The Division of Healthcare Financing is discontinuing the use of EqualityCare to describe Wyoming’s Medicaid Program. The program will now be called Medicaid. This change will not affect benefits or services. EqualityCare cards will continue to be used for the current clients and for new clients until the current supply is depleted. Until the transition is complete you may see EqualityCare and Medicaid used interchangeably.

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. Medicaid has incorporated the former General Manual, CMS-1500 Covered Services Module and CMS-1500 Billing Module into one CMS-1500 Manual. 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.
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 (Section 2.2, Quick Website 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.

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 (Section 2.1, Quick Address and Telephone Reference).

Medicaid manuals, bulletins, fee schedules, forms, and other resources are available on the Medicaid/EqualityCare website or by contacting Provider Relations.
The Wyoming Department of Health is the single state agency appointed pursuant to the Social Security Act to administer the Medicaid Program in Wyoming. The Division of Healthcare Financing 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 Procedures 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.
Chapter One
General Information

Chapter One .............................................................................................................. 1-1

1.1 How the CMS-1500 Manual is Organized ......................................................... 1-2
1.2 Updating the Manual ....................................................................................... 1-3
1.3 State Agency Responsibilities ......................................................................... 1-5
1.4 Fiscal Agent Responsibilities .......................................................................... 1-5
## 1.1 How the CMS-1500 Manual is Organized

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

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two</td>
<td><strong>Getting Help When You Need It</strong> – telephone numbers and addresses for help and training. When and how to order forms.</td>
</tr>
<tr>
<td>Three</td>
<td><strong>Provider Responsibilities</strong> – obligations and rights as a Medicaid provider. The topics covered include enrollment changes, civil rights, group practices, provider-patient relationship, and record keeping requirements.</td>
</tr>
<tr>
<td>Four</td>
<td><strong>Utilization Review</strong> – fraud and abuse definitions, the review process, and the rights and responsibilities.</td>
</tr>
<tr>
<td>Five</td>
<td><strong>Client Eligibility</strong> – how to get eligibility information when a client presents their Medicaid card.</td>
</tr>
<tr>
<td>Six</td>
<td><strong>Common Billing Information</strong> – basic claim information, completing the CMS-1500 claim form, cap limits, newborn/unborn billing, working a Remittance Advice and completing adjustments.</td>
</tr>
<tr>
<td>Seven</td>
<td><strong>Third Party Liability (TPL)</strong> – explains what TPL is, how to bill it and exceptions to it.</td>
</tr>
<tr>
<td>Eight</td>
<td><strong>Electronic Data Interchange (EDI)</strong> – explains the advantages of exchanging documents electronically.</td>
</tr>
<tr>
<td>Nine</td>
<td><strong>Wyoming Specific HIPAA 5010 Electronic Specifications</strong> – this chapter covers the Wyoming Specific requirements pertaining to electronic billing.</td>
</tr>
<tr>
<td>Ten</td>
<td><strong>CMS-1500 Covered Services</strong> – this chapter is alphabetical by professional service and provides information such as: definitions, procedure code ranges, covered services and non-covered services.</td>
</tr>
<tr>
<td>Appendices</td>
<td><strong>Appendices</strong> – provide key information in an at-a-glance format. These include Social Security Administration (SSA) district office information, a list of Department of Family Services (DFS) offices, Medicaid and State Health Care Benefit Plans.</td>
</tr>
</tbody>
</table>
1.2 Updating the Manual

When there is a change in the Medicaid Program that affects you, Medicaid will update the manuals posted on the Medicaid/EqualityCare website. Most of the changes come in the form of provider bulletins and Remittance Advice (RA) banners, although others may be newsletters or even letters from state officials. It is in your best interest to periodically download an updated provider manual. Bulletin, RA and newsletter information will be immediately incorporated into the provider manuals to ensure you have access to the most up to date information regarding Medicaid policies and procedures.

All bulletins and updates can be found on the Medicaid/EqualityCare website (Section 2.2, Quick Website Reference) or you may contact Provider Relations (Section 2.1, Quick Address and Telephone Reference).
Example Bulletin:

Please share this bulletin with the following staff:

□ Office Manager

□ Medicaid Biller

□ Physician(s)

□ Other ____________

DUE TO A CHANGE IN THE WYOMING STATUTE, MEDICAID WILL ENROLL LICENSED INDIVIDUAL SPEECH THERAPISTS/PATHOLOGISTS BEGINNING JULY 1, 2009.

THIS UPDATED POLICY ALSO APPLIES TO SPEECH THERAPY SERVICES PROVIDED BY A HOSPITAL, CORF, DEVELOPMENTAL CENTER OR HOME HEALTH AGENCY.

Description of Service
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 presence of a communication disability.

Policy
Medicaid provides coverage for medically necessary, restorative speech therapy services as long as services remain medically necessary to the treatment of the client’s illness or injury.
Example RA Banner:

**********************************************************

THE WEEK OF FEBRUARY 20TH:

* MEDICAID PAYMENT WILL BE PROCESSED ON WEDNESDAY THE 22ND AS NORMAL.

* THE STATE AUDITORS OFFICE WILL PROCESS PAYMENT ON FRIDAY THE 24TH.

* MANUAL CHECKS WILL BE PLACED IN THE MAIL ON MONDAY THE 27TH.

PLEASE REFER TO THE MEDICAID/EQUALITYCARE WEBSITE FOR THIS AND OTHER CHANGES TO THE 2006 PAYMENT SCHEDULE. CHANGES IN THE PAYMENT PROCESS TAKE PLACE DUE TO HOLIDAYS AND MONTH END PROCESSING.

HTTP://WYMEDICAID.ACS-INC.COM

**********************************************************

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

Xerox State Healthcare, LLC is the fiscal agent for Medicaid. They process all claims and adjustments. They also answer provider inquiries regarding claim status, payments, client eligibility, known third party insurance information and on-site visits to train and assist your office staff on Medicaid billing procedures or to resolve claims payment issues.
Chapter Two
Getting Help When You Need It

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Quick Address and Telephone Reference</td>
<td>2-2</td>
</tr>
<tr>
<td>2.2 Quick Website Reference</td>
<td>2-5</td>
</tr>
<tr>
<td>2.3 How to Call for Help</td>
<td>2-6</td>
</tr>
<tr>
<td>2.4 How to Write for Help</td>
<td>2-6</td>
</tr>
<tr>
<td>2.5 How to Get On-Site Help</td>
<td>2-8</td>
</tr>
<tr>
<td>2.6 How to Get Help Online</td>
<td>2-8</td>
</tr>
<tr>
<td>2.7 Training Seminars</td>
<td>2-8</td>
</tr>
<tr>
<td>2.8 Ordering Forms</td>
<td>2-9</td>
</tr>
</tbody>
</table>
# 2.1 Quick Address and Telephone Reference

<table>
<thead>
<tr>
<th>Agency Name &amp; Address</th>
<th>Phone Numbers And Hours</th>
<th>Fax</th>
<th>Contact For:</th>
</tr>
</thead>
</table>
| Interactive Voice Response (IVR) System | 1-800-251-1270  
24 hrs a day  
7 days per week | N/A | • Payment inquiries  
• Client eligibility  
• Medicaid client number and information  
• Lock-in status  
• Medicare Buy-In data  
• Service limitations  
• Client third party coverage information  

NOTE: For a complete listing of Medicaid and State Healthcare Benefit Plans refer to Section A.3.  
NOTE: The client’s Medicaid ID number or social security number is required for accessing client information. |
| Claims  
PO Box 547  
Cheyenne, WY  
82003-0547 | 8-5pm MST M-F | N/A | • Claims adjustment requests  
• Hardcopy claims processing  
• Returning Medicaid checks |
| Dental Service  
PO Box 667  
Cheyenne, WY  
82003-0667 | 1-888-863-5806  
9-5pm MST M-F | | • 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 | 1-800-672-4959  
OPTION 3  
9-5pm MST M-F | (307) 772-8405 | • EDI Enrollment Form  
• Trading Partner Agreement  
• WINASAP software  
• Technical support for WINASAP  
• Technical support for vendors, billing agents and clearing houses  
• Web Portal registration  
• Technical support for Web Portal |
| Medical Policy  
PO Box 667  
Cheyenne, WY  
82003-0667 | 1-800-251-1268  
OPTIONS 1,1,4,3  
9-5pm MST M-F  
(Voicemail Available) | (307) 772-8405 | Prior authorization requests for:  
• Out-of-State Home Health  
• Surgeries requiring prior authorization  
• Hospice Services: Limited to clients residing in a nursing home  
• Status of a pending prior authorization  
• Cap limit Waiver requests |
<table>
<thead>
<tr>
<th>Agency Name &amp; Address</th>
<th>Phone Numbers And Hours</th>
<th>Fax</th>
<th>Contact For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td>1-800-251-1268</td>
<td>(307) 772-8405</td>
<td>• Bulletin/Manuals inquiries</td>
</tr>
<tr>
<td></td>
<td>Call Center Agents are available - 9-5pm MST M-F</td>
<td></td>
<td>• Cap limits</td>
</tr>
<tr>
<td></td>
<td>Touchtone phone required</td>
<td></td>
<td>• Claim inquiries</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Claim submission problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Client eligibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• How to complete forms</td>
</tr>
<tr>
<td>Third Party Liability (TPL)</td>
<td>1-800-251-1268 OPTION 2</td>
<td>(307) 772-8405</td>
<td>• Payment inquiries</td>
</tr>
<tr>
<td></td>
<td>9-5pm MST M-F</td>
<td></td>
<td>• Request Field Representative visit</td>
</tr>
<tr>
<td></td>
<td>Select Option 2 if you need Medicare or estate and trust recovery assistance</td>
<td></td>
<td>• Training seminar questions</td>
</tr>
<tr>
<td></td>
<td>THEN</td>
<td></td>
<td>• Timely filing inquiries</td>
</tr>
<tr>
<td></td>
<td>Select Option 2 if you are with an insurance company, attorney’s office or child support enforcement</td>
<td></td>
<td>• Troubleshooting prior authorization problems</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
<td>• Verifying validity of procedure codes</td>
</tr>
<tr>
<td></td>
<td>Select Option 3 for Medicare and Medicare Premium payments</td>
<td></td>
<td>• Claim void/adjustment inquiries</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
<td>• WINASAP training</td>
</tr>
<tr>
<td></td>
<td>Select Option 4 for estate and trust recovery inquiries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation Call Center</td>
<td>1-800-595-0011</td>
<td>(307) 772-8405</td>
<td>• Medicare Buy-In status</td>
</tr>
<tr>
<td></td>
<td>9-5pm MST M-F</td>
<td></td>
<td>• Client accident covered by liability or casualty insurance or legal liability is being pursued</td>
</tr>
<tr>
<td></td>
<td>(Voicemail Available 24 hours/day)</td>
<td></td>
<td>• Reporting client TPL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Estate and Trust Recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• New insurance coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Policy no longer active</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Problems getting insurance information needed to bill</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Questions or problems regarding third party coverage or payers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• WHIPP program</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Agency Name &amp; Address</td>
<td>Phone Numbers and Hours</td>
<td>Fax</td>
<td>Contact For:</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>KePRO (DME)</td>
<td>1-855-294-1196</td>
<td>(855) 294-1197</td>
<td>• Prior authorization request for Durable Medical Equipment (DME)</td>
</tr>
<tr>
<td>2810 North Parham Rd Suite 305 Henrico, VA 23294</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xerox Care and Quality Solutions (Utilization and Care Management)</td>
<td>1-888-545-1710</td>
<td>For PASRRs Only</td>
<td>Prior authorization for:</td>
</tr>
<tr>
<td>PO Box 49 Cheyenne, WY 82003-0049</td>
<td></td>
<td>(888) 245-1928 Attn: PASRR Processing Specialist</td>
<td>• Extraordinary heavy care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Gastric Bypass</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Inpatient rehabilitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Acute Psych</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Extended Psych</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Psychiatric Residential Treatment Facility (PRTF)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Transplants</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Vagus Nerve Stimulator</td>
</tr>
<tr>
<td>ADAP Aids Drug Assistance Program</td>
<td>(307) 777-5800</td>
<td>(307) 777-7382</td>
<td>Prescription medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MFH Children Special Health</td>
<td>(307) 777-6921 or (800) 438-5795</td>
<td>(307) 777-7215</td>
<td>Children’s Special Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• High Risk Maternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Newborn intensive care</td>
</tr>
<tr>
<td>MDP Marginal Dental</td>
<td>(307) 777-7945</td>
<td></td>
<td>Eligibility for Marginal Dental Program</td>
</tr>
<tr>
<td>Medicare</td>
<td>1-800-633-4277</td>
<td></td>
<td>General information regarding Medicare</td>
</tr>
<tr>
<td>Division of Healthcare Financing</td>
<td>(307) 777-7531</td>
<td></td>
<td>• Health Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Health Check</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Medicaid State Rules</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Program Integrity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Utilization of Services</td>
</tr>
<tr>
<td>Division of Healthcare Financing Program Integrity</td>
<td>1-855-846-2563</td>
<td></td>
<td>Client or Provider Fraud</td>
</tr>
<tr>
<td>Division of Healthcare Financing Pharmacy Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6101 Yellowstone Rd. Ste. 210 Cheyenne, WY 82002</td>
<td>1-800-438-5785</td>
<td>(307) 777-8623</td>
<td>General questions</td>
</tr>
<tr>
<td></td>
<td>1-877-207-1126 (Goold Health Systems, Inc)</td>
<td></td>
<td>Pharmacy prior authorization questions</td>
</tr>
</tbody>
</table>
## 2.2 Quick Website Reference

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Web Address</th>
<th>Phone Number</th>
<th>Reference for</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS EDI Gateway</td>
<td><a href="http://www.acs-gcro.com">http://www.acs-gcro.com</a></td>
<td>1-800-672-4959</td>
<td>• WINASAP software</td>
</tr>
</tbody>
</table>
| Wyoming Medicaid (Medicaid EqualityCare) | http://wymedicaid.acs-inc.com | N/A | • Billing Manuals  
• HIPAA electronic transaction data exchange  
• Fee schedules  
• Frequently asked questions (FAQs)  
• Forms (e.g., Claim Adjustment/Void Request Form)  
• HIPAA  
• IVR Navigation  
• Outpatient Perspective Payment System (OPPS)  
• Publications  
• Remittance Advice Retrieval  
• WINASAP software  
• EDI enrollment form  
• Trading Partner Agreement  
• Secure Provider Web Portal |
| Division of Healthcare Financing | http://www.health.wyo.gov/healthcarefin/equalitycare/index.html | (307) 777-7531 | • Eligibility information  
• FAQs  
• Health Management  
• Health Check  
• Medicaid State Rules  
• Program Integrity |
• FAQs  
• Prior Authorizations |
2.3 **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, services limits, third party coverage, and provider payment issues.

2.4 **How to Write for Help**

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

To expedite the handling of written inquiries, we recommend you use a Provider Inquiry Form (Section 2.4.1). You may copy the form in this manual. Provider Relations will respond to your inquiry within ten business days of receipt.
### 2.4.1 Provider Inquiry Form

<table>
<thead>
<tr>
<th>1. Provider Name and Address</th>
<th>2. Provider/NPI Number</th>
<th>3. Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Person to contact in Provider's Office</th>
<th>5. Date of Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Client Name: Last, First, MI.</th>
<th>7. Medicaid ID Number</th>
<th>8. Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Nature of Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15. Fiscal Agent Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Mail completed form to:

Wyoming Medicaid  
Attn: Provider Relations  
PO Box 667  
Cheyenne, WY  82003-0667
2.5 **How to Get On-Site Help**

Provider Relations Field Representatives are available to make on-site visits to train or address questions your office staff may have on Medicaid billing procedures or to resolve claims payment issues.

2.6 **How to Get Help Online**

The address for Medicaid’s public website is http://wymedicaid.acs-inc.com. This site connects Wyoming’s provider community to a variety of information including:

- Answers to your 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

The Medicaid public website also links providers to Medicaid’s Secure 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
- **User Administration** – add, edit, and delete users within your organization who can access the Secure Provider Web Portal
- **837 Electronic Claim Entry** – interactively enter dental, institutional and medical claims without buying expensive software

2.7 **Training Seminars**

The fiscal agent and the Division of Healthcare Financing sponsor periodic training seminars at selected in-state and out-of-state locations. You may receive advance notice of seminars by Provider Email Campaigns, provider bulletins (hard copies) or Remittance Advice banners. You may also check the Medicaid/EqualityCare website for any recent seminar information.
2.8 Ordering Forms

The following is a list of forms that can be ordered from Provider Relations. We recommend you use the order form (Section 2.8.1, Order Form) which you may copy from this manual. For a complete list of forms accepted by Medicaid, refer to the website (Section 2.2, Quick Website Reference).

<table>
<thead>
<tr>
<th>Type of Claim or Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Living Facility Waiver Plan of Care Form (C-501C)</td>
</tr>
<tr>
<td>LT101 Screening Form</td>
</tr>
<tr>
<td>LTC Consumer-Directed Plan of Care Form (C-501B)</td>
</tr>
<tr>
<td>LTC Waiver Plan of Care Form (C-501A)</td>
</tr>
</tbody>
</table>
### Order Form

**PLEASE ENTER THE QUANTITY DESIRED FOR EACH FORM**

- **Assisted Living Facility**
  - ____ Waiver Plan of Care Form (C-501C)

- **LTC Waiver Plan of Care Form**
  - ____ (C-501A)

- ____ LT101 Screening Form

- **LTC Consumer Directed Plan of Care Form**
  - ____ (C-501B)

**PLEASE TYPE OR PRINT YOUR NAME AND ADDRESS ON THE LABEL BELOW. IT WILL BE USED TO SHIP YOUR FORMS.**
Chapter Three
Provider Responsibilities

Chapter Three
Provider Responsibilities

3.1 Enrollment
3.2 Accepting Medicaid Clients
3.3 Medical Necessity
3.4 Medicaid Payment is Payment in Full
3.5 Out-of-State Service Limitations
3.6 Medicare Covered Services
3.7 Usual and Customary Charges
3.8 Record Keeping, Retention, and Access
3.9 Tamper Resistant RX Pads
3.1 **Enrollment**

Medicaid payment is made only to providers who are actively enrolled in the Medicaid Program. To be enrolled, you must complete an enrollment application and a Provider Agreement. In addition, certain providers are required to submit proof of licensure and/or certification. These requirements apply to both in-state and out-of-state providers.

To enroll as a Medicaid provider, contact Provider Relations or complete an on-line application from the Medicaid/EqualityCare website (Section 2.2, Quick Website Reference).

After your enrollment application has been approved, a welcome letter will be sent to you.

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

3.1.1 **Notifying Medicaid of Updated Provider Information**

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

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

3.1.2 **Re-Certification**

Annually, Medicaid sends out-of-state providers a letter requesting a copy of their license or other certifications. If these documents are not submitted within sixty days of their expiration date, the provider will be terminated as a Medicaid provider.
3.1.3 Discontinuing Participation in the Medicaid Program

You may discontinue participation in the Medicaid Program at any time. Thirty days written notice of voluntary termination is requested. Notices should be addressed to Provider Relations (Section 2.1, Quick Address and Telephone Reference).

3.2 Accepting Medicaid Patients

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

If a client’s financial status is unknown, it is your responsibility to determine his/her financial resources and arrange for payment of services. If the client is insured, you must submit a Third Party Resources Information Sheet to TPL (Section 7.7.1). If you fail to fulfill this responsibility and the individual is eligible for Medicaid, it is assumed that you will accept Medicaid payment. You may not discriminate based on whether or not a client is insured.

Once this agreement has been reached, all services you render to an eligible client are billed to Medicaid. If you have collected money from the client for services rendered during the eligibility period and decide to accept payment from Medicaid, it is your responsibility to refund any payment made by the client prior to billing Medicaid.

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

3.2.3  **Do Not Bill Before Services Are Provided**

Medicaid covers only those services that are medically necessary and cost-efficient. It is your responsibility to be knowledgeable regarding covered services, limitations, and exclusions of the Medicaid Program. Therefore, if you, without mutual 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, you may not obtain payment from the client.

If you 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 you inform the client of his/her financial responsibility prior to rendering service, then you may bill the client for the services rendered.
3.3 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.

3.4 Medicaid Payment is Payment in Full

As a condition of becoming a Medicaid provider, you must accept payment from Medicaid as payment in full for a covered service. You may never bill a Medicaid client:

- When you bill Medicaid for a covered service, and Medicaid denies your claim due to billing errors such as wrong procedure and diagnosis codes, lack of prior authorization, invalid consent forms, missing attachments and 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 your charges and the amount Medicaid has paid.

You may bill a Medicaid client:

• If you have not billed Medicaid, the service provided is not covered by Medicaid, and prior to providing service, you informed the client in writing that the service is non-covered and he/she is responsible for the charges.
• If the client is not Medicaid eligible at the time you provide the services or on a plan that does not cover those particular services. (Section A.3, Medicaid and State Healthcare Benefit Plans).
• If the client has exceeded the Medicaid limits on physical therapy, occupational therapy, prescriptions, and/or office/outpatient hospital visits. You may contact Provider Relations or the Interactive Voice Response System to receive this information (Section 2.1, Quick Address and Telephone Reference).

3.5 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:

<table>
<thead>
<tr>
<th>Colorado</th>
<th>Montana</th>
<th>South Dakota</th>
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</thead>
<tbody>
<tr>
<td>Craig</td>
<td>Billings</td>
<td>Deadwood</td>
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<td></td>
<td>Bozeman</td>
<td>Custer</td>
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<td>Idaho</td>
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<td>Rapid City</td>
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<tr>
<td>Montpelier</td>
<td>Nebraska</td>
<td>Spearfish</td>
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<td>Pocatello</td>
<td>Kimball</td>
<td>Belle Fourche</td>
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<td>Idaho Falls</td>
<td>Scottsbluff</td>
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<tr>
<td>Utah</td>
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<tr>
<td>Salt Lake City</td>
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<tr>
<td>Ogden</td>
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</table>

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 (Section 6.12).
- Children in out-of-state placement

If you are an out-of-state, non-enrolled provider and render services to a Medicaid client, you may choose to enroll in the Medicaid Program and submit your 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.

Out-of-state Wyoming residents requiring nursing facility services must submit the following documentation upon request prior to placement in an out-of-state nursing facility:

- Statement by the attending physician stating the resident’s health would be endangered if he/she would be required to return to Wyoming; and
- Current medical history, physical and comprehensive drug history; PASRR Level I and/or Level II; documentation to support the “statement of endangered health;” and any other documentation requested; and
- The facility is enrolled as a Medicaid provider

Prior Approval must be obtained from the Division of Healthcare Financing, Long Term Waiver.

### 3.6 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 Office (Section A.1) closest to the client’s permanent place of residence.

3.7 Usual and Customary Charges

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

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

3.8 Record Keeping, Retention, and Access

3.8.1 Requirements

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

- 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.
- 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 office, clinic, nursing home, or hospital visit 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, to include beginning time and ending time for services billed.
3.8.2 Retention of Records

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

3.8.3 Access to Records

Under the Provider Agreement, you 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, the Wyoming Attorney General’s Office, the Wyoming Department of Family Services (DFS), 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 your records must be granted regardless of your continued participation in the program.

In addition, you are required to furnish copies of claims and any other documentation upon request from Medicaid.

3.8.4 Audits and On-Site Visits

Medicaid has the authority to conduct routine audits and on-site visits to monitor compliance with program requirements.

Audits and on-site visits may include, but are not limited to:

- Examination of records;
- Interviews of providers, their associates, and employees;
- Interviews of program 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 program clients;
- Examination of prescriptions written for program 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.
You 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 you before examining such records.

Medicaid reserves the right to make unscheduled visits under extraordinary circumstances, i.e., when the client’s health may be endangered, when criminal/fraud activities are suspected, etc.

Medicaid is authorized to examine all your 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 to access their financial and medical records.

Your 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-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.

3.9 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 April 1, 2008 must contain one, and as October 1, 2008, must contain all three of the following characteristics:
1. One 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 or that meets the standards set forth in this category.

2. One 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 one or that meets the standards set forth in this category.

3. One 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 or that meets that standards set forth in this category.

- **Computer Printed Prescriptions:** As of April 1, 2008 must contain one, and as October 1, 2008, must contain all three of the following characteristics:

1. One 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 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 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 or that meets that 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.

The security paper that the Wyoming Board of Pharmacy allows for their requirement that all controlled substance prescriptions written by a Wyoming practitioner shall be issued on security paper meets at least one if not all three requirements listed above. The Board’s website, under "Items of Interest from the Board" has a section on security paper and a listing of approved vendors. Please contact vendors directly for information on security features of their products.

Audits of pharmacies will be performed in the future by the Wyoming Department of Health, Program Integrity Unit to ensure that the above requirement is being followed. If you have any questions about these audits or this regulation, please contact the Wyoming Department of Health, Division of Healthcare Financing Pharmacy Program (Section 2.1, Quick Address and Telephone Reference).
Chapter Four
Utilization Review

Chapter Four ................................................................................................................4-1
4.1 Utilization Review ..................................................................................................... 4-2
4.2 Complaint Referral ................................................................................................. 4-2
4.3 Release of Medical Records .................................................................................... 4-2
4.4 Client Lock-In .......................................................................................................... 4-3
4.5 Fraud and Abuse ...................................................................................................... 4-3
4.6 Provider Responsibilities ......................................................................................... 4-4
4.7 Referral of Suspected Fraud and Abuse ................................................................. 4-4
4.8 Sanctions .................................................................................................................. 4-6
4.9 Adverse Actions ...................................................................................................... 4-6
4.1 Utilization Review

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

- Review of claims submitted for payment;
- Review of medical records and documents related to covered services;
- On-site review of medical records and client interviews;
- Review of client Explanation of Medical Benefits (EOMB) responses;
- Case Management oversight;
- Operation of the Surveillance/Utilization Review (SUR) process; and
- Oversight of the Professional Review Organization (PRO) contract.

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 access to 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 agency or its agent requests records.
4.4 Client Lock-In

In certain circumstances, it may be necessary to restrict certain services or “lock-in” a client to a certain physician, 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 (Section 2.1, Quick Address and Telephone 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 (Section 2.2, Quick Website Reference).

4.5 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 suspicions of fraud and abuse arise.
Medicaid has the responsibility, under Federal Regulations and Medicaid Rules, to refer all cases of suspected 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:

<table>
<thead>
<tr>
<th>Fraud</th>
<th>“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.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>“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.”</td>
</tr>
</tbody>
</table>

4.6 **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, providers are responsible for ensuring the completeness and accuracy of all claims submitted to Medicaid.

4.7 **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 (Section 4.7.1) 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
4.7.1  Report of Suspected Abuse of the Medicaid Healthcare System

NAME(s) OF MEDICAID CLIENT/PROVIDER: ________________________________
ADDRESS OF MEDICAID CLIENT/PROVIDER: ________________________________
TELEPHONE NUMBER OF MEDICAID CLIENT/ PROVIDER: ________________

Please give a brief description of how the Medicaid client/provider is abusing the 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
4.8 **Sanctions**

The Division of Healthcare Financing may invoke administrative sanctions against a Medicaid provider who has been suspected of or has committed fraud, abuse, non-compliance (i.e., Provider Agreement and/or Medicaid Rules) or who is under sanction by another regulatory entity.

Providers who have had sanctions levied against them may be subject to prohibitions or additional requirements as defined by Medicaid Rules.

4.9 **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 1, entitled “Rules for Medicaid Administrative Hearings”. 
Chapter Five
Client Eligibility

Chapter Five…………………………………………………………………5-1
5.1 What is Medicaid? ............................................................................. 5-2
5.2 Who is Eligible? ............................................................................... 5-2
5.3 Eligibility Determination ................................................................. 5-5
5.4 Client Identification Cards .............................................................. 5-6
5.5 Other Types of Eligibility Identification ......................................... 5-7
5.6 Clients without Cards ..................................................................... 5-7
5.7 Freedom of Choice .......................................................................... 5-8
5.8 Verification of Client Eligibility ....................................................... 5-8
5.9 Verification Options ......................................................................... 5-9
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 care adults and the aged, blind and disabled.

5.2 Who is Eligible?

Eligibility is generally based on family income and sometimes assets and/or healthcare needs. Federal statutes define more than fifty (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 Care Adults; and
- Aged, Blind, and Disabled

NOTE: For a complete listing of Medicaid and State Healthcare Benefit Plans refer to Section A.3.

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 below 100% federal poverty level (FPL) or 133% FPL, dependent on age of the child
- Family Care Children are eligible when a caretaker is determined eligible based on family income below the 1996 Family Care Standard
- 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 twenty-one (21)

5.2.2 Pregnant Women

- Pregnant Women are eligible if family income is below 133% FPL and women with income less than or equal to the 1996 Family Care Standard must cooperate with child support
- Presumptive Eligibility allows coverage for outpatient services for up to 60 days pending Medicaid eligibility determination
5.2.3 **Family Care Adult**

- Family Care Adults (caretaker relatives with a dependent child) are eligible if family income is below the 1996 Family Care Standard.

5.2.4 **Aged, Blind, and 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 MR – State Training School
- INPAT-PSYCH – WY State Hospital – are 65 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.

- Child Developmental Disabilities
- Adult Developmental Disabilities
- Acquired Brain Injury
- Assisted Living Facilities
- Long Term Care
- Children’s Mental Health waiver

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 below 250% FPL
- Tuberculosis (TB) Program – Individuals diagnosed with tuberculosis are eligible based on the TB Standard
5.2.5.2 Employed Individuals with Disabilities

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

5.2.5.3 Medicare Savings Programs

- Qualified Medicare Beneficiaries are income eligible under 100% FPL. Benefits include payment of Medicare premiums, deductibles, and cost sharing.
- Specified Low Income Beneficiaries are income eligible under 135% FPL. Benefits include payment of Medicare premiums only.

5.2.5.4 Non-Citizens with Medical Emergencies

- 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 Family Health (MFH)

Maternal and Family Health (MFH) provides services for high-risk pregnant women and high-risk newborns along with the Children’s Special Health (CSH) program which covers children with special healthcare needs. The purpose of these programs is to identify these clients, assure diagnostic and treatment services, provide payment for authorized specialty care, and provide tracking and care coordination services. CSH does not cover acute or emergency care.

- A client may be eligible only for a MFH program or may be dually eligible for a MFH program for other Medicaid programs. Care coordination for both MFH only and dually eligible clients is provided through the Public Health Nurse’s office.
- MFH has a dollar cap and service limits on some services that apply to clients who are eligible for MFH only. Refer to the provider manual issued by CSH. The CSH provider manual is provided by CSH when a provider enrolls with the CSH program.
- Contact MFH for the following information:
  - The nearest Public Health Nurse
  - A replacement CSH provider manual
  - Questions related to eligibility determination or the type of services authorized by MFH.
Maternal & Family 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 MFH to receive payment for MFH services. Claims for both programs are submitted to and processed by the fiscal agent for Wyoming Medicaid (Section 2.1, Quick Address and Telephone Reference). Medical records for visits, which result from MFH referrals, must be sent directly to MFH for appointment tracking and case management. An optional form is available from CSH, which may be used to submit the medical information. Providers are asked to submit the record as soon after the visit as possible to assure timely coordination of referrals and services.

5.4 Eligibility Determination

5.4.1 Applying for Medicaid

Persons applying for Children, Pregnant Women and/or Family Care Adult programs may complete the Application for Wyoming’s Healthcare Coverage Programs, which is also used for the Kid Care CHIP program. The application may be mailed to Kid Care CHIP or to a local DFS office. Applicants may also apply online at healthlink.wyo.gov.

Pregnant women may also apply through a qualified provider for the pregnant women program. If determined presumptively eligible they will have up to sixty (60) days of coverage for outpatient services.

Persons applying for all other Medicaid Programs or who want to apply for other programs offered through the Department of Family Services (DFS) such as SNAP (Supplemental Nutrition Assistance Program) or child care need to apply in person at their local DFS office. Persons applying for Supplemental Security Income (SSI) need to apply at the Social Security Administration Office.
5.4.2 **Determination**

Eligibility determination is conducted by the DFS through local field service offices (Section A.2), or the Federal Social Security Administration (SSA) (Section A.1).

Medicaid assumes no financial responsibility for services rendered prior to the effective date of client eligibility as determined by DFS or the SSA. However, the effective date of eligibility as determined by DFS 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 (Section 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 the AIDS Drug Assistance Program (ADAP), Children’s Special Health (CSH), Prescription Drug Assistance Program (PDAP), and Marginal Dental Program (MDP). A complete listing of ways to check client eligibility is provided later in this chapter. An example of the Medicaid/EqualityCare ID Card is shown below:
5.6 Other Types of Eligibility Identification

5.6.1 Notice of Award

In some cases, a provider may be presented with a copy of a Notice of Award in lieu of the client’s Medicaid ID Card. Providers should always contact Provider Relations to verify eligibility before rendering services to a client who presents a Notice of Award. (Section 2.1, Quick Address and Telephone Reference)

5.7 Clients without Cards

5.7.1 Responsibility for Provider Payment

Any client who seeks service without a valid Medicaid ID Card is responsible for all charges. If a client cannot produce a Medicaid ID Card upon a provider’s request, the provider may:

- Require the client to return with the card; or
- Verify the client’s eligibility for Medicaid and ID number by using a variety of free or fee-for-service eligibility inquiry options

NOTE: Telephone verification of client eligibility is not binding for reimbursement.

If, initially, 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), but the provider agrees at a later date to accept Medicaid benefits:

- The provider must refund the entire amount paid by the client prior to billing Medicaid; and
- The twelve-month timely filing deadline will not be waived (Section 6.20, Timely Filing).

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

- The provider must refund the entire amount paid by the client prior to billing Medicaid; and
- The twelve-month timely filing deadline will be waived.

In the event of retroactive eligibility, claims must be submitted within six months of the date of determination of retroactive eligibility.
NOTE: Medicaid will not pay for services rendered to clients until eligibility has been determined for the month services were rendered.

5.8 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.

5.9 Verification of Client Eligibility

Verification of client eligibility is the responsibility of every Medicaid provider. Possession of a Medicaid ID Card by a patient is not a guarantee of eligibility. Medicaid will only pay for covered services performed during the period of the client’s eligibility. Therefore, it is in the provider’s interest to always check eligibility before a service is rendered.

5.9.2 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 (Section 4.7.1).

5.9.3 Verification of Client Age

Because certain services have age restrictions, such as services covered only under the Health Check Program 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 twenty-first birthday.
5.10 Verification Options

One 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.

5.10.1 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.
- (Section 2.1, Quick Address and Telephone Reference).
- Use the Ask EqualityCare feature on the Secure Provider Web Portal (Section 2.2, Quick Website Reference)

Note: For a complete listing of Medicaid and State Healthcare Benefit Plans refer to Section A.3.

5.10.2 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/EqualityCare website.
Chapter Six
Common Billing Information

Chapter Six.....................................................................................................................6-1
6.1 Basic Claim Information............................................................................................6-3
6.2 Authorized Signatures..............................................................................................6-4
6.3 Completing the CMS-1500 Claim Form .................................................................6-5
6.4 Medicare Crossovers...............................................................................................6-12
6.5 Examples of Billing...................................................................................................6-13
6.6 Cap Limits................................................................................................................6-22
6.7 Reimbursement Methodologies..............................................................................6-25
6.8 Co-Payment Schedule .........................................................................................6-25
6.9 How to Bill for Newborns ......................................................................................6-26
6.10 No Show Appointments .......................................................................................6-26
6.11 Home Health .........................................................................................................6-26
6.12 Prior Authorization ..............................................................................................6-28
6.13 Submitting Attachments for Electronic Claims .....................................................6-36
6.13.1 Attachment Cover Sheet......................................................................................6-37
6.14 Sterilization, Hysterectomy, and Abortion Consent Forms..................................6-38
6.14.1 Sterilization Consent Guidelines .........................................................................6-39
6.14.2 Hysterectomy Acknowledgment of Consent ....................................................6-42
6.14.3 Abortion Certification Guidelines ......................................................................6-44
6.15 The Remittance Advice .........................................................................................6-46
6.15.1 Sample Professional Remittance Advice ...........................................................6-48
6.15.2 How to Read Your Remittance Advice..............................................................6-49
6.15.3 Obtain Your RA from the Web ........................................................................6-50
6.15.4 When Your Client Has Other Insurance ............................................................6-52
6.16 Resubmitting Verses Adjusting Claims ...............................................................6-52
6.16.1 How long do I have to resubmit or adjust a claim? ............................................6-53
6.16.2 Resubmitting a Claim........................................................................................6-53
6.16.3 Adjustments.......................................................................................................6-54
6.16.4 How to request a cancellation of an entire Remittance Advice (RA) ..............6-57
6.17 Returning a Medicaid Check ..............................................................................6-57
6.18  Credit Balances ........................................................................................................ 6-58
6.19  Third Party Payments Received after Medicaid’s Payment ................................... 6-58
6.20  Timely Filing ............................................................................................................ 6-58
6.20.1 Exceptions to the Twelve-Month Limit ................................................................. 6-59
6.20.2 Appeal of Timely Filing ....................................................................................... 6-60
6.21  Important Information Regarding Retroactive Eligibility Decisions .................... 6-60
6.22  Failure to Notify a Provider of Eligibility .............................................................. 6-61
6.23  Billing Tips to Avoid Timely Filing Denials ............................................................ 6-61
6.1 Basic Claim Information

The Fiscal Agent processes paper CMS-1500 and UB04 claims using Optical Character Recognition (OCR). OCR is the process of using a scanner to read the information on a claim and convert it into electronic format instead of being manually entered. This process improves accuracy and increases the speed at which claims are entered into the claims processing system. The quality of the claim 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 (08/05) 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
- Using fonts smaller than 8 point
- Handwritten information on the claim form
- Entering “none”, “NA”, or “Same” if there is no information (leave the box blank, instead)
- 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 will be returned unprocessed with a letter. When a claim is returned because of billing errors and/or missing attachments, the provider may correct the claim and return it to Medicaid for processing.
NOTE: The fiscal agent and the Division of Healthcare Financing 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 (Section 6.16, Resubmitting Verses Adjusting Claims).

NOTE: Claims are to be submitted only after service(s) have been rendered, not before.

6.2 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.
6.3 Completing the CMS-1500 Claim Form

### CMS-1500 Claim Form

#### General Provider Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NPI (National Provider Identifier)</td>
</tr>
<tr>
<td>2.</td>
<td>Providers Name (Last Name, First Name, Middle Name)</td>
</tr>
<tr>
<td>3.</td>
<td>Address (City, State, Zip Code)</td>
</tr>
<tr>
<td>4.</td>
<td>Tax Identification Number (TIN)</td>
</tr>
</tbody>
</table>

#### Common Billing Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Employer's Name or City Name</td>
</tr>
<tr>
<td>6.</td>
<td>Date of Service (MM/DD/YYYY)</td>
</tr>
</tbody>
</table>

**Patient Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Patient's Name (Last Name, First Name, Middle Name)</td>
</tr>
<tr>
<td>8.</td>
<td>Patient's Relationship to Insured</td>
</tr>
</tbody>
</table>

**Beneficiary Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Insured's Name (Last Name, First Name, Middle Name)</td>
</tr>
</tbody>
</table>

**Employer/Billing Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>Employer's Name or City Name</td>
</tr>
</tbody>
</table>

**Service Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>Service or Procedure Code</td>
</tr>
</tbody>
</table>

**Diagnosis Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>Diagnosis Code</td>
</tr>
</tbody>
</table>

**Diagnosis Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>Diagnosis Code</td>
</tr>
</tbody>
</table>

**Provider Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>Provider's Name</td>
</tr>
</tbody>
</table>

**Billing Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Payment Remittance Address</td>
</tr>
</tbody>
</table>

**Other Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.</td>
<td>Signature of Provider or Authorized Representative</td>
</tr>
</tbody>
</table>

**Important Notes**

- **Completing the CMS-1500 Claim Form** should be done accurately to ensure timely payment and avoid denials.
- **Read Back of Form Before Closing** to ensure all information entered is correct.
- **Patient Comments** and **Supplementary Information** should be noted as necessary.
- **Signatures** should be obtained where required to confirm accuracy and compliance.
- **Read and Sign** the CMS-1500 to confirm all information is accurate and complete.
### Instructions for Completing the CMS-1500 Claim Form

<table>
<thead>
<tr>
<th>Claim Item</th>
<th>Title</th>
<th>Required</th>
<th>Conditionally Required</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insurance Type</td>
<td></td>
<td>X</td>
<td>Place an &quot;X&quot; in the &quot;Medicaid&quot; box.</td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s ID Number</td>
<td></td>
<td>X</td>
<td>Enter the client’s ten-digit Medicaid ID number that appears on the Medicaid Identification card.</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td></td>
<td>X</td>
<td>Enter the client’s last name, first name, and middle initial.</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Date of Birth/Sex</td>
<td></td>
<td>X</td>
<td>Information that will identify the patient and distinguishes persons with similar names.</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td></td>
<td>X</td>
<td>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.</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td></td>
<td>X</td>
<td>Refers to patient’s permanent residence.</td>
</tr>
<tr>
<td>6</td>
<td>Patient’s Relationship to Insured</td>
<td></td>
<td>X</td>
<td>If the client is covered by other insurance, mark the appropriate box to show relationship.</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td></td>
<td>X</td>
<td>Enter the address of the insured.</td>
</tr>
<tr>
<td>8</td>
<td>Patient Status</td>
<td></td>
<td></td>
<td>Indicates patient’s marital and employment status.</td>
</tr>
<tr>
<td>9</td>
<td>Other Insurance Information</td>
<td></td>
<td>X</td>
<td>If item number 11d is marked complete fields 9 and 9a-d.</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Name</td>
<td></td>
<td>X</td>
<td>When additional group health coverage exists, enter other insured’s full last name, first name and middle initial if different from item number 2.</td>
</tr>
<tr>
<td>9b</td>
<td>Other Insured’s Date of Birth, Sex</td>
<td></td>
<td>X</td>
<td>Enter the 8-digit date of birth (MM/DD/CCYY) and sex of the other insured.</td>
</tr>
<tr>
<td>9c</td>
<td>Employer’s Name or School</td>
<td></td>
<td>X</td>
<td>Enter the Name of the other insured’s employer or school.</td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan or Program Name</td>
<td></td>
<td>X</td>
<td>Enter the other insured’s insurance plan or program name.</td>
</tr>
<tr>
<td>10a-c</td>
<td>Is Patient’s Condition Related to?</td>
<td></td>
<td>X</td>
<td>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.</td>
</tr>
<tr>
<td>10d</td>
<td>Reserved for Local Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy, group or FECA Number</td>
<td></td>
<td>X</td>
<td>Enter the insured’s policy or group number as it appears on the ID card. Only complete if Item Number 4 is completed.</td>
</tr>
<tr>
<td>11a</td>
<td>Insured’s Date of Birth, Sex</td>
<td></td>
<td>X</td>
<td>Enter the 8- digit date of birth (MM/DD/CCYY) and an X to indicate the sex of the insured.</td>
</tr>
<tr>
<td>11b</td>
<td>Insured’s Employer’s Name or School Name</td>
<td></td>
<td>X</td>
<td>Enter the Name of the insured’s employer or school.</td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td></td>
<td>X</td>
<td>Enter the insurance plan or program name of the insured.</td>
</tr>
<tr>
<td>11d</td>
<td>Is there another Health Benefit Plan?</td>
<td></td>
<td>X</td>
<td>When appropriate, enter an X in the correct box. If marked “YES”, complete 9 and 9a-d.</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or Authorized Person’s Policy</td>
<td></td>
<td></td>
<td>Indicates there is an authorization on file for the release of any medical or other information necessary to process the</td>
</tr>
<tr>
<td>Claim Item</td>
<td>Title</td>
<td>Required</td>
<td>Conditionally Required</td>
<td>Action/Description</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------</td>
<td>----------</td>
<td>------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Signature</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Payment Authorization Signature</td>
<td></td>
<td></td>
<td>Indicates that there is a signature on file authorizing payment of medical benefits.</td>
</tr>
<tr>
<td>14</td>
<td>Date of current illness, injury or pregnancy</td>
<td>X</td>
<td></td>
<td>Enter the date of illness, injury or pregnancy.</td>
</tr>
<tr>
<td>15</td>
<td>If Patient has had Same or Similar Illness</td>
<td></td>
<td></td>
<td>A patient having had same or similar illness would indicate that the patient had a previously related condition.</td>
</tr>
<tr>
<td>16</td>
<td>Date Patient Unable to Work in Current Occupation</td>
<td></td>
<td></td>
<td>Time span the patient is or was unable to work.</td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Physician</td>
<td>X</td>
<td></td>
<td>Enter the name and credentials of the professional who referred, ordered or supervised the service on the claim.</td>
</tr>
<tr>
<td>17a</td>
<td>17a Other ID #</td>
<td>X</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>17b</td>
<td>NPI #</td>
<td>X</td>
<td></td>
<td>Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Service</td>
<td></td>
<td></td>
<td>The hospitalization dates related to current services would refer to an inpatient stay and indicates admission and discharge dates.</td>
</tr>
<tr>
<td>19</td>
<td>Reserved for Local Use</td>
<td></td>
<td></td>
<td>Indicates that services have been rendered by an independent provider as indicated in Item Number 32 and related Costs.</td>
</tr>
<tr>
<td>20</td>
<td>Outside lab? $ Charges</td>
<td></td>
<td></td>
<td>Enter the ten-digit Prior Authorization number from the approval letter if this claim has been prior authorized. Claims for these services are subject to service limits and the twelve-month filing limit.</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>X</td>
<td></td>
<td>Enter the patient’s diagnosis/condition. List up to four ICD-PCM codes. Use the highest level of specificity. Do not provide a description in this field.</td>
</tr>
<tr>
<td>22</td>
<td>Medicaid Resubmission Code</td>
<td></td>
<td></td>
<td>The code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim.</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization</td>
<td>X</td>
<td></td>
<td>Enter the ten-digit Prior Authorization number from the approval letter if this claim has been prior authorized. Claims for these services are subject to service limits and the twelve-month filing limit.</td>
</tr>
<tr>
<td>24</td>
<td>Claim Line Detail</td>
<td></td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>24A</td>
<td>Dates of Service</td>
<td>X</td>
<td></td>
<td>Enter date(s) of service, from and to. If one 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, please refer to the NDC entry information following this chart.</td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td>X</td>
<td></td>
<td>Enter the two-digit Place of Service (POS) for each procedure performed.</td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td></td>
<td></td>
<td>This Item Number was originally titled “Type of Service”. This is no longer used and has been eliminated. Leave blank.</td>
</tr>
<tr>
<td>Claim Item</td>
<td>Title</td>
<td>Required</td>
<td>Conditionally Required</td>
<td>Action/Description</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------</td>
<td>----------</td>
<td>------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, Services, or Supplies</td>
<td>X</td>
<td></td>
<td>Enter the CPT or HCPCS codes and modifiers from the appropriate code set in effect on the date of service.</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
<td>X</td>
<td></td>
<td>Enter the diagnosis code reference number (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. Do Not enter ICD-9CM diagnosis codes in this box.</td>
</tr>
<tr>
<td>24F</td>
<td>$ Charges</td>
<td>X</td>
<td></td>
<td>Enter the charge for each listed service.</td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units</td>
<td>X</td>
<td></td>
<td>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 service is performed, the numeral 1 must be entered.</td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT/Family Plan</td>
<td>X</td>
<td></td>
<td>Identifies certain services that may be covered under some state plans.</td>
</tr>
<tr>
<td>24I</td>
<td>ID Qualifier</td>
<td>X</td>
<td></td>
<td>If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area.</td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider ID #</td>
<td>X</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax ID Number</td>
<td></td>
<td></td>
<td>Refers to the unique identifier assigned by a federal or state agency.</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account Number</td>
<td></td>
<td></td>
<td>The patient’s account number refers to the identifier assigned by the provider. This is optional.</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment?</td>
<td>X</td>
<td></td>
<td>Enter X in the correct box. Indicated that the provider agrees to accept assignment under the terms of the Medicare program.</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>X</td>
<td></td>
<td>Add together all charges in Column 24F and enter the total amount in this field.</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td>X</td>
<td></td>
<td>Enter total amount the patient or other payers paid on the covered services only. This field is reserved for third party coverage only.</td>
</tr>
<tr>
<td>30</td>
<td>Balance Due</td>
<td></td>
<td></td>
<td>Enter the total amount due.</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier Including Degrees or Credentials</td>
<td>X</td>
<td></td>
<td>Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative. Enter date the form was signed.</td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information</td>
<td>X</td>
<td></td>
<td>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 digit qualifier identifying the non-NPI number followed by the ID number.</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info &amp; Ph#</td>
<td>X</td>
<td></td>
<td>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 digit qualifier identifying the non-NPI number followed by the ID number.</td>
</tr>
</tbody>
</table>
### Place of Services

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Place of Service Name</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>School</td>
<td>A facility whose primary purpose is education.</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
<td>A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health Service Free-standing Facility</td>
<td>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.</td>
</tr>
<tr>
<td>06</td>
<td>Indian Health Service Provider-based Facility</td>
<td>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.</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-standing Facility</td>
<td>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.</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-based Facility</td>
<td>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.</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
<td>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.</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
<td>Location, other than a Hospital or other Facility, where the patient receives care in a private session.</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
<td>Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some healthcare and other services.</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
<td>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).</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
<td>A facility/unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services.</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
<td>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.</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
<td>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.</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
<td>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.</td>
</tr>
<tr>
<td>Place of Service</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
<td>A portion of a Hospital where emergency diagnosis and treatment of illness or injury is provided.</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
<td>A free standing facility, other than a physician’s office, where surgical and diagnostic services are provided on an ambulatory basis.</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
<td>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.</td>
</tr>
<tr>
<td>26</td>
<td>Military treatment Facility</td>
<td>A medical facility operated by one 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).</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
<td>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.</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
<td>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.</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
<td>A facility which provides room, board and other personal assistance services, generally on a long-term basis, which does not include a medical component.</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
<td>A facility, other than a patient’s home, in which palliative and supportive care for terminally ill patients and their families are provided.</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance – Land</td>
<td>A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance – Air or Water</td>
<td>An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
<td>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.</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
<td>A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
<td>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.</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility-Partial Hospitalization</td>
<td>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.</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
<td>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.</td>
</tr>
<tr>
<td>Place of Service</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility / Mentally Retarded</td>
<td>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.</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
<td>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.</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
<td>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.</td>
</tr>
<tr>
<td>57</td>
<td>Non-residential Substance Abuse Treatment Facility</td>
<td>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.</td>
</tr>
<tr>
<td>60</td>
<td>Mass Immunization Center</td>
<td>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.</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
<td>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.</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
<td>A facility that provides comprehensive rehabilitation services to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.</td>
</tr>
<tr>
<td>65</td>
<td>End-Stage Renal Disease Treatment Facility</td>
<td>A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.</td>
</tr>
<tr>
<td>71</td>
<td>State or Local Public Health Clinic</td>
<td>A facility maintained by either State or local health department that provides ambulatory primary medical care under the general direction of a physician.</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
<td>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.</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
<td>A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician’s office.</td>
</tr>
<tr>
<td>99</td>
<td>Other Place of Service</td>
<td>Other place of service not listed above.</td>
</tr>
</tbody>
</table>
6.4 Medicare Crossovers

Medicaid reimburses for Medicare/Medicaid services when provided to an eligible client.

6.4.1 General Information

- Dually eligible clients are clients that are eligible for Medicare and Medicaid.
- Providers may verify Medicare and Medicaid eligibility through the IVR (Section 2.1, Quick Address and Telephone Reference).
- Providers must accept assignment of claims for dually eligible clients.
- Medicaid reimburses providers for 100% of deductible amounts and 100% of coinsurance amounts due on Medicare covered services for dually eligible clients.

6.4.2 Billing Information

- Medicare is primary 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.
- The time limit for filing Medicare crossover claims to Medicaid is twelve months from the date of service or six 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 paper claim to Medicaid. The line items on the paper claim being submitted to Medicaid must be exactly the same as the claim submitted to Medicare and have the Medicare EOMB attached.

NOTE: Do not resubmit a claim for coinsurance or deductible amounts unless you have 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.
6.5 **Examples of Billing**

6.5.1 **Client Has Medicaid Coverage Only or Medicaid and Medicare Coverage**

**NOTE:** When client has dual coverage, (Medicaid and Medicare) attach the EOMB to the claim.
6.5.2 Client has Medicaid and Third Party Liability (TPL) or Client has Medicaid, Medicare, and TPL

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.
6.5.3 Provider Preventable Conditions (PPC)

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

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

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

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

6.5.3.3 Providers included in the PPC Review

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

Wyoming Medicaid requires POA indicators on all inpatient claims, regardless of provider type, participating in Wyoming Medicaid. Wyoming Medicaid has adopted Medicare’s list of exempt ICD-9 diagnosis codes. The list of diagnosis codes exempt from POA requirement can be found at:

http://www.cms.gov/HospitalAcqCond/05_Coding.asp#TopOfPage

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

1. At the end of each quarter, identify inpatient claims from the prior quarter for non-exempt providers with non-principle diagnosis codes falling into one of the five Hospital-Acquired Condition (HAC) categories.

2. Request POA indicator information from the providers for each of the claims identified in Step 1. Effective January 1, 2012, review POA indicators submitted on the claim instead of requesting information from the providers.

3. Review POA indicator information submitted by the providers and, based on the indicator, take the following actions:

<table>
<thead>
<tr>
<th>POA Indicator</th>
<th>Definition</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at time of inpatient admission</td>
<td>Claim is not a HAC. Drop from HAC adjustment consideration.</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at time of inpatient admission.</td>
<td>Claim is a HAC. Request adjusted claim from the provider (see Step 4).</td>
</tr>
<tr>
<td>U</td>
<td>Documentation insufficient to determine if condition was present at the time of inpatient admission.</td>
<td>Request medical records related to the claim to determine appropriateness of the “U” indicator assignment (see Step 6).</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.</td>
<td>Claim cannot be confirmed as a HAC. Drop from HAC adjustment consideration.</td>
</tr>
<tr>
<td>Blank</td>
<td>Exempt from POA reporting.</td>
<td>Diagnosis code is not subject to HAC payment policy. Drop claim from adjustment consideration.</td>
</tr>
</tbody>
</table>

**NOTE**: The number “1” is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for diagnosis codes exempt from POA reporting.
4. For all claims with a POA indicator of “N,” request that the provider submit an adjusted claim which identifies all charges associated with the HAC as “non-covered” and all charges not associated with the HAC as “covered.”

5. Determine the LOC assignment and outlier payment for each of the adjusted claims received in Step 4. If the total payment is less than what was originally paid for the claim, then request a refund from the provider for the difference. The fiscal agent for Wyoming Medicaid will maintain a listing of these claims, including the submitted charges and payment, and the adjusted charges and payment.

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

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

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

\[
\begin{array}{ccc}
6 & 5 & 2 \\
3 & 0 & 0 \\
1 & 0 & 1 \\
\end{array}
\]

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

- Labeler Code - Five-digit (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-digit (4 digit) number that identifies the specific drug, strength and dosage form.
- Package Code - Two-digit (2 digit) number that identifies the package size.

6.5.4.1 Converting 10-Digit NDCs to 11 Digits

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

<table>
<thead>
<tr>
<th>10-Digit Format</th>
<th>Sample 10-Digit NDC</th>
<th>Required 11-Digit Format</th>
<th>Sample 10-Digit NDC Converted to 11 Digits</th>
</tr>
</thead>
<tbody>
<tr>
<td>99999-9999-99 (4-4-2)</td>
<td>0002-7597-01 Zyprexa 10mg vial</td>
<td>09999-9999-99 (5-4-2)</td>
<td>00002-7597-01</td>
</tr>
<tr>
<td>99999-9999-99 (5-3-2)</td>
<td>50242-040-62 Xolair 150mg vial</td>
<td>99999-0999-99 (5-4-2)</td>
<td>50242-0040-62</td>
</tr>
<tr>
<td>99999-9999-9 (5-4-1)</td>
<td>60575-4112-1 Synagis 50mg vial</td>
<td>99999-9999-09 (5-4-2)</td>
<td>60575-4112-01</td>
</tr>
</tbody>
</table>

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

6.5.4.2 Documenting and Billing the Appropriate NDC

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

6.5.4.3 Rebateable NDCs

When a procedure code requires a NDC, Medicaid will only cover those NDCs that are Rebateable per the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). A NDC is considered rebateable only if all of the following conditions are met:

The DESI indicator assigned to the NDC is 2, 3 or 4;
The drug has not been terminated as of the date of service; and
The NDC’s labeler has a signed rebate agreement with the Secretary of the Department of Health and Human Services (HHS) in effect on the date of service.

To simplify the identification of rebateable NDCs, Medicaid will maintain a list on its website (http://wymedicaid.acs-inc.com). Providers are encouraged to use the list to verify an NDC’s rebate status before billing it. NDCs that are not rebateable will be denied.

6.5.4.4 Procedure Code / NDC Combinations

The list of rebateable NDCs Medicaid will post to its website will also give providers a way to validate procedure code / NDC combinations. The table below illustrates a few sample entries from the list.

<table>
<thead>
<tr>
<th>NDC</th>
<th>Procedure Code</th>
<th>Procedure Description</th>
<th>NDC Label</th>
<th>Rebateable</th>
<th>Rebate Start Date</th>
<th>Rebate End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>58468-0040-01</td>
<td>J0180</td>
<td>Injection, Agalsidase Beta, 1 MG</td>
<td>Fabrazyme (PF) 35 MG</td>
<td>Y</td>
<td>01/01/1991</td>
<td>99/99/9999</td>
</tr>
<tr>
<td>58468-0041-01</td>
<td>J0180</td>
<td>Injection, Agalsidase Beta, 1 MG</td>
<td>Fabrazyme (PF) 5 MG</td>
<td>Y</td>
<td>01/01/1991</td>
<td>99/99/9999</td>
</tr>
<tr>
<td>58468-1060-01</td>
<td>J0205</td>
<td>Injection, Alglucerase, Per 10</td>
<td>Ceredase 80 U/ML</td>
<td>Y</td>
<td>01/01/1991</td>
<td>99/99/9999</td>
</tr>
<tr>
<td>00517-8905-01</td>
<td>J0210</td>
<td>Injection, Methyldopate HCL</td>
<td>Methyldopate HCL (S.D.V.) 50</td>
<td>Y</td>
<td>10/01/1991</td>
<td>99/99/9999</td>
</tr>
</tbody>
</table>

The first two entries show NDCs 58468-0040-01 and 58468-0041-01 can only be paired with one procedure code, J0180. These are the only valid procedure code / NDC combinations when billing Agalsidase. Pairing either NDC with a different procedure code OR pairing the procedure code with a different NDC would create an invalid combination. Procedure code / NDC combinations deemed invalid according to the list will be denied.
6.5.4.5 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.

6.5.4.6 Submitting One NDC per Procedure Code

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

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Procedure Quantity</th>
<th>NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>90378</td>
<td></td>
<td>2</td>
<td>60574-4111-01</td>
</tr>
</tbody>
</table>

6.5.4.7 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 procedure code, 90378. So, the procedure code would be reported twice on the claim, but paired with different NDCs.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Procedure Quantity</th>
<th>NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>90378</td>
<td>KP</td>
<td>2</td>
<td>60574-4111-01</td>
</tr>
<tr>
<td>90378</td>
<td>KQ</td>
<td>1</td>
<td>60574-4112-01</td>
</tr>
</tbody>
</table>

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.

6.5.4.8 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. Beginning with dates of service on and
after March 1, 2008, crossover claim lines that are missing a required NDC will be denied.

6.5.4.9 **CMS-1500 (08/05) Billing Instructions**

To report a procedure code with a NDC on the CMS-1500 (08/05) 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 (08/05) - One (1) NDC per Procedure Code:**

| N460574411301 | 03 01 07 | 03 01 07 | 11 | 90378 | ... | ... | 13 | 500 00 | 2 | N | NPI | 0123456789 |

**CMS-1500 (08/05) - Two (2) NDCs per Procedure Code:**

| N460574411301 | 03 01 07 | 03 01 07 | 11 | 90378 | KP | ... | ... | 13 | 500 00 | 2 | N | NPI | 0123456789 |
| N460574411401 | 03 01 07 | 03 01 07 | 11 | 90378 | KQ | ... | ... | 13 | 250 00 | 1 | N | NPI | 0123456789 |

**NOTE:** Medicaid’s instructions follow the National Uniform Claim Committee’s (NUCC) recommended guidelines for reporting the NDC on the CMS-1500 (08/05) claim form. Provider claims that do not adhere to these guidelines will be returned unprocessed.
6.6 Cap Limits

Medicaid clients 21 years of age and older are subject to service cap limits on the number of office/outpatient hospital visits, physical/occupational/speech therapy visits and emergency dental visits they receive.

<table>
<thead>
<tr>
<th>OFFICE AND OUTPATIENT HOSPITAL VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes</td>
</tr>
<tr>
<td>Procedure Codes:</td>
</tr>
<tr>
<td>99281-99285</td>
</tr>
<tr>
<td>99201-99215</td>
</tr>
<tr>
<td>Revenue Codes:</td>
</tr>
<tr>
<td>450-459</td>
</tr>
<tr>
<td>510-519</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes</td>
</tr>
<tr>
<td>Procedure code:</td>
</tr>
<tr>
<td>92507-92508; 92526;</td>
</tr>
<tr>
<td>97010-97039; 97110-97546 (all modalities on</td>
</tr>
<tr>
<td>same date of service count as 1 visit)</td>
</tr>
<tr>
<td>Revenue Code:</td>
</tr>
<tr>
<td>420, 421, 422, 424, 430, 431, 432, 434, 439, 440,</td>
</tr>
<tr>
<td>441, 442, 444, and 449 (each unit counts as 1</td>
</tr>
<tr>
<td>visit)</td>
</tr>
</tbody>
</table>

If a client has exceeded the Medicaid limits on office/outpatient hospital visits, or physical/occupational/speech therapy visits, you may bill him/her or request the cap limit be waived.
6.6.1 Cap Limit Waiver

Physicians, nurse practitioners, and physical, occupational and speech therapists may request a waiver of a cap limit once a limit has been reached. Waiver requests will only be accepted on official office letterhead or the Medicaid Cap Limit Waiver Request Form (Section 6.6.2) and must cite specific medical necessity. A physician or nurse practitioner must sign the letter for office/outpatient hospital visits. A physical, occupational or speech therapist must sign the letter for physical/occupational/speech therapy visits. The letter must be mailed to:


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

If granted, a cap limit waiver is valid for one calendar year. For additional information, please contact Medical Policy (Section 2.1, Quick Address and Telephone Reference).
### 6.6.2 Cap Limit Waiver Request Form

<table>
<thead>
<tr>
<th>WYOMING MEDICAID CAP LIMIT WAIVER REQUEST FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client Name:</td>
</tr>
<tr>
<td>3. Pay-to Provider or Facility Name &amp; Address:</td>
</tr>
<tr>
<td>2. Client ID:</td>
</tr>
<tr>
<td>4. NPI Number:</td>
</tr>
<tr>
<td>5. Which calendar year are you requesting the cap limit waiver for?</td>
</tr>
</tbody>
</table>

6. Instructions: In the space below, please document reason for waiver request *(must be medically necessary)*:

7. Physician's Signature *(Must be an original signature, not a stamp)*:
6.7 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
- ASC Grouping

6.7.1 Invoice Charges

- Invoice must be dated within 12 months prior to the date of service being billed
- All discounts will be taken on the invoice
- The discounting pricing or codes cannot be marked out
- A packing slip, purchase order, delivery ticket, etc. cannot be used in place of an invoice
- Items must be clearly marked. (i.e. how many calories are in a can of formula, items in a case, milligrams, ounces, etc.)

6.8 Co-Payment Schedule

<table>
<thead>
<tr>
<th>Procedure and Revenue Code(s)</th>
<th>Description</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 – 99215</td>
<td>Office Visits only when the place of service code is 11</td>
<td>Co-payment requirements do not apply to:</td>
</tr>
<tr>
<td>99341 -99350</td>
<td>Home Visits</td>
<td>- Clients under age 21</td>
</tr>
<tr>
<td>92002, 92004, 92014</td>
<td>Eye Examinations</td>
<td>- Nursing Facility Residents</td>
</tr>
<tr>
<td>90804 - 90815</td>
<td>Medical psychotherapy – co-payment only applies when the place of service code is 11</td>
<td>- Pregnant Women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Family planning services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Emergency services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Hospice services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medicare Crossovers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Members of a Federally recognized tribe</td>
</tr>
</tbody>
</table>
6.9 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 year. However, DFS must be notified of the newborn’s name and date of birth for a Medicaid ID Card to be issued. A provider will need to have the newborn client ID in order to bill newborn claims.

6.10 No Show Appointments

Appointments cancelled or missed by Medicaid clients cannot be billed to Medicaid. However, if a provider’s policy is to bill all patients for canceled or missed appointments, then the provider may bill Medicaid clients.

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 and providers may not impose separate charges on Medicaid clients.

6.11 Home Health

The Home Health Exemption Letter (Section 6.11.1) may be used in place of a Medicare denial for dual eligible clients who no longer meet the Medicare criteria for Home Health (i.e., chronic state of his/her condition or homebound status), but continues to meet Medicaid Home Health criteria.
6.11.1 Home Health Exemption Letter

(Agency Name)

(Address)

(Address)

(City, State and Zip)

I certify that __________________________ continues to not meet Medicare Home Health criteria because of the chronic state of his/her condition or because of his/her homebound status.

I also certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

(Signature)          (Title)   (Date)

Each provider must submit this form with each claim being submitted to Medicaid for reimbursement.

Mail To:
Wyoming Medicaid
Attn: Provider Relations
PO Box 547
Cheyenne, WY 82003
6.12 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:

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Phone</th>
<th>Services Requiring PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Healthcare Financing (DHCF)</td>
<td>Contact case manager Case manager will contact the DHCF</td>
<td>• Assisted Living Facility (ALF) Waiver • Long Term Care (LTC) Waiver • Out-of-State Home Health • Out-of-State Placement for LTC Facilities</td>
</tr>
<tr>
<td>Dental Health Services</td>
<td>1-307-777-7945</td>
<td>• Crippling Malocclusion • Marginal Dental Program</td>
</tr>
<tr>
<td>Behavioral Health Division</td>
<td>Contact case manager Case manager will contact the Behavioral Health Division</td>
<td>• Acquired Brain Injury (ABI) Waiver Services • Developmentally Disabled Adult Waiver Services • Developmentally Disabled Children Waiver Services</td>
</tr>
<tr>
<td>Goold Health Systems Inc. (GHS)</td>
<td>1-877-207-1126</td>
<td>• Pharmacy</td>
</tr>
<tr>
<td>Division of Healthcare Financing (DHCF)</td>
<td>Contact case manager Case manager will contact - DHCF</td>
<td>• Children’s Mental Health Waiver Services</td>
</tr>
<tr>
<td>Medical Policy</td>
<td>1-800-251-1268</td>
<td>• Hospice Services: Limited to clients residing in a nursing home • Out-of-State Home Health • Surgeries Requiring PA (not listed in this table) • Tysabri IV Infusion Treatment • Contact Lenses</td>
</tr>
<tr>
<td>KePRO (DME)</td>
<td>1-855-294-1196</td>
<td>• Durable Medical Equipment (DME)</td>
</tr>
<tr>
<td>Xerox Care and Quality Solutions, Inc. (Utilization and Care Management)</td>
<td>1-888-545-1710</td>
<td>• Acute Psych • Extended Psych • Extraordinary Care • Gastric Bypass • Inpatient Rehabilitation • PRTF – Psychiatric Residential Treatment Facility • Transplants • Vagus Nerve Stimulator</td>
</tr>
</tbody>
</table>
6.12.1 Requesting Prior Authorization from Medical Policy

NOTE: This section only applies to providers requesting PA for out-of-state Home Health, certain surgeries and hospice services (limited to client’s 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 ways to request and receive a PA:

- Medicaid Prior Authorization Form (Section 6.12.1.1). 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 (Section 6.12.1.2).
- 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. A web-based option for entering PA requests and receiving responses via Medicaid/EqualityCare secure Provider Web Portal. For direction on entering a PA request through the Secure Provider Web Portal, view the Web Portal Tutorial found on the website. (Section 2.2, Quick Website Reference) For additional information, refer to Chapter 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications.
6.12.1.1 Medicaid Prior Authorization Form

<table>
<thead>
<tr>
<th>I. PATIENT INFORMATION</th>
<th>II. PROVIDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DOB</td>
<td>9. NPI NUMBER</td>
</tr>
<tr>
<td>2. SEX</td>
<td>10. TAXONOMY</td>
</tr>
<tr>
<td>3. AGE</td>
<td></td>
</tr>
<tr>
<td>4. MEDICAID ID#</td>
<td></td>
</tr>
<tr>
<td>5. PATIENT NAME (LAST, FIRST, MI)</td>
<td>11. PROVIDER NAME</td>
</tr>
<tr>
<td>6. STREET ADDRESS</td>
<td>12. STREET ADDRESS</td>
</tr>
<tr>
<td>7. CITY, STATE, ZIP CODE</td>
<td>13. CITY, STATE, ZIP CODE</td>
</tr>
<tr>
<td>8. TELEPHONE NUMBER</td>
<td>14. TELEPHONE NUMBER</td>
</tr>
<tr>
<td></td>
<td>CONTACT NAME</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. SERVICE INFORMATION</th>
<th>15. DATE(S) OF SERVICE MM/DD/YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. PROPOSED MEDICAL SUPPLIES, PHARMACY, SURGICAL PROCEDURES OR OTHER SERVICES, (LIST PRIMARY PROCEDURE FIRST)</td>
<td>FROM</td>
</tr>
<tr>
<td></td>
<td>TO</td>
</tr>
<tr>
<td>17. PROCEDURE, NDC OR REVENUE CODE(S)</td>
<td>18. UNITS</td>
</tr>
<tr>
<td>19. ESTIMATED COST</td>
<td>20. TREATING PROVIDER NPI NUMBER</td>
</tr>
<tr>
<td>21. SUMMARY OF HISTORY (DIAGNOSIS, DATE OF ONSET, PROGNOSIS, PHYSICAL EXAMINATION, LABORATORY, X-RAY STUDIES, PHARMACY, AND APPLICABLE DOCUMENTATION MUST BE SUPPLIED IN SUFFICIENT DETAIL TO SATISFY THE MEDICAL NECESSITY FOR THE PRESCRIBED SERVICE. ADDITIONAL DOCUMENTATION MAY BE ATTACHED WHEN NECESSARY.)</td>
<td></td>
</tr>
<tr>
<td>22. REFERRING WYOMING PHYSICIAN:</td>
<td>TELEPHONE NUMBER:</td>
</tr>
<tr>
<td>(IF THIS AUTHORIZATION REQUEST IS FOR SERVICE TO BE RENDERED OUT-OF-STATE, A BRIEF JUSTIFICATION STATEMENT IS REQUIRED)</td>
<td></td>
</tr>
<tr>
<td>23. VERBAL AUTHORIZATION GIVEN BY:</td>
<td>DATE:</td>
</tr>
<tr>
<td>PA NUMBER:</td>
<td></td>
</tr>
<tr>
<td>24. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.</td>
<td></td>
</tr>
<tr>
<td>SIGNATURE OF PROVIDER:</td>
<td>DATE:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. AUTHORIZATION (FOR STATE USE ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTHORIZATION IS VALID FOR SERVICES 25. FROM DATE: 26. TO DATE: 27. PRIOR AUTHORIZATION NUMBER:</td>
</tr>
<tr>
<td>28. COMMENTS/EXPLANATION:</td>
</tr>
</tbody>
</table>

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO THE PATIENT'S ELIGIBILITY AND WYOMING BENEFIT LIMITATIONS. BE SURE THE MEDICAID IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICES.
**Instructions for completing the Medicaid Prior Authorization Form**

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Title</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Date of Birth</td>
<td>Enter MMDDYY of client’s date of birth.</td>
</tr>
<tr>
<td>2</td>
<td>Sex</td>
<td>Enter client’s sex.</td>
</tr>
<tr>
<td>3</td>
<td>Age</td>
<td>Enter client’s age.</td>
</tr>
<tr>
<td>4*</td>
<td>Medicaid Identification Number</td>
<td>Enter the client’s ten-digit Medicaid ID number.</td>
</tr>
<tr>
<td>5*</td>
<td>Patient Name</td>
<td>Enter last name, first name, and middle initial exactly as it appears on the Medicaid ID Card.</td>
</tr>
<tr>
<td>6*</td>
<td>Patient Address</td>
<td>Enter the street address, including PO Box and apartment number, where client resides.</td>
</tr>
<tr>
<td>7*</td>
<td>City, State, Zip Code</td>
<td>Enter the city, state, and zip code at which the client resides.</td>
</tr>
<tr>
<td>8</td>
<td>Telephone Number</td>
<td>Enter the telephone number of the client.</td>
</tr>
<tr>
<td>9*</td>
<td>NPI</td>
<td>Enter the provider’s ten-digit NPI number.</td>
</tr>
<tr>
<td>10</td>
<td>Provider Taxonomy</td>
<td>Enter the provider’s taxonomy code.</td>
</tr>
<tr>
<td>11*</td>
<td>Provider Name</td>
<td>Enter the provider’s name as it appears on the provider enrollment form</td>
</tr>
<tr>
<td>12*</td>
<td>Provider Address</td>
<td>Enter the provider’s street address or PO Box.</td>
</tr>
<tr>
<td>13*</td>
<td>City, State, Zip Code</td>
<td>Enter the city, state, and zip code of the provider.</td>
</tr>
<tr>
<td>14*</td>
<td>Telephone Number</td>
<td>Enter the telephone number of the provider and a contact name.</td>
</tr>
<tr>
<td>15*</td>
<td>Date(s) of Service</td>
<td>Enter the date(s) of service this request will cover.</td>
</tr>
<tr>
<td>16*</td>
<td>Proposed Services</td>
<td>Enter narrative description of service(s) being requested.</td>
</tr>
<tr>
<td>17*</td>
<td>Procedure/NDC/Revenue Codes</td>
<td>Enter the codes for the service(s) being requested should reflect the narrative description.</td>
</tr>
<tr>
<td>18*</td>
<td>Units</td>
<td>Enter number of each service being requested.</td>
</tr>
<tr>
<td>19*</td>
<td>Estimated Cost</td>
<td>Enter dollar amount times the units for each service being requested.</td>
</tr>
<tr>
<td>20*</td>
<td>Treating Provider NPI Number</td>
<td>Enter the treating provider’s ten-digit NPI number.</td>
</tr>
<tr>
<td>21</td>
<td>Summary of History</td>
<td>Provide as much information as possible supporting the need for the service(s) requested. Attach additional sheets if necessary.</td>
</tr>
<tr>
<td>22</td>
<td>Out-of-State Justification</td>
<td>Enter the Wyoming physician’s name referring the client for out-of-state services. Enter the telephone number of the referring physician. The justification for out-of-state services can be brief.</td>
</tr>
<tr>
<td>23</td>
<td>Verbal Authorization</td>
<td>Enter the name verbal authorization was given by, the date authorization was given, and the PA number.</td>
</tr>
<tr>
<td>24*</td>
<td>Signature/Date</td>
<td>The form should be signed and dated by the entity requesting prior authorization of services.</td>
</tr>
<tr>
<td>25-28</td>
<td>Authorization (State Use Only)</td>
<td>The fiscal agent will complete these fields when prior authorization is approved.</td>
</tr>
</tbody>
</table>
6.12.2 Requesting an Emergency Prior Authorization

In the case of a medical emergency, providers should contact Medical Policy by telephone. 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 (Section 6.12).


Once a request has been reviewed, a letter is sent communicating whether the PA has been approved or denied.

NOTE: A PA may have both approved and denied lines.

6.12.3.1 Prior Authorization Approved

Once a PA is approved, an approval letter (Section 6.12.3.1.1) is mailed that includes the PA number. The PA number must be entered in box 23 of the CMS-1500 (08/05) 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.)
6.12.3.1.1  Prior Authorization Notice Approved

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Units</th>
<th>Price</th>
<th>Used Units</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/26/10</td>
<td>MEDICAID PRIOR AUTHORIZATION NOTICE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAMPLE PROVIDER OF WYOMING</td>
<td>LTC WAIVER SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1234 SAMPLE STREET</td>
<td>Client: SAMPLE CLIENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAMPLE</td>
<td>WY 82001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PA-NUMBER 0012900194</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waiver Case Manager:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

- **01/01/10-01/31/10**  T2041  - SUPPORTS BROKERAGE, SELF DIRECTED, 12 MIN  APPROVED
  - APPR UNITS: 300  UNIT PRICE: $3.32  USED UNITS: 202

- **02/01/10-02/28/10**  T2041  - SUPPORTS BROKERAGE, SELF DIRECTED, 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.
6.12.3.2 Prior Authorization Denied

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

6.12.3.2.1 Prior Authorization Notice - Denied

---

**MEDICAID PRIOR AUTHORIZATION NOTICE**

01/19/10

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
APPR UNITS: 0 USED UNITS: 0
DENIED

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.
6.12.3.3 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 (Section 2.1 Quick Address and Telephone Reference).

6.12.3.3.1 Prior Authorization Notice - Pending

MEDICAID PRIOR AUTHORIZATION NOTICE

01/19/10

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:

01/18/10-01/18/11 V2715 - PRISM, PER LENS
                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 CLIENT'S ELIGIBILITY AND MEDICAID BENEFIT LIMITATIONS. VERIFY ELIGIBILITY BEFORE RENDERING SERVICES.

PA-Number: 00198000002
A1500RB2
6.13 Submitting Attachments for Electronic Claims

- **Steps for submitting paper attachments**
  
  ➢ 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 your 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.
    - Complete Attachment Cover Sheet (Section 6.13.1) and mail it with the attachment to Claims.

  **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.**

- **Steps for submitting electronic attachments**

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

    - Mark the attachment indicator on the electronic claim. For more information on the attachment indicator, consult your 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 Secure Provider Web Portal
    - Under the submissions menu select Electronic Attachments
    - Complete required information
    - Select Browse
    - Navigate to the location of the electronic attachment on your computer
    - Click Upload
    - For support and additional information refer to Chapters 8 and 9 or contact EDI Services (Section 2.1, Quick Address and Telephone Reference).
### 6.13.1 Attachment Cover Sheet

**Wyoming Medicaid Program**

<table>
<thead>
<tr>
<th>Provider or NPI Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Medicaid ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Service (MMDDYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01042023</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Document – One must be checked</th>
</tr>
</thead>
<tbody>
<tr>
<td>C – Consent Form (Abortion, Hysterectomy, Sterilization)</td>
</tr>
<tr>
<td>H – Hospice Waiver</td>
</tr>
<tr>
<td>I – Invoice</td>
</tr>
<tr>
<td>M – Medicare EOMB</td>
</tr>
<tr>
<td>O – Operative Reports</td>
</tr>
<tr>
<td>P – Prior Authorization Form and/or Documentation</td>
</tr>
<tr>
<td>S – Swing Bed Exemption Letter</td>
</tr>
<tr>
<td>T – Third Party Liability Documentation (EOB’s, Denial Letters, Letters attempting to collect)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attachment Control Number – For Office Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
6.14 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 (Section 6.14.1.1)
- Hysterectomy Consent Form (Section 6.14.2.2)
- Abortion Certification Form (Section 6.14.3.2)
### 6.14.1 Sterilization Consent Guidelines

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

The Sterilization Consent Form (Section 6.14.1.1) 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**

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Details</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>The waiting period between consent and sterilization must not exceed 180</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>days and must be at least 30 days, except in cases of premature delivery</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>and emergency abdominal surgery. The day the client signs the consent form</td>
<td>In the event of emergency abdominal surgery, the client must complete and sign the consent form at least 72 hours prior to sterilization.</td>
<td></td>
</tr>
<tr>
<td>on July 1. To determine when the waiting period is completed, count 30</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>days beginning on July 2. The last day of the waiting period would be July</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>31; therefore, surgery may be performed on August 1.</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

---

6-39
## Sterilization Consent Form

**CONSENT TO STERILIZATION**

I have asked for and received information about sterilization from [insert number]. 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 [insert type of operation]. 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 of age and was born on [insert date].

---

**STATEMENT OF PERSON OBTAINING CONSENT**

Before [insert date], [insert name] (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation [insert 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 appears to understand the nature and consequences of the procedure.

---

**PHYSICIAN’S STATEMENT**

Shortly before I performed a sterilization operation upon [insert name] (name of individual to be sterilized) on [insert date], the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I informed 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.

---

**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 [insert language] and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

---

HCF-01
6.14.1.2 Instructions for Completing the Sterilization Consent Form

Important tips for completing the Sterilization Consent Form

- 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 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.

<table>
<thead>
<tr>
<th>Section</th>
<th>Field #</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to Sterilization</td>
<td>1</td>
<td>Enter the name of the physician or the name of the clinic from which the client received sterilization information.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Enter the type of operation (no abbreviations)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Enter the client’s date of birth (MM/DD/YY). Client must be at least 21 years</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Enter the client’s name</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Enter the name of the physician performing the surgery</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Enter the name of the type of operation (no abbreviations)</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>The client to be sterilized signs here</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>The client dates signature here</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Check one box appropriate for client. This item is requested but NOT required.</td>
</tr>
<tr>
<td>Interpreter’s Statement</td>
<td>10</td>
<td>Enter the name of the language the information was translated to</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Interpreter signs here</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Interpreter dates signature here</td>
</tr>
<tr>
<td>Statement of person obtaining consent</td>
<td>13</td>
<td>Enter clients name</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Enter the name of the operation (no abbreviations)</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>The person obtaining consent from the client signs here</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>The person obtaining consent from the client dates signature here</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>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</td>
</tr>
<tr>
<td>Physician’s Statement</td>
<td>19</td>
<td>Enter the client’s name</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Enter the date of sterilization operations</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>Enter type of operation (no abbreviations)</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>Check applicable box:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If premature delivery is checked, you must write in the expected date of delivery here</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If emergency abdominal surgery is checked, describe circumstances here</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>Physician performing the sterilization signs here</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>Physician performing the sterilization dates signature here</td>
</tr>
</tbody>
</table>
6.14.2 **Hysterectomy Acknowledgment of Consent**

The Hysterectomy Acknowledgment of Consent Form (Section 6.14.2.2) 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.

6.14.2.1 **Instructions for Completing the Hysterectomy Acknowledgment of Consent Form**

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

2 Diagnosis:_______________________________________________________

3 Signature of Patient:_________________________________________ Date:________________________

4 Signature of Person Explaining Hysterectomy:________________________ Date:________________________

===============================================================================

Complete PART B if consent is obtained AFTER surgery

5 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.

6 Diagnosis:_______________________________________________________

7 Signature of Patient:_________________________________________ Date:________________________

8 Signature of Person Explaining Hysterectomy:________________________ Date:________________________

===============================================================================

COMPLETE PART C IF NO CONSENT IS OBTAINED

9 Diagnosis:_______________________________________________________

10 Check which is applicable:

[  ] Other reason for sterility:

[  ] Previous tubal Date:________________________

[  ] Emergency situation (describe)

[  ] Other reason:

11 Physician Signature Date

===============================================================================

HCF-03
6.14.3 Abortion Certification Guidelines

The Abortion Certification Form (Section 6.14.3.2) 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, and hospital.

6.14.3.1 Instructions for completing the Abortion Certification Form

<table>
<thead>
<tr>
<th>Field #</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter the name of the attending physician or surgeon</td>
</tr>
<tr>
<td>2</td>
<td>Check the option (1,2 or 3) that is appropriate for the client</td>
</tr>
<tr>
<td>3</td>
<td>Enter the name of the client receiving the surgery and their address</td>
</tr>
<tr>
<td>4</td>
<td>The physician or surgeon performing the abortion signs here</td>
</tr>
<tr>
<td>5</td>
<td>Enter the performing physician’s address</td>
</tr>
</tbody>
</table>
6.14.3.2 ABORTION CERTIFICATION FORM

I, Doctor 1 ____________________________________________, certify that:

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

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

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

Patient Name: _____________________________________

Address: _____________________________________ 3

________________________

Physician Signature: _________________________________ 4

Address: _________________________________ 5

________________________
6.15 The Remittance Advice

After claims have been processed, Medicaid distributes a Remittance Advice (RA) (Section 6.15.1) 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. Typically, the claims processing time from receipt to payment is five to ten business days. Providers receiving manual checks will receive their check and RA in the same mailing.

The RA is organized in the following manner:

- 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:

![TCN Diagram]

- The RA Summary Section reports the number of claim transactions, and total payment or check amount.
6.15.1 Sample Professional Remittance Advice

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

REMITTANCE ADVICE

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.   IIBLE   AMT.   PAID   OFF   PROVIDER S PLAN

* * * CLAIM TYPE: HCFA 1500
* * * CLAIM STATUS: DENIED

ORIGINAL CLAIMS:

* BUSH   GEORGE   RECIP ID: 0000123456   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 04/28/07 42830  1  80.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  1234567890 K LTCS

* GORE   ALBERT   RECIP ID: 0600123456   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 05/02/07 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 TOTALS
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   0  ---------   0.00  0.00
DENIED ADJUSTMENT CLAIMS: NUMBER OF CLAIMS  4  ---------   320.00  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.
300 THE PROVIDER NUMBER CANNOT BE BILLED ON THIS CLAIM TYPE. VERIFY YOU ARE USING THE CORRECT PROVIDER NUMBER FOR THIS CLAIM TYPE AND RESUBMIT.
### How to Read Your Remittance Advice

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

<table>
<thead>
<tr>
<th>FIELD NAME</th>
<th>HEADER DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>To</td>
<td>Provider Name</td>
</tr>
<tr>
<td>R.A. Number</td>
<td>Remittance Advice Number assigned.</td>
</tr>
<tr>
<td>Date Paid</td>
<td>Payment date.</td>
</tr>
<tr>
<td>Provider Number</td>
<td>Medicaid provider number/NPI number</td>
</tr>
<tr>
<td>Page</td>
<td>Page Number</td>
</tr>
<tr>
<td>Last, MI, and First</td>
<td>The client’s name as found on the Medicaid ID Card.</td>
</tr>
<tr>
<td>Recip ID</td>
<td>The client’s Medicaid ID Number.</td>
</tr>
<tr>
<td>Patient Acct #</td>
<td>The patient account number reported by the provider on the claim.</td>
</tr>
<tr>
<td>Trans Control Number</td>
<td>Transaction Control Number: The unique identifying number assigned to each claim submitted.</td>
</tr>
<tr>
<td>Billed Amt.</td>
<td>Total amount billed on the claim</td>
</tr>
<tr>
<td>Mcare Paid</td>
<td>Amount paid by Medicare</td>
</tr>
<tr>
<td>Copay Amt.</td>
<td>The amount due from the client for their co-payment.</td>
</tr>
<tr>
<td>Other Ins.</td>
<td>Amount paid by other insurance.</td>
</tr>
<tr>
<td>Deductible</td>
<td>Medicare deductible amount.</td>
</tr>
<tr>
<td>Coins Amt.</td>
<td>Medicare coinsurance amount.</td>
</tr>
<tr>
<td>Mcaid Paid</td>
<td>The amount paid by Medicaid</td>
</tr>
<tr>
<td>Write off</td>
<td>Difference between Medicaid paid amount and the provider’s billed amount.</td>
</tr>
<tr>
<td>Header EOB(s)</td>
<td>Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA</td>
</tr>
<tr>
<td>Li</td>
<td>The line item number of the claim.</td>
</tr>
<tr>
<td>Svc date</td>
<td>The date of service.</td>
</tr>
<tr>
<td>Proc / Mods</td>
<td>The procedure code and applicable modifier.</td>
</tr>
<tr>
<td>Units</td>
<td>The number of units submitted.</td>
</tr>
<tr>
<td>Billed Amt.</td>
<td>Total amount billed on the line.</td>
</tr>
<tr>
<td>Mcare Paid</td>
<td>Amount paid by Medicare</td>
</tr>
<tr>
<td>Copay Amt.</td>
<td>The amount due from the client for their co-payment.</td>
</tr>
<tr>
<td>Other Ins.</td>
<td>Amount paid by other insurance.</td>
</tr>
<tr>
<td>Deductible</td>
<td>Medicare deductible amount.</td>
</tr>
<tr>
<td>Coins Amt.</td>
<td>Medicare coinsurance amount.</td>
</tr>
<tr>
<td>Mcaid Paid</td>
<td>The amount paid by Medicaid</td>
</tr>
<tr>
<td>Write off</td>
<td>Difference between Medicaid paid amount and the provider’s billed amount.</td>
</tr>
<tr>
<td>Treating Provider</td>
<td>The treating provider’s NPI number.</td>
</tr>
<tr>
<td>S</td>
<td>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:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>B</td>
<td>Billed Charge</td>
</tr>
<tr>
<td>C</td>
<td>Percent-of-Charges</td>
</tr>
<tr>
<td>D</td>
<td>Inpatient Per Diem Rate</td>
</tr>
<tr>
<td>E</td>
<td>EAC Priced Plus Dispensing Fee</td>
</tr>
<tr>
<td>F</td>
<td>Fee Schedule</td>
</tr>
<tr>
<td>G</td>
<td>FMAC Priced Plus Dispensing Fee</td>
</tr>
<tr>
<td>H</td>
<td>Encounter Rate</td>
</tr>
<tr>
<td>I</td>
<td>Institutional Care Rate</td>
</tr>
<tr>
<td>K</td>
<td>Denied</td>
</tr>
<tr>
<td>L</td>
<td>Maximum Suspend Ceiling</td>
</tr>
<tr>
<td>M</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>N</td>
<td>Provider Charge</td>
</tr>
<tr>
<td>O</td>
<td>Relative Value Units TC</td>
</tr>
<tr>
<td>P</td>
<td>Prior Authorization Rate</td>
</tr>
<tr>
<td>R</td>
<td>Relative Value Unit Rate</td>
</tr>
<tr>
<td>S</td>
<td>Relative Value Unit PC</td>
</tr>
<tr>
<td>T</td>
<td>Fee Schedule TC</td>
</tr>
<tr>
<td>X</td>
<td>Medicare Coinsurance and Deductible</td>
</tr>
<tr>
<td>Y</td>
<td>Fee Schedule PC</td>
</tr>
<tr>
<td>Z</td>
<td>Fee Plus Injection</td>
</tr>
</tbody>
</table>

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.
6.15.3 Remittance Advice Replacement Request Policy

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

- Print the Remittance Advice (RA) replacement request form (Section 6.15.3.1)
- For replacement of a complete RA contact Provider Relations (Section 2.1, Quick Address and Telephone 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 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 (Section 2.1, Quick Address and Telephone 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 10 pages cannot be faxed.

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

<table>
<thead>
<tr>
<th>Total Number of RA Pages</th>
<th>Cost for Replacement RA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 10</td>
<td>$2.50</td>
</tr>
<tr>
<td>11 - 20</td>
<td>$5.00</td>
</tr>
<tr>
<td>21 - 30</td>
<td>$7.50</td>
</tr>
<tr>
<td>31 - 40</td>
<td>$10.00</td>
</tr>
<tr>
<td>41 - 50</td>
<td>$12.50</td>
</tr>
<tr>
<td>51+</td>
<td>Contact Provider Relations for rates</td>
</tr>
</tbody>
</table>
6.15.3.1 Remittance Advice (RA) Replacement Request Form
(Print Legibly)

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.
6.15.4 **Obtain Your RA from the Web**

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

6.15.5 **When Your Client Has Other Insurance**

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

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

The information is specific to the individual client. The Third Party Resources Information Sheet (Section 7.7.1) should be used for reporting new insurance coverage or changes in insurance coverage on a client’s policy.

6.16 **Resubmitting Verses Adjusting Claims**

Resubmitting and adjusting claims are important steps in correcting any billing problems. Knowing when to resubmit a claim verses adjusting it is important.
6.16.1 How long do I have to resubmit or adjust a claim?

The deadlines for resubmitting and adjusting claims are different:

- Providers may resubmit any claim within twelve-months (12 months) of the date of service.
- Providers may adjust any claim within six-months (6 months) of the date of payment.

Adjustment requests for overpayments are accepted indefinitely. However, the Provider Agreement requires you to notify Medicaid within 30 days of learning of an overpayment. When Medicaid discovers an overpayment during a claims review, the provider is notified in writing of the error and has 30 days to either refund the overpayment by check or have it deducted from future payments. While either option is acceptable, **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.

6.16.2 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. Claims are often returned to providers before processing because key information such as an authorized signature or required attachment is missing or unreadable.

6.16.2.1 How to Resubmit

- Check EOB codes on your RA and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- If the claim was denied because Medicaid has record of other insurance coverage, enter the missing insurance payment on the claim or attach insurance denial information, and resubmit it to Medicaid.

6.16.2.2 When to Resubmit to Medicaid

- Claim Denied. Providers can resubmit to Medicaid when a claim is denied in full, 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, make the appropriate corrections, and resubmit the claim on the appropriate claim form.
- Line Denied. Providers can submit individually denied lines.
- Claim Returned. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional
information is needed. Correct the information as directed and resubmit your claim.

6.16.3 Adjustments

If you believe a claim has been paid incorrectly, contact Provider Relations for verification. Once the incorrect payment has been verified, you may submit an Adjustment/Void Request Form (Section 6.16.3.1). If the incorrect payment was the result of a keying error, by the fiscal agent contact Provider Relations to have the claim corrected (Section 2.1, Quick Address and Telephone Reference).

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 as two 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 as the credit transaction. The replacement claim will have nearly the same TCN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. Adjustments are processed in the same time frame as original claims.
### 6.16.3.1 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 red 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**.

- **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 and Medicaid check

#### SECTION B

**TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:**

1. **17-DIGIT TCN:**
2. **DATE OF SERVICE**

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:**

epad (FOR FISCAL AGENT USE ONLY)

**CASH CONTROL NUMBER:** ___________________________

**ADJUSTED BY:** ___________________________ **DATE:** __________
6.16.3.2 How to request an adjustment/void

To request an adjustment, use the Adjustment/Void Request Form (Section 6.16.3.1). 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-months (6 months) of the claim payment date.
- A separate Adjustment/Void Request Form must be used for each claim.
- If you are correcting more than one (1) error per claim, use only one (1) Adjustment/Void Request Form, and include each error on the 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 of the adjustment form.

6.16.3.3 How to Complete the Adjustment/Void Request Form

<table>
<thead>
<tr>
<th>Section</th>
<th>Field #</th>
<th>Field Name</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1a</td>
<td>Claim Adjustment</td>
<td>Mark this box if any adjustments need to be made to a claim. Attach a copy of the claim with corrections made in red ink. Sections B and C must be completed. Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the Remittance Advice.</td>
</tr>
<tr>
<td></td>
<td>1b</td>
<td>Void Claim</td>
<td>Mark this box if any adjustments need to be made to a claim. Attach a copy of the claim with corrections made in red ink. Sections B and C must be completed. Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the Remittance Advice.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Cancellation of the Entire Remittance Advice</td>
<td>Mark this box if an error or change would result in a <strong>complete</strong> refund of the Medicaid payment. Attach a copy of the Remittance Advice and the Medicaid check. Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances. (Skip to Section C)</td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>17-digit TCN</td>
<td>Enter the 17-digit transaction control number assigned to each claim from the Remittance Advice.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Date of Service</td>
<td>Enter the Date of Service</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>9-digit Provider or 10-digit NPI Number</td>
<td>Enter your 9-digit Medicaid provider number or 10-digit NPI number, if applicable.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Provider Name</td>
<td>Enter your provider name</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>10-digit Client Number</td>
<td>Enter the client’s 10-digit Medicaid ID number.</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>10-digit PA Number</td>
<td>Enter the 10-digit Prior Authorization number, if applicable.</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Reason for Adjustment or Void</td>
<td>Indicate if this is an adjustment or void. Enter the specific reason and any pertinent information that may assist the fiscal agent.</td>
</tr>
</tbody>
</table>

| C       | Provider Signature and Date | Signature of the provider or the provider’s authorized representative and the date. |
6.16.3.4 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.)

6.16.3.5 When to Request a Void

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

6.16.4 How to request a cancellation of an entire Remittance Advice (RA)

To request a cancellation of an entire RA, complete the Adjustment/Void Request Form (Section 6.16.3.1) and attach a copy of the RA and the Medicaid check. All claims listed on the RA will be voided from the system. If, at a later date, the claims need to be reprocessed, then they must be resubmitted by the provider.

6.17 Returning a Medicaid Check

Return a check issued by Medicaid only when every claim listed on the Remittance Advice (RA) is not correct. Return the Remittance Advice and check to Wyoming Medicaid Attn: Claims with the Adjustment/Void Request Form (Section 6.16.3.1) attached and Section A, box 2 marked.

If you receive a Remittance Advice that lists some correct payments and some incorrect payments, do not return the Medicaid check. Deposit the check and file an adjustment request for each individual claim paid incorrectly.
6.18 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 can be resolved in two 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) 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. A notice is typically sent from Medicaid to the provider requesting the credit balance 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 your provider number to ensure the money is applied correctly.

6.19 Third Party Payments Received after Medicaid’s Payment

If Medicaid pays your claim and you subsequently receive payment from a third party payer, you must adjust your claim to reflect the amount paid (Section 6.16.3.1)

Complete the Adjustment/Void Request Form, 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.

6.20 Timely Filing

The Division of Healthcare Financing adheres strictly to its timely filing policy. You must submit a clean claim to Medicaid within twelve months (12 months) of the date of service. A clean claim is an original, correctly completed claim that will process and approve to pay in the twelve-month time period. Submit claims immediately after providing services so that if a claim is denied, you have time to correct any errors and resubmit. Be sure that Medicaid receives a clean claim within the twelve-month deadline. Claims are to be filed only after the service(s) have been provided, not before.
### 6.20.1 Exceptions to the Twelve-Month Limit

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

<table>
<thead>
<tr>
<th>When the situation is:</th>
<th>The time limit is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Crossover</td>
<td>A claim must be submitted within twelve months of the date of service or within six months from the payment date on the Explanation of Medicare Benefits (EOMB), <strong>whichever is later.</strong></td>
</tr>
<tr>
<td>Client is determined to be eligible on appeal, reconsideration, or court decision.</td>
<td>Claims must be submitted within six-months of the date of the determination of retroactive eligibility. If a claim exceeds timely filing, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be a SSI award notice or a notice from DFS.</td>
</tr>
<tr>
<td>Client is determined to be eligible due to agency corrective actions.</td>
<td>Claims must be submitted within six-months of the date of the determination of retroactive eligibility. If a claim exceeds timely filing, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

**NOTE:** The notice of retroactive eligibility may be a SSI award notice or a notice from DFS.
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 twelve-months of the date of service; and
- The provider made at least one attempt to resubmit the claim within twelve-months of the date of service; or
- A Medicaid computer or policy problem beyond the provider’s control prevented the provider from finalizing the claim within twelve months of the date of service.

Any appeal that does not meet the above criteria must be denied. Timely filing cannot 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 should appeal directly to Provider Relations (Section 2.1, Quick Address and Telephone Reference) and should include the following:

- Documentation of previous claim submission;
- An explanation of the problem; and
- A clean copy of the claim, along with any required attachments.

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 would need to be refunded prior to a claim being submitted to Medicaid.
In the event of retroactive eligibility, claims must be submitted within six 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 thirty days after the hospital receives notice of eligibility. To obtain certification, contact Xerox Care and Quality Solutions, Inc. (Utilization and Care Management)(Section 2.1, Quick Address and Telephone Reference).

### 6.22 Failure 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 must be refunded prior to billing Medicaid;
- The client can no longer be billed for the service; and
- Timely filing criteria are in effect.

### 6.23 Billing Tips to Avoid Timely Filing Denials

- File claims soon after services are rendered.
- Carefully review EOB codes on the Remittance Advice.
- Resubmit the entire claim or denied line only after all corrections have been made.
- Contact Provider Relations if you have any questions regarding billing or denials.
- If you have not received payment within thirty (30) days of submission, contact Provider Relations regarding the status of the claim.
- If you have had multiple denials on a claim, contact Provider Relations and request a review of the denials prior to resubmission (Section 2.1, Quick Address and Telephone Reference).

**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).

6.24.1 **Covered Services**

**Originating Sites (HUB Site)**

The Originating site or HUB 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 with specialty of psych/mental health
- 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.
**Distant Site Providers (Spoke Site)**

The location of the physician or practitioner providing the professional services via a telecommunications system is called the distant site or spoke 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 (billed under the supervising physician)
- Psychologist or Neuropsychologist
- Licensed Mental Health Professional (LCSW, LPC, LMFT, LAT)

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.

**6.24.1.1 Non-Covered Services**

Telehealth does not include a telephone conversation, electronic mail message (email), or facsimile transmission (fax) between a healthcare practitioner and a patient.

**6.24.1.2 Billing Requirements**

In order to obtain Medicaid reimbursement for services delivered through telehealth technology, 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.
• 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.

• 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 90805 billed with modifier GT). 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 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.
### Spoke Sites Billing Code(s) (site without patient)

<table>
<thead>
<tr>
<th>CPT-4 and HCPCS Level II Codes</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241 - 99255</td>
<td>GT</td>
<td>Consultations</td>
</tr>
<tr>
<td>99201 – 99215</td>
<td>GT</td>
<td>Office or other outpatient visits</td>
</tr>
<tr>
<td>90832-90838</td>
<td>GT</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>90791-90792</td>
<td>GT</td>
<td>Psychiatric diagnostic interview examination</td>
</tr>
<tr>
<td>96116</td>
<td>GT</td>
<td>Neurobehavioral status exam</td>
</tr>
<tr>
<td>90951,90952,90954,90955,90957,90958,90960 and 90961</td>
<td>GT</td>
<td>End stage renal disease related services</td>
</tr>
<tr>
<td>G0270</td>
<td>GT</td>
<td>Individual medical nutrition therapy</td>
</tr>
<tr>
<td>H0031, H2019, T1007, T1017, H0006, G9012</td>
<td>GT</td>
<td>Mental Health and Substance Abuse Treatment Services</td>
</tr>
</tbody>
</table>

### Hub Site Billing Code (site with patient)

<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3014</td>
<td>Telehealth originating site facility fee</td>
</tr>
</tbody>
</table>

For accurate listing of codes, refer to the fee schedule on the Medicaid/EqualityCare website (Section 2.2, Quick Website Reference).
Chapter Seven
Third Party Liability

Chapter Seven
Third Party Liability

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Definition of a Third Party Payer</td>
</tr>
<tr>
<td>7.2</td>
<td>When Clients Have Third Party Liability (TPL)</td>
</tr>
<tr>
<td>7.3</td>
<td>Identifying Other Sources of Coverage</td>
</tr>
<tr>
<td>7.4</td>
<td>Exceptions to Billing Third Party Payers First</td>
</tr>
<tr>
<td>7.4.1</td>
<td>Preventive Pediatric Care</td>
</tr>
<tr>
<td>7.4.2</td>
<td>Prenatal Care</td>
</tr>
<tr>
<td>7.4.3</td>
<td>Health Insurance Policies Held by Absent Parents</td>
</tr>
<tr>
<td>7.4.4</td>
<td>100% Federally Funded Programs</td>
</tr>
<tr>
<td>7.4.5</td>
<td>Legal Liability Has Not Been Established</td>
</tr>
<tr>
<td>7.5</td>
<td>Billing Third Party Payers</td>
</tr>
<tr>
<td>7.5.1</td>
<td>Previous Attempts to Bill Services Letter</td>
</tr>
<tr>
<td>7.6</td>
<td>Coordination of Benefits</td>
</tr>
<tr>
<td>7.7</td>
<td>Questions about TPL</td>
</tr>
<tr>
<td>7.7.1</td>
<td>Third Party Resources Information Sheet</td>
</tr>
</tbody>
</table>
7.1 Definition of a Third Party Payer

A third party payer is defined as “…a person, entity, agency, or government program that may be liable to pay, or that pays all or part of the costs of services provided to a client. ‘Third party payer’ includes but is not limited to, Medicare, insurance companies, workers’ compensation, defendants or potential defendants in legal actions involving clients or an individual or entity acting on behalf of a client, a spouse or parent who is obligated by law or court order to pay all or part of such costs, or a client’s estate…” as per the Wyoming Department of Health, Wyoming Medicaid Rules, Medical Benefit Recovery, Chapter 35, Section 5, Item (f), Sub Item (ii).

7.2 When Clients Have Third Party Liability (TPL)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (TPL). In most cases, the provider must bill third party payers before billing Medicaid, but there are some exceptions (Section 7.4, Exceptions to Billing Third Party Payers First).

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid must be turned over to Medicaid. The following words printed on the client’s statement will fulfill this requirement: “When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid.”

NOTE: Providers cannot refuse service to a Medicaid client because of a third party payer or potential third party payer.
7.3 Identifying Other Sources of Coverage

If a client shows proof of other coverage, the provider must follow up with the other payer, keeping in mind that Medicaid is the payer of last resort. Some examples of third party payers include:

- Medicare
- Private health insurance
- Employment-related health insurance
- Workers’ compensation insurance
- Health insurance from an absent parent
- Automobile insurance
- Court judgments and settlements
- Long term care insurance
- Court ordered services

Providers must use the same procedures for locating third party payers for Medicaid clients as for their non-Medicaid clients. If Medicaid is aware of other coverage for a client, the information is available to providers by calling the Interactive Voice Response (IVR) System or Provider Relations (Section 2.1, Quick Address and Telephone Reference).

7.4 Exceptions to Billing Third Party Payers First

Providers must bill third party payers before billing Medicaid except in the following cases:

7.4.1 Preventive Pediatric Care

Preventive Pediatric Care is defined as screening and diagnostic services to identify congenital physical or mental disorders, routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infections and communicable diseases from occurring in children under age 21. This includes immunizations, screening tests for congenital disorders, well child visits, preventive medicine visits, preventive dental care, and screening and preventive treatment for infectious and communicable diseases. Diagnosis codes include V01-V07, V20, V70, and V72.0-V82. (Refer to Section 10.12, The Early and Periodic, Screening, Diagnosis and Treatment Program for preventative billing services).
7.4.2 Prenatal Care

Prenatal Care is defined as services provided to pregnant women when the services relate to the pregnancy or to any other medical condition, which may complicate the pregnancy. The types of services involved are those for routine prenatal care, prenatal screening of the mother or fetus, and care provided in the prenatal period to the mother for complications of pregnancy. Diagnosis codes include V22-V23, V28, 640-659, 671, 673, and 675-676.

NOTE: Other insurance carriers must be billed first (1st) for claims associated with the inpatient hospital stay for labor and delivery, and post-partum care.

7.4.3 Health Insurance Policies Held by Absent Parents

The absent parent’s obligation to provide medical support must be court ordered and Medicaid must have a copy of the court order on file. Providers have the option to bill the absent parent’s policy first since the reimbursement may be greater than Medicaid’s. If the absent parent’s policy does not provide notification of payment or denial within thirty days of submission, the provider may then bill Medicaid, but must certify on an attachment to the claim that a third party payer has been billed and that thirty days has elapsed without notification.

7.4.4 100% Federally Funded Programs

Medicaid is the payer of last resort except when a client is covered by 100% federally funded programs such as Indian Health Services (IHS) and the Ryan White Foundation.
7.4.5 Legal Liability Has Not Been Established

If there is auto, homeowners, or other casualty insurance, which may cover medical expenses associated with an accident, it is not necessary to bill the carrier until the carrier accepts responsibility for the claims. If a provider believes there may be casualty insurance, they should contact TPL (Section 2.1, Quick Address and Telephone Reference). TPL will investigate and advise whether the other insurance carrier is responsible to pay the claims. Since auto, homeowners, or other casualty insurances often pay 100% of billed charges, the provider may choose to wait for legal liability to be established before billing the other insurance, keeping in mind that Medicaid will not pay claims that exceed the twelve-month (12 month) timely filing limit. If legal action is pending, the provider may submit claims to Medicaid for payment pending establishment of legal liability through judgment or settlement.

7.5 Billing Third Party Payers

If a client has a third party payer that may cover or partially cover the services provided, take the following steps:

1) **Locate the potential payer’s address and phone number.** If the Medicaid claim was denied due to other insurance coverage, the address will appear on the Remittance Advice.

2) **Contact the other payer**
   - **If the coverage has expired or is not applicable.** Request the payer send a denial letter. If the other payer will not supply a written denial, write a letter in place of the denial. Document the client’s name, Medicaid ID number, contact person’s name and telephone number, date of the phone call, and nature of information provided.
   - **If the coverage is applicable.** Bill the third party payer. If the payer does not respond to the first attempt to bill within sixty (60) days, resubmit the claim. Wait an additional thirty (30) days for the third party payer to respond to the second billing. After ninety (90) days from the initial claim submission, if they still have not responded, send the claim to Medicaid with the Previous Attempts to Bill Services Letter (Section 7.5.1) attached. This form is not allowed for Medicare.

3) **If a written denial is obtained from the third party payer.** Attach the denial to the claim and submit it to Medicaid. The denial will be accepted for one calendar year.

4) **If a verbal denial is obtained from the third party payer.** Type a letter of explanation on office letterhead. In the letter, include the date of the verbal denial, the payer’s name and contact person’s name and telephone number, date of service, and client’s name and Medicaid ID number. Attach this letter to the
claim and submit to Medicaid. The denial will be accepted for one (1) calendar year.

5) **If payment is received from the other payer.** Compare the amount received per procedure code with Medicaid’s maximum fee for the same procedure code.
   - **If the payment from the other payer is less than Medicaid’s maximum payment for a procedure.** Indicate the payment in the appropriate box on the claim form. If the insurance paid less than 40% of the total bill, attach a copy of the Explanation of Benefits (EOB) from the other payer.
   - **If payment is received from the other payer after Medicaid has 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 (Section 6.16, Resubmitting Versus Adjusting Claims). A copy of the EOB from the other payer must be included with the refund showing the reimbursement amount.

**NOTE:** Contact Provider Relations before timely filing becomes a problem (Section 2.1, Quick Address and Telephone Reference). Waivers of timely filing will not be granted due to unresponsive third party payers.
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
7.6 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 and indicate the payer, payment date, and payment amount. (Electronic COB information may be submitted as a part of the 837 transaction.)

Attachments may be sent indicating denial/payment of TPL to accompany an electronic claim (Section 6.13, Submitting Attachments for Electronic Claims).

7.7 Questions about TPL

Below answers to three common questions providers have about TPL.

1) Why is TPL important to my practice?

- Before Medicaid can pay, all third party payers must be billed. This may help to pay for the services that have been provided, and shift the payment of medical services to the legally liable private sector.
- If the other carrier is not billed first, Medicaid will deny the claim.
- If Medicaid has a record of a third party payer for a client, the other payer must be billed (or contacted) first.
- When a claim is denied, the Remittance Advice provides the name, address, and policy number so that the other carrier can be billed before the claim is resubmitted to Medicaid.
- Finding out about other insurance up front will save time and the expense of billing (and being denied by) Medicaid when there is other insurance.

Contact TPL for the following reasons (Section 2.1, Quick Address and Telephone Reference):

- If a policy is no longer in effect, Medicaid will not require the policy to be billed if it has expired;
- If a client has a new insurance carrier;
- If a client has been in an accident which may be covered by liability or casualty insurance or legal liability is being pursued; or
- If a request for medical information has been received from an insurance company, attorney, or another third party.
2) **Can I refuse to accept Medicaid clients who have other insurance if my office doesn’t bill other insurance?**
   A provider **cannot** refuse to see a client because he/she has other insurance. A provider may limit the number of Medicaid clients he/she is willing to admit in his/her practice. The provider may not discriminate in establishing the limit. 42 (Code of Federal Regulations) C.F.R. 447.20 states:

   “A provider may not refuse to furnish services covered under the plan to an individual who is eligible for Medical Assistance under the plan on account of a third party’s potential liability for the service(s).”

3) **What if I do not participate with a health insurance company?**
   Include a letter with the claim indicating that you do not participate with a specific health insurance company such as BCBS of Wyoming or WINHealth. This exception excludes Medicare.

4) **Why does Medicaid need my help?**
   Pursuing third party payers allows Medicaid to save money without denying access to quality healthcare. It also benefits providers since third party payers may reimburse at a higher rate than Medicaid.

   Please fulfill all requirements for notifying Medicaid of any insurance information you have by providing a complete Third Party Resources Information Sheet (Section 7.7.1) or by contacting TPL (Section 2.1, Quick Address and Telephone Reference).
### 7.7.1 Third Party Resources Information Sheet

<table>
<thead>
<tr>
<th>NEW</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CLIENT NAME:</td>
<td>2. CLIENT ID NUMBER:</td>
</tr>
<tr>
<td>3. INSURANCE COMPANY NAME:</td>
<td>4. INSURANCE COMPANY ADDRESS:</td>
</tr>
<tr>
<td>5. TYPE OF COVERAGE:</td>
<td>6. PERSON CARRYING THE POLICY:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>9. POLICY NUMBER:</td>
<td>10. GROUP NUMBER</td>
</tr>
<tr>
<td>11. RELATIONSHIP OF CLIENT TO CASE HEAD:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>12. NAME OF PROVIDER:</td>
<td></td>
</tr>
<tr>
<td>13. COMPLETED BY:</td>
<td>14. DATE SUBMITTED:</td>
</tr>
</tbody>
</table>

RETURN TO WYOMING MEDICAID
ATTN: TPL
PO Box 667
CHEYENNE, WYOMING
82003-0667
FAX: (307) 772-8405

FISCAL AGENT USE ONLY

AUTHORIZED BY: ___________________ DATE: __________
INPUT BY: ___________________ DATE: __________
Chapter Eight
Electronic Data Interchange (EDI)

8.1 What is Electronic Data Interchange (EDI) ............................................................... 8-2
8.2 Benefits............................................................................................................................. 8-2
8.3 Standard HIPAA Transaction Formats........................................................................ 8-3
8.4 Sending and Receiving Transactions.......................................................................... 8-4
8.5 EDI Services.................................................................................................................... 8-6
  8.5.2 Web Portal ................................................................................................................ 8-6
  8.5.3 WINASAP ................................................................................................................. 8-7
8.6 Additional Information Sources ..................................................................................... 8-8
8.7 Scheduled Web Portal Downtime .................................................................................. 8-8
8.1 **What is Electronic Data Interchange (EDI)***?

In its simplest form, EDI is the electronic exchange of information between two 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 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.

<table>
<thead>
<tr>
<th>Method</th>
<th>Requirements</th>
<th>Access Cost</th>
<th>Transactions Supported</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Bulletin Board System (BBS)   | 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: www.acs-gcro.com |
### EDI Options

<table>
<thead>
<tr>
<th>Method</th>
<th>Requirements</th>
<th>Access Cost</th>
<th>Transactions Supported</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web Portal</td>
<td>Computer Internet Explorer 5.5 (or higher) or Netscape Navigator 7.0 (or higher). Whichever browser version is used, it must support 128-bit encryption Internet access Additional requirements for uploading and downloading batch transactions: File decompression utility, Software capable of formatting and reading EDI transactions</td>
<td>Free</td>
<td>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</td>
<td>EDI Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Note:</strong> Only the 278 and 837 transactions can be entered interactively.</td>
<td></td>
</tr>
<tr>
<td>WINASAP 2003</td>
<td>Computer Hayes-compatible 9600-baud asynchronous modem Windows 98 (or higher) operating system Pentium processor 25 megabytes of free disk space 128 megabytes of RAM Monitor resolution of 800 x 600 pixels Telephone connectivity</td>
<td>Free</td>
<td>X12N 837 Dental, Professional and Institutional Claims X12N 277CA Implementation Guide Error Reporting X12N 999 - Functional Acknowledgement</td>
<td>EDI Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EDI Services
Telephone: (800) 672-4959 9-5pm MST M-F
OPTION 3
Website: wymedicaid.acs-inc.com
8.5 EDI Services

8.5.1 Getting Started
The first step you need to complete before you are able to start sending electronic information is to complete the EDI Enrollment Application. The application can be found on the Medicaid/EqualityCare website (Section 2.2 Quick Website Reference) under Forms and Enrollment/Agreement Forms.

Once the form is completed and sent to Medicaid you 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.

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

What can you do with Web Portal?
- Submit claims
- Upload claim attachments (Section 6.13 Submitting Attachments for Electronic Claims)
- Retrieve Remittance Advices (stores the last 24 RAs)
- Submit Ask EqualityCare questions
- Submit and retrieve Prior Authorization requests and responses
- Perform LT101 Inquires
- Enter PASRR
- The Office Administrator can set up additional users and give them only the access that they need
- Build Claims Templates to save standard information such as
  - NPI numbers
  - Procedure Codes
  - Fees

8.5.2.1 Secure Provider Web Portal Registration Process:
1. Go to the Medicaid/EqualityCare website: http://wymedicaid.acs-inc.com
2. Select Provider
3. Select Provider Portal from the left hand menu
4. Under “New Providers” select Web Portal to register
5. Enter the following information from the Welcome Letter:
   a. Provider ID: Trading Partner/Submitter ID
   b. Trading Partner ID: Trading Partner/Submitter ID
c. EIN/SSN: Your tax-id as entered on the EDI application

d. Trading Partner Password: Password/User ID - Must be entered exactly as shown on the welcome letter.

6. Select Continue
   a. Confirm that the information that you entered is correct. If it is, choose Continue, if not re-enter information.

7. Additional Trading Partner IDs:
   a. If you need to enter additional Trading Partner IDs enter the ID and the Trading Partner password on this page.
   b. If you do not have any additional Trading Partner IDs select Continue.

8.5.2.2 Creating an Office Administrator

Your Office Administrator will be the person responsible for adding and deleting new users as necessary for your 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 you want 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 you receive 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 you have logged in. To do this, select update or remove users. Enter your user ID and select search. When the user information is brought up, click on the user ID link.
   a. Select which privileges you wish to have. Once you have chosen these privileges click Submit.

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

8.5.2.3 Creating additional users

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

8.5.3 WINASAP

WINASAP allows all Trading Partners to submit claims 24 hours a day, 7 days a week from any computer with a dial up modem over an analog phone line that you have installed the software on. WINASAP can be downloaded from the ACS EDI Gateway, Inc. website (section 2.2 Quick Website Reference) or you can call EDI Services (section 2.1 Quick Address and Telephone Reference) and request a CD to be mailed to you.
General Provider Information  
Electronic Data Interchange (EDI)

Requirements

- 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

WINASAP Start-up

1. Download program from the ACS EDI Gateway, Inc. website or install the program from the CD you 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 your 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
      1. The user ID and password are the same for everyone using WINASAP, we suggest that you do 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 you run the program that says Open Payer
      i. Select Wyoming Medicaid and choose OK
   b. Choose File and Trading Partner – Enter the following
      i. Primary Identification: Enter your Trading Partner ID from the EDI Welcome Letter
      ii. Secondary Identification – Re-enter your Trading Partner ID (primary and secondary identification will be the same)
   c. Trading Partner Name:
      i. Entity Type: select person or non-person.
      1. Choose person if you are an individual such as; a waiver provider, physician, therapist, or nurse practitioner
2. Choose non-person if you are a facility such as; a hospital, pharmacy or nursing home.
   ii. Enter your last name, first name and middle initial (optional) OR the organization name

d. Contact Information:
   i. Contact Name: Your Name
   ii. Telephone Number: Enter your phone number
   iii. Fax Number: Enter your fax number (optional)
   iv. Email: Enter your email address

4. The following criteria must be completed:
   a. WINASAP2003 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 your Password/User ID exactly as it appears.
      iii. User Name: Enter your 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.: 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: www.wedi.org. This industry group promotes electronic transactions in the healthcare industry.
- Designated standard maintenance organizations: www.hipaa-dsmo.org. This website explains how changes are made to the transaction standards.
# 8.7 Scheduled Web Portal Downtime

<table>
<thead>
<tr>
<th>What is Impacted</th>
<th>Functionality Impact</th>
<th>Why</th>
<th>Downtimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire website (Provider/Client)</td>
<td>Website not available</td>
<td>Regular scheduled</td>
<td>• 4 a.m. – 4:30 a.m. MST Saturdays</td>
</tr>
<tr>
<td>Static web pages</td>
<td></td>
<td>maintenance</td>
<td>• 3 p.m. – 6 p.m. MST Sundays</td>
</tr>
<tr>
<td>• <a href="http://wymedicaid.acs-inc.com/">http://wymedicaid.acs-inc.com/</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secured Provider Web Portal</td>
<td>Verification of claims</td>
<td>Regular scheduled</td>
<td>• 10 p.m. – 12 a.m. (midnight) Sundays</td>
</tr>
<tr>
<td>• <a href="https://wyequalitycare.acs-inc.com/wy/general/home.do">https://wyequalitycare.acs-inc.com/wy/general/home.do</a></td>
<td>submission will not be available</td>
<td>maintenance</td>
<td></td>
</tr>
</tbody>
</table>
Chapter Nine
Wyoming Specific HIPAA 5010 Electronic Specifications

9.1 Wyoming Specific HIPAA 5010 Electronic Specifications
9.2 Transaction Definition
9.3 Transmission Methods and Procedures
9.4 Acknowledgement and Error Reports
9.5 Testing
9.6 270/271 Eligibility Request and Response
9.7 276/277 Claim Request and Response
9.8 278 Request for Review and Response
9.9 835 Claim Payment/Advice
9.10 837 Professional Claims Transactions
9.11 837 Institutional Claims Transactions
9.12 837 Dental Claims Transactions
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 Xerox 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 or more files into a single ZIP archive.
  - WINZIP will compress one or more files into a single ZIP archive.
- **Data Format**:
  - 8 data bit
  - 1 stop bit
  - no parity
  - full duplex

9.3.1.3 Transmission Protocol:
- ZMODEM uses 128 byte to 1024 byte variable packets and a 16-bit or 32-bit Cyclical Redundancy Check (CRC).
- XMODEM uses 128 byte blocks and a 16-bit CRC.
- YMODEM uses 1024 byte blocks and a 16-bit CRC.
- KERMIT can be accepted if X, Y, or ZMODEM capabilities are not available with your communication software.

9.3.1.4 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
### 9.3.1.5 Transmission Procedures:

<table>
<thead>
<tr>
<th>SUBMITTER</th>
<th>HOST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dials Host 1(800) 334-2832 or (800) 334-4650</td>
<td>Answers call, negotiates a common baud rate, and sends to the Trading Partner:</td>
</tr>
</tbody>
</table>

**Prompt: “Please enter your Logon=>”**

Enters User Name (From the EDI Welcome Letter) <CR>

Receives User Name and sends prompt to the Trading Partner:

**Prompt: “Please enter your 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 you 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. (Section 8.5.2.1Secure Provider Web Portal Registration Process)

Trading partners can submit files via the web portal in two 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 transmission is available twenty-four hours (24) 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
- Payor 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 Acknowledgement

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 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

**Secure Web Portal**

The web portal allows all trading partners to retrieve data via the internet 24 hours a day, 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 Secure Provider Web Portal system using the user ID and password provided upon completion of the enrollment process. (Section 8.5.2.1 Web Registration and computer requirements) Contact the EDI Services for more information. (Section 2.1 Quick Address and Telephone Reference Guide)

### 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. (Section 2.1 Quick Address and Telephone Reference Guide) By testing the submitter is validating their software prior to submitting production transactions.

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

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

### 9.5.1 Testing Requirements

Contact EDI Services and explain that you are ready to test your software.

- Testing via EDIFECS
Submitters cannot obtain direct Internet access to EDIFECS, the EDI Services call center staff will set this up at your request.

A user ID and password will be generated for your use.

You are required to submit test files through EDIFECS.

You are required to address any errors discovered during testing prior to moving on to testing with the EDI Clearinghouse.

After your software has received approval provide EDI Services with the EDIFECS certification.

- Testing with EDI Clearinghouse
  - The call center will have you 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

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C Page C.5</td>
<td>Header</td>
<td>ISA</td>
<td>08</td>
<td>100000 Followed by spaces</td>
</tr>
</tbody>
</table>

9.6.2 GS Functional Group Header

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
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</thead>
<tbody>
<tr>
<td>Appendix C page C.7</td>
<td>Header</td>
<td>GS</td>
<td>03</td>
<td>Enter 77046</td>
</tr>
</tbody>
</table>

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 CCYMMDD) 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

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
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<tbody>
<tr>
<td>Page 72</td>
<td>2100A</td>
<td>NM1</td>
<td>03</td>
<td>Wyoming Medicaid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: SV should be used only when a Wyoming Provider is an Atypical Provider/non-medical.</td>
</tr>
<tr>
<td>Page 79</td>
<td>2100B</td>
<td>NM1</td>
<td>08</td>
<td></td>
</tr>
</tbody>
</table>
9.6.5 271 Eligibility Response

No Wyoming Specific Requirement

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

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Appendix C</td>
<td></td>
<td>ISA</td>
<td>08</td>
<td>Enter 100000 followed by spaces</td>
</tr>
<tr>
<td>Page C.5</td>
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9.7.2 GS Functional Group Header

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<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C</td>
<td></td>
<td>GS</td>
<td>03</td>
<td>Enter 77046</td>
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<tr>
<td>Page C.7</td>
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9.7.3 276 Claim Status Request

<table>
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<tr>
<td>Page 46</td>
<td>2100B</td>
<td>NM1</td>
<td>09</td>
<td>Note: Enter the 9-digit Wyoming Medicaid Provider ID when a Wyoming Provider is an Atypical Provider/non-medical</td>
</tr>
<tr>
<td>Page 51</td>
<td>2100C</td>
<td>NM1</td>
<td>08</td>
<td>Note: SV should be used only when a Wyoming Provider is an Atypical Provider/non-medical.</td>
</tr>
<tr>
<td>Page 73</td>
<td>2210D</td>
<td>REF</td>
<td>01</td>
<td>The Line Item Control Number inquiry is not supported by Wyoming Medicaid. The Claim Status Response will return all claim line items</td>
</tr>
<tr>
<td>Page 73</td>
<td>2210D</td>
<td>REF</td>
<td>02</td>
<td>The Line Item Control Number inquiry is not supported by Wyoming Medicaid. The Claim Status Response will return all claim line items</td>
</tr>
</tbody>
</table>

9.7.4 277 Claim Status Response

No Wyoming Specific Requirement

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

<table>
<thead>
<tr>
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<th>Wyoming Requirements</th>
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</thead>
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<td>Appendix C Page C.5</td>
<td>Interchange Control Header</td>
<td>ISA</td>
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<td>Enter 100000 followed by spaces</td>
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### 9.8.2 GS Functional Group Header

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
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</thead>
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<td>Appendix C Page C.7</td>
<td>Functional Group Header</td>
<td>GS</td>
<td>03</td>
<td>Enter 77046</td>
</tr>
</tbody>
</table>

### 9.8.3 278 Prior Authorization Request – Data Clarifications Inbound

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Wyoming Requirements</th>
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<td>2010A</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Wyoming Requirements</th>
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</thead>
<tbody>
<tr>
<td>Page 107</td>
<td>1000B</td>
<td>REF</td>
<td>01</td>
<td>If the provider does not have an NPI then REF01 will contain “PQ” (Payee Identification) and REF02 will contain the Wyoming Medicaid Provider ID</td>
</tr>
<tr>
<td>108</td>
<td>1000B</td>
<td>REF</td>
<td>02</td>
<td>If the provider does not have an NPI then REF01 will contain “PQ” (Payee Identification) and REF02 will contain the Wyoming Medicaid Provider ID</td>
</tr>
<tr>
<td>TR3 Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Data Element</td>
<td>Wyoming Requirements</td>
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<tr>
<td>----------</td>
<td>------</td>
<td>---------</td>
<td>--------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Page 207-208</td>
<td>2110</td>
<td>REF</td>
<td>01</td>
<td>Either HPI or G2 will be displayed note: G2 will be displayed only for WY Medicaid Atypical Providers</td>
</tr>
<tr>
<td>Page 208</td>
<td>2110</td>
<td>REF</td>
<td>02</td>
<td>Note: Enter the 9-digit Wyoming Medicaid Provider ID when a Wyoming Provider is an Atypical/non-medical</td>
</tr>
</tbody>
</table>

9.10 **837 Professional Claims Transactions**

**Wyoming Medicaid Professional Claims**

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

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

9.10.1 **ISA Interchange Control Header**

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### 9.10.3 837 Professional

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<td>SBR 09</td>
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<td>Do not use code MC</td>
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<td>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 (<a href="http://wymedicaid.acs-inc.com">http://wymedicaid.acs-inc.com</a>).</td>
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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.

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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.

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Chapter Ten

CMS-1500 Covered Services

Chapter Ten ............................................................................................................................ 10-1

10.1 Claims Review ................................................................................................................ 10-3
10.2 Physician Supervision Definition .................................................................................. 10-3
10.3 Coding ............................................................................................................................ 10-4
10.4 Importance of Fee Schedules and Provider’s Responsibility ......................................... 10-4
10.5 Ambulance Services ....................................................................................................... 10-5
10.6 Ambulatory Surgical Centers ....................................................................................... 10-11
10.7 Audiology Services ......................................................................................................... 10-11
10.8 Children’s Mental Health Waiver (CMHW) .................................................................. 10-14
10.9 Community Mental Health and Substance Abuse Centers ......................................... 10-17
10.10 Developmental Centers ............................................................................................... 10-30
10.11 Family Planning Clinics ............................................................................................... 10-33
10.12 Health Check – EPSDT ................................................................................................ 10-34
10.13 Interpreter Services ..................................................................................................... 10-51
10.14 Laboratory Services .................................................................................................... 10-51
10.15 Physician and Nurse Practitioner Services ................................................................... 10-54
10.15.1 Covered Services ....................................................................................................... 10-54
10.15.2 Abortion .................................................................................................................... 10-55
10.15.3 Anesthesia Services ................................................................................................. 10-56
10.15.4 Dermatology ............................................................................................................ 10-61
10.15.5 Diabetic Training ...................................................................................................... 10-63
10.15.6 Family Planning Services ....................................................................................... 10-62
10.15.7 Hysterectomies ......................................................................................................... 10-63
10.15.8 Immunizations .......................................................................................................... 10-64
10.15.9 Incentive Payment Program – Currently replaced by the PCP Attestation. Incentive Payment Program will resume January 1, 2015 .................................................................................. 10-72
10.15.10 Injections ............................................................................................................... 10-74
10.15.11 Interpretation Services ............................................................................................ 10-79
10.15.12 Laboratory Services ................................................................. 10-80
10.15.13 Locum Tenens ........................................................................ 10-83
10.15.14 Maternity Care ........................................................................ 10-83
10.15.15 Medical Supplies (Disposable) .................................................. 10-88
10.15.16 Practitioner Visits ..................................................................... 10-88
10.15.17 Preventive Medicine ................................................................. 10-97
10.15.18 Psychiatric & Mental Health Services ......................................... 10-97
10.15.19 Public Health Services ............................................................... 10-104
10.15.20 Radiology Services .................................................................. 10-104
10.15.21 Screening, Brief Intervention, Referral and Treatment (SBIRT) ........................................................................... 10-107
10.15.22 Sterilizations and Hysterectomies ............................................... 10-109
10.15.23 Surgical Services ...................................................................... 10-109
10.15.24 Transplant Policy ...................................................................... 10-124
10.15.25 Vision Services .......................................................................... 10-125
10.16 Pregnant By Choice / Family Planning Waiver ............................... 10-129
10.17 Therapy Services ........................................................................... 10-132
10.17.1 Physical Therapy & Occupational Therapy .................................. 10-132
10.17.2 Speech Therapy .......................................................................... 10-134
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**

Medicaid allows healthcare practitioners and allied health professionals to bill using the supervising physician’s NPI. The practitioner may work in the office of the supervising physician where the primary practice is maintained and at sites outside that office as directed by the physician.

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

Fiscal responsibility and documentation integrity for claims billed by practitioners or allied health professionals under the supervising physician’s NPI remains that of the supervising physician.
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:

- 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 unit may equal “one 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, Attn: Claims Reconsiderations, PO Box 667, Cheyenne, WY 82003.

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 (Section 2.2, Quick Website 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 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

10.5.1 Covered Services

10.5.1.1 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
10.5.1.2 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 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

10.5.1.3 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).

**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 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 separate administrations of one 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 of the ALS2 procedures listed below:
   - Manual defibrillation/cardio version
   - Endotracheal intubation
   - Central venous line
   - Cardiac pacing
   - Chest decompression
   - Surgical airway
   - Intravenous 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 inpatient facility and transferred and admitted to another inpatient facility when distance or urgency precludes the use of ground ambulance.

10.5.2 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.
10.5.3 **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.

10.5.4 **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.

10.5.5 **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

10.5.6 Multiple Client Transportation

When more than one 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.

10.5.7 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.

10.5.8 Billing Requirements

The following are the procedure codes accepted for ambulance services:

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

**NOTE:** An ambulance trip report must accompany all ambulance claims.
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

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.

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 5-year period unless:

• The original hearing aid has been irreparably broken or lost after the one-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.

### 10.6.3 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.

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

10.6.4 **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 and handling 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 (Section 2.1, Quick Address and Telephone Reference).

10.6.5 **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 and handling only.

10.6.6 **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.
10.7 Children’s Mental Health Waiver (CMHW)

The Children’s Mental Health Waiver is a short-term home and community based waiver designed to provide a community-based mental health service alternative for youth with serious emotional disturbance who might otherwise be hospitalized and whose parents may be required to relinquish custody of their child in order for them to receive needed mental health treatment and services. The Children’s Mental Health Waiver seeks to (1) prevent custody relinquishment in order for youth to receive mental health treatment; (2) prevent or reduce the length of costly psychiatric hospital stays; and (3) provide a mechanism to offer mental health support services to youth with serious emotional disturbance and families in identified service areas. The Children’s Mental Health Waiver is not a long-term care waiver.

For additional information (i.e. provider availability, provider requirements, client eligibility, etc.) refer to the Children’s Mental Health Waiver website at:

http://www.health.wyo.gov/mhsa/treatment/waiverindex.html

10.7.1 Covered Services

The Children’s Mental Health Waiver covers the following non-clinical services:

- **Family Care Coordination:** Services that advocate for and support the youth and family, including but not limited to, initiation and completion of needed mental health assessments, evaluations and re-evaluations; coordination of a Family Care Team to wrap-around the family; facilitation of the development of a multi-service individual community based plan that supports access to clinical and non-clinical services, information, community resources and natural supports, facilitation of regular service plan reviews to monitor continued appropriateness and adequacy of services; and facilitation of transition for children or youth who may be served in out-of-home placements and/or children or youth leaving waiver services.

- **Individualized Child Training and Support (Respite):** Services that focus on supporting and enhancing the child or youth’s overall service plan goals, including but not limited to, one-on-one services and activities which may include: recreational activities, exposure of the youth to new ideas and experiences, or skills training. Services may be provides in the youth’s home or place of residence, community, foster home, or emergency shelter.

- **Family Training and Support (Training for Unpaid Care Givers):** Training and services for individuals (Family members as well as
neighbors, friends, or companions identified by the child, youth or family) who provide uncompensated care, training, guidance, companionship, or support to the child or youth to maintain their ability to care for the child/youth in his/her home and community, including but not limited to, training related to the role of supporting the youth in areas specified in the individual's service plan; providing instruction about treatment regimen and other services to include behavior management and/or crisis intervention training specific to the youth’s individual service plan; coaching aimed at increasing knowledge and awareness of the child or youth’s needs, available service and resources and developing abilities to monitor and evaluate those services.

10.7.2 Billing Requirements

- Services must be documented on the Individualized Service Plan (ISP), and
- Services must be prior authorized by the Division of Healthcare Financing
- The following table indicates the procedure code, the defined unit and applicable modifiers.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier(s)</th>
<th>1 Unit Equals</th>
<th>Procedure Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1016</td>
<td></td>
<td>Per 15 minutes</td>
<td></td>
<td>Family Care Coordination</td>
</tr>
<tr>
<td>H0023</td>
<td></td>
<td>Per 15 minutes</td>
<td>Limited to 416 units per waiver year; 104 units per quarterly plan</td>
<td>Individualized Child Training and Support (Respite with requirements)</td>
</tr>
<tr>
<td>T1027</td>
<td></td>
<td>Per 15 minutes</td>
<td></td>
<td>Family Training and Support (Training for unpaid care givers)</td>
</tr>
</tbody>
</table>

10.7.3 CASII (Child and Adolescent Service Intensity Instrument) Evaluations

CASII evaluations are performed for waiver applicants initially as a step in the eligibility process in order to receive waiver services, then again every twelve (12) months for re-certification.

10.8.3.1 Requirements

- Reimbursement for CASII evaluations will be made to providers approved by the Children’s Mental Health Waiver program, and only after all billing requirements are met.
10.8.3.2 Billing Requirements

- Upon completion of the CASII the provider must submit the following documentation to the Children’s Mental Health Waiver staff:
  - CASII scoring sheet– completed and signed
  - CASII instrument identifying selected letter items for each numbered anchor point.
  - Waiver services application

- Claims cannot be submitted for at least 72 hours after all required documentation is sent to Children’s Mental Health.
- Clients who are not eligible for any other Medicaid plan will be made eligible for the date of the CASII evaluation for the processing of these claims.
  - All services billed in relation to the CASII evaluation will be billed on a single date of service. This date should be the date listed with the evaluators’ signature on the submitted forms.
    - Example – The CASII evaluation process was conducted on August 1, August 8, and August 9. The CASII evaluation was signed and submitted on August 9 therefore 1 unit will be billed with a date of service of August 9.

<table>
<thead>
<tr>
<th>CASII Evaluation Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>H0002</td>
</tr>
</tbody>
</table>
10.8 Community Mental Health and Substance Abuse Centers

10.8.1 Requirements

Community Mental Health Centers (CMHC) and Substance Abuse Centers (SAC) should refer to the Medicaid Policies and Procedures Manual for Mental Health/Substance Abuse Rehabilitative Option Services (http://wyequalitycare.acs-inc.com/MHSA.html) for detailed information regarding provider qualifications and requirements, covered services and their definitions, and quality assurance/utilization review standards.

10.8.2 Documentation Requirements

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.
- 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.
- 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.

All documentation, including required signatures, must be completed before or at the time the provider submits a claim to Medicaid.

10.8.3 Psychiatrist 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. Please refer to Psychiatric and Mental Health Services (Section 10.15.18).
### Community Mental Health Center Billing Procedures

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).

<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Modifier(s)</th>
<th>1 Unit Equals</th>
<th>Description</th>
<th>Taxonomies Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td></td>
<td>Per 15 minutes</td>
<td>Clinical Assessment – Mental Health Assessment by non-physician</td>
<td>101Y00000X , 101Y0A0400X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 2084P0800X, 364SP0808X</td>
</tr>
<tr>
<td>H0034</td>
<td></td>
<td>Per 15 minutes</td>
<td>Comprehensive Medication Service – Medication Training and Support</td>
<td>163W00000X, 164W00000X</td>
</tr>
<tr>
<td>H2014</td>
<td>HH</td>
<td>Per 15 minutes</td>
<td>Certified Peer Specialists</td>
<td>172V00000X</td>
</tr>
<tr>
<td>H2014</td>
<td>HH + HQ</td>
<td>Per 15 minutes</td>
<td>Certified Peer Specialists</td>
<td>172V00000X</td>
</tr>
<tr>
<td>H2017</td>
<td></td>
<td>Per 15 minutes</td>
<td>Psychosocial Rehabilitation Services</td>
<td>101Y00000X, 101Y0A0400X, 1041C0700X, 106H00000X, 163W00000X, 171M00000X</td>
</tr>
<tr>
<td>H2017</td>
<td>EP</td>
<td>Per 15 minutes</td>
<td>Children’s Psychosocial Rehabilitation Services</td>
<td>101Y00000X, 101Y0A0400X, 1041C0700X, 106H00000X, 163W00000X, 171M00000X</td>
</tr>
<tr>
<td>Service Description</td>
<td>CPT Codes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2019 Per 15 minutes Agency Based Individual/Family Therapy</td>
<td>101Y00000X, 101YA0400X, 1041C0700X, 106H00000X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2019 HQ Per 15 minutes Group Therapy – Group Counseling by Clinician</td>
<td>101Y00000X, 101YA0400X, 1041C0700X, 106H00000X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2021 Per 15 minutes Community-Based Individual/Family Therapy</td>
<td>101Y00000X, 101YA0400X, 1041C0700X, 106H00000X</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>90785 CPT Defined Interactive complexity (list separately in addition to the code for primary procedure)</td>
<td>103G00000X, 103TC0700X, 364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90791 CPT Defined Psychiatric Diagnostic Evaluation</td>
<td>103G00000X, 103TC0700X, 364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90792 CPT Defined Psychiatric diagnostic evaluation with medical services</td>
<td>364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Type</td>
<td>Description</td>
<td>Codes</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>90832</td>
<td>CPT</td>
<td>Psychotherapy, 30 minutes with patient and/or family member</td>
<td>103G00000X, 103TC07000X, 364SP0808X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td></td>
<td>Taxonomies beginning with 20 (Physicians)</td>
<td></td>
</tr>
<tr>
<td>90833</td>
<td>CPT</td>
<td>Psychotherapy, 30 minutes with patient and/or family member when performed</td>
<td>103TC07000X, 103G00000X, 364SP0808X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td>with and evaluation and management service (list separately in addition to the code for primary procedure)</td>
<td>Taxonomies beginning with 20 (Physicians)</td>
<td></td>
</tr>
<tr>
<td>90834</td>
<td>CPT</td>
<td>Psychotherapy, 45 minutes with patient and/or family member</td>
<td>103G00000X, 103TC07000X, 364SP0808X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td></td>
<td>Taxonomies beginning with 20 (Physicians)</td>
<td></td>
</tr>
<tr>
<td>90836</td>
<td>CPT</td>
<td>Psychotherapy, 45 minutes with patient and/or family member when performed</td>
<td>103TC07000X, 103G00000X, 364SP0808X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td>with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
<td>Taxonomies beginning with 20 (Physicians)</td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>CPT</td>
<td>Psychotherapy, 60 minutes with patient and/or family member</td>
<td>103G00000X, 103TC07000X, 364SP0808X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td></td>
<td>Taxonomies beginning with 20 (Physicians)</td>
<td></td>
</tr>
<tr>
<td>90839</td>
<td>CPT</td>
<td>Psychotherapy, 60 minutes with patient and/or family member when performed</td>
<td>103G00000X, 103TC07000X, 364SP0808X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td>with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
<td>Taxonomies beginning with 20 (Physicians)</td>
<td></td>
</tr>
<tr>
<td>90845</td>
<td>CPT</td>
<td>Psychoanalysis</td>
<td>103G00000X, 103TC07000X, 2084P0800X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td></td>
<td>364SP0808X</td>
<td></td>
</tr>
<tr>
<td>90846</td>
<td>CPT</td>
<td>Family Medical Psychotherapy (without the patient present)</td>
<td>103G00000X, 103TC07000X, 364SP0808X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td></td>
<td>Taxonomies beginning with 20 (Physicians)</td>
<td></td>
</tr>
<tr>
<td>90847</td>
<td>CPT</td>
<td>Family Psychotherapy</td>
<td>103G00000X, 103TC07000X, 364SP0808X,</td>
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</tr>
<tr>
<td></td>
<td>Defined</td>
<td></td>
<td>Taxonomies beginning with 20 (Physicians)</td>
<td></td>
</tr>
<tr>
<td>90849</td>
<td>CPT</td>
<td>Multiple-Family Group Psychotherapy</td>
<td>103G00000X, 103TC07000X, 2084P0800X,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined</td>
<td></td>
<td>364SP0808X</td>
<td></td>
</tr>
</tbody>
</table>
### Community Mental Health Centers

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Provider Types</th>
<th>Allowed Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>103G00000X</td>
<td>Neuropsychologist</td>
<td>H0031, T1017, T1017 + EP, T2011, 90785, 90791, 90792, 90832-90834, 90836-90838, 90845-90847, 90849, 90853, 96101-96125</td>
</tr>
<tr>
<td>103TC0700X</td>
<td>Clinical Psychologist</td>
<td>H0031, T1017, T1017 + EP, T2011, 90785, 90791, 90792, 90832-90834, 90836-90838, 90845-90847, 90849, 90853, 96101-96125</td>
</tr>
<tr>
<td>106H00000X</td>
<td>Marriage and Family Therapist (MFT), Provisionally</td>
<td>H0031, H2014, H2014 + HK,</td>
</tr>
</tbody>
</table>
**Licensed Marriage and Family Therapist (PMFT)**  

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Title</th>
<th>Accepted Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>164W00000X</td>
<td>LPN</td>
<td>H0034, H2014, H2014 + HK</td>
</tr>
</tbody>
</table>

**Taxonomies beginning with 20**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90785, 90791, 90792, 90832-90834, 90836-90838, 90845-90847, 90849, 90853, 96101-96125</td>
<td>Physicians</td>
</tr>
</tbody>
</table>

**Psychiatry and Neurology, Psychiatry**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>

**Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>

---

**10.8.5 Substance Abuse Centers Billing Procedures**

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).

<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Modifier(s)</th>
<th>1 Unit Equals</th>
<th>Description</th>
<th>Taxonomies Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td>Per 15 minutes</td>
<td>Clinical Assessment</td>
<td>101Y00000X, 101Y0A0400X, 1041C0700X, 106H00000X, 2084P0800X, 364SP0808X</td>
<td></td>
</tr>
<tr>
<td>T1007</td>
<td>Per 15 minutes</td>
<td>Alcohol/Drug Services – Office Based Individual/Family Therapy</td>
<td>101Y00000X, 101Y0A0400X, 1041C0700X, 106H00000X</td>
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<tr>
<td>Code</td>
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<td>H2010</td>
<td>Comprehensive Medication Therapy</td>
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<td>H0047</td>
<td>Alcohol/Drug Services – Community Based Individual/Family Therapy</td>
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<td>H0005</td>
<td>Alcohol/Drug Services – Group Counseling by Clinician</td>
<td>101Y00000X, 101YA0400X, 1041C0700X, 106H00000X</td>
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<td>H2015</td>
<td>Certified Peer Specialists</td>
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<td>H2015</td>
<td>Certified Peer Specialist – Group</td>
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<tr>
<td>H0006</td>
<td>Substance Abuse Case Management (Youth)</td>
<td>101Y00000X, 101YA0400X, 103TC0700X, 103G00000X, 1041C0700X, 106H00000X, 171M00000X</td>
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<td>H0006</td>
<td>HQ</td>
<td>Per 15 minutes</td>
<td>Alcohol/Drug Services – Case Management – Group</td>
<td>2084P0800X, 364SP0808X</td>
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<tr>
<td>90785</td>
<td>CPT Defined</td>
<td>Interactive complexity (list separately in addition to the code for primary procedure)</td>
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<td>90791</td>
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<tr>
<td>90792</td>
<td>CPT Defined</td>
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<td>90832</td>
<td>CPT Defined</td>
<td>Psychotherapy, 30 minutes with patient and/or family member</td>
<td>103G00000X, 103TC0700X, 364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
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<tr>
<td>90833</td>
<td>CPT Defined</td>
<td>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)</td>
<td>103G00000X, 103TC0700X</td>
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<tr>
<td>90834</td>
<td>CPT Defined</td>
<td>Psychotherapy, 45 minutes with patient and/or family member</td>
<td>103G00000X, 103TC0700X, 364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
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<td>90836</td>
<td>CPT Defined</td>
<td>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)</td>
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<td>90837</td>
<td>CPT Defined</td>
<td>Psychotherapy, 60 minutes with patient and/or family member</td>
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10-24
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Taxonomy Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient and/or family member when performed</td>
<td>103G00000X, 103TC0700X, 364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
</tr>
<tr>
<td></td>
<td>with an evaluation and management services (list separately in addition to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the code for primary procedure)</td>
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<tr>
<td>90845</td>
<td>Psychoanalysis</td>
<td>103G00000X, 103TC0700X, 2084P0800X, 364SP0808X</td>
</tr>
<tr>
<td>90846</td>
<td>Family Medical Psychotherapy (without the patient present)</td>
<td>103G00000X, 103TC0700X, 364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy</td>
<td>103G00000X, 103TC0700X, 364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-Family Group Psychotherapy</td>
<td>103G00000X, 103TC0700X, 2084P0800X, 364SP0808X</td>
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<tr>
<td>90853</td>
<td>Group Medical Psychotherapy</td>
<td>103G00000X, 103TC0700X, 2084P0800X, 364SP0808X</td>
</tr>
<tr>
<td>96101-</td>
<td>Central Nervous System Assessments/Psychological Testing</td>
<td>103G00000X, 103TC0700X, 364SP0808X, Taxonomies beginning with 20 (Physicians)</td>
</tr>
<tr>
<td>96125</td>
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### Substance Abuse Centers

<table>
<thead>
<tr>
<th>Modifiers (s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP</td>
<td>Services Provided as part of EPSDT</td>
</tr>
<tr>
<td>HK</td>
<td>Specialized mental health programs for high-risk populations</td>
</tr>
<tr>
<td>HH</td>
<td>Peer Specialist</td>
</tr>
<tr>
<td>HQ</td>
<td>Group setting</td>
</tr>
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</table>
### Substance Abuse Centers

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Provider Types</th>
<th>Allowed Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>101Y00000X</td>
<td>Licensed Professional Counselor (LPC), Provisional Professional Counselor (PPC), Certified Addictions Practitioner (CAP)</td>
<td>H0031, H0005, H0006, H0006 + EP, H0006 + HQ, H0047, H2015, H2015 + HK, T1007, T1012</td>
</tr>
<tr>
<td>103G00000X</td>
<td>Neuropsychologist</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90832-90834, 90836 – 90838, 90845-90847, 90849,90853, 96101-96125</td>
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<tr>
<td>103TC0700X</td>
<td>Clinical Psychologist</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90832-90834, 90836 – 90838, 90845-90847, 90849,90853, 96101-96125</td>
</tr>
<tr>
<td>1041C0700X</td>
<td>Licensed Clinical Social Worker (LCSW), Certified Social Worker (CSW)</td>
<td>H0031, H0005, H0006, H0006 + EP, H0006 + HQ, H0047, H2015, H2015 + HK, T1007, T1012</td>
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<tr>
<td>106H00000X</td>
<td>Marriage and Family Therapist (MFT), Provisionally Licensed Marriage and Family Therapist (PMFT)</td>
<td>H0031, H0005, H0006, H0006 + EP, H0006 + HQ, H0047, H2015, H2015 + HK, T1007, T1012</td>
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<tr>
<td>163W00000X</td>
<td>RN</td>
<td>H2010, H2015, H2015 + HK, T1012</td>
</tr>
<tr>
<td>164W00000X</td>
<td>LPN</td>
<td>H2010, H2015, H2015 + HK</td>
</tr>
<tr>
<td>171M00000X</td>
<td>Case Manager</td>
<td>H0006, H0006 + EP, H0006 + HQ, H2015, H2015 + HK + T1012</td>
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<tr>
<td>172V00000X</td>
<td>Community Health Worker – Individual Rehabilitative Services Worker (IRS), Certified Peer Specialist, Certified Addictions Practitioner Assistant (CAPA)</td>
<td>H2015, H2015 + HK, H2015 + HH, H2015 + HH + HQ</td>
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<tr>
<td>2084P0800X</td>
<td>Psychiatry and Neurology, Psychiatry</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90792, 90832-90834, 90836 – 90838, 90845-90847, 90849, 90853, 96101-96125</td>
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<tr>
<td>364SP0808X</td>
<td>Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90792, 90832-90834, 90836 – 90838, 90845-90847, 90849, 90853, 96101-96125</td>
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Taxonomies beginning with 20

**Physicians**

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<thead>
<tr>
<th>Taxonomy</th>
<th>Provider Types</th>
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<tbody>
<tr>
<td>364SP0808X</td>
<td>Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90792, 90832-90834, 90836 – 90838, 90845-90847, 90849, 90853, 96101-96125</td>
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**Taxonomies begin with 20**

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<tr>
<th>Provider Types</th>
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<tr>
<td>Psychiatry and Neurology, Psychiatry</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90792, 90832-90834, 90836 – 90838, 90845-90847, 90849, 90853, 96101-96125</td>
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**Physicians**

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<tr>
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<th>Allowed Codes</th>
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<td>Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90792, 90832-90834, 90836 – 90838, 90845-90847, 90849, 90853, 96101-96125</td>
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**Taxonomies begin with 20**

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<tr>
<th>Provider Types</th>
<th>Allowed Codes</th>
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<tbody>
<tr>
<td>Psychiatry and Neurology, Psychiatry</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90792, 90832-90834, 90836 – 90838, 90845-90847, 90849, 90853, 96101-96125</td>
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**Physicians**

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<tr>
<th>Taxonomy</th>
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<th>Allowed Codes</th>
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<tbody>
<tr>
<td>364SP0808X</td>
<td>Nurse Practitioner, Advanced Practice, Psychiatric/Mental Health</td>
<td>H0006, H0006 + EP, H0006 + HQ, 90785, 90791, 90792, 90832-90834, 90836 – 90838, 90845-90847, 90849, 90853, 96101-96125</td>
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</tbody>
</table>
10.9 Developmental Centers

A developmental center is a state or privately funded facility, which provides services to clients with developmental disabilities who have been determined to require programs, training, care, treatment and supervision in a structured 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).

10.9.1 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 (Section 3.8.1, 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.

10.9.2 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.
10.9.3 **Time and Frequency**

Time and frequency are required on the physician’s order and must be specific. Time is a unit of fifteen (15) minutes. 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. For example, six (6) months duration three (3) times per day is an acceptable time and frequency.

10.9.4 **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.

10.9.5 **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.

10.9.6 **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), and licensed addiction therapists (LAT).

- **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 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 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 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 thirty (30) days.
## Billing Requirements

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

<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Modifier</th>
<th>1 Unit Equals</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92506</td>
<td>Per evaluation</td>
<td></td>
<td>Individual evaluation of speech, language, voice, communication and/or audio processing disorder (includes aural rehab)</td>
</tr>
<tr>
<td>92507</td>
<td>Per Instance</td>
<td></td>
<td>Individual treatment of speech language voice communication and/or auditory processing disorder (including aural rehab).</td>
</tr>
<tr>
<td>92508</td>
<td>Per Instance</td>
<td></td>
<td>Treatment of speech, language, voice communication, and/or auditory processing disorder (including aural rehab); group, two or more individuals.</td>
</tr>
<tr>
<td>92526</td>
<td>Per Instance</td>
<td></td>
<td>Treatment of swallowing dysfunction and or oral function for feeding</td>
</tr>
<tr>
<td>97001</td>
<td>Per 15 minutes</td>
<td></td>
<td>Physical therapy evaluation</td>
</tr>
<tr>
<td>97002</td>
<td>Per 15 minutes</td>
<td></td>
<td>Physical therapy re-evaluation</td>
</tr>
<tr>
<td>97003</td>
<td>Per 15 minutes</td>
<td></td>
<td>Occupational therapy evaluation</td>
</tr>
<tr>
<td>97004</td>
<td>Per 15 minutes</td>
<td></td>
<td>Occupational therapy re-evaluation</td>
</tr>
<tr>
<td>97110</td>
<td>Per 15 minutes</td>
<td></td>
<td>Therapeutic procedure, one or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
</tr>
<tr>
<td>97112</td>
<td>Per 15 minutes</td>
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<td>Therapeutic procedure, one or more areas; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities</td>
</tr>
<tr>
<td>97113</td>
<td>Per 15 minutes</td>
<td></td>
<td>Therapeutic procedure, one or more areas; aquatic therapy with therapeutic exercises</td>
</tr>
<tr>
<td>97124</td>
<td>Per 15 minutes</td>
<td></td>
<td>Therapeutic procedure, one or more areas; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)</td>
</tr>
<tr>
<td>97150</td>
<td>Per 15 minutes</td>
<td></td>
<td>Therapeutic procedure(s); group, two or more individuals</td>
</tr>
<tr>
<td>97530</td>
<td>Per 15 minutes</td>
<td></td>
<td>Therapeutic activities, direct (one to one) client contact by the provider</td>
</tr>
<tr>
<td>97533</td>
<td>Per 15 minutes</td>
<td></td>
<td>Sensory integrative techniques to enhance sensory processing and promote adaptive responses of environmental demands, direct (one-on-one) client contact by the provider</td>
</tr>
<tr>
<td>G9012</td>
<td>Per 15 minutes</td>
<td></td>
<td>Other specified case management service not elsewhere classified</td>
</tr>
<tr>
<td>H0031</td>
<td>Per 15 minutes</td>
<td></td>
<td>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, and establishing DSM (latest edition) or acceptable “V” code diagnosis.</td>
</tr>
<tr>
<td>H2019</td>
<td>Per 15 minutes</td>
<td></td>
<td>Agency Based Individual/Family Therapy - Therapist contact at the developmental center with the enrolled client and/or collaterals as necessary, for the purpose of developing and</td>
</tr>
</tbody>
</table>
### Developmental Centers

<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Modifier</th>
<th>1 Unit Equals</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2019</td>
<td>HQ</td>
<td>Per 15 minutes</td>
<td>Group Therapy - Therapist contact with two or more unrelated clients and/or collaterals as necessary, for the purpose of implementing each client’s treatment plan.</td>
</tr>
<tr>
<td>H2021</td>
<td></td>
<td>Per 15 minutes</td>
<td>Community-Based Individual/Family 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.</td>
</tr>
<tr>
<td>T2011</td>
<td>HI</td>
<td>N/A</td>
<td>PASRR Level II Developmental Disabilities Evaluation</td>
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### Developmental Centers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
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<tbody>
<tr>
<td>HI</td>
<td>Multi-Disciplinary Team</td>
</tr>
<tr>
<td>HQ</td>
<td>Group Setting</td>
</tr>
</tbody>
</table>
10.10 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.

10.10.1 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)
- Pap smears
- Pregnancy tests

10.10.2 Limitations

Evaluation and Management office procedure code should not be billed separately on the same day as any one of these procedures:

- Insertion or removal of implantable capsules
- Removal or insertion of intrauterine devices (IUD’s)

10.10.3 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. (Section 10.16)
10.11 **Health Check – EPSDT**

The Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT):

- Brings comprehensive healthcare to children from birth up to and including twenty (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, 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 office visit.
10.11.1 Periodicity Schedule

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

<table>
<thead>
<tr>
<th>Well Child Screen Requirements</th>
<th>Newborn – 12 months</th>
<th>15 months to 4 years</th>
<th>5 – 10 years</th>
<th>11 - 21 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial/Interval</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Measurements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height &amp; Weight</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Head circumference</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Sensory Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td>s</td>
<td>s</td>
<td>o</td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td>s</td>
<td>s</td>
<td>o</td>
</tr>
<tr>
<td><strong>Developmental / Behavioral Assessment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imomunizations</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Health Check Immunizations</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Screening</td>
<td></td>
<td>(9-12 mo)</td>
<td>(24 mo)</td>
<td></td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>(12 mo)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical Fluoride Varnish</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>(6-12mo)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(24 mo-4 yrs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD Screening</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Pelvic Exam</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td><strong>Anticipatory Guidance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury Prevention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Violence Prevention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sleep Positioning Counseling</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>(up to 6 mo)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition Counseling</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**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
10.11.2 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.

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 you have 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 your convenience the codes, modifiers, and diagnosis codes for EPSDT – Health Check and the most current fee schedule for the above mentioned codes are attached. Please note that the fees are subject to change without notice.

At a minimum, these screens 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 – (Please note that Blood Lead Level testing is now required at twelve (12) and twenty four (24) months for all children).
- The most current copy of the immunization schedule can be found at http://www.cdc.gov/vaccines/recs/schedules/default.htm

10-36
### Diagnosis Codes to be used when billing for EPSDT—Well Child Checks

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V20</td>
<td>Health Supervision of infant or child</td>
</tr>
<tr>
<td>V20.0</td>
<td>Health Supervision of foundling</td>
</tr>
<tr>
<td>V20.1</td>
<td>Other Healthy infant or child receiving care</td>
</tr>
<tr>
<td>V20.2</td>
<td>Routine infant or child Health Check</td>
</tr>
</tbody>
</table>

### Topical Fluoride Treatment

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1206</td>
<td>32</td>
<td>Topical fluoride varnish</td>
</tr>
</tbody>
</table>

### Preventative Medicine Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>32</td>
<td>Initial comprehensive preventative Medicine age 0 – through 11 months.</td>
</tr>
<tr>
<td>99382</td>
<td>32</td>
<td>Early childhood age 1-4 years</td>
</tr>
<tr>
<td>99383</td>
<td>32</td>
<td>Late childhood age 5 – 11 years</td>
</tr>
<tr>
<td>99384</td>
<td>32</td>
<td>Adolescent age 12 – 17</td>
</tr>
<tr>
<td>99385</td>
<td>32</td>
<td>Age 18 – 20</td>
</tr>
</tbody>
</table>

### Modifier

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Mandated Services – Referral</td>
</tr>
</tbody>
</table>

### Evaluation and Management Services – New Patient

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
</table>
| 99201          | 25       | Office or other outpatient visit for the E & M of a new patient – requires three 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 key components;  
|                |          | • An expanded problem focused history  
|                |          | • An expanded problem focused exam  
|                |          | • Straightforward medical decision making                                    |
| 99203          | 25       | Office or other outpatient visit for the E & M of a new patient – requires three key components;  
|                |          | • A detailed history  
|                |          | • A detailed exam  
|                |          | • Medical decision making of low complexity                                  |
### Evaluation and Management Services – New Patient

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
</table>
| 99204          | 25       | Office or other outpatient visit for the E & M of a new patient – requires three key components;  
• A comprehensive history  
• A comprehensive exam  
• Medical decision making of moderate complexity |
| 99205          | 25       | Office or other outpatient visit for the E & M of a new patient – requires three key components;  
• A comprehensive history  
• A comprehensive exam  
• Medical decision making of high complexity |

### Evaluation and Management Services—Established Patient

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>25</td>
<td>Office or other outpatient visit for the E &amp; M of an established patient that may not require the presence of a physician. Usually the presenting problems are minimal. Typically 5 minutes are spent performing or supervising these services</td>
</tr>
</tbody>
</table>
| 99212          | 25       | Office or other outpatient visit for the E & M of an established patient which requires at least of these three 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 components;  
• An expanded problem focused history  
• An expanded problem focused exam  
• Straightforward medical decision making |
| 99214          | 25       | Office or other outpatient visit for the E & M of an established patient which requires at least of these three 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 components;  
• A comprehensive history  
• A comprehensive exam  
• Medical decision making of high complexity |
### Modified

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Significant, separately identifiably E &amp; M service by the same physician on the same day of the procedure or other service.</td>
</tr>
</tbody>
</table>

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

#### 10.11.3 Detailed Information for Well Child Screens

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

#### 10.11.4 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.
10.11.5 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:

- Prescreening Developmental Questionnaire
- Denver Developmental Screening Test
- 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 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.
10.11.6 **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)

10.11.7 **Head Circumference**

An Occipital Frontal Head Circumference (OFHC) should be measured on each child 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.
10.11.8 **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 and fifth 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.

10.11.9 **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-line difference in visual acuity between the two 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-line difference in visual acuity between the two eyes within the passing range.
10.11.10 **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 CDT code D1206 on the CMS-1500 form.
- Fluoride varnish application can be done up to three 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 twelve (12) months of age.

10.11.11 **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 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 semicircular canals (balance).
  - Unilateral hearing loss of sudden or recent onset within the previous 90 days. Could be caused by mumps, virus, head trauma, menieres 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
- Severe 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.

10.11.12 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.

10.11.12.1 Hematocrit and Hemoglobin

Hematocrit or Hemoglobin is completed at the following ages:

- Newborns (for high risk infants),
- 2 months (for high risk infants),
- 8-12 months,
- 18-24 months,
- 3-4 years, and
- 11-12 years.

10.11.12.2 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 6 (72 months).

Beginning at six (6) months of age and at each visit thereafter until six (6) years of age (72 months), 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 your 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.
10.11.13 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.

10.11.14 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 years, five years and eight years.
- Children who have had previous urinary tract infections should be re-screened more frequently.
- If test results are positive but the history and physical examination are negative, the child should be tested again in seven (7) days.
- If the results are positive a second time or if there are supportive findings in the history and physical examination from the first 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.

10.12.14 Other

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

10.12.15 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 www.cdc.gov/vaccines/recs/schedules/child-schedule.htm

### 10.12.16 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 section (section 10.12.10)

### 10.12.17 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 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

### 10.12.18 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 (Section 10.13 Interpreter Services).
10.13 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

10.13.1 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 (Section 2.1, Quick Address and Telephone 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.

10.13.2 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.
10.13.3 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 Mental Retardation (ICF-MR)
  - 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

10.13.4 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 V65.19
- The procedure code for interpretation services is T1013 and should be billed with the appropriate number of units provided.
  - 1 unit = 15 minutes of service.
- When not providing services in-person the GT modifier must be used.

10.13.5 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.
10.14 **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 certification number
- Providers may bill Medicaid only for those lab services they have performed themselves. Medicaid does not cover reference lab services.

**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.

10.14.1 **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 (Section 2.2, Quick Website Reference) located on Medicaid website for actual coverage and fees. Content is subject to change at any time, without notice.
<table>
<thead>
<tr>
<th>CLIA CERTIFICATE TYPE</th>
<th>ALLOWED TO BILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>REGISTRATION, COMPLIANCE, OR ACCREDITATION (LABORATORY) (1)</td>
<td>78110 78111 78120 78121 78122 78130 80000-89999</td>
</tr>
<tr>
<td></td>
<td>78191 78267 78268 78270 78271 78272</td>
</tr>
<tr>
<td>AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)</td>
<td></td>
</tr>
<tr>
<td>PROVIDER-PERFORMED MICROSCOPY PROCEDURES (PPMP) (4)</td>
<td>Q0111 Q0112</td>
</tr>
<tr>
<td></td>
<td>Q0113 Q0114</td>
</tr>
<tr>
<td></td>
<td>Q0115 81015</td>
</tr>
<tr>
<td></td>
<td>81000 81001</td>
</tr>
<tr>
<td></td>
<td>81020 89055</td>
</tr>
<tr>
<td></td>
<td>G0027 89190</td>
</tr>
<tr>
<td>AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)</td>
<td></td>
</tr>
<tr>
<td>WAIVER (2)</td>
<td>81002 81025 82270 82272 82962 83026 84830</td>
</tr>
<tr>
<td></td>
<td>85013 85651 80047QW 82330QW 82374QW 82435QW 82565QW</td>
</tr>
<tr>
<td></td>
<td>82947QW 82950QW 82951QW 82952QW 84132QW 84295QW 84520QW</td>
</tr>
<tr>
<td></td>
<td>85014QW 80048QW 80051QW 80053QW 80061QW 82465QW 83718QW</td>
</tr>
<tr>
<td></td>
<td>84478QW 84460QW 84450QW 80069QW 80178QW 81003QW 82044QW</td>
</tr>
<tr>
<td></td>
<td>82570QW 84703QW 81007QW 82010QW 82040QW 82150QW 82247QW</td>
</tr>
<tr>
<td></td>
<td>82310QW 82977QW 84075QW 84155QW 82043QW 82055QW 82120QW</td>
</tr>
<tr>
<td></td>
<td>83986QW 82271QW 82274QW G0328QW 82550QW 83036QW 82679QW</td>
</tr>
<tr>
<td></td>
<td>83002QW 82985QW 83001QW 83037QW 83065QW 83655QW 83721QW</td>
</tr>
<tr>
<td></td>
<td>83880QW 84443QW 85018QW 85576QW 85610QW 86294QW 86308QW</td>
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<tr>
<td></td>
<td>86318QW 86618QW 86701QW 86803QW 87077QW 87210QW 87449QW</td>
</tr>
<tr>
<td></td>
<td>87804QW 87807QW 87808QW 87809QW 87880QW 87899QW 89300QW</td>
</tr>
<tr>
<td>AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)</td>
<td></td>
</tr>
</tbody>
</table>

| NO CERTIFICATION | 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

<table>
<thead>
<tr>
<th>CODES EXCLUDED FROM CLIA REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>80103 80500 80502 81050 82075 83013 83014 83987 84061 86077</td>
</tr>
<tr>
<td>86078 86079 86485 86490 86510 86580 86891 86910 86912 86923</td>
</tr>
<tr>
<td>86927 86930 86931 86932 86945 86950 86960 86965 86985 86999</td>
</tr>
<tr>
<td>87900 88305(TC) 88311 88312(TC) 88313(TC) 88314(TC) 88329 88720 88738 88740</td>
</tr>
<tr>
<td>88304(TC) 88741 89049 89220 89398</td>
</tr>
</tbody>
</table>

10.14.2 Genetic Testing

Procedure Codes: 81201-81355; 96040

10.14.2.1 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; 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.

10.14.2.2 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 \textit{BRCA1} or \textit{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

**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 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
• Internal medicine
• Internal medicine, medical oncology
• General surgery

10.14.2.3 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 (Section 2.1, Quick Address and Telephone 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 (Section 2.1, Quick Address and Telephone 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.

10.15 Physician and Nurse Practitioner Services

The following mid-level practitioners are able to bill for services provided in a physician or nurse practitioner’s office, under their direct supervision, using the physician’s Medicaid provider number:

• Physician Assistant - Physician Assistants may enroll individually, but can only receive payment for Medicare crossovers.
• Licensed Master’s Level Counselors.

10.15.1 Covered Services

Medicaid covers almost all services provided by practitioners, including limited preventative care. This section provides covered services information that applies specifically to services performed by physicians, mid-level practitioners, independent labs, independent imaging facilities, and independent diagnostic testing facilities including:

• Abortion
• Anesthesia Services
• Dermatology
• Diabetic Training
• Family Planning
• Hysterectomies
• Imaging Services
• Immunizations
• Incentive Payments
• Injections
• Interpretation Services
• Laboratory Services
• Locum Tenens
• Maternity Care
• Medical Supplies
• Practitioner Visits
• Pregnant by Choice/Family Planning Waiver
• Preventative Medicine
• Psychiatric Services
• Public Health Services
• Screening, Brief Intervention, Referral and Treatment (SBIRT)
• Sterilization
• Surgical Services
• Tamper Resistant Rx Pads
• Telehealth
• Transplant Policy
• Vision Services

10.15.2 Abortion

**Procedure Code Range: 59812-59857**

10.15.2.1 Covered Services

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

- The client suffers from a 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 of death unless an abortion is performed;
- The pregnancy is the 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
• The pregnancy is the result of incest.

10.15.2.2 Reimbursement Requirements
The Abortion Certification Form (Section 6.14.3.2) must accompany all claims from the attending practitioner, assistant surgeon, anesthesiologist, pathologist and hospital. The attending practitioner 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 hydatidiform 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 (Section 6.14.3.2) is completed prior to performing the induced abortion.

10.15.3 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

10.15.3.1 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 the review the Medicaid fee schedule on the website or contact Provider Relations (Section 2.1, Quick Address and Telephone Reference).

### 10.15.3.2 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 1 hour 5 minutes.
  - For example, 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.
- 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 deliver), 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.

### 10.15.3.3 Obstetrical Exceptions

- Procedure code 01967 is a global fee per the fee schedule and should be billed as 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.

### 10.15.3.4 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.
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal healthy client.</td>
<td>No change</td>
</tr>
<tr>
<td>P2</td>
<td>A client with mild systemic disease.</td>
<td>No change</td>
</tr>
<tr>
<td>P3</td>
<td>A client with severe systemic disease.</td>
<td>Additional 5%</td>
</tr>
<tr>
<td>P4</td>
<td>A client with severe systemic disease that is a constant threat to life.</td>
<td>Additional 10%</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund client who is not expected to survive without the operation.</td>
<td>Additional 15%</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead client whose organs are removed for donor purposes</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**NOTE:** The use of other optional modifiers may be appropriate.

**10.15.3.5 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.
- 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 deliver), documentation must be submitted with the claim to support the necessity of these services.

**10.15.4 Dermatology**

Medicaid covers medically necessary services rendered in the treatment of dermatological illnesses.
10.15.4.1 Covered Services

- Acne surgery due to disfigurement requires prior authorization (Section 6.12, 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.

10.15.4.2 Benign Lesion Removal and Destruction of Benign or Premalignant Lesions

**Procedure Code Range:** 11400-11446 (Removal)
**Procedure Code Range:** 17106-17111 (Destruction)

10.15.4.2.1 Covered Services

Benign skin lesions include seborrheic keratoses, sebaceous (epidermoid) cysts, skin tags, milia (keratin-filled cysts), nevi (moles) acquired hyperkeratosis (keratoderma), papillomas, hemangiomas and viral warts.

10.15.4.2.2 Billing Requirements

Prior authorization 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 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 body area to another, particularly in immunosuppressed patients.
- Lesions are condyloma acuminata or molluscum contagiosum.
- Cervical dysplasia or pregnancy associated with genital warts

**NOTE:** Wyoming Medicaid does not consider removal of skin lesions to improve appearance 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.

**10.15.4.2.3 Documentation Requirements**

- Complete Prior Authorizations Form (Section 6.12)
- One or more of the above conditions, clearly documented in the medical record, operative report or pathology report

**10.15.5 Diabetic Training**

Physicians and nurse practitioners managing a client’s diabetic condition are responsible for ordering diabetic training sessions. Certified Diabetic Educators (CDE) or dieticians employed by a physician, nurse practitioner, or facility may furnish outpatient diabetes self-management training.

**Procedure Code Range:** G0108-G0109
10.15.5.1 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

10.15.5.2 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, 1 unit equals 30 minutes. A maximum of 2 units applies.
- For group services, 1 unit equals 30 minutes. A maximum of 5 units per individual per training session applies.
- Billing is to be done under the physician, nurse practitioner or hospital’s provider number.

10.15.5.3 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.

10.15.6 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

10.15.6.1 Covered Services

- Sterilization procedures are covered only when all Medicaid guidelines have been met (Section 6.14.1, Sterilization Consent Guidelines)
- 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

10.15.6.2 Limitations

An Evaluation/Management code will not be reimbursed if performed on the same day as any one of the following procedures:

- Insertion of implantable capsules. (This code does not include the cost of the contraceptive.)
- Removal of implantable contraceptive capsules.
- Removal with reinsertion of implantable contraceptive capsules. (This code does not include the cost of the contraceptive.)

NOTE: Pregnant by Choice/Family Planning Waiver has specific covered and non-covered services. The plan information can be found in section 10.16

10.15.7 Hysterectomies

Procedure Code Range: 58150-58294

Refer to the following sections for information:

- Section 6.14.2, Hysterectomy Acknowledgement of Consent
  - Section 6.14.2.2, Hysterectomy Consent Form
  - Section 6.14.2.1, Instructions for Completing the Hysterectomy Acknowledgement Consent Form
10.15.8 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.

10.15.8.1 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, you 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 CDC regional cap of $14.31 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
  - Use CPT-4 code, 90649, for HPV Types 6, 11, 16, and 18 (quadrivalent)
  - Administer intramuscularly as three separate doses, with the first dose given at an elected date, second dose given 2 months after the first dose and the third dose given six-months after the first dose.
  - If the client turns 19 years of age between the 2nd and 3rd dose administration, a WyVIP supplied vaccine may still be used for the 3rd dose. This only applies in situations where the 1st and 2nd doses were given BEFORE the client turned 19.
  - If the vaccine is supplied by WyVIP, bill code 90649 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.

• Influenza Vaccine
  - Medicaid covers influenza vaccines for clients considered at risk.
  - 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 100% of invoice cost along with the administration code.
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 clients considered at risk.
  - 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**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td>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</td>
</tr>
<tr>
<td>90461</td>
<td>Each additional vaccine/toxoid component (list separately in addition to code for 1&lt;sup&gt;st&lt;/sup&gt; component) for age 0-18</td>
</tr>
</tbody>
</table>

**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.

**10.15.8.1.1 Billing Examples**

Example 1: Provider administers the HPV vaccine, state supplied with physician counseling:

<table>
<thead>
<tr>
<th>DOS (24A)</th>
<th>Procedure Code (24C)</th>
<th>Charges (24F)</th>
<th>Units (24G)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/10</td>
<td>90649</td>
<td>$0.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/10</td>
<td>90460</td>
<td>$21.72</td>
<td>1</td>
</tr>
</tbody>
</table>

Example 2: Provider administers Tdap, MMR and Influenza. All are state supplied with physician counseling:

<table>
<thead>
<tr>
<th>DOS (24A)</th>
<th>Procedure Code (24C)</th>
<th>Charges (24F)</th>
<th>Units (24G)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/10</td>
<td>90707</td>
<td>$0.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/10</td>
<td>90715</td>
<td>$0.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/10</td>
<td>90656</td>
<td>$0.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/10</td>
<td>90460</td>
<td>$65.16</td>
<td>3</td>
</tr>
<tr>
<td>01/10/10</td>
<td>90461</td>
<td>$0.00</td>
<td>4</td>
</tr>
</tbody>
</table>

Explanation of Example 2: 3 units of 90460 (1 for each vaccine administered to indicate each 1<sup>st</sup> component) and 4 units of 90461 (1 for each additional component in the Tdap and the MMR vaccine beyond the 1<sup>st</sup>).
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:

<table>
<thead>
<tr>
<th>DOS (24A)</th>
<th>Procedure Code (24C)</th>
<th>Charges (24F)</th>
<th>Units (24G)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/11</td>
<td>90649 SL</td>
<td>$0.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/11</td>
<td>90471</td>
<td>$14.00</td>
<td>1</td>
</tr>
</tbody>
</table>

Example 5: Provider administers Tdap, MMR and Influenza, all state supplied, without physician counseling:

<table>
<thead>
<tr>
<th>DOS (24A)</th>
<th>Procedure Code (24C)</th>
<th>Charges (24F)</th>
<th>Units (24G)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/11</td>
<td>90707 SL</td>
<td>$0.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/11</td>
<td>90715 SL</td>
<td>$0.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/11</td>
<td>90656 SL</td>
<td>$0.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/11</td>
<td>90471</td>
<td>$14.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/11</td>
<td>90472</td>
<td>$28.00</td>
<td>2</td>
</tr>
</tbody>
</table>

Explanation of Example 5: 1 unit of 90471 for the first vaccine, and 2 units of 90472 for the other 2 vaccines.

NOTE: WyVIP is not intended for private pay patients.
10.15.8.2 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:
    - Prevention of serious RSV disease in patients with a history of prematurity (less than 28 weeks gestation) up to 12 months of age or infants born at 29-32 weeks of gestation up to 6 months of age
    - Prevention of serious RSV disease in children with hemodynamically significant congestial heart disease and
    - Prophylaxis of infants with severe immune deficiency exposed to RSV.
  - 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 (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 6 hour allotment is suggested.
  - Synagis may be billed one of two ways:
    - Supplied by a pharmacy and injected at the physician’s office.
      - Retail pharmacies may not have Synagis in stock due to the expense, but most are able to obtain it within a day or two of notification. Call the prescription into the pharmacy to determine availability. This will prevent the client from making two (2) trips to the pharmacy.
      - The pharmacy will submit their claim for the medication using an NDC.
      - 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, along with the
procedure code 90378 and appropriate NDC for the Synagis and the 90772 for the injection fee.
- The units for the Synagis must be billed per 50MG.
- The invoice must be attached to the claim indicating the cost to the physician for the medication.
- If the vial was used on additional clients, it must be documented and kept in the clients’ records.
- If there is unused medication, the physician will be reimbursed for the entire vial. Again, keep in mind that every effort should be used to make sure that the least amount is wasted.

NOTE: Because of the cost associated with Synagis, only one 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 (Section 2.2, Quick Website Reference).

10.15.9 Incentive Payment Program

NOTE: In March of 2013, the Affordable Care Act required payment by State Medicaid agencies of at least the Medicare rates in effect in calendar years 2013 and 2014 for primary care services furnished by the physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. Evaluation and Management (E&M) codes 99201 – 99499, 90460, 90471, 90472, 90473, and 90474 that are currently covered by Wyoming Medicaid will be eligible for supplemental payments.

Physician Attestation is a requirement of the ACA to receive supplemental payments; as such Wyoming Medicaid has provided a self-attestation form for the Wyoming Medicaid Primary Care Physicians to print and complete. This Physician Attestation will be replacing the current Incentive Payment Program for the years 2013, and 2014.
Physician Attestation communication and form can be found on the website (Section 2.2, Quick Website Reference).

Each year Medicaid provider’s may enroll, or recertify, as incentive payment providers if they serve a disproportionate share of Medicaid clients for the specific procedures which are associated with primary care, obstetric, newborn and pediatric care.

In order to qualify for an incentive payment, a provider must complete the Certification of Disproportionate Share Form (Section 10.15.9.1). This form certifies that 25% or more of the total patients seen in the practice (individual or group) during the provider’s most recent fiscal reporting of at least six-months, were Medicaid clients. Documentation must be available upon request by the Division of Healthcare Financing for audit purposes.

Providers may apply any time after the minimum requirement has been met. In addition, the form is mailed in May every year to all providers that have qualified in the past year. Re-certification is required every June. Upon receipt of the completed certification, Medicaid will advise the provider of the approval date. From that date, the provider will receive an additional 10% over the Medicaid allowed fee for the specific procedure codes listed. In no case will the Medicaid reimbursement exceed the billed charge.
### Incentive Procedure Codes

#### Evaluation and Management Codes

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99215</td>
<td>Evaluation and Management Codes</td>
</tr>
</tbody>
</table>

#### Preventive Codes

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381-99385</td>
<td>New client</td>
</tr>
<tr>
<td>99391-99395</td>
<td>Established client</td>
</tr>
</tbody>
</table>

#### Maternity Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>Total routine obstetric care, vaginal delivery</td>
</tr>
<tr>
<td>59409</td>
<td>Vaginal delivery only</td>
</tr>
<tr>
<td>59410</td>
<td>Vaginal delivery including postpartum care</td>
</tr>
<tr>
<td>59425</td>
<td>Antepartum care only; 4th, 5th, and 6th visits</td>
</tr>
<tr>
<td>59426</td>
<td>Antepartum care only; 7th or more visits</td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum visit - separate</td>
</tr>
<tr>
<td>59500</td>
<td>Total routine obstetric care, C-section delivery</td>
</tr>
<tr>
<td>59514</td>
<td>C-section delivery only</td>
</tr>
<tr>
<td>59515</td>
<td>C-section delivery including postpartum care</td>
</tr>
<tr>
<td>59610</td>
<td>Global care, vaginal delivery, following previous C-section</td>
</tr>
<tr>
<td>59612</td>
<td>Vaginal delivery only, after previous C-section</td>
</tr>
<tr>
<td>59614</td>
<td>Vaginal delivery only, after previous C-section including postpartum care</td>
</tr>
<tr>
<td>59618</td>
<td>Global care, C-section delivery, following attempted vaginal delivery after previous C-section</td>
</tr>
<tr>
<td>59620</td>
<td>C-section delivery only, following attempted vaginal delivery after previous C-section</td>
</tr>
<tr>
<td>59622</td>
<td>C-section delivery including postpartum care, following attempted vaginal delivery after previous C-section</td>
</tr>
</tbody>
</table>

### Hospital Codes - Newborn Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99460</td>
<td>History and exam, normal newborn</td>
</tr>
<tr>
<td>99462</td>
<td>Subsequent care, each day</td>
</tr>
</tbody>
</table>
10.15.9.1 Medicaid’s Incentive Pay Program Certification Form of Disproportionate Share

I hereby certify that 25% or more of the total patients seen in this practice or 25% or more of the pregnant patients who were seen by a physician, nurse practitioner, or nurse midwife in this group practice during the most current fiscal reporting period of at least six (6) months were Medicaid clients.

Complete the option, which qualifies your practice for incentive payment:

_________ Total number of patients
_________ Total number of Medicaid clients

OR

_________ Total number of pregnant patients
_________ Total number of pregnant Medicaid clients

Reporting period_____________________ to ___________________.
month/year    month/year

FOR AUDIT PURPOSES, DOCUMENTATION MUST BE AVAILABLE FOR REVIEW BY DIVISION OF HEALTHCARE FINANCING UPON REQUEST.

I understand that recertification will be required every twelve (12) months from the date I am certified as a disproportionate provider.

Billing Provider NPI Number: ______________________________

Billing Provider Name: ______________________________

Billing Provider Address: ______________________________

________________________________________

Signature: ______________________________

Date: ______________________________

A provider’s form must be received by June 30 of the current year in order to qualify for the July 1-June 30 dates of the coming year. If forms are received after that date, they will not be made retroactive - instead they will become eligible as of the date received.

Return To:
Wyoming Medicaid
ATTN: Provider Relations
PO Box 667
Cheyenne, WY 82003-0067
10.15.10 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 (Section 6.5.4, 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 code.

For an accurate listing of codes, refer to the fee schedule on the Medicaid/EqualityCare website (Section 2.2, Quick Website Reference).

10.15.10.1 Belimuab (Benlysta®) Criteria

Procedure Code: J0490

10.15.10.1.1 Covered Services

Belimumab is covered and considered medically necessary if the below requirements are met.

10.15.10.1.2 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 of the following:**
  - The patient is currently on a standard of care SLE treatment regimen comprised of at least one of the following: corticosteroids, hydroxychloroquine, chloroquine, nonsteroidal anti-inflammatory drugs (NSAIDS), aspirin, and/or immunosuppressives (azathioprine, methotrexate, cyclosporine, oral cyclophosphamide, or mycophenolate)
  - The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the standard of care drug classes listed above
- The patient does NOT have severe active lupus nephritis [proteinuria >6 g/24 hour or equivalent or serum creatinine >2.5 mg/dL OR required hemodialysis or high-dose prednisone >100 mg/day] within the past 90 days
- The patient does NOT have severe active central nervous system lupus [e.g. seizures, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis, CNS vasculitis requiring therapeutic intervention] within the past 60 days
- The patient has NOT been treated with intravenous cyclophosphamide in the previous 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 2-week intervals for the first 3 doses and at 4-week intervals thereafter

NOTE:  Length of Approval:  12 months

10.15.10.2 Botox®, Dysport®, and Myobloc®

Procedure Code Range:  J0585 - J0587

10.15.10.2.1 Covered Services
Botulinum toxin type A (e.g., onabotulinumtoxinA [Botox®], or abobotulinumtoxinA [Dysport®]) or B (fimabotulinintoxinB [Myobloc®] for the treatment of the following conditions and are considered medically necessary when specific criteria is met.

10.15.10.2.2 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:
     - Duane’s syndrome with lateral rectus weakness
     - Restrictive strabismus
- Strabismus secondary to prior surgical over-recession of the antagonist
- Strabismus deviations more than 50 prism diopters
- 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** of the following:
     - Axillary
     - Palmar
  2) Treatment is not adequately managed with topical agents
  3) The condition causes **ANY ONE** of the following:
     - Functional impairment
     - 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** (e.g. Hemifacial spasms)

Wyoming Medicaid considers Botulinum toxin type A (e.g., onabotulinumtoxinA [Botox®], or abobotulinumtoxinA [Dysport®]) or B (fimabotulinintoxinB [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 the following criteria met:

1) Initial 6-month trial for migraine headaches with ALL the following:
   - Occur fifteen days or more per month
   - Last four hours a day or longer
   - Experienced for 3 months or more
   - Symptoms persist despite adequate trials of a minimum of 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

2) Continuation of therapy after 6-month trial for the prevention of migraines with ANY ONE of the following:
   - Frequency reduced by at least 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.

10.15.10.3 Synvisc Injections (hyaluronan, hyaluronic acid, sodium hyaluronate, hylan polymers)

Procedure Code: J7325

10.15.10.3.1 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.

10.15.10.3.2 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 intra-articular corticosteroid injection

Repeat doses of any viscosupplement will be approved only when the following criteria are met:

• At least 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.

**NOTE:** **Limits on Synvise**

Euflexxa is injected into the affected knee, 20 mg once weekly for 3 weeks, a total of 3 injections.

Synvisc-One is injected into the affected knee, 48 mg for one dose only.

Synvisc is injected into the affected knee, 16 mg once weekly for 3 weeks, a total of 3 injections.

Hyalgan is injected into the affected knee, 20 mg once weekly for a total of 5 injections.

Orthovisc is injected into the affected knee, 30 mg once weekly for 3 or 4 injections.

Supartz is injected into the affected knee, 25 mg once weekly for a total of 5 injections.

Gel-One is injected into the affected knee, 30 mg, for one dose only.

10.15.10.4 Tysabri

**Procedure Code: J2323**

**10.15.10.4.1 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.

10.15.10.4.2 Billing Requirements

Prior authorization 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.

10.15.10.4.3 Documentation Requirements

- Physician’s prescription
- Complete Prior Authorization Form (Section 6.12)
- Must document an inadequate response to, or inability to tolerate an appropriate trial with at least one 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.

10.15.11 Interpretation Services

The Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (DHHS) Enforces Federal laws that prohibit discrimination by healthcare and human service providers that receive funds from the DHHS. Such laws include Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act of 1990.
In efforts to maintain compliance with this law and ensure that Medicaid clients receive quality medical services, interpretation service should be provided for clients who have Limited English Proficiency (LEP) or are deaf/hard of hearing. **The purpose of providing services must be to assist the client in communicating effectively about health and medical issues.**

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

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 is available on the Medicaid/EqualityCare website or upon request from Provider Relations (Section 2.1, Quick Address and Telephone 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

### 10.15.12 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 (g) certification number
• Providers may bill Medicaid only for those lab services they have performed themselves. Medicaid does not cover reference lab services

**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.

**10.15.12.1 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/EqualityCare website for actual coverage and fees. Content is subject to change at any time, without notice (Section 2.2, Quick Website Reference).

<table>
<thead>
<tr>
<th>CLIA Certificate Type</th>
<th>Allowed to Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>78110 78111 78120 78121 78122 78130 80000-89999</td>
</tr>
<tr>
<td></td>
<td>78191 78267 78268 78270 78271 78272</td>
</tr>
<tr>
<td>Registration, Compliance, or Accreditation [Laboratory (1)]</td>
<td>And all Codes Excluded from CLIA Requirements (Refer to table below).</td>
</tr>
<tr>
<td>Provider-Performed Microscopy Procedures (PPMP) (4)</td>
<td>80061 85018 82570 87449 82952 89190 84703</td>
</tr>
<tr>
<td></td>
<td>81007 86294 82951 81000 83002 84443 QW 85014</td>
</tr>
<tr>
<td></td>
<td>82120 87077 83001 89055 83605 81003 86038</td>
</tr>
<tr>
<td></td>
<td>82523 89300 83518 82010 QW 84478 82055 86618</td>
</tr>
<tr>
<td></td>
<td>82950 81020 84460 81002 85013 82465 87880</td>
</tr>
<tr>
<td></td>
<td>82985 Q0112 84999 82044 85651 82947 81015</td>
</tr>
<tr>
<td></td>
<td>83036 80101 85610 82274 86318 82962 Q0111</td>
</tr>
<tr>
<td></td>
<td>83986 81205 86308 82679 87804 83026 84445 QW</td>
</tr>
<tr>
<td></td>
<td>84830 82270 81001 83718 85576 QW</td>
</tr>
<tr>
<td>And all Codes Excluded from CLIA Requirements (Refer to table below).</td>
<td></td>
</tr>
</tbody>
</table>
And all Codes Excluded from CLIA Requirements (Refer to table below).

| No Certification | All codes excluded from CLIA requirements (see below). |

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

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### 10.15.12.2 Genetic Testing

**Procedure Codes**: 83891 and 88385-88386

#### 10.15.12.2.1 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; and
- Genetic testing of children might confirm current symptomatology or predict adult onset diseases and finding might result in medical benefit to the child or as the child reaches adulthood.

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**Codes Excluded from CLIA Requirements**

<table>
<thead>
<tr>
<th>Codes Excluded from CLIA Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0050 80100 80102 80103 80050 80072 80422 80430 80432 80434 80435 80500 80502</td>
</tr>
<tr>
<td>81050 82016 82017 82075 82127 82136 82139 82247 82248 83013 83014 83019 84019</td>
</tr>
<tr>
<td>84061 85095 85102 86077 86078 86079 86485 86490 86510 86850 86856 86891 86910</td>
</tr>
<tr>
<td>86911 86915 86927 86930 86931 86932 86945 86950 86955 86965 86995 86999 88040 88045</td>
</tr>
<tr>
<td>88125 88170 88171 88240 88304(26) 88305(26) 88311 88329 883313 88314 88329 89100 89105</td>
</tr>
<tr>
<td>89130 89132 89135 89136 89140 89141 89250 89251 89252 89254 89255 89256 89257</td>
</tr>
</tbody>
</table>
10.15.12.2 Billing Requirements

Enrolled laboratories should bill Medicaid directly for genetic testing, refer to Section 10.14.2.

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:
  - 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.

10.15.13 Locum Tenens

Locum tenen is a substitute practitioner that stands-in for a practitioner who is either on vacation or changing practices.

10.15.13.1 Billing Requirements

- Use the practice’s or the practitioner’s NPI number; or
- Use the locum tenen’s NPI number, if the locum tenen is enrolled with the Medicaid Program and has been “set-up” as a treating provider with the practice

NOTE: When the locum tenen is assisting a surgeon, the services must be billed using the locum tenens NPI number.

10.15.13.2 Documentation

When services are billed with a locum tenen’s number, the medical records will need to substantiate the service that was provided by the locum tenen.

10.15.14 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

10.15.14.1 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 weeks’ gestation, biweekly visits to 36 weeks’ 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** of the following two antepartum procedure codes (depending on the total number of antepartum visits):
  - 59425 – Antepartum care only; 4-6 visits. This code would be used in the case where the patient was only seen for 4 to 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 4
times and no more than 6 times, this is the correct code the provider would submit.

- **59426** – Antepartum care only; 7 or more visits. This code would be used for the patient who was seen for 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 you need to treat the patient for additional services due to complication of pregnancy, use the proper CPT and ICD-9 codes to reflect the complication.
- If you attempt to bill a separate E/M visit and only code the encounter as a normal pregnancy code, (V22.0 or V22.1) 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 separate delivery codes for the delivery of twins except, when one 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.
NOTE: Refer to Section 6.14.1, 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 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 only pay for two (2) routine ultrasounds per pregnancy.

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.

10.15.15 Medical Supplies (Disposable)

Disposable medical supplies are intended for one-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 (Section 2.2, Quick Website 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.

**Procedure Code Range: 99070**

10.15.16 Practitioner Visits

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

**Procedure Code Range: 99201-99443**

10.15.16.1 New Client

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 years, or more.

**Procedure Code Range: 99201-99205**

10.15.16.2 Established Client

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.

**Procedure Code Range: 99211-99215**
10.15.16.3 After Hour 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.

<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99050</td>
<td>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</td>
</tr>
<tr>
<td>99051</td>
<td>Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service</td>
</tr>
<tr>
<td>99058</td>
<td>Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service</td>
</tr>
</tbody>
</table>

NOTE: Do not use these codes for seeing clients in the emergency room.

10.15.16.4 Consultation Services

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.

**Procedure Code Range: 99241-99245**

10.15.16.4.1 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 entered in field 17A or if the referring provider does not have an NPI, then the provider name must appear in field 17 of the CMS-1500 Claim Form

NOTE: For an accurate listing of codes, refer to the fee schedule on the Medicaid/EqualityCare website (Section 2.2, Quick Website Reference).
10.15.16.4.2 Documentation

Medicaid requires Documentation of Medical Necessity (Section 3.3, Medical Necessity) to be attached to a claim submitted by the consulting practitioner when a client is seen for an additional consultation within one year of the initial consultation.

10.15.16.5 Emergency Department Services

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 twenty-four hours a day.

Procedure Code Range: 99281-99288

10.15.16.5.1 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 (Section 2.1, Quick Address and Telephone Reference).

10.15.16.6 Home Visits

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.

Procedure Code Range: 99341-99350

10.15.16.6.1 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

10.15.16.7 Hospital Services

Procedure Code Range: 99221-99233

10.15.16.7.1 Limitations

• Medicaid will reimburse the admitting practitioner for only one initial visit per client for each hospital stay.
• A comprehensive inpatient hospital visit is not allowed within thirty 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.

10.15.16.7.2 Billing Requirements

• Initial Hospital Care (99221-99223) - All evaluation and management 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 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 (Section 3.3, Documentation of 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 body system;
  - The condition or injury is so severe or complex that one practitioner alone cannot handle the client’s care; and
  - The practitioners are actively co-managing the client’s treatment.

### 10.15.16.7.3 Critical Care Services

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.

**Procedure Code Range: 99291**

10.15.16.7.4 Prolonged Service

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 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 (Section 3.3, Medical Necessity).

**Procedure Code Range: face-to-face 99354-99357 and non-face-to-face 99358-99359**

10.15.16.7.5 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**
10.15.16.7.6 Inpatient Pediatric/Neonatal Critical Care

Procedure Code Range: 99291

10.15.16.7.6.1 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

10.15.16.7.6.2 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 sats.

In addition, specific services are included in the parenthetetic 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.

10.15.16.8 Nursing Facilities
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.

Procedure Code Range: 99304-99318

10.15.16.8.1 Covered Services
Practitioner services are covered when they are medically necessary and are performed to meet the requirements of continued long-term care.

10.15.16.8.2 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.

- Initial Nursing Facility Care Comprehensive Nursing Facility Assessments (99304-99306). Codes 99301-99303 are no longer valid
- Subsequent Nursing Facility Care per Day (99307-99310). Codes 99311-13 are no longer valid

10.15.16.8.3 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; thirty minutes or less
- 99316 Nursing Facility discharge day management, more than thirty minutes

**NOTE:** For an accurate listing of codes, refer to the fee schedule on the Medicaid/EqualityCare website (Section 2.2, Quick Website Reference).

10.15.16.9 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.

10.15.16.9.1 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/EqualityCare website (Section 2.2, Quick Website Reference).
10.15.16.10 Telephone Services

Procedure Code Range: 99441-99443, limited to physician use only

10.15.16.10.1 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

10.15.17 Preventive Medicine

Procedure Code Range: 99381-99379

10.15.17.1 Covered Services

For specific information on preventive health services for clients under age 21, refer to section 10.12, HealthCheck – 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 screening mammography per year after age 40. All mammograms require a referral.
- Annual gynecological exam including a Pap smear. One 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.

10.15.18 Psychiatric & Mental Health Services

10.15.18.1 Psychiatric Services

- Psychiatric Services - Medicaid covers medically necessary psychiatric and mental health services when provided by the following practitioners:
  - Psychiatrists or Physicians; or
The following practitioners that are employed and supervised by the psychiatrist/physician:

- A licensed master’s level counselor (LAT, LMFT, LPC or LCSW), or
- A licensed physician’s assistant.

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.

10.15.18.1.1 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:

- Licensed professional counselor (master’s level)
- Licensed clinical social worker
- Licensed marriage and family therapist
- Licensed addictions therapist
- 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.

10.15.18.1.2 Licensed Mental Health Professionals

Licensed Mental Health Professionals (LMHPs) are required to bill via a supervising psychiatrist/physician/psychologist’s National Provider Identifier (NPI) and are reimbursed at 75% of the full fee for CPT coded behavioral health services. Licensed Mental Health Professionals (LMHPs) must 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.

Different types of LMHP are required to be supervised by different levels of practitioners. In order to bill Wyoming Medicaid the LMHP must be enrolled as a member of the correct type of group. For information regarding these
requirements contact Provider Relations. (Section 2.1, Quick Address and Telephone Reference)

10.15.18.1.3 Supervision

Supervision is defined as the ready availability of the psychiatrist/physician or psychologist for consultation and direction of the activities of the mental health professionals in the office. Contact with the supervising practitioner (physician/psychiatrist or psychologist) 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.

10.15.18.2 Covered Services

The following matrix indicates the Psychiatrist and APN/PMHNP CPT-4 codes, the Medicaid defined unit (for codes without specific time spans in the CPT-4 book), acceptable modifiers, and maximum units allowed.

Span billing is not allowed for fee for service behavioral health services. Each date of service must be billed on its own separate line.

<table>
<thead>
<tr>
<th>Psychiatrists/Physicians &amp; APN/PMHNP Billing Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT-4 Code</strong></td>
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<tr>
<td>----------------</td>
</tr>
<tr>
<td>99201-99205</td>
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<tr>
<td>99211-99215</td>
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<tr>
<td>99217-99226</td>
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<tr>
<td>99231-99236</td>
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<tr>
<td>99238-99239</td>
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<td>99241-99245</td>
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<td>99251-99255</td>
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<td>99304-99318</td>
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<td>99324-99337</td>
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<tr>
<td>90833</td>
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<tr>
<td>90834</td>
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<tr>
<td>90836</td>
</tr>
</tbody>
</table>
**Psychiatrists/Physicians & APN/PMHNP Billing Codes**

<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>90837</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90838</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90845</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90846 - 90847</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90849</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90853</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90870</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>G9012</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

*This list of codes is not all-inclusive; it does not contain all codes that Psychiatrists/Physicians & APN/PMHNP can bill.

**NOTE:** Medicaid does not cover CPT-4 codes: 90863, 90865, 90875, 90876, 90880, 90882, 90885, 90887, 90889 and 90899.

The following matrix indicates the CPT-4 codes specific to psychological services, the Medicaid defined unit (for codes without specific time spans in the CPT-4 book), acceptable modifiers, and maximum units allowed.

**Psychologist Billing Codes**

<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>9201-9255, 99304-99337 &amp; 99341-99359</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90785</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90791</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90832</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90833</td>
<td>CPT Defined</td>
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<tr>
<td>90834</td>
<td>CPT Defined</td>
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<tr>
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<td>CPT Defined</td>
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<td>CPT Defined</td>
</tr>
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<tr>
<td>90845</td>
<td>CPT Defined</td>
</tr>
</tbody>
</table>
### Psychologist Billing Codes

<table>
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<tr>
<th>CPT-4 Code</th>
<th>Unit</th>
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<tbody>
<tr>
<td>90846-90847</td>
<td>CPT Defined</td>
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<tr>
<td>90849</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>90853</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>96101-96125</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>99366</td>
<td>CPT Defined</td>
</tr>
<tr>
<td>G9012</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

Licensed Mental Health Professionals who are supervised by a psychiatrist / physician or psychologist have the following HCPCS Level II codes available to them for service provision:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td>Clinical Assessment</td>
<td>Contact with the enrolled client and/or collaterals for the purpose of completing an evaluation of the client’s mental health/substance abuse disorder(s) and treatment needs, including psychological testing if indicated, and established a Diagnostic and Statistical manual of Mental Disorders (DSM – latest edition) diagnosis</td>
</tr>
<tr>
<td>H2019</td>
<td>Office-Based Individual/Family Therapy</td>
<td>Office-based contact with a client and/or collaterals for the purpose of developing and implementing a treatment plan for an individual client or family. The services shall be targeted at reducing or eliminating specific symptoms or behaviors that are identified in the treatment plan.</td>
</tr>
<tr>
<td>H2019 + HQ modifier</td>
<td>Group Therapy</td>
<td>Contact with two (2) or more unrelated clients and/or collaterals for the purpose of implementing each client’s treatment plan</td>
</tr>
<tr>
<td>H2021</td>
<td>Community-Based Individual/Family Therapy</td>
<td>Contact outside the psychologist’s office with the client and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the client.</td>
</tr>
</tbody>
</table>
10.15.18.3 Limitations

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.

10.15.18.4 Documentation

Documentation of the services must contain the following:

- Name of the individual
- Identify the covered services provided
- Identify the date, length of time (start and end times), and location of the service
- Identify all persons involved
- Be legible and contain complete written medical records that accurately describe the medical services rendered to the patient, including the patient’s history, pertinent findings, examination, results, test results and all treatment provided.
- Full signature, including licensure of the clinical professional involved

10.15.18.5 Billing Requirements

All services must be provided under the supervision of a physician/psychiatrist or psychologist and billed using the supervising practitioners National Provider Identifier (NPI) number. Licensed Mental Health Professionals (LMHPs) must 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.

Different types of LMHP are required to be supervised by different levels of practitioners. In order to bill Wyoming Medicaid the LMHP must be enrolled as a member of the correct type of group. For information regarding these requirements contact Provider Relations. (Section 2.1, Quick Address and Telephone Reference)

- Interpretations or explanation of results of psychiatric services to family members or other responsible persons is included in the fee for psychotherapy.

10.15.18.5.1 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 three (3) months.

Treatment plans must also:
- Be developed by qualified provider(s) working within the State scope of practice acts with significant input from the individual, individual’s family, the individual’s authorized healthcare decision maker and/or persons of the individual’s choosing;
- Ensure the active participation of the individual, individual’s family, the individual’s authorized healthcare decision maker and/or persons of the individual’s choosing in the development, review and modification of these goals and services;
- Specify the individual’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 addressed;
- Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder;
- Identify the methods that would be used to deliver services;
- Specify the anticipated outcomes;
- 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 three months;
- 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
- Document that the services have been determined to be rehabilitative services consistent with the regulatory definition;
- Include the name of the individual; and
- The date of the rehabilitative services or services provided; and
- The nature, content, and units of rehabilitative services provided; and
- The progress made toward functional improvement and attainment of the individual’s goals.

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

10.15.18.6.1 Billing Requirements
- Submit PASRR Level II claims to the Medicaid Program.
- PASRR Level II assessments should be sent to Xerox Care and Quality Solutions (Utilization and Care Management) (Section 2.1, Quick Address and Telephone Reference)
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).

Non-Covered Services

Services not covered by Medicaid include, but are not limited to the following:

- Acupuncture
- Naturopath service
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- Services considered experimental, investigational, or complimentary
- Medicaid does not cover services that are not direct client care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone service in home

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).

10.15.20.1 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.

10.15.20.2 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 (Section 2.1, Quick Address and Telephone 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.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Professional Component</td>
<td>70% of allowed fee</td>
</tr>
<tr>
<td>TC</td>
<td>Technical Component</td>
<td>30% of allowed fee</td>
</tr>
</tbody>
</table>

10.15.20.3 Limitations
- Screening mammographies are limited to a baseline mammography between ages 35 and 39; one screening mammography per year after age 40. 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.

10.15.21 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.

10.15.21.1 Covered Services and Billing Codes:

Acceptable billing providers for SBIRT include:

• Physician- (all 20X taxonomy types)
• Public Health Clinic- (251K00000X)
• FQHC- 261QF0400X
• RHC – 261QR1300X
• 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 fifteen(15) minute units – Maximum of 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.

10.15.21.2 Limitations

SBIRT services will not be covered for clients with services limited to emergency services only.

10.15.22 Sterilizations and Hysterectomies

Procedure Code Range: 58150-58294, 58541-58554, 58600-58720

10.15.22.1 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 (Section 6.14.1, 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 (Section 10.15.11, Interpretation Services).

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

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

10.15.22.2 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 orchietomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:
• A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one 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 (Section 6.14.2, 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 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 (Section 10.16).

10.15.23 Surgical Services

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.

Procedure Code Range: 10021-69990

10.15.23.1 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 related 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 postanesthesia 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).

10.15.23.2 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.)

10.15.23.3 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/EqualityCare website (Section 2.2, Quick Website Reference).

10.15.23.4 Billing Requirements

10.15.23.5 All surgical claims for reimbursement for multiple surgical procedures must have an operative report attached. 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/EqualityCare website for the most accurate fee schedule (Section 2.2, Quick Website 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 one unit of service on line one and one 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:

<table>
<thead>
<tr>
<th>Line</th>
<th>Unit</th>
<th>CPT Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>1</td>
<td>69433</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>1</td>
<td>69433</td>
<td>50</td>
</tr>
</tbody>
</table>

**NOTE:** Operative reports are required for bilateral procedures.

**10.15.23.6 Assistant Surgeon**

Assistant surgeon fees are billed with an 80 modifier using the same procedure code billed by the primary surgeon.

**10.15.23.7 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 should 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 APP/APP acts as an “extra” pair of hands and not a surgical assistant in place of another surgeon.
10.15.23.8 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.

10.15.23.9 Modifiers

Medicaid recognizes the following list of modifiers when used in conjunction with CPT-4 surgical procedure codes:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Unusual Procedural Services - An operative report is required.</td>
<td>Allowed fee plus 20%</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedures</td>
<td>75% of allowed fee</td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedures</td>
<td>50% of allowed fee</td>
</tr>
<tr>
<td>62</td>
<td>Two (2) Surgeons - An operative report is required.</td>
<td>100% of allowed fee</td>
</tr>
<tr>
<td>80</td>
<td>Assistant Surgeons</td>
<td>20% of allowed fee</td>
</tr>
<tr>
<td>AS</td>
<td>Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery</td>
<td>15% of allowed fee</td>
</tr>
</tbody>
</table>

10.15.23.10 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 6.12 for Prior Authorization procedures and Section 2.1 for the Address and Telephone Reference. The fee schedule on the Medicaid/EqualityCare website indicates which codes require prior authorization (Section 2.2, Quick Website Reference).
10.15.23.11 Oral and Maxillofacial Surgeons

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.

**Procedure Code Range: 21010-21499**

**Covered Services:**
- Removal of tumor
- Maxillofacial Prosthetics – Introduction and Removal
- Repair, Revision and/or Reconstruction
- Temporomandibular Joint (TMJ) Treatment

**Procedure Code Range: 40490-42999**

**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)

**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 (Section 2.2, Quick Website Reference).

10.15.23.12 Breast Reconstruction
Procedure Code Range: 19316-19499

10.15.22.12 Covered Services
Breast reconstruction following breast cancer treatment

10.15.22.12 Billing Requirements
Prior authorization requirements:

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 include 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)

10.15.23.13 Breast Reduction

Procedure Code Range: 19318

10.15.22.13.1 Covered Services
Breast reductions are covered and considered medically necessary if the below requirements are met.

10.15.22.13.2 Billing Requirements
Prior authorization requirements:

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 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.

10.15.22.13.3 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

10.15.23.14 Cochlear Device, Implantation and Replacement

Procedure Code Range: 69930

10.15.23.14.1 Covered Services

Wyoming Medicaid has instituted the following policy for Cochlear Device Implantation and Replacement. Medicaid reimburses for the implant, external processor and headset.

10.15.23.14.2 Billing Requirements

Prior authorization is required for the procedure, device and replacement device only. (Section 6.12, Prior Authorization) Medicaid clients must meet all the following criteria:

- There must be a diagnosis of bilateral profound (90 db 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 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 twelve (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.

10.15.23.14.3 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.

10.15.23.15 Gastric Bypass Surgery

Procedure Code Range: 43644, 43770, 43842-43843, 43846-43848
10.15.23.12.1 Requirements

Medicaid will consider coverage of gastric bypass surgery on adults on a case-by-case basis, with the appropriate documentation, if it is medically appropriate for the individual to have such surgery and if the surgery is to correct an illness that is aggravated by the obesity.

- To receive prior authorization (Section 6.12, Prior Authorization) and to qualify for Medicaid reimbursement, the following criteria must be met.
  - The client must meet the weight criteria for clinically severe obesity, which is a Body Mass Index (BMI) equal to or greater than 40, or 35-40 with co-morbid conditions. Documentation of the client’s BMI and obesity related co-morbid medical conditions exacerbated by the obesity are required.
  - The primary physician must submit a complete client history and physical examination notes, including a three-year record of the client’s weight and documented efforts to lose weight by conventional means. Conventional means must describe at least two (2) different non-surgical programs of dietary regimens that include appropriate exercise and a supported behavioral modification program utilizing licensed mental health therapists.
  - Documentation of pre-operative psychological evaluation by a psychiatrist or licensed clinical psychologist affiliated with a clinic (not associated with the physician’s group recommending the procedure) within the last 90-days to determine if the client has the emotional stability to follow through with the medical regimen that must accompany the surgery.

- Physician Documentation:
  - Weight control medications currently taken, or taken in the past, and the duration of time on these medications
  - Proposed treatment plan
  - Client’s goal weight
  - Documentation of lab work up to include:
    - Liver function
    - Lipid level for all
    - Renal panel
    - CBC
    - Thyroid panel
    - Two (2) fasting blood sugars or a two-hour Glucose Tolerance Test

- The surgeon performing the gastric bypass must submit a written request documenting the CPT-4 code(s) to be used. The morbid obesity criteria must be met in order to qualify for benefits. The client will be notified by mail if the criteria have been met and what services will be covered.
Documentation indicating the client is actively participating in an ongoing dietary management program that has dietary and behavior modification components, as well as practitioner supervised exercise program.

Documentation of the post-operative plan of care, which should include behavior modification, dietary management and physician supervised exercise program.

**10.15.23.12.2 Covered Services**

Gastric bypass (Roux-en-Y) occurs when a small tube of bowel connects the top of the stomach directly to the middle of the small bowel. The rest of the stomach is either cut or stapled, so food can fill only about 10% of the stomach.

Gastric partitioning (Vertical-banded gastroploasty or gastric stapling) occurs when a row of staples is placed across the stomach, so food can only pass through a narrow part of the stomach. The "band" is a ring that keeps the opening narrowed. Clients become full after only a small amount of food is consumed.

Bariatric surgeries (43770-43774) bariatric surgery is given the name to any type of surgery that involves a reduction in stomach size and/or a bypass of the normal sequence of digestion and absorption.

**10.15.23.16 Lumbar Spinal Surgery**

**Procedure Code Range:** 22207, 22214, 22224, 22533, 22534, 22558, 22612, 22630, 22633, 22800 - 22808, 22812, 22818, 22840, 22857 and 22862

**10.15.23.16.1 Covered Services**

Authorization for lumbar spinal surgery has been separated into three 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.)

**10.15.23.16.2 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 months.

NOTE: The requesting surgeon should have personally evaluated the patient on at least two occasions prior to requesting surgery.

10.15.23.17 Panniculectomy / Abdominoplasty

Procedure Code Range: 15830 and 15847

10.15.23.17.1 Covered Services

Panniculectomies / Abdominoplasties are covered and considered medically necessary if the below requirements are met.

10.15.23.17.2 Reimbursement

Prior Authorization requirements:

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 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.

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 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 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.

10.15.23.18 Seapoplasty & Rhinoplasty

Procedure Code Range:  30520, 30400-30420, 30430-30450 and 30460-30462

10.15.23.18.1 Covered Services

Septoplasty and Rhinoplasty are covered and considered medically necessary if the below requirements are met.

10.15.23.18.2 Reimbursement

Prior Authorization requirements:

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.

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 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.

10.15.23.18.3 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

10.15.23.19 Vagus Nerve Stimulation (VNS) for Epilepsy
In some cases there are clients whose seizures cannot be treated with medicine, either because the medicine is ineffective or due to severe side effects. Surgery might be an option in some cases, but is not appropriate for all clients. The VNS system offers an option for clients in this situation.
Procedure Code Range: 61850-61888, 64573

VNS is a covered service upon Prior Authorization only for clients who have been evaluated by a Board Certified Neurologist and meet the following criteria (Section 6.12, Prior Authorization):

- Coverage applies only to partial onset seizures (with or without secondary generalization) that are clinically recognizable and documented. A diagnosis of primary generalized seizures will not meet the criteria for VNS coverage. Documentation must be of true epileptic seizures.
- VNS clients must be 12 years of age or older. However, consideration will be applied on a case by case basis to clients who do not meet this age criteria.
- The client must have had a diagnosis of intractable epilepsy for at least two (2) years and have experienced at least 4-6 identifiable partial onset seizures each month. Documented seizures must have been refractory to at least three anti-epileptic drugs and newer FDA approved anti-convulsant drugs given as add-on treatments.
- VNS clients must not be candidates for epilepsy surgery or be a failure of prior curative epilepsy surgery. If both VNS and epilepsy surgery are options, the treating physician must clearly document why VNS is the preferred treatment.
- Clients must have a completed Quality of Living (QOL) Assessment.
- Mental retardation (MR) or psychoses are not contraindications by themselves. However, behavioral and somatic manifestations of MR or psychosis may obscure recognitions of seizure phenomena and the evaluation of possible benefits resulting from VNS. If one of those diagnoses coexists with partial onset seizures, the practitioner must document how VNS will benefit the client in spite of the MR or psychosis.
- VNS insertion will not be considered for clients with a progressive disorder including, but not limited to: brain tumor, Landau-Kleffner syndrome, or progressive metabolic and degenerative ulcer, or severe neurological disease, i.e., Parkinson’s, Multiple Sclerosis, and Stroke/Brain Attack.
- Evaluation for the necessity of VNS must be completed by a Board Certified Neurologist.
- The procedure may only be performed with FDA-approved devices and systems. (Currently, NeuroCybernetics Prostheses (NCP) System is the only FDA-approved device for this procedure).
- Coverage is limited to stimulation of the left vagus nerve as it is likely to cause cardiac effects.

10.15.23.14.1 Reimbursement

Medicaid will reimburse practitioners, in Wyoming, who are treating Medicaid clients post-operatively when surgical procedures are performed out-of-state. For an accurate listing of codes, refer to the fee schedule on the Medicaid/EqualityCare website (Section 2.2, Quick Website Reference).
10.15.23.20 Varicose Vein Treatment

Procedure Code Range: 36475-36479, 37770-37785

10.15.24.24.1 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)

10.15.24.24.2 Billing Requirements

Prior authorization requirements:

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 4/5 mm 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 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 3.5 mm or greater with outward flow duration of 500 milliseconds duration or more, located underneath an active or healed venous
10.15.24 Transplant Policy

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

10.15.24.1 Eligibility

Medically necessary organ transplants must be pre-certified/prior authorized. Pre-certification/prior authorization must be obtained before services are rendered.

10.15.24.2 Coordination of Care

Coordination of care will be provided by the case manager and Xerox Care and Quality Solutions, Inc. (Utilization and Care Management).

Hospitals are required to obtain pre-certification/prior authorization for transplants listed below prior to admission and procedure. Xerox Care and Quality Solutions, Inc. (Utilization and Care Management) will complete pre-certification/prior authorization (Section 6.12, Prior Authorization).

10.15.24.3 Covered Services

Medicaid covered transplants include:

- Bone marrow*
- Heart
- Heart/Lung
- Kidney*
- Pancreas
- Lung
- Liver*

* Transplants are limited to bone marrow, kidney and liver for clients over 21 years of age.

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

10.15.24.4 Reimbursement

Transplant services will be reimbursed, after discharge, at fifty-five percent (55%) of billed charges. Transplant services include:

- Initial evaluation
- Procurement/Acquisition (included on facility claim)
- Facility fees
• Professional fees (included on the claim)
• Follow-up care for inpatient transplants using Medicare’s standard global period. This period refers to the time frame during which all services integral to the surgical procedure are covered by a single payment.

10.15.24.5 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.

10.15.24.6 Non-Covered Services

Transportation of organs from one facility to another is not covered.

10.15.25 Vision Services

A licensed ophthalmologist, optometrist, or optician, within the Scope of Practice Act within their respective profession, may provide vision services.

10.15.25.1 Covered Services for clients 21 years of age and older:

Procedure Code Range: 92002, 92004, 92012, and 92014

• Treatment of eye disease or eye injury, based on the appropriate ICD-9 diagnosis code
• Payment of deductible and/or coinsurance due on Medicare crossover claims for post-surgical contact lenses and/or eyeglasses.

10.15.25.2 Covered Services for clients under the age of 21:

10.15.25.2.1 Examinations

Procedure Code Range: 92002, 92004, 92012, and 92014

• Eye exams determine visual acuity and refraction, binocular vision, and eye health.
  ➢ Special ophthalmologic services should be performed only when medically necessary (92015-92140).
  ➢ Eye care provider records must reflect medical necessity and include interpretation and report, as appropriate, of the procedure.
• Office exams as medically necessary for the treatment of eye disease or eye injury.

10.15.25.2.2 Eyeglasses

Procedure Code Range: V2020- V2499
• One pair of eyeglasses is covered per 365 days.
  ➢ Providers may contact Provider Relations (Section 2.1, Quick Address and Telephone Reference) to see when the last time a client had eyeglasses reimbursed.
  ➢ Medicaid may allow one replacement of lenses and frames if the glasses are lost or broken beyond repair with documentation stating it was not due to blatant abuse or neglect.
  ➢ Replacement of eyeglasses within a twelve-month period must be due to medical necessity. This includes but is not limited to:
    ▪ A change in prescription
    ▪ Use existing frames when applicable
    ▪ Replacement due to normal wear and tear
  ➢ Repair of eyeglasses may be billed upon expiration of the warranty.
  ➢ The provider is responsible for submitting documentation of medical necessity to substantiate why the additional glasses are needed.
  ➢ Medicaid allows up to $76.00 for standard frames. The provider may not “balance bill” the client for glasses that cost more than the allowable amount.
    ▪ For example: When the client selects $120 frames and Medicaid allows up to $76 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 $76 and accept this payment as payment in full for the frames.
• Single vision, bifocal or trifocal lens are covered.
  ➢ Miscellaneous services [V2700-V2799 (Prior Authorization Required), with the exception of V2715 and V2784] are covered only with prior authorization and when deemed medically necessary by an ophthalmologist or optometrist (Section 6.12 Prior Authorization). Also, the physician records must reflect medical necessity.
• Polycarbonate lenses (V2784), includes scratch resistant coating are a covered service. The procedure code must be billed as an add-on to a standard C-39 lens.
• Reimbursement for dispensing of frames, frame parts, and/or lenses is not allowed in addition to reimbursement for dispensing of total eyeglasses.
• Providers must use the date of delivery as the date of service.

10.15.25.2.2.1 High Index Aspheric Policy

Procedure codes: V2410, V2430 and V2499

A High Index lens bends light faster than lower index lens. This results in a lens that is thinner and lighter than a standard index. As Aspheric lens is a lens that has a changing curve throughout the lens which decreases the thickness, but also will improve the patients’ vision in the periphery. This is especially true in hyperopic (plus) prescriptions. Most high index lenses will also be aspheric, but not always. Polycarbonate can be ordered regular or aspheric.
• Aspheric lenses will only be covered when medically necessary and when they meet the guidelines listed below.
  o High index aspheric lenses can be used for clients when the power in the highest meridian is – (minus) 6 diopters or more
  o 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
  o High index aspheric lenses can be used for plus prescriptions when the power in the highest meridian is + (plus) 4.00 diopters or more
    ▪ 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
• Lenses should be ordered as pairs. If the lens on one side aspheric or high index, then the matching lens should also aspheric or high index, even if it does not meet the threshold

10.15.25.2.3 Contact Lenses

**Procedure Code Range: V2500-V2599**

• Contact lenses are covered for correction of pathological conditions when useful vision cannot be obtained with regular lenses.
• Prior authorization is required for contact lenses, and documentation provided must show medical necessity and state why the client’s vision cannot be corrected with eyeglasses.
• Contact lenses will be reimbursed at the invoice, plus shipping and handling, plus 15%.

10.15.25.3 Vision Therapy

**Procedure Code Range: 92065**

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.

Vision therapy is 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.

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

Prior authorization is not required.

### 10.15.25.3.1 Training Aids

Vision Therapy training aids will be reimbursed at cost of invoice. Please submit invoice with statement of medical necessity using CPT-4 code 99070.

**Coding For under the age of 21:**

- Vision therapy visits are capped at 32 per 365 days for treatment of ICD-9 diagnosis.
- Additional visits or exceptions to these diagnosis codes will be considered on a case by case basis only. Please submit a written request with justification of medical necessity to Wyoming Medicaid for consideration.
- In addition to the below referenced ICD-9 codes, vision therapy services performed in office are reported with CPT-4 code 92065; orthoptic and/or pleoptic training, with continuing medical direction and evaluation.

<table>
<thead>
<tr>
<th><strong>Vision Therapy Coding</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis Codes</strong></td>
</tr>
<tr>
<td><strong>Amblyopia</strong></td>
</tr>
<tr>
<td>368.01</td>
</tr>
<tr>
<td>368.02</td>
</tr>
<tr>
<td>368.03</td>
</tr>
<tr>
<td><strong>Strabismus (Concomitant)</strong></td>
</tr>
<tr>
<td>378.01</td>
</tr>
<tr>
<td>378.05</td>
</tr>
<tr>
<td>378.11</td>
</tr>
<tr>
<td>378.15</td>
</tr>
<tr>
<td>378.21</td>
</tr>
</tbody>
</table>
Coding for clients over the age of 21:

The following diagnosis codes are considered appropriate for adult clients eligible for Medicaid services under the Acquired Brain Injury (ABI) Waiver program:

- Vision Therapy for individuals receiving services under the Acquired Brain Injury (ABI) Program with qualifying medical diagnosis.
- In addition to the below referenced ICD-9 codes, vision therapy services performed in office are reported with CPT-4 code 92065; orthoptic and/or pleoptic training, with continuing medical direction and evaluation.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>438.7</td>
<td>Disturbances of vision</td>
</tr>
<tr>
<td>907.0</td>
<td>Late effect injury intracranial injury without mention of skull fracture</td>
</tr>
<tr>
<td>997.0</td>
<td>Central Nervous System complications, not classified elsewhere</td>
</tr>
<tr>
<td>V57.4</td>
<td>Care involving orthoptic training</td>
</tr>
</tbody>
</table>

### 10.16 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.
10.16.1 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

10.16.2 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

10.16.3 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

10.16.4 Enrollment Process

- Department of Family Services (DFS) must be notified of pregnancy/birth of baby
- DFS will send a review form 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
### Pregnant by Choice Covered Codes

<table>
<thead>
<tr>
<th>Covered Diagnosis Codes</th>
<th>Diagnosis Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V25.01</td>
<td>General counseling on prescription of oral contraceptives</td>
</tr>
<tr>
<td>V25.02</td>
<td>General counseling on initiation of other contraceptive</td>
</tr>
<tr>
<td>V25.03</td>
<td>Encounter for emergency contraceptive counseling and prescription</td>
</tr>
<tr>
<td>V25.04</td>
<td>Natrl Family pln – avoid preg</td>
</tr>
<tr>
<td>V25.09</td>
<td>Other general counseling and advice on contraception</td>
</tr>
<tr>
<td>V25.1</td>
<td>Insertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V25.2</td>
<td>Sterilization</td>
</tr>
<tr>
<td>V25.11</td>
<td>Encounter for insertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V25.12</td>
<td>Encounter for removal of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V25.13</td>
<td>Encounter for removal and reinsertion of IUD</td>
</tr>
<tr>
<td>V25.40</td>
<td>Contraceptive surveillance, unspecified</td>
</tr>
<tr>
<td>V25.41</td>
<td>Surveillance of contraceptive pill</td>
</tr>
<tr>
<td>V25.42</td>
<td>Surveillance of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V25.43</td>
<td>Surveillance of implantable subdermal contraceptive</td>
</tr>
<tr>
<td>V25.49</td>
<td>Surveillance of other contraceptive method</td>
</tr>
<tr>
<td>V25.5</td>
<td>Surveillance of previously prescribed contraceptive methods</td>
</tr>
<tr>
<td>V25.8</td>
<td>Other specified contraceptive management</td>
</tr>
<tr>
<td>V25.9</td>
<td>Unspecified contraceptive management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Procedures</th>
<th>Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99203</td>
<td>Office/Outpatient New</td>
</tr>
<tr>
<td>99211-99213</td>
<td>Office/Outpatient Established</td>
</tr>
<tr>
<td>11976</td>
<td>Removal, implantable contraceptive capsules</td>
</tr>
<tr>
<td>11977</td>
<td>Removal with reinsertion, implantable contraceptive capsules</td>
</tr>
<tr>
<td>11981</td>
<td>Insertion, Non-Biodegradable drug delivery implant</td>
</tr>
<tr>
<td>57170</td>
<td>Diaphragm or cervical cap fitting with instructions</td>
</tr>
<tr>
<td>58300</td>
<td>Insertion of Intrauterine device (IUD)</td>
</tr>
<tr>
<td>58301</td>
<td>Removal of intrauterine device (IUD)</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular</td>
</tr>
<tr>
<td>80048</td>
<td>Basic metabolic panel (calcium, total)</td>
</tr>
<tr>
<td>80076</td>
<td>Hepatic function panel</td>
</tr>
<tr>
<td>81000-81015</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>82465</td>
<td>Cholesterol</td>
</tr>
<tr>
<td>82947-82948</td>
<td>Glucose</td>
</tr>
<tr>
<td>84703</td>
<td>Gonadotropin, Chorionic (HCG)</td>
</tr>
<tr>
<td>85013</td>
<td>Blood count</td>
</tr>
<tr>
<td>85014-85018</td>
<td>Blood smear exam</td>
</tr>
<tr>
<td>86592</td>
<td>Syphilis Test</td>
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<tr>
<td>86689</td>
<td>HTLV or HIV antibody, confirmatory test (EG, Western Blot)</td>
</tr>
<tr>
<td>86701</td>
<td>HIV – 1 – Antibody</td>
</tr>
<tr>
<td>86702</td>
<td>HIV – 2 – Antibody</td>
</tr>
<tr>
<td>86703</td>
<td>HIV – 1 and HIV – 2, single assay – antibody</td>
</tr>
<tr>
<td>87070-87081</td>
<td>Culture, bacterial</td>
</tr>
<tr>
<td>87110</td>
<td>Culture, Chlamydia</td>
</tr>
<tr>
<td>87205-87210</td>
<td>Smear, primary source</td>
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<tr>
<td>87270</td>
<td>Infectious agent antigen detection Chlamydia</td>
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<tr>
<td>87274</td>
<td>Infectious agent antigen detection Herpes Simplex virus type 1</td>
</tr>
<tr>
<td>87320</td>
<td>Infectious agent antigen detection multiple step method; Chlamydia Trachomatis</td>
</tr>
<tr>
<td>87340</td>
<td>Infectious agent antigen detection Hepatitis B surface antigen (HBcAg)</td>
</tr>
<tr>
<td>87490</td>
<td>Infectious agent detection by Nucleic Acid (DNA or RNA); Chlamydia Trachomatis, direct probe technique</td>
</tr>
</tbody>
</table>
10.17 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 – Physical therapy involving the therapeutic use of crafts and hobbies for the rehabilitation of handicapped or convalescing clients.

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 presence of a communication disability.

10.17.1 Physical Therapy & Occupational Therapy

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 – Physical therapy involving the therapeutic use of crafts and hobbies for the rehabilitation of handicapped or convalescing clients.

10.17.1.1 Covered Services

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

10.17.1.2 Limitations

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

• Physical and occupational therapy visits are limited to 20 per calendar year for clients age 21 and older.
  ➢ 20 visits per physical therapy; 20 visits per occupational therapy (Section 6.6, Cap Limits)
• Visits made more than once daily are generally not considered reasonable.
• There should be a decreasing frequency of visits as the client improves.
• Restorative therapy is only available for clients 21 and over. 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.

10.17.1.3 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 30 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 30 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.

10.17.2 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 presence of a communication disability.

10.17.2.1 Covered Services

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

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

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

In order for speech therapy services to be covered, the services must be related directly to an active written treatment plan established by a physician 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.

### Limitations

10.17.2.2

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

- Maintenance therapy, with the exception of clients age 20 and under. Restorative therapy is for clients 21 and older.
- 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.

### Speech Therapy Billing Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92506</td>
<td>Evaluation of speech, language, voice, communication and/or auditory processing</td>
</tr>
<tr>
<td>92507</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual (1 unit = 15 minutes)</td>
</tr>
<tr>
<td>92508</td>
<td>Treatment of speech language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two (2) or more individuals</td>
</tr>
<tr>
<td>92526</td>
<td>Treatment of swallowing dysfunction and/or oral function for feeding</td>
</tr>
</tbody>
</table>
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.

10.17.2.3 Cap Limits

Medicaid clients age 21 and over will be limited to 20 speech therapy visits per year. If the client has exceeded the Medicaid limits on speech therapy visits, the provider may bill him/her, or request the cap limit be waived, as long as the services are still medically necessary (Section 6.6, Cap Limits).
Appendices

A.1 APPENDIX A – Social Security Administration

A.2 APPENDIX B – County DFS Offices

A.3 APPENDIX C – Medicaid and State Health Care Benefit Plan
# A.1 APPENDIX A – Social Security Administration

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>LOCATION/MAILING ADDRESS</th>
<th>PHONE</th>
</tr>
</thead>
</table>
| Casper     | 100 East B St., Room 1008
Casper, WY  82601
Areas Covered: Converse
Natrona
Niobrara
Washakie | 307-261-5360
800-772-1213 |
| Cheyenne   | 5353 Yellowstone Rd. Room 210
Cheyenne, WY  82009
Areas Covered: Albany
Carbon
Goshen
Laramie
Platte | 307-772-2135
800-773-2144 |
| Cody       | 1285 Sheridan Ave., Ste. 265
Cody, WY  82414
Areas Covered: Big Horn
Park | 307-587-8155
800-770-2652 |
| Riverton   | 215 Big Bend Ave.
Riverton, WY  82501
Areas Covered: Fremont
Hot Springs
Lincoln | 307-856-7737
800-305-6919 |
| Rock Springs | 79 Winston Dr., Suite 131
Rock Springs, WY  82901
Areas Covered: Sublette
Sweetwater
Teton
Uinta | 307-362-4634
877-593-3952 |
| Sheridan   | 909 Long Dr., Ste. A
Sheridan, WY  82801
Areas Covered: Campbell
Crook
Johnson
Sheridan
Weston | 307-672-5390
877-593-3952 |
## APPENDIX B – County DFS Offices

<table>
<thead>
<tr>
<th>County DFS</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany County DFS</td>
<td>3817 Beech Street, Suite 200</td>
<td>Laramie WY 82070</td>
</tr>
<tr>
<td></td>
<td>307-745-7324</td>
<td></td>
</tr>
<tr>
<td>Big Horn County DFS</td>
<td>616 Second Ave., North</td>
<td>Greybull WY 82426</td>
</tr>
<tr>
<td></td>
<td>307-765-9453</td>
<td></td>
</tr>
<tr>
<td>Campbell County DFS</td>
<td>1901 Energy Court suite 300</td>
<td>Gillette WY 82716</td>
</tr>
<tr>
<td></td>
<td>307-682-7277</td>
<td></td>
</tr>
<tr>
<td>Carbon County DFS</td>
<td>PO Box 2409</td>
<td>Rawlins WY 82301</td>
</tr>
<tr>
<td></td>
<td>307-328-0612</td>
<td></td>
</tr>
<tr>
<td>Converse County DFS</td>
<td>219 North Russell</td>
<td>Douglas WY 82633</td>
</tr>
<tr>
<td></td>
<td>307-358-3138</td>
<td></td>
</tr>
<tr>
<td>Crook County DFS</td>
<td>PO Box 57</td>
<td>Sundance, WY 82729</td>
</tr>
<tr>
<td></td>
<td>307-283-2014</td>
<td></td>
</tr>
<tr>
<td>Fremont County DFS</td>
<td>201 N. 4th</td>
<td>Lander WY 82520</td>
</tr>
<tr>
<td></td>
<td>307-332-4038</td>
<td></td>
</tr>
<tr>
<td>Fremont County DFS</td>
<td>120 N. 6th E.</td>
<td>Riverton WY 82501</td>
</tr>
<tr>
<td></td>
<td>307-856-6521</td>
<td></td>
</tr>
<tr>
<td>Eastern Shoshone</td>
<td>PO Box 1150</td>
<td>Ft Washakie, WY 82514</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Hot Springs County DFS</td>
<td>403 Big Horn</td>
<td>Thermopolis WY 82443</td>
</tr>
<tr>
<td></td>
<td>307-864-2158</td>
<td></td>
</tr>
<tr>
<td>Johnson County DFS</td>
<td>381 N. Main</td>
<td>Buffalo WY 82834</td>
</tr>
<tr>
<td></td>
<td>307-684-5513</td>
<td></td>
</tr>
<tr>
<td>Lincoln County DFS</td>
<td>PO Box 470</td>
<td>Kemmerer WY 83101</td>
</tr>
<tr>
<td></td>
<td>307-877-6670</td>
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</tr>
<tr>
<td>Lincoln County DFS</td>
<td>PO Box 1336</td>
<td>Afton WY 83110</td>
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<tr>
<td></td>
<td>307-886-9232</td>
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<tr>
<td>Niobrara County DFS</td>
<td>PO Box 389</td>
<td>Lusk WY 82225</td>
</tr>
<tr>
<td></td>
<td>307-334-2153</td>
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<tr>
<td>Park County DFS</td>
<td>1301 Rumsey</td>
<td>Cody WY 82414</td>
</tr>
<tr>
<td></td>
<td>307-587-6246</td>
<td></td>
</tr>
<tr>
<td>Sheridan County DFS</td>
<td>111 E Works</td>
<td>Sheridan WY 82801</td>
</tr>
<tr>
<td></td>
<td>307-672-2404</td>
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<tr>
<td>Platte County DFS</td>
<td>975 Gilchrist</td>
<td>Wheatland WY 82201</td>
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<tr>
<td></td>
<td>307-322-3790</td>
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</tr>
<tr>
<td>Sublette County DFS</td>
<td>111 N Sublette B. 1070</td>
<td>Pinedale WY 82941</td>
</tr>
<tr>
<td></td>
<td>307-367-4124</td>
<td></td>
</tr>
<tr>
<td>Sweetwater County DFS</td>
<td>2451 Foothill Blvd Suite 103</td>
<td>Rock Springs WY 82901</td>
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<tr>
<td></td>
<td>307-362-5630</td>
<td></td>
</tr>
<tr>
<td>Teton County DFS</td>
<td>PO Box 547</td>
<td>Jackson WY 83001</td>
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<td>307-733-7757</td>
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<tr>
<td>Sublette County DFS</td>
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<tr>
<td></td>
<td>307-367-4124</td>
<td></td>
</tr>
<tr>
<td>Uinta County DFS</td>
<td>PO Box 1109</td>
<td>Mountain View WY 82939</td>
</tr>
<tr>
<td></td>
<td>307-786-4011</td>
<td></td>
</tr>
<tr>
<td>Washakie County DFS</td>
<td>1700 Robertson</td>
<td>Worland WY 82401</td>
</tr>
<tr>
<td></td>
<td>307-347-6181</td>
<td></td>
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<tr>
<td>Weston County DFS</td>
<td>2013 West Main Suite #101</td>
<td>Newcastle WY 82701</td>
</tr>
<tr>
<td></td>
<td>307-746-4657</td>
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<td>Plan Name</td>
<td>Plan Description</td>
<td>Copay*</td>
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<tr>
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</tr>
<tr>
<td>ABIW</td>
<td>Acquired Brain Injury</td>
<td>Y</td>
</tr>
<tr>
<td>ADAP</td>
<td>Aids Drug Assistance Program</td>
<td>N</td>
</tr>
<tr>
<td>ADSS</td>
<td>Aged/Disabled SSI Related (Additional Information: Clients under 21 - no co-pay and no cap limits)</td>
<td>Y</td>
</tr>
<tr>
<td>ALEN</td>
<td>Emergency Services for Non-Citizens</td>
<td>N</td>
</tr>
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## A.3 Appendix C

### Medicaid and State Healthcare Benefit Plans

#### Provider Eligibility Job Aid

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay*</th>
<th>Coverage Types*</th>
<th>Cap Limits*</th>
<th>Covered Services</th>
<th>Limitations</th>
<th>ID Card</th>
</tr>
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<tbody>
<tr>
<td><strong>BCC</strong> Breast and Cervical Cancer</td>
<td>N x x</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>This plan covers outpatient hospital and medical services for providers who are enrolled with the Breast and Cervical Cancer Program. In addition, coverage is limited to specific screening and diagnostic services. For more information contact the BCC Program at 800-264-1296.</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CASI</strong> Child &amp; Adolescent Service Intensity Instrument (CASII Evaluations)</td>
<td>N x x</td>
<td></td>
<td>This plan covers CASII evaluations only</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHPR</strong> CHIPRA Care Management</td>
<td>N</td>
<td></td>
<td>This plan covers clients who are eligible for CHIPRA services. For additional information contact Wyoming Access at 1-855-883-8740 or Wyoaccess.net</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CMHW</strong> Children's Mental Health Waiver</td>
<td>N x x x x x x x x</td>
<td></td>
<td>This plan covers dental, medical, vision, outpatient hospital and waiver services, prescriptions, inpatient hospital stays and pays co-insurance and deductibles on Medicare claims. This plan does not cover nursing home services.</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COLR</strong> Colorectal Cancer Screening Program</td>
<td>N x x</td>
<td></td>
<td>This plan covers outpatient hospital and medical services related to specific screening and diagnostic services. The medical provider must be enrolled with the Colorectal Cancer Screening Program. For more information contact the CRC Program at 1-866-205-5292.</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CSH1</strong> Children's Special Health - Special Needs Children</td>
<td>N x x x x x</td>
<td></td>
<td>This plan covers services for specific diagnoses or conditions as approved by the CSH Program. For additional information contact CSH at 1-800-438-5795.</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Description</td>
<td>Copay*</td>
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<td>-------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>CSH2</td>
<td>Children's Special Health - Moms and Babies</td>
<td>N</td>
<td>D Rx I O M V W N</td>
<td></td>
<td>This plan covers services for specific diagnoses or conditions as approved by the CSH Program. For additional information contact CSH at 1-800-438-5795.</td>
<td>No nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
<td>Y</td>
</tr>
<tr>
<td>DDAW</td>
<td>DD Adult Waiver</td>
<td>Y</td>
<td>RX I O M V W N</td>
<td>20 20 20 12</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>No nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
<td>Y</td>
</tr>
<tr>
<td>DDCW</td>
<td>DD Children's Waiver</td>
<td>N</td>
<td>D Rx I O M V W N</td>
<td></td>
<td>This plan covers dental, medical, vision, outpatient hospital and waiver services, prescriptions, inpatient hospital stays and pays co-insurance and deductibles on Medicare claims.</td>
<td>This plan does not cover nursing home services.</td>
<td>Y</td>
</tr>
<tr>
<td>DDP</td>
<td>Disability Determination</td>
<td>N</td>
<td>RX I O M V W N</td>
<td></td>
<td>This plan covers a physician consultation and diagnostic screening and testing for SSI determination only.</td>
<td>This plan does not cover nursing home services.</td>
<td>N</td>
</tr>
<tr>
<td>FPW</td>
<td>Pregnant By Choice</td>
<td>N</td>
<td>RX I O M V W N</td>
<td></td>
<td>This plan only covers prescriptions, inpatient hospital stays, outpatient hospital and medical services related to family planning methods and products approved by the FDA.</td>
<td>This plan does not cover abortion, infertility services and/or treatments, or sterilization reversals.</td>
<td>Y</td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Description</td>
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<td>Cover Types*</td>
<td>Cap Limits*</td>
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</tr>
<tr>
<td>MDP</td>
<td>Marginal Dental Program</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D</td>
<td>T OT PT ST OV</td>
<td>This plan receives Dental coverage only, with a maximum of 1,000 dollars total payment limitation per year and receives 85% of billed charges, the client is responsible for remaining 15%. Eligibility is determined annually. For additional information contact the Marginal Dental Program at (307)777-7945.</td>
<td>No waiver or nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
<td>Y</td>
</tr>
<tr>
<td>EID</td>
<td>Employed Individual Disabled</td>
<td>Y</td>
<td>x x x x x x x x</td>
<td>x x 20 20 20 12</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>No nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
<td>Y</td>
</tr>
<tr>
<td>HSPC</td>
<td>Hospice Only</td>
<td>N</td>
<td>N x x x x x x</td>
<td>x x 20 20 20 12</td>
<td>This plan covers services provided by physicians and the attending hospice provider. Prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, co-insurance and deductibles on Medicare claims and limited dental and vision services are covered when not related to the client's terminal illness and approved by the hospice provider.</td>
<td>No nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
<td>Y</td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Description</td>
<td>Copay*</td>
<td>Coverage Types*</td>
<td>Cap Limits*</td>
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</tr>
<tr>
<td>IP65</td>
<td>Inpatient Psychology Services</td>
<td>Y</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>20 20 20 12</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and nursing home services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>KIDA</td>
<td>Standard Full Coverage Child Medicaid</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x</td>
<td>This plan covers dental, medical, vision, outpatient hospital and waiver services, prescriptions, inpatient hospital stays and pays co-insurance and deductibles on Medicare claims.</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>LTCS</td>
<td>Long Term Care Screening</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x</td>
<td>This plan covers LT101 and PASRR screenings only.</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>MATR</td>
<td>Maternity</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
# Medicaid and State Healthcare Benefit Plans

## Provider Eligibility Job Aid

### Coverage Types *

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
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<th>Coverage Types</th>
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<tr>
<td></td>
<td></td>
<td>D</td>
<td>Rx</td>
<td>I</td>
</tr>
<tr>
<td>MCAD</td>
<td>Standard Full Coverage Adult Medicaid</td>
<td>Y</td>
<td>x</td>
<td>x</td>
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<tr>
<td>MMRX</td>
<td>Renal Program</td>
<td>N</td>
<td>x</td>
<td>x</td>
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<tr>
<td>MQIB</td>
<td>Medicare Qualified Individual - B Premium</td>
<td>N</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>MQIP</td>
<td>Medicare Qualified Individual - B Premium and Prescriptions</td>
<td>Y</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>NH</td>
<td>Nursing Home</td>
<td>N</td>
<td>x</td>
<td>x</td>
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</tbody>
</table>

### Covered Services

- This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.

### Limitations

- This plan does not cover waiver or nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.

- This plan covers specific renal prescriptions only.

- This plan pays Medicare Part B premiums only.

- This plan covers 3 prescriptions per month, pays Medicare Part B premiums.

- No waiver services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.
## Medicaid and State Healthcare Benefit Plans

### Provider Eligibility Job Aid

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<tr>
<th>Plan Name</th>
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<th>Covered Services</th>
<th>Limitations</th>
<th>ID Card</th>
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<tbody>
<tr>
<td>NONH</td>
<td>No Nursing Home or Wavier</td>
<td>Y</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>20 20 20 12</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>No waiver or nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
<td>Y</td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Description</td>
<td>Copay*</td>
<td>Coverage Types*</td>
<td>Cap Limits*</td>
<td>Covered Services</td>
<td>Limitations</td>
<td>ID Card</td>
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<tr>
<td>PACE</td>
<td>Program of All-Inclusive Care for the Elderly</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>This plan covers Medicaid eligible medical services as well as home and community based services for participants 55 years of age and older who meet nursing home level of care. All services must be provided by a PACE provider in Wyoming. For additional information contact Wyoming Medicaid at (307)777-7531.</td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>PDAP /MMP</td>
<td>Prescription Drug Assistance Program</td>
<td>Y x x x</td>
<td></td>
<td>This plan covers 3 prescriptions per month.</td>
<td>This plan does not cover inpatient hospital stays, waiver, nursing home or dental services. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>PE</td>
<td>Presumptive Eligibility</td>
<td>N x x x x x</td>
<td>x x 20 20 20 12</td>
<td>This plan covers prescriptions, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited vision services.</td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>POUT</td>
<td>Project Out</td>
<td>N x</td>
<td></td>
<td>This plan is limited to providers who are enrolled with the Project Out Program and coverage is limited specific medical services. For more information contact the Project Out Program at 800-442-2766.</td>
<td></td>
<td>N</td>
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</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
<td>N x</td>
<td>x x</td>
<td>This plan pays Medicare Part B premiums and co-insurance and deductibles on Medicare claims only.</td>
<td></td>
<td>Y</td>
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</tr>
<tr>
<td>QMBP</td>
<td>Qualified Medicare Beneficiary with Prescriptions</td>
<td>Y x x</td>
<td></td>
<td>This plan covers 3 prescriptions per month, pays co-insurance and deductibles on Medicare claims, pays Medicare Part B premiums.</td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>QWDI</td>
<td>Qualified Working Disabled Individual</td>
<td>N x</td>
<td></td>
<td>This plan pays Medicare Part A premiums only.</td>
<td></td>
<td>N</td>
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</tbody>
</table>
## A.3 Appendix C  Medicaid and State Healthcare Benefit Plans  
### Provider Eligibility Job Aid

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay*</th>
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<th>Limitations</th>
<th>ID Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCM</td>
<td>Targeted Case Management</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers screening services for the Developmentally Disabled Waiver Program only.</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>SHPS</td>
<td>State Licensed Shelter Care</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x</td>
<td>This plan covers nursing home services only and pays co-insurance and deductibles on Medicare claims.</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>SLMB</td>
<td>Special Low-Income Medicare Beneficiaries</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x</td>
<td>This plan pays Medicare Part B premiums only.</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>SLMP</td>
<td>Special Low-Income Medicare Beneficiaries with Prescriptions</td>
<td>Y</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x</td>
<td>This plan covers 3 prescriptions per month, pays Medicare Part B premiums.</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>TBI</td>
<td>Tuberculosis Infected</td>
<td>Y</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x 20 20 20 12</td>
<td>This plan covers prescriptions, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>Y</td>
<td></td>
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<tr>
<td>TBRX</td>
<td>Tuberculosis State Only Program</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x</td>
<td>This plan covers specific prescriptions only</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
### Provider Eligibility Job Aid

#### Medicaid and State Healthcare Benefit Plans

<table>
<thead>
<tr>
<th>Plan Name</th>
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<tr>
<td>WLTC</td>
<td>Waiver Long Term Care</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>Cap Limits*</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>This plan does not cover nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
</tr>
</tbody>
</table>

#### *Key*
- **D**: Dental
- **Rx**: Pharmacy
- **I**: Inpatient
- **O**: Outpatient
- **M**: Medicaid / CMS-1500
- **V**: Vision
- **W**: Waiver
- **N**: Nursing Home
- **AP**: Part A Premiums
- **BP**: Part B Premiums
- **C/D**: Medicare Co-Insurance and Deductable
- **T**: Transportation Coverage
- **OT**: Occupational Therapy
- **PT**: Physical Therapy
- **ST**: Speech Therapy
- **OV**: Office Visits

**NOTE:** Co-payments and cap limitations do not apply to clients under the age of 21 years of age even though the plan may have a co-payments and cap limitations. For specific information (procedure codes, etc.) refer to Chapter 6 in the Provider Manuals.

**Cap Limits = Number of visits per calendar year**

Revision Date: 6/17/13