DIVISION OF HEALTHCARE FINANCING

CMS 1500 ICD-10

April 5, 2018

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, http://soswy.state.wy.us/Rules/default.aspx.

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 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 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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Chapter One – General Information

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1.1 How the CMS-1500 Manual is Organized

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

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

Chapter	Description
Appendices	**Appendices** – Provide key information in an at-a-glance format. This includes the Provider Manual Version Control Table, and last quarters Provider Notifications.

1.2 Updating the Manual

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

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

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

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

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

1.2.1 RA Banner Notices/Samples

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

Sample RA Banner:

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

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

TROUBLESHOOTING TIPS PRIOR TO CALLING THE CALL CENTERS:

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

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

****

Sample RA Payment Summary (weekly email notification):

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

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

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

Dear Provider Name,

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

****
RA PAYMENT SUMMARY
****
To: Provider Name
NPI Number: 1234567890
Provider ID: 111111111

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

1.2.2 Medicaid Bulletin Notification/Sample

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

Sample bulletin email notification (HTML format):

Wyoming Department of Health

Attention Providers - Phototherapy Services Email Deployed 2/20/15

Medicaid Website | Manual & Bulletins | Forms | Client Benefit Plans

Changes in Phototherapy for High Bilirubin levels - E0202 Rental (RR)

Sign In | Update Your Profile

- Medicaid Website
- Manual & Bulletins
- Fee Schedule
- What's New
- Links
- IVR Navigation Tips
- Web Portal Tutorials

In order to provide better access to home therapy for newborns with high bilirubin levels, and reduce the number of hospital readmissions for Wyoming Medicaid infants, Wyoming Medicaid will be making the following changes regarding the policy and reimbursement of the E0202 RR (phototherapy - rental) HCPCS code.

Effective with dates of service April 1st, 2015 and forward, the E0202 RR code will be allowed for the following provider types and taxonomies:

- All Physicians (20s)
- Nurse Practitioners (363Ls, 367A00000X)
- Durable Medical Equipment Suppliers (332B00000X)
- Public Health Nurse's Offices (251K00000X)

Procedure code E0202 with the RR modifier will be billed using daily units, as a rental only (using the RR modifier), with a maximum allowable of 5 units per lifetime.

Reimbursement for this code will be set at $55.22 per day for the physicians, nurse practitioners, DME suppliers, and public health nurses offices.

Note: This rate is subject to change, verify rate using the online fee schedule.

Practitioner services, such as home or office based visits, home health visits, lab tests, etc., can be billed as appropriate in addition to the rental of the Bilblanket or other phototherapy device.

Appeal Process for clients requiring over 5 days

Wyoming Medicaid encourages providers to submit the initial claim to receive reimbursement for the 5 days. Then, when appealing, submit an adjustment form with a corrected claim that has the additional units included along with medical necessity and appeal to the below address.

Providers can also choose to submit the claim which includes additional units along with medical necessity and appeal to:

DME Provider Services Manager
6101 Yellowstone Road, Suite 210
Cheyenne, WY 82002

Criteria for the Use of Photo Therapy (available in the DME Covered Services Manual)

Covered on a rental basis for infants with:

- Neonatal hyperbilirubinemia is the infant's sole clinical problem
- Infant greater than or equal to 37 weeks gestational age and birth weight greater than 2.270 gm (5lbs)
- Infant more than 48 hours old
- Bilirubin level, without hemolysis, at initiation of phototherapy (after infant reaches 48 hours of age or more) is ***14 mgs per deciliter or above***; and
- Bilirubin level, without hemolysis, less than two mgs per deciliter

The following conditions must be met prior to initiation of home phototherapy:

- History and physical assessment conducted by infant's attending physician. Newborn discharge exam will suffice if home phototherapy begins immediately upon discharge from the hospital
- Required laboratory studies must have been performed, including CBC, blood type on mother and infant, direct Coombs and direct Bilirubin level, without hemolysis
- Physician certifies that parent/caregiver is capable of administering home phototherapy
- Parent/caregiver has successfully completed training on use of equipment; and
- Equipment must be delivered and set up within four hours of discharge from the hospital or notification of provider, whichever is more appropriate
- Repair and/or replacement service **must** be available 24-hours per day

A global fee has been established that includes:

- Rental of the phototherapy unit, and also **all** supplies, accessories, and services necessary for proper functioning and effective use of the therapy
- Complete caregiver training on use of equipment and completion of necessary records

Documentation:

- Written Order
- Narrative report outlining client's progress
- Documentation of the above outlined criteria and conditions necessitating therapy must be maintained in provider's records

Stop Medicaid Fraud

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

- http://stopwyomedicaidfraud.com
- 1-855-846-2563

WYhealth...Get Plugged In! is a Medicaid Program offered through Xerox Care and Quality Solutions, Inc.. Medicaid Clients and Providers will benefit from a wide array of programs and services. Visit www.wyhealth.net for more information.

WYhealth ...get plugged in

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

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

Sample WDH email notification (HTML format):

To view in your browser or on a mobile device, click here.

Wyoming Department of Health

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

Thomas O. Forslund, Director

Governor Matthew H. Mead

December 1, 2014

Effective February 1, 2015, Wyoming Medicaid will no longer be identifying an emergency service by diagnosis code. Rather, an emergency indicator will need to be entered on the claim in the appropriate box.

Emergency services for non-citizens will no longer be determined by diagnosis, but rather the appropriate indicator.

UB04 Paper Claim

Box 14- this is a mandatory field:

The physician or medical professional will need to determine if the visit or the service was an emergency.

When billing, ensure Box 14, Admission Type prints on your paper claim form.

Emergency Indicators:

1	Emergency	4	Newborn
2	Urgent Care	5	Trauma

Non-Emergency Indicators:

3	Elective

Co-pay for outpatient hospital visits (non-emergency) will still apply. Co-payment requirements do not apply to emergency services.

UB04 Electronic Claim- Loop 2300, Admission Type Code is required. Be sure that this indicator is included in your file transfer to the clearing house, or that your software captures this field.

All indicated emergency services must be supported with medical documentation kept on file with the provider's office.

CMS 1500 Paper Claim

Box 24c - this field is situational, but required when the service is deemed an emergency:

The physician or medical professional will need to determine if the visit or the service was an emergency.

When billing, ensure Box 24c, EMG (Emergency Indicator) prints on your paper claim form.

Emergency Indicators:

Y	Yes

Non-Emergency Indicators:

N	No	Blank	No

Co-pay for non-emergency will still apply. Co-payment requirements do not apply to emergency services.

CMS 1500 Electronic Claim- Loop 2400, Emergency Indicator is situational. Be sure that this indicator is included in your file transfer to the clearing house, or that your software captures this field.

All indicated emergency services must be supported with medical documentation kept on file with the provider's office.

Division of Healthcare Financing/Medicaid
6101 Yellowstone Road, Suite 210 • Cheyenne WY 82002
Web Page: http://www.health.wyo.gov/healthcarefin/index.html
Toll Free 1-866-571-0944 • Main Number (307) 777-7531 • FAX (307) 777-6964

Unsubscribe

Be sure to add wycustomersvc@xerox.com to your address book 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 inquires will not be read.

1.3 State Agency Responsibilities

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

1.4 Fiscal Agent Responsibilities

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

NOTE: Wyoming Medicaid is not responsible for the training of the provider's billing staff or to provide procedure or diagnosis codes or coding training.

Chapter Two – Getting Help When You Need It

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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	• Payment inquiries • Client eligibility • Medicaid client number and information • Lock-in status • Authorization of Medical Necessity • Medicare Buy-In data • Service limitations • Client third party coverage information **NOTE:** The client's Medicaid ID number or social security number is required to verify client eligibility.
Claims PO Box 547 Cheyenne, WY 82003-0547	N/A	N/A	• Claim adjustment submissions • Hardcopy claims submissions • Returning Medicaid checks
Dental Service PO Box 667 Cheyenne, WY 82003-0667	Tel (888)863-5806 9-5pm MST M-F Fax (307)772-8405	https://wymedicaid.portal.conduent.com/provider_home.html	• Bulletin/manual inquiries • Claim inquiries • Claim submission problems • Client eligibility • How to complete forms • Payment inquiries • Request Field Representative visit • Training seminar questions • Timely filing inquiries • Verifying validity of procedure codes • Claim void/adjustment inquiries • WINASAP training • Web Portal training
EDI Services PO Box 667 Cheyenne, WY 82003-0667	Tel (800)672-4959 OPTION 3 9-5pm MST M-F Fax (307)772-8405	https://wymedicaid.portal.conduent.com	• EDI Enrollment Forms • Trading Partner Agreement • WINASAP software • Technical support for WINASAP • Technical support for vendors, billing agents and clearing houses • Web Portal registration/password resets • Technical support for Web Portal
Conduent EDI Solutions	N/A	http://edisolutionsmmis.portal.conduent.com/gcro/	• Download WINASAP software • Submit and view EDI files

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Medical Policy PO Box 667 Cheyenne, WY 82003-0667	Tel (800)251-1268 OPTIONS 1,1,4,3 9-5pm MST M-F (24/7 Voicemail Available) Fax (307)772-8405	https://wymedicaid.portal.conduent.com/manuals.html	Authorization for Medical Necessity requests and Prior authorization requests for: • Surgeries requiring prior authorization • Hospice Services: Limited to clients residing in a nursing home
Provider Relations PO Box 667 Cheyenne, WY 82003-0667 (IVR Navigation Tips available on the website)	Tel (800)251-1268 9-5pm MST M-F (call center hours) Fax (307)772-8405 24 / 7 (IVR availability)	https://wymedicaid.portal.conduent.com https://wymedicaid.portal.conduent.com/contact.html	• Provider enrollment questions • Bulletin/Manuals inquiries • Authorization for Medical Necessity Requirements • Claim inquiries • Claim submission problems • Client eligibility • Claim void/adjustment inquiries • Form completion • Payment inquiries • Request Field Representative visit • Training seminar questions • Timely filing inquiries • Troubleshooting prior authorization problems • Verifying validity of procedure codes
Third Party Liability (TPL) PO Box 667 Cheyenne, WY 82003-0667	Tel (800)251-1268 OPTION 2 9-5pm MST M-F Fax (307)772-8405 Select Option 2 if you need Medicare or estate and trust recovery assistance THEN Select Option 2 if you are with an insurance company, attorney's office or child support enforcement OR Select Option 3 for Medicare and Medicare Premium payments OR Select Option 4 for estate and trust	N/A	• Client accident covered by liability or casualty insurance or legal liability is being pursued • Estate and Trust Recovery • Medicare Buy-In status • Reporting client TPL • New insurance coverage • Policy no longer active • Problems getting insurance information needed to bill • Questions or problems regarding third party coverage or payers • WHIPP program

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
	recovery inquires		
Transportation Services PO Box 667 Cheyenne, WY 82003-0667	Tel (800)595-0011 9-5pm MST M-F (24/7 Voicemail Available) Fax (307)772-8405	https://wymedicaid.portal.conduent.com/client/	Client inquiries: • Prior authorize transportation arrangements • Request travel assistance • Verify transportation is reimbursable
Qualis Health DMEPOS PO Box 33400 Seattle, WA 98133	Tel (800)783-8606 8a-6pm MST M-F Fax (877)810-9265	http://www.qualishealth.org/	• DMEPOS Covered Services manual • Prior authorization request for Durable Medical Equipment (DME) or Prosthetic/Orthotic Services (POS) • PT/OT/ST/BH PAs after service threshold has been met • Questions related to documentation or clinical criteria for DMEPOS • Home Health
WYhealth (Utilization and Care Management) PO Box 49 Cheyenne, WY 82003-0049	Tel (888)545-1710 Nurse Line: (OPTION 2) **Fax PASRRs Only** (888)245-1928 (Attn: PASRR Processing Specialist)	http://www.WYhealth.net/	• Medicaid Incentive Programs • Diabetes Incentive Program • ER Utilization Program • P4P • SBIRT • Educational Information about WYhealth Programs Prior authorization for: • Acute Psych • Extended Psych • Extraordinary heavy care • Gastric Bypass • Inpatient rehabilitation • Psychiatric Residential Treatment Facility (PRTF) • Transplants • Vagus Nerve Stimulator
Aids Drug Assistance Program (ADAP)	Tel (307)777-5800 Fax (307)777-7382	N/A	• Prescription medications • Program information
Maternal & Child Health (MCH) /Children Special Health (CSH) 6101 N. Yellowstone Rd. Ste. 420 Cheyenne, WY 82002	Tel (307)777-7941 Tel (800)438-5795 Fax (307)777-7215	N/A	• High Risk Maternal • Newborn intensive care • Program information

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Severe Malocclusion	Tel (307)777-8088 Fax (307)777-6964	N/A	• Severe Malocclusion Applications and Criteria
Social Security Administration (SSA)	Tel (800)772-1213	N/A	Social Security benefits
Medicare	Tel (800)633-4227	N/A	Medicare information
Division of Healthcare Financing (DHCF) 6101 Yellowstone Rd. Ste. 210 Cheyenne, WY 82002	Tel (307)777-7531 Tel (866)571-0944 Fax (307)777-6964	http://www.health.wyo.gov/healthcarefin/index.html	• Medicaid State Rules • State Policy and Procedures • Concerns/Issues with state Contractors/Vendors
DHCF Program Integrity 6101 Yellowstone Rd. Ste. 210 Cheyenne, WY 82002	Tel (855)846-2563	N/A	Client or Provider Fraud, Waste and Abuse **NOTE:** Callers may remain anonymous when reporting
Stop Medicaid Fraud	Tel (855)846-2563	http://stopmedicaidfraud.wyo.gov	• Information and education regarding fraud, waste, and abuse in the Wyoming Medicaid program • To report fraud, waste and abuse
DHCF Pharmacy Program 6101 Yellowstone Rd. Ste. 210 Cheyenne, WY 82002	Tel (307)777-7531 Fax (307)777-6964	N/A	General questions
Change Healthcare	Tel (877)209-1264 (Pharmacy Help Desk) Tel (877)207-1126 (PA Help Desk)	http://www.wymedicaid.org/	• Pharmacy prior authorization • Enrollment • Pharmacy manuals • FAQs
Customer Service Center (CSC) , Wyoming Department of Health 2232 Dell Range Blvd, Suite 300 Cheyenne, WY 82009	Tel (855)294-2127 TTY/TDD (855)29-5205 (**Clients Only**, CSC cannot speak to providers) 7-6pm MST M-F Fax (855)329-5205	www.wesystem.wyo.gov	• Client Medicaid applications Eligibility questions regarding: • Family and Children's programs • Tuberculosis Assistance Program • Medicare Savings Programs • Employed Individuals with Disabilities

Agency Name & Address	Telephone/Fax Numbers	Web Address	Contact For:
Wyoming Department of Health Long Term Care Unit (LTC)	Tel (855)203-2936 8-5pm MST M-F Fax (307)777-8399	N/A	• Nursing home program eligibility questions • Patient Contribution • Waiver Programs • Inpatient Hospital • Hospice • Home Health
Wyoming Medicaid	N/A	https://wymedicaid.portal.conduent.com	• Provider manuals • HIPAA electronic transaction data exchange • Fee schedules • On-line Provider Enrollment • Frequently asked questions (FAQs) • Forms (e.g., Claim Adjustment/Void Request Form) • Contacts • What's new • Remittance Advice Retrieval • EDI enrollment form • Trading Partner Agreement • Secured Provider Web Portal • Training Tutorials

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 claim, 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 procedures or to resolve claims payment issues.

Provider Relations Field Representatives are available to assist providers with help in their location, by phone, or webinar with Wyoming Medicaid billing questions and issues. Generally, to assist a provider with claims specific questions, it is best for the Field Representative to communicate via phone or webinar as they will then have access to the systems and tools needed to review claims and policy information. Provider Training visits may be conducted when larger groups are interested in training related to Wyoming Medicaid billing. When conducted with an individual provider's office, a Provider Training visit generally consists of a review of a provider's claims statistics, including top reasons for denials 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 public website also links providers to Medicaid's Secured Provider Web Portal, which 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
- **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 Medicaid bulletin email notifications, provider bulletins (hard copies) or Remittance Advice (RA) banners. Providers 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 requirement of enrollments, backdating enrollments must be handled through an appeal process. If the provider is requesting an effective date prior to the completion of the enrollment, a letter of appeal must be submitted with proof of enrollment with Medicare or another State's Medicaid that covers the requested effective date to present.

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

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

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

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

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

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

The application fee is required for:

- New enrollments
- Enrollments for new locations
- Re-enrollments
- Medicaid requested re-enrollments (as a 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 providers 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 providers and attending providers 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. Providers who are enrolled as an ORP ONLY will not term due to 12 months of inactivity (no paid claims on file). If they are enrolled as a treating provider but only being used as an ORP provider, these providers will term due to 12 months of inactivity (no paid claims on file).

Taxonomies that may order, refer, or prescribe	
Taxonomy	**Taxonomy Description**
All 20s	Physicians (MD, DO, interns, residents and fellows)
363A00000X	Physician Assistants (PA)
363Ls	Nurse Practitioners
364SP0808X	Advanced Practice Nurses (APN)
235X00000X	Speech Therapist
231H00000X	Audiologist
225100000X	Physical Therapists
225X00000X	Occupational Therapists
213E00000X	Podiatrist
152W00000X	Optometrists
1223s	Dentists
111N00000X	Chiropractic

Taxonomies always required to include an ORP/attending NPI	
Taxonomy	**Taxonomy Description**
332S00000X	Hearing Aid Equipment
332B00000X	Durable Medical Equipment (DME) & Supplies
335E00000X	Prosthetic/Orthotic Supplier
291U00000X	Clinical Medical Laboratory
261QA1903X	Ambulatory Surgical Center (ASC)
261QE0700X	End-Stage Renal Disease (ESRD) Treatment
261QF0400X	Federally Qualified Health Center (FQHC)
261QR0208X	Radiology, Mobile
261QR0401X	Comprehensive Outpatient Rehabilitation Facility (CORF)
261QR1300X	Rural Health Clinic (RHC)
225X00000X	Occupational Therapist
225100000X	Physical Therapist
235Z00000X	Speech Therapist
251E00000X	Home Health
251G00000X	Hospice Care, Community Based
261Q00000X	Development Centers (Clinics/Centers)
261QP0904X	Public Health, Federal/Health Programs Operated by IHS
282N00000X	General Acute Care Hospital
282NR1301X	Critical Access Hospital (CAH)
283Q00000X	Psychiatric Hospital
283X00000X	Rehabilitation Hospital
323P00000X	Psychiatric Residential Treatment Facility
111N00000X	Chiropractors
231H00000X	Audiologist
133V00000X	Dieticians

3.1.2 Enrollment Termination

3.1.2.1 License/Certification

Sixty (60) days prior to licensure/certification expiration, Medicaid sends all providers a letter requesting a copy of their license or other certifications. If these documents are not submitted within 60-days of their expiration date, the provider will be terminated 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 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 notifications 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. If the information is updated within the 30 days, the claim will be released to complete normal processing; if a claim is held for this reason for more than 30 days, it will then be denied and the provider will have to resubmit once the incorrect information is updated. The letter will document the information currently on file with Wyoming Medicaid and allow you to make updates/changes as needed.

3.1.2.3 Inactivity

Providers who do not submit a claim within one year will be terminated due to inactivity and a new enrollment will be required. No notification will be sent out to providers for this type of termination.

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 an 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 addressed 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 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 providers 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/herself as a Medicaid client, the provider

must determine whether the provider is willing to accept the client as a Medicaid patient before treatment is rendered.

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

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

It is the provider's responsibility to determine all sources of coverage for any client. If the client is insured, by an entity other than Medicaid and Medicaid is unaware of the insurance, the provider must submit a Third Party Resources Information Sheet (7.2.1, Third Party Resources Information Sheet) to Medicaid. The provider may not discriminate based on whether or not a client is insured.

Providers 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 may be billed to a Medicaid client.

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

	Client is Covered by a FULL COVERAGE Medicaid Program and the provider accepts the client as a Medicaid client	**Client is Covered by a LIMITED COVERAGE Medicaid Program and the provider accepts the client as a Medicaid client**	**FULL COVERAGE or LIMITED COVERAGE Medicaid Program and the provider does not accept the client as a Medicaid client**	**Client is not covered by Medicaid (not a Medicaid client)**
Service is covered by Medicaid	Provider can bill the client only for any applicable copay	Provider can bill the client if the category of service is not covered by the client's limited plan	Provider can bill the client if written notification has been	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

	Client is Covered by a FULL COVERAGE Medicaid Program and the provider accepts the client as a Medicaid client	**Client is Covered by a LIMITED COVERAGE Medicaid Program and the provider accepts the client as a Medicaid client**	**FULL COVERAGE or LIMITED COVERAGE Medicaid Program and the provider does not accept the client as a Medicaid client**	**Client is not covered by Medicaid (not a Medicaid client)**
Service is 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 you bill 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).

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 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 twelve month 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, deliver 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 his/her 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 provider's overall cost of doing business. The Medicaid reimbursement rates set by the State are designed to cover the cost of doing business.

3.3 Medicare Covered Services

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

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

3.4 Medical Necessity

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

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

Additionally, the service must be:

- Consistent with the diagnosis and treatment of the patient's condition.
- In accordance with standards of good medical practice.

- Required to meet the medical needs of the patient and undertaken for reasons other than the convenience of the patient or his/her 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 denies the providers claim due to billing errors such as wrong procedure and diagnosis codes, 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 service, 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 on a plan that does not cover those particular services. Refer to the table above for guidance.
- If the client has reached the threshold on physical therapy, occupational therapy, speech therapy, behavioral health services, chiropractic services, prescriptions, and/or office/outpatient hospital visits and has been notified that

the services are not medically necessary in writing by the provider. (6.8 Services 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, Referral of Suspected Fraud and Abuse).

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 he/she is covered by Medicaid, but not have any proof of eligibility. This can occur if the client is newly eligible or if his/her card was lost. Providers have several options when checking patient eligibility.

3.8.1 Free Services

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

- Contact Provider Relations. There is a limit of three (3) verifications per call but no limit on the number of calls.

- Fax a list of identifying information to Provider Relations for verification. Send a list of beneficiaries for verification and receive a response within ten (10) business days.
- Call the Interactive Voice Response (IVR) System. IVR is available 24-hours a day, seven (7) days a week. The IVR System allows 30 minutes per phone call. (2.1, Quick Reference).
- Use the Ask Wyoming Medicaid feature on the Secured Provider Web Portal (2.1, Quick Reference).

3.8.2 Fee for Service

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

3.9 Freedom of Choice

Any eligible non-restricted client may select any provider of health services in Wyoming who participates in the Medicaid Program, unless Medicaid specifically restricts his/her 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

Utah
Salt Lake City

South Dakota
Deadwood
Custer
Rapid City
Spearfish
Belle Fourche

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 providers within the WMSA when:

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

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

- **Emergency Care** – When a client is traveling and an emergency arises due to accident or illness.
- **Other Care** – When a client is referred by a Wyoming physician to a provider outside the WMSA for services not available within the WMSA. The referral must be documented in the provider's records. Prior authorization is not required unless the specific service is identified as requiring prior authorization (6.13, 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 include but are not limited to:

- The record must be typed or legibly written.
- The record must identify the client on each page.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

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

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

3.11.2 Retention of Records

The provider must retain medical and financial records, including information regarding dates of service, diagnoses, and 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; and/or
- Audit of facility financial records for reimbursement.
- Actual records reviewed may be extrapolated and applied to all services billed by the provider.

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

Medicaid reserves the right to make unscheduled visits i.e., when the client's health may be endangered, when criminal/fraud 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 representative's 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 request 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 the Wyoming Statute.

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 requirements 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 quantity 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 that 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 compliant written prescription within 72-hours.

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

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

4.2 Complaint Referral

The Program Integrity Unit 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:

Program Integrity Unit
Division of Healthcare Financing
6101 Yellowstone Rd., Suite 210
Cheyenne, WY 82002
Or contact: (855) 846-2563
Or email: programintegrity@wyo.gov

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 agent's access to all medical and financial records. In addition, each client agrees to the release of medical records to the Division of Healthcare Financing when they accept Medicaid benefits.

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

4.4 Client Lock-In

In designated circumstances, it may be necessary to restrict certain services or "lock-in" a client to a certain physician, hospice, pharmacy or other provider. If a lock-in restriction applies to a client, the lock-in information is provided on the Interactive Voice Response System (2.1, Quick Reference).

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

- In a medical emergency where a delay in treatment may cause death or result in lasting injury or harm to the client.
- As a physician covering for the designated primary 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 he/she may bill for services provided to a lock-in client. Contact Provider Relations in circumstances where coverage of a lock-in client is unclear. Refer to the Medicaid Pharmacy Provider Manual (2.1, Quick Reference).

4.5 Pharmacy Lock-In

The Medicaid Pharmacy Lock-In Program limits certain Medicaid clients to receiving prescription services from multiple prescribers and utilizes multiple pharmacies within a designated time period is a candidate for the Lock-In Program.

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 findings 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 http://worxpdmp.com/ 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/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).

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 service and controlling improper or illegal utilization of the program. While the surveillance function addresses administrative concerns, utilization review addresses medical concerns and 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 his/her signature or the signature of his/her 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:

Program Integrity Unit
Division of Healthcare Financing
6101 Yellowstone Rd., Suite 210
Cheyenne, WY 82002
Or contact: (855)846-2563
http://stopmedicaidfraud.wyo.gov/

4.9.1 Report of Suspected Abuse of the Medicaid Healthcare System

Wyoming Department of Health | Commit to your health. visit www.health.wyo.gov

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

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, non-compliance (i.e., Provider Agreement and/or Medicaid Rules) exists or who is under sanction by another regulatory entity (i.e. Medicare, licensing boards, OIG, 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

Providers 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.

5.2.1 Children

- Newborns are automatically eligible if the mother is Medicaid eligible at the time of the birth.
- Low Income Children are eligible if family income is at or below 133% federal poverty level (FPL) or 154% FPL, dependent on 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 are eligible in different income levels including some who enter subsidized adoption or who age out of foster care until they are age 26.
- Presumptive Eligibility (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% 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.
- Presumptive Eligibility (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% SSI Standard.

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

5.2.4.3 Home and Community Based Waiver

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

- Acquired Brain Injury
- Community Choice
- Children's Mental Health
- Comprehensive
- Supports

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 100% 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 receive all services coordinated through the PACE provider. This program is currently available in Laramie County only.

5.2.5.2 Employed Individuals with Disabilities (EID)

As of 9/1/17 Employed Individuals with Disabilities are income eligible when income is less than or equal to 100% SSI using unearned income and must pay a premium calculated using total gross income.

5.2.5.3 Medicare Savings Programs

- Qualified Medicare Beneficiaries (QMB) are income eligible at or below 100% FPL. Benefits include payment of Medicare premiums, deductibles, and cost sharing.
- Specified Low Income Beneficiaries (SLMB) are income eligible at or below 135% FPL. Benefits include payment of Medicare 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 Public Health Nurse (PHN)
  - Questions related to eligibility determination
  - Questions related to the type of services authorized by MCH.

Maternal & Child Health
6101 N. Yellowstone Rd., Ste. 420
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 assure coordination of referrals and services.

5.4 Eligibility Determination

5.4.1 Applying for Medicaid

- Persons applying for Children, Pregnant Women and/or Family MAGI Adult programs may complete the Application for Wyoming's Healthcare Coverage, which is also used for the Kid Care CHIP program. The application may be

mailed to the Wyoming Department of Health (WDH). Applicants may also apply online at https://www.wesystem.wyo.gov/ or by 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 Administration (SSA) (2.1, Quick Reference).

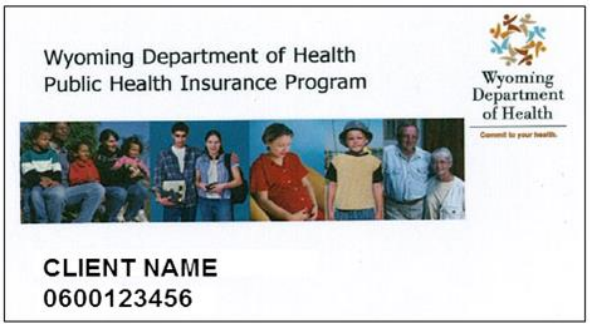
Medicaid assumes no financial responsibility for services rendered prior to the effective date of client eligibility as determined by the WDH or the SSA. However, the effective date of eligibility as determined by the WDH may be retroactive up to 90-days prior to the month in which the application is 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 timely filing deadline for Medicaid claims (6.20, Timely Filing). This situation could arise for the following reasons:

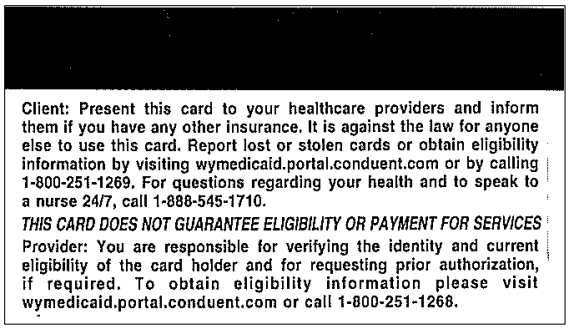
- Administrative Law Judge decisions or reversals.
- Delays encountered in processing applications or receiving necessary client information concerning income or resources.

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), Children's Special Health (CSH), and Prescription Drug Assistance Program (PDAP). 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.

Sample Medicaid ID 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 a Medicaid Approval Notice in lieu of the client's Medicaid ID Card. Providers should always verify eligibility before rendering services 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

As of July 1, 2015 Wyoming Medicaid requires all providers to submit electronically. There are two (2) exceptions to this requirement:

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

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

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

Mail to:

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

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

6.2 Basic 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 will affect the accuracy in which the claim is processed through OCR. The following is a list of tips to aid providers in avoiding paper 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 the 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).

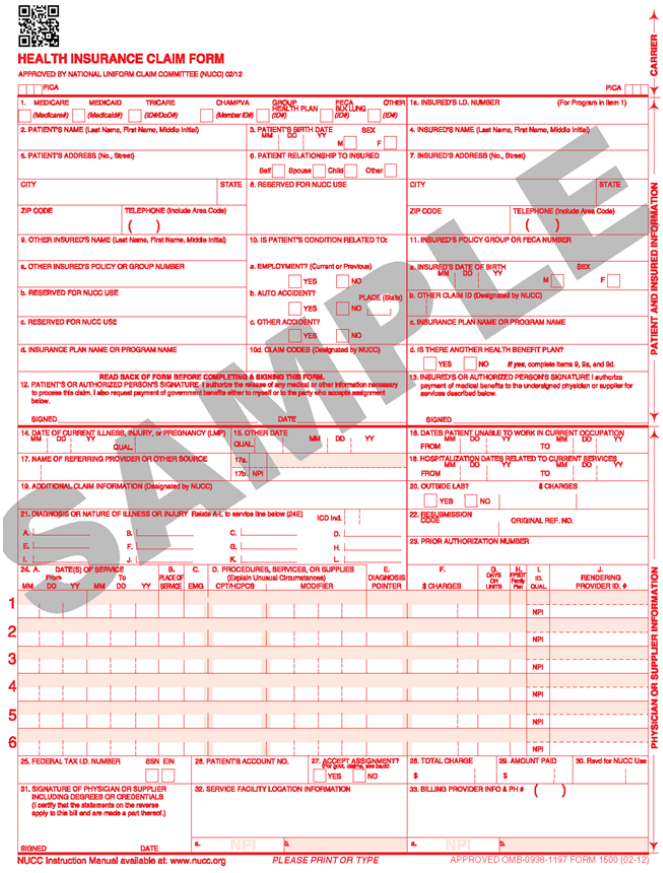
NOTE: Claims are to be submitted only after service(s) have been rendered, not before. For deliverable items (i.e. dentures, DME, glasses, hearing aids, etc.) the date of service must be the date of delivery, not the order date.

6.3 Authorized Signatures

All paper claims must be signed by the provider or the provider's 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 Completing the CMS-1500 Claim Form



6.4.1 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 client’s 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.

Claim Item	Title	Required	Conditionally Required	Action/Description
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			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.
Instructions 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.
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.

Claim Item	Title	Required	Conditionally Required	Action/Description
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.
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.

Claim Item	Title	Required	Conditionally Required	Action/Description
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 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.
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.

Claim Item	Title	Required	Conditionally Required	Action/Description
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 9, 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).
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.

Claim Item	Title	Required	Conditionally Required	Action/Description
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 supplier's 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.

6.4.2 Place of Service

Place of Service	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (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.

Place of Service	Place of Service Name	Place of Service Description
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.
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, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

Place of Service	Place of Service Name	Place of Service Description
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.
24	Ambulatory Surgical Center	A free standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born 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

Place of Service	Place of Service Name	Place of Service Description
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.
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.

Place of Service	Place of Service Name	Place of Service Description
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
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.

Place of Service	Place of Service Name	Place of Service Description
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 that 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.

6.5 Medicare Crossovers

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

6.5.1 General Information

- Dually eligible clients are clients that are eligible for Medicare and Medicaid.
- Providers may verify Medicare and Medicaid eligibility through the IVR (2.1, Quick Reference).
- Providers must accept assignment of claims for dually eligible clients.
- Be sure Wyoming Medicaid has record of all applicable NPIs under which the provider is submitting to Medicare to facilitate the electronic crossover process.
- Medicaid reimburses the lesser of the assigned coinsurance and deductible amounts or the difference between the Medicaid allowable and the Medicare paid amount for dually eligible clients as indicated on the Medicare (Explanation of Medicare Benefits) EOMB.

- Wyoming Medicaid's payment is payment in full. The client is not responsible for any amount left over, even if assigned to coinsurance or deductible by Medicare.

6.5.2 Billing Information

- Medicare is primary to Medicaid and must be billed first. Direct Medicare claims processing questions to the Medicare carrier.
- When posting the Medicare payment, the EOMB (Explanation of Medicare Benefits) 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 from the date of service or six (6) months 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 or Medicaid and Medicare Coverage

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0600XXXXXX

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

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 1976 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 THIS STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

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

CITY: THIS TOWN STATE:

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 82009 TELEPHONE (Include Area Code): (307)555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

c. OTHER ACCIDENT? YES [ ] NO [ ]

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: DATE:

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

SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 30 2015 QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JOHN SMITH MD

17a.

17b. NPI: 1234567890

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 [X] $ CHARGES

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

A. Z00.121 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										ZZ	208000000X
10 01 15		24		99381		A	100 00	1		NPI	1234444444
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 000000000 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 200345

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

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 100 00

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

JOHN DOE MD 10/6/15

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

THIS TOWN MEDICAL OFFICE
123 MEDICAL DRIVE
THIS TOWN, WY 82009

a. 1234555555 b. ZZ261QA1903X

33. BILLING PROVIDER INFO & PH # ( )

THE PEDIATRIC OFFICE
456 PROVIDER DRIVE
THIS TOWN, WY 82003

a. 12345666666 b. ZZ 208000000X

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

6.6.2 Client has Medicaid and Third Party Liability (TPL) or Client has Medicaid, Medicare and TPL

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0600XXXXXX

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

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 1976 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 THIS STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

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

CITY: THIS TOWN STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 82009 TELEPHONE (Include Area Code): (307)555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 1313133

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: INSURANCE COMPANY

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 30 2015 QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JOHN SMITH MD

17a.

17b. NPI 1234567890

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 [X] $ CHARGES

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

A. Z00.121 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
									ZZ	208000000X
10 01 15	24		99381		A	100 00	1		NPI	1234444444
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 000000000 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 200345

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

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 100 00

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

JOHN DOE MD 10/6/15

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

THIS TOWN MEDICAL OFFICE
123 MEDICAL DRIVE
THIS TOWN, WY 82009

a. 1234555555 b. ZZ261QA1903X

33. BILLING PROVIDER INFO & PH # ( )

THE PEDIATRIC OFFICE
456 PROVIDER DRIVE
THIS TOWN, WY 82003

a. 12345666666 b. ZZ 208000000X

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

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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

6.7 National Drug Code (NDC) Billing Requirement

Effective for dates of service on and after March 1, 2008 Medicaid will require providers to include National Drug Codes (NDCs) on professional and institutional claims when certain drug-related procedure codes are billed. This policy is mandated by the Federal Deficit Reduction Act (DRA) of 2005, which requires state Medicaid programs to collect rebates from drug manufacturers when their products are administered in an office, clinic, hospital or other outpatient setting.

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

6 5 2 9 3 - 0 0 0 1 - 0 1

Labeler Code (5 Digits) | Product Code (4 Digits) | Package Code (2 Digits)

- **Labeler Code** – Five (5) digit number assigned by the Food and Drug Administration (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.

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

Many NDCs are displayed on drug products using a ten (10) digit format. However, to meet the requirements of the new policy, NDCs must be billed to Medicaid using the 11-digits FDA standard. Converting an NDC from ten (10) to 11-digits requires the strategic placement of a zero (0). The following table shows three (3) common ten (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	09999-9999-99 (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
99999-9999-9 (5-4-1)	60575-4112-1 Synagis 50mg vial	99999-9999-09 (5-4-2)	60575-4112-01

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

6.7.2 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.

6.7.3 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.

6.7.4 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
90378		2	60574-4111-01

6.7.5 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 150 mg of Synagis, a 50 mg vial and a 100 mg vial would be used. Although the vials have separate NDCs, the drug has one (1) procedure code, 90378. So, the procedure code would be reported twice on the claim, but paired with different NDCs.

Procedure Code	Modifier	Procedure Quantity	NDC
90378	KP	2	60574-4111-01
90378	KQ	1	60574-4112-01

On the first (1st) 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.

6.7.6 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.

6.7.7 CMS-1500 02-12 Billing Instructions

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

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

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

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

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

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

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

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 these guidelines will be returned unprocessed.

6.8 Service Thresholds

6.8.1 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
- Dietician visits
- Emergency dental visits

6.8.2 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
- Dietician visits
- Emergency dental visits
- Behavioral health visits

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

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

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, BEHAVIORAL HEALTH VISITS, CHIROPRACTIC VISITS AND DIETICIAN		
Codes	**Service Threshold**	**Does not apply to:**
Procedure codes: 90785; 90792; 90832-90834; 90836-90839; 90845-90849; 90853; 90857;92507-92508; 92526; 96101-96125; 97010-97039; 97110-97546, 97802-97804, 98940-98942; (all modalities on same date of service count as 1 visit) **HCPCS Level II codes:** G9012; H0004; H0031; H0038; H2010; H2014; H2017; H2019; T1017 (all modalities on same date of service count as 1 visit) **Revenue codes:** 0420,0421, 0422,0 424, 0430, 0431, 0432, 0434, 0439, 0440, 0441, 0442, 0444, and 0449 (each unit counts as 1 visit)	20 physical therapy visits per calendar year 20 occupational therapy visits per calendar year 20 speech therapy visits per calendar year 20 behavioral health visits per calendar year (21 and over only) 20 chiropractic visits per calendar year 20 dietician visits per calendar year	• Medicare Paid Crossovers • Inpatient and ER behavioral health services

6.8.3 Authorization of Medical Necessity

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 requested for the following services:

- Office/outpatient hospital visits
- Dietician visits
- Chiropractic visits

Requests can be made by:

- Physicians
- Nurse practitioner

- Chiropractors
- Dieticians

Authorizations of Medical Necessity must be submitted on the Authorization of Medical Necessity form and cite specific medical necessity. Below is the Authorization of Medical Necessity form (6.8.3.1 Authorization of Medical Necessity Request Form).

The form must be mailed to:

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

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

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

6.8.3.1 Authorization of Medical Necessity Request Form

Wyoming Department of Health

Authorization of Medical Necessity – Clients Age 21 and Older

Pay to (Group) NPI:		Pay to (Group) Name:	
Taxonomy Code:		Contact Email:	
Treating/Rendering NPI:		Treating/Rendering Name:	
Client ID:	Client Name:		Client Age/DOB:
Authorization of Medical Necessity Year:	Begin Date:	End Date:	Frequency:
Services Type (check box): Behavioral Health Chiropractic Services Dietician Services Occupational Therapy Office Visits Physical Therapy Speech Therapy			
Date of Onset Condition:		Diagnosis code (up to 4):	
Ordering Provider Name & NPI (required for Speech, Occupational or Physical Therapy):			
Describe injury, illness, surgery or triggering event that initiated the need for services:			
Describe acute condition requiring **rehabilitative or medically necessary services**. Include progress to date to include treatment methods, goals and progress, and dates of treatment (For Behavioral Health services, you must attach the last 5 Progress Reports and treatment plan):			
Describe anticipated rehabilitative progress and length of additional treatment (For Physical, Occupational, or Speech therapy services, you must attach a copy of the practitioner's order):			

In signing 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.

Treating Provider Signature:_____Date_____

Wyoming Medicaid
Attn: Medical Policy
PO Box 667
Cheyenne, WY 82003-0667
Fax: 307-772-8405 Revised 6/27/17

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

6.8.3.2 Authorization of Medical Necessity Request Form Instructions

Field	Action
Pay to (Group) NPI	Complete with the ten digit NPI number for the Pay to/Group Provider
Pay to (Group) Name	Complete with the name of the Pay to/Group Provider
Taxonomy	Enter the taxonomy code for the Pay to/Group Provider
Contact Email	Complete with the contact email for the provider
Treating/Rendering NPI	Complete with the ten digit NPI number for the treating provider
Treating/Rendering Name	Complete with the name of the treating provider
Client ID	Complete with the client's Wyoming Medicaid ID number
Client Name	Complete with the client's full name
Client Age/DOB	Complete with the client's age at the time of the request and the date of birth
Authorization of Medical Necessity Year	Complete with the requested calendar year for the authorization of medical necessity
Authorization of Medical Necessity Begin/End Date	Complete with the dates the authorization of medical necessity will need to begin and when it will end
Frequency	Complete with the frequency of services needed (i.e. 3x/week)
Services Type	Check the appropriate box for which type services you are requesting
Date of Onset Condition	Complete with the date the onset condition began
Diagnosis Code	Complete with the diagnosis codes – up to four are allowed
Ordering Provider Name & NPI	Complete with the Name and NPI number for the ordering provider – this section is required for Speech, Occupational or Physical Therapy
Describe injury, illness, surgery or triggering event that initiated the need for services	Complete with what caused the acute condition (i.e. post-surgery, personal injury, auto accident, etc.)
Describe acute condition requiring rehabilitative services	A detailed explanation as to the diagnosis and rehabilitative need for services for acute conditions only. Indicate why the client has exceeded their threshold limit. For Behavioral Health services, ensure to include last

	5 progress reports and treatment plan.
Describe anticipated rehabilitative progress and length of additional treatment	Describe the rehabilitative progress anticipated and the length needed for additional treatment. For physical, occupational, or speech therapy services, ensure you attach a copy of the practitioner's order.
Treating provider signature and date	The provider providing the services will need to sign and date the Authorization of Medical Necessity Form

6.8.3.3 Authorization of Medical Necessity Additional Information for Clients Under the Age of 21

In addition to the completion of the Authorization of Medical Necessity Request Form, the Additional Information sheet must be completed for clients under the age of 21.

Wyoming Department of Health
Commit to your health.

Authorization of Medical Necessity – PT/OT/ST FOR CLIENTS UNDER 21

*****If the client is on an IEP, request must include pages from the IEP related to the type of therapy this request is for*****

For children who are school age:

1. Is this child on an IEP? ☐ Yes ☐ No
2. What services is the child receiving through the school system under the IEP?

3. How are the services you are providing distinct from the services being provided through the school system, and how are you avoiding conflict with the services being provided by the school system?

Revised 6/12/17

Wyoming Department of Health
Commit to your health.

For kids who are younger than school age:

1. Has this child been evaluated at a Child Developmental Center? ☐ Yes ☐ No
2. What services is this child receiving through the Child Developmental Center?

3. How are the services you are providing distinct from the services being provided through the Child Developmental Center, and how are you avoiding conflict with the services being provided through the CDC?

Revised 6/12/17

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

6.8.3.4 Authorization of Medical Necessity Additional Information Instructions

Authorization of Medical Necessity Additional Information For Children who are school age:	
Field	Action
Is this child on IEP?	Indicate whether or not the child is on an Individualized Education Program (IEP)

What services is the child receiving through school system?	Describe the services the child is receiving through the school system under the IEP
How are the services you are provider distinct from the services being provided through the school system and how are you avoiding conflict with the services being provided?	Describe how the services you are providing to the client are different from the services that are being provided through the school system and how you are avoiding conflict with those services
For kids who are younger than school age	
Has this child been evaluated at a Child Development Center?	Indicate whether or not this child has been evaluated at a Child Development Center (CDC)
What services is the child receiving through the CDC?	Describe the services the child is receiving through the Child Development Center
How are the services you are providing distinct from the services being provided through the CDC and how are you avoiding conflict with the services being provided?	Describe the services you are providing and how they are distinct from the services that are being provided through the Child Development Center and how you are avoiding conflict with those services being provided through the CDC

6.8.4 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 Qualis Health (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
- Psychiatrist
- 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 center
- Substance abuse treatment center

6.9 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
- RBRVS (Resource Based Relative Value Scale)

6.10 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.

6.10.1 Invoice Charges

- Invoice must be dated within 12-months 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.)

6.11 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: • Clients under age 21 • Nursing Facility Residents • Pregnant Women • Family planning services • Emergency services • Hospice services • Medicare Crossovers • Members of a Federally recognized tribe
99341 -99350	Home Visits	
92002, 92004, 92014	Eye Examinations	
90804 – 90815	Medical psychotherapy – co-payment only applies when the place of service code is 11	

6.12 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.

6.13 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)	Contact case manager Case manager will contact the DHCF	• Assisted Living Facility (ALF) Waiver • Long Term Care (LTC) Waiver • Out-of-State Home Health • Out-of-State Placement for LTC Facilities
Dental Services	(888)863-5806 Reference Dental Manual for details	• Malocclusion (PA) • Implants & fixed bridges (PA) • Maxillofacial Surgeries (PA)
Behavioral Health Division	Contact case manager Case manager will contact the Behavioral Health Division	• Acquired Brain Injury (ABI) Waiver Services • Developmentally Disabled Adult Waiver Services • Developmentally Disabled Children Waiver Services
Change Healthcare	(877)207-1126	• Pharmacy
Magellan	(855)883-8740	• Children's Mental Health Waiver Services
Medical Policy	(800)251-1268 Option 1, 1, 4, 3	• Hospice Services: Limited to clients residing in a nursing home • Surgeries Requiring PA (not listed in this table) • Tysabri IV Infusion Treatment • Ocrelizumab (Ocrevus) • Contact Lenses • Certain Eyeglass Lenses • Scleral Cover Shell
Qualis Health (DMEPOS)	(800)783-8606	• Durable Medical Equipment (DME) • Prosthetic and Orthotic Supplies (POS) • Home Health • PT/OT/ST/BH once threshold has been met

Agency Name	Phone	Services Requiring PA
WYhealth (Utilization and Care Management)	(888)545-1710	• Acute Psych • Extended Psych • Extraordinary Care • Gastric Bypass • Inpatient Rehabilitation • PRTF – Psychiatric Residential Treatment Facility • Transplants • Vagus Nerve Stimulator

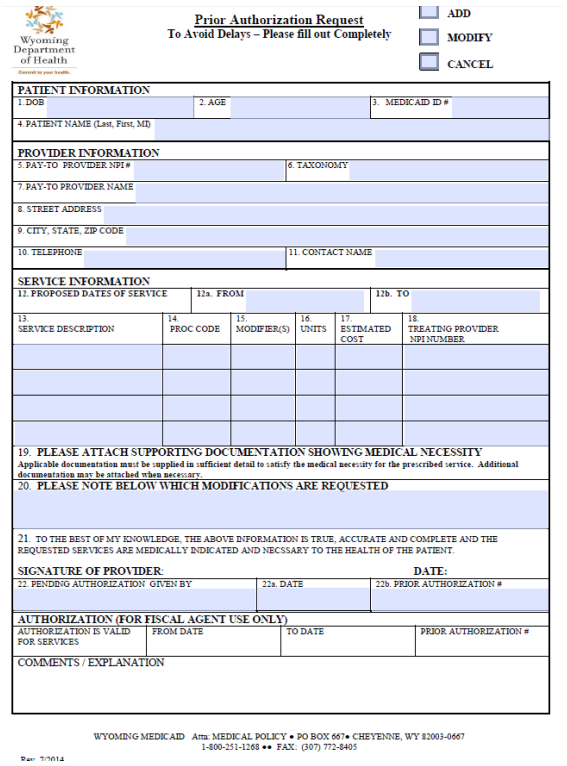
6.13.1 Requesting Prior Authorization from Medical Policy

This section only applies to providers requesting PA for out-of-state Home Health, 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 (6.13.1.2, Medicaid Prior Authorization Form). A hardcopy form for requesting a PA by mail or fax. For a copy of the form and instructions on how to complete it, refer to the following section.
- X12N 278 Prior Authorization Request and Response. A standard electronic file format used to transmit PA requests and receive responses. For additional information, refer to Chapter 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications; 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 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications.

6.13.1.1 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 NECSSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PROVIDER: **DATE:**

22. PENDING AUTHORIZATION GIVEN BY	22a. DATE	22b. PRIOR AUTHORIZATION #

AUTHORIZATION (FOR FISCAL AGENT USE ONLY)

AUTHORIZATION IS VALID FOR SERVICES	FROM DATE	TO DATE	PRIOR AUTHORIZATION #

COMMENTS / EXPLANATION

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

Rev. 7/2014

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

6.13.1.2 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 NPI Numbers.**
6*	**Pay To Provider Taxonomy**	**Enter the Pay To Provider Taxonomy.**
7*	**Pay To Provider Name**	**Enter the Pay To Provider Name.**

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**
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 to the best of the providers ability, what dates of service the provider is looking for. 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 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.**
16*	**Unit(s)**	**Enter number of each service requested.**
17*	**Estimated Cost**	**Enter dollar amount times the unit(s) for each service 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	This is the entry of changes that are needed by the provider from the original 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 must match the lines on the claim that are being billed.

6.13.2 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 (6.13, Prior Authorization).

6.13.2.1 Prior Authorization Approval

Once a PA is approved, an approval letter (sample approval letter below) is mailed that includes the PA number. The 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 http://www.wpc-edi.com.

6.13.2.2 Sample PA Approval Letter

Wyoming Department of Health
Commit to your health.

02/26/15
SAMPLE PROVIDER OF WYOMING
LTC WAIVER SERVICES
1234 SAMPLE STREET
SAMPLE WY 82001

MEDICAID PRIOR
AUTHORIZATION NOTICE

Client : SAMPLE CLIENT
Client ID: 0000062141

PA-NUMBER 0012900194

Waiver Case Manager :

PRIOR AUTHORIZATION APPROVAL DOES NOT GUARANTEE ELIGIBILITY

The prior authorization request submitted on behalf of Sample Client has been determined as follows:

01/01/15-01/31/15 T2041 – SUPPORTS BROKERAGE, SELF DIRECTED, 12 MIN APPROVED
APPR UNITS: 300 UNIT PRICE $ 3.32 USED UNITS: 202

02/01/15-02/28/15 T2041 – SUPPORTS BROKERAGE, SELF DRIECTED, 15 MIN APPROVED
APPR UNITS: 300 UNIT PRICE $ 3.32 USED UNITS: 0

CODE EXPLANATIONS:

NO DENIAL REASON PROVIDED

COMMENT:

A8200RB1

NOTE: PRIOR AUTHORIZATION APPROVAL DOES NOT GUARANTEE ELIGIBILITY. PAYMENT IS SUBJECT TO THE CLIENT'S ELIGIBILITY AND MEDICAID BENEFIT LIMITATIONS. VERIFY ELIGIBILITY BEFORE RENDERING SERVICES

PA-NUMBER 0012900194
A8200RB1

NOTE: For lines that are approved, the corresponding item may be purchased or delivered, or service may be rendered.

6.13.2.3 Prior Authorization Denial

If a PA request is denied, the provider may request reconsideration to the appropriate agency. This request must be in accordance with Medicaid rules.

6.13.2.4 Sample Prior Authorization Denial Letter

Wyoming Department of Health
Commit to your health.

01/19/15 MEDICAID PRIOR AUTHORIZATION NOTICE

SAMPLE PROVIDER OF WYOMING
1234 SAMPLE STREET
SAMPLE WY 82001

Client: SAMPLE CLIENT
Client ID: 0000062141

PA-Number: 00198000001

PRIOR AUTHORIZATION APPROVAL DOES NOT GUARANTEE ELIGIBILITY

The prior authorization request submitted on behalf of Sample Client has been determined as follows:

01/18/10-01/18/11 V2715 – PRISM, PER LENS DENIED
APPR UNITS: 0 USED UNITS: 0

CODE EXPLANATIONS:

800 SERVICE NOT COVERED BY WYOMING MEDICAID

COMMENT:

DOES NOT FALL WITHIN AGE GUIDELINES FOR PROC CODE

NOTE: PRIOR AUTHORIZATION APPROVAL DOES NOT GUARANTEE ELIGIBILITY. PAYMENT IS SUBJECT TO THE CLIENT'S ELIGIBILITY AND MEDICAID BENEFIT LIMITATIONS. VERIFY ELIGIBILITY BEFORE RENDERING SERVICES.

PA-Number: 00198000001
A1500RB2

NOTE: For lines that are denied, additional information may be needed before the item or service can be reconsidered for approval. It is imperative this information be supplied to the appropriate agency.

6.13.2.5 Prior Authorization Pending

If a PA request is in a pending status, it was likely the result of an emergency request made over the phone to Medical Policy. A claim cannot be billed using a PA number from a pending request (2.1, Quick Reference).

6.13.2.6 Sample Prior Authorization Pending

Wyoming Department of Health
Commit to your health.

10/01/15 MEDICAID PRIOR AUTHORIZATION NOTICE

SAMPLE PROVIDER OF WYOMING
1234 SAMPLE STREET
SAMPLE WY 82001

Client: SAMPLE CLIENT
Client ID: 0000062141

*** PRIOR AUTHORIZATION APPROVAL DOES NOT GUARANTEE ELIGIBILITY***

The prior authorization request submitted on behalf of SAMPLE CLIENT has been determined as follows:

01/18/15-01/18/16 V2715 – PRISM, PER LENS PENDING
APPR UNITS: 2 UNIT PRICE:$ 9.32 USED UNITS: 0

CODE EXPLANATIONS:

NO DENIAL REASON PROVIDED

COMMENT:

RECEIVED GLASSES LESS THAN A YEAR AGO
NEED DOCUMENTATION SAYING WILL REUSE OLD FRAMES

NOTE: PRIOR AUTHORIZATION APPROVAL DOES NOT GUARANTEE ELIGIBILITY. PAYMENT IS SUBJECT TO THE RECIPIENT'S ELIGIBILITY AND MEDICAID BENEFIT LIMITATIONS. VERIFY ELIGIBILITY BEFORE RENDERING SERVICES.

PA-Number: 00198000002
A1500RB2

6.14 Order vs Delivery Date

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" (link to form below)
- Complete the form and fax or mail the form 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 clinical records is performed, and it is found that the provider billed on the order date but does not have a signed "Order vs Delivery Date Exception Form" for the client and the DOS, the money paid will be recovered.

6.14.1 Order vs Delivery Date Exception Form

Wyoming Department of Health

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

Thomas O. Forslund, Director

Governor Matthew H. Mead

ORDER VS DELIVERY DATE BILLING ATTESTATION FORM

PROVIDER NAME: _____ NPI: _____

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 FAXED OR MAILED TO THE ADDRESS BELOW. DO NOT BILL ON THE ORDER DATE UNTIL YOU HAVE RECEIVED AN APPROVED FORM BACK FROM MEDICAID.

Division of Healthcare Financing, Medicaid • 6101 Yellowstone Road, Suite 210
Cheyenne WY 82002 • WEB Page: http://wdh.state.wy.us/healthcarefin/index.html
Toll Free: 1-866-571-0944•FAX (307) 777-6964 • **(307) 777-7531**

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

6.15 Submitting Attachments for Electronic Claims

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

- Steps for submitting electronic attachments:
  1. The fiscal agent has created a process that allows providers to submit electronic attachments for electronic claims. Providers need only follow these steps:

- 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 http://www.wpc-edi.com.
- Log onto Secured Provider Web Portal.
- Under the submissions menu select Electronic Attachments.
- 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 electronic file (with no spaces).
- Select Browse
- Navigate to the location of the electronic attachment on the provider's computer.
- Click Upload.
- For support and additional information refer to Chapter 8 and Chapter 9 or contact EDI Services (2.1, Quick Reference).

NOTE: One (1) attachment per claim, providers may not attach one (1) document to many claims. Also, 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
  1. 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:
     - 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 http://www.wpc-edi.com.The data entered on the form must match the claim exactly in DOS, client information, provider information, etc.
     - Complete Attachment Cover Sheet (6.15.1, Attachment Cover Sheet) and mail it with the attachment to Claims (2.1, Quick Reference).

NOTE: Both steps must be followed; otherwise, the fiscal agent will not be able to join the electronic claim and paper attachment, and the claim will deny. Also, if the paper attachment is not received within 30-days of the

electronic claim submission, the claim will deny and it will be necessary to resubmit it with the proper attachment.

6.15.1 Attachment Cover Sheet

Attachment Cover Sheet

Please use this form when submitting a claim electronically which requires attachments. The supporting documentation (EOB, medical records, etc.) must be attached to this cover sheet. If the documentation is received without a cover sheet the request CANNOT be processed and the documents will be shredded.

All information entered on this cover sheet must match the data entered in the 837 claim transaction, including the Attachment Type and Attachment Control Number. Also, the Attachment Transmission Code in the 837 claim transaction must be set to 'BM' (By Mail) to indicate the attachment is being sent separately.

Pay-to Provider Name:

Pay-to Provider or NPI Number:

Client Name:

Medicaid ID Number:

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

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

Attachment Control Number: (Required)

Must include no spaces and match the 837 file exactly

TCN: (Required)

Attachment Type: (Required)

- AS: Admission Summary
- B2: Prescription
- B3: Physician Order
- B4: Referral Order
- CT: Certification
- CK: Consent Form(s)
- DA: Dental Models
- DG: Diagnostic Report
- DS: Discharge Summary
- EB: Explanation of Benefits
- MT: Models
- NN: Nursing Notes
- OB: Operative Notes
- OZ: Support Date for Claim
- PN: Physical Therapy Notes
- PO: Prosthetics or Orthotic Certification
- PZ: Physical Therapy certification
- RB: Radiology Films
- RR: Radiology Reports
- RT: Report of Tests and Analysis Report

RETURN THIS DOCUMENT WITH ATTACHMENTS TO:
Wyoming Medicaid
Attn: Claims
PO Box 547
Cheyenne, WY 82003-0547

NOTE: Click 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

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

CONSENT TO STERILIZATION

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

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

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

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

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

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

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

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

I have received a copy of this form.

_____ Date: _____
Signature Month Day Year

You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)

__American Indian or Alaska Native __Black (not of Hispanic origin)

__Asian or Pacific Islander __Hispanic

__White (not of Hispanic origin)

INTERPRETER'S STATEMENT

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

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

_____ _____
Signature of Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

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

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

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

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

_____ _____
Signature of person obtaining consent Date

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized) on _____, (date of sterilization operation) I explained to him/her the nature of the sterilization operation _____, (specify type of operation) the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

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

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

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

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

_____ _____
Physician Date

HCF-01

NOTE: Click 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” 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)

Section	Field #	Action
	3	Enter the client's date of birth (MM/DD/YY). Client must be at least 21 years
	4	Enter the client's name
	5	Enter the name of the physician performing the surgery
	6	Enter the name of the type of operation (no abbreviations)
	7	The client to be sterilized signs here
	8	The client dates signature here
	9	Check one (1) box appropriate for client. This item is requested but NOT required.
Interpreter's Statement	10	Enter the name of the language the information was translated to
	11	Interpreter signs here
	12	Interpreter dates signature here
Statement of person obtaining consent	13	Enter clients name
Statement of person obtaining consent Physician's Statement	14	Enter the name of the operation (no abbreviations)
	15	The person obtaining consent from the client signs here
	16	The person obtaining consent from the client dates signature here
	17	The person obtaining consent from the client enters the name of the facility where the person obtaining consent is employed. The facility name must be completely spelled out (no abbreviations)
	18	The person obtaining consent from the client enters the complete address of the facility in #17 above. Address must be complete, including state and zip code
	19	Enter the client's name
Physician's Statement	20	Enter the date of sterilization operation
	21	Enter type of operation (no abbreviations)
	22	Check applicable box: • If premature delivery is checked, the provider must write in the expected date of delivery here. • 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: Instructions for attaching documents to claims refer to Section 6.15.

6.16.2.1 Hysterectomy Acknowledgment 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 image above to be taken to a printable version of this form.

6.16.2.2 Instructions for Completing the Hysterectomy Acknowledgment of Consent Form

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

		description.
	11	• The physician who performed the hysterectomy signs here and dates.

6.16.3 Abortion Certification Guidelines

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

6.16.3.1 Abortion Certification Form

ABORTION CERTIFICATION FORM

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

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

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

   ☐ (3) This pregnancy is the result of a sexual assault as defined in Wyoming Statute W.S. 6-2-301 and the client was unable, for physical or psychological reasons, to comply with the reporting requirements: or

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

3. Patient Name:_____

4. Address:_____

   _____

5. Physician Signature:_____Date_____

6. Address:_____

   _____

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

6.16.3.2 Instructions for Completing the Abortion Certification Form

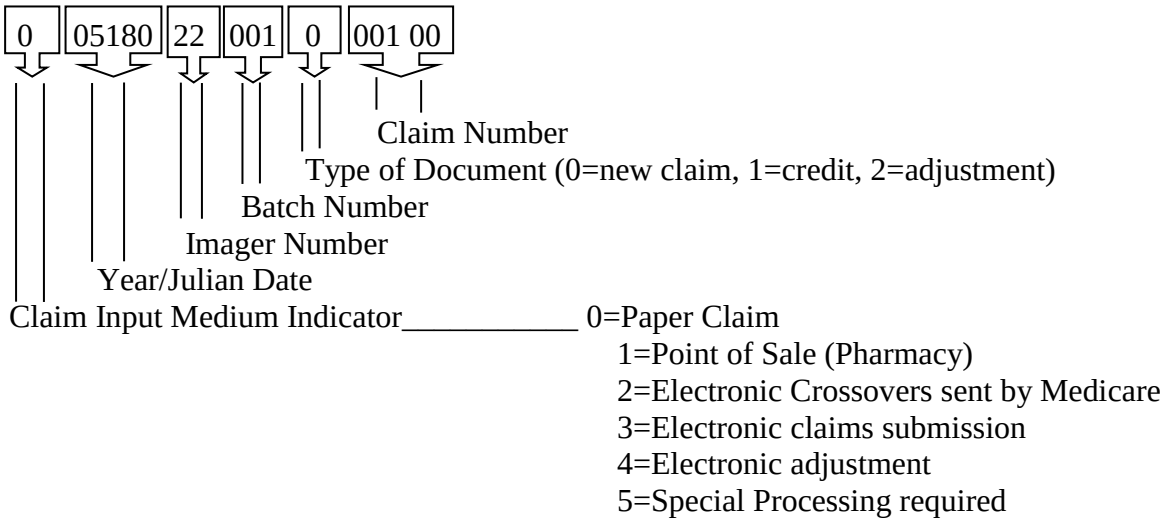
Field #	Action
1	Enter the name of the attending physician or surgeon.
2	Check the option (1, 2, 3 or 4) that is appropriate
3	Enter the name of the client receiving the surgery
4	Enter the client's address
5	The physician or surgeon performing the abortion will sign and date here.
6	Enter the performing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

6.17 Remittance Advice

After claims have been processed weekly, Medicaid distributes a Medicaid proprietary Remittance Advice (RA) to providers. The Remittance Advice (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. Providers receiving manual checks will receive their check and RA in the same mailing.

The RA is organized in the following manner:

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



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

6.17.1 Sample Professional Remittance Advice

```
                                                WYOMING DEPARTMENT OF HEALTH
                                        MEDICAID MANAGEMENT INFORMATION SYSTEM                    RUN DATE  00/00/00

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

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

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 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

6.17.3 Remittance Advice Replacement Request Policy

If you are unable to obtain a copy from the web portal, a paper copy may be requested as follows:

To request a printed replacement copy of a Remittance Advice, complete the following steps:

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

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

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

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

6.17.3.1 Remittance Advice (RA) Replacement Request Form

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

Provider Name (as enrolled with Wyoming Medicaid): _____

Provider NPI: _____ Provider Taxonomy: _____

OR

Wyoming Medicaid Provider ID: _____

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

To request a complete RA:

RA Number: _____

RA Date: _____

RA Amount: _____

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

Specific Claim TCN: _____

Specific Claim Client ID and Date of Service: _____

Delivery Method (select one):

__ Email Address (preferred): _____

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

__ Mailing Address: _____

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

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

Enclosed Check Info:
Total Amount: _____
Check Number: _____

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

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

6.17.4 Obtain an RA from the Web

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

6.17.5 When a Client Has Other Insurance

If the client has other insurance coverage reflected in Medicaid records, payment may be denied unless providers report the coverage on the claim. Medicaid is always the payor of last resort. For exceptions and additional information regarding Third Party Liability, refer to Chapter 7 of this manual. To assist providers in filing with the other carrier, the following information is provided on the RA directly below the denied claim:

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

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

6.18 Resubmitting Versus Adjusting Claims

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

Action	Description	Timely Filing Limitation
VOID	**Claim has paid**; however, the provider would like to completely cancel the claim as if it was never billed.	May be completed any time after the claim has been paid.
ADJUST	**Claim has paid, even if paid $0.00**; however, the provider would like to make a correction or change to this paid claim	Must be completed within six (6) months 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 from the date of service.

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

The deadlines for resubmitting and adjusting claims are different:

- Providers may resubmit any denied claim or line within 12-months of the date of service.
- Providers may adjust any paid claim within six (6) months 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 maybe notified in writing, in most cases, the over-payment will be deducted from future payments. Refund checks are not encouraged. Refund checks are not reflected on the Remittance Advice. However, deductions from future payments are reflected on the Remittance Advice, providing a hardcopy record of the repayment.

6.18.2 Resubmitting a Claim

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

How to Resubmit:

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

6.18.2.1 When to Resubmit to Medicaid

- Claim Denied. Providers may resubmit to Medicaid when the entire claim has been denied, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the explanation of benefits (EOB) code on the RA/835 transaction, make the appropriate corrections, and resubmit the claim.
- Paid Claim With One (1) or More Line(s) Denied. – Providers may submit 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 Adjustment/Void Request Form Electronically Adjusting Paid Claims via Hardcopy/Paper

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).

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.

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 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 debit.

6.18.3.1 Adjustment/Void Request Form

Adjustment/void Request Form

EXHIBIT 6.9

ADJUSTMENT/VOID REQUEST FORM

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

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

DO NOT USE HIGHLIGHTER

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

Complete Sections B and C.
If attaching a check, the check should be payable to **Division of Healthcare Financing (DHCF).**

☐ **2) CANCELLATION OF THE ENTIRE REMITTANCE ADVICE.** Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances.

Complete Section C only.
Attach RA. If manual check attach the check from the DHCF or if EFT make check payable to the DHCF for the entire remit amount.

SECTION B

TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:

1. 17-DIGIT TCN:
2. PAYMENT DATE:
3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER:
4. PROVIDER NAME:
5. 10-DIGIT CLIENT NUMBER:
6. 10-DIGIT PA NUMBER:
7. REASON FOR ADJUSTMENT OR VOID:

SECTION C: SIGNATURE AND DATE REQUIRED

PROVIDER SIGNATURE:_____ DATE: _____

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

REMARKS/STATUS:

(FOR INTERNAL USE ONLY)

CASH CONTROL NUMBER: _____

ADJUSTED BY: _____ DATE: _____

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

6.18.3.2 How to Request an Adjustment/Void

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

- An adjustment/void can only be processed if the claim has been paid by Medicaid.
- Medicaid must receive individual claim adjustment requests within six (6) months 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 one 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.

6.18.3.3 How to Complete the Adjustment/Void Request Form

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

Adjusting a claim electronically via an 837 transaction.

Wyoming Medicaid accepts claim adjustments electronically, refer to Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications, for complete details.

6.18.3.4 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 payor, the provider must adjust the paid claim to reflect the TPL amount paid.
    - If an adjustment is submitted stating that TPL paid on the claim, but the TPL paid amount is not indicated on the adjustment or an EOB is not sent in with the claim, Medicaid will list the TPL amount as either the billed or reimbursement amount from the adjusted claim (whichever is greater). It will be up to the provider to adjust again, with the corrected information.
- Attach a corrected claim showing the insurance payment and attach a copy of the insurance EOB if the payment is less than 40% of the total claim charge.
- For the complete policy regarding Third Party Liability refer to Chapter 7.

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

6.18.3.5 When to Request a Void

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

6.19 Credit Balances

A credit balance occurs when a provider's credits (take backs) exceed their debits (pay outs), 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 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 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 time period. Submit claims immediately after providing services so 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 Limit

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 of the date of service or within six (6) months 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 with in six (6) months 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 me attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be a SSI award notice or a notice from WDH.
Client is determined to be eligible due to agency corrective actions (retroactive eligibility)	Claims must be submitted within six (6) months 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 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 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 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 six (6) months of the date of determination of retroactive eligibility.

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

6.22 Client Fails to Notify a 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.

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 won't 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. Any telehealth provider such as Community Mental Health Centers and Substance Abuse Treatment Centers can bill telehealth services where the provider is at one location and the client is at a different location even though the pay to provider is the same. 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
- Client's Home (Telehealth consent form must be completed and kept in the client's medical records)

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. 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)
- 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 provider's practice or business in Wyoming and must not currently be excluded from participating in Medicaid by state or federal sanctions.

Hub Sites Billing Code(s) (site with provider)		
CPT-4 and HCPCS Level II Codes	**Modifier**	**Description**
99241-99255	GT	Consultations
99201-99215	GT	Office or other outpatient visits
90832-90838	GT	Psychotherapy
90791-90792	GT	Psychiatric diagnostic interview examination
96116	GT	Neurobehavioral status exam
90951,90952,90954,90955,90957,90958,90960 and 90961	GT	End stage renal disease related services
G0270	GT	Individual medical nutrition therapy
H0031, H2019, T1017, H0004, G9012	GT	Mental Health and Substance Abuse Treatment Services
92586, 92602, 92604, 92626	GT	Remote Cochlear Implant

Modifier	Description
GT	Telehealth Service

Spoke Site Billing Code (site with patient)	
HCPCS Level II Code	**Description**
Q3014	Telehealth originating site facility fee

For accurate listing of codes, refer to the fee schedule on the Medicaid website (2.1, Quick Reference).

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.

6.24.3 Billing Requirements

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

- Telehealth Consent form must be completed 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.
- 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.
- 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.
    - 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 isn't 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.

- 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.

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 Telehealth Consent Form

Wyoming Department of Health

Wyoming Medicaid Telehealth
Patient Consent Form

I (Client Name)_____agree to receive this health care service (type of service)_____, as a telehealth service. I understand that the health care provider (name)_____ is located in another location (facility name and address)_____. A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for six months for follow-up telehealth services with the health care provider.

I also understand that:

- I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care provider in-person if I decline telehealth service.
- If I decline the telehealth services, the other options/alternatives available to me, including in person services are as follows:

_____

_____

- The same confidentiality protections that apply to my other medical care also apply to the telehealth service.
- I will have access to all medical information resulting from the telehealth service as provided by law.
- The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- I will be information of all people who will be present at all sites during my telehealth service.
- I may exclude anyone from any site during my telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the telehealth service in an urgent need arises OR I will be told ahead of time that this is not available.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Patient:_____ Date_____

Or

Signature of Parent or Legal Representative:_____ Date_____

Telehealth Consent:
Signature of Person Obtaining Consent:_____ Date_____

Facility Name:_____

Facility Address:_____

Wyoming Medicaid
PO Box 667 Cheyenne, WY 82003
(800) 251.1268

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

6.24.5 Telehealth Consent Form Instructions

Beginning October 1, 2017 Wyoming Medicaid will allow the client's home to be a valid Origination site. Written client consent is required.

- Completion: The appropriate person at either the client's site or the health care practitioner site completes the form and obtains the client's signature prior to the services.
- Distribution: The original form is completed by the provider of the telehealth service and is retained in the client's medical record. A copy is also given to the client or parent/guardian.

Field	Action
Client Name	Enter the client's name
Type of Service	Define the service to be provided as a telehealth service on the second line
Provider Name	Enter the name of the health care practitioner who will be seeing the client from the distant site
Facility Name and Address	Enter the facility name and address of the distant site where the health care practitioner is located
Alternative Services	Describe in writing any other options that are available to the client
Signature and date	The client, parent or legal representative must sign and date the form
Signature of Person Obtaining Consent	Person obtaining consent must sign and date the form
Facility Name	Enter the Facility for the person obtaining consent
Facility Address	Enter the Facility address for the person obtaining consent

Chapter Seven – Third Party Liability

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7.1 Definition of a Third Party Liability

7.1.1 Third Party Liability (TPL)

TPL is defined as the right of the department to recover, on behalf of a client, from a third party payer the costs of Medicaid services furnished to the client (Wyoming Department of Health, Medicaid Rules, Chapter 1, Section 3 Part (b) subpart (ccxlviii)).

In simple terms, third party liability (TPL) is often referred to as other insurance, other health insurance, medical coverage, or other insurance coverage. Other insurance is considered a third-party resource for the client. Third-party resources may include but are not limited to:

- Health insurance (including Medicare)
- Vision coverage
- Dental coverage
- Casualty coverage resulting from an accidental injury or personal injury
- Payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more clients.

7.1.2 Third Party Payer

Third Party Payer is defined as a person, entity, agency, insurer, or government program that may be liable to pay, or that pays pursuant to a client's right of recovery arising from an illness, injury, or disability for which Medicaid funds were paid or are obligated to be paid on behalf of the client. Third party payers include, but are not limited to:

- Medicare
- Medicare Replacement (Advantage or Risk Plans)
- Medicare Supplemental Insurance
- Insurance Companies
- Other
    - Disability Insurance
    - Workers' Compensation
    - Spouse or parent who is obligated by law or by court order to pay all or part of such costs (absent parent)
    - Client's estate
    - Title 25

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

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

7.1.3 Medicare

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

7.1.4 Medicare Replacement Plans

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

7.1.5 Disability Insurance Payments

If the disability insurance carrier pays for health care items and services, the payments must be assigned to Wyoming Medicaid. The client may choose to receive a cash benefit. If the payments from the disability insurance carrier are related to a medical event that required submission of claims for payment, the reimbursement from the disability carrier is considered a third party payment. If the disability policy does not meet any of these, payments made to the Wyoming Medicaid client may be treated as income for Medicaid eligibility purposes.

7.1.6 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 the calculation of the client's patient contribution to the nursing facility.

7.1.7 Exceptions

The only exceptions to this policy are referenced below:

- Children's Special Health (CSH) – Medical claims are sent to Wyoming Medicaid's MMIS fiscal agent
- Indian Health Services (IHS) – 100% federally funded program

- Ryan White Foundation – 100% federally funded program
- Wyoming Division of Victim Services/Wyoming Crime Victim Compensation Program
- Policyholder is an absent parent
  - Upon billing Medicaid, providers are required to certify if a third party has been billed prior to submission. The provider must also certify that they have waited 30 days from the date of service before billing Medicaid and has not received payment from the third party
- Services are for preventative pediatric care (Early and Periodic Screening, Diagnosis, and Treatment/EPSDT), prenatal care.

NOTE: Inpatient labor and delivery services and post-partum care must be cost avoided or billed to the primary health insurance. See State Medicaid Manual Section 3904.3B – Prenatal and Preventative Pediatric Care. An internet search may be performed to locate this citation by performing an internet query of the State Medicaid Manual, select Chapter 3 and go to Section sm_3_3900_to_3910.15.

- The probable existence of third-party liability cannot be established at the time the claim is filed.
- Home and community based (HCBS) waiver services as most insurance companies do not cover these types of services.

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

7.2 Provider's Responsibilities

Providers have an obligation to investigate and report the existence of other third-party liability information. Providers play an integral and vital role as they have direct contact with the client. The contribution providers make to Medicaid in the TPL arena is significant. Their cooperation is essential to the functioning of the Medicaid Program and to ensuring prompt payment.

At the time of client intake, the provider must obtain Medicaid billing information from the client. At the same time, the provider should also ascertain if additional insurance resources exist. When a TPL/Medicare has been reported to the provider, these resources must be identified on the claim in order for claims to be processed properly. Other insurance information may be reported to Medicaid using the Third Party Resources Information Sheet. Claims should not be submitted prior to billing TPL/Medicare.

7.2.1 Third Party Resources Information Sheet

Third Party Resources Information Sheet

☐ NEW ☐ CHANGE

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

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

FISCAL AGENT USE ONLY

AUTHORIZED BY:_____ DATE:_____

INPUT BY:_____ DATE:_____

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

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

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

7.2.2 Provider is not enrolled with TPL Carrier

Medicaid will **no** longer accept a letter with a claim indicating that a provider does not participate with a specific health insurance company. The provider must work with the insurance company and/or client to have the claim submitted to the carrier. Providers cannot refuse to accept Medicaid clients who have other insurance if their

office does not bill other insurance. However, a provider may limit the number of Medicaid clients s/he is willing to admit into his/her practice. The provider may not discriminate in establishing a limit. If a provider chooses to opt-out of participation with a health insurance or governmental insurance, Medicaid will not pay for services covered by, but not billed to, the health insurance or governmental insurance.

7.2.3 Medicare Opt-Out

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

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

7.3 Billing Requirements

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

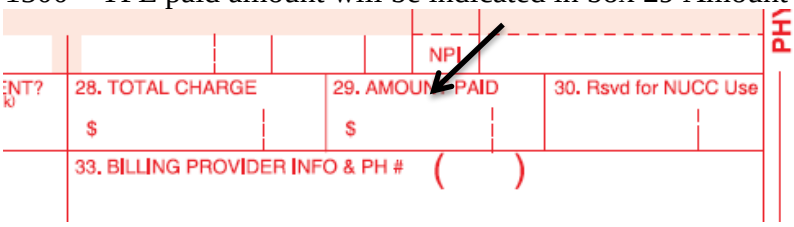
Medicaid will not pay for and will recover for payments made for services that could have been covered by the TPL/Medicare if the applicable rules of that plan had been followed. It is important that providers maintain adequate records of the third-party recovery efforts for a period of time not less 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 Medicare Services (CMS), the state Medicaid agency, or any designee.

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

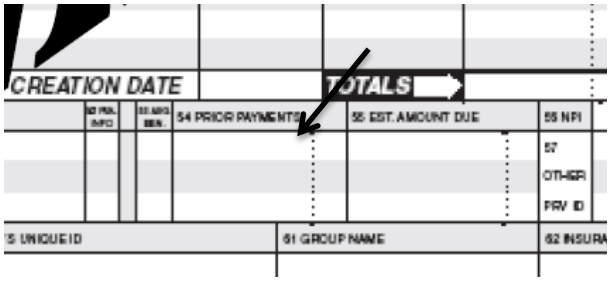
Once payment/denial is received by TPL/Medicare, the claim may then be billed to Medicaid as a secondary claim. If payment is received from the other payer, the provider should compare the amount received with Medicaid's maximum allowable fee for the same claim.

- If payment is less than Medicaid's allowed amount for the same claim, indicate the payment in the appropriate field on the claim form.

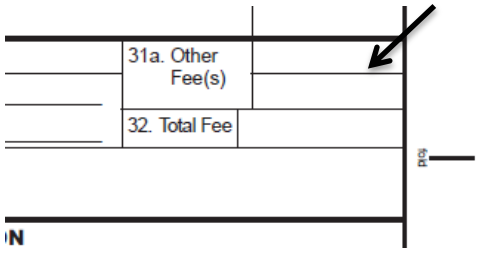
- CMS 1500 – TPL paid amount will be indicated in box 29 Amount Paid



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



- Dental – TPL/Medicare amount will be indicated in box 33A Other Fees



- If the TPL payer paid less than 40% of the total billed charges, include 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 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, 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 and 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 Address and Telephone 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.
- If the client receives reimbursement from the primary insurance, the provider must pursue payment form the patient. If there are any further Medicaid benefits allowed after the other insurance payment, the provider may still submit a claim for those benefits. The provider, on submission, must supply all necessary documentation of the other insurance payment. Medicaid will not pay the provider the amount paid by the other insurance.
- Providers may not charge Medicaid clients, or any other financially responsible relative or representative of that individual any amount in excess of the Medicaid paid amount. Medicaid payment is payment in full. There is no balance billing.

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

7.3.1 How TPL is applied

The amount paid to providers by primary insurance payers is often less than the original amount billed, for the following reasons:

Reductions resulting from a contractual agreement between the payer and the provider (contractual write-off); and,

Reductions reflecting patient responsibility (copayment, 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.(See the State Medicaid Manual Chapter 3, Section 3904.7 for more information.)

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

Example:

- Total claim billed to Medicaid is for $100.00, with a Medicaid allowable for the total claim of $50.00. TPL has paid $25.00 for only the second line of the claim. Claim will be processed as follows: Medicaid allowable ($50.00) minus the TPL paid amount ($25) = $25.00 Medicaid Payment.

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

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

7.3.1.1 Previous Attempts to Bill Services Letter

Wyoming Department of Health

Commit to your health.

July 13, 2015

Wyoming Medicaid,

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

Thank you.

Sincerely,

Authorized Representative of _____ (Billing Facility)

Name of Insurance Company billed: _____

Date billing attempts made: _____

Policyholder's name:
_____

Policyholder's policy number:
_____

Comments: _____
_____
_____
_____
_____

Wyoming Medicaid
Attn: Claims
PO Box 547
Cheyenne, WY 82003-0547

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

7.3.2 Acceptable proof of Payment or Denial

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

7.3.3 Coordination of Benefits

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

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

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

7.3.4 Blanket Denials and Non-Covered Services

When a service is not covered by a client's primary insurance plan, a blanket denial letter should be requested from the TPL/Medicare. The insurance carrier should then issue, on company letterhead, a document stating the service is not covered by the insurance plan. The provider can also provide proof from a benefits booklet from the other insurance, as it shows that the service is not covered or the provider may use benefits information from the carrier's website. Providers should retain this statement in the client's file to be used as proof of denial for **one calendar year**. The non-covered status must be reviewed and a new letter obtained as the end of **one calendar year**.

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. The EOB must clearly state the services are not covered. The provider must still follow the rules of the primary insurance prior to filing the claim to Medicaid.

7.3.5 TPL and Copays

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

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

7.4 Medicare Pricing

Effective dates of service beginning January 1, 2017, 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

7.4.1 Medicaid Covered Services

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

Example:

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

NOTE: If the method for Medicaid covered services results in a Medicaid payment of $0 and the claim contains lines billed for physician-administered pharmaceuticals, the line will pay out at $0.01.

7.4.2 Medicaid Non-Covered Services

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

Example:

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

- Assigned Coinsurance and Deductible - $209.13
  - First payment method option: [(Medicare Allowable 311.58 ÷ 2)] – 102.45 Medicare paid amount = $155.79 (Calculated Medicaid allowable) – (Medicare Paid Amount) 102.45 = $53.34
  - Second payment method option: Coinsurance and deductible = 209.13
- Medicaid will pay the lesser of the Medicaid payment methodology or the coinsurance and deductible
  - This procedure code would pay $53.34 since it is less than $209.13

NOTE: If the method for Medicaid non-covered services results in a Medicaid payment of $0 and the claim contains lines billed for physician-administered pharmaceuticals, the line will pay out at $0.01.

7.4.3 Coinsurance and Deductible

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

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

Chapter Eight – Electronic Data Interchange (EDI)

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8.1 What is Electronic Data Interchange (EDI)?

In its simplest form, EDI is the electronic exchange of information between two (2) business concerns (trading partners), in a specific, predetermined format. The exchange occurs in basic units called transactions, which typically relate to standard business documents, such as healthcare claims or remittance advices.

8.2 Benefits

Several immediate advantages can be realized by exchanging documents electronically:

- **Speed** – Information moving between computers moves more rapidly, and with little or no human intervention. Sending an electronic message across the country takes minutes or less. Mailing the same document will usually take a minimum of one (1) day.
- **Accuracy** – Information that passes directly between computers without having to be re-entered eliminates the chance of data entry errors.
- **Reduction in Labor Costs** – In a paper-based system, labor costs are higher due to data entry, document storage and retrieval, document matching, etc. As stated above, EDI only requires the data to be keyed once, thus lowering labor costs.

8.3 Standard Transaction Formats

In October 2000, under the authority of the Health Insurance Portability and Accountability Act (HIPAA), the Department of Health and Human Services (DHHS) adopted a series of standard EDI transaction formats developed by the Accredited Standards Committee (ASC) X12N. These HIPAA-compliant formats cover a wide range of business needs in the healthcare industry from eligibility verification to claims submission. The specific transaction formats adopted by DHHS are listed below.

- X12N 270/271 Eligibility Benefit Inquiry and Response
- X12N 276/277 Claims Status Request and Response
- X12N 278 Request for Prior Authorization and Response
- X12N 277CA Implementation Guide Error Reporting
- X12N 835 Claim Payment/Remittance Advice
- X12N 837 Dental, Professional and Institutional Claims
- X12N 999 Functional Acknowledgement

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

8.4 Sending and Receiving Transactions

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

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

EDI Options				
Method	**Requirements**	**Access Cost**	**Transactions Supported**	**Contact Information**
interface for entering individual transactions and a separate data exchange facility for uploading and downloading batch transactions.	Whichever browser version is used, it must support 128-bit encryption Internet access Additional requirements for uploading and downloading batch transactions: File decompression utility. Software capable of formatting and reading EDI transactions		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:** Only the 278 and 837 transactions can be entered interactively.	Website: https://wymedicaid.portal.conduent.com
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	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	Free	X12N 837 Dental, Professional and Institutional Claims X12N 277CAImplementation Guide Error Reporting X12N 999 – Functional Acknowledgement	EDI Services Telephone: (800)672-4959 9-5pm MST M-F OPTION 3 Website: http://edisolutionsmmis.portal.conduent.com/gcro/

EDI Options				
Method	**Requirements**	**Access Cost**	**Transactions Supported**	**Contact Information**
using a personal computer.	Monitor resolution of 800 x 600 pixels Telephone connectivity			

8.5 EDI Services

8.5.1 Getting Started

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

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

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

8.5.2 Web Portal

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

8.5.2.1 Secured Provider Web Portal Registration Process

- Go to the Medicaid website: https://wymedicaid.portal.conduent.com.
- Select Provider.
- Select Provider Portal from the left hand menu.

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

8.5.2.2 Creating an Office Administrator

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

1. Select Create a new user.

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

8.5.2.3 Creating Additional Users

1. Return to the home page and choose Manage Users.

   a. Follow the steps as listed above.

8.5.3 WINASAP

WINASAP allows all Trading Partners to submit claims 24-hours a day, seven (7) days a week from any computer with a dial up modem over an analog phone line that the provider has installed the software on. WINASAP5010 software can be downloaded from the Conduent EDI Solutions website (2.1, Quick Reference) or the provider can call EDI Services (2.1, Quick Reference) and request a CD to be mailed to the provider.

Requirements:

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

8.5.3.1 WINASAP Start-up

1. Download program from the Conduent EDI Solutions website or install the program from the CD the provider requested.

    a. When the welcome screen appears click next
    b. Read and accept the terms of the Software License Agreement
    c. Enter User Information
    d. Choose Destination Location
    e. Confirm provider current settings and choose Next
    f. Check Yes, launch the program file and Finish.
2. Creating a WINASAP login
    a. The user ID auto fills as ADMIN
    b. Tab to password and type ASAP
        i. The user ID and password are the same for everyone using WINASAP, we suggest that the provider does not change them
    c. After successfully logging in choose ok

3. Steps that must be completed
    a. The screen will automatically open the first (1st) time the provider runs the program that says Open Payer
        i. Select Wyoming Medicaid and choose OK
        ii. Choose File and Trading Partner – Enter the following
        iii. Primary Identification: Enter the provider Trading Partner ID from the EDI Welcome Letter

iv. Secondary Identification – Re-enter the provider Trading Partner ID (primary and secondary identification will be the same)

b. Trading Partner Name:
   i. Entity Type: select person or non-person.
      1. Choose person if the provider is an individual such as; a waiver provider, physician, therapist, or nurse practitioner
      2. Choose non-person if the provider is a facility such as; a hospital, pharmacy or nursing home.

c. Enter the providers last name, first name and middle initial (optional) OR the organization name
   i. Contact Information:
      1. Contact Name: provider Name
      2. Telephone Number: Enter provider phone number
      3. Fax Number: Enter provider fax number (optional)
      4. Email: Enter provider email address

4. The following criteria must be completed:
   a. WINASAP5010 Communications:
      i. Host Telephone Number: This phone number is listed as the Submission Telephone Number on the EDI Welcome Letter. Enter it with no spaces, dashes, commas, or other punctuation marks.
      ii. User ID Number: Enter providers Password/User ID exactly as it appears.
      iii. User Name: Enter providers User Name exactly as it appears.
      iv. Choose Save

8.6 Additional Information Sources

For more information regarding EDI, please refer to the following websites:

- Centers for Medicare and Medicaid Services: www.cms.gov/hipaa2/default.asp. 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.
- Workgroup for Electronic Data Interchange: http://www.wedi.org/. This industry group promotes electronic transactions in the healthcare industry.
- Designated standard maintenance organizations: http://www.hipaa-dsmo.org/. This website explains how changes are made to the transaction standards.

8.7 Scheduled Web Portal Downtime

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

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9.1 Wyoming Specific HIPAA 5010 Electronic Specifications

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

9.2 Transaction Definitions

- 270/271 – Health Care Eligibility Benefit Inquiry and Response.
- 276/277 – Health Care Claim Status Request and Response.
- 278/278 – Health Care Services – Request for Review and Response; Health Care Services Notification and Acknowledgement.
- 835 – Health Care Claim Payment/Advice.
- 837 – Health Care Claim (Professional, Institutional, and Dental), including Coordination of Benefits (COB) and Subrogation Claims.
- Acknowledgement Transaction Definitions.
- TA1 – Interchange Acknowledgement.
- 999 – Implementation acknowledgement for Health Care Insurance .
- 277CA – Health Care Claim Acknowledgement.

9.3 Transmission Methods and Procedures

9.3.1 Asynchronous Dial-up

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

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

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

9.3.1.1 Communication Protocols

The EDI Clearinghouse currently supports the following communication options:

- XMODEM
- YMODEM
- ZMODEM
- KERMIT

9.3.1.2 Teleprocessing Requirements

The general specifications for communication with EDI Clearinghouse are:

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

9.3.1.3 Teleprocessing Settings

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

9.3.1.4 Transmission Procedures

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

9.3.2 Web Portal

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

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

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

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

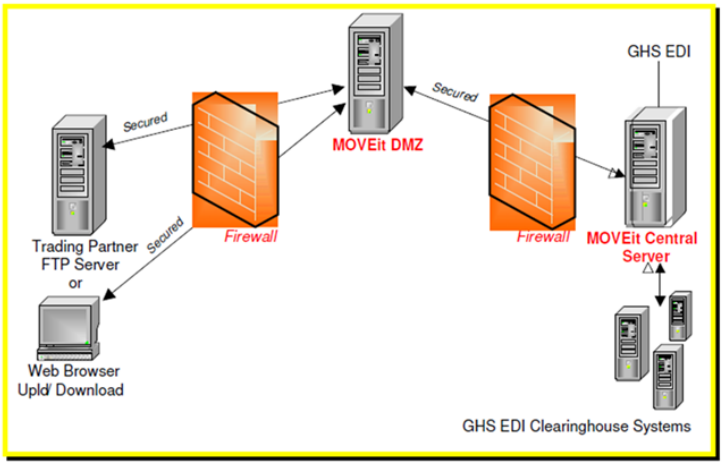
Transaction files can be uploaded and downloaded through the Secured Provider Web Portal at https://wymedicaid.portal.conduent.com.

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

9.3.3 Managed File Transfer (MOVEit)

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

Diagram 3. MOVEit Managed File Transfer



9.4 Acknowledgement and Error Reports

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

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

9.4.1 Confirmation Report

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

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

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

The Confirmation Report includes the following information:

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

9.4.2 Interchange Level Errors and TA1 Rejection Report

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

The TA1 reports the syntactical analysis of the interchange header and trailer. The TA1 allows EDI Clearinghouse to notify the trading partner that a valid X12N transaction envelope was received; or if problems were encountered with the interchange control structure or the trading partner relationship.

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

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

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

9.4.3 999 Implementation Acknowledgements

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

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

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

9.4.3.1 Batch and Real-Time Usage

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

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

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

9.4.4 Data Retrieval Method

Secured Web Portal

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

9.5 Testing

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

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

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

9.5.1 Testing Requirements

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

- Testing via EDIFECS
  - Submitters cannot obtain direct Internet access to EDIFECS, the EDI Services call center staff will set this up at the provider's request.
  - A user ID and password will be generated for the providers use.
  - The provider is required to submit test files through EDIFECS.
  - The provider is required to address any errors discovered during testing prior to moving on to testing with the EDI Clearinghouse.
  - After the provider's software has received approval provide EDI Services with the EDIFECS certification.

- Testing with EDI Clearinghouse
  - The call center will have the provider submit a test file.
  - After 24-hours contact the call center for test file results.

- Make corrections based on the TR3s and Wyoming Specific HIPAA 5010 Specifications.
- Resubmit test files as necessary.
- Successful completion of the testing process is required before a submitter will be approved for production.

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

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

9.6 270/271 Eligibility Request and Response

Health Care Eligibility Benefit Inquiry Request and Response for Wyoming Medicaid.

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

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

9.6.1 ISA Interchange Control Header

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

9.6.2 GS Functional Group Header

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

9.6.3 The Following are Access Methods Supported by Wyoming Medicaid

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

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

9.6.4 270 Eligibility Request

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

9.6.5 271 Eligibility Response

No Wyoming Specific Requirements.

9.7 276/277 Claim Request and Response

Health Care Claim Status Request and Response for Wyoming Medicaid.

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

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

9.7.1 ISA Interchange Control Header

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

9.7.2 GS Functional Group Header

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

9.7.3 276 Claim Status Request

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-medical
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.

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 73	2210D	REF	02	The Line Item Control Number inquiry is not supported by Wyoming Medicaid. The Claim Status Response will return all claim line items.

9.7.4 277 Claim Status Response

No Wyoming Specific Requirements.

9.8 278 Request for Review and Response

Health Care Services Request for Review/Response for Wyoming Medicaid

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

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

9.8.1 ISA Interchange Control header

TR3 Page	Loop	Segment	Data Element	Wyoming Requirements
Appendix C Page C.5	Interchange Control Header	ISA	08	Enter 100000 followed by spaces

9.8.2 GS Functional Group Header

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

9.8.3 278 Prior Authorization Request – Data Clarifications Inbound

TR3 Page	Loop	Segment	Data Element	Wyoming Requirements
Page 73	2010A	NM1	09	Enter 77046

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

9.9 835 Claim Payment/Advice

Health Care Claim Payment Advice for Wyoming Medicaid.

9.9.1 Payment/Advice

TR3 Page	Loop	Segment	Data Element	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.
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.
Page 207-208	2110	REF	01	Either HPI or G2 will be displayed. **NOTE:** G2 will be displayed only for WY Medicaid Atypical Providers.
Page 208	2110	REF	02	**NOTE:** Enter the nine (9) digit Wyoming Medicaid Provider ID when a Wyoming Provider is an Atypical/non-medical.

9.10 837 Professional Claims Transactions Wyoming Medical Professional Claims

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

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

9.10.1 ISA Interchange Control Header

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

9.10.2 GS Functional Group Header

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

9.10.3 837 Professional

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

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 (12-month 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.

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 427	2410	LIN	03	Enter the 11 digit National Drug Code (NDC). NDC's less than 11-digits will cause the service line to be denied by Wyoming Medicaid. Do not enter hyphens or spaces within the NDC. **NOTE:** Only the first iteration of Loop 2410 will be used for claims processing. If two (2) or more NDCs need to be reported for the same procedure code on the same claim, the procedure code must be repeated on a separate service line with the first iteration of Loop 2410 used to report each unique NDC. For more information consult the Wyoming Medicaid website (https://wymedicaid.portal.conduent.com).
Page 436	2420A	PRV	03	If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.
Page 437	2420A	REF	01	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 471	2420 F	REF	01	If 'XX' is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.
Page 472	2420F	REF	02	If 'XX' is used to pass the NPI number is NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter 'G2' (Provider Commercial Number) in REF01 and Wyoming Medicaid Provider ID in REF02.

9.11 837 Institutional Claims Transactions Wyoming Medicaid Institutional Claims

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

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

9.11.1 ISA Interchange Control header

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

9.11.2 GS Functional Group Header

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

9.11.3 837 Institutional

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 77	1000B	NM1	03	Enter Wyoming Medicaid
Page 77	1000B	NM1	09	Enter 77046
Page 147	2300	CLM	05:3	Void/Adjustment (Frequency Type Code) should be 6 (Adjustment) only if paid date was within the last six (6) months (12 month

TR3 Page	Loop	Segment	Reference Description	Wyoming Requirements
				timely filing will be waived), or seven (7) (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.

9.12 837 Dental Claims Transactions Wyoming Medicaid Dental Claims

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

9.12.1 ISA Interchange Control Header

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

9.12.2 GS Functional Group Header

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

9.12.3 Dental

TR3Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 75	1000B	NM1	03	Enter Wyoming Medicaid

TR3Page	Loop	Segment	Reference Description	Wyoming Requirements
Page 75	1000B	NM1	09	Enter 77046
Page 125	2010BB	NM1	03	Enter Wyoming Medicaid
Page 125	2010BB	NM1	08	Enter PI (Payor 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 (12 month timely filing will be waived), or seven (7) (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.

Chapter Ten – Important Information

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10.1 Claims Review

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

10.2 Physician Supervision Definition

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

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

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

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

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

10.3 Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Division of Healthcare Financing cannot suggest specific

codes to be used in billing services. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM/ICD-10 coding books.

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).

10.4 Importance of Fee Schedules and Provider's Responsibility

Procedure codes listed in the following sections are subject to change at any time without prior notice. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedules on the website (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.

10.5 Face-to-Face Visit Requirement

For practitioners ordering new Durable Medical Equipment (DME) or Prosthetic/Orthotic Supplies (POS) for a client, the client must have a face-to-face visit related to the condition for which the item(s) are being ordered within the previous six (6) months with the ordering or prescribing practitioner. The supplying

provider will need the date and the name of the practitioner with whom the face-to-face visit occurred for their records in order to bill Wyoming Medicaid for the DME or POS supplied.

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

Chapter Eleven – Covered Services – Ambulance

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11.1 Ambulance Services

Ambulance providers are independent ambulances or hospital-based ambulances.

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

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

Each ambulance service provided to a client (transport, life support, oxygen, etc.) **must be medically necessary** to be covered by Medicaid.

Procedure Code Range: A0380-A0436

11.2 Covered Services

11.2.1 Emergency Transportation

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

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

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

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

11.2.2 Non-Emergency Transportation

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

- Continuous dependence on oxygen.
- Continuous confinement to bed.
- Cardiac disease resulting in the inability to perform any physical activity without discomfort.
- Receiving intravenous treatment.
- Heavily sedated.
- Comatose.
- Post pneumo/encephalogram, myelogram, spinal tap, or cardiac catheterization.
- Hip spicas and other casts that prevent flexion at the hip.
- Requirement for isolette in perinatal period.
- State of unconsciousness or semi-consciousness.

11.2.3 Definitions of Service Levels

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

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

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

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

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

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

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

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

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

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

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

11.3 Disposable Supplies

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

11.4 Oxygen and Oxygen Supplies

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

11.5 Mileage

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

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

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

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

11.6 Non-covered Services

Medicaid does not reimburse for the following ambulance services:

- Transportation to receive services that are not covered services.
- No-load trips and unloaded mileage (when no patient is aboard the ambulance), including transportation of life-support equipment in response to an emergency call.
- Transportation of a client who is pronounced dead before an ambulance is called.
- When a client is pronounced dead after an ambulance is called but before transport.
- Transportation of a family member or friend to visit a client or consult with the client's physician or other provider of medical services.
- Transportation to pick up pharmaceuticals.
- A client's return home when ambulance transportation is not medically necessary or a client's return back to a nursing facility.
- Transportation of a resident of a nursing facility to receive services that are available at the nursing facility.
- Transportation to a mental health facility if no other appropriate ambulance criteria is met.
- Air ambulance services to transport a client from a hospital capable of treating the client to another hospital because the client or family prefers a specific hospital or practitioner.
- Transportation of a client in response to detention ordered by a court or law enforcement agency.
- Transportation based on a physician's standing orders.
- Stand-by time.
- Special attendants.
- Specialty Care Transport (SCT).
- Paramedic Intercept (PI).

- When a client can be transported by a mode other than ambulance without endangering the client's health, regardless of whether other transportation is available.
- If a client is an inpatient at a hospital, Medicaid does not pay separately for round trip ambulance transport for an outpatient service (e.g., e-ray or other procedure) at a different hospital. This type of transport is included in the Medicaid payment to the hospital for the inpatient stay.
- Transportation of a client having suicidal ideations, if no other appropriate ambulance criteria is met.
- Transports related to Emergency/Involuntary Detainment/Title 25.

11.7 Multiple Client Transportation

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

11.8 Usual and Customary Charge

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

11.9 Billing Requirements

The following are the procedure codes accepted for ambulance services:

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

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

In order for Wyoming Medicaid to be able to view the report, EMS providers or billing agents must select either the "Primary Method of Payment" or "Insurance Company Name" as Wyoming Medicaid. Both of these data elements are in the Billing section of WATRS. Failure to select the proper data element will prohibit

Wyoming Medicaid staff from being able to review your entered information, and your claim will be denied for not having a Trip Report.

Effective June 1, 2017 Wyoming Medicaid will no longer accept paper trip reports for any billed claim, and will only review the data entered into WATRS. Please see the Rules and Regulations for Wyoming Emergency Medical Services W.S. 33-36-101 through -115 Chapter 4, Section 4 for reporting requirements.

The WATRS reporting requirements apply if:

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

Transports that do not touch ground in Wyoming at any point will still be permitted to submit paper trip reports.

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

The paper trip report must include the following:

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

11.10 Community Emergency Medical Services (CEMS)

Effective January 1, 2018, Community Emergency Medical Services (CEMS) provided by CEMS programs and their employed EMTs and Paramedics who have completed the required training programs and have been endorsed as CEMS providers by the Office of Emergency Medical Services will be covered.

11.10.1 Enrollment

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

CEMS Group Enrollment

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

EMT or Paramedic Individual/Treating Enrollment

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

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

11.10.2 Covered Services

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

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

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

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

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

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

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

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

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

11.10.4 Billing Requirements

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

Chapter Twelve – Covered Services – Audiology

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12.1 Audiology Services

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.

Procedure Code Range: V5000-V5275 and 92550-92700

12.2 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 individual's hearing loss.

12.3 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.

12.4 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. Providers are responsible for billing services provided within the scope of their practice and licensure. It is essential for providers to have the most current HCPCS and CPT editions for proper billing.

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).

The provider bills Medicaid for hearing aids using two (2) separate procedure codes; one (1) for the hearing aid and one (1) for the dispensing fee. The hearing aid must be billed under the appropriate procedure code(s).

12.5 Reimbursement

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

Medicaid reimburses for hearing aids either by fee schedule or invoice plus shipping plus 15%. 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).

12.6 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 fees 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.

12.7 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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13.1 Behavioral Health Services

Outpatient Behavioral Health Services are a group of services designed to provide medically necessary mental health or substance abuse treatment services to Medicaid 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 provider's 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.
- 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.

13.2 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:	
	• Psychiatry • CMHC • SATC • Developmental Center	• Psychologist • Neuropsychologist • Physician
Licensed Addictions Therapist (LAT) 101YA0400X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• Psychiatry • CMHC • SATC • Developmental Center	• Psychologist • Neuropsychologist • Physician
Neuropsychologist 103G00000X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• CMHC • Physician	• SATC
Clinical Psychologist 103TC0700X	Shall be enrolled as an individual or in one (1) of the following groups:	
	• CMHC • Physician	• SATC • LAT

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

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:	
	• Psychologist • CMHC	• 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:	
	• Psychologist • CMHC	• 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:	
	• Psychologist • CMHC	• 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:	
	• CMHC	• 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:	
	• CMHC	• SATC

Providers MUST be enrolled in a group		
Provisional Professional Counselor (PPC) 101Y00000X	Shall be enrolled in one (1) of the following groups:	
	• CMHC • Psychiatry • Neuropsychologist • LPC • LAT • Developmental Center	• SATC • Psychologist • Physician • LCSW • LMFT
Provisional Licensed Addictions Therapist (PLAT) 101YA0400X	Shall be enrolled in one (1) of the following groups:	
	• CMHC • Psychiatry • Neuropsychologist • LPC • LAT • Developmental Center	• 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:	
	• CMHC • Psychiatry • Neuropsychologist • LPC • LAT • Developmental Center	• SATC • Psychologist • Physician • LCSW • LMFT
Provisional Marriage and Family Therapist (PMFT) 106H00000X	Shall be enrolled in one (1) of the following groups:	
	• CMHC • Psychiatry • Neuropsychologist • LPC • LAT • Developmental Center	• 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 172V00000X	Shall only be enrolled in one (1) of the following groups:	
	• CMHC	• SATC
Certified Peer Specialist 172V00000X	Shall only be enrolled in one (1) of the following groups:	
	• CMHC	• SATC

13.3 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.

13.3.1 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.

13.3.2 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 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 provider's 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.

13.3.3 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.

- 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 eighteen years of age or older.
- Be credentialed by the Behavioral Health Division as a peer specialist, and
- Be supervised for the position by a person licensed by the Wyoming Mental Health Professions Licensing Board or by a person with at least five (5) contiguous years of experience as a Credentialed Peer Specialist. Supervisors of Peer Specialists must complete at least 16 hours of direct contact training on the supervision of Peer Specialists.
- 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.

13.3.4 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

13.3.5 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.

13.3.5.1 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.

13.3.5.2 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.

13.3.5.3 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.

13.3.5.4 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.

13.3.6 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
1041C0700X	Licensed Clinical Social Worker (LCSW)

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.

13.4 Covered Services

- Adult Psychosocial Rehabilitation (Community Mental Health and Substance Abuse Treatment Centers only): 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.
- Agency/Based Individual/Family Therapy: Contact at the agency's office with the enrolled client and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the enrolled client, including medication management by licensed medical personnel as indicated.
- Peer Specialist Services (Community Mental Health and Substance Abuse Treatment Centers only): Contact with enrolled clients (and collaterals as necessary) for the purpose of 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 use disorder to prevent out-of-home placement; to teach and support the restoration and exercise of skills needed for management of symptoms; and for utilization of natural resources within the community. 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 disorder. 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) and treatment needs, including psychological testing if indicated, and establishing DSM (current edition) diagnosis.
- Community-Based Individual/Family Therapy: Contact outside the agency's office with the enrolled client and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the enrolled client including medication management by licensed medical personnel as indicated.
- 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 counselors, 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.
- 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 and for the purpose of restoring those skills necessary to enable and maintain independent living in the community 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 minute 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.

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

Targeted Case Management for adults with serious mental illness age twenty-one (21) and over 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.

13.4.2 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.

13.4.3 Limitations to Mental Health/Substance Abuse Services

- Medicaid Mental Health Rehabilitative Targeted Case Management Option and EPSDT mental health services are limited to those eligible persons who 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 diagnosis resulting from clinical assessment:
    - Sole DSM diagnosis of mental retardation
    - 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.
- Psychiatric Services - Community Mental Health Centers will be reimbursed for psychiatric services at the same fee currently established for psychiatrists in private practices. Community Mental Health Centers must use current CPT codes when billing for these services. Refer to Psychiatric and Mental Health Services (13.2, Eligible Providers).

13.4.4 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. Psychologists have certain legal and ethical responsibilities to patients, 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 patient, to provide information to the therapist and never attend another session. In another case, a collateral might attend all of the patient'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.

13.4.4.1 Collateral Visits

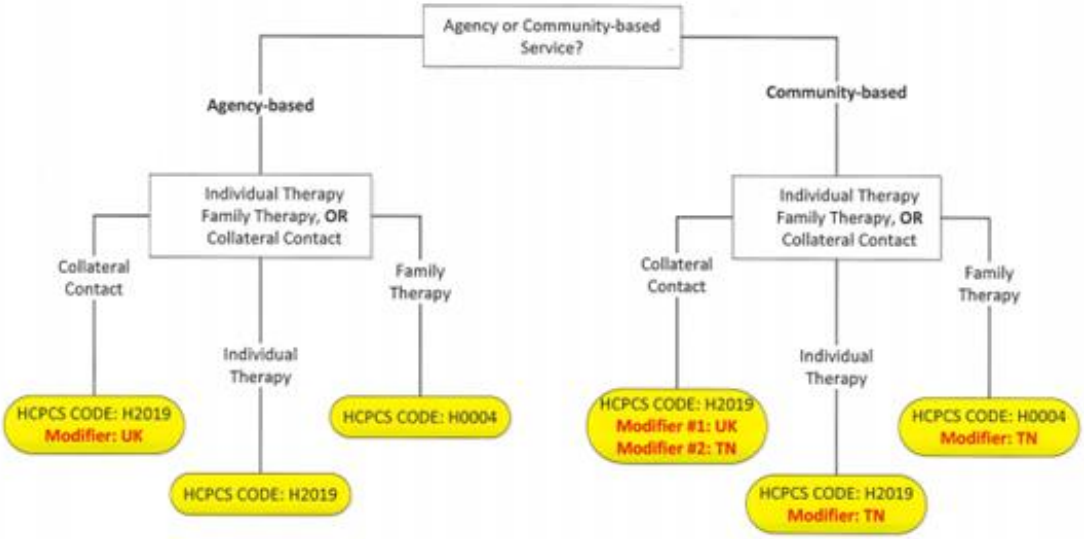
- A collateral can attend a session with the therapist with or without the client present.
- Generally, unlike patients, collaterals do not have the right to access clinical records unless they are a parent or legal guardian.
- Collaterals are not responsible for the fees of the sessions they attend, 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 your patients. You do not have the same responsibility for collaterals as you have for your patients.
- 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.

13.4.5 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.



13.5 Covered Service Codes

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

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
G9012	Ongoing Case Management (≤ 20 years)	Per 15 minutes	GT, HQ, 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, 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)

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
H0004	Family Therapy	Per 15 minutes	GT, HQ, 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	Per 15 minutes	GT, 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)
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
H2010	Comprehensive Medication Therapy	Per 15 minutes		CMHC, SATC	LPC, RN, LPN, APRN

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
H2014	Individual Rehabilitative Service - Skills Training and Development	Per 15 minutes	HQ	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	HQ	CMHC, SATC	LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Case Manager, Psychiatrist, APRN
H2019	Agency Based Individual Therapy	Per 15 minutes	GT, TN, UK	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)

HCPCS Level II Code	Description	1 Unit Equals	Modifiers Allowed	Pay-to Providers with the appropriate Taxonomy Code	Treating Providers
H2019+HQ	Group Therapy - Group Counseling by Clinician	Per 15 minutes	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)
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)

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, CSW, 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)

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

CPT Code	Description	1 Unit Equals	Pay-to Providers Taxonomies Allowed	Treating Provider Taxonomies Allowed
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, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management services (list separately in addition to the code for primary procedure)	CPT-Defined	CMHC, SATC, Clinical Psychologist, Neuropsychologist, APRN, , Taxonomies beginning with 20 (Physicians)	Clinical Psychologist, Neuropsychologist, APRN, Taxonomies beginning with 20 (Physicians)

CPT Code	Description	1 Unit Equals	Pay-to Providers Taxonomies Allowed	Treating Provider Taxonomies Allowed
90845	Psychoanalysis	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
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, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)

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, CSW, 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, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)
96101-96103, 96105, 96110-96111, 96116, 96118-96120, 96125	Central Nervous System Assessments/Psychological Testing	CPT-Defined	Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)	Clinical Psychologist, Neuropsychologist, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)

Interpretations or explanation of results of psychiatric services to family members or other responsible persons is included in the fee for psychotherapy. The following matrix indicates the CPT-4 codes specific to psychological services. Please refer to the most current version of the CPT book.

Allowable Behavioral Health Modifiers	
Modifier(s)	**Description**
UK	Services on behalf of the client- Collateral Contact
TN	Community-Based Setting: Rural/outside providers' customary service area
HQ	Group setting
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, H2014, H2017, H2017, H2019, H2019 + HQ, 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, H2014, H2017, H2019, H2019 + HQ, T1017, T2011, 90785, 90791, 90832, 90834,90837, 90845, 90847, 90849, 90853
101YP2500X	Licensed Professional Counselor (LPC)	G9012, H0004, H0031, H2010, H2014, H2017, H2019, H2019 + HQ, T1017,90791, 90785, 90832, 90834, 90837, 90846, 90847, 90849, 90853
103G00000X	Neuropsychologist	G9012, H0004, H0031, H2014, H2017, H2019, H2019 + HQ,T1017, T2011, 90785, 90791, 90792, 90832- 90834, 90836-90839, 90845-90847,90849, 90853, 96101-96103, 96105, 96110-96111, 96116, 96118-96120, 96125

Community Mental Health Centers & Substance Abuse Treatment Centers Only		
Taxonomy	**Provider Types**	**Allowed Codes**
103TC0700X	Clinical Psychologist	G9012, H0004, H0031, H2014, H2017, H2019, H2019 + HQ, T1017, T2011, 90785, 90791, 90792, 90832-90834, 90836-90839, 90845-90847,90849, 90853, 96101-96103, 96105, 96110-96111, 96116, 96118-96120, 96125
1041C0700X	Licensed Clinical Social Worker (LCSW), Certified Social Worker (CSW)	G9012, H0004, H0031, H2014, H2017, H2019, H2019 + HQ, T1017, T2011, 90785, 90791, 90832, 90834,90837, 90845
106H00000X	Marriage and Family Therapist (MFT), Provisionally Licensed Marriage and Family Therapist (PMFT)	G9012, H0004, H0031, H2014, H2017, H2019, H2019 + HQ, T1017, T2011, 90785, 90791, 90832, 90834,90837, 90845, 90849, 90853
163W00000X	RN	G9012, H0004, H0031, H2010, H2014, H2017, H2019, T1017
164W00000X	LPN	G9012 , H2010, H2014
171M00000X	Case Manager	G9012, H2014, H2017, T1017
172V00000X	Certified Peer Specialist	H0038
172V00000X	Community Health Worker – Individual Rehabilitative Services Worker (IRS), Certified Peer Specialist, Certified Addictions Practitioner Assistant (CAPA)	H2014
Taxonomies beginning with 20	Physicians	G9012, H0004, H0031, H2019, H2019 + HQ, T1017, 90785, 90791, 90792, 90832-90834, 90836-90839, 90845 90846, 90847, 90849, 90853, 96101-96103,96105, 96110-96111, 96116, 96118-96120, 96125
2084P0800X	Psychiatry and Neurology, Psychiatry	G9012, H0004, H0031, H2017, H2019,H2019 + HQ, T1017, T2011, 90785, 90791, 90792, 90832-90834, 90836-90839,90845-90847, 90849, 90853, 96101-96103, 96105, 96110-96111, 96116, 96118-96120,96125

Community Mental Health Centers & Substance Abuse Treatment Centers Only		
Taxonomy	**Provider Types**	**Allowed Codes**
364SP0808X	Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health	G9012, H0004, H0031, H2010, H2017, T1017, T2011, 90785, 90791, 90792,90832-90834, 90836-90839, 90845-90847, 90849, 90853, 96101-96103, 96105,96110-96111, 96116, 96118-96120, 96125

13.6 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.

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

13.6.1 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

13.7 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. Applied Behavior Analysis 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.

13.7.1 Covered Services

- **Behavior identification assessment** – Direct contact with the recipient (and collaterals as necessary) for the purposes of identification of deficient adaptive or maladaptive behaviors, completing an evaluation of the recipient's mental health and/or substance abuse disorder(s) to determine treatment needs and establish a treatment plan. This service may include psychological testing if indicated.
- **Observational behavioral follow-up assessment** – Direct contact with the recipient (and collaterals as necessary) for the purposes of identification and evaluation factors that may impede the expression of adaptive behavior. This assessment utilizes structured observation and/or standardized and non-

standardized test to determine adaptive behavior. This service may include psychological testing if indicated.

- **Adaptive behavior treatment** – Direct contact with the recipient (and collaterals as necessary) for the purpose of addressing the patient's specific target problems and treatment goals as defined by the assessments. Adaptive behavior treatment is based on principles including analysis and alteration of contextual events and motivating factors, stimulus-consequence strategies and replacement behavior, and monitoring of outcome metrics.
- **Family adaptive behavior treatment guidance** – Direct contact with the family/caregiver to provide specialized training and education to assist with the child's needs and development. The provider will observe, instruct and train the family/caregivers on the child's development status, and techniques and strategies to promote the child's development that is established in the treatment plan.

Code	Description	Taxonomy Allowed	Limits
0359T	Behavior identification assessment + plan of care.	103K00000X	Twice A Year
0360T	Observational Follow Up Assessment - 1st 30 minutes.	103K00000X 106S00000X 106E00000X	30 Minutes
0361T	Observational Follow Up Assessment - Additional 30 minutes.	103K00000X 106S00000X 106E00000X	30 Minutes
0364T	Behavior treatment by protocol administered by technician first 30 minutes.	106E00000X, 106S00000X, 103K00000X	30 Minutes
0365T	Behavior treatment by protocol administered by technician each additional 30 minutes.	106E00000X, 106S00000X, 103K00000X	30 Minutes
0366T	Group behavior treatment by protocol administered by technician first 30 minutes.	106E00000X, 106S00000X, 103K00000X	30 Minutes
0367T	Group behavior treatment by protocol administered by technician additional 30 minutes / Group.	106E00000X, 106S00000X, 103K00000X	30 Minutes
0368T	Behavior treatment with protocol modification administered by physician or other qualified health care professional first 30 minutes.	103K00000X 106E00000X 106S00000X	30 Minutes
0369T	Behavior treatment with protocol modification administered by physician or other qualified health care professional each additional 30 minutes.	103K00000X 106E00000X 106S00000X	30 Minutes
0370T	Family behavior treatment guidance administered by qualified health care professional 60 - 75 min.	103K00000X	60-75 Minutes
0371T	Family behavior treatment guidance administered by qualified health care professional 60 - 75 min. / Group.	103K00000X	60-75 Minutes

13.7.2 Applied Behavior Analysis Providers

Applied Behavior Analysis Providers must follow the requirements set by the Board of Certified Behavior Analysts as per http://bacb.com/credentials/ in order to provide applied behavior analysis treatment services to Wyoming Medicaid clients.

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** 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.

13.7.3 ABA Supervision of Technicians

Supervision by a qualified health care professional (QHCP) 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 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 human resources supervision, and adaptive behavior treatment with protocol modification codes 0368T and 0369T were created to cover them. Code 0368T is billed for the first 30 minutes of an encounter, and code 0369T is billed for each additional 30 minutes.

When a qualified health care professional (QHCP) 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 QHCP would bill for this time using the adaptive behavior treatment with protocol modification codes (0368T for the first 30 minutes and 0369T for each additional 30 minutes). **The QHCP cannot submit these codes and the codes for the technician's time simultaneously** (e.g., the codes 0368T/0369T can be used for supervision of a technician when a patient is present, but a BCBA cannot report these codes at the same time a technician is reporting 0364T/0365T). There is no separate code for 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 QHCP 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.

13.8 Limitations for Behavioral Health Services

The report writing segment, for the purpose of compiling a formal report of psychological test findings, is limited to a maximum of three (3) hours.

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:

- 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.
- Services are not medically necessary.
- Treatment whose purpose is vocationally or recreationally based.
- Diagnosis or treatment in a school-based setting.

13.8.1 Prior Authorization Once Thresholds are Met

For Medicaid clients age 21 and over, dates of service in excess of twenty (20) per calendar year will require a prior authorization which can be obtained through Qualis Health (6.8 Service Thresholds).

13.8.1.1 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Qualis Health, 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 Qualis Health's system. The appeal will be reviewed in conjunction with the documentation uploaded into Qualis Health's system.

13.9 Documentation Requirements for All Behavioral Health Providers (Including ABA Providers)

13.9.1 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 (Division of Healthcare Financing, Medicaid). Documentation prepared or completed after the submission of a claim will be deemed to be insufficient to substantiate the claim and Medicaid funds shall be withheld or recovered.

13.9.2 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

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, 13.9 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. The importance of proper documentation of

services is important to differentiate the times of services being rendered, as you cannot bill times on a CMS 1500.

13.9.3 Client Records

Providers of mental health/substance use services under the 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.

13.9.3.1 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 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
  - The 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 chart 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 chart 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 chart note shall document each contract 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. O 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.

13.9.3.2 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 any client receiving ten or more therapeutic contacts, a discharge summary which includes each type of Medicaid service provided, client's progress in achieving treatment goal, and plans for follow-up. The discharge summary shall be completed within 90 days of the last contact. Any clinical record shall document the reason for case closure.

13.9.4 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 acts 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; and
- Include the name of the individual; and
- The date span of services the treatment plan covers; and
- The progress made toward functional improvement and attainment of the individual's goals.

13.9.5 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 made according to Medicaid billing instructions.

13.9.6 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.

13.9.7 Pre-Admission Screening and Resident Review (PASRR) Assessments

13.9.7.1 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 Fourteen – Covered Services – Children's Mental Health Waiver

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14.1 Children's Mental Health Waiver (CMHW) Services as Administered by Magellan Healthcare, Inc., Through the Care Management Entity

Wyoming Medicaid's Care Management Entity (CME) contractor, Magellan Healthcare, serves Medicaid-covered children and youth ages of four through twenty 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 Children's Mental Health Waiver (CMHW).

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.

14.1.1 Enrollment Requirements

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, Lisa Brockman (lisa.brockman@wyo.gov) as having met the 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, and
- Meet ongoing recertification requirements as specified in policy
- Once the IA 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.

14.1.2 ECSII/CASII Eligibility Add Form

For clients who are not currently eligible for Wyoming Medicaid, the Independent Assessor's (IA's) who is performing the ECSII/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 Care Management Entity (CME), Magellan Healthcare Inc., website: http://magellanofwyoming.com, under the Provider Hub, Independent Assessors (IA) section.

- Completed ECSII/CASII Eligibility Add Form and the High Fidelity Wraparound Application (14.1.3 High Fidelity Wraparound Application) will be sent to Magellan Healthcare. The CMHW/CME Program Manager will provide the IA with the client's Medicaid ID number and the date of service for billing.

14.1.3 High Fidelity Wraparound Application

All clients who are applying for the Children's Mental Health Waiver (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. Application can be found on the Magellan Healthcare website http://magellanofwyoming.com under Applications.

IAs that assists in the completion of the High Fidelity Wraparound Application will need to use the CG modifier when billing.

Modifier	Description	Reimbursement
CG	CME Application Assistance	Increases payment of the procedure code by 25%

14.1.4 Covered Services

Procedure code: H0002

- Early Childhood Service Intensity Instrument (ECSII) for children 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 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

ECSII/CASII Evaluation Procedure Code & Modifier				
Procedure Code	**Modifier**	**1 Unit Equals**	**Procedure Quantity**	**Description**
H0002		1 Evaluation	1 Max Unit	Evaluation Only
H0002	CG	1 Evaluation	1 Max Unit	Evaluation and Completed CMHW/CME Application

NOTE: The same IA can perform two-consecutive ECSII/CASII evaluations on the same client. But the third that is used to determine ongoing eligibility needs to be completed by a different IA than the IA who performed the last two assessments.

Chapter Fifteen – Covered Services – Chiropractic Services

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15.1 Coverage Indications

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; and
- Vertebral manipulation or adjustment.

15.2 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.

15.3 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.

15.4 Authorization of Medical Necessity

Evaluation and Management (E & M) Services:

- For Medicaid clients 21 years of age and over in excess of twelve (12) per calendar year will require authorization of medical necessity. This includes all E & M procedure codes. (6.8 Service Thresholds)

Chiropractic Services:

- For Medicaid clients, dates of service in excess of twenty (20) per calendar year will require authorization of medical necessity. (6.8 Service Thresholds).

15.5 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 of the CMS 1500 Manual.

98940, 98941, 98942

70100 -77086 Diagnostic Radiology codes

- Refer to the Wyoming Medicaid CMS 1500 Manual for additional information regarding radiology services.
- Some diagnostic radiology services require prior authorization. A complete list of codes and requirements may be viewed at WYhealth or by contacting (888)545-1710 prompt 4.

15.6 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.

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.

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16.1 Development Centers

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

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

16.2 General Documentation Requirements

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

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

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

16.3 Location

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

16.4 Time and Frequency

Time and frequency are required on the physician's order and must be specific so time in and time out must be reflected on the document in standard or military format. Time is a unit of 15 minutes. If seven (7) minutes or less of the next 15 minute unit is utilized, the unit must be rounded down. However, if eight (8) or more minutes of the

next 15 minute unit are utilized, the units can be rounded up. Date ranges are not acceptable. For example, six (6) months duration three (3) times per day is an acceptable time and frequency.

16.5 Missed Appointments/Make-up Session

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

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

16.6 Diagnosis

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

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

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

16.7 Covered Services

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

- Procedures followed
- Findings of the evaluation/assessment shall be developed
- Provide a copy to the referring practitioner

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

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

- Diagnosis and onset date of client's condition;
- Client's rehabilitation potential;
- Restorative and/or maintenance program goals;
- Therapy modalities determined to be medically necessary to attain the program goals;
- Therapy duration (not to exceed six (6) months); and
- Practitioner's signature and date signed.

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

16.8 Service Threshold

For Medicaid clients, dates of service in excess of twenty (20) per calendar year for each service (PT, OT, ST, BH), providers will need to contact Qualis Health to obtain prior authorization. (6.8 Service Thresholds)

16.9 Billing Requirements

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

Developmental Centers			
HCPCS Level II Code	**Modifier**	**1 Unit Equals**	**Description**
92507		Per Instance	Individual treatment of speech language voice communication and/or auditory processing disorder (including aural rehab).
92508		Per Instance	Treatment of speech, language, voice communication, and/or auditory processing disorder (including aural rehab); group, two (2) or more individuals.
92521		Per Evaluation	Evaluation of speech fluency.
92522		Per Evaluation	Evaluation of speech fluency.
92523		Per Evaluation	Evaluation of speech sound production with evaluation of language comprehension and expression.
92524		Per Evaluation	Behavioral and qualitative analysis of voice and resonance.
92526		Per Instance	Treatment of swallowing dysfunction and or oral function for feeding.
97001		Per 15 minutes	Physical therapy evaluation.
97002		Per 15 minutes	Physical therapy re-evaluation.
97003		Per 15 minutes	Occupational therapy evaluation.
97004		Per 15 minutes	Occupational therapy re-evaluation.
97110		Per 15 minutes	Therapeutic procedure, one (1) or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97112		Per 15 minutes	Therapeutic procedure, one (1) or more areas; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.
97113		Per 15 minutes	Therapeutic procedure, one (1) or more areas; aquatic therapy with therapeutic exercises.
97124		Per 15 minutes	Therapeutic procedure, one (1) or more areas; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).
97150		Per 15 minutes	Therapeutic procedure(s); group, two (2) or more individuals.

Developmental Centers			
HCPCS Level II Code	**Modifier**	**1 Unit Equals**	**Description**
97530		Per 15 minutes	Therapeutic activities, direct (one to one) client contact by the provider.
97533		Per 15 minutes	Sensory integrative techniques to enhance sensory processing and promote adaptive responses of environmental demands, direct (one-on-one) client contact by the provider.
G9012		Per 15 minutes	Other specified case management service not elsewhere classified.
H0004		Per 15 minutes	Family Therapy – Therapist contact at the developmental center with the enrolled client, family and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the enrolled client.
H0031		Per 15 minutes	Clinical assessment – Therapist contact with the client and/or collaterals as necessary, for the purpose of completing an evaluation of the client's mental health and substance abuse disorder(s) and treatment needs, including psychological testing if indicated.
H2019		Per 15 minutes	Agency Based Individual Therapy – Therapist contact at the developmental center with the enrolled client and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the enrolled client.
H2019	HQ	Per 15 minutes	Group Therapy – Therapist contact with two (2) or more unrelated clients and/or collaterals as necessary, for the purpose of implementing each client's treatment plan.
H2019	TN	Per 15 minutes	Community-Based Individual Therapy – Therapist contact outside the developmental center with the enrolled client and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the enrolled client.
T2011		N/A	PASRR Level II Developmental Disabilities Evaluation.

Developmental Centers	
Modifier	**Description**
HI	Multi-Disciplinary Team
HQ	Group Setting
TN	Rural/outside provider's customer service area

Chapter Seventeen – Covered Services – Dietician

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17.2 Covered CPT Codes and Documentation 237
17.3 Medical Nutrition Therapy Documentation Requirements 237

17.1 Limitations

- Dietician services must be ordered by a physician or nurse practitioner.
- For Medicaid clients, dates of service in excess of twenty (20) per calendar year will require authorization of medical necessity. (6.8 Service Thresholds)

17.2 Covered CPT Codes and Documentation

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.

17.3 Medical Nutrition Therapy 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;
3. Subjective Data:
    a. Client's reason for visit
    b. Primary care physician
    c. History
        i. Past and present medical
        ii. Nutrition including food patterns and intake
        iii. Weight
        iv. Medication
        v. Exercise
4. Objective Data:
    a. Laboratory results (if available)
    b. Height, Weight
    c. BMI
    d. Calorie Needs
    e. Drug/Nutrient Interactions
5. Individual Assessment of Diet/Intake:
    a. Laboratory results (if available)
    b. Height, Weight
    c. BMI
    d. Calorie Needs
    e. Drug/Nutrient Interactions
6. Plan:

a. Individualized dietary instruction that incorporates diet therapy counseling and education handouts for nutrition related problem.
b. Plan for follow-up.
c. Documentation of referral for identified needs.
d. 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.

7. Date and legible identity of provider:
    a. All entries must be signed and dated by the provider.

Chapter Eighteen – Covered Services – DME Billing

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18.2 DME Billing Requirement Exception 240
18.2.1 K0108/E1399 Crossover Claim Form 242

18.1 Order vs Delivery Date

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. (6.14 Order Vs Delivery Date)

18.2 DME Billing Requirement Exception

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

NOTE: K0108 and E1399 only and the client is dual eligible, Medicare and Medicaid.

Refer to the DME Covered Services manual and Chapters 1-10 of this manual for the complete Medicaid policy.

Provider must obtain a prior authorization (PA) through the Medicaid DME vendor

1. Submit the claim first to Medicare according to Medicare instructions.
2. Medicare should crossover the claim electronically to Medicaid, and any units approved by Medicare will be processed to pay co-insurance and deductible as per usual. Lines that Medicare denied will deny on the crossover claim as exact duplicates conflicting with the paid lines of the same code, but the crossover claim will be in a paid status.
    a. If crossover claim is not received electronically from Medicare the providers will need to submit this crossover claim electronically to Medicaid (Refer to the Web Portal Tutorials)
3. Providers need to wait for the **paid** crossover to appear on the Medicaid remittance advice (RA)/835 before continuing the DME billing requirement exception process (Step 5).
4. Once the paid crossover claim appears on the Medicaid RA, the provider will need to complete a CMS-1500 **paper** claim form. Complete the paper claim form according to Medicaid's billing requirements, not the way it was previously submitted to Medicare.
    a. Bill according to Medicaid's PA, enter the PA number in box 23
    b. All units denied by Medicare must be combined onto one line with multiple units or they will deny as exact duplicates.
        i. Billed charge/units must add up and match the Medicare EOMB.

5. Review the invoice(s) for each item and clearly mark for each line item
    a. Medicaid must be able to match descriptions from the PA to the invoice(s), to assist with this process complete the K0108/E1399 Crossover Claim Form (18.2.1 K0108/E1399 Crossover Claim Form)
6. Completing the K0108/E1399 Crossover Claim Form – the purpose of this form is to assist in matching up the descriptions of the items/components of the PA to the appropriate items on the invoice(s).
    a. When entering the first item description on line 1 of the form place (1) on the invoice next to the item on the invoice that matches it, continue the same process until all items are documented on the form.
        i. Complete as many forms as necessary.
7. Finalization and mailing process: Providers must include all of the following in the mailing
    a. K0108/E1399 Crossover Claim Form (place on top to ensure appropriate routing)
    b. Completed CMS-1500 paper claim form
    c. Medicare's EOMB
    d. Invoice(s)
    e. Mail the documents to:

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

18.2.1 K0108/E1399 Crossover Claim Form

Wyoming Department of Health

K0108/E1399 Crossover Claim Form

Client Name: _____ Provider Name: _____

Client Medicaid ID: _____ Provider NPI: _____

Claim Date(s) of Service: _____ Medicaid RA No.:_____

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

Circle One	Item Description	Billed Amount	Medicare Paid/Denied	Denial Reason
Example:				
K0108 / E1399	Foot Rest	$75.83	Denied	PR-204
1. K0108 / E1399				
2. K0108 / E1399				
3. K0108 / E1399				
4. K0108 / E1399				
5. K0108 / E1399				
6. K0108 / E1399				
7. K0108 / E1399				
8. K0108 / E1399				
9. K0108 / E1399				
10. K0108 / E1399				
11. K0108 / E1399				
12. K0108 / E1399				
13. K0108 / E1399				
14. K0108 / E1399				

Contact Name: _____ Phone No.: _(_____)_____

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

Chapter Nineteen – Covered Services – Family Planning

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19.2 Covered Services 244
19.3 Non-Covered Services 244

19.1 Family Planning Clinics

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.

19.2 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.

19.3 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 (25.1, Pregnant By Choice/Family Planning Waiver).

Chapter Twenty – Covered Services – Health Check

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20.1 Health Check – EPSDT

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.

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, diagnosis, and treat during one (1) office visit.

20.2 Periodicity Schedule

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

Key: ✓ = to be performed ✘ = to be performed for 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.

20.3 Reimbursement

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

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

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

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

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

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

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

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

Evaluation and Management Services – New Patient		
Procedure Code	**Modifier**	**Description**
99201	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: • A problem focused history. • A problem focused exam. • Straight forward medical decision making.
99202	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: • An expanded focused history. • An expanded focused exam. • Straight forward medical decision making.
99203	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: • A detailed history. • A detailed exam • Medical decision making of low complexity.
99204	25	Office or other outpatient visit for the E&M of a new patient requires three (3) key components: • A comprehensive history. • A comprehensive exam. • Medical decision making of moderate complexity.
99211	25	Office or other outpatient visit for the E&M of an established patient that may not require the presence of a physician. Usually the presenting problems are minimal. Typically five (5) minutes are spent performing or supervising these services.
99212	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: • A problem focused history. • A problem focused exam. • Straight forward medical decision making.
99213	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: • An expanded problem focused history. • An expanded problem focused exam. • Straightforward medical decision making.

Evaluation and Management Services – New Patient		
Procedure Code	**Modifier**	**Description**
99214	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: • A detailed history. • A detailed exam. • Medical decision making of low complexity.
99215	25	Office or other outpatient visit for the E&M of an established patient which requires at least of these three (3) components: • A comprehensive history. • A comprehensive exam. • Medical decision making of high complexity.

NOTE: Please refer to the current CPT for additional information regarding preventative services.

20.4 Detailed Information for Well Child Screens

- In some instances, Well Child Screens may not be completed at the suggested age (example: immunizations); the healthcare professional must follow recommended practices to ensure the child becomes current.
- Results may indicate further testing or referrals are needed. Healthcare professionals should complete tests or make referrals according to standard procedures and practices.
- Well Child Screens must be completed when there is no acute diagnosis applicable (i.e. otitis media).
- 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.

20.5 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.

20.6 Assessments

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

- 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;
- 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); and
- Screening for iron deficiency at the appropriate ages and/or intervals.

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

20.7 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:

- 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).

20.8 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.

20.9 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.

20.10 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.

20.11 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.

20.12 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 that 15dB between the air conduction test results and results by bone conduction.
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
- Pain or discomfort simply indicates there is something wrong and should be seen by a medical doctor.
- Infants and children whose medical, physical, or developmental history indicates possible hearing loss:
- Positive family history of hearing loss.
- Viral or other non-bacterial transplacental infection.
  - Defects of ear, nose or throat system; malformed, low-set to absent pinnae; cleft lip or palate.
  - Birth weight under 1500 grams.

- Unconjugated bilirubin over 24 mg/100 ml or over infant's weight in decagrams.
- Bacterial meningitis.
- Sever asphyxia with arterial flow less than 7.25, coma, seizures or need for continuous assisted ventilation.
- Children found positive when tested with pure tone screening.

20.13 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.

20.13.1 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, and
- 11-12 years.

20.13.2 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 of 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.

20.13.3 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.

20.13.4 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 (2nd) 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.

20.13.5 Other

Other laboratory tests (i.e., chest x-ray, Pap smear, sickle cell testing, etc.) should be completed if medically necessary.

20.14 Immunizations

- The immunization status of each child should be reviewed at each Well Child Screen.
- Reviewing 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.

20.15 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 (20.11, Topical Fluoride Varnish).

20.16 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 hypernasality 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.

20.17 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.

NOTE: Interpretation services are available upon request (21.1, Interpreter Services).

Chapter Twenty One – Covered Services – Interpreter Services

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21.1 Interpreter Services

Enrolled providers assisting Medicaid clients with oral interpretation or sign language interpretation must adhere to national standards developed by the National Council on Interpreting in Healthcare (NCIHC). These include:

- **Accuracy** – To enable other parties to know precisely what each speaker has spoken.
- **Confidentiality** – To honor the private and personal nature of the healthcare interaction and maintain trust among all parties.
- **Impartiality** – To eliminate the effect of interpreter bias or preference.
- **Role Boundaries** – To clarify the scope and limits of the interpreting role, in order to avoid conflicts of interest.
- **Professionalism** – To uphold the public's trust in the interpreting profession.
- **Professional Development** – To attain the highest possible level of competence and service.
- **Advocacy** – To prevent harm to parties whom the interpreter serves.

Procedure Code: T1013

21.2 How it Works

A need for interpreter services is determined by a medical appointment.

- The healthcare provider accesses the Medicaid website or contact Provider Relations for a current list of enrolled interpretation providers (2.1, Quick Reference).
- The healthcare provider will contact and provide the interpretation service the following information:
  - Name of client
  - Client's Medicaid ID number
  - Name of referring provider
  - Time and date service will be required
  - Location where services will take place (telephonically or in person)
  - Estimated length of time service will be required
- The appointment takes place and interpretation services are provided.
- If any follow-up appointments are needed after the initial appointment, the interpretation services may be arranged at that time.

21.3 Covered Services

The interpretation provider may only bill Medicaid for time spent with the client in conjunction with Medicaid healthcare services delivered by different providers.

21.4 Non-Covered Services

- Medicaid will not pay for interpreter services in conjunction with the following services:
  - Inpatient or outpatient hospital services.
  - Intermediate Care Facilities for persons with Intellectual Disability (ICF-ID).
  - Nursing facilities.
  - Ambulance services by public providers.
  - Psychiatric Residential Treatment Facilities.
  - Comprehensive inpatient or outpatient rehabilitation facilities.
  - Other agencies/organizations receiving direct federal funding.
- Interpreter services provided by family members or by a volunteer, associate or friend.
- Reimbursement for travel to and from the appointment.
- Services provided to a client on an ALEN program that are not emergency services.

21.5 Billing Procedures

Following are the interpretation services billing procedures or requirements:

- Interpreters may bill for the same client on the same day more than once if provided in conjunction with Medicaid healthcare services delivered by different providers.
- The diagnosis code for interpretation services is Z71.0.
- The procedure code for interpretation services is T1013 and should be billed with the appropriate number of units provided.
  - One (1) unit = 15 minutes of service.
- When not providing services in-person the GT modifier must be used.

21.6 Required Documentation

Interpretation providers must maintain documentation to support that the service occurred. This should include (at minimum) the client's name, date of service, times in and out, service provided, and signature of provider.

Chapter Twenty Two – Covered Services – Laboratory Services

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22.1 Laboratory Services

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.

Procedure Code Range: 80047-89356

NOTE: Non-covered services include routine handling charges, stat fees, post-mortem examination and specimen collection fees for throat culture or Pap Smears.

22.2 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 (2.1, Quick Reference) located on Medicaid website 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.

CLIA CERTIFICATE TYPE	ALLOWED TO BILL						
REGRISTRATION, COMPLIANCE, OR ACCREDITATION (LABORATORY) (1)	G0103	G0123	G0124	G0141	G0143	G0144	G0145
	G0147	G0148	G0306	G0307	G0328	G0416	G0432
	G0433	G0434	G0477	G9143	P3000	17311	17312
	17313	17314	17315	78110	78111	78120	78121
	78122	78130	78191	78270	78271	78272	
	80000-89999 (UNLESS OTHERWISE SPECIFIED ELSEWHERE IN THIS TABLE)						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE LABORATORY (CLIA TYPE 1) SECTION AND ALL CODES FOR PPMP (CLIA TYPE 4) SECTION AND WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
PROVIDER-PERFORMED MICROSCOPY PROCEDURES (PPMP) (4)	81000	81001	81015	81020	89055	89190	G0027
	Q0111	Q0112	Q0113	Q0114	Q0115		
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE PPMP (CLIA TYPE 4) SECTION AND ALL CODES FOR WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
WAIVER (2)	80047 QW	80048 QW	80051 QW	80053 QW	80061 QW	80069 QW	80178 QW
	81003 QW	81007 QW	82010 QW	82040 QW	82043 QW	82044 QW	82120 QW
	82150 QW	82247 QW	82271 QW	82274 QW	82310 QW	82330 QW	82374 QW
	82435 QW	82465 QW	82523 QW	82550 QW	82565 QW	82570 QW	82679 QW
	82947 QW	82950 QW	82951 QW	82952 QW	82977 QW	82985 QW	83001 QW
	83002 QW	83036 QW	83037 QW	83516 QW	83605 QW	83655 QW	83718 QW
	83721 QW	83861 QW	83880 QW	83986 QW	84075 QW	84132 QW	84155 QW
	84295 QW	84443 QW	84450 QW	84460 QW	84478 QW	84520 QW	84550 QW
	84703 QW	85014 QW	85018 QW	85576 QW	85610 QW	86294 QW	86308 QW
	86318 QW	86386 QW	86618 QW	86701 QW	86803 QW	87077 QW	87210 QW
	87449 QW	87804 QW	87807 QW	87808 QW	87809 QW	87880 QW	87899 QW
	89300 QW	89321 QW	G0328 QW	G0433 QW	G0434 QW	G0477 QW	81002
	81025	82270	82272	82962	83026	84830	85013
	85651						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE WAIVER (CLIA TYPE 2) SECTION AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
NO CERTIFICATION	PROVIDERS WITHOUT A CLIA MAY BILL ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (SEE BELOW)						

NOTE: QW next to a laboratory code signifies that a QW modifier must be used.

CODES EXCLUDED FROM CLIA REQUIREMENTS									
80500	80502	81050	82075	83013	83014	83987	84061	86077	86078
86079	86485	86486	86490	86510	86580	86891	86910	86923	86927
86930	86931	86932	86945	86950	86960	86965	86985	86999	87900
88125	88240	88241	88304 TC	88305 TC	88311	88312 TC	88313 TC	88314 TC	88329
88720	88738	88741	88749	89049	89220	89240	89251	89255	89261
89272	89281	89290	89354	89398					

For updated Medicare CLIA information visit:

http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Categorization_of_Tests.html

22.3 Genetic Testing

Procedure Codes: 81201-81507; 96040

Prior Authorization is required for all genetic testing codes. Prior authorization documentation must document the following:

- 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; 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. (6.13, Prior Authorization).
- 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

22.3.1 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). 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
- Pre-test genetic counseling has been prior authorized.

22.3.2 Counseling

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

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

Physician specialties that may bill for BRCA genetic counseling are:

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

22.3.3 Billing Requirements

- Prior authorization is required for BRCA pre-test counseling and must be submitted by a physician with a specialty listed above.
- BRCA testing CPT codes will only be paid with an approved prior authorization for pre-test counseling.
- Prior authorization requests will need to be submitted to Medical Policy (2.1, Quick Reference)
- Prior authorization documents should include:
  - The reason for the test(s); and
  - Previous lab results; and
  - How the test results will be utilized; and
  - How the test results will contribute to improved health outcomes; and
  - How the test results will alter the client's treatment management.

Providers may contact Medical Policy (2.1, Quick Reference) by telephone for verbal prior authorization. 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.

Chapter Twenty Three – Covered Services – Non-Emergency Medical Transportation

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23.1 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.

23.1.1 Covered services

23.1.1.1 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
- Transportation Call Center will contact Ride Provider once the ride is approved
- Transportation Call Center will supply client ID for billing purposes to Ride provider

23.1.1.2 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)

23.2 Billing Information

23.2.1 Taxi Rides

Procedure codes A0100, S0215

- Taxi provider must receive authorization for the taxi ride from the Transportation Call Center
- Transportation Call Center will provide client ID and TAC number for billing purposes
  - The TAC number will be entered as the client's account number on the claim when billing
- Bill procedure code A0100 – Base Rate – 1 unit for each one way trip
- Bill procedure code S0215 – mileage for each mile or part of a mile
  - Mileage is always rounded up. Example: 5.2 miles would be billed as 6 miles.
- 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
  - 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.

23.2.2 Non-Taxi Rides

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 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

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

  - 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)
- 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
  - 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.

23.2.3 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

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24.1 Practitioner Services

Practitioners Include:

- Physicians (MD/DO).
- Locum Tenens.
- Nurse Practitioners.
- Physician's Assistants, prior to 7/1/16 can only bill for Medicare crossover claims.
- Mental Health Providers.
- Ordering, Rendering and Prescribing Providers.

24.2 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

24.2.1 Abortion

24.2.1.1 Covered Services

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

- The client suffers from a physical injury, or physical illness, including endangering the physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion was performed; or

- The pregnancy is the result of sexual assault as defined in Wyoming Statute W.S. 6-2-301, which was reported to a law enforcement agency within five (5) days after the assault or with five days after the time the victim was capable of reporting the assault; or
- The pregnancy is the result of sexual assault as defined in Wyoming Statute W.S. 6-2-301, and the client was unable for physical or psychological reasons to comply with the reporting requirements; or
- The pregnancy is the result of incest.

24.2.1.2 Reimbursement Requirements

The Abortion Certification Form (6.16.3.1, Abortion Certification Form) must accompany all claims from the attending physician, assistant surgeon, anesthesiologist, pathologist and hospital. The attending physician is required to supply all other billing providers with a copy of the consent form.

- In cases of sexual assault, submission of medical records is not required prior to payment; however, documentation of the circumstances of the case must be maintained in the client's medical records.
- Other abortion-related procedures, including spontaneous, missed, incomplete, septic, and hydatiform mole, do not require the certification form; however, all abortion related procedure codes are subject to audit, and all pertinent records must substantiate the medical necessity and be available for review.
- Pregnancies that terminate in spontaneous abortion/miscarriage in any trimester must bill with the appropriate CPT-4 code and documentation is required in the client's record. Prenatal visits and additional services may be billed in addition to the abortion code.
- RU-486 under the same guidelines as the legally induced abortion is covered when administered by a practitioner in the practitioner's office.

NOTE: Reimbursement is available for those induced abortions performed during periods of retroactive eligibility only if the Abortion Certification Form (6.16.3.1, Abortion Certification Form) is completed prior to performing the induced abortion.

24.3 Anesthesia Services

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

Procedure Code Range: 00100-01999

24.3.1 Covered Services

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

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

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

24.3.2 Billing Guidelines

- When billing ASA procedure codes, enter actual minutes for procedures where time is necessary. Fractions of time are always rounded up to the next full number.
  - For example, enter 65 minutes, rather than one (1) hour five (5) minutes.
  - For example, nine (9) minutes would be rounded up to 15 minutes.
- Anesthesia units must be billed in minutes. Do not convert or change time by dividing by 15, the Medicaid's claims processing system does this automatically.
- Anesthesia CPT Codes are reimbursed based on the units of the anesthesia procedure and the time units allowed. The total units are multiplied by a conversion factor to determine the allowed amount. Medical supervision is not reimbursed.
  - For example, claim is billed with 105 units: 105(units billed)/15 = 7 (Anesthesia Units). Add the anesthesia units to the base value (RVU) assigned to the procedure code: 7 + 7= 14. Times that total by the conversion factor for that procedure code: 14 x 27.04 = $378.56 = total paid.

    Conversion Factor Amt: 27.04
    RVU: 7.00
    NDC Indicator: N/A
    Prior Authorization : N

    Note: The conversion factor and RVU for each anesthesia procedure code can be found on the fee schedule on the Wyoming Medicaid website.
- Anesthesia time begins when the anesthesiologist starts to prepare for the induction of the anesthesia and ends when the anesthesiologist is no longer in

personal attendance. Anesthesia time is the total number of minutes the surgery(ies) is performed.
  - For example, preparation of the induction began at 11:00 am and the anesthesiologist was no longer in attendance by 2:15 pm, total minutes would be 195 and is also the number of units to be billed.
- Providers should bill the appropriate CPT-4 procedure codes for induction/injection of anesthetic agent.
- When multiple procedures are performed during a single anesthetic administration, Medicaid will pay the anesthesia code representing the most complex procedure reported. The time reported is the combined total for all procedures.
- Anesthesia is a global service just as the surgical procedure for which it is given. No pre or postoperative services will be recognized for separate payment, including those for:
  - Pain Management on the same day as surgery.
  - Routine monitoring is included in the primary anesthesia and not reimbursed separately. For specific information regarding routine monitoring, refer to the current version of the ASA relative value guide.
  - Laryngoscopy codes 31505, 31515, and 31527 are incidental or included within the anesthesia time.
  - Any anesthesia substance administered at the time of the procedure for circumcision, cannot be billed separately as this is considered part of the global package.
- If two (2) anesthesia codes are billed on the same day, (i.e. tubal ligation following vaginal delivery), documentation must be submitted with the claim to support the necessity of these services.

NOTE: Anesthesiologists and CRNA's are not required to request prior authorization (PA) directly from Medicaid for any anesthesia procedure.

24.3.3 Obstetrical Exceptions

- Procedure code 01967 is a global fee per the fee schedule and should be billed as one (1) unit, not the number of minutes. The Global fee includes:
  - Establishing and maintaining the anesthesia for the time the client requires it.
  - If the anesthesia should continue into the next day, use procedure code 01996.
- Anesthesia for multiple obstetrical procedures may be paid for both procedures in the following circumstances.
  - Neuraxial analgesia/anesthesia for planned vaginal delivery which becomes a Cesarean delivery.

- Use procedure code 01967 to begin the procedure and discontinue its use when a C-section is imminent, then begin using procedure code 01968 and continue on with straight time (minutes) as for a general surgery.

- Neuraxial analgesia/anesthesia for planned vaginal delivery followed by tubal ligation on same or the next day following delivery.
  - Use procedure code 01967 for delivery.
  - Use procedure code 00851 for intraperitoneal lower abdomen, tubal ligation/ transection.

NOTE: Medicaid does not allow CPT 01996 on the same day as placement of an epidural catheter.

24.3.4 Modifiers

When billing for anesthesia, indicate the appropriate physical status modifier. These modifiers indicate various levels of complexity of the anesthesia service provided. If a physical status modifier is billed, additional payment will be added, if appropriate to the claim payment.

Physical Status Modifiers		
Modifier	**Description**	**Reimbursement**
P1	A normal healthy client.	No change
P2	A client with mild systemic disease.	No change
P3	A client with severe systemic disease.	Additional 5%
P4	A client with severe systemic disease that is a constant threat to life.	Additional 10%
P5	A moribund client who is not expected to survive without the operation.	Additional 15%
P6	A declared brain-dead client whose organs are removed for donor purposes	Not covered

NOTE: The use of other optional modifiers may be appropriate.

24.3.5 Documentation Requirements

- Begin and end times must be documented in the anesthesia record and must be legible.
- Anesthesia time begins when the anesthesiologist begins to prepare the client for anesthesia care in the operating room or an equivalent area and ends when

the anesthesiologist is no longer in personal attendance and the client is safely placed under post-anesthesia supervision.

- If two (2) anesthesia codes are billed on the same day, (i.e. tubal ligation following vaginal delivery), documentation must be submitted with the claim to support the necessity of these services.

24.4 Dermatology

Medicaid covers medically necessary services rendered in the treatment of dermatological illnesses.

24.4.1 Covered Services

- Acne surgery due to disfigurement requires prior authorization. (6.13, 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.

24.4.2 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)**

24.4.3 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.

24.4.4 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.

24.4.5 Documentation Requirements

One (1) or more of the above conditions, clearly documented in the medical record, operative report or pathology report.

24.5 Diabetic Training

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 dieticians may furnish outpatient diabetes self-management training.

24.5.1 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.

24.5.2 Billing Requirements

- HCPCS Level II codes, G0108 (individual session) and G0109 (group session) should be used.
- Do not bill a separate office visit on the same date of service.
- For individual services, one (1) unit equals 30 minutes. A maximum of two (2) units applies.
- For group services, one (1) unit equals 30 minutes. A maximum of five (5) units per individual per training session applies.
- Billing is to be done under the physician, nurse practitioner or hospital's provider number.

24.5.3 Documentation

- 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.

24.6 Family Planning Services

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

24.6.1 Covered Services

- Sterilization procedures are covered only when all Medicaid guidelines have been met (6.16.1.1, 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 25.1.

24.6.2 Hysterectomies

Procedure Code Range: 58150-58294

Refer to the following sections for information:

- 6.16.2, Hysterectomy Acknowledgement of Consent.
- Section 6.16.2.2, Instructions for Completing the Hysterectomy Acknowledgement Consent Form.
- Section 6.16.2.1, Hysterectomy Consent Form.

24.7 Immunizations

Wyoming Vaccinates Important People (WyVIP) Program (formerly VFC).

Providers must enroll with the WyVIP program to receive and distribute WyVIP vaccines. The WyVIP 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). WyVIP covered vaccines may change from year to year. For more information on the WyVIP program current WyVIP covered vaccines or how to enroll as a WyVIP provider contact the Wyoming Immunization Program at (307)777-7952.

24.7.1 Billing Procedures: WyVIP Supplied or Private Stock

Use the following guidelines when submitting claims to Medicaid:

- Providers must use a WyVIP provided vaccine when available and client appropriate. If the vaccine is supplied by WyVIP, 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 WyVIP 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 WyVIP 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 WyVIP 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 WyVIP, 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.

- **Human Papilloma Virus (HPV) Vaccine**
    - For Codes & 90650 90649
        - Use CPT-4 code, 90649, for HPV Types 6, 11, 16, and 18 (quadrivalent)
        - Administer intramuscularly as three (3) separate doses. Use CPT code 90650, for HPV Types 16, 18 (bivalent)
        - Administer intramuscularly as three (3) separate doses.
        - If the client turns 19 years of age between the 1st and 2nd doses administration, a VFC supplied vaccine cannot be used to complete the series. Any HPV vaccine administered at age 19 or older must be administered from a provider's private stock vaccine.
        - If the vaccine is supplied by VFC, bill code 90649 or 90650 with the SL modifier. Also bill the appropriate administration code (see table below). Only the administration code will be reimbursed.
        - If the vaccine is supplied from private stock, bill code 90649 without the SL modifier and attach the manufacturers' invoice. Also bill the appropriate administration code (see table below).

The vaccine will be reimbursed at 100% of invoice cost along with the administration code.

- **For Code 90651**
  - Use CPT-4 code, 90651, for HPV Types 6, 11, 16, 18, 31, 33, 45, 52, and 58 nonvalent (HPV) for females only
    - Administer intramuscularly as three (3) separate doses. If the client turns 19 years of age between the first (1st) and second (2nd) doses administration, a VFC supplied vaccine cannot be used to complete the series. Any HPV vaccine administered at age 19 or older must be administered from a provider's private stock vaccine.
    - The vaccine must be supplied by VFC, bill code 90651 with the SL modifier. Also bill the appropriate administration code (see table below). Only the administration code will be reimbursed.

- **Influenza Vaccine**
  - Medicaid covers influenza vaccines for clients age 6 months and older.
    - If the vaccine is supplied by WyVIP, bill the appropriate procedure code and use the SL modifier. Also bill the appropriate administration code (see table below). Only the administration code will be reimbursed.
  - For codes 90656 and 90660:
    - If the vaccine is supplied from private stock and the client is 18 years of age or younger, **DO NOT USE** the SL modifier, and attach a manufacturers' invoice. Also bill the appropriate administration code (see table below). The vaccine will be reimbursed at 100% of invoice cost, along with the administration code.
    - If the vaccine is supplied from private stock, and the client is 19 years of age or older, **DO NOT USE** the SL modifier. No manufacturers' invoice is necessary. Also bill the appropriate administration code (see table below). The vaccine will be reimbursed at a flat $15.00 rate along with the administration code.

- **For code 90658:**
  - If the vaccine is supplied from private stock and the client is 18 years of age or younger, **DO NOT USE** the SL modifier, and attach a manufacturers' invoice. Also bill the appropriate administration code (see table below). The vaccine will be reimbursed at 100% of invoice cost, along with the administration code.

- If the vaccine is supplied from private stock, and the client is 19 years of age or older, **DO NOT USE** the SL modifier. No manufacturers' invoice is necessary. Also bill the appropriate administration code (see table below). The vaccine will be reimbursed at a flat $20.00 rate along with the administration code.

- **All other influenza vaccine codes:**
  - If the vaccine is supplied from private stock and the client is of any age, **DO NOT USE** the SL modifier, and attach a manufactures' invoice. Also bill the appropriate administration code (see table below). The vaccine will be reimbursed at 100% of invoice cost, along with the administration code.
  - When a Medicaid client is a resident of a long-term care facility, the vaccine and administration are included in the nursing home per diem rate, and not paid separately.

- **Pneumococcal Vaccine**
  - Medicaid covers pneumococcal vaccines for where it is medically indicated.
  - If the vaccine is supplied by WyVIP, bill the appropriate procedure code and use the SL modifier. Also bill the appropriate administration code (see table below). Only the administration code will be reimbursed.
  - If the vaccine is supplied from private stock and the client is of any age, **DO NOT USE** the SL modifier, and attach a manufacturers' invoice. Also bill the appropriate administration at 100% of invoice cost, along with the administration code.
  - When a Medicaid client is a resident of a long-term care facility, the vaccine and administration are included in the nursing home per diem rate, and not paid separately.

NOTE: If a significant separately identifiable Evaluation and Management service (e.g. Office or other outpatient services, preventive medicine services) is performed, the appropriate E&M service code should be reported in addition to the vaccine and toxoid administration codes.

Administration Codes – Physician Provides Face-to-Face Vaccine Counseling	
CPT Code	**Description**
90460	Immunization administration 0-18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
90461	Each additional vaccine/toxoid component (list separately in addition to code for 1st component) for age 0-18

Administration notes: For vaccines where physician or other qualified health care professional provides counseling, code 90460 will be reported once for each vaccine administered. For any vaccine with multiple components (i.e. DtaP or Tdap), 90461 will be reported for each additional component. If multiple vaccines are administered, "like codes" must be combined onto the same line, using multiple units to avoid denials for duplicates. Medicaid will pay up to the allowable on each unit of 90460, and $0.00 for each unit of 90461. Providers should bill their usual and customary fee for 90460 and $0.00 for 90461.

24.7.2 Billing Examples

Example 1: Provider administers the HPV vaccine, state supplied with physician counseling:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/15	90649 SL	$0.00	1
01/01/15	90460	$21.72	1

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/15	90651 SL	$0.00	1
01/01/15	90460	$21.72	1

Example 2: Provider administers Tdap, MMR and Influenza. All are state supplied with physician counseling:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/15	90707 SL	$0.00	1
01/01/15	90715 SL	$0.00	1
01/01/15	9065 SL	$0.00	1
01/01/15	90460	$65.16	3
01/10/15	90461	$0.00	4

Explanation of Example 2: Three (3) units of 90460 (one (1) for each vaccine administered to indicate each 1st component) and four (4) units of 90461 (one (1) for each additional component in the Tdap and the MMR vaccine beyond the 1st.

Administration Codes – Face-to-Face Vaccine Counseling Not Provided by Physician	
CPT Code	**Description**
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one (1) vaccine (single or combination vaccine/toxoid). Do not report in conjunction with 90473.
90472	Each additional vaccine (single or combination vaccine/toxoid). List separately in addition to code for primary procedure (90471 or 90473).
90473	Immunization administration by intranasal or oral route; one (1) vaccine (single or combination vaccine/toxoid). Do not report with 90471.
90474	Each additional vaccine (single or combination vaccine/toxoid). List separately in addition to code for primary procedure (90471 or 90473).

For vaccinations where face to face counseling is not provided, 90471 or 90473 is reported for the first vaccine, and 90472 or 90474 (units combined for multiples) for each additional vaccine.

Example 4: Provider administers the HPV vaccine, state supplied, without physician counseling:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/15	90649 SL	$0.00	1
01/01/15	90471	$14.00	1

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/15	90651 SL	$0.00	1
01/01/15	90471	$14.00	1

Example 5: Provider administers Tdap, MMR and Influenza, all state supplied, without physician counseling:

DOS (24A)	Procedure Code (24C)	Charges (24F)	Units (24G)
01/01/15	90707 SL	$0.00	1
01/01/15	90715 SL	$0.00	1
01/01/15	90656 SL	$0.00	1
01/01/15	90471	$14.00	1
01/01/15	90472	$28.00	2

Explanation of Example 5: One (1) unit of 90471 for the first (1st) vaccine, and two (2) units of 90472 for the other two (2) vaccines.

NOTE: WyVIP is not intended for private pay patients.

24.7.3 Other Immunizations

Other immunizations include, but are not limited to:

- Synagis
  - Synagis is used for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in infants and children under two (2) years of age with chronic lung disease who have required medical therapy for their chronic lung disease within six (6) months before the anticipated RSV season (American Academy of Pediatrics Committee on Infectious Diseases and Committee on Fetus and Newborns).
  - Wyoming Medicaid will pay for Synagis when ordered by a physician to prevent RSV when the following conditions are met:
    - Chronic Lung Disease: Client is < 24-months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia), continues to require medical intervention (chronic corticosteroid or diuretic therapy) or required supplemental oxygen for at least 28 days after birth.
    - Congenital Heart Disease: Client is < 12 months of age at start of therapy and has hemodynamically significant congenital heart disease and one (1) or more of the following:
      - Is receiving medication to control congestive heart failure.
      - Has a diagnosis of moderate to severe pulmonary hypertension.
      - Has a diagnosis of cyanotic heart disease.
    - Prematurity:
      - Client is < 12 months of age at start of RSV season and born at < 28 weeks, six (6) days gestational age.
      - Client is < 12 months of age at start of RSV season and born at 34-weeks, six (6) days or less gestational age and has either severe neuromuscular disease or congenital abnormalities, either of which compromise handling of respiratory secretions.
      - Client is < six (6) months of age at start of RSV season and born between 29 weeks, zero (0) days and 35 weeks, six (6) days gestational age.
  - If Synagis is prescribed outside the normal prescribing guidelines, the physician will need to supply documentation of medical necessity to support prescribing.

- Synagis may be provided in a physician's office or in an outpatient hospital or clinic setting. Because of the short stability once mixed (six (6) hours) and the expense of this medication, every effort should be made to ensure the least amount of waste. Scheduling multiple clients that are in need of this medication within the six (6) hour allotment is suggested.
- Synagis may be billed one (1) of two (2) ways:
  - Supplied by a pharmacy and injected at the physician's office.
    - The physician's office may bill the appropriate Evaluation and Management code, procedure code 90772 for the injection fee.
  - The physician's office supplies the medication and gives the injection.
    - The physician submits a claim for the appropriate Evaluation and Management code, procedure code 90378 and appropriated NDC for the Synagis and the 90772 for the injection fee.

NOTE: Because of the cost associated with Synagis, only one (1) month's dose should be billed at a time.

- 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 WyVIP 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).

24.8 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 (6.8, 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).

24.8.1 Belimuab (Benlysta®) Criteria

Procedure Code: J0490

24.8.1.1 Covered Services

Belimumab is covered and considered medically necessary if the below requirements are met.

24.8.1.2 Billing Requirements

Prior authorization requirements:

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 18 years of age or older.
- 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.
- Benlysta® (belimumab) PA Criteria Page two (2) of four (4) Current Procedural Terminology copyright American Medical Association. All Rights Reserved. Contains Public Information.
- 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 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.

NOTE: Length of Approval: 12 months.

24.8.2 Botox®, Dysport® and Myobloc®

Procedure Code Range: J0585-J0587

24.8.2.1 Covered Services

Botulinum toxin type A (e.g., onabotulinumtoxinA [Botox®], or abobotulinumtoxinA [Dysport®]) or B (fimabotulintoxinB [Myobloc®] for the treatment of the following conditions and are considered medically necessary when specific criteria is met.

24.8.2.2 Billing Requirements

Prior authorization requirements:

Wyoming Medicaid considers Botulinum toxin A (onabotulinumtoxinA [Botox®] and abobotulinumtoxinA [Dysport®]) appropriate for the treatment of the following conditions and meet medical necessity criteria where it is stated:

- Strabismus with ALL of the following:
  1. Associated with dystonia (impaired or disordered tonicity)
  2. ABSENCE of ALL of the following:
     a. Duane's syndrome with lateral rectus weakness.
     b. Restrictive strabismus.
     c. Strabismus secondary to prior surgical over-recession of the antagonist.
     d. Strabismus deviations more than 50 prism diopters.
     e. Chronic paralytic strabismus except when used with surgical repair to reduce antagonist contracture.

- Severe primary hyperhidrosis with ALL of the following:
  1. Location is ANY ONE (1) of the following:
     a. Axillary
     b. Palmar
  2. Treatment is not adequately managed with topical agents

3. The condition causes ANY ONE (1) of the following:
    a. Functional impairment
    b. Medical complications

- Urinary incontinence with ALL of the following:
    1. Individual has undergone urodynamic studies with diagnosis of idiopathic detrusor over-activity (IDO).
    2. Anticholinergic therapy has failed to provide adequate control.

NOTE: Not allowed when an individual has a urinary tract infection, in patients with urinary retention and in patients with post-void residual (PVR) urine volume > 200 mL who are not routinely performing clean intermittent self-catheterization (CIC).

- Blepharospasm
- Cranial nerve VII disorders (eg. Hemifacial spasms)

Wyoming Medicaid considers Botulinum toxin type A (e.g., onabotulinumtoxinA [Botox®], or abobotulinumtoxinA [Dysport®]) or B (fimabotulintoxinB [Myobloc®] for the treatment of the following conditions are considered **medically necessary**:

- Achalasia
- Cervical Dystonia
- Chronic anal fissure
- Hereditary spastic paraplegia
- Idiopathic torsion dystonia
- Infantile cerebral palsy, spastic
- Organic writer's cramp
- Orofacial dyskinesia
- Oromandibular dystonia
- Spasmodic dysphonia
- Spasmodic torticollis
- Spastic hemiplegia
- Symptomatic torsion dystonia

Botulinum toxin type A (e.g., onabotulinumtoxinA [**Botox**®]) for the prevention of migraine headaches 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.
  - Last four (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/antiotensin 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 with **ANY ONE (1)** of the following:
  - Frequency reduced by at least seven (7) days per month.
  - Duration of headache reduced by at least 100 hours per month.

NOTE: Botox® can only be requested one (1) session at a time, with medical necessity provided for each session and only 360 units (three (3) month supply) per limb.

24.8.3 Ocrelizumab (Ocrevus)

Procedure Code: J2350 - ONLY NDC Approved 50242.0150.01

24.8.3.1 Covered Services

Ocrelizumab (Ocrevus) is used for the treatment of patients with relapsing or primary progressive forms of multiple sclerosis and considered medically necessary if the medical appropriateness criteria are met. (See Medical Appropriateness below.)

24.8.3.2 Billing Requirements

Prior Authorization Requirements:

Initial Approval

- Ocrelizumab (Ocrevus) for the treatment of multiple sclerosis is considered medically appropriate 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

Quantity Limits and PA issuance:

- Product comes as 300mg/10ml, single dose vial
- Patient receives initial dose of 300mg (IV), with a second 300 mg dose two weeks later
- Subsequent dose is 600mg every six months
  - A single PA will be provided in 600mg increments

PA Renewal Criteria

- Ocrelizumab is considered medically appropriate for renewal only when ALL of the following criteria are met:
  - Documented 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 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 for denial of PA request

- Unclear indication
- Active hepatitis B virus infection
- History of life-threatening infusion reaction
- Patient has not completed an adequate trial with the preferred drugs (RRMS only)

24.8.4 Synvisc® Injections

(Hyaluronan, Hyaluronic acid, Sodium Hyaluronate, Hylan polymers)

Procedure Code: J7321-J7326

24.8.4.1 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.

24.8.4.2 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.

24.8.4.3 Billing Requirements

Prior authorization requirements:

Wyoming Medicaid considers Synvisc injections as medically necessary when any of the following is met and is clearly documented in the medical record, operative report or pathology report. The following criteria must be met for approval of coverage:

Documented diagnosis of symptomatic osteoarthritis of the knee.

- 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.
- Pain interferes with functional activities such as ambulation and prolonged standing.
- 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.

24.8.5 Tysabri®

Procedure Code: J2323

24.8.5.1 Covered Services

Tysabri® is a treatment for MS to delay the accumulation of physical disability and reduce the frequency of clinical exacerbations. It is used as a monotherapy. Tysabri® is recommended for patients who have had an inadequate response to, or are unable to tolerate alternate MS therapies.

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.

24.8.5.2 Billing Requirements

Prior authorization (PA) requirements:

- 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.
- Length of PA: 12 months
- For continued PA the neurologist must submit documentation to show improvement or stabilization.
- 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.

24.8.5.3 Documentation Requirements

- Physician's prescription
- Complete Prior Authorization Form (6.13, Prior Authorization)
- 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.

24.9 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 services 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."

Medicaid providers should arrange this service for their clients by contacting an enrolled interpretation provider prior to the medical appointment. A current list of enrolled interpretation providers and is available on the Medicaid website or upon request from Provider Relations (2.1, Quick Reference). Interpretation services may be provided telephonically (via a language line service) or in person. When coordinating interpreter services for a client it will be necessary to provide the enrolled interpretation provider with the following information:

- Name of client.
- Client's Medicaid ID number.
- Name of referring provider.
- Time and date service will be rendered.
- Location of where service will take place (telephonically or in person).
- Estimated length of time service will be rendered.

24.10 Laboratory Services

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

- Services are ordered and provided by physicians, dentists, or other providers 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.

Procedure Code Range: 80048-89331

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

24.10.1 CLIA Requirements

The type of CLIA certificate required to cover specific codes is listed in the table below. These codes are identified by Center for Medicare and Medicaid Services (CMS) as requiring CLIA certification; however, Medicaid may not cover all of the codes listed. Refer to the fee schedule located on Medicaid website for actual

coverage and fees. Content is subject to change at any time, without notice (2.1, Quick Reference).

NOTE: Codes within the below table are Wyoming Medicaid specific. It is the provider's responsibility to ensure the codes being billed are covered by Wyoming Medicaid.

CLIA CERTIFICATE TYPE	ALLOWED TO BILL						
REGRISTRATION, COMPLIANCE, OR ACCREDITATION (LABORATORY) (1)	G0103	G0123	G0124	G0141	G0143	G0144	G0145
	G0147	G0148	G0306	G0307	G0328	G0416	G0432
	G0433	G0434	G9143	P3000	17311	17312	17313
	17314	17315	78110	78111	78120	78121	78122
	78130	78191	78270	78271	78272		
	80000-89999 (UNLESS OTHERWISE SPECIFIED ELSEWHERE IN THIS TABLE)						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE LABORATORY (CLIA TYPE 1) SECTION AND ALL CODES FOR PPMP (CLIA TYPE 4) SECTION AND WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
PROVIDER-PERFORMED MICROSCOPY PROCEDURES (PPMP) (4)	81000	81001	81015	81020	89055	89190	G0027
	Q0111	Q0112	Q0113	Q0114	Q0115		
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE PPMP (CLIA TYPE 4) SECTION AND ALL CODES FOR WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
WAIVER (2)	80047 QW	80048 QW	80051 QW	80053 QW	80061 QW	80069 QW	80178 QW
	81003 QW	81007 QW	82010 QW	82040 QW	82043 QW	82044 QW	82120 QW
	82150 QW	82247 QW	82271 QW	82274 QW	82310 QW	82330 QW	82374 QW
	82435 QW	82465 QW	82523 QW	82550 QW	82565 QW	82570 QW	82679 QW
	82947 QW	82950 QW	82951 QW	82952 QW	82977 QW	82985 QW	83001 QW
	83002 QW	83036 QW	83037 QW	83516 QW	83605 QW	83655 QW	83718 QW
	83721 QW	83861 QW	83880 QW	83986 QW	84075 QW	84132 QW	84155 QW
	84295 QW	84443 QW	84450 QW	84460 QW	84478 QW	84520 QW	84550 QW
	84703 QW	85014 QW	85018 QW	85576 QW	85610 QW	86294 QW	86308 QW
	86318 QW	86386 QW	86618 QW	86701 QW	86803 QW	87077 QW	87210 QW
	87449 QW	87804 QW	87807 QW	87808 QW	87809 QW	87880 QW	87899 QW
	89300 QW	89321 QW	G0328 QW	G0433 QW	G0434 QW	G0477 QW	81002
	81025	82270	82272	82962	83026	84830	85013
	85651						
	PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE WAIVER (CLIA TYPE 2) SECTION AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)						
NO CERTIFICATION	PROVIDERS WITHOUT A CLIA MAY BILL ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (SEE BELOW)						

NOTE: QW next to a laboratory code signifies that a QW modifier must be used.

CODES EXCLUDED FROM CLIA REQUIREMENTS									
80500	80502	81050	82075	83013	83014	83987	84061	86077	86078
86079	86485	86486	86490	86510	86580	86891	86910	86923	86927
86930	86931	86932	86945	86950	86960	86965	86985	86999	87900
88125	88240	88241	88304 TC	88305 TC	88311	88312 TC	88313 TC	88314 TC	88329
88720	88738	88741	88749	89049	89220	89240	89251	89255	89261
89272	89281	89290	89354	89398					

24.10.2 Genetic Testing

Procedure Codes: 81201-81479; 96040

Prior Authorization is required for all genetic testing codes. Prior authorization documentation must document the following:

24.10.2.1 Covered Services

Medicaid covers genetic testing under the following conditions:

- There is reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists; and
- Test results will influence decisions concerning disease treatment or prevention (in ways that not knowing the test results would not); and
- Genetic testing of children might confirm current symptomatology or predict adult onset diseases and findings might result in medical benefit to the child or as the child reaches adulthood; and
- Referral is made by a genetic specialist (codes 81223 and 81224) or a specialist in the field of the condition to be tested; and
- All other methods of testing and diagnosis have met without success to determine the client's condition such that medically appropriate treatment can be determined and rendered without the genetic testing. (6.13, Prior Authorization).
- 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

24.10.2.2 BRCA Testing and Counseling

The U.S. Preventive Services Task Force (USPSTF) recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for evaluation for BRCA testing (81211-81217). 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
- Pre-test genetic counseling has been prior authorized.

24.10.2.3 Billing Requirements

Enrolled laboratories should bill Medicaid directly for genetic testing, refer to Section 20.3.

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 (6.15, 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%).
- No prior authorization is required.

NOTE: Post payment claim review will be conducted.

24.11 Maternity Care

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.

Procedure Code Range: 59000-59898

24.11.1 Billing Requirements

Global Care for Routine Obstetric Care

According to the AMA, if the global care is provided by the same physician or same physician group, then the appropriate global code must be reported. Global services are to be billed in all cases of a single physician or group providing uncomplicated maternity care.

- **59400** – Routine OB care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care.
- **59510** – Routine OB care including antepartum care, cesarean delivery and postpartum.
- **59610** – Routine OB care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous C-section.
- **59618** – Routine OB care including antepartum care, C-section and postpartum care, following attempted vaginal delivery after previous C-section.

NOTE: The E&M services (visits) provided within the Global package are included in the antepartum care and are not to be coded separately. The date of service is the date of delivery.

The services normally provided in uncomplicated maternity cases include antepartum care, delivery and postpartum care. Antepartum care includes:

- The initial and subsequent.
- Physical examination.
- Recording of the weight, blood pressures and fetal heart tones.
- Routine chemical urinalysis.
- Monthly visits up to 28-week's gestation, biweekly visits to 36 week's gestation and then weekly visits until delivery.

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.

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 delivery code and documentation must accompany the claim. 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 Guidelines for more information if the client is considering sterilization.

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.

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.

24.12 Medical Supplies (Disposable)

Procedure Code: 99070

Disposable medical supplies are intended for one (1) time use, not re-use, and specifically related to the active treatment or therapy of the client for a medical illness or physical condition. These supplies have a medical purpose, are consumable and/or expendable and non-durable. This does not include personal care items. They are not to be confused with durable medical supplies/equipment. The following is a partial list:

- Ace bandage
- Sling
- Rib belt
- Straight Catheter Kit
- Surgical tray

Reimbursement may be allowed for a surgical tray if minor surgery necessitates local anesthesia and other supplies (i.e., gauze, sterile equipment, suturing material) and the surgery is performed in the provider's office. Examples of procedures requiring a major surgical tray include:

- Diagnosis biopsies.
- Wound closures.
- Removal of cysts or other lesions.

Expendable medical supplies such as gauze, dressing, syringes and culture plates, are included in the reimbursement rate for the office visit or test performed. The most accurate way to verify coverage for a specific service/supply is to review the fee schedule on the Medicaid website (2.1, Quick Reference).

Supplies and materials, which do not have procedure codes, may be billed with CPT code 99070, which will reimburse billed charge up to $10.00. Claims for more than $10.00 require an attached invoice. These claims will be reimbursed at invoice plus shipping and handling plus 15%. Claims billed with this code will be subject to pre- and post-payment review (6.15, Submitting Attachments for Electronic Claims).

24.13 Phototherapy for High Bilirubin Levels

Procedure Code: E0202 RR

Effective with dates of service April 1, 2015 and forward, in order to provide better access to home therapy for newborns with high bilirubin levels, and reduce the number of hospital readmissions for Wyoming Medicaid infants, Wyoming Medicaid will be allowing the below taxonomies to bill the E0202 RR (phototherapy – rental) HCPCS code.

- All physicians (20s)
- Nurse Practitioners (363Ls, 367A00000X)
- Durable Medical Equipment Suppliers (332B00000X)
- Public Health Nurse's Offices (251K00000X)

24.13.1 Billing Requirements

Procedure code E0202 with the RR (rental only) modifier may be billed using daily units with a maximum of five (5) per lifetime.

Practitioner services, such as home or office based visits, home health visits, lab tests, etc., should be billed as appropriate in addition to the rental of the Biliblanket or other phototherapy device.

For clinical requirements, refer to the DME Covered Services Manual on the website (2.1, Quick Reference).

24.13.2 Phototherapy Maximum Allowable Appeal Process

Wyoming Medicaid encourages providers to submit the initial claim to receive reimbursement for the initial five (5) days. Then, when appealing, submit an Adjustment/Void Request Form (6.18.3.1, Adjustment/Void Request Form) with a corrected claim that has the additional units included along with medical necessity and an appeal letter to the below address.

Providers may choose to submit only one (1) claim which includes the additional units along with the medical necessity and the appeal letter to:

DME Provider Services Manager
6101 Yellowstone Road, Suite 210
Cheyenne, WY 82002

24.14 Practitioner Visits

Procedure Code Range: 99201-99443

Practitioner services are provided in inpatient and outpatient settings and include:

- Consultation services

- Emergency department services
- Home visits
- Hospital services
- Nursing facilities
- Office visits
- Telephone services

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.

24.14.1 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.

24.14.2 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.

24.14.3 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.

24.14.4 Consultation Services

Procedure Code Range: 99241-99245

Consultation services are when a practitioner's opinion or advice is sought by another practitioner for further evaluation and/or management of a client for a specific problem.

24.14.4.1 Billing Requirements

- The request and need for a consultation from the attending practitioner, along with the consultant's opinion and any service that was ordered or performed, must be documented in the client's record and communicated to the requesting practitioner.
- If subsequent to the completion of a consultation, the consultant assumes responsibility for management of all or a portion of the client's condition(s), the follow-up consultation codes should not be used.
- If an additional request for an opinion or advice regarding the same or new problem is received from the attending practitioner and documented in the medical record, the office consultation codes may be used again.
- When billing for a consultation, the NPI of the referring practitioner must be provided on the claim.

NOTE: For an accurate listing of codes, refer to the fee schedule on the Medicaid website (2.1, Quick Reference).

24.14.4.2 Documentation

Medicaid requires Documentation of Medical Necessity (3.4, Medical Necessity) to be attached to a claim submitted by the consulting practitioner when a client is seen for an additional consultation within one (1) year of the initial consultation.

24.14.5 Emergency Department Services

Procedure Code Range: 99281-99288

Emergency department services provide evaluation, management, treatment and prevention of unexpected illnesses or injuries. Emergency Department is defined as an organized hospital-based facility for the provision of unscheduled, episodic services to clients who present themselves for immediate attention. The facility must be available 24-hours a day.

24.14.5.1 Covered Services

Medicaid covers practitioner services performed by:

- A hospital-based emergency room practitioner;
- A private practitioner who furnished emergency room services through arrangement with the hospital; or
- A private practitioner who is called to the hospital to treat an emergency.
- The practitioner must document in the client's medical record if the client's visit to the emergency room was actually an emergency situation.

NOTE: Practitioners are requested to report any potential abuse of emergency room visits to Provider Relations (2.1, Quick Reference).

24.14.6 Home Visits

Procedure Code Range: 99341-99350

Home visits are evaluation and management services provided by a practitioner in a private residence.

This benefit is not intended to replace those services available in the community through other agency programs, (Best Beginnings, Public Health Nurse, Home Health, etc.) but to offer the attending practitioner another alternative to care for clients.

24.14.6.1 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.

24.14.6.2 Limitations

- Medicaid will reimburse the admitting practitioner for only one (1) initial visit per client for each hospital stay.
- A comprehensive inpatient hospital visit is not allowed within 30-days of a previous hospital admission with the same diagnosis.
- Medicaid will not reimburse a comprehensive hospital inpatient exam on the same day as an office visit, nursing home visit or ER visit by the same provider.

NOTE: For initial inpatient encounters by practitioners other than the admitting practitioner use initial inpatient consultation codes or subsequent hospital care codes.

24.14.6.3 Billing Requirements

- **Initial Hospital Care (99221-99223)** – All E&M services (e.g., office visits) related to and provided on the same date as an inpatient hospital admission are considered part of that hospital admission.
- **Subsequent Hospital Care (99231-99233)** – Subsequent visits are limited to one (1) visit per day unless a Documentation of Medical Necessity is attached and approved by Medicaid. All subsequent hospital care visits are to include the medical record and the results of diagnostic studies and changes in the status since the last assessment by the practitioner (3.4, Medical Necessity).
- **Observation or Inpatient Care Services (99234-99236)** – These codes are used when the client is admitted and discharged on the same day. These codes are used to report observation or inpatient hospital care services provided to clients admitted and discharged on the same date of service. It is not required that the client be located in an observation area designated by the hospital as a separate unit. These codes are to be used based on the level of care the client received rather than location.
- **Hospital Discharge Services (99238-99239)** – Practitioners may bill for the final day of an inpatient hospital stay when they provide a final examination, discussion of the stay, instructions for continuing care and preparation of discharge records. These codes are only allowed when an initial or subsequent hospital visit is billed on the day of discharge.
    - To report services provided to a client admitted to the hospital after receiving hospital observation care services on the same date, refer to the hospital inpatient billing instructions. For a client admitted to the hospital on a date subsequent to the date of observation status, the hospital admission is reported using the appropriate initial hospital care codes. Do not report the observation discharge in conjunction with the hospital admission.
    - All evaluation and management services related to and provided on the same day as an admission to observation status are considered part of that admission. Do not report them separately. This applies regardless of the setting in which the services are provided (e.g., a hospital emergency department, a physician's office or a nursing facility, etc.).
    - These codes apply to all practitioner services provided on the same date of client admission to observation status. Do not use these codes for postoperative recovery if the procedure is considered a global procedure.
- **Concurrent Care** – Inpatient hospital care provided by two (2) or more practitioners to the same client on the same day. Practitioners who are

providing concurrent care should use the subsequent hospital care billing codes. Medicaid will reimburse for these services when all of the following criteria are met:

- The practitioners have different specialties or subspecialties;
- The condition or injury involves more than one (1) body system;
- The condition or injury is so severe or complex that one (1) practitioner alone cannot handle the client's care; and
- The practitioners are actively co-managing the client's treatment.

24.14.7 Critical Care Services

Procedure Code Range: 99291

Critical care is the treatment of critically ill clients experiencing medical emergencies requiring constant attendance of the practitioner. Critical care is typically provided in a critical care unit. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the client's condition Critical Care services include:

- The interpretation of cardiac output measurements (93561, 93562)
- Chest x-rays (71010, 71015, 71020)
- Blood gases
- Data stored in computers
- Gastric intubation (43752, 91105)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94002-94003, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36600)
- Pulse oximetry (94760, 94762)

The critical care codes are used to report the total duration of time spent by a practitioner providing constant attention to a critically ill client. The procedure code 99291 is to report the first 30-74 minutes of critical care should be used only once per day even if the time spent by the physician is not continuous that day. Another procedure code 99292 is used to report each additional 30 minutes (30 minutes = 1 unit) beyond the first 74 minutes.

24.14.8 Prolonged Service

Procedure Code Range: face-to-face 99354-99357 and non-face-to-face 99358-99359

Prolonged physician services either direct face-to-face or non-face-to-face contact may be billed to Medicaid in addition to other physician's services. This service is reported when the service is beyond the usual service in either the inpatient or

outpatient setting. In addition to other physician service, including E&M services at any level.

NOTE: Prolonged services that exceed three (3) hours on the same date of service must be documented as medically necessary in the patient's medical record, including the purpose and actual time the physician was detained (3.4, Medical Necessity).

24.14.9 Practitioner Standby Service

This procedure code is used to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct (face-to-face) client contact. The physician may not be providing care or services to other clients during this period. This code is not used if the period of standby ends with the performance of a procedure subject to a "surgical" package by the physician who was on standby.

Standby service of less than 30-minutes duration on a given day is not reported separately.

Second and subsequent periods of standby beyond the first 30-minutes may be reported only if a full 30-minutes of standby was provided for each unit of service reported.

NOTE: This code may not be reported in addition to CPT-4 code 99464 for attendance at delivery.

Procedure Code Range: 99360

24.14.10 Inpatient Pediatric/Neonatal Critical Care

Procedure Code Range: 99291

24.14.10.1 Covered Services

Critical care codes include the following:

- Management
- Monitoring treatment of the client
- Parent counseling
- Direct supervision of the healthcare team in the performance of cognitive and procedural activities
- Cardiac and respiratory monitoring
- Continuous and/or frequent vital sign monitoring

- Heat maintenance
- Enteral and/or parenteral nutritional adjustments
- Laboratory service
- Oxygen

24.14.10.2 Billing Requirements

Services start with the date of admission to the NICU and may be reported only once per day, per client. Once the neonate is no longer considered to be critically ill, the appropriate codes for subsequent hospital care should be utilized.

The following procedures are also included as part of the global descriptors:

- Interpretation of chest x-rays.
- Cardiac output measurements.
- Pulse oximetry.
- Blood gases and other information stored in computers.
- Gastric intubation.
- Ventilation management.
- Temporary transcutaneous pacing.
- Vascular procedures.
- Chest X-rays.
- Umbilical venous and arterial catheters.
- Arterial, central venous or peripheral vessel catheterization.
- Vascular access procedures.
- Vascular punctures.
- Oral or nasogastric tube placement.
- Endotracheal intubation.
- Lumbar puncture.
- Suprapubic bladder aspiration.
- Bladder catheterization.
- CPAP management.
- Surfactant administration.
- Intravascular fluid administration.
- Blood transfusion.
- Monitoring of electronic vital signs.
- Bedside pulmonary function testing and/or monitoring or interpretation of blood gases or O2 saturation.

In addition, specific services are included in the parenthetic note following each NICU code.

NOTE: The most accurate way to verify coverage for a specific service is to review the CPT-4 book for the appropriate date of service.

24.14.11 Nursing Facilities

Procedure Code Range: 99304-99318

A nursing facility is an entity that provides skilled nursing care and rehabilitation services to people with illnesses, injuries or functional disabilities. Most facilities serve the elderly. However, some facilities provide services to younger individuals with special needs such as the developmentally disabled, mentally ill and those requiring drug and alcohol rehabilitation.

24.14.11.1 Covered Services

Practitioner services are covered when they are medically necessary and are performed to meet the requirements of continued long-term care.

24.14.11.2 Billing Requirements

When a client is admitted to the nursing facility in the course of an encounter in another site of service, such as office or emergency room, all evaluation and management service in conjunction with the admission is considered part of the initial nursing facility care if performed on the same date, and will not be reimbursed separately.

Initial client care may be billed only once per long-term care stay unless the client has moved to a different facility and/or changes providers.

Evaluation and management codes billed in addition to procedure code 99304 are not reimbursed when performed on the same date as the admission.

Hospital discharge or observation discharge services performed on the same date of nursing facility admission or readmission may not be reported separately.

Discharge planning codes may not be billed on date of the client's death.

Two (2) subcategories of nursing facility services are recognized. Both subcategories apply to new or established clients; and must be billed by the provider.

24.14.11.3 Nursing Facility Discharge Services

Nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a client.

- 99315 Nursing Facility discharge day management; 30-minutes or less.
- 99316 Nursing Facility discharge day management, more than 30-minutes.

NOTE: For an accurate listing of codes, refer to the fee schedule on the Medicaid website (2.1, Quick Reference).

24.14.12 Office Visits

An office visit is considered evaluation and management services provided in a practitioner's office or in an outpatient or other ambulatory facility.

24.14.12.1 Billing Requirements

- Office visits for new clients must be billed using CPT-4 codes 99201-99205.
- Established clients must be billed using CPT-4 codes 99211-99215.
- Several codes may be used in addition to the above codes when services are provided in a physician or practitioner's office for emergency care after scheduled routine office hours.
- Documentation must support the CPT-4 code(s) billed by the practitioner.

NOTE: For an accurate listing of codes, refer to the fee schedule on the Medicaid website (2.1, Quick Reference).

24.14.12.2 Telephone Services

Procedure Code Range: 99441-99443, limited to physician use only

24.14.12.3 Billing Requirements

Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related evaluation and management service provided within the previous seven (7) days nor leading to an evaluation and management service or procedure within the next 24-hours or soonest available appointment.

- Procedure code 99441: 5 to 10 minutes of medical discussion.
- Procedure code 99442: 11 to 20 minutes of medical discussion.
- Procedure code 99443: 21 to 30 minutes of medical discussion.

24.15 Preventive Medicine

Procedure Code Range: 99381-99385

24.15.1 Covered Services

For specific information on preventive health services for clients under age 21, refer to Section 18.1, 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.

24.16 Public Health Services

- Public health clinic services are physician and mid-level practitioner services provided in a clinic designated by the Department of Health as a public health clinic.
- Services must be provided directly by a physician or by a public health nurse under a physician's immediate supervision (i.e., the physician has seen the client and ordered the service).

24.17 Radiology Services

Procedure Code Range: 70010-79999

Radiology services are ordered and provided by practitioners, dentists, or other providers licensed within the scope of their practice as defined by law. Radiology providers must be supervised by a practitioner licensed to practice medicine within the state the services are provided. Imaging providers must meet state facility licensing requirements. Facilities must also meet any additional federal or state requirements that apply to specific tests (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).

24.17.1 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.

24.17.2 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

24.17.3 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.

24.18 Screening, Brief Intervention, Referral and Treatment (SBIRT)

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.

24.18.1 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.

24.18.2 Limitations

SBIRT will not be covered for clients with services limited to emergency services only.

24.19 Sterilizations and Hysterectomies

Procedure Code Range: 58150-58294, 58541-58554, 58600-58720

24.19.1 Elective Sterilization

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

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

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

- **Premature Delivery** – The Sterilization Consent Form must be completed and signed by the client at least 30-days prior to the estimated delivery date and at least 72-hours prior to the sterilization.
- **Emergency Abdominal Surgery** – The Sterilization Consent Form must be completed and signed by the client at least 72-hours prior to the sterilization procedure.
    - Clients must be at least 21 years of age when signing the form.

- Clients must not have been declared mentally incompetent by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.
- Clients must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing sterilizations, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent any time before the sterilization without being subject to retribution or loss of benefits.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks, which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits associated with the sterilization procedure.
- The client must know that he/she must have at least 30-days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the client has been informed (19.1, Interpreter Services).

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

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

24.19.2 Hysterectomies

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

- A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only

one (1) section (A, B or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client must sign and date section A of this form (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C apply. If this form is not properly completed, payment will be denied (6.16.2, Hysterectomy Acknowledgement of Consent).

- For clients that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one (1) of the following:
  - The client was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
  - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

NOTE: Pregnant by Choice/Family Planning Waiver has specific covered and non-covered services (25.1, Pregnant by Choice/Family Planning Waiver).

24.20 Surgical Services

Procedure Code Range: 10021-69990

Medicaid only covers surgical procedures that are medically necessary. In general, surgical procedures are covered if the condition directly threatens the life of a client, results from trauma demanding immediate treatment, or had the potential for causing irreparable physical damage, the loss or serious impairment of a bodily function, or impairment of normal physical growth and development.

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

24.20.1 Surgical Packages, Separate Surgical Procedures and Incidental Surgical Procedures

- **Surgical Packages** – Procedures that are commonly performed as an integral part of a total service and may not be billed separately. The following services are included in the surgical package in addition to the operation:
  - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
  - Subsequent to the decision for surgery, one (1) related Evaluation and Management (E&M) encounter on the date immediately prior to or on the date of procedure (including history and physical)
  - Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
  - Writing orders
  - Evaluating the patient in the post anesthesia recovery area

- Typical post-operative follow-up care.

- **Separate Surgical Procedures** – When a procedure is performed independently of, and is not immediately related to, other services, it may be reported separately under its unique procedure code (e.g., a tonsillectomy and an adenoidectomy may be billed separately), only if performed on a different day.
- **Incidental Surgical Procedures** – Incidental procedures are those procedures performed subsequent to surgery which do not add significantly to the major surgery or are rendered incidental and performed at the same time as the major surgery (e.g., incidental appendectomies, incidental scar excisions).

24.20.2 Covered Services

Normal preoperative and postoperative care includes:

- Pre-Op lab and radiology.
- Office examinations.
- Emergency room visits, and hospital visits, including discharge management
- Routine post-operative care (The number of post-operative days for each procedure is listed within the fee schedules.).

24.20.3 Limitations

Consultations and hospital admission are not considered part of the surgical package.

NOTE: Services provided to diagnose or treat conditions unrelated to the surgery may be billed with a separate examination code if the primary diagnosis code reflects a different complaint or service.

For an accurate listing of codes and the number of postoperative days for each procedure, refer to the fee schedule on the Medicaid website (2.1, Quick Reference).

24.20.4 Billing Requirements

All surgical claims for reimbursement for multiple surgical procedures must have an operative report attached (6.15, Submitting Attachments for Electronic Claims). The following methodology applies to reimbursement for surgical procedures (refer to the CPT-4 book for correct use of modifiers):

- **Unusual Procedural Services** – When the service(s) provided is greater than that usually required for the listed procedure, it may be identified adding modifier 22 to the usual procedure number. An operative report must accompany the claim for payment.

- **Multiple Procedures** – When multiple procedures are performed during the same session, the primary procedure will be paid at 100% of the fee assigned on the fee schedule. The primary procedure must be billed on the first line; the subsequent procedure(s) must be billed on the following line(s) using the 51 modifier, if applicable. Operative reports are required for multiple procedures. Refer to the Medicaid website for the most accurate fee schedule (2.1, Quick Reference).

NOTE: The 51 modifier pays at 50% of the customary rate.

- **Bilateral Procedures** – When bilateral procedures are performed during the same session, the second procedure will be paid at 75% of the customary rate. If the procedure performed is bilateral, providers should report the procedure with 1 unit of service on line 1 and 1 unit of service on line two (2) using the same procedure code with the 50 modifier. Care should be taken not to designate a procedure as bilateral when the procedure is already identified as a bilateral service in the CPT-4 definition. An example of a bilateral procedure would be a client having a tympanostomy (tubes inserted in the ears) performed on both the left and right ears; it should be billed as follows:

Line	Unit	CPT Code	Modifier
01	1	69433	
02	1	69433	50

NOTE: Operative reports are required for bilateral procedures.

24.20.5 Assistant Surgeon

Assistant surgeon fees are billed with an 80 modifier using the same procedure code billed by the primary surgeon.

24.20.5.1 Surgical Assistant Service

- Physician assistant, nurse practitioner or clinical nurse specialist service fees are billed with an AS modifier using the same procedure code billed by the primary surgeon.
- Non-physician providers (NPP) should bill with the AS modifier using the same procedure code billed by the primary surgeon.
- The provider must report the services using his/her own provider identification number with the appropriate site of service.
- The modifier AS is appended to the CPT-4 code(s) for the procedure(s) the NPP/APP assisted with.

- Do not use modifier AS if the NPP/APP acts as an "extra" pair of hands and not a surgical assistant in place of another surgeon.

24.20.5.2 Two (2) Surgeons

When two (2) surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62.

NOTE: If the co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier AS added, as appropriate. If the procedure code(s) require Prior Authorization, it is the responsibility of the individual practitioner to obtain that authorization. Example; two surgeons perform a surgery and utilize the 62 modifier; both surgeons MUST receive Prior Authorization.

24.20.5.3 Modifiers

Medicaid recognizes the following list of modifiers when used in conjunction with CPT-4 surgical procedure codes:

Modifier	Description	Reimbursement
22	Unusual Procedural Services – An operative report is required.	Allowed fee plus 20%
50	Bilateral Procedures	75% of allowed fee
51	Multiple Procedures	50% of allowed fee
62	Two (2) Surgeons – An operative report is required.	100% of allowed fee
80	Assistant Surgeons	20% of allowed fee
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery	15% of allowed fee

24.20.6 Cosmetic Services

Medicaid covers cosmetic services only when it is medically necessary (e.g., restore bodily function or correct a deformity). Before cosmetic services are performed, they must be prior authorized.

NOTE: Refer to Section 6.13 for Prior Authorization procedures and the fee schedule on the Medicaid website indicates which codes require prior authorization (2.1, Quick Reference).

24.20.7 Oral and Maxillofacial Surgeons

Procedure Code Range: 21010-21499

Oral and maxillofacial surgery is surgery to correct a wide spectrum of diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the oral and maxillofacial region.

24.20.7.1 Covered Services

- Removal of tumor
- Maxillofacial Prosthetics – Introduction and Removal
- Repair, Revision and/or Reconstruction
- Temporomandibular Joint (TMJ) Treatment

Procedure Code Range: 40490-42999

24.20.7.2 Covered Services

- Lips (excision and repair)
- Vestibule of mouth (incision, excision and repair)
- Tongue and Floor of mouth (incision, excision and repair)
- Dentoalveolar Structures (incision, excision and other)
- Palate and Uvula (incision, repair and other)
- Salivary Gland and Ducts (incision, excision, repair and other)
- Pharynx, Adenoids, and Tonsils (incision, excision, repair and other)

24.20.7.3 Billing Requirements

In order to obtain Medicaid reimbursement for services, the following standards must be observed.

- The services must be medically necessary and follow generally accepted standards of care
- The service must be a service covered by Medicaid
- Claims must be made according to Medicaid billing instructions
- Review the entire surgical section to verify appropriate use of modifiers
- When billing dental codes refer to the dental manual

NOTE: The most accurate way to verify coverage for a specific service is to review the CPT-4 book, the CDT book and the Medicaid fee schedule on the website (2.1, Quick Reference).

24.20.8 Breast Reconstruction

Procedure Code Range: 19316-19499

24.20.8.1 Covered Services

Breast reconstruction following breast cancer treatment

24.20.8.2 Billing Requirements

Prior authorization requirements (6.13, Prior Authorization):

Wyoming Medicaid covers surgical reconstruction following breast cancer treatment. Additional revisions may only be approved for a repeated constructive surgery based on medical necessity such as the procedures listed below:

- Secondary surgery includes implant rupture.
- Wound dehiscence (bursting open).
- Wound infection.
- Tattooing of the nipple (included in 19350, 19357-19369 unless the procedure is done after the global setting – then 11920-11921 is appropriate).

24.20.9 Breast Reduction

Procedure Code Range: 19318

24.20.9.1 Covered Services

Breast reductions are covered and considered medically necessary if the below requirements are met.

24.20.9.2 Billing Requirements

Prior authorization requirements (6.13, Prior Authorization):

Wyoming Medicaid considers breast reduction surgery as medically necessary, when **all** of the following is met and is clearly documented in the medical records.

- Client must be 18 years or older.
- Amount to be removed from each breast is greater than or equal to 500 grams, or the total to be removed from both breasts exceeds 1000 grams.
- Preoperative indications for breast surgery must include one (1) or more of the following symptoms:
    - Breast pain

  - Shoulder, neck, or back pain
  - Other persistent neurological symptoms attributable to breast size or weight.
  - Refractory intertrigo
  - Significant activities
- This procedure may be done as a hospital inpatient, hospital outpatient, or in an ASC.

24.20.9.3 Documentation Requirements

Documentation must show medical necessity. The patient's clinical records must be specific and contain the following information:

- Current clinical notes including history, physical, and preoperative indications for breast surgery.
- Height and weight.
- Current bra size.
- Proposed amount of tissue to be removed from each breast.
- Duration of time that symptoms have persisted.
- Conservative methods of treatment tried, such as weight loss or support bras.
- Photographs of the shoulder to waist, front and lateral.

24.20.10 Cochlear Device, Implantation and Replacement

Procedure Code: 69930

24.20.10.1 Covered Services

Wyoming Medicaid has instituted the following policy for Cochlear Device Implantation and Replacement. Medicaid reimburses for the implant, external processor and headset.

24.20.10.2 Billing Requirements

Prior authorization is required for the procedure, device and replacement device only. (6.13, Prior Authorization) Medicaid clients must meet all the following criteria:

- There must be a diagnosis of bilateral profound (90db hearing loss) sensorineural hearing impairment that cannot be mitigated by the use of a hearing aid in clients whose auditory cranial nerves can be stimulated.
- The client must have demonstrated that they cannot benefit from hearing amplification through a trial period of a minimum of six (6) months.
- There must be freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and be free of lesions in the auditory nerve and acoustic areas of the central nervous system.

- There must not be a contraindication to having the surgery.
- The client must have the cognitive ability to use auditory clues.
- The procedure may only be performed using FDA-approved devices.
- Evaluation and continued treatment for cochlear transplants must be completed by a Board Certified Specialist.
- Only one (1) cochlear implant per five (5) year period. An exception may be possible if the implant is proven to no longer be working sufficiently and the manufacture warranty has expired.
- Initial first year calibration visits are part of the global fee for implementation. Follow up calibration visits will be covered one (1) per year if the implant is authorized or if the client had an existing cochlear device that needs calibration.
- Additional equipment will be allowed only to replace defective equipment and will not be allowed solely to update equipment. Upgrade equipment can be evaluated once every five (5) years.
- In addition, the following criteria must be met for adults 21 and older:
    - Must be highly motivated and have appropriate expectations to complete prescribed pre- and post-surgical treatment.
- In addition the following criteria must be met for children 20 and under:
    - Implantation will not be considered before the age of 12-months.
    - Children may be pre-linguistically deafened.
    - Family members or caregivers must have appropriate expectations, motivation, and resources to assist in completion of treatment and educational services.
    - Family members must agree to accompany a young child to training sessions and be able to reinforce learning.

NOTE: Only the procedure for implantation needs prior authorization; the device does not require a separate prior authorization and must be supplied by the hospital.

24.20.10.3 Documentation

The client's clinical records must be specific and contain the following information:

- A complete history and physical indicating how the diagnosis of sensorineural hearing impairment was determined.
- Demonstration of lack of benefit from hearing amplification through a trial period of six (6) months, using appropriate fitted amplification.
- Documentation of other health conditions.
- Notation that there has been active family involvement during the diagnosis and treatment sessions for a child who is to have a cochlear transplant.

24.20.11 Gastric Bypass Surgery

Procedure Code Range: 43644, 43770, 43842-43843, 43846-43848

For prior authorization for the above listed procedure codes, please contact WYhealth at (888)545-1710.

24.20.12 Lumbar Spinal Surgery

Procedure Code Range: 22207, 22214, 22224, 22533, 22534, 22558, 22612, 22630, 22633, 22800-22808, 22812, 22818, 22840, 22857 and 22862

24.20.12.1 Covered Services

Authorization for lumbar spinal surgery has been separated into three (3) general categories:

- Surgery related to the treatment of sciatica or other nerve root impingements where primary intervention is related to removal of an offending herniated disk.
- Surgery related to mechanical and anatomical abnormalities for which spinal fusion may be appropriate treatment.
- Spinal fracture or dislocation, spinal infection (These can be approved with documentation of said fracture/dislocation or infection.).

24.20.12.2 Reimbursement

Prior Authorization requirements:

In the absence of red flag symptoms or progressive neurological symptoms or signs, members presenting with:

- Low back pain should undergo conservative therapy, which may include the use of anti-inflammatory medications, aggressive physical therapy with home exercise program, activity modification, physical reconditioning or facet or epidural injections.
- A patient should undergo at least 12-weeks of conservative management for symptomatic spinal stenosis or spondylolisthesis.
- Patients with only axial low back pain (absence of leg or neurological symptoms) and without demonstrable instability, spondylolisthesis or spinal stenosis should go through conservative therapy for at least six (6) months.

Documentation Requirements:

- Office notes, including history and physical.
- Detailed documentation of extent and response to conservative therapy (PT, Steroids, Anti-inflammatory Medications, etc.).
- Radiology reports for MRI's, CT's, etc.

- Complete the prior authorization form with specific procedures with CPT codes.

NOTE: The requesting surgeon must personally evaluate the patient on at least two (2) occasions prior within the preceding six (6) months to requesting surgery.

24.20.12.3 Scoliosis

The treatment of idiopathic scoliosis medically necessary for any of the following conditions:

- An increasing curve (greater than 40 degrees) in a growing child; or
- Scoliosis related pain that is refractory to conservative treatments; or
- Severe deformity (curve greater than 50 degrees) with trunk asymmetry in children and adolescents; or
- Thoracic lordosis that cannot be treated conservatively.

In the absence of the above-mentioned criteria, idiopathic scoliosis surgery is considered experimental and investigational.

Documentation Requirements:

- Office notes, including history and physical.
- Detailed documentation of extent and response to conservative therapy (PT, Steroids, Anti-inflammatory Medications, etc.).
- Radiology reports for MRI's, CT's, etc.
- Complete the prior authorization form with specific procedures with CPT codes.

NOTE: The requesting surgeon must personally evaluate the patient on at least two (2) occasions prior within the preceding six (6) months to requesting surgery.

24.20.13 Panniculectomy/Abdominoplasty

Procedure Code Range: 15830 and 15847

24.20.13.1 Covered Services

Panniculectomies/Abdominoplasties are covered and considered medically necessary if the below requirements are met.

24.20.13.2 Reimbursement

Prior Authorization requirements (6.13, Prior Authorization):

Wyoming Medicaid considers a Panniculectomy/Abdominoplasty as medically necessary, when all of the following is met and clearly documented in the medical records.

- Pannus hangs at or below the level of the symphysis pubis.
- Pannus causes a chronic and persistent skin condition that is refractory to at least six (6) months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics.
- Include photographs documenting the skin condition.

NOTE: If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six (6) months. If the weight loss is the result of bariatric surgery, abdominoplasty/panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six (6) months.

Medicaid does not cover abdominoplasty or panniculectomy when performed primarily for **ANY** of the following indications because it is considered not medically necessary (this list may not be all-inclusive).

- Treatment of neck or back pain.
- Improving appearance (i.e. cosmesis).
- Repairing abdominal wall laxity or diastasis recti.
- Treating psychological symptomatology or psychosocial complaints.
- When performed in conjuncture with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery) unless criteria for panniculectomy or abdominoplasty are met separately.

24.20.14 Pectus Excavatum and Poland's Syndrome

Procedure Code Range: 21743

24.20.14.1 Covered Services

Surgical repair of severe pectus excavatum deformities that cause functional deficit are covered and considered medically necessary when done for medical reasons in clients who meet the criteria listed below.

24.20.14.2 Reimbursement

Prior Authorization requirements (6.13, Prior Authorization):

Wyoming Medicaid considers a Pectus Excavatum medically necessary, when all of the following is met and clearly documented in the medical records.

- Medical documentation outlining evidence of complications from the sternal deformity. Complications may include but are not limited to:
  - Asthma
  - Atypical chest pain.
  - Cardiopulmonary impairment documented by respiratory and/or cardiac function tests.
  - Exercise limitation.
- Frequent lower respiratory tract infections.
- An electrocardiogram or echocardiogram is documented in the instance(s) of known heart disease in order to define the relationship between the sternal deformity and cardiac issues; and
- A CT scan of the test is completed and demonstrates a pectus index of greater than 3.25. The pectus index is calculated by dividing the transverse diameter of the chest by the anterior-posterior diameter.

In the absence of the above-mentioned criteria, surgery for pectus excavatum is considered cosmetic.

The following interventions are considered experimental and investigational secondary to their effectiveness in the treatment of pectus excavatum:

- The magnetic min-mover procedure.
- The vacuum bell.
- Dynamic Compression Syndrome.
- Surgery for reconstruction of musculo-skeletal chest wall deformities associated with Poland's Syndrome are considered medical necessary if syndrome causes functional deficits.

24.20.15 Ptosis and Blepharoplasty Repair

Procedure Code Range: 67900-67909

24.20.15.1 Covered Services

Surgical repair of ptosis and blepharoplasty that cause functional deficit are covered and considered medically necessary when done for medical reasons in clients who meet the criteria listed below.

24.20.15.2 Ptosis (Belpharoptosis)

Repair for laxity of the muscles of the upper eyelid causing functional visual impairment when photographs in straight gaze show the margin reflex difference (distance from the upper lid margin to the reflected corneal light reflex at normal gaze) of 2mm or less.

Brow ptosis repair for laxity of the forehead muscles causing functional visual impairment when photographs show the eyebrow below the supra-orbital rim.

Eyelid ectropion or entropion repair is considered medically necessary for corneal or conjunctival injury due to ectropion, entropion or trichiasis.

Upper eyelid tightening procedures (block resection or tarsal strip with lateral canthal tightening) for member who has refractory corneal or conjunctival inflammation related to exposure from floppy eyelid syndrome.

Canthoplasty – Is considered medically necessary as part of a blepharoplasty procedure to correct eyelids that sag so much that they pull down the upper eyelid so that vision is obstructed.

NOTE: Visual field testing is not routinely necessary to determine the presence of excess upper eyelid skin, upper eyelid ptosis, or brow ptosis. Each of these three (3) components can be present alone or in any combination, and each may require correction. If both a blepharoplasty and ptosis repair are requested, two (2) photographs may be necessary to demonstrate the need for both procedures: one (1) photograph should show the excess skin above the eye resting on the eyelashes, and a second (2nd) photograph should show persistence of lid lag, with the upper eyelid crossing or slightly above the pupil margin, despite lifting the excess skin above the eye off of the eyelids with tape. If all three (3) procedures (i.e., blepharoplasty, blepharoptosis repair, and brow ptosis repair) are requested, three (3) photographs may be necessary.

Congenital Ptosis – Surgical correction of congenital ptosis is medically necessary to allow proper visual development and prevent amblyopia in infants and children with moderate to severe ptosis interfering with vision. Surgery is considered cosmetic if performed for mild ptosis that is only of cosmetic concern. Photographs must be available for review to document that the skin or upper eyelid margin obstructs a portion of the pupil.

24.20.15.3 Reimbursement

Prior Authorization requirements (6.13, Prior Authorization):

Wyoming Medicaid considers surgical repair for Ptosis and Blepharoplasty when the criteria below are met.

Blepharoplasty is considered medically necessary for any of the following indications:

- To correct prosthesis difficulties in an anophthalmia socket; or
- To remove excess tissue of the upper eyelid causing functional visual impairment when photographs in straight gaze show eyelid tissue resting on or pushing down on the eye lashes (Excess tissue beneath the eye rarely obstructs vision, so the lower lid blepharoplasty is rarely covered for this indication); or
- To repair defects predisposing to corneal or conjunctival irritation:
  - Corneal exposure
  - Ectropion (eyelid turned outward)
  - Entropion (eyelid turned inward)
  - Pseudotrichiasis (inward misdirection of eyelashes caused by entropion); or
- To relieve painful symptoms of blepharospasm; or
- To treat peri-orbital sequelae of thyroid disease and nerve palsy, and peri-orbital sequelae of other nerve palsy (e.g., the oculomotor nerve).

24.20.16 Septoplasty and Rhinoplasty

Procedure Code Range: 30520, 30400-30420, 30430-30450 and 30460-30462

24.20.16.1 Covered Services

Septoplasty and Rhinoplasty are covered and considered medically necessary if the below requirements are met.

- Septoplasty is medically necessary when any of the following clinical criteria is met.
  - Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medical necessary surgical procedures (e.g., ethmoidectomy); or
  - Documented recurrent sinusitis felt to be due to a deviated septum not relieved by appropriate medical and antibiotic therapy; or
  - Recurrent epistaxis (nosebleeds) related to a septal deformity; or
  - Septal deviation causing continuous nasal airway obstruction resulting in nasal breathing difficulty not responding to appropriate medical therapy; or
  - When done in association with cleft palate repair.

NOTE: Septoplasty is considered experimental and investigational for all other indications (e.g., allergic rhinitis) because its effectiveness other than the ones listed above has not been established.

- Rhinoplasty may be considered medically necessary only in the following limited circumstances:
  - When it is being performed to correct a nasal deformity secondary to congenital cleft lip and/or palate;
  - Upon individual case review, to correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect, when all of the following criteria are met:
    - Prolonged, persistent obstructed nasal breathing; and
    - Physical examination confirming moderate to severe vestibular obstruction; and
    - Airway obstruction will not respond to septoplasty and turbinectomy alone; and
    - Nasal airway obstruction is causing significant symptoms (e.g., chronic rhinosinusitis, difficulty breathing); and
    - Obstructive symptoms persist despite conservative management for three (3) months or greater, which includes, where appropriate, nasal steroids or immunotherapy; and
    - Photographs demonstrate an external nasal deformity; and
    - There is an average 50 % or greater obstruction of nares (e.g., 50 % obstruction of both nares, or 75 % obstruction of one nare and 25 % obstruction of other nare, or 100 % obstruction of one nare), documented by nasal endoscopy, computed tomography (CT) scan or other appropriate imaging modality.

24.20.16.2 Documentation Requirements

- Documentation of duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, etc.; and
- Documentation of results of conservative management of symptoms; and
- If there is an external nasal deformity, pre-operative photographs showing the standard 4-way view: anterior-posterior, right and left lateral views, and base of nose (also known as worm's eye view confirming vestibular stenosis; this view is from the bottom of nasal septum pointing upwards); and
- Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g., Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity); and
- Results of nasal endoscopy, CT or other appropriate imaging modality documenting degree of nasal obstruction.
- When rhinoplasty for nasal airway obstruction is performed as an integral part of a medically necessary septoplasty and there is documentation of gross nasal obstruction on the same side as the septal deviation

24.20.16.3 Reimbursement

Prior Authorization requirements (6.13, Prior Authorization)

24.20.17 Transcranial Magnetic Stimulation (TMS)

Procedure Code Range: 90867-90868

Diagnosis Code Range: F32.2 & F33.2

24.20.17.1 Covered Services

Wyoming Medicaid considers left prefrontal TMS is reasonable and necessary for patients diagnosed with severe Major Depression (single or recurrent episode) as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), who have at least one of the following:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack or clinically significant response to four trials of such agents, in the current depressive episode, from at least two different agent classes. At least one of the treatment trials must have been administered at the adequate course of one or more drug therapies; or
- Inability to tolerate psychopharmacologic agents as evidenced by trials of four such agents with distinct side effects; or
- History of good response to TMS in a previous episode; or
- If patient is currently receiving electro-convulsive therapy, TMS may be considered reasonable and necessary as a less invasive treatment option.

24.20.17.2 Reimbursement

Prior Authorization is required and must meet at least one of the above criteria and only for diagnosis code(s):

- F32.2 – Major depressive disorder, single episode, severe without psychotic features
- F33.2 – Major depressive disorder, recurrent severe without psychotic features.

90867 – Prior Authorization will only be allow once per course of treatment. (This report is necessary to the treatment planning once per course of treatment, and must be kept as part of the permanent patient record.)

90868 – Prior Authorization will be issued for up to 30 visits over a 7 week period, followed by 6 taper treatments (for a total of 36 units) the taper period is defined as up to 3 treatments in a week, 2 treatments the following week and 1 treatment in the third week.

24.20.17.3 Documentation Requirements

- All documentation must be maintained in the patient's medical record and available upon request
- Every page of the record must be legible and include appropriate patient identification, date of service(s) and must include the legible signature of the physician or non-physician practitioner
- The medical record must support the use of the selected ICD -10-CM code(s) and the submitted CPT code must describe the service performed
- The documentation must support the medical necessity of the service(s) as directed in this policy
- The attending physician or non-physician practitioner must monitor and document the patient's clinical progress during treatment. The attending physician or non-physician must use evidence based validated depression monitoring scales i.e. Geriatric Depression Scale (GDS), The personal Health Questionnaire Depression Scale (PHQ-9) Beck Depression Scale (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomology (QIDS) or the Inventory for Depressive Symptomatology Systems Review (IDS-SR) to monitor treatment response and the achievement of remission of symptoms.

Repeat acute Treatment for relapse of depressive symptoms is considered medically necessary only if the patient responded to prior treatments. Specifically at least a 50% improvement in standard rating, additionally this record must accompany the new prior authorization request.

24.20.17.4 Non-Covered Services

The use of TMS as a maintenance therapy is not supported by controlled clinical trial at this time and is therefore not considered medically necessary.

24.20.18 Vagus Nerve Simulation (VNS) for Epilepsy

Procedure Code Range: 61850-61888, 64570, 64573

For prior authorization for the above listed procedure codes, please contact WYhealth at (888)545-1710.

24.20.19 Varicose Vein Treatment

Procedure Code Range: 36471- 36479, 37770-37785

24.20.19.1 Covered Services

Wyoming Medicaid considers the following procedures medically necessary for treatment of varicose veins:

- Great saphenous vein or small saphenous vein ligation/division/ stripping,
- Radiofrequency endovenous occlusion (VNUS procedure)
- Endovenous laser ablation of the saphenous vein (ELAS) – also known as endovenous laser treatment (EVLT)

24.20.19.2 Billing Requirements

Prior authorization requirements (6.13, Prior Authorization):

Incompetence at the saphenofemoral junction or saphenopopliteal junction is documented by Doppler or duplex ultrasound scanning, and all of the following criteria are met.

- Documented reflux duration of 500 milliseconds (ms) or greater in the vein to be treated; and
- Vein size is 4mm to 5mm or greater in diameter (not valve diameter at junction); and
- Saphenous varicosities result in any of the following:
  - Intractable ulceration secondary to venous stasis; or
  - More than 1 episode of minor hemorrhage from a ruptured superficial varicosity; or a single significant hemorrhage from a ruptured superficial varicosity , especially if transfusion of blood is required; or
  - Saphenous varicosities result in either of the following and symptoms persist despite a three (3) month trial of conservative management (e.g., analgesics and prescription gradient support compression stockings).

NOTE: A trial conservative management is not required for persons with persistent or recurrent varicosities who have undergone prior endovenous catheter ablation procedures or stripping/division/ligation in the same leg because conservative management is unlikely to be successful.

  - Recurrent superficial thrombophlebitis; or
  - Severe and persistent pain and swelling interfering with activities of daily living and requiring chronic analgesic medication.

Endovenous ablation procedures are considered medically necessary for the treatment of incompetent perforating veins with vein diameter of 3.5mm or great with outward flow duration of 500 milliseconds duration or more, located underneath an active or healed venous.

24.21 Transplant Policy

For prior authorization for transplant services, please contact WYhealth at (888)545-1710.

24.21.1 Outpatient Stem Cell/Bone Marrow

The hospital performing a bone marrow/stem cell transplant on an outpatient basis must bill using procedure code 38240 or 38241 and will be reimbursed at 55% of billed charges.

24.21.1.1 Non-Covered Services

Transportation of organs from one (1) facility to another is not covered.

24.22 Vision Services

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.

24.22.1 Eye and Office Examinations

Procedure Code Range: 92002-92014, 99201-99215, 92018-92060, 92081-92226, 92230-92287

24.22.1.1 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.

24.22.1.2 Non Covered Services

- Exam codes should not be billed for routine eye exams for clients over 21 years old.

24.22.2 Eyeglasses/Materials

Procedure Code Range: V2020, V2100-V2499, V2627, V2784

24.22.2.1 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 and when they meet the following guidelines listed below:
            - When the power in the highest meridian is - (minus) 6 diopters or more. For example:
                - A spectacle prescription of -2.00 -4.00 x 180 - 4.00 + -2.00 = -6.00. This Rx would qualify
                - A spectacle prescription of -2.00 +5.00 x 180 - 2.00 + +5.00 = +3.00. This Rx would not qualify for high index aspheric material
            - When the power in the highest meridian is + (plus) 4.00 diopters or more. For example:
                - A spectacle prescription of -2.00 -4.00 x 180 - 4.00 + -2.00 = -6.00. This Rx would qualify
                - A spectacle prescription of -2.00 + +5.00 = +3.00. This Rx would not qualify for a high index aspheric material

- **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-V2781** 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 condition the add-on is needed for in order to treat the medical condition. (6.13 Prior Authorizations)
  - 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. (6.15 Submitting Attachments)
- Repair of eyeglasses may be billed upon expiration of the warranty
- **V2623, V2629 (Prosthetic eyes) V2627 (Scleral cover shell)** –requires a prior authorization. (6.13 Prior Authorizations)

24.22.2.2 Non Covered Charges

- 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

24.22.2.3 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. (6.14 Order Vs Delivery Date)

24.22.3 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.

24.22.3.1 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% (6.15, 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.

24.22.3.2 Non-Covered Services

- Contact lenses are not covered for clients 21 and older.

24.22.4 Vision Therapy

Procedure Code: 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.

24.22.4.1 Covered Services

- **92065** – Vision Therapy can be billed for clients under the age of 21 and clients eligible for the Acquired Brain Injury Waiver benefit plan 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 (6.15, 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 on Acquired Brain Injury Waiver Benefit Plan	
Diagnosis Codes	**Description**
I69.998	Disturbances of vision
S06 Family of Codes	Late effect injury intracranial injury without mention of skull fracture.

Chapter Twenty Five – Covered Services – Pregnant by Choice

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25.1 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.

25.1.1 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.

25.1.2 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.

25.1.3 Eligibility Criteria

- The client must be transitioning from the Pregnant Women Program.
- She 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.

25.1.4 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.

25.2 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

Pregnant By Choice Covered Codes	
Covered Diagnosis Codes	**Diagnosis Code Description**
99211-99213	Office/Outpatient Established
11976	Removal, implantable contraceptive capsules
11980	Implant hormone pellet(s)
11981	Implant hormone pellet(s)
11982	Remove drug implant device
11983	Remove/insert drug implant
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of Intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
58600	Division of fallopian tube
58615	Occlude fallopian tube(s)
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)

Pregnant By Choice Covered Codes	
Covered Diagnosis Codes	**Diagnosis Code Description**
87490	Infectious agent detection by Nucleic Acid (DNA or RNA); Chlamydia Trachomatis, direct probe technique
87491	Infectious agent detection by Nucleic Acid (DNA or RNA); Chlamydia Trachomatis, amplified probe technique
87590	N.Gonorrhoeae DNA dir prob
87591	Infectious agent detection by Nucleic Acid (DNA or RNA); Neisseria Gonorrhoeae, amplified probe technique
88141-88143	Cytopathology
88164-88167	Cytopathology
88175	Cytopath C/V auto fluid redo
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom, male, each
A4268	Contraceptive supply, condom, female, each
J0696	Injection, Ceftriaxone sodium, Per 250MG
J1050	Injection, medroxyprogesterone acetate, contraceptive 150 MG (Depo-Provera)
J7296	KYLEENA, 19.5 MG
J7300	Intauterine copper contraceptive
J7301	Skyla 13.5MG
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive patch
J7307	Etonogestrel (Contraceptive) implant system, including implant and supplies
S4993	Contraceptive pills for birth control
T1015	Clinic encounter, per visit
58600	Ligation or transaction of fallopian tube(s) abdominal or biginal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by devices (EG, Bank, Clip, Falope Ring) Vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without tran-section)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (EG, Bank, Clip or Falope ring)
00851	Laparoscopy; tubal ligation/transaction

Chapter Twenty Six – Covered Services – Therapy Services

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26.1 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.

26.2 Physical and Occupational Therapy

26.2.1 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.

26.2.2 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 Qualis Health for prior authorization
  - Physical therapy visits and occupational therapy visits are counted separately. (6.8 Service Thresholds)
- 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.

26.2.3 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.

26.3 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.

26.3.1 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.

26.3.2 Limitations

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

- 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, mental retardation, developmental delays, stammering and stuttering).
- Services that are not medically necessary.
- Treatment of dialect and accent reduction.
- Treatment whose purpose is vocationally or recreationally based.
- Diagnosis or treatment in a school-bases setting.

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

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.

26.3.3 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.

26.3.4 Prior Authorization Once Threshold is Met

For Medicaid clients, dates of service in excess of twenty (20) per calendar year, providers will need to contact Qualis Health for prior authorization (6.8 Service Thresholds).

26.4 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Qualis Health, 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 Provider Services Manager, Amy Buxton (amy.buxton@wyo.gov).
    - The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from Qualis Health's system. The appeal will be reviewed in conjunction with the documentation uploaded into Qualis Health's system.

Appendix

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APPENDIX A – CMS1500 Manual Version Control Table

Revision Date	Change(s)
4/1/18	3.1.1 ORP – added to paragraph, ORP providers will not term due to inactivity
	6.16.3 Updated the Abortion Certification Form
	7.3.1 How TPL is applied – added sentence regarding billing Medicaid for the write off amount
	13.5 Covered Service Codes – Added age guidelines on G9012 and T1017, GT modifier added
	13.7 Applied Behavior Analysis Treatment – Added note regarding ABA providers must follow Wyoming Medicaid policies
	24.2.1 Abortion – Updated covered scenarios
	24.8.5 – Added Ocrevus J2350
	25.2 Pregnant by Choice Covered Codes – Added J7296 KYLEENA
4/5/18	24.8.5 Ocrevus – Removed
	24.8.3 Ocrelizumab (Ocrevus) – Updated entire section

APPENDIX B – Provider Notifications Log

Date	Notification Type	Title	Audience
1/10/18	Email	1099 Address	All Pay-to Providers
1/11/18	RA Banner	Procreative Services	Physicians, Nurses, Hospitals, Labs, FQHC, RHC, IHS
2/1/18	Email	Changes to Attachment Cover Sheet	All Providers
2/2/18	Email	Behavioral Health PAs	All Behavioral Health Providers
2/8/18	Email	Record Keeping, Retention and Access	All Providers
2/9/18 and 2/23/18	Email	URL Changes	All Pay-to Providers
2/26/18	Email	Clinical Assessments	All Behavioral Health Providers
3/30/18	Email	Transportation Changes	Transportation Services Providers

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

Wyoming Department of Health

Wyoming Medicaid

reminder

Has your business moved within the last year? Have you submitted a new Vendor Management Packet and W9 for your new address? To prevent any payment delays, ensure to complete the Vendor Management Packet and W9 with your updated address information as soon as possible. Providers who have 1099s sent and are returned for an invalid address will not receive payments until addresses have been updated. Forms may be found by clicking on the following link: http://sao.wyo.gov/vendor-resources Print out the Vendor Management Packet and W9 (W9 must be the most recent version 11-2017) and mail forms with original signatures to Wyoming Medicaid PO Box 667 Cheyenne, WY 82003.

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.
http://wymedicaid.acs-inc.com/contact.html

Deployment:

Date: 1/10/18

Time: 10am MST

Audience: All pay-to providers

****

WYOMING MEDICAID WILL BEGIN VOIDING PAID CLAIMS THAT WERE SUBMITTED WITH A DOS 10/1/15-CURRENT WITH PROCREATIVE DIAGNOSIS CODES (Z31.0-Z31.90). AS A REMINDER, WYOMING MEDICAID DOES NOT REIMBURSE FOR PROCREATIVE SERVICES INCLUDING:

- REVERSAL OF STERILIZATIONS
- ARTIFICIAL INSEMINATION
- FERTILITY TESTING
- FERTILITY PRESERVATION
- INFERTILITY COUNSELING
- PROCREATIVE MANAGEMENT

PROVIDERS WILL BEGIN SEEING THESE VOIDS ON THEIR RAS AS SOON AS 1/17/18.

****

Deployment

Date: 1/11/18-2/15/18

Audience: Hospital, Physicians, Nurses, FQHC, RHC, PHN, Family Planning Clinics, Labs

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

Wyoming Department of Health

Wyoming Medicaid

Changes to the Attachment Cover Sheet

Effective beginning March 1, 2018, the new Attachment Form will be required for any paper attachment submitted to Wyoming Medicaid. The new form has been uploaded to the Wyoming Medicaid Web Portal for ease of printing. It can be found at https://wymedicaid.portal.conduent.com/forms/Attachment_Cover_Sheet.pdf .

The new form contains the same basic information, but now requires the Transaction Control Number (TCN) as well as the Attachment Control Number. Please be sure this new form is filled out completely and accurately to aide in claims processing. Missing information, or receipt of the old form without the TCN number after the implementation date will be returned with the attachments, and will cause a delay in processing.

There are a couple ways to obtain the TCN for your claim. TCNs are generated when we receive the electronic claim in our system which can take up to two business days. Your remittance advice (RA) will contain the needed TCN under "Claim Status: Suspended". Or you can contact the IVR (1-800-251-1268).

IVR Steps:

- Press 1 claim status
- Press 1 bill w/NPI
  - Enter NPI followed by # (IVR will repeat NPI that was entered, if correct press 1)
- Press 2 for claim status
- Press 2 to enter client's ID
  - Enter 10 digit id followed by # (IVR will repeat client ID entered, if correct press 1)
- Enter the first date of service (mmddyyyy format)
- If the end date is the same press 1; if different, press 2 and enter the end date (mmddyyyy format)
- The IVR will provide the 17-digit TCN if available

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

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

Deployment:

Date: 2/1/18

Time: 10am MST

Audience: All pay-to providers

Wyoming Department of Health

Wyoming Medicaid

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Attention All Behavioral Health Providers:

Wyoming Medicaid began requiring prior authorization for all behavioral health services through Qualis Health effective for claim dates of service November 1, 2017. With a new calendar year starting, Wyoming Medicaid would like to address some of the concerns that have come up over the first two months of reviews.

Treatment Plans (per CMS 1500 Provider Manual, Chapter 13)

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

In some cases, the submitted treatment plans do not match the services that are being requested. For example, the request to Qualis Health may be for multiple visits per week but the treatment plan is for monthly visits. Providers need to verify that the correct code was submitted and the documentation supports the requested codes.

The written treatment plan is one of the key elements to providing medical necessity. According to the Centers for Medicare and Medicaid Services (CMS), it should include a recommended level of care (duration and frequency of visits), specific treatment goals, and objective measures to evaluate treatment effectiveness. A treatment plan is important to help establish the clinical

reasoning or thought process behind the care given and is an important document that should be updated frequently to match the progress the patient is making in their treatment. Wyoming Medicaid requires that the treatment plan be updated every 90 days, or more frequently if necessary.

Documentation of Services/Progress Notes (per CMS 1500 Provider Manual, Chapter 13)

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

In 2017, the most recent five (5) progress notes for clients were requested. **This process has changed.** Qualis Health needs to review the **5 most recent progress notes for each requested code**. For example, there are multiple requests for services (medication services, targeted case management services, individual therapy, etc.). The five most recent progress notes may not have medication services or targeted case management progress notes included, therefore Qualis Health doesn't have enough information to determine if the services are medically necessary.

Another example may be a request for family therapy but within the submitted documented progress notes, there is nothing to support the request. The reasoning for the five progress notes per code is that a provider that bills as a facility or organization may have different treating providers that provide different services (medication services, targeted case management, etc.) at different times. Medication service may be provided monthly while targeted case management might be provided every other week while individual therapy is provided weekly.

***Please note that if you don't have five progress notes, you may send Qualis Health what is currently in the chart on that service along with an explanation of why more notes aren't available. This process will decrease the back and forth between Qualis Health and the provider.

Clinical Assessments/Intake Assessments (per CMS 1500 Provider Manual, Chapter 13)

A clinical assessment 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

A clinical assessment or intake assessment should be completed at the first visit. This is an important part of proper documentation. During the evaluation or assessment visit, information is collected regarding the patient's history and condition through various forms and examinations.

The training and professional judgement of the healthcare provider is used to develop a diagnosis and a treatment plan with measurable goals. It should also be updated once a year or more frequently if needed. (Effective April 1, 2018, Wyoming Medicaid will require the clinical assessment be updated at least annually).

Prior authorization submissions will require the initial assessment and the most current updated assessment. All assessments need to be signed by the treating provider.

Denials/Appeals Process (per CMS 1500 Provider Manual, Chapter 13)

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Qualis Health, including any additional clinical information that supports the request for services.
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via email to the 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 Qualis Health's system. The appeal will be reviewed in conjunction with the documentation uploaded into Qualis Health's system.

      For questions, please contact Brenda Stout, Medicaid Behavioral Health Manager at brenda.stout1@wyo.gov .

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- **http://stopmedicaidfraud.wyo.gov**
- **1-855-846-2563**

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

Deployment:

Date: 2/2/18

Time: 10am MST

Audience: Mental health providers

Wyoming Department of Health

Wyoming Medicaid

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Important Policy Reminder

WY Medicaid Record Keeping, Retention and Access Requirements

Chapter 3 of Medicaid Rule, Subsection 7:

Section 7. Provider Records.

a. Retention. A provider shall maintain medical and financial records, including information regarding dates of services, diagnoses, services furnished, and claims, for at least six years after the end of the state fiscal year in which payment for services was rendered. If any litigation, claim, audit or other action involving the records is initiated before the expiration of the six years, the records must be maintained until the litigation, claim, audit or other action and any subsequent administrative or legal proceedings are resolved. Such records must be maintained for three years in hard-copy, after which they may be maintained on micro-fiche or micro-film.
b. 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. 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.
c. Availability of records. A provider shall make financial or medical records available upon request to representatives of the Division, the United States Department of Health and Human Services, HCFA, the Comptroller General of the United States, the Wyoming Attorney General or the MFCU. Such visits may be made pursuant to Chapter 16, and may be announced or unannounced.
d. Refusal to produce or maintain records. The refusal of a provider to make financial or medical records available and accessible shall result in:
    i. The immediate suspension of all Medicaid payments to the provider;
    ii. All Medicaid payments made to the provider during the record retention period for which records supporting such payments are not produced shall be repaid to the Division within ten days after written request for such repayment; and
    iii. The suspension of all Medicaid payments for services furnished after such date.
    iv. Reimbursement shall not be reinstated until the Division determines that adequate records have been produced or are being maintained.
e. Copying records. The Division may copy records pursuant to the record copying provisions of Chapter 16, which are incorporated by this reference.

Wyoming Medicaid Provider Policy States:

Requirements

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

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

Retention of Records

The provider must retain medical and financial records, including information regarding dates of service, diagnoses, and 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.

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.

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; and/or

- Audit of facility financial records for reimbursement.
- Actual records reviewed may be extrapolated and applied to all services billed by the provider.

The provider must grant the State and its representative's access during regular business hours to examine medical and financial records related to healthcare billed to the program. Medicaid notifies the provider before examining such records. Medicaid reserves the right to make unscheduled visits i.e., when the client's health may be endangered, when criminal/fraud 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 representative's 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 request 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 the Wyoming Statute.

Complete Provider Manuals can be found at:
https://wymedicaid.portal.conduent.com/manuals.html

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Deployment:

Date: 2/8/18

Time: 3:00 pm MST

Audience: All Providers except Waiver

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Wyoming Department of Health

Wyoming Medicaid

UPDATE: URL Changes for EDI Services

Original email sent on 2/9/18 had errors in the URL changes. We apologize for any confusion. Please see below for the corrected URLs.

As part of the Conduent EDI Solutions rebranding effort, the URL's used for access to the Wyoming Medicaid websites are being updated to reflect our current business entity. The new URL's will be available for use beginning on January 23, 2018. The current state will be decommissioned on March 31, 2018, but will remain operational for an interim period until the transition to the new site is complete.

Use	State	URL's
Web Portal (X12 File Submission/Retrieval)	Current	https://edionline.acs-inc.com/EDIOnline/redirect.action
	Future	https://edionline.portal.conduent.com/EDIOnline/redirect.action
Safe Harbor (SOAP Web Address)	Current	https://edisolutions.acs-inc.com/batchWS/services/Core?wsdl
	Future	https://edisolutions.services.conduent.com/batchWS/services/Core?wsdl
Safe Harbor (MIME Web Address)	Current	https://edisolutions.acs-inc.com/batchrs/services/application.wadl
	Future	https://edisolutions.services.conduent.com/batchrs/services/application.wadl
EDI GCRO Web Address	Current	http://www.acs-gcro.com/gcro/
	Future	http://edisolutionsmmis.portal.conduent.com/gcro/

If you are using automated scripts to access any of these websites, you will need to update your coding prior to COB 03-31-18 to avoid disruption of service. We would suggest that you update and test your connection to the new URLs prior to 03-31-18, as we will not be able to extend access to the current URL's beyond that

deadline.

There will not be any change of your existing credential or access to the new web site.

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Deployment:

Date: 2/23/18

Time: 3pm MST

Audience: All Pay to providers

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Attention Behavioral Health Providers:

Starting April 1st, 2018, Wyoming Medicaid will require the clinical assessment to be updated annually.

A clinical assessment or intake assessment should be completed at the first visit. This is an important part of proper documentation. During the evaluation or assessment visit, information is collected regarding the patient's history and condition through various forms and examinations. The training and professional judgment of the healthcare provider is used to develop a diagnosis and a treatment plan with measurable goals. The clinical assessment or intake assessment is required to be updated once a year or more frequently if needed.

Below is the section from the CMS 1500 Provider Manual, Chapter 13:

13.9.3.2 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 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 any client receiving ten or more therapeutic contacts, a discharge summary which includes each type of Medicaid service provided, client's progress in achieving treatment goal, and plans for follow-up. The discharge summary shall be completed within 90 days of the last contact. Any clinical record shall document the reason for case closure.

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

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

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

Deployment:
Date: 2/26/18
Time: 10am MST
Audience: All Mental Health Providers

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Wyoming Department of Health

Wyoming Medicaid

Attention Taxi and Non-Taxi Transportation Providers

Starting date of service 5/1/18, all rides will require a prior authorization (PA) number that will need to be entered on all claims. Billing for rides on or after date of service 5/1/18 without a PA will cause your claims to deny.

When clients contact the transportation call center regarding travel, a Travel Authorization Confirmation (TAC) will be created. The TAC will then initiate the creation of a prior authorization number. Once a PA has been created, approval PA letters will be sent out to the transportation providers. These letters will have the client name, client ID number, PA number and the authorized travel dates. The PA letters will NOT contain procedure codes, please see the tutorial for further help with procedure codes.

For billing, a tutorial has been created that will assist you in entering all the required information including the PA number https://wymedicaid.portal.conduent.com/Training/Transportation_Services_Tutorial_3_16_18.pdf. No other changes will be made to the billing for rides, only the addition of the PA number.

For additional questions, please contact Provider Relations at 1-800-251-1268

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Deployment:

Date: 3/30/18

Time: 10am MST

Audience: Transportation Providers