, 207Q00000X, 207R00000X, 364SP0808X, 363LP0200X,
363L00000X, 363LA2200X, 363LF0000X, 106S00000X, 163W00000X,
164W00000X, 171M00000X, 172V00000X, 101YA0400X, 101YP2500X,
103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X,
106H00000X, 261QM0801X, 261QR0405X, 101Y00000X, 251E00000X,
332B00000X, 261Q00000X, 261QP0904X

Bulletin – Medicaid Budget Reduction Changes

To view this email as a web page, go [here](#).



Division of Healthcare Financing
Wyoming Medicaid
122 West 25th St., 4th Floor West
Cheyenne, WY 82002
Phone (307) 777-7531 • 1-866-571-0944
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November 1, 2020

Attention WY Medicaid Providers

The Wyoming Department of Health is in the process of implementing a variety of budget reductions due to declining state revenues. On August 26, 2020, Director Ceballos provided general information on these budget reductions. As outlined in the Wyoming Department of Health's Biennium 2021-2022 Budget Reduction Proposal, Division of Healthcare Financing, Table 5, the 2021/22 State General Fund budget will be reduced by \$46,550,796 and its total budget by \$95,537,448. Specifically, there will be a 2.5% reduction to most provider rates for a total reduction of \$22,640,000 (State General Fund and Federal Funds combined).

Effective January 1, 2021, Wyoming Medicaid will implement the below reductions.

Hospitals	Outpatient Prospective Payment System (OPPS) conversion factors will be adjusted to result in a 2.5% reduction in payment in the April 2021 OPPS implementation for the effective date of January 1, 2021. Inpatient APR DRG hospital base rates will be adjusted to result in a 2.5% reduction in payment
RBRVS, Anesthesia, Radiology	-RBRVS conversion factor will be adjusted to \$35.94 & -Anesthesia conversion factor will be adjusted to \$25.84 -Radiology conversion factor will be adjusted to \$33.42
Fee Schedule	Individual rates for codes not paid through RBRVS will be reduced by 2.5%
Dental	All dental rates will be reduced by 2.5%
Nursing Facility/Swing Bed/NH Hospice	Nursing Facility, Swing Bed, and NH Hospice per diem rates will be reduced by 2.5%
PRTF	PRTF per diem rates will be reduced by 2.5%
Chiropractic	Chiropractic services will be eliminated effective January 1, 2021.
Title 25	Title 25 per diem rate will be reduced to \$610.00 per day.

CME/Children's Mental Health Waiver	All codes with the exception of T2025 will be reduced by 2.5%
-------------------------------------	---

For detailed information on changes by procedure or billing code, the fee schedule on the Medicaid website will reflect the updated information on or after January 1, 2021:

https://wymedicaid.portal.conduent.com/fee_schedule.html

Please watch for additional budget information and impacts in the upcoming months.

Be sure to add wycustomersvc@conduent.com to your email contact list to ensure the proper delivery of your Wyoming Medicaid updates and weekly payment summary information.

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Deployment Information:

- Deployment Date: 11/2/20
- Deployment Time: 3:30 PM
- Audience:

- Taxonomies: 341600000X, 231H00000X, 332S00000X, 111N00000X, 1223G0001X, 122300000X, 1223X0400X, 1223P0221X, 1223P0300X, 1223S0112X, 1223E0200X, 251K00000X, 251S00000X, 261Q00000X, 261QA0005X, 322D00000X, 133V00000X, 332B00000X, 335E00000X, 251E00000X, 282N00000X, 282NR1301X, 275N00000X, 283Q00000X, 283X00000X, 171R00000X, 291U00000X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 314000000X, 367A00000X, 367S00000X, 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X, 364SP0808X, 207KA0200X, 207L00000X, 207SG0201X, 207N00000X, 2085R0202X, 207P00000X, 207Q00000X, 207R00000X, 207RC0000X, 207RE0101X, 207RG0100X, 207RG0300X, 207RX0202X, 207RN0300X, 207RP1001X, 207RR0500X, 207T00000X, 204D00000X, 207V00000X, 207VG0400X, 207VX0000X, 207W00000X, 207Y00000X, 207ZP0105X, 2080N0001X, 208100000X, 363A00000X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X, 2084P0800X, 208600000X, 207X00000X, 2086S0120X, 2082S0099X, 208G00000X, 2086S0129X, 208800000X, 213E00000X, 323P00000X, 261QA1903X, 261QE0700X, 261QR0208X, 261QR0401X, 225X00000X, 225100000X, 235Z00000X, 177F00000X, 344600000X, 347C00000X, 152W00000X, 156FX1800X

Bulletin – 2020 1099 & W-9 Update Reminder

To view this email as a web page, go [here](#).



Wyoming Medicaid

IRS W-9

The State Auditor's policy is to accept only the most current published version of the [IRS W-9 \(Rev. 10-2018\)](#) Form. **Original documentation is currently required for the voided check and bank letters. If sending in a voided check or bank letter, a W-9 must accompany it. Faxed or emailed W-9s will be accepted.**

- [IRS W-9 \(Rev. 10-2018\)](#) Form is available on the [SAO website](#).
- All W-9's submitted on outdated forms will be returned unprocessed.
- Electronic or stamped signatures are NOT accepted

Voided Check Requirements:

- Original check, printed by your financial institution
- No temp checks are accepted
- Must include name and address
- Must have no alterations to the check beyond the written "VOID"

Bank Letter Requirements:

- On Bank Letterhead
- Dated within one (1) year
- Account name must match what is listed on the W9
- Account and Routing Numbers
- Account type – Checking or savings (not ACH or EFT)
- Original Signature of bank representative

When 1099's Are Returned, Medicaid Payments Are Held

ALL PAY-TO PROVIDERS

In preparation of the State Auditor's mailing of the 1099 Forms in January 2021, it is imperative for pay-to providers' addresses to be correct with the SAO and Medicaid.

1099 Forms will not be forwarded by the Post Office and when returned to the SAO as

undeliverable your Medicaid payments will be placed on hold until an [IRS W-9 \(rev. 10-2018\)](#) Form is completed and processed.

PAY-TO PROVIDERS

- Did you have a change of address in 2020?
 - No - No action required
 - **Yes - Action may be required**
- Did you complete the IRS W-9 Form at the time of the address change?
 - **No - Action is required**
 - Yes - No action required
- If action is required DO NOT DELAY!
 - Only the [IRS W-9 \(rev. 10-2018\) Form](#) will be accepted, all other versions will be returned unprocessed.
 - Complete and mail the form to:

Wyoming Medicaid
Attn: Enrollment
PO Box 667
Cheyenne, WY 82003-0667

NOTE: Behavioral Health/DD providers (taxonomy 251C00000X), to avoid delays mail your completed W-9 Form to the address above BUT also notify the Behavioral Health Division of your new address.

[Unsubscribe](#)

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Wyoming Medicaid, Provider Relations, PO Box 667, Cheyenne, WY 82003

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<https://wymedicaid.portal.conduent.com/>

Deployment Information:

- Deployment Date: 11/13/20
- Deployment Time: 10:30 AM
- Audience: All Providers

RA Banner – Wyoming Medicaid Enrollment Vendor Transition

COMING SOON!

WYOMING MEDICAID WOULD LIKE TO ANNOUNCE THE TRANSITIONING OF THE MEDICAID PROVIDER ENROLLMENT AND PROVIDER UPDATES TO OUR NEW VENDOR, HHS TECH GROUP.

WITH THIS TRANSITION THERE WILL BE A NEW PROVIDER PORTAL SPECIFICALLY FOR PROVIDERS TO COMPLETE ENROLLMENTS, RE-ENROLLMENTS, MAKE UPDATES, AND UPLOAD DOCUMENTS TO THEIR MEDICAID PROVIDER FILE.

IN ADDITION TO THE ENROLLMENT/UPDATE PORTAL HHS WILL HAVE A PROVIDER ENROLLMENT CALL CENTER TO ASSIST WITH QUESTIONS.

MORE INFORMATION TO COME!


TO STAY UP-TO-DATE ON THIS TRANSITION PROVIDERS ARE ENCOURAGED TO VISIT THE "ENROLLMENT TRANSITION" SECTION THAT WILL BE ADDED TO THE WHAT'S NEW PAGE ON THE WEBSITE,
[HTTPS://WYMEDICAID.PORTAL.CONDUENT.COM/NEW.HTML](https://wymedicaid.portal.conduent.com/new.html)

Deployment Information:

- Deployment Start Date: 11/19/20
- Deployment End Date: **TBD**
- Audience: All Providers

Bulletin – CARES Act Funding for Mental Health & Substance Abuse Services

To view this email as a web page, go [here](#).



Wyoming Medicaid

Attention Behavioral Health Providers

The Wyoming Department of Health (WDH), together with Governor Mark Gordon, is providing enhanced CARES Act funding for mental health and substance abuse services for Wyoming residents requiring services resulting from the COVID-19 pandemic.

Please visit the following link for more information:
<https://health.wyo.gov/publichealth/infectious-disease-epidemiology-unit/disease/novel-coronavirus/covid-19-mental-health-and-substance-abuse-provider-funding/>

[Unsubscribe](#)

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<https://wymedicaid.portal.conduent.com/>

Deployment Information:

- Deployment Date: 11/20/20
- Deployment Time: 10:30 AM
- Audience: Behavioral Health Providers
- Taxonomies: 261Q00000X, 261QP0904X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 364SP0808X, 2084N0400X, 2084P0800X, 261QF0400X, 261QR1300X

Bulletin – URGENT! DECEMBER PAYMENT DATE CHANGES – MEDICAID

To view this email as a web page, go [here](#).



Wyoming Medicaid

Attention Providers and Billers!

Important Medicaid Payment Date Changes for December

2020 DECEMBER CHANGES IN MEDICAID'S PAYMENT SCHEDULE					
***** <i>READ NOTES BELOW</i> *****					
WEEK OF	WYOMING MEDICAID PAYMENT DATES	STATE AUDITOR'S PAYMENT DATES	EFT TRANSMIT DATES <i>(Banks have up to 3 business days to post to accounts)</i>	CHECK MAIL DATES	SUGGESTED BILL DATES **
MONDAY 12/21/2020	TUESDAY 12/22/2020	WEDNESDAY 12/23/2020	MONDAY 12/28/2020	MONDAY 12/28/2020	DECEMBER 16, 17, 18, 19 & 20
MONDAY 12/28/2020	TUESDAY 12/29/2020	WEDNESDAY 12/30/2020	THURSDAY 12/31/2020	THURSDAY 12/31/2020	DECEMBER 23, 24, 25, 26 & 27

NOTE: Medicaid's Normal Weekly Payment Schedule: Medicaid payment runs on Wednesdays, the State Auditor's Office runs payment on Thursdays and EFT (electronic fund transfers) & check mail dates occur on Fridays. The above schedule documents changes to this schedule. Keep in mind, the EFT date is the date the SAO transmits the payment to banks (financial institutions) and they have up to three (3) business days to post to accounts.

**** NOTE :** Submitting claims on suggested bill dates **DOES NOT** guarantee payment.

The [2020 Payment Exceptions](#) schedule on the Medicaid website has been updated to reflect these changes.

[Unsubscribe](#)

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Wyoming Medicaid, Provider Relations, PO Box 667, Cheyenne, WY 82003

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<https://wymedicaid.portal.conduent.com/>

Deployment Information:

- Deployment Date: 12/7/20
- Deployment Time: 10:40 AM
- Audience: All Providers

Bulletin – Telehealth Updates for Originating Sites



Wyoming Medicaid

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IMPORTANT NOTICE

Attention Telehealth Providers

Effective January 1, 2021, providers are not allowed to bill Q3014 for the originating site when the originating site is the client's home. This also applies when the client uses their personal telephone or computer while at an authorized originating site or when the client is at any location that is not listed below.

Claims that are submitted for payment may be reviewed through our utilization management vendor for appropriate use of telehealth codes.

The originating sites will be updated in the January 1, 2021 quarterly CMS 1500 Provider Manual update to show as follows.

Originating Sites (Spoke Site)

The Originating Site or Spoke site is the location of an eligible Medicaid client at the time the service is being furnished via the site's telecommunications system.

Authorized originating sites are:

- Hospitals
- Office of a physician or other practitioner (this includes medical clinics)
- Office of a psychologist or neuropsychologist
- Community mental health or substance abuse treatment center (CMHC/SATC)
- Office of an advanced practice nurse (APN) with specialty of psych/mental health
- Office of a Licensed Mental Health Professional (LCSW, LPC, LMFT, LAT)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)

- Skilled nursing facility (SNF)
- Indian Health Services Clinic (IHS)
- Hospital-based or Critical Access Hospital-based renal dialysis centers (including satellites). Independent Renal Dialysis Facilities are not eligible originating sites
- Developmental Center
- Family Planning Clinics
- Public Health Offices

Please refer to the [CMS 1500 Provider Manual](#) section 6.24, for additional telehealth policy information. If you have any questions about this policy update, please call Provider Relation at 1-800-251-1268.



Help identify and combat Medicaid Fraud by visiting the website or contacting the Fraud Hotline:

• <https://health.wyo.gov/healthcarefin/program-integrity/>

• 1-855-846-2563

WYhealth is a Medicaid health management and utilization management program offered by the Wyoming Department of Health through Optum. Medicaid clients and providers will benefit from a wide array of programs and services offered and coordinated by Optum. Visit <https://www.wyhealth.net/tpa-ap-web/> for more information



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Deployment Information

- Deployment Date: 12/10/2020
- Deployment Time: 3:00 PM
- Audience: Telehealth Originating Site Providers
 - Taxonomy: 261Q00000X, 261QP0904X, 251E00000X, 282NR1301X, 261QM0801X, 261QR0405X, 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103K00000X, 103TC0700X, 1041C0700X, 106E00000X, 106H00000X, 106S00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 367A00000X, 367500000X, 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X, 364SP0808X,

207KA0200X, 207L000000X, 207SG0201X, 207N000000X, 2085R0202X, 207P000000X,
207Q000000X, 207R000000X, 207RC0000X, 207RE0101X, 207RG0100X, 207RG0300X,
207RX0202X, 207RN0300X, 207RP1001X, 207RR0500X, 207T000000X, 204D000000X,
207V000000X, 207VG0400X, 207VX0000X, 207W000000X, 207Y000000X, 207ZP0105X,
2080N0001X, 208100000X, 363A000000X, 208D000000X, 208000000X, 2083P0901X,
2084N0400X, 2084P0800X, 261QF0400X, 261QR0401X, 261QR1300X

Bulletin – Kid Care CHIP Medical & Outpatient Claims Reprocessing

To view this email as a web page, go [here](#).



Wyoming Medicaid

Attention Providers & Billers!

Kid Care CHIP Co-Payments Not Applied to Medical and Outpatient Claims

Provider Impact:

- Claims submitted and **paid** for children on the KIDC benefit plan only between the dates of 10/1/2020 and 11/19/2020 did not have co-payments applied
- 681 claims have been identified

Provider Action:

- No action is required to be taken by the provider or billing staff

Next Steps:

- Medicaid will adjust these paid claims on behalf of the providers and billers the week of 12/14/2020
- On 12/17/2020, these claim adjustments will begin appearing on Medicaid remittance advices (RAs) and 835 transactions

Contact provider Relations for questions and provide the adjusted TCN number for the best assistance in this matter. Provider Relations can be called at 1-800-251-1268 and following the below directions:

- Press 1
- Enter NPI or Provider ID
- Press 5 (listen to all the options)
- Press 0 to be transferred to an agent

We apologize for any inconvenience this may cause. Thank you for your patience.

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Deployment Information:

- Deployment Date: 12/16/2020
- Deployment Time: 3:00 PM
- Audience: All Providers

State Letter – Vaccine Partner Update December 2020

To view this email as a web page, go [here](#).



Division of Healthcare Financing
Wyoming Medicaid
122 West 25th St., 4th Floor West
Cheyenne, WY 82002
Phone (307) 777-7531 • 1-866-571-0944
Fax (307) 777-6964 • www.health.wyo.gov



December 18, 2020

Ref: SP-2020-088

Dear WDH Partner:

The COVID-19 vaccine is arriving in states and is currently in limited supply. States will continue to receive limited allocations in the coming weeks. At this time, the vaccine is being administered to specific populations. Those who will be eligible to receive the vaccination in the next several weeks include:

- ▶ Persons working in healthcare who have regular potential for exposure to COVID-19 patients;
- ▶ Persons who have regular exposure to those who are potentially positive for COVID-19, or those who are exposed to infectious materials.
- ▶ Persons who reside in a long-term care facility or setting.

A more detailed list of the groups included in this first phase, Phase 1a, can be found [here](#). COVID-19 vaccine is being allocated to counties and then further allocated to hospitals and local public health agencies. Five counties received vaccine during the week of December 14. Going forward, all counties will receive allocations of vaccine. As vaccine becomes available, local public health or hospitals will reach out to agencies and entities that employ individuals who fit within the Phase 1a group to make plans for administering vaccine to those individuals. This communication may not be immediate, but will occur as soon as vaccine becomes available to specific groups. Scheduling will take place once the vaccine is available

locally through hospitals or local public health agencies. As additional vaccine becomes available, local public health agencies will continue to reach out to specific groups as they become eligible to receive the vaccine.

Vaccination of long-term care and assisted living facility residents is being coordinated through a federal partnership with two national pharmacy chains, as well as with local public health offices. This effort will tentatively begin in early January.

Due to limited vaccine availability and the need to vaccinate groups in Phase 1a, vaccine is not yet available for other groups or the general public. We do not have an exact timeframe for when the vaccine will be more readily available, but expect it will be months before the general public will be able to receive the vaccine. As such, it is important to continue following our primary recommendations of wearing masks, social distancing, frequent handwashing, and staying home when ill.

Please visit the [Wyoming Department of Health website](#) for more COVID-19 vaccine resources. Information on the remainder of the phases will be forthcoming as we move forward in vaccinating Wyoming. If you have any additional questions, please contact Angie Van Houten, Community Health Section Chief, at angie.vanhouten@wyo.gov or 307-777-2067.

Sincerely,



Stephanie Pyle, MBA, Senior Administrator
Public Health Division
Wyoming Department of Health

SP/ts

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Deployment Information:


- Deployment Date: 12/21/2020
- Deployment Time: Approx. 3:15 PM
- Audience: All Providers

Bulletin – Update to Denture Adjustment and Reline Frequency Policy



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NEW

Attention Providers

Upcoming Policy Change for Removable Prosthetics for Children

Effective starting January 1, 2021, the policy on Denture Alignment and Reline Frequency is changing. Under the new policy:

- Codes D5730-D5761 for relines will only be allowed **once every three (3) years**.
- Codes D5410-D5422 will be limited to two (2) adjustments **per arch** per 12 month period

These codes will no longer conflict with each other.

This policy change will be reflected in the upcoming Quarterly Manual Updates for January 1, 2021. For questions please call Dental Services at 888-863-5806.



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• <https://health.wyo.gov/healthcarefin/program-integrity/>

• 1-855-846-2563

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Deployment Information:

- Deployment Date: 12/23/2020
- Deployment Time: 10:00 AM
- Audience: Dental Providers
 - Taxonomies: Beginning with 12