Overview

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

Rule References

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

Procedure codes listed in the following Sections are subject to change at any time without prior notice. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedules on the website (2.1, Quick Reference). Fee schedules list Medicaid covered codes, provide clarification of indicators, such as whether a code requires prior authorization and the number of days in which follow-up procedures are included. Not all codes are covered by Medicaid or are allowed for all taxonomy codes (provider types). It is the provider’s responsibility to verify this information. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service. Wyoming Medicaid is required to comply with the coding restrictions under the National Correct Coding Initiative (NCCI) and providers should be familiar with the NCCI billing guidelines. NCCI information may be reviewed at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

Getting Questions Answered

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

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

AUTHORITY

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

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

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## 1.1 How the Institutional UB-04 Manual is Organized

The table below provides a quick reference describing how the Institutional UB-04 Manual is organized.

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two</td>
<td><strong>Getting Help When Needed</strong> – Quick Reference guide – telephone numbers</td>
</tr>
<tr>
<td></td>
<td>and addresses and web sites for help and training.</td>
</tr>
<tr>
<td>Three</td>
<td><strong>Provider Responsibilities</strong> – Obligations and rights as a Medicaid provider.</td>
</tr>
<tr>
<td></td>
<td>The topics covered include enrollment changes, civil rights, group practices,</td>
</tr>
<tr>
<td></td>
<td>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,</td>
</tr>
<tr>
<td></td>
<td>and rights and responsibilities.</td>
</tr>
<tr>
<td>Five</td>
<td><strong>Client Eligibility</strong> – How to verify eligibility when a client presents</td>
</tr>
<tr>
<td></td>
<td>their Medicaid card.</td>
</tr>
<tr>
<td>Six</td>
<td><strong>Common Billing Information</strong> – Basic claim information, completing the</td>
</tr>
<tr>
<td></td>
<td>claim form, authorization of medical necessity requirements, co-pays, prior</td>
</tr>
<tr>
<td></td>
<td>authorizations, timely filing, consent forms, NDC, working the Medicaid</td>
</tr>
<tr>
<td></td>
<td>remittance advice (RA) and completing adjustments.</td>
</tr>
<tr>
<td>Seven</td>
<td><strong>Third Party Liability (TPL)/Medicare</strong>– Explains what TPL/Medicare is,</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>documents electronically. Secured Provider Web Portal registration process.</td>
</tr>
<tr>
<td>Nine</td>
<td><strong>Wyoming Specific HIPAA 5010 Electronic Specifications</strong> – This chapter</td>
</tr>
<tr>
<td></td>
<td>covers the Wyoming Specific requirements pertaining to electronic billing.</td>
</tr>
<tr>
<td></td>
<td>Wyoming payer number and electronic adjustments/voids.</td>
</tr>
<tr>
<td>Ten</td>
<td><strong>Important Information</strong> – This chapter contains important information such</td>
</tr>
<tr>
<td></td>
<td>as claims review, coding and fee schedule information.</td>
</tr>
<tr>
<td>Eleven-</td>
<td><strong>Institutional UB-04 Covered Services</strong> – These chapters contain information</td>
</tr>
<tr>
<td>Twenty One</td>
<td>regarding covered services: definitions, procedure code ranges, documentation</td>
</tr>
<tr>
<td></td>
<td>requirements, and billing requirements and examples.</td>
</tr>
<tr>
<td>Appendices</td>
<td><strong>Appendices</strong> – Provide key information in an at-a-glance format. This</td>
</tr>
<tr>
<td></td>
<td>includes Provider Manual Version Control Table and last quarter’s Provider</td>
</tr>
<tr>
<td></td>
<td>Notifications.</td>
</tr>
</tbody>
</table>
1.2 Updating the Manual

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

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

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

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

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

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

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

Sample RA Banner:

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

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

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

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

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

Sample RA Payment Summary (weekly email notification):

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

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

Sent: Thursday, May 28, 2015 5:17 AM
To: Provider Email Name
Subject: Remittance Advice Payment Summary

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

Dear Provider Name,

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

**************************************************************************
RA PAYMENT SUMMARY
**************************************************************************

To: Provider Name
NPI Number: 1234567890
Provider ID: 111111111

Remittance Advice Number: 123456
Amount of Check: 16,070.85

The RA banner notification will appear here when activated for the provider’s taxonomy (provider type)
1.2.2 Medicaid Bulletin Notification/Sample

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

Sample bulletin email notification (HTML format):

From: Wyoming Medicaid [mailto:wycustomersvc@conduent.com]
Sent: Tuesday, September 22, 2015 3:31 PM
To: Provider Email Name
Subject: ICD-10 Important Facts
1.2.3 Wyoming Department of health (WDH) State Letter/Sample

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

Sample WDH email notification (HTML format):

1.3 State Agency Responsibilities

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

1.4 Fiscal Agent Responsibilities

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

NOTE: Wyoming Medicaid is not responsible for the training of the provider’s billing staff or to provide procedure or diagnosis codes or coding training.
Chapter Two – Getting Help When Needed

2.1 Quick Reference
2.2 How to Call for Help
2.3 How to Write for Help
  2.3.1 Provider Inquiry Form
2.4 How to Get a Provider Training Visit
2.5 How to Get Help Online
2.6 Training Seminars
## 2.1 Quick Reference

<table>
<thead>
<tr>
<th>Agency Name &amp; Address</th>
<th>Telephone/Fax Numbers</th>
<th>Web Address</th>
<th>Contact For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services – Interactive Voice Response (IVR) System</td>
<td>Tel (800)251-1270 24/7</td>
<td>N/A</td>
<td>• Payment inquiries&lt;br&gt;• Client eligibility&lt;br&gt;• Medicaid client number and information&lt;br&gt;• Lock-in status&lt;br&gt;• Authorization of Medical Necessity&lt;br&gt;• Medicare Buy-In data&lt;br&gt;• Service limitations&lt;br&gt;• Client third party coverage information&lt;br&gt;<strong>NOTE:</strong> The client’s Medicaid ID number or social security number is required to verify client eligibility.</td>
</tr>
<tr>
<td>Claims PO Box 547 Cheyenne, WY 82003-0547</td>
<td>N/A</td>
<td>N/A</td>
<td>• Claim adjustment submissions&lt;br&gt;• Hardcopy claims submissions&lt;br&gt;• Returning Medicaid checks</td>
</tr>
<tr>
<td>Dental Service PO Box 667 Cheyenne, WY 82003-0667</td>
<td>Tel (888)863-5806 9-5pm MST M-F Fax (307)772-8405</td>
<td><a href="https://wymedicaid.portal.conduent.com/provider_home.html">https://wymedicaid.portal.conduent.com/provider_home.html</a></td>
<td>• Bulletin/manual inquiries&lt;br&gt;• Claim inquiries&lt;br&gt;• Claim submission problems&lt;br&gt;• Client eligibility&lt;br&gt;• How to complete forms&lt;br&gt;• Payment inquiries&lt;br&gt;• Request Field Representative visit&lt;br&gt;• Training seminar questions&lt;br&gt;• Timely filing inquiries&lt;br&gt;• Verifying validity of procedure codes&lt;br&gt;• Claim void/adjustment inquiries&lt;br&gt;• WINASAP training&lt;br&gt;• Web Portal training</td>
</tr>
<tr>
<td>EDI Services PO Box 667 Cheyenne, WY 82003-0667</td>
<td>Tel (800)672-4959 OPTION 3 9-5pm MST M-F Fax (307)772-8405</td>
<td><a href="https://wymedicaid.portal.conduent.com">https://wymedicaid.portal.conduent.com</a></td>
<td>• EDI Enrollment Forms&lt;br&gt;• Trading Partner Agreement&lt;br&gt;• WINASAP software&lt;br&gt;• Technical support for WINASAP&lt;br&gt;• Technical support for vendors, billing agents and clearing houses&lt;br&gt;• Web Portal registration/password resets&lt;br&gt;• Technical support for Web Portal</td>
</tr>
<tr>
<td>Conduent EDI Solutions</td>
<td>N/A</td>
<td><a href="http://edisolutionsmmis.portal.conduent.com/gcro/">http://edisolutionsmmis.portal.conduent.com/gcro/</a></td>
<td>• Download WINASAP software&lt;br&gt;• Submit and view EDI files</td>
</tr>
<tr>
<td>Medical Policy PO Box 667 Cheyenne, WY 82003-0667</td>
<td>Tel (800)251-1268 OPTIONS 1,1,4,3 9-5pm MST M-F (24/7 Voicemail Available) Fax (307)772-8405</td>
<td><a href="https://wymedicaid.portal.conduent.com/manuals.html">https://wymedicaid.portal.conduent.com/manuals.html</a></td>
<td>Authorization for Medical Necessity&lt;br&gt;• Dietician&lt;br&gt;• Chiropractic&lt;br&gt;• Prior Authorization requests for:&lt;br&gt;• Dental Services&lt;br&gt;• Hospice Services: Limited to clients residing in a nursing home&lt;br&gt;• Injections that require PA (listed in 6.13 Prior Authorization)&lt;br&gt;• Severe Malocclusion</td>
</tr>
</tbody>
</table>
## Getting Help When Needed

<table>
<thead>
<tr>
<th>Agency Name &amp; Address</th>
<th>Telephone/Fax Numbers</th>
<th>Web Address</th>
<th>Contact For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td>Tel (800)251-1268 9-5pm MST M-F (call center hours)</td>
<td><strong><a href="https://wymedicaid.portal.conduent.com">https://wymedicaid.portal.conduent.com</a></strong>&lt;br&gt;<a href="https://wymedicaid.portal.conduent.com/contact.html">https://wymedicaid.portal.conduent.com/contact.html</a></td>
<td>• Surgeries that require PA with dates of service prior to 02/01/2020 (listed in 6.13, Prior Authorization)&lt;br&gt;• Vision services that require PA with dates of service prior to 02/01/2020 (listed in 6.13, Prior Authorization)</td>
</tr>
<tr>
<td>PO Box 667, Cheyenne, WY 82003-0667</td>
<td>Fax (307)772-8405 24 / 7 (IVR availability)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:wycustomersvc@conduent.com">wycustomersvc@conduent.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Party Liability (TPL)</td>
<td>Tel (800)251-1268 OPTION 2 9-5pm MST M-F Fax (307)772-8405</td>
<td>N/A</td>
<td>• Provider enrollment questions&lt;br&gt;• Bulletin/Manuals inquiries&lt;br&gt;• Authorization for Medical Necessity Requirements&lt;br&gt;• Claim inquiries&lt;br&gt;• Claim submission problems&lt;br&gt;• Client eligibility&lt;br&gt;• Claim void/adjustment inquiries&lt;br&gt;• Form completion&lt;br&gt;• Payment inquiries&lt;br&gt;• Request Field Representative visit&lt;br&gt;• Training seminar questions&lt;br&gt;• Timely filing inquiries&lt;br&gt;• Troubleshooting prior authorization problems&lt;br&gt;• Verifying validity of procedure codes</td>
</tr>
<tr>
<td>PO Box 667, Cheyenne, WY 82003-0667</td>
<td>Select Option 2 for Medicare or estate and trust recovery assistance THEN Select Option 2 for callers who are with an insurance company, attorney’s office, or child support enforcement OR Select Option 3 for Medicare and Medicare Premium payments OR Select Option 4 for estate and trust recovery inquires</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Third Party Liability (TPL)**<br>PO Box 667<br>Cheyenne, WY 82003-0667

**IWR Navigation Tips available on the website**

**wycustomersvc@conduent.com**

**Tel (800)251-1268**

**OPTION 2** 9-5pm MST M-F Fax (307)772-8405

Select Option 2 for Medicare or estate and trust recovery assistance

THEN Select Option 2 for callers who are with an insurance company, attorney’s office, or child support enforcement

OR Select Option 3 for Medicare and Medicare Premium payments

OR Select Option 4 for estate and trust recovery inquires

---

**Client accident covered by liability or casualty insurance or legal liability is being pursued**

**Estate and Trust Recovery**

**Medicare Buy-In status**

**Reporting client TPL**

**New insurance coverage**

**Policy no longer active**

**Problems getting insurance information needed to bill**

**Questions or problems regarding third party coverage or payers**

**WHIPP program**
## Getting Help When Needed

<table>
<thead>
<tr>
<th>Agency Name &amp; Address</th>
<th>Telephone/Fax Numbers</th>
<th>Web Address</th>
<th>Contact For:</th>
</tr>
</thead>
</table>
| **Transportation Services**  
PO Box 667  
Cheyenne, WY 82003-0667 | Tel (800)595-0011  
9-5pm MST M-F  
(24/7 Voicemail Available)  
Fax (307)772-8405 | [https://wymedicaid.portal.conduent.com/client/](https://wymedicaid.portal.conduent.com/client/) | Client inquiries:  
- Prior authorize transportation arrangements  
- Request travel assistance  
- Verify transportation is reimbursable |
| **Comagine Health DMEPOS**  
PO Box 33400  
Seattle, WA 98133  
(Formerly known as Qualis Health) | Tel (800)783-8606  
8a-6pm MST M-F  
[ ] Prior authorization request for Durable Medical Equipment (DME) or Prosthetic/Orthotic Services (POS)  
[ ] PT/OT/ST/BH PAs after service threshold has been met  
[ ] Questions related to documentation or clinical criteria for DMEPOS  
[ ] Home Health |
| **WYhealth (Utilization and Care Management)**  
PO Box 49  
Cheyenne, WY 82003-0049 | Tel (888)545-1710  
Nurse Line: (OPTION 2)  
Fax PASRRs Only (888)245-1928 (Attn: PASRR Processing Specialist) | [http://www.WYhealth.net/](http://www.WYhealth.net/) | [ ] Medicaid Incentive Programs  
[ ] Diabetes Incentive Program  
[ ] ER Utilization Program  
[ ] P4P  
[ ] SBIRT  
[ ] Educational Information about WYhealth Programs  
Prior Authorization for:  
[ ] Acute Psych  
[ ] Extended Psych  
[ ] Extraordinary heavy care  
[ ] Gastric Bypass  
[ ] Genetic Testing  
[ ] Psychiatric Residential Treatment Facility (PRTF)  
[ ] Transplants  
[ ] Vagus Nerve Stimulator  
[ ] Surgeries that require PA with dates of service on or after 02/01/2020 (listed in 6.13, Prior Authorization)  
[ ] Vision services that require PA with dates of service on or after 02/01/2020 (listed in 6.13, Prior Authorization)  
[ ] Unlisted Procedures with dates of service on or after 02/01/2020 |
| **Aids Drug Assistance Program (ADAP)** | Tel (307)777-5800  
Fax (307)777-7382 | N/A | [ ] Prescription medications  
[ ] Program information |
| **Maternal & Child Health (MCH) /Children Special Health (CSH) Public Health Division**  
122 West 25th Street  
3rd Floor West  
Cheyenne, WY 82002 | Tel (307)777-7941  
Tel (800)438-5795  
Fax (307)777-7215 | N/A | [ ] High Risk Maternal  
[ ] Newborn intensive care  
[ ] Program information |
## Getting Help When Needed

<table>
<thead>
<tr>
<th>Agency Name &amp; Address</th>
<th>Telephone/Fax Numbers</th>
<th>Web Address</th>
<th>Contact For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Administration (SSA)</td>
<td>Tel (800)772-1213</td>
<td>N/A</td>
<td>Social Security benefits</td>
</tr>
<tr>
<td>Medicare</td>
<td>Tel (800)633-4227</td>
<td>N/A</td>
<td>Medicare information</td>
</tr>
<tr>
<td>122 West 25th St, 4th Floor West Cheyenne, WY 82002</td>
<td>Tel (866)571-0944 Fax (307)777-6964</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHCF Program Integrity</td>
<td>Tel (855)846-2563</td>
<td>N/A</td>
<td>Client or Provider Fraud, Waste and Abuse</td>
</tr>
<tr>
<td>122 West 25th St, 4th Floor West Cheyenne, WY 82002</td>
<td></td>
<td></td>
<td>NOTE: Callers may remain anonymous when reporting</td>
</tr>
<tr>
<td>Stop Medicaid Fraud</td>
<td>Tel (855)846-2563</td>
<td><a href="https://health.wyo.gov/healthcarefin/program-integrity/">https://health.wyo.gov/healthcarefin/program-integrity/</a></td>
<td>Information and education regarding fraud, waste, and abuse in the Wyoming Medicaid program, To report fraud, waste and abuse</td>
</tr>
<tr>
<td>DHCF Pharmacy Program</td>
<td>Tel (307)777-7531</td>
<td>N/A</td>
<td>General questions</td>
</tr>
<tr>
<td>122 West 25th St, 4th Floor West Cheyenne, WY 82002</td>
<td>Fax (307)777-6964</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change Healthcare</td>
<td>Tel (877)209-1264</td>
<td><a href="http://www.wymedicaid.org/">http://www.wymedicaid.org/</a></td>
<td>Pharmacy prior authorization, Enrollment, Pharmacy manuals, FAQs</td>
</tr>
<tr>
<td>(Pharmacy Help Desk)</td>
<td>Tel (877)207-1126 (PA Help Desk)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Customer Service Center (CSC) , Wyoming Department of Health | Tel (855)294-2127 TTY/TDD (855)29-5205 (Clients Only, CSC cannot speak to providers) 7-6pm MST M-F Fax (855)329-5205  | www.wesystem.wyo.gov | Client Medicaid applications, Eligibility questions regarding:  
  - Family and Children’s programs  
  - Tuberculosis Assistance Program  
  - Medicare Savings Programs  
  - Employed Individuals with Disabilities |
| 2232 Dell Range Blvd, Suite 300 Cheyenne, WY 82009 | | | |
| Wyoming Department of Health Long Term Care Unit (LTC) | Tel (855)203-2936 8-5pm MST M-F Fax (307)777-8399 | N/A | Nursing home program eligibility questions, Patient Contribution, Waiver Programs, Inpatient Hospital, Hospice, Home Health |
| Wyoming Medicaid                         | N/A                                    | https://wymedicaid.portal.conditional.com        | Provider manuals, HIPAA electronic transaction data exchange, Fee schedules, On-line Provider Enrollment, Frequently asked questions (FAQs), Forms (e.g., Claim Adjustment/Void Request Form), Contacts |

Ch. 2 Index 10 Revision 04/01/20
## 2.2 How to Call for Help

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

## 2.3 How to Write for Help

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

Reasons to write vs. calling:

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

To expedite the handling of written inquiries, we recommend providers use a Provider Inquiry Form ([2.3.1, Provider Inquiry Form](#)). Providers may copy the form in this manual. Provider Relations will respond to the provider inquiry within ten (10) business days of receipt.
2.3.1 Provider Inquiry Form

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

2.4 How to Get a Provider Training Visit

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

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

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

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

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

The Medicaid public website also links providers to Medicaid’s Secured Provider Web Portal, which delivers the following services:

- **278 Electronic Prior Authorization Requests** – Ability to submit and retrieve prior authorization requests and responses electronically via the web.
- **Data Exchange** – Upload and download of electronic HIPAA transaction files.
- **Remittance Advice Reports** – Retrieve recent Remittance Advices.
  - Wyoming Medicaid proprietary RA
    - 835 transaction
- **User Administration** – Add, edit, and delete users within the provider’s organization who can access the Secure Provider Web Portal.
- **837 Electronic Claim Entry** – Interactively enter dental, institutional and medical claims without buying expensive software.
- PASRR entry
- LT101 Look-Up

2.6 Training Seminars

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

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3.1 Enrollment/Re-Enrollment

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

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

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

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

<table>
<thead>
<tr>
<th>Screening Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Independent diagnostic testing facilities</td>
</tr>
<tr>
<td>• Physical therapists enrolling as individuals or as group practices</td>
</tr>
<tr>
<td>• Portable x-ray suppliers</td>
</tr>
<tr>
<td>• Revalidating home health agencies</td>
</tr>
<tr>
<td>• Revalidating DMEPOS suppliers</td>
</tr>
</tbody>
</table>

### HIGH

Includes:

- Prospective (newly enrolling) home health agencies
- Prospective (newly enrolling) DMEPOS suppliers
- Prosthetic/orthotic (newly enrolling) suppliers
- Individual practitioners suspected of identity theft, placed on previous payment suspension, previously excluded by the OIG, and/or previously had billing privileges denied or revoked within the last ten (10) years

Performs the “limited” and “moderate” screening requirements listed above.

Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a five (5) percent or greater direct or indirect ownership interest in the provider or supplier.

Conducts a fingerprint-based criminal history record check of the FBI’s Integrated Automated Fingerprint Identification System on all individuals who maintain a five (5) percent or greater direct or indirect ownership interest in the provider or supplier.

Categorical Risk Adjustment:

CMS adjusts the screening level from limited or moderate to high if any of the following occur:

- Exclusion from Medicare by the OIG
- Had billing privileges revoked by a Medicare contractor within the previous ten (10) years and is attempting to establish additional Medicare billing privilege by—
  - Enrolling as a new provider or supplier
  - Billing privileges for a new practice location
- Has been terminated or is otherwise precluded from billing Medicaid
- Has been excluded from any Federal health care program

Has been subject to a final adverse action as defined in §424.502 within the previous ten (10) years

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

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

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

The application fee is required for:

- New enrollments
- Enrollments for new locations
- Re-enrollments
• Medicaid requested re-enrollments (as a result of inactive enrollment statuses)

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

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

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

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

### 3.1.1 Ordering, Referring and Prescribing Providers (ORP)

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

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Taxonomy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 20s</td>
<td>Physicians (MD, DO, interns, residents and fellows)</td>
</tr>
<tr>
<td>111N00000X</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>1223s</td>
<td>Dentists</td>
</tr>
<tr>
<td>152W00000X</td>
<td>Optometrists</td>
</tr>
<tr>
<td>176B00000X</td>
<td>Midwife</td>
</tr>
<tr>
<td>213E00000X</td>
<td>Podiatrist</td>
</tr>
<tr>
<td>225100000X</td>
<td>Physical Therapists</td>
</tr>
<tr>
<td>225X00000X</td>
<td>Occupational Therapists</td>
</tr>
<tr>
<td>231H00000X</td>
<td>Audiologist</td>
</tr>
<tr>
<td>235X00000X</td>
<td>Speech Therapist</td>
</tr>
<tr>
<td>363A00000X</td>
<td>Physician Assistants (PA)</td>
</tr>
<tr>
<td>363Ls</td>
<td>Nurse Practitioners</td>
</tr>
</tbody>
</table>
### Taxonomies always required to include an ORP/attending NPI

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

### 3.1.2 Enrollment Termination

#### 3.1.2.1 License/Certification

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

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

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

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

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

3.1.2.3 Inactivity

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

3.1.2.4 Re-enrollment

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

3.1.3 Discontinuing Participation in the Medicaid Program

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

Notices should be addressed to Provider Relations, attention Enrollment Services (2.1, Quick Reference).

3.2 Accepting Medicaid Clients

3.2.1 Compliance Requirements

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

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

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

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

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

3.2.2 Provider-Patient Relationship

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

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

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

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

**When and what may be billed to a Medicaid client**

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

<table>
<thead>
<tr>
<th>Service is covered by Medicaid</th>
<th>Client is Covered by a FULL COVERAGE Medicaid Program and the provider accepts the client as a Medicaid client</th>
<th>Client is Covered by a LIMITED COVERAGE Medicaid Program and the provider accepts the client as a Medicaid client</th>
<th>FULL COVERAGE or LIMITED COVERAGE Medicaid Program and the provider does not accept the client as a Medicaid client</th>
<th>Client is not covered by Medicaid (not a Medicaid client)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider can bill the client only for any applicable copay</td>
<td>Provider can bill the client if the category of service is not covered by the client’s limited plan</td>
<td>Provider can bill the client if written notification has been given to the client that they are not being accepted as a Medicaid client</td>
<td>Provider may bill client</td>
<td></td>
</tr>
<tr>
<td>Service is covered by Medicaid, but client has exceeded his/her service limitations</td>
<td>Provider can bill the client OR provider can request authorization of medical necessity/prior authorization and bill Medicaid</td>
<td>Provider can bill the client OR provider can request authorization of medical necessity/prior authorization and bill Medicaid</td>
<td>Provider can bill the client if written notification has been given to the client that they are not being accepted as a Medicaid client</td>
<td>Provider can bill client</td>
</tr>
<tr>
<td>Service is not covered by Medicaid</td>
<td>Provider can bill the client only if a specific financial agreement has been made in writing</td>
<td>Provider can bill the client if the Category of service is not covered by the client’s limited plan. If the Category of service is covered, the provider can only bill the client if a specific financial agreement has been made in writing</td>
<td>Provider can bill the client if written notification has been given to the client that they are not being accepted as a Medicaid client</td>
<td>Provider can bill client</td>
</tr>
</tbody>
</table>
**Full Coverage Plan** – Plan covers the full range of medical, dental, hospital, and pharmacy services and may cover additional nursing home or waiver services.

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

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

### 3.2.2.1 Medicare/Medicaid Dual Eligible Clients

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

For clients on other plans who are dual eligible, coinsurance and deductible amounts remaining after Medicare payment cannot be billed to the client if the claim was billed to Wyoming Medicaid, regardless of payment amount (including claims that Medicaid pays at $0).

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

### 3.2.2.2 Accepting a Client as Medicaid after Billing the Client

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

- Prior to submitting the claim to Medicaid, the provider must refund the entire amount previously collected from the client to him or her for the services rendered; and
- The 12-month timely filing deadline will not be waived (**6.19, Timely Filing**).

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

- Prior to billing Medicaid, the provider must refund the entire amount previously collected from the client to him or her for the services rendered; and
- The 12 month timely filing deadline will be waived (**6.19, Timely Filing**).

**NOTE:** Medicaid will not pay for services rendered to the clients until eligibility has been determined for the month services were rendered.
The provider may, at a subsequent date, decide not to further treat the client as a Medicaid patient. If this occurs, the provider must advise the client of this fact in writing before rendering treatment.

### 3.2.2.3 Mutual Agreements between the Provider & Client

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

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

### 3.2.3 Missed Appointments

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

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

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

### 3.3 Medicare Covered Services

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

Questions concerning a client’s Medicare eligibility should be directed to the Social Security Administration (Quick Reference).
3.4 Medical Necessity

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

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

Additionally, the service must be:

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

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

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

3.5 Medicaid Payment is Payment in Full

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

The provider may never bill a Medicaid client:

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

- If the provider has not billed Medicaid, the service provided is not covered by Medicaid, and prior to providing service, the provider informed the client in writing that the service is non-covered and he/she is responsible for the charges.
- If a provider does not accept a patient as a Medicaid client (because they cannot produce a Medicaid ID card or because they did not inform the provider they are eligible).
- If the client is not Medicaid eligible at the time the provider provides the services or on a plan that does not cover those particular services. Refer the table above for guidance.
- If the client has reached the threshold on physical therapy, occupational therapy, speech therapy, chiropractic services, prescriptions, and/or office/outpatient hospital visits and has been notified that the services are not medical necessary in writing by the provider. (6.9 Service Thresholds)

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

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

### 3.6 Medicaid ID Card

It is each provider’s responsibility to verify the person receiving services is the same person listed on the card. If necessary, providers should request additional materials to confirm identification. It is illegal for anyone other than the person named on the Medicaid ID Card to obtain or attempt to obtain services by using the card. Providers who suspect misuse of a card should report the occurrence to the Program Integrity Unit or complete the Report of Suspected Abuse of the Medicaid Healthcare System Form (4.9, Referral of Suspected Fraud and Abuse).

### 3.7 Verification of Client Age

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

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

### 3.8 Verification Options

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

3.8.1 Free Services

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

- Contact Provider Relations. There is a limit of three (3) verifications per call but no limit on the number of calls.
- Fax a list of identifying information to Provider Relations for verification. Send a list of beneficiaries for verification and receive a response within ten (10) business days.
- Call the Interactive Voice Response (IVR) System. IVR is available 24 hours a day, seven (7) days a week. The IVR System allows 30 minutes per phone call. (2.1, Quick Reference).
- Use the Ask Wyoming Medicaid feature on the Secure Provider Web Portal (2.1, Quick Reference).

3.8.2 Fee-For-Service

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

3.9 Freedom of Choice

Any eligible non-restricted client may select any provider of health services in Wyoming who participates in the Medicaid Program, unless Medicaid specifically restricts his/her choice through provider lock-in or an approved Freedom of Choice waiver. However, payments can be made only to health service providers who are enrolled in the Medicaid Program.

3.10 Out-of-State Service Limitations

Medicaid covers services rendered to Medicaid clients when providers participating in the Medicaid Program administer the services. If services are available in Wyoming within a reasonable distance from the client’s home, the client must not utilize an out-of-state provider.
Medicaid has designated the Wyoming Medical Service Area (WMSA) to be Wyoming and selected border cities in adjacent states. WMSA cities include:

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

**Utah**
Salt Lake City
Ogden

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

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

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

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

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

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

Out-of-state providers furnishing services within the state on a routine or extended basis must meet all of the certification requirements of the State of Wyoming. The provider must enroll in Medicaid prior to furnishing service.
3.11 Record Keeping, Retention and Access

3.11.1 Requirements

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

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

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

3.11.2 Retention of Records

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

3.11.3 Access to Records

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

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

3.11.4 Audits

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

Audits may include, but are not limited to:

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

Actual records reviewed may be extrapolated and applied to all services billed by the provider.

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

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

Medicaid is authorized to examine all provider records in that:

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

Provider’s refusal to grant the State and its representative’s access to examine records or to provide copies of records when requested may result in:

- Immediate suspension of all Medicaid payments.
- All Medicaid payments made to the provider during the six (6) year record retention period for which records supporting such payments are not produced.
shall be repaid to the Division of Healthcare Financing after written request for such repayment is made.

- Suspension of all Medicaid payments furnished after the requested date of service.
- Reimbursement will not be reinstated until adequate records are produced or are being maintained.
- Prosecution under the Wyoming Statute.

### 3.12 Tamper Resistant RX Pads

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

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

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

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

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

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4.1 Utilization Review

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

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

4.2 Complaint Referral

The Program Integrity Unit receives and reviews complaints regarding fraud, waste and abuse from providers and clients. No action is taken without a complete investigation. To file a complaint, please call or submit the details in writing and attach supporting documentation to:

Division of Healthcare Financing
122 West 25th St, 4th Floor West
Attn: Program Integrity Unit
Cheyenne, WY 82002
Or contact: (855)846-2563
https://health.wyo.gov/healthcarefin/program-integrity/

4.3 Release of Medical Records

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

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

4.4 Client Lock-In

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

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

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

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

### 4.5 Pharmacy Lock-In

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

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

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

Expectations of a Medicaid designated Lock-In pharmacy:

- Medicaid pharmacy providers should be aware of the Pharmacy Lock-In Program and the criteria for client lock-in status as stated above. The entire pharmacy staff should be notified of current Lock-In clients.

- Review and monitor all drug interactions, allergies duplicate therapy, and seeking of medications from multiple prescribers. Be aware that the client is locked-in when “refill too soon” or “therapeutic duplication” edits occur. Cash payment for controlled substances should serve as an alert and require further review.
  - Gather additional information which may include, but is not limited to, asking the client for more information and/or contacting the prescriber. Document findings and outcomes. The Wyoming Board of Pharmacy will be contacted when early refills and cash payment are allowed without appropriate clinical care and documentation.
When doctor shopping for controlled substances is suspected, please contact the Medicaid Pharmacy Case Manager at (307)777-8773. The Wyoming Online Prescription Database (WORx) is online with 24/7 access for practitioners and pharmacists. The WORx program is managed by the Wyoming Board of Pharmacy at https://worxpdm.com/ to view client profiles with all scheduled II through IV prescriptions the client has received. The Wyoming Board of Pharmacy may be reached at (307)634-9636 to answer questions about WORx.

EMERGENCY LOCK-IN PRESCRIPTIONS

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

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

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

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

### 4.6 Hospice Lock-In

Clients requesting coverage of hospice services under Wyoming Medicaid are locked-in to the hospice for all care related to their terminal illness. All services and supplies must be billed to the hospice provider, and the hospice provider will bill Wyoming Medicaid for covered services. For more information regarding the hospice program, refer to the Chapter 17.

### 4.7 Fraud and Abuse

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

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

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

<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>

### 4.8 Provider Responsibilities

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

### 4.9 Referral of Suspected Fraud and Abuse

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

Division of Healthcare Financing  
122 West 25th St, 4th Floor West  
Attn: Program Integrity Unit  
Cheyenne, WY 82002  
Or contact: (855)846-2563  
https://health.wyo.gov/healthcarefin/program-integrity/
4.9.1 Report of Suspected Abuse of the Medicaid Healthcare System

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

4.10 Sanctions

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

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

4.11 Adverse Actions

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

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5.1 What is Medicaid?

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

5.2 Who is Eligible?

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

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

5.2.1 Children

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

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

5.2.3 **Family MAGI Adult**

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

5.2.4 **Aged, Blind or Disabled**

5.2.4.1 **Supplemental Security Income (SSI) and SSI Related**

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

5.2.4.2 **Institution**

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

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

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

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

5.2.5 Other

5.2.5.1 Special Groups

- Breast and Cervical Cancer (BCC) Treatment Program – Uninsured women diagnosed with breast or cervical cancer are income eligible at or below 250% of the FPL.
- Presumptive Eligibility (PE) for BCC allows temporary coverage for a woman who meets eligibility criteria for the full BCC Medicaid program.
  o PE Coverage will end the date a determination is made on the full Medicaid application or the last day of the next month after PE is approved if a full Medicaid application is not submitted.
- Tuberculosis (TB) Program – Individuals diagnosed with tuberculosis are eligible based on the SSI Standard.
- Program for All Inclusive Care for the Elderly (PACE) – Individuals over the age of 55 assessed to be in need of nursing home level of care, with income less than or equal to 300% of the SSI Standard, receive all services coordinated through the PACE provider. This program is currently available in Laramie County only.

5.2.5.2 Employed Individuals with Disabilities (EID)

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

5.2.5.3 Medicare Savings Programs

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

### 5.2.5.4 Non-Citizens with Medical Emergencies (ALEN)

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

### 5.3 Maternal and Child Health (MCH)

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

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

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

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

5.4.1 Applying for Medicaid

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

5.4.2 Determination

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

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

Medicaid assumes no financial responsibility for services rendered prior to the effective date of a client’s eligibility as determined by the WDH or the SSA. However, the effective date of eligibility as determined by the WDH may be retroactive up to 90 days prior to the month in which the application is filed, as long as the client meets eligibility criteria during each month of the retroactive period. If the SSA deems the client eligible, the period of original entitlement could precede the application date beyond the 90-day retroactive eligibility period and/or the 12 month timely filing deadline for Medicaid claims (6.19, Timely Filing). This situation could arise for the following reasons:

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

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

Sample Medicaid ID card:

![Sample Medicaid ID card](image)

5.6 Other Types of Eligibility Identification

5.6.1 Medicaid Approval Notice

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

NOTE: Refer to “Verification Options” (3.8, Verification Options) on ways to verify a client’s eligibility.
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6.1 Electronic Billing

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

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

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

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

Mail requests to:

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

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

6.2 Basic Claim Information

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

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

Billing errors detected after a claim is submitted cannot be corrected until after Medicaid has made payment or notified the provider of the denial. Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice ([6.17, Resubmitting Versus Adjusting Claims](#)).

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

### 6.3 Authorized Signatures

All paper claims must be signed by the provider or the provider’s authorized representative. Acceptable signatures may be either handwritten, a stamped facsimile, typed, computer generated, or initialed. The signature certifies all information on the claim is true, accurate, complete, and contains no false or erroneous information. Remarks such as signature on file or facility names will not be accepted.
6.4 The UB-04 Claim Form

6.4.1 Instructions for Completing the UB-04 Claim Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Item Description</th>
<th>Required Outpatient</th>
<th>Required Inpatient</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name and Address and Telephone</td>
<td>X</td>
<td>X</td>
<td>Enter the name of the provider submitting the bill, complete mailing address and telephone number.</td>
</tr>
<tr>
<td>2</td>
<td>Pay-To Name and Address</td>
<td>X</td>
<td>X</td>
<td>Enter the Pay-To Name and Address if different from 1.</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Control Number</td>
<td>X</td>
<td>X</td>
<td>(Optional) Enter the providers account number for the client. Any alpha/numeric character will be accepted and referenced on the R.A. No special characters are allowed.</td>
</tr>
<tr>
<td>3b</td>
<td>Medical Record Number</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Common Billing Information

Ch. 6 Index 51 Revision 04/01/20
<table>
<thead>
<tr>
<th>Field</th>
<th>Item Description</th>
<th>Required Outpatient</th>
<th>Required Inpatient</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>First Digit</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1 Hospital</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td></td>
<td>2 Skilled Nursing</td>
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<td>3 Home Health</td>
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<td>4 Clinic</td>
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<td></td>
<td>(ESRD,FQHC,RHC, or CORF)</td>
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<td></td>
<td>5 Special Facility (Hospital, CAH)</td>
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<td></td>
<td>Enter the three (3) digit code indicating the specific type of bill. The code sequence is as follows:</td>
<td></td>
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<tr>
<td></td>
<td>Second Digit</td>
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</tr>
<tr>
<td></td>
<td>1 Inpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 ESRD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Outpatient</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>4 Other</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>5 Intermediate</td>
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<td>Care Level 1</td>
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<td>Care Level 2</td>
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<td>6 Intermediate</td>
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<td>7 Subacute Inpatient</td>
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<tr>
<td></td>
<td>8 Swing bed</td>
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<td>Medicare/Medicaid</td>
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<tr>
<td>5</td>
<td>Federal Tax Number</td>
<td></td>
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</tr>
<tr>
<td>6</td>
<td>Statement Covers Period From/Through Dates</td>
<td>X</td>
<td>X</td>
<td>Refers to the unique identifier assigned by a federal or state agency.</td>
</tr>
<tr>
<td>7</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>Patient ID</td>
<td>X</td>
<td>X</td>
<td>Enter client’s Medicaid number.</td>
</tr>
<tr>
<td>8b</td>
<td>Patient Name</td>
<td>X</td>
<td>X</td>
<td>Enter the client’s name as shown on the front of the Medicaid card.</td>
</tr>
<tr>
<td>Field</td>
<td>Item Description</td>
<td>Required Outpatient</td>
<td>Required Inpatient</td>
<td>Action</td>
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<tr>
<td>9</td>
<td>Patient Address</td>
<td>X</td>
<td>X</td>
<td>Enter the full mailing address of client.</td>
</tr>
<tr>
<td>10</td>
<td>Patient Birthdate</td>
<td>X</td>
<td>X</td>
<td>Enter client’s birthdate (MMDDYY).</td>
</tr>
<tr>
<td>11</td>
<td>Patient Sex</td>
<td>X</td>
<td>X</td>
<td>(Optional) Enter appropriate code.</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>X</td>
<td>X</td>
<td>Enter the date the patient was admitted as an inpatient or the date of outpatient care.</td>
</tr>
<tr>
<td>14</td>
<td>Type of Admission/Visit</td>
<td>X</td>
<td>X</td>
<td>Enter appropriate code: 1 = Emergency 2 = Urgent Care 3 = Elective (non-emergency) 4 = Newborn 5 = Trauma Physician/medical professional will need to determine if the visit or service was an emergency.</td>
</tr>
<tr>
<td>15</td>
<td>Source of Admission</td>
<td>X</td>
<td>X</td>
<td>Enter the Source of Admission Code</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour</td>
<td>X</td>
<td>N/A</td>
<td>(When applicable) Enter the hour the client was discharged.</td>
</tr>
<tr>
<td>17</td>
<td>Patient Discharge Status</td>
<td>X</td>
<td>X</td>
<td>Enter the two (2) digit code indicating the status of the patient as noted below: Code Description</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Code</td>
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<td>01</td>
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## Common Billing Information

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<thead>
<tr>
<th>Field</th>
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<th>Action</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Outpatient</td>
<td>Inpatient</td>
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</tr>
<tr>
<td>18-28</td>
<td>Condition Codes</td>
<td>Situational</td>
<td>Situational</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Accident State</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence Code and Dates</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence Span Codes and Dates</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable</td>
</tr>
<tr>
<td>37</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Subscriber Name and Address</td>
<td>X</td>
<td>X</td>
<td>Enter client’s name and address.</td>
</tr>
<tr>
<td>39-41</td>
<td>Value Codes and Amounts</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Codes</td>
<td>X</td>
<td>X</td>
<td>Enter the appropriate revenue codes.</td>
</tr>
<tr>
<td>43</td>
<td>Revenue Code Description</td>
<td>X</td>
<td>X</td>
<td>Enter appropriate revenue code descriptions.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Rates</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable</td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td>X</td>
<td>X</td>
<td>Enter date(s) of service.</td>
</tr>
<tr>
<td>46</td>
<td>Units of Service</td>
<td>X</td>
<td>X</td>
<td>Enter the units of services rendered for each detail line. A unit of service is the number of time a procedure is performed. If only one (1) service is performed, the numeral 1 must be entered.</td>
</tr>
<tr>
<td>48</td>
<td>Non-Covered Charges</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>49</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Payer Identification (Name)</td>
<td>X</td>
<td>X</td>
<td>Enter name of payer.</td>
</tr>
<tr>
<td>51</td>
<td>Health Plan Identification Number</td>
<td>X</td>
<td>X</td>
<td>(Optional) Enter Health Plan ID for payer.</td>
</tr>
<tr>
<td>52</td>
<td>Release of Info Certification</td>
<td>X</td>
<td>X</td>
<td>Enter Y for release on file</td>
</tr>
<tr>
<td>53</td>
<td>Assignment of Benefit Certification</td>
<td>X</td>
<td>X</td>
<td>Y marked in this box indicates provider agrees to accept assignment under the terms of the Medicare program.</td>
</tr>
<tr>
<td>54</td>
<td>Prior Payments</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>55</td>
<td>Estimated Amount Due</td>
<td>X</td>
<td>X</td>
<td>Enter remaining total is prior payment was made.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>X</td>
<td>X</td>
<td>Enter Pay-To NPI.</td>
</tr>
<tr>
<td>57</td>
<td>Other Provider IDs</td>
<td>Optional</td>
<td>Optional</td>
<td>Enter legacy ID.</td>
</tr>
<tr>
<td>58</td>
<td>Insured’s Name</td>
<td>X</td>
<td>X</td>
<td>Enter client or insured’s name.</td>
</tr>
<tr>
<td>Field</td>
<td>Item Description</td>
<td>Required</td>
<td>Required</td>
<td>Action</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>59</td>
<td>Patient’s Relation to the Insured</td>
<td>X</td>
<td>X</td>
<td>Enter appropriate relationship to insured.</td>
</tr>
<tr>
<td>60</td>
<td>Insured’s Unique ID</td>
<td>X</td>
<td>X</td>
<td>Enter client’s Medicaid ID.</td>
</tr>
<tr>
<td>61</td>
<td>Insured Group Name</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>62</td>
<td>Insured Group Name</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>64</td>
<td>Document Control Number</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>65</td>
<td>Employer Name</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>66</td>
<td>Diagnosis/Procedure Code Qualifier</td>
<td>X</td>
<td>X</td>
<td>Enter appropriate qualifier.</td>
</tr>
<tr>
<td>67</td>
<td>Principal Diagnosis Code/Other Diagnosis Codes</td>
<td>X</td>
<td>X</td>
<td>Enter all applicable diagnosis codes.</td>
</tr>
<tr>
<td>67</td>
<td>Present on Admission Indicator (shaded area)</td>
<td>X</td>
<td></td>
<td>Enter the appropriate POA indicator on each required diagnosis in the shaded area to the right of the diagnosis box</td>
</tr>
<tr>
<td>68</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis Code</td>
<td>X</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>70</td>
<td>Patient’s Reason for Visit Code</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>71</td>
<td>PPS Code</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>72</td>
<td>External Cause of Injury Code</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>73</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Principal Procedure Code/Date</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>75</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Attending Name/ID-Qualifier 1-G</td>
<td>X</td>
<td>X</td>
<td>Enter the Attending Physician’s NPI, appropriate qualifier, last name, and first name.</td>
</tr>
<tr>
<td>77</td>
<td>Operating ID</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>78-79</td>
<td>Other ID</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>Situational</td>
<td>Situational</td>
<td>Enter if applicable.</td>
</tr>
<tr>
<td>81</td>
<td>Code/Code Field Qualifiers *B3 Taxonomy</td>
<td>X</td>
<td>X</td>
<td>Enter B3 to indicate taxonomy and follow with the appropriate taxonomy code.</td>
</tr>
</tbody>
</table>
## 6.4.2 Appropriate Bill Type and Provider Taxonomy Table

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

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

6.5.1 General information

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

6.5.2 Billing Information

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

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

6.6.1 Client has Medicaid Coverage Only
### 6.6.2 Client has Medicaid and Medicare

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

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

NOTE: If the client has both Medicare and TPL in addition to Medicaid, attach the TPL EOB and the Medicare EOMB to the claim. If the client has TPL and Medicaid but no Medicare, attach the TPL EOB to the claim.
6.7 Provider Preventable Conditions (PPC)

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

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

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

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

6.7.1 Providers Included in the PPC Review

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

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

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

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

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

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

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

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

6.8 Value Codes

Most frequently used value codes by Wyoming Medicaid providers:

**Value code 54**

- Must be populated on Inpatient and Inpatient crossover claims.
- Must be populated when:
  - Newborn is less than or equal to 29 days old.
- Inpatient/Inpatient crossover claims will be denied if:
  - If value code 54 is submitted with value of 0 or less
  - Or value code 54 is submitted with value of 10,000 greater
  - Or value code 54 is submitted multiple times on a claim
Value Code 80 and 81

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

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

6.9 National Drug Code (NDC) Billings Requirement

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

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

\[
\begin{array}{ccc}
6 & 5 & 2 & 9 & 3 & - & 0 & 0 & 0 & 1 & - & 0 & 1 \\
\text{Labeler Code} & \text{Product Code} & \text{Package Code} \\
(5 \text{ Digits}) & (4 \text{ Digits}) & (2 \text{ Digits})
\end{array}
\]

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

6.9.1 Converting 10-Digit NDCs to 11 Digits

Many NDCs are displayed on drug products using a 10-digit format. However, to meet the requirements of the new policy, NDCs must be billed to Medicaid using the 11-digit FDA standard. Converting an NDC from 10 to 11 digits requires the strategic placement of a zero (0). The following table shows three (3) common 10 digit NDC formats converted to 11 digits.
### 6.9.2 Documenting and Billing the Appropriate NDC

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

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

### 6.9.3 Billing Requirements

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

### 6.9.4 Submitting One NDC per Procedure Code

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

<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>
6.9.5 Submitting Multiple NDCs per Procedure Code

If two (2) or more NDCs are to be submitted for a procedure code, the procedure code must be repeated on separate lines for each unique NDC. For example, if a provider administers 150 mg of Synagis, a 50 mg vial and a 100 mg vial would be used. Although the vials have separate NDCs, the drug has one (1) procedure code, 90378. So, the procedure code would be reported twice on the claim, but paired with different NDCs.

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

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

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

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

6.9.7 UB-04 Billing Instructions

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

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

Do not enter a space between the N4 qualifier and the NDC. Do not enter hyphens or spaces within the NDC.
6.9.7.1  **UB-04 One NDC per Procedure Code**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>NDC Group 1</th>
<th>Date</th>
<th>Units</th>
<th>Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0636</td>
<td>N46057441101</td>
<td>100115</td>
<td>2</td>
<td>500.00</td>
</tr>
</tbody>
</table>

6.9.7.2  **UB-04 Two NDCs per Procedure Code**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>NDC Group 1</th>
<th>Date</th>
<th>Units</th>
<th>Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0636</td>
<td>N46057441101</td>
<td>100115</td>
<td>2</td>
<td>500.00</td>
</tr>
<tr>
<td>0636</td>
<td>N46057441101</td>
<td>100115</td>
<td>1</td>
<td>250.00</td>
</tr>
</tbody>
</table>

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

6.10  **Service Thresholds**

6.10.1  **Under Age 21**

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

- Physical therapy visits
- Occupational therapy visits
- Speech therapy visits
- Chiropractic visits
- Dietitian visits
- Emergency dental visits

6.10.2  **Ages 21 and older**

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

- Office/outpatient hospital visits
- Physical therapy visits
- Occupational therapy visits
- Speech therapy visits
- Chiropractic visits
- Dietitian visits
- Emergency dental visits
- Behavioral health visits
### OFFICE AND OUTPATIENT HOSPITAL VISITS

<table>
<thead>
<tr>
<th>Codes</th>
<th>Service Threshold</th>
<th>Does not apply to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Procedure Codes:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99281-99285</td>
<td>12 combined visits per calendar year</td>
<td>• Clients Under Age 21</td>
</tr>
<tr>
<td>99201-99215</td>
<td></td>
<td>• Emergency Visits</td>
</tr>
<tr>
<td><strong>Revenue Codes:</strong></td>
<td></td>
<td>• Family Planning Services</td>
</tr>
<tr>
<td>0450-0459</td>
<td></td>
<td>• Medicare Paid Crossovers</td>
</tr>
<tr>
<td>0510-0519</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, BEHAVIORAL HEALTH VISITS, CHIROPRACTIC VISITS AND DIETITIAN

<table>
<thead>
<tr>
<th>Codes</th>
<th>Service Threshold</th>
<th>Does not apply to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Procedure codes:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90785; 90791; 90792; 90832-90834; 90836-90839; 90845-90849; 90853; 90857; 92507-92508; 92526; 92609; 96105-96146; 97010-97039; 97110-97150; 97161-97546; 97802-97804; 98940-98942; (all modalities on same date of service count as 1 visit)</td>
<td>20 physical therapy visits per calendar year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>20 occupational therapy visits per calendar year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 speech therapy visits per calendar year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 behavioral health visits per calendar year (21 and over only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20 chiropractic visits per calendar year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20 dietitian visits per calendar year</td>
</tr>
<tr>
<td><strong>HCPCS Level II codes:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G9012; H0004; H0031; H0038; H2010; H2014; H2017; H2019; T1017 (all modalities on same date of service count as 1 visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Revenue codes:</strong></td>
<td>0421 and 0441 (each unit counts as 1 visit)</td>
<td>• Medicare Paid Crossovers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inpatient and ER behavioral health services</td>
</tr>
</tbody>
</table>
6.10.3 Authorization of Medical Necessity

Once the threshold has been reached, or once the provider is aware the threshold will be met and the client is nearing the threshold, an Authorization of Medical Necessity may be requested for the following services:

- Dietitian visits
- Chiropractic visits

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

The form must be mailed to:

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

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

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

NOTE: Click image above to be taken to a printable version of this form.
### 6.10.3.2 Instructions for Completing the Authorization of Medical Necessity Form

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

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

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

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

- When a claim is submitted for the 13th office or outpatient hospital visit, the client will be enrolled into a care management program with our partner, WYhealth to help manage their medical conditions and healthcare needs.
- Both the client and any providers who have billed office or outpatient hospital visits for the client in that calendar year will receive a letter informing them the client has exceeded the 12 visit threshold and the client has been enrolled into the care management program.
- Wyoming Medicaid will use the client’s participation in the care management program to determine the medical necessity for services provided, and will continue to process additional claims for office or outpatient hospital visits according to Medicaid guidelines.
- As long as the client continues to participate in the care management program, no further action is required, by the provider, for claims to process as normal.
- Should the client choose not to participate in the program, the client and the provider will receive another letter informing them that office visit and outpatient hospital visit claims will need to be reviewed for medical necessity before being processed for payment.
  - The review of medical necessity may include review of diagnosis codes on the claim, a call from the UM Coordinator to the provider’s office, or a written request for medical records regarding the visit.
  - Providers may choose to bill the client so long as they have informed the client up front in writing before the service that the service is not medically necessary, or that they will not be providing medical records to help Medicaid determine the medical necessity of the visit, or that they will not be billing Medicaid.
- The client can begin or resume participation in the care management program at any point after meeting the threshold to reinstate claims processing without additional verification of medical necessity by the provider.
NOTE: Claims that are for clients under the age of 21 that are coded as emergencies, family planning, or where Medicare has paid as primary are not subject to this process and do not count towards this threshold.

6.10.5 Prior Authorization Once Thresholds are Met

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

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

Requests can be made by:

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

6.11 Reimbursement Methodologies

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

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

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

6.12 Co-Payment Schedule

<table>
<thead>
<tr>
<th>Procedure and Revenue Code(s)</th>
<th>Description</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015 and 0521 Revenue Code</td>
<td>Rural Health Clinic encounters</td>
<td>Co-payment requirements do not apply to:</td>
</tr>
<tr>
<td>T1015 and 0520 Revenue Code</td>
<td>Federally Qualified Health Center encounters</td>
<td>• Clients under age 21</td>
</tr>
<tr>
<td>0450-0459 and 0510-0519</td>
<td>Outpatient hospital visits (non–emergency)</td>
<td>• Nursing Facility Residents</td>
</tr>
<tr>
<td></td>
<td></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>• Inpatient Hospital stays</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Members of a Federally recognized tribe</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Type of Admission/Visit Indicator Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emergency</td>
</tr>
<tr>
<td>2</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>3</td>
<td>Elective (non-emergent)</td>
</tr>
<tr>
<td>4</td>
<td>Newborn</td>
</tr>
<tr>
<td>5</td>
<td>Trauma</td>
</tr>
</tbody>
</table>
6.13 How to Bill for Newborns

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

6.14 Prior Authorization

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

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

<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</td>
<td>• Community Choice Waiver (CCW)</td>
</tr>
<tr>
<td></td>
<td>Case manager will contact the DHCF</td>
<td>• Out-of-State Home Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-State Placement for LTC Facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comprehensive Developmental Disability Waivers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support Developmental Disability Waivers</td>
</tr>
<tr>
<td>Change Healthcare</td>
<td>(877)207-1126</td>
<td>• Pharmacy</td>
</tr>
<tr>
<td>Magellan</td>
<td>(855)883-8740</td>
<td>• Children’s Mental Health Waiver Services</td>
</tr>
<tr>
<td>Medical Policy</td>
<td>(800)251-1268 Option 1, 1, 4, 3</td>
<td>• Belimuab Injections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Botox, Dysport, and Myobloc Injections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dental Implants &amp; fixed bridges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hospice Services: Limited to clients residing in a nursing home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ilaris/Cankinumab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ocrevus/Ocrelizumab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Oral &amp; Maxillofacial Surgeries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pralatrexate</td>
</tr>
</tbody>
</table>
### Agency Name | Phone | Services Requiring PA
---|---|---
Comagine Health (DMEPOS) | (800)783-8606 | - Reslizumab (CINQAIR) IV Infusion Treatment
- Severe Malocclusion
- Specialized Denture Services
- Synvisc & Hylagen Injections
- Tysabri IV Infusion Treatment

**Requests with dates of service prior to 02/01/2020**
- Any code within range 10000-99999 that required prior authorization
- Cochlear Implant – 1x/5yrs
- Vision – Lenses, Contacts, & Scleral Shells

WYhealth (Utilization and Care Management) | (888)545-1710 | - Durable Medical Equipment (DME)
- Prosthetic and Orthotic Supplies (POS)
- Home Health
- PT/OT/ST/BH once threshold has been met

**Requests with dates of service on or after 02/01/2020:**
- Any code within range 10000-99999 that requires prior authorization
- Cochlear Implant – 1x/5yrs
- Unlisted Codes
- Vision – Lenses, Contacts, & Scleral Shells

---

### 6.14.1 Requesting Prior Authorization from Medical Policy

This section only applies to providers requesting PA for 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 (3) ways to request and receive a PA:

- **Phone Call**
- **Fax**
- **Electronic System**
• Prior Authorization Form (6.14.1.1, Medicaid Prior Authorization Form). A hardcopy form for requesting a PA by mail or fax. For a copy of the form and instructions on how to complete it, refer to the following section.

• X12N 278 Prior Authorization Request and Response. A standard electronic file format used to transmit PA requests and receive responses. For additional information, refer to Chapter 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications; or

• Web-Based Entry (Limited to Medical Policy PA requests). A web-based option for entering PA requests and receiving responses via Medicaid’s Secured 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. (2.1, Quick Reference). For additional information, refer to Chapter 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications.

6.14.1 Medicaid Prior Authorization Form

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

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

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

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

6.14.3 Prior Authorization Approval

Once a PA is approved, an approval letter (sample approval letter below) is mailed that includes the PA number. The PA number must be entered in box 63 of the UB-04 claim form. For placement in an electronic X12N 837 Institutional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at http://www.wpc-edi.com.

NOTE: A PA may have both approved and denied lines.
### 6.14.3.1 Sample PA Approval Letter

<table>
<thead>
<tr>
<th>Date</th>
<th>Authorization Period</th>
<th>Service Description</th>
<th>Approved Units</th>
<th>Unit Price</th>
<th>Used Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/15</td>
<td>01/01/15 - 01/31/15</td>
<td>T2041 - Supports Brokerage, Self Directed, 12 Min</td>
<td>300</td>
<td>$3.32</td>
<td>202</td>
</tr>
<tr>
<td>02/01/15</td>
<td>02/01/15 - 02/28/15</td>
<td>T2041 - Supports Brokerage, Self Directed, 15 Min</td>
<td>300</td>
<td>$3.32</td>
<td>0</td>
</tr>
</tbody>
</table>

**Code Explanations:**

**No Denial Reason Provided**

**Comment:**

A8200RB1

**Note:** Prior Authorization Approval does not guarantee eligibility. Payment is subject to the recipient's eligibility and Medicaid benefit limitations. Verify eligibility before rendering services.

<table>
<thead>
<tr>
<th>PA-Number</th>
<th>A8200RB1</th>
</tr>
</thead>
</table>

**NOTE:** For lines that are approved, the corresponding item may be purchased or delivered, or service may be rendered.
6.14.4 Prior Authorization Pending

If a PA request is in a pending status, it is either the result of an emergency request made over the phone to Medical Policy or the form and/or documentation are incomplete. A claim cannot be billed using a PA number from a pending request (2.1, Quick Reference).

6.14.4.1 Sample PA Pending Letter:

![Sample PA Pending Letter]

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

### 6.14.5 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.

#### 6.14.5.1 Sample PA Denial Letter:

```
10/01/15 MEDICAID PRIOR AUTHORIZATION NOTICE

SAMPLE PROVIDER OF WYOMING
1234 SAMPLE STREET
SAMPLE WY 82001

Client: Sample Client
Client ID: 0000062141
PA-Number: 00198000001

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

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

01/18/15-01/18/16 V2715 - PRISM, PER LENS DENIED
  APPR UNITS: 0 USED UNITS: 0

CODE EXPLANATIONS:

800 SERVICE NOT COVERED BY WYOMING MEDICAID

COMMENT:

DOES NOT FALL WITHIN AGE GUIDELINES FOR PROC CODE

NOTE: PRIOR AUTHORIZATION APPROVAL DOES NOT GUARANTEE ELIGIBILITY. PAYMENT IS SUBJECT TO THE RECIPIENT'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.
6.15 Submitting Attachments for Electronic Claims

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

Steps for submitting electronic attachments

- The fiscal agent has created a process that allows providers to submit electronic attachments for electronic claims. Providers need only follow these steps:
  1. Mark the attachment indicator on the electronic claim. For more information on the attachment indicator, consult the provider software vendor or clearinghouse, or the X12N 837 Professional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at http://www.wpc-edi.com.
  2. Log onto Secured Provider Web Portal
  3. Under the submissions menu select Electronic Attachments
  4. Complete required information – information must match the claim as submitted i.e., DOS, client information, provider information, and the name of the attachment must be identical to what was submitted in the electronic file (with no spaces).
  5. Select Browse
  6. Navigate to the location of the electronic attachment on the provider’s computer
  7. Click Upload
  8. For support and additional information refer to Chapter 8 and Chapter 9 or contact EDI Services (2.1, Quick Reference).

**NOTE:** One (1) attachment per claim, providers may not attach one (1) document to many claims. Also, if the attachment is not received within 30 days of the electronic claim submission, the claim will deny and it will be necessary to resubmit it with the proper attachment.

Steps for submitting paper attachments by mail.

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

Steps for submitting paper attachments by email.

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

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

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

6.16 Sterilization, Hysterectomy and Abortion Consent Form

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

- Sterilization Consent Form
- Hysterectomy Consent Form
- Abortion Certification Form
6.16.1 Sterilization Consent Form and Guidelines

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

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

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

---

**FEDERAL GUIDELINES**

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

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

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

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

All blanks on the consent form must be completed with the requested information. The consent form must be signed and dated by the client, the interpreter (if one is necessary), the person who obtained the consent, and the physician who will perform the sterilization. The physician statement on the consent form must be signed and dated by the physician who will perform the sterilization on the date of the sterilization or after the sterilization procedure was performed. The date on the sterilization claim form must be identical to the date and type of operation given in the physician’s statement.
6.16.1.1 Sterilization Consent Form

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

6.16.1.2 Instructions for Completing the Sterilization Consent Form

Important tips for completing the Sterilization Consent Form

- Print legibly to avoid denials – the entire form must be legible.
- The originating practitioner has ownership of this form and must supply correct, accurate copies to all involved billing parties.
- Fields 7, 8 and 15, 16 must be completed prior to the procedure.
- All fields may be corrected; however, corrections must be made with one (1) line through the error and must be initialed.
  - The person that signed the line is the only person that can make the alteration
  - Whiteout/Correction Tape 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 (1) 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>Statement of person obtaining consent</td>
<td>14</td>
<td>Enter the name of the operation (no abbreviations)</td>
</tr>
<tr>
<td>Physician’s Statement</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></td>
<td>19</td>
<td>Enter the client’s name</td>
</tr>
<tr>
<td>Physician’s Statement</td>
<td>20</td>
<td>Enter the date of sterilization operation</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, the provider 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>
6.16.2 Hysterectomy Acknowledgment of Consent

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

NOTE: Instructions for attaching documents to claims refer to Chapter 6 (6.14, Submitting Attachments for Electronic Claims).

6.16.2.1 Hysterectomy Acknowledgement of Consent

Hysterectomy Acknowledgment of Consent

NOTE: Click image above to be taken to a printable version of this form.
### 6.16.2.2 Instructions for Completing the Hysterectomy Acknowledgement 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>
</tbody>
</table>
| | 10 | Check applicable box:  
  - If other reason for sterility is checked, the provider must write what was done.  
  - If previous tubal is checked, the provider must enter the date of the tubal.  
  - If emergency situation is checked, the provider must enter the description. |
| | 11 | The physician who performed the hysterectomy signs here and dates. |

### 6.16.3 Abortion Certification Guidelines

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

![Abortion Certification Form](image)

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

## 6.16.3.2 Instructions for Completing the Abortion Certification Form

<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, 3 or 4) that is appropriate</td>
</tr>
<tr>
<td>3</td>
<td>Enter the name of the client receiving the surgery</td>
</tr>
<tr>
<td>4</td>
<td>Enter the client’s address</td>
</tr>
<tr>
<td>5</td>
<td>The physician or surgeon performing the abortion will sign and date here.</td>
</tr>
<tr>
<td>6</td>
<td>Enter the performing physician’s address.</td>
</tr>
</tbody>
</table>
6.17 Remittance Advice

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

The RA is organized in the following manner:

- The first page or cover page is important and should not be overlooked it may include an RA Banner notification from Wyoming Medicaid (1.2.1, RA Banner Notices/Samples).
- Claims are grouped by disposition category.
  - Claim Status PAID group contains all the paid claims.
  - Claim Status DENIED group reports denied claims.
  - Claim Status PENDED group reports claims pended for review. Do not resubmit these claims. All claims in pended status are reported each payment cycle until paid or denied. Claims can be in a pended status for up to 30 days.
  - Claim Status ADJUSTED group reports adjusted claims.
- All paid, denied, and pended claims and claim adjustments are itemized within each group in alphabetic order by client last name.
- A unique Transaction Control Number (TCN) is assigned to each claim. TCNs allow each claim to be tracked throughout the Medicaid claims processing system. The digits and groups of digits in the TCN have specific meanings, as explained below:

```
00518022001000100
```

- Claim Number
- Type of Document (0=new claim, 1=credit, 2=adjustment)
- Batch Number
- Imager Number
- Year/Julian Date
- Claim Input Medium Indicator
  - 0=Paper Claim
  - 1=Point of Sale (Pharmacy)
  - 2=Electronic Crossovers sent by Medicare
  - 3=Electronic claims submission
  - 4=Electronic adjustment
  - 5=Special Processing required
• The RA Summary Section reports the number of claim transactions, and total payment or check amount.
6.17.1 Sample Institutional Remittance Advice

<table>
<thead>
<tr>
<th>TRANS-CONTROL NUMBER</th>
<th>BILLED</th>
<th>OTHER</th>
<th>PAID BY</th>
<th>COPAY</th>
<th>WRITE</th>
<th>DIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1ST-LAST DATE</td>
<td>PROC/MOD</td>
<td>REV</td>
<td>UNITS</td>
<td>AMT.</td>
<td>INS.</td>
<td>MCAID</td>
</tr>
<tr>
<td>3-08241-00-029-0000-08</td>
<td>797.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>LI: 001 08/19/15 08/19/15</td>
<td>0270</td>
<td>3</td>
<td>24.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>LINE EOB (S): 690</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LI: 002 08/19/15 08/19/15</td>
<td>0272</td>
<td>2</td>
<td>54.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>LINE EOB (S): 690</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LI: 003 08/19/15 08/19/15 44310</td>
<td>0320</td>
<td>1</td>
<td>541.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>LINE EOB (S): 661</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LI: 004 08/19/15 08/19/15</td>
<td>0621</td>
<td>1</td>
<td>78.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>LINE EOB (S): 690</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REMITTANCE ADVICE

TO: SAMPLE PROVIDER R.A. NO.: 0101010 DATE PAID: 00/00/00 PROVIDER NUMBER: 1234567890 PAGE: 2

PAID ORIGINAL CLAIMS: NUMBER OF CLAIMS 0 ------ 0.00 0.00
PAID ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0 ------ 0.00 0.00
DENIED ORIGINAL CLAIMS: NUMBER OF CLAIMS 4 ------ 320.00 0.00
DENIED ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0 ------ 0.00 0.00
PENDED CLAIMS (IN PROCESS): NUMBER OF CLAIMS 0 ------ 0.00 0.00
AMOUNT OF CHECK: ------------------------------ 0.00

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

690 SERVICE ON SAME DAY AS INPATIENT PROCEDURE CODE

661 INPATIENT PROCEDURES AND INPATIENT SEPARATE PROCEDURES NOT PAID
### 6.17.2 How to Read a 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>
</tbody>
</table>
| S                | How the system priced each claim. For example, claims priced manually have a distinct code. Claims paid according to the Medicaid fee schedule have another code. Below is a table which describes these pricing source codes:
Plan The Medicaid and State Healthcare Benefit Plan the client is eligible for (Section A.3).

Line EOB(s) Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA.

### 6.17.3 Remittance Advice Replacement Request Policy

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

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

The replacement RA will be emailed, faxed or mailed as requested on the form. Email is the preferred method of delivery, and RAs of more than ten (10) pages will not be faxed.
RA less than 24 weeks old can be obtained from the Secured Provider Web Portal, once a provider has registered for access (8.5.2.1. 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>

6.17.3.1 Remittance Advice (RA) Replacement Request Form

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

6.17.4 Obtaining an RA from the Web

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

If the client has other insurance coverage reflected in Medicaid records, payment 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 (7.2.1, Third Party Resources Information Sheet) should be used for reporting new insurance coverage or changes in insurance coverage on a client’s policy.

6.18 Resubmitting Versus Adjusting Claims

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Timely Filing Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOID</td>
<td>Claim has paid; however, the provider would like to completely cancel the claim as if it was never billed.</td>
<td>May be completed any time after the claim has been paid.</td>
</tr>
<tr>
<td>ADJUST</td>
<td>Claim has paid, even if paid $0.00; however, the provider would like to make a correction or change to this paid claim</td>
<td>Must be completed within six (6) months after the claim has paid UNLESS the result will be a lower payment being made to the provider, then no time limit.</td>
</tr>
<tr>
<td>RESUBMIT</td>
<td>Claim has denied entirely or a single line has denied, the provider may resubmit on a separate claim.</td>
<td>One (1) year from the date of service.</td>
</tr>
</tbody>
</table>
6.18.1 How Long do Providers Have to Resubmit or Adjust a Claim?

The deadlines for resubmitting and adjusting claims are different:

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

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

6.18.2 Resubmitting a Claim

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

How to Resubmit:

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

6.18.2.1 When to Resubmit to Medicaid

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

Adjusting paid claims via hardcopy/paper.

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

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

Denied claims cannot be adjusted.

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

6.18.3.1 Adjustment/Void Request Form

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

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

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

6.18.3.3 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, 1b</td>
<td>Claim Adjustment 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 BLUE ink (do not use red ink or highlighter) or the RA. Attach all supporting documentation required to process the claim, i.e. EOB, EOMB, consent forms, invoice, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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></td>
<td></td>
<td>Sections B and C must be completed.</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>Payment Date</td>
<td>Enter the Payment Date</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Nine (9) digit Provider or ten (10) digit NPI Number</td>
<td>Enter provider’s nine (9) digit Medicaid provider number or ten (10) digit NPI number, if applicable.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Provider Name</td>
<td>Enter the provider name.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Ten (10) digit Client Number</td>
<td>Enter the client’s ten (10) digit Medicaid ID number.</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Ten (10) digit PA Number</td>
<td>Enter the ten (10)-digit Prior Authorization number, if applicable.</td>
</tr>
</tbody>
</table>
Adjusting a claim electronically via an 837 transaction

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

6.18.3.4 When to Request an Adjustment

- When a claim was overpaid or underpaid.
- When a claim was paid, but the information on the claim was incorrect (such as client ID, date of service, procedure code, diagnoses, units, etc.)
- When Medicaid pays a claim and the provider subsequently receives payment from a third party payer, the provider must adjust the paid claim to reflect the TPL amount paid.
  - If an adjustment is submitted stating that TPL paid on the claim, but the TPL paid amount is not indicated on the adjustment or an EOB is not sent in with the claim, Medicaid will list the TPL amount as either the billed or reimbursement amount from the adjusted claim (whichever is greater). It will be up to the provider to adjust again, with the corrected information.

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

6.18.3.5 When to Request a Void

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

6.19 Credit Balances

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

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

1. Working off the credit balance. By taking no action, remaining credit balances will be deducted from future claim payments. The deductions appear as credits on the provider’s RA(s) 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 the provider number to ensure the money is applied correctly.

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

6.20 Timely Filing

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

6.20.1 Exceptions to the Twelve-Month Limit

Exceptions to the 12-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>Exceptions Beyond the Control of the Provider</th>
<th>The time limit is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Crossover</td>
<td>A claim must be submitted within 12-months of the date of service or within six (6) months from the payment date on the Explanation of Medicare Benefits (EOMB), whichever is later.</td>
</tr>
<tr>
<td>Client is determined to be eligible on appeal, reconsideration, or court decision (retroactive eligibility)</td>
<td>Claims must be submitted within six (6) months of the date of the determination of retroactive eligibility. The client must provide a copy of the dated letter to the provider to document retroactive eligibility. If a claim exceeds timely filing, and the provider elects to accept the client as a Medicaid client and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be a SSI award notice or a notice</td>
</tr>
</tbody>
</table>
### Exceptions Beyond the Control of the Provider

<table>
<thead>
<tr>
<th>When the situation is:</th>
<th>The time limit is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client is determined to be eligible due to agency corrective actions (retroactive eligibility)</td>
<td>Claims must be submitted within six (6) months of the date of the determination of retroactive eligibility. The client must provide a copy of the dated letter to the provider to document retroactive eligibility. If a claim exceeds timely filing, and the provider elects to accept the client as a Medicaid client and bill Wyoming Medicaid, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing.</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 citing this policy.</td>
</tr>
</tbody>
</table>

### 6.20.2 Appeal of Timely Filing

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

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

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

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

- Documentation of previous claim submission (TCNs, documentation of the corrections made to the subsequent claims);
- Documentation of contact with Provider Relations
- An explanation of the problem; and
- A clean copy of the claim, along with any required attachments and required information on the attachments. A clean claim is an error free, correctly completed claim, with all required attachments, that will process and pay.

### 6.21 Important Information Regarding Retroactive Eligibility Decisions

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

A provider is responsible for billing Medicaid only if:

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

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

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

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

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

- Any money paid by the client for the service being billed to Wyoming Medicaid must be refunded prior to billing Medicaid;
- The client can no longer be billed for the service; and
- Timely filing criteria is in effect.

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

6.23 Billing Tips to Avoid Timely Filing Denials

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

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

6.24 Telehealth

Telehealth is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the client is performed via a real time interactive audio and video telecommunications system. This means that the client must be able to see and interact with the off-site practitioner at the time services are provided via telehealth technology. Telehealth services must be properly documented when offered at the discretion of the provider as deemed medically necessary.
It is the intent that telehealth services will provide better access to care by delivering services as they are needed when the client is residing in an area that does not have specialty services available. It is expected that this modality will be used when travel is prohibitive or resources 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). Each site will be able to bill for their own services as long as they are an enrolled Medicaid provider (this includes out-of-state Medicaid providers). Providers shall not bill for both the spoke and hub site. Any telehealth provider such as Community Mental Health Centers and Substance Abuse Treatment Centers can bill telehealth services where the provider is at one location and the client is at a different location even though the pay to provider is the same. A single pay to provider can bill both the originating site (spoke site) and the distant site provider (hub site) when applicable. See below for billing and documentation requirements.

6.24.1 Covered Services

Originating Sites (Spoke Site)

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

Examples of authorized originating sites are:

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

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

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

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

Provisionally licensed mental health professional 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 used 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.

6.24.2 Non-Covered Services

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

- Group psychotherapy is not a covered service.

6.24.3 Billing Requirements

In order to obtain Medicaid reimbursement for services delivered through telehealth technology, the following standards must be observed:
• Telehealth Consent form must be completed if the originating site is the client’s home.
• The services must be medically necessary and follow generally accepted standards of care.
• The service must be a service covered by Medicaid.
• Claims must be made according to Medicaid billing instructions.
• The same procedure codes and rates apply as for services delivered in person.
  o The modifier to indicate a telehealth service is “GT” which must be used in conjunction with the appropriate procedure code to identify the professional telehealth services provided by the distant site provider (e.g., procedure code 90832 billed with modifier GT). **GT modifier MUST be billed by the distant site.** Using the GT modifier does not change the reimbursement fee.
• When billing for the originating site facility fee, use procedure code Q3014. A separate or distinct progress note isn’t required to bill Q3014. Validation of service delivery would be confirmed by the accompanying practitioner’s claim with the GT modifier indicating the practitioner’s service was delivered via telehealth. Medicaid will reimburse the originating site provider the lesser of charge or the current Medicaid fee.
  o 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.
• Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented and monitored.
• Providers need to develop and document evaluation processes and patient outcomes related to the telehealth program, visits, provider access, and patient satisfaction.
• All service providers are required to develop and maintain written documentation in the form of progress notes the same as is originated during an in-person visit or consultation with the exception that the mode of communication (i.e. teleconference) should be noted.
• Documentation must be maintained at the hub and spoke locations to substantiate the services provided. Documentation must indicate that the services were rendered via telehealth and must clearly identify the location of the hub and spoke sites.
• Medicaid will not reimburse for the use or upgrade of technology, for transmission charges, for charges of an attendant who instructs a patient on the use of the equipment or supervises/monitors a patient during the telehealth encounter, or for consultations between professionals.
• For ESRD-related services, at least one (1) face-to-face, “hands on” visit (not telehealth) must be furnished each month to examine the vascular access site by a qualified provider.
NOTE: If the patient and/or legal guardian indicate at any point that he/she wants to stop using the technology, the service should cease immediately and an alternative appointment set up.

### 6.24.3.1 Billing Examples

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

<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>01/01/19</td>
<td>Q3014</td>
<td>20.00</td>
<td>1</td>
</tr>
</tbody>
</table>

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

<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>01/01/19</td>
<td>99214 GT</td>
<td>120.00</td>
<td>1</td>
</tr>
</tbody>
</table>

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

<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>01/01/19</td>
<td>Q3014</td>
<td>20.00</td>
<td>1</td>
</tr>
<tr>
<td>01/01/18</td>
<td>99214 GT</td>
<td>240.00</td>
<td>1</td>
</tr>
</tbody>
</table>
6.24.4 Telehealth Consent Form

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

6.24.5 Telehealth Consent Form Instructions

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

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name</td>
<td>Enter the client’s name</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Define the service to be provided as a telehealth service on the second line</td>
</tr>
</tbody>
</table>
### Common Billing Information

<table>
<thead>
<tr>
<th><strong>Provider Name</strong></th>
<th>Enter the name of the health care practitioner who will be seeing the client from the distant site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility Name and Address</strong></td>
<td>Enter the facility name and address of the distant site where the health care practitioner is located</td>
</tr>
<tr>
<td><strong>Alternative Services</strong></td>
<td>Describe in writing any other options that are available to the client</td>
</tr>
<tr>
<td><strong>Signature and date</strong></td>
<td>The client, parent or legal representative must sign and date the form</td>
</tr>
<tr>
<td><strong>Signature of Person Obtaining Consent</strong></td>
<td>Person obtaining consent must sign and date the form</td>
</tr>
<tr>
<td><strong>Facility Name</strong></td>
<td>Enter the Facility for the person obtaining consent</td>
</tr>
<tr>
<td><strong>Facility Address</strong></td>
<td>Enter the Facility address for the person obtaining consent</td>
</tr>
</tbody>
</table>
Chapter Seven – Third Party Liability

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7.1 Definition of a Third Party Liability

7.1.1 Third Party Liability (TPL)

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

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

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

7.1.2 Third Party Payer

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

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

Medicaid is the payer of last resort. It is a secondary payer to all other payment sources and programs and should be billed only after payment or denial has been received from such carriers.
NOTE: When attaching an EOMB to a claim and the TPL is Medicare Replacement or Medicare Supplement, hand-write the applicable type of Medicare coverage on the EOMB (i.e. Medicare Replacement, Medicare Supplement).

7.1.3 Medicare

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

7.1.4 Medicare Replacement Plans

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

7.1.5 Medicare Supplement Plans

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

7.1.6 Disability Insurance Payments

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

7.1.7 Long-Term Care Insurance

When a long-term care (LTC) insurance policy exists, it must be treated as TPL and be cost-avoided. The provider must either collect the LTC policy money from the
client or have the policy assigned to the provider. However, if the provider is a nursing facility and the LTC payment is sent to the client, the monies are considered income. The funds will be included in the calculation of the client’s patient contribution to the nursing facility.

7.1.8 Exceptions

The only exceptions to this policy are referenced below:

- Children’s Special Health (CSH) – Medical claims are sent to Wyoming Medicaid’s MMIS fiscal agent
- Indian Health Services (IHS) – 100% federally funded program
- Ryan White Foundation – 100% federally funded program
- Wyoming Division of Victim Services/Wyoming Crime Victim Compensation Program
- Policyholder is an absent parent
  - Upon billing Medicaid, providers are required to certify if a third party has been billed prior to submission. The provider must also certify that they have waited 30 days from the date of service before billing Medicaid and has not received payment from the third party

NOTE: Inpatient labor and delivery services and post-partum care must be cost avoided or billed to the primary health insurance

- The probable existence of third-party liability cannot be established at the time the claim is filed.
- Home and community based (HCBS) waiver services as most insurance companies do not cover these types of services.
- Services are for preventative pediatric care (Early and Periodic Screening, Diagnosis, and Treatment/EPSDT), prenatal care.

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

7.2 Provider’s Responsibilities

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

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

7.2.1 Third Party Resources Information Sheet

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

Medicaid maintains a reference file of known commercial health insurance as well as a file for Medicare Part A and Part B entitlement information. Both files are used to deny claims that do not show proof of payment or denial by the commercial health insurer or by Medicare. Providers must use the same procedures for locating third party payers for Medicaid clients as for their non-Medicaid clients.
Providers may not refuse to furnish services to a Medicaid client because of a third party’s potential liability for payment for the service (S.S.A. §1902(a)(25)(D)) (3.2 Accepting Medicaid Clients)

7.2.2 Provider is not enrolled with TPL Carrier

Medicaid will no longer accept a letter with a claim indicating that a provider does not participate with a specific health insurance company. The provider must work with the insurance company and/or client to have the claim submitted to the carrier. Providers cannot refuse to accept Medicaid clients who have other insurance if their office does not bill other insurance. However, a provider may limit the number of Medicaid clients s/he is willing to admit into his/her practice. The provider may not discriminate in establishing a limit. If a provider chooses to opt-out of participation with a health insurance or governmental insurance, Medicaid will not pay for services covered by, but not billed to, the health insurance or governmental insurance.

7.2.3 Medicare Opt-Out

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

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

7.3 Billing Requirements

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

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

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

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

- If payment is less than Medicaid’s allowed amount for the same claim, indicate the payment in the appropriate field on the claim form.
  - CMS 1500 – TPL paid amount will be indicated in box 29 Amount Paid
  - CMS 1500 – Medicare paid amount will not be indicated on the claim, a COB must be attached for claim processing
  - UB-04 – TPL/Medicare amount will be indicated in box 54 Prior Payments
  - Dental – TPL/Medicare amount will be indicated in box 31A Other Fees

- If the TPL payer paid less than 40% of the total billed charges, include the appropriate claim reason and remark codes or attach an explanation of benefits (EOB) with the electronic claim (Electronic Attachments).
- If payment is received from the other payer after Medicaid already paid the claim, Medicaid’s payment must be refunded for either the amount of the Medicaid payment or the amount of the insurance payment, whichever is less. A copy of the
EOB from the other payer must be included with the refund showing the reimbursement amount.

**NOTE:** Medicaid will accept refunds from a provider at any time. Timely filing will not apply to adjustments where money is owed to Medicaid (6.19 Timely Filing).

- If denial is obtained from the third party payer/Medicare that a service is not covered, attach the denial to the claim (6.14 Submitting Attachments for Electronic Claims). The denial will be accepted for one (1) calendar year, but will still need to be attached with each claim.
- If verbal denial is obtained from a third party payer, type a letter of explanation on official office letterhead. The letter must include:
  - Date of verbal denial
  - Payer’s name and contact person’s name and phone number
  - Date of Service
  - Client’s name and Medicaid ID number
  - Reason for denial
- If the third party payer/Medicare sends a request to the provider for additional information, the provider must respond. If the provider complies with the request for additional information and after ninety (90) days from the date of the original claim and the provider has not received payment or denial, the provider may submit the claim to Medicaid with the Previous Attempts to Bill Services Letter.

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

- In situations involving litigation or other extended delays in obtaining benefits from other sources, Medicaid should be billed as soon as possible to avoid timely filing. If the provider believes there may be casualty insurance, contact TPL Unit (2.1 Quick Address and Telephone Reference) TPL will investigate the responsibility of the other party. Medicaid does not require providers to bill a third party when liability has not been established. However, the provider cannot bill the casualty carrier and Medicaid at the same time. The provider must choose to bill Medicaid or the casualty carrier (estate). Medicaid will seek recovery of payments from liable third parties. If providers bill the casualty carrier (estate) and Medicaid, this may result in duplicate payments.
- If the client receives reimbursement from the primary insurance, the provider must pursue payment form the patient. If there are any further Medicaid benefits allowed after the other insurance payment, the provider may still submit a claim for those benefits. The provider, on submission, must supply all necessary documentation of the other insurance payment. Medicaid will not pay the provider the amount paid by the other insurance.
• Providers may not charge Medicaid clients, or any other financially responsible relative or representative of that individual any amount in excess of the Medicaid paid amount. Medicaid payment is payment in full. There is no balance billing.

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

### 7.3.1 How TPL is Applied

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

- Reductions resulting from a contractual agreement between the payer and the provider (contractual write-off); and,
- Reductions reflecting patient responsibility (copay, coinsurance, deductible, etc.). Wyoming Medicaid will pay no more than the remaining patient responsibility (PR) after payment by the primary insurance.

Wyoming Medicaid will reimburse the provider for the patient liability up to the Medicaid Allowable Amount. For preferred provider agreements or preferred patient care agreements, do not bill Medicaid for the difference between the payment received from the third party based on such agreement and the providers billed charges (See the State Medicaid Manual Chapter 3, Section 3904.7 for more information).

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

**Example:**

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

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

**NOTE:** Waivers of timely filing will not be granted due to unresponsive third party payers.
7.3.1.1 Previous Attempts to Bill Services Letter

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

7.3.2 Acceptable Proof of Payment or Denial

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

7.3.3 Coordination of Benefits

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

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

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

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

If a client specific denial letter or EOB is received, the provider may use that denial or EOB as valid documentation for the denied services for that member for one calendar year or benefit plan year, as appropriate. The EOB must clearly state the services are not covered. The provider must still follow the rules of the primary insurance prior to filing the claim to Medicaid.

7.3.5 TPL and Copays

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

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

7.3.6 Primary Insurance Recoup after Medicaid Payment

In the instance where primary insurance recovers payment after the timely filing threshold, and in order to bill Wyoming Medicaid as primary, the provider will need to submit an appeal for timely filing. The appeal must include proof from the primary insurance company that money was taken back as well as the reasoning. The appeal must be submitted within 90 days of recovered payment or notification from the primary insurance in order for it to be reviewed and processed appropriately.
7.4 Medicare Pricing

Effective dates of service beginning January 1, 2017, Wyoming Medicaid changed how reimbursement is calculated for Medicare crossover claims. This change applies to all service providers.

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

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

7.4.1 Medicaid Covered Services

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

Example:

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

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

7.4.2 Medicaid Non-Covered Services

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

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

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

7.4.3 Coinsurance and Deductible

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

For clients on other plans who are dual eligible, coinsurance and deductible amounts remaining after Medicare payment cannot be billed to the client if the claim was billed to Wyoming Medicaid, regardless of payment amount (including claims that Medicaid pays at $0).

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

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8.1 What is Electronic Data Interchange (EDI)?

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

8.2 Benefits

Several immediate advantages can be realized by exchanging documents electronically:

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

8.3 Standard Transaction Formats

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

- X12N 270/271 Eligibility Benefit Inquiry and Response
- X12N 276/277 Claims Status Request and Response
- X12N 278 Request for Prior Authorization and Response
- X12N 277CA Implementation Guide Error Reporting
- X12N 835 Claim Payment/Remittance Advice
- X12N 837 Dental, Professional and Institutional Claims
- X12N 999 Functional Acknowledgement
NOTE: As there is no business need, Medicaid does not currently accept nor generate X12N 820 and X12N 834 transactions.

8.4 Sending and Receiving Transactions

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

<table>
<thead>
<tr>
<th>EDI Options</th>
<th>Method</th>
<th>Requirements</th>
<th>Access Cost</th>
<th>Transactions Supported</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulletin Board System (BBS)</td>
<td>Computer</td>
<td>Free</td>
<td>X12N 270/271 Eligibility Benefit Inquiry and Response</td>
<td>EDI Services Telephone: (800)672-4959 9-5pm MST M-F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hayes-compatible 9600-baud or greater asynchronous modem</td>
<td></td>
<td>X12N 276/277 Claims Status Request and Response</td>
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<tr>
<td></td>
<td>Dial-up connection utility (e.g., ProComm, Hyperterminal, etc.)</td>
<td></td>
<td>X12N 278 Request for Prior Authorization and Response</td>
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<tr>
<td></td>
<td>File decompression utility</td>
<td></td>
<td>X12N 277CA Implementation Guide Error Reporting</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Software capable of formatting and reading EDI transactions</td>
<td></td>
<td>X12N 835 Claim Payment/Remittance Advice</td>
<td></td>
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<tr>
<td></td>
<td>Telephone connectivity</td>
<td></td>
<td>X12N 837 Dental, Professional and Institutional Claims</td>
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<td></td>
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<td></td>
<td>X12N 999 Functional Acknowledgement</td>
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<tr>
<td>Web Portal</td>
<td>Computer</td>
<td>Free</td>
<td>X12N 270/271 Eligibility Benefit Inquiry and Response</td>
<td>EDI Services Telephone: (800)672-4959 9-5pm MST M-F</td>
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<tr>
<td>The Medicaid Secure Web Portal provides an interactive, web-based interface for entering individual transactions and a</td>
<td>Internet Explorer 5.5 (or higher) or Netscape Navigator 7.0 (or higher). Whichever browser version is used, it must support 128-bit encryption</td>
<td></td>
<td>X12N 276/277 Claims Status Request and Response</td>
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<tr>
<td></td>
<td>Internet access</td>
<td></td>
<td>X12N 278 Request for Prior Authorization and Response</td>
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<tr>
<td></td>
<td>Additional</td>
<td></td>
<td>X12N 277CA Implementation Guide</td>
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</tbody>
</table>

Website: [http://edisolutionsmmis.portal.conduent.com/gcrol](http://edisolutionsmmis.portal.conduent.com/gcrol)

Website: [https://wymedicaid.portal.conduent.com](https://wymedicaid.portal.conduent.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>separate data exchange facility for uploading and downloading batch transactions.</td>
<td>requirements for uploading and downloading batch transactions: File decompression utility. Software capable of formatting and reading EDI transactions</td>
<td>Error Reporting</td>
<td>X12N 835 Claim</td>
<td>Telephone: (800)672-4959</td>
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<td></td>
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<td>Payment/Remittance Advice</td>
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<td>X12N 837 Dental, Professional and Institutional Claims*</td>
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<td>X12N 999 – Functional Acknowledgement</td>
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<td><strong>NOTE:</strong> Only the 278 and 837 transactions can be entered interactively.</td>
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<tr>
<td>WINASAP5 010</td>
<td>Computer</td>
<td>Free</td>
<td>X12N 837 Dental, Professional and Institutional Claims</td>
<td></td>
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<tr>
<td></td>
<td>Hayes-compatible 9600-baud asynchronous modem</td>
<td></td>
<td>X12N 277CA Implementation Guide Error Reporting</td>
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<td></td>
<td>Windows 98 (or higher) operating system</td>
<td></td>
<td>X12N 999 – Functional Acknowledgement</td>
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<td></td>
<td>Pentium processor</td>
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<td></td>
<td>25 megabytes of free disk space</td>
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<td></td>
<td>128 megabytes of RAM</td>
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<td>Monitor resolution of 800 x 600 pixels</td>
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<td></td>
<td>Telephone connectivity</td>
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</table>

**WINASAP5 010**

Windows Accelerated Submission and Processing (WINASAP) is a Windows-based software application that allows users to enter and submit dental, professional and institutional claims electronically using a personal computer.

**EDI Services**

Telephone: (800)672-4959 9-5pm MST M-F

**OPTION 3**

Website: http://edisolutionsmmis.portal.conduent.com/gcro/
8.5 EDI Services

8.5.1 Getting Started

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

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

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

8.5.2 Web Portal

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

What can the provider do with the Web Portal?

- Submit claims.
- Upload claim attachments (6.15, Submitting Attachments for Electronic Claims).
- Retrieve Medicaid Remittance Advices (stores the last 24 RAs).
- Submit Ask Wyoming Medicaid questions.
- Submit and retrieve Prior Authorization requests and responses (limited to PAs processed by Medical Policy (6.14, Prior Authorization).
- Perform LT101 Inquires.
- Enter PASRR.
- The Office Administrator can set up additional users and give them only the access that they need.
- Build Claims Templates to save standard information such as:
  - NPI numbers
  - Procedure Codes
  - Fees

8.5.2.1 Secured Provider Web Portal Registration Process

1. Go to the Medicaid website: https://wymedicaid.portal.conduent.com
2. Select Provider.
3. Select Provider Portal from the left hand menu.
5. Enter the following information from the EDI Welcome Letter:
   a. Provider ID: Trading Partner/Submitter ID.
   b. Trading Partner ID: Trading Partner/Submitter ID.
   c. EIN/SSN: The provider 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 entered is correct. If it is, choose continue, if not re-enter information.

7. Additional Trading Partner IDs:
   a. If the provider needs to enter additional Trading Partner IDs enter the ID and the Trading Partner Password on this page.
   b. If the provider does not have any additional Trading Partner IDs select continue.

8.5.2.2 Creating an Office Administrator

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

1. Select “Create a new user”.
   a. Enter a unique user ID, last name, first name, email address and phone number for the person that should be the office administrator.
   b. Confirm the information entered is correct.
   c. This completes the web registration for the office administrator, an email will be sent to the email address entered with a one (1) time use password.
   d. Once the provider receives the single use password, (it is easiest to copy and paste this directly from the email to avoid typographical errors) and must be changed upon logging in for the first (1st) time. Return to the home page and log in.

2. All permissions will be set once the provider has logged in. To do this, select update or remove users. Enter the provider user ID and select search. When the user information is brought up, click on the user ID link.
   a. Select which privileges the provider wishes to have. Once the provider has chosen these privileges click Submit.

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

8.5.2.3 Creating Additional Users

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

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

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

8.5.3.1 WINASAP Start-Up

1. Download program from the Conduent EDI Solutions website or install the program from the CD 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 current settings and choose Next.
   f. Check Yes, launch the program file and Finish.

2. Creating a WINASAP login:
   a. The user ID auto fills as ADMIN.
   b. Tab to password and type ASAP.
      i. The user ID and password are the same for everyone using WINASAP, we suggest that the provider does not change them.
   c. After successfully logging in choose OK.

3. Steps that must be completed:
   a. The screen will automatically open the first (1st) time the provider runs the program that says Open Payer.
      i. Select Wyoming Medicaid and choose OK.
   b. Choose File and Trading Partner – Enter the following:
      i. Primary Identification: Enter the Trading Partner ID from the EDI Welcome Letter.
      ii. Secondary Identification – Re-enter the 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 the provider is an individual such as; a waiver provider, physician, therapist, or nurse practitioner.
      2. Choose non-person if the provider is a facility such as; a hospital, pharmacy or nursing home.
         a. Enter the provider’s last name, first name and middle initial (optional) OR the organization name.

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

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

8.6 Additional Information Sources

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

- Washington Publishing Co.: http://www.wpc-edi.com/hipaa/HIPAA_40.asp. This website is the official source of the implementation guides for each of the ASC X12 N transactions.
- Workgroup for Electronic Data Interchange: http://www.wedi.org. This industry group promotes electronic transactions in the healthcare industry.
- Designated standard maintenance organizations: http://www.hipaa-dsmo.org. This website explains how changes are made to the transaction standards.
### 8.7 Scheduled Web Portal Downtime

<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) Static web pages</td>
<td>Website not available</td>
<td>Regular scheduled maintenance</td>
<td>• 4 a.m. – 4:30 a.m. MST Saturdays</td>
</tr>
<tr>
<td>• <a href="https://wymedicaid.portal.conduent.com">https://wymedicaid.portal.conduent.com</a></td>
<td></td>
<td></td>
<td>• 3 p.m. – 6 p.m. MST Sundays</td>
</tr>
<tr>
<td>Secured Provider Web Portal</td>
<td>Verification of claims submission will not be available</td>
<td>Regular scheduled maintenance</td>
<td>• 10 p.m. – 12 a.m. (midnight) Sundays</td>
</tr>
<tr>
<td>• <a href="https://wymedicaid.portal.conduent.com/provider_home.html">https://wymedicaid.portal.conduent.com/provider_home.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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9.1 Wyoming Specific HIPAA 5010 Electronic Specifications

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

9.2 Transaction Dates

- 270/271 – Health Care Eligibility Benefit Inquiry and Response.
- 276/277 – Health Care Claim Status Request and Response.
- 835 – Health Care Claim Payment/Advice.
- 837 – Health Care Claim (Professional, Institutional, and Dental), including Coordination of Benefits (COB) and Subrogation Claims.

9.3 Transmission Methods and Procedures

9.3.1 Asynchronous Dial-up

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

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

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

The EDI Clearinghouse currently supports the following communication options:

- XMODEM
- YMODEM
- ZMODEM
- KERMIT

9.3.1.2 Teleprocessing Requirements

The general specifications for communication with EDI Clearinghouse are:

- Telecommunications: Hayes-compatible 2400-56K BPS asynchronous modem
- File Format: ASCII text data
- Compression Techniques - EDI Clearinghouse accepts transmission with any of these compression techniques, as well as non-compression:
  - PKZIP will compress one (1) or more files into a single ZIP archive.
  - WINZIP will compress one (1) or more files into a single ZIP archive.
- Data Format:
  - 8 data bit
  - 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 the provider’s 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>
<tr>
<td><strong>Prompt:</strong> “Please enter provider Logon=&gt;”</td>
<td></td>
</tr>
<tr>
<td>Enters User Name (From the EDI Welcome Letter) &lt;CR&gt;</td>
<td>Receives User Name and sends prompt to the Trading Partner:</td>
</tr>
<tr>
<td><strong>Prompt:</strong> “Please enter provider password=&gt;”</td>
<td></td>
</tr>
<tr>
<td>Enters Password/User ID (From the EDI Welcome Letter) &lt;CR&gt;</td>
<td>Receives Password/User ID and verifies if Trading Partner is an authorized user. Sends HOST selection menu followed by a user prompt:</td>
</tr>
<tr>
<td><strong>Prompt:</strong> “Please Select from the Menu Options Below=&gt;”</td>
<td></td>
</tr>
<tr>
<td>Enters Desired Selection &lt;CR&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>#1. Electronic File Submission:</strong> Assigns and sends the transmission file name then waits for ZMODEM (by default) file transfer to be initiated by the Trading Partner. <strong>#2. View Submitter Profile</strong> <strong>#3. Select File Transfer Protocol:</strong> Allows the provider to change the protocol for the current submission only. The protocol may be changed to (k) ermit, (x) Modem, (y) Modem, or (z) Modem. Enter selection [k, x, y, z]:</td>
<td></td>
</tr>
<tr>
<td><strong>#4. Download Confirmation</strong></td>
<td>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=&gt;</td>
</tr>
<tr>
<td><strong>#9. Exit &amp; Disconnect:</strong> Terminates connection.</td>
<td></td>
</tr>
</tbody>
</table>
9.3.2 Web Portal

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

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

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

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


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

9.3.3 Managed File Transfer (MOVEit)

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

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

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

9.4.1 Confirmation Report

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

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

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

The Confirmation Report includes the following information:

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

9.4.2 Interchange Level Errors and TA1 Rejection Report

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

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

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

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

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

### 9.4.3 999 Implementation 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 TR3 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 Type3 (TR3).

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

#### 9.4.3.1 Batch and Real-Time Usage

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

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

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

### 9.4.4 Data Retrieval Method

**Secure Web Portal**

The Web portal allows all trading partners to retrieve data via the internet 24 hours a day, seven (7) days a week. Each provider has the option of retrieving the transaction responses and reports themselves or allowing billing agents and clearinghouses to retrieve on their behalf. The trading partner will access the Secure Provider Web Portal system using the user ID and password provided upon completion of the enrollment process. ([8.5.2.1, Secured Provider Web Portal Registration Process](#) and [8.4, Sending and Receiving Transactions](#)) Contact EDI Services for more information ([2.1, Quick Reference](#)).

### 9.5 Testing

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

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

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

### 9.5.1 Testing Requirements

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

• **Testing via EDIFECS**
  - Submitters cannot obtain direct Internet access to EDIFECS; the EDI Services call center staff will set this up upon request.
  - A user ID and password will be generated for use.
  - Providers are required to submit test files through EDIFECS.
  - Providers are required to address any errors discovered during testing prior to moving on to testing with EDI Clearinghouse.
  - After the provider’s software has received approval provide EDI Services with the EDIFECS certification.
• Testing with EDI Clearinghouse
  o The call center will have the provider submit a test file.
  o After 24 hours contact the call center for test file results.
  o Make corrections based on the TR3s and Wyoming Specific HIPAA 5010 Specifications.
  o Resubmit test files as necessary.
  o 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>
</tr>
</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 Access Methods Supported by Wyoming Medicaid

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

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

9.6.4 270 Eligibility Request

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
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<tbody>
<tr>
<td>Page 72</td>
<td>2100A</td>
<td>NM1</td>
<td>03</td>
<td>Wyoming Medicaid</td>
</tr>
</tbody>
</table>
| Page 79  | 2100B | NM1 | 08 | Either use XX (National Provider Identifier) or SV (Service Provider Number).  
**NOTE:** SV should be used only when a Wyoming Provider is an Atypical Provider/non-medical. |
| Page 80  | 2100B | NM1 | 09 | **NOTE:** Enter Wyoming Medicaid Provider ID when NM108 is SV. |
9.6.5 271 Eligibility Response

No Wyoming Specific 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 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 Health Care Claim Status Request and Response for the 276/277 005010X212, August 2006.

9.7.1 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</td>
<td>Header</td>
<td>ISA</td>
<td>08</td>
<td>Enter 100000 followed by spaces</td>
</tr>
<tr>
<td>Page C.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.7.2 GS Functional 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</td>
<td>Header</td>
<td>GS</td>
<td>03</td>
<td>Enter 77046</td>
</tr>
<tr>
<td>Page C.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.7.3 276 Claim Status Request

<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>Page 46</td>
<td>2100B</td>
<td>NM1</td>
<td>09</td>
<td>NOTE: Enter the nine (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>
</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 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 Health Care Services Review - Request for Review and Response for the (278) 005010X217, May 2006.

9.8.1  ISA Interchange Control Header

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9.8.3 278 Prior Authorization Request – Data Clarifications Inbound

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9.9 835 Claim Payment/Advice

Health Care Claim Payment Advice for Wyoming Medicaid

9.9.1 Payment Advice

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<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>Page 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>
</tbody>
</table>
| Page 207-208 | 2110 | REF     | 01                    | Either HPI or G2 will be displayed. **NOTE:** G2 will be displayed only for the WY Medicaid Atypical Providers.
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.

9.10.1 ISA Interchange Control Header

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<td>01</td>
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<td>Appendix C Page C.4</td>
<td>Header</td>
<td>ISA</td>
<td>03</td>
<td>Enter 00</td>
</tr>
<tr>
<td>Appendix C Page C.4</td>
<td>Header</td>
<td>ISA</td>
<td>06</td>
<td>Enter Trading Partner ID</td>
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9.10.2 GS Functional Group Header

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### Wyoming HIPAA 5010 Electronic Specifications

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#### 9.10.3 837 Professional

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<tbody>
<tr>
<td>Page 72</td>
<td>Header</td>
<td>BHT</td>
<td>06</td>
<td>Wyoming Medicaid only accepts the CH code.</td>
</tr>
<tr>
<td>Page 80</td>
<td>1000B</td>
<td>NM1</td>
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<td>Enter Wyoming Medicaid.</td>
</tr>
<tr>
<td>Page 80</td>
<td>1000B</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046.</td>
</tr>
<tr>
<td>Page 83</td>
<td>2000A</td>
<td>PRV</td>
<td>03</td>
<td>If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.</td>
</tr>
<tr>
<td>Page 115</td>
<td>2000B</td>
<td>HL</td>
<td>04</td>
<td>Enter 0. The subscriber is always the patient; therefore, the dependent level will not be utilized.</td>
</tr>
<tr>
<td>Page 116-117</td>
<td>2000B</td>
<td>SBR</td>
<td>01</td>
<td>Enter P (Primary-Payer Responsibility Sequence Number Code) Client has only Medicaid coverage.</td>
</tr>
<tr>
<td>Page 123</td>
<td>2010BA</td>
<td>NM1</td>
<td>09</td>
<td>Enter the ten (10) digit Wyoming Medicaid Client ID.</td>
</tr>
<tr>
<td>Page 134</td>
<td>2010BB</td>
<td>NM1</td>
<td>03</td>
<td>Enter Wyoming Medicaid.</td>
</tr>
<tr>
<td>Page 134</td>
<td>2010BB</td>
<td>NM1</td>
<td>08</td>
<td>Enter PI (Payer Identification).</td>
</tr>
<tr>
<td>Page 134</td>
<td>2010BB</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046.</td>
</tr>
<tr>
<td>Page 140</td>
<td>2010BB</td>
<td>REF</td>
<td>01</td>
<td>If ‘XX’ is used to pass the NPI number in 2010AA, NM109, then Medicaid Provider Number is no longer allowed do not submit this segment. If no NPI was submitted then submit ‘G2’ (provider Commercial Number) in 2010BB REF01, and submit the Wyoming Medicaid Provider number in 2010BB REF02.</td>
</tr>
<tr>
<td>Page 140-141</td>
<td>2010BB</td>
<td>REF</td>
<td>02</td>
<td>If ‘XX’ is used to pass the NPI number in 2010AA, NM109, Then Medicaid Provider Number is no longer allowed, do no submit this segment. If no NPI was submitted then submit ‘G2’ (Provider Commercial Number) in 2010BB REF01, and submit the Wyoming Medicaid Provider Number in 2010BB REF02.</td>
</tr>
<tr>
<td>TR3 Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Reference Description</td>
<td>Wyoming Requirements</td>
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<tr>
<td>Page 161</td>
<td>2300</td>
<td>CLM</td>
<td>05:3</td>
<td>Void/Adjustment (Frequency Type Code) should be 6 (Adjustment) only if paid date was within the last 6 months (12 month timely filing will be waived), or 7 (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.</td>
</tr>
<tr>
<td>Page 262-263</td>
<td>2310A</td>
<td>REF</td>
<td>01</td>
<td>If ‘XX’ is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
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<tr>
<td>Page 262-263</td>
<td>2310A</td>
<td>REF</td>
<td>02</td>
<td>If ‘XX’ is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
</tr>
<tr>
<td>Page 269-270</td>
<td>2310B</td>
<td>Ref</td>
<td>01</td>
<td>If ‘XX’ is used to pass the NPI number in NM09, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
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<tr>
<td>Page 269-270</td>
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<td>REF</td>
<td>02</td>
<td>If ‘XX’ is used to pass the NPI Number is NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
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<td>2320</td>
<td>SBR</td>
<td>09</td>
<td>Do not use code MC.</td>
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<td>Reference Description</td>
<td>Wyoming Requirements</td>
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<td>----------------------</td>
</tr>
<tr>
<td>Page 427</td>
<td>2410</td>
<td>LIN</td>
<td>03</td>
<td>Enter the 11-digit National Drug Code (NDC). NDCs less than 11-digits will cause the service line to be denied by Wyoming Medicaid. Do not enter hyphens or spaces with 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 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="https://wymedicaid.portal.conduent.com">https://wymedicaid.portal.conduent.com</a>).</td>
</tr>
<tr>
<td>Page 436</td>
<td>2420A</td>
<td>PRV</td>
<td>03</td>
<td>If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.</td>
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<td>2420A</td>
<td>REF</td>
<td>01</td>
<td>If ‘XX’ is used to pass the NPI number is NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
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<td>If ‘XX’ is used to pass the NPI Number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
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<td>02</td>
<td>If ‘XX’ is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
</tr>
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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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### 9.11.3 837 Institutional

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<td>Page 147</td>
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<td>CLM</td>
<td>05:3</td>
<td>Void/Adjustment (Frequency Type Code) should be 6 (Adjustment) only</td>
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9.12 837 Dental Claims Transactions

Wyoming Medicaid Dental Claims

This section is for use along with the ANSI ASC X12 Health Care 837 Claims Transactions. It should not be considered a replacement for the 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 Claim: Dental (837), 005010X224/005010X224A1/005010X224A2, June 2010.

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<td>Enter 100000 followed by spaces</td>
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</tr>
<tr>
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<td>2010BB</td>
<td>NM1</td>
<td>08</td>
<td>Enter PI (Payer Identification)</td>
</tr>
<tr>
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<td>2010BB</td>
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<td>Enter 77046</td>
</tr>
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<td>01</td>
<td>Enter PO Box 547</td>
</tr>
<tr>
<td>Page 127</td>
<td>2010BB</td>
<td>N4</td>
<td>01</td>
<td>Enter Cheyenne</td>
</tr>
<tr>
<td>Page 128</td>
<td>2010BB</td>
<td>N4</td>
<td>02</td>
<td>Enter WY</td>
</tr>
<tr>
<td>Page 128</td>
<td>2010BB</td>
<td>N4</td>
<td>03</td>
<td>Enter 82003</td>
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<td>Page 161</td>
<td>2300</td>
<td>CLM</td>
<td>05:3</td>
<td>Void/Adjustment (Frequency Type Code) should be 6 (Adjustment) only if paid date was within the last 6 months (12 month timely filing will be waived), or 7 (Void/Replace) which is subject to timely filing. Adjustments can only be submitted on a previously paid claim. Do not adjust a denied claim. For non-adjustment options see the TR3.</td>
</tr>
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</table>
Chapter Ten – Important Information

10.1 Claims Review .......................................................... 159
10.2 Coding ........................................................................ 159
10.3 Importance of Fee Schedules ....................................... 160
10.4 Interpretation Services ................................................ 160
10.5 340B Attestation .......................................................... 161
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 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:

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

10.3 Importance of Fee Schedules

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


10.4 Interpretation Services

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

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

- Interpretation between English and a foreign language is a covered service for Medicaid clients who have LEP. LEP is defined as “the inability to speak, read, write, or understand the English language at a level that permits an individual to interact effectively with healthcare providers.”
- Interpretation between sign language or lip reading and spoken language is a covered service for Medicaid clients who are deaf or hard of hearing. Hard of hearing is defined as “limited hearing which prevents an individual from hearing well enough to interact effectively with healthcare providers.”
10.5 340B Attestation

Wyoming Medicaid 340B Attestation Form

Completion Instructions and Provisions

1. Submission of this form is required by 340B Covered Entities that use drug products purchased under Section 340B of the Public Health Service Act for Wyoming Medicaid clients.
2. Separate forms must be completed for each “pay to” provider enrolled with Wyoming Medicaid that is designated as a 340B Covered Entity and caring for Wyoming Medicaid clients.
3. Completion of this form does not release the Covered Entity’s responsibility to register and appropriately report to the HSA/Exclusion File.
4. Annual submission of this form will be required by Covered Entities continuing to care for.

Covered Entity Information

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

“Pay To” Provider Name: ______________________________
Physical/Address: __________________________________
City: __________ State: ______ Zip: __________
Phone: __________ NPI: __________
Wyoming Medicaid Provider ID: __________

340B Carve In Information

1. Has the provider listed above been designated as a 340B Covered Entity by HSA? Yes □ No □
2. Does the provider use drug products purchased under Section 340B of the Public Health Service Act for Wyoming Medicaid clients? Yes □ No □
3. Carve In Effective Date: This should be a date on or about April 1, 2017 or the beginning of the quarter in which the provider began caring for all Wyoming Medicaid clients to the 340B program.
   - January 1, 20 ___ (Q1) □ April 1, 20 ___ (Q2) □ July 1, 20 ___ (Q3) □ October 1, 20 ___ (Q4)

Contact Information for 340B Program

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

Contact Name: ___________________________ Email: ___________________________
Phone: ___________________________ Ext: __________

Signature and Date

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

_____________________________ ___________________________
Signature Date

Name of Signer (please print) Phone Number

Please submit completed forms to:
Wyoming Department of Health, Division of Healthcare Financing
Attention: Pharmacy Program Manager
6101 Yellowstone Road, Suite 200
Cheyenne, Wyoming 82002

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Chapter Eleven – Outpatient Services

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11.1 General Coverage Principle and Definitions

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

11.1.1 Ambulatory Surgical Center (ASC)

Appropriate Bill Type(s): 83X

Pay-to Provider’s Taxonomy: 261QA1903X

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

11.1.1.1 Covered Services

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

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

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

Bill Type: 11X-14X, 85X

Pay-to Provider’s Taxonomy: 282NR1301X

A hospital that meets the following CMS criteria:

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

11.1.3 General Acute Care Hospital

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

11.1.4 Outpatient Services

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

- Medically necessary outpatient hospital services are covered pursuant to written orders by a physician or staff under the supervision of a physician, a dentist or other appropriate practitioner.
- Services are considered outpatient services when the treatment is expected to keep the patient less than 24 hours regardless of the hour of admission, whether or not a bed is used and whether or not the patient remained in the hospital past midnight.
- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are
Outpatient Services

- treated as inpatient services for billing purposes. For inpatient information (Chapter 12, Critical Access Hospital and General Hospital Inpatient).

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

11.1.4.1 Reimbursement

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

11.2 Abortion

11.2.1 Covered Services

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

- The client suffers from a physical injury, or physical illness, including endangering the physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion was performed; or

- The pregnancy is the result of sexual assault as defined in Wyoming Statute W.S. 6-2-301, which was reported to a law enforcement agency within five (5) days after the assault or with five days after the time the victim was capable of reporting the assault; or

- The pregnancy is the result of sexual assault as defined in Wyoming Statute W.S. 6-2-301, and the client was unable for physical or psychological reasons to comply with the reporting requirements; or

- The pregnancy is the result of incest.

11.2.2 Billing Requirements

An Abortion Certification Form (6.15.3.1, Abortion Certification Form) must accompany all claims from the attending physician, assistant surgeon, anesthesiologist, and hospital. The attending physician is required to supply all other billing providers with a copy of the consent form.
- In cases of sexual assault, submission of medical records is not required prior to payment; however documentation of the circumstances of the case must be maintained in the client’s medical records.
- Other abortion related procedures, including spontaneous, missed, incomplete, septic, and hydatiform mole, do not require the certification form; however, all abortion related procedure codes are subject to audit, and all pertinent records must substantiate the medical necessity and be available for review.

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

11.3 Ambulance Services

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

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

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

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

11.4 Diabetic Training

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

Revenue Code: 0942

Procedure Code Range: G0108-G0109

11.4.1 Covered Services

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

- Medication education.
- Dietetic/nutrition counseling.
- Weight management.
- Glucometer education.
- Exercise education.
Outpatient Services

- Foot/skin care.
- Individual plan of care services received by the client.

11.4.2 Billing Requirements

- HCPCS Level II codes, G0108 (individual session) and G0109 (group session) should be billed with appropriate revenue codes.
- For individual services, one (1) unit equals 30 minutes. A maximum of two (2) units applies.
- For group services, one (1) unit equals 30 minutes. A maximum of five (5) units per individual per training session applies.

11.4.3 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.

11.5 Durable Medical Equipment

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

11.6 Emergency Department Services

Revenue Codes: 0450 – 0459

Procedure Code Range: 99281 - 99285

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

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

The facility must be available 24 hours a day.

Emergency department services provide evaluation, management, treatment and prevention of unexpected illness or injuries.
“Per visit” means all occurrences of a service provided on the same date of service during a separate visit. If more than one (1) visit to an emergency room or clinic takes place on the same date of service, the second or subsequent visits to the emergency room must be for medically necessary services. Any same-day subsequent visits to the ER must have medical documentation, of all visits, attached to receive reimbursement.

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

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

### 11.6.1 Covered Services

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

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

### 11.6.2 Limitations

- If a significant surgery is performed in the emergency room, enter a HCPCS surgery code on the claim. Otherwise, a CPT Evaluation/Management code can be reported.
- The 12 visits per calendar year threshold before requiring an authorization of medical necessity requirement for clients age 21 and older will apply to non-emergency visits to the emergency room (6.10 Service Thresholds).
  - Determination of a claim’s status of emergent/non-emergent is determined based on the Type of Admission/Visit Code (6.12, Co-Payment Schedule).
- Ancillary charges will be paid. Providers can apply for an authorization of medical necessity or clients can be billed for denied visits that are not medically necessary (6.10 Service Thresholds).
- A co-payment of $3.65 is also required for non-emergency visits to the emergency room. This amount will be automatically deducted from the emergency room payment (6.12, Co-Payment Schedule).
  - Determination of a claim’s status of emergent/non-emergent is determined based on the Type of Admission/Visit Code (6.12, Co-Payment Schedule).
Outpatient Services

- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes (Chapter 12, Critical Access Hospital and General Hospital Inpatient).
- When a patient receives outpatient services from a different hospital each facility bills as appropriate. Services that were rendered as outpatient are billed as outpatient by that facility and the inpatient services are billed as inpatient by that facility.
- Physician services are billed and paid separately via CMS-1500/837P.

11.7 Laboratory Services

Revenue Codes: 030X - 031X

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

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

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

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

Modifier L1 – unrelated lab update

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

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

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

Critical Access Hospitals - use bill type 141 when billing for unrelated lab services
11.7.1 CLIA Requirements

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

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

<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>G0103, G0123, G0124, G0141, G0143, G0144, G0145</td>
</tr>
<tr>
<td>17313, 17314, 17315, 78110, 78111, 78120, 78121 (0001U-0083U)</td>
<td>80000-89999 (UNLESS OTHERWISE SPECIFIED ELSEWHERE IN THIS TABLE)</td>
</tr>
<tr>
<td>PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE LABORATORY (CLIA TYPE 1) SECTION AND ALL CODES FOR PPMP (CLIA TYPE 4) SECTION AND WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)</td>
<td></td>
</tr>
<tr>
<td>PROVIDER-PERFORMED MICROSCOPY PROCEDURES (PPMP) (4)</td>
<td>81000, 81001, 81015, 81020, 89055, 89190, G0027</td>
</tr>
<tr>
<td>Q0111, Q0112, Q0113, Q0114, Q0115</td>
<td>PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE PPMP (CLIA TYPE 4) SECTION AND ALL CODES FOR WAIVER (CLIA TYPE 2) SECTION AND THE CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)</td>
</tr>
<tr>
<td>WAIVER (2)</td>
<td>80305, 81002, 81025, 82044QW, 82150QW, 82270, 82272</td>
</tr>
<tr>
<td>82274QW, 82962, 83026, 83036QW, 84830, 85013, 85025QW</td>
<td>PROVIDERS WITH THIS CLIA TYPE MAY BILL THE CODES WITHIN THE WAIVER (CLIA TYPE 2) SECTION AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)</td>
</tr>
<tr>
<td>85651, 86618QW, 86780QW, 87502QW, 87631QW, 87633QW, 87634QW, 87651QW</td>
<td>PROVIDERS WITHOUT A CLIA MAY BILL ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (SEE BELOW)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CODES EXCLUDED FROM CLIA REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>80500, 80502, 81050, 82075, 83013, 83014, 83987, 86077, 86078, 86079</td>
</tr>
<tr>
<td>86910, 86960, 88125, 88240, 88241, 88304, 88305, 88311, 88312, 88313</td>
</tr>
<tr>
<td>88314, 88329, 88720, 88738, 88741, 89049, 89220</td>
</tr>
</tbody>
</table>
NOTE: The Integrated Outpatient Code Editor has numerous edits that verify combinations of lab codes billed on the same claim to determine if they are on the NCCI Table 1 and Table 2 documents as invalid combinations of codes. Please review these documents on Medicare’s website if the provider has questions regarding denials for mutually exclusive lab codes.


11.7.2 Genetic Testing

Revenue Codes: 030X - 031X

Procedure Codes: 81200-81599 & 96040

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

11.7.2.1 Covered Services

Medicaid covers genetic testing under the following conditions:

- There is reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists; and
- Test results will influence decisions concerning disease treatment or prevention (in ways that not knowing the test results would not); and
- Genetic testing of children might confirm current symptomatology or predict adult onset diseases and findings might result in medical benefit to the child or as the child reaches adulthood; and
- Referral is made by a genetic specialist (codes 81223 and 81224) or a specialist in the field of the condition to be tested; and
- All other methods of testing and diagnosis have met without success to determine the client’s condition such that medically appropriate treatment cannot be determined and rendered without the genetic testing. (6.13, Prior Authorization)
- Codes 81420, 81507 - Mother must be documented as high-risk to include: advanced maternal age >35 (at EDC), previous "birth" of embryo/fetus/child with aneuploidy, parent with known balanced translocation, screen positive on standard genetic screening test (FTCS, multiple marker screen of one type or another, etc), ultrasound finding on embryo/fetus consistent with increased risk of aneuploidy
- Code 81519 - All of the following conditions must be met and documented in the prior authorization request:
  - The test will be performed within 6 months of the diagnosis
  - Node negative (micrometastases less than 2mm in size are considered node negative)
hormone receptor positive (ER-positive or PR-positive)
- Tumor size 0.6-1.0 cm with moderate/poor differentiation or unfavorable features (i.e., angiolymphatic invasion, high nuclear grade, high histologic grade) OR tumor size >1 cm
- Unilateral disease
- Her-2 negative
- Patient will be treated with adjuvant endocrine therapy
- The test result will help the patient make decisions about chemotherapy when chemotherapy is a therapeutic option

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

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

11.7.2.2 BRCA Testing and Counseling

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

- Personal and/or family history of breast cancer, especially if associated with young age of onset; or
- Multiple tumors; or
- Triple-negative (i.e., estrogen receptor, progesterone receptor, and human epidermal growth factor receptor 2-negative) or medullary histology; or
- History of ovarian cancer; and
- 18 years or older
11.8 Obstetrical Ultrasounds

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

Procedure Codes: 76801-76828

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

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

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

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

- Determining gender
- Baby pictures
- Elective
- Observation for any signs of abuse
- Observation of any physical abnormality
11.9 Preventative Medicine – Clients over 21 years of age

11.9.1 Covered Services

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

11.10 Radiology Services

Revenue Code: 032X - 035X, 040X, 061X

Procedure Code: 70000 - 79999 and 90000 - 99999

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

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

11.10.1 Billing Requirements

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

11.10.2 Limitations

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

Revenue Codes: 036X or 049X

11.11.1 Elective Sterilization

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

- Clients must complete and sign the Sterilization Consent Form at least 30 days, but not more than 180 days, prior to the sterilization procedure. There are no exceptions to the 180-day limitation of the effective time period of the informed consent agreement (e.g., retroactive eligibility). This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly completed, payment will be denied. A complete Sterilization Consent Form must be obtained from the primary physician for all related services (6.15.1, Sterilization Consent).

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 (10.4, Interpretation Services).

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

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

11.11.2 Hysterectomies

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

• A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one (1) section (A, B or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client must sign and date Section A of this form (refer to 42 CFR 441.250 for the Federal policy on hysterectomies and sterilizations). The client does not need to sign this form when Sections B or C apply. If this form is not properly completed, payment will be denied. (6.15.2, Hysterectomy Acknowledgement of Consent)
  o If the surgery does not render the client sterile, operative notes can be submitted in place of the form indicating reason for non-sterility.
• For clients that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one (1) of the following:
  o The client was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
  o The client was already sterile at the time of the hysterectomy and the reason for prior sterility.
**11.12 Surgical Services**

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

**Procedure Codes:** 10000 - 69999

Medicaid only covers surgical procedures that are medically necessary. In general, surgical procedures are covered if the condition directly threatens the life of a client, results from trauma demanding immediate treatment, or had the potential for causing irreparable physical damage, the loss or serious impairment of a bodily function, or impairment of normal physical growth and development.

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

**11.12.1 Billing Requirements**

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

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

**11.12.2 Limitations**

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

11.13 Transplant Policy

11.13.1 Eligibility

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

11.13.2 Coordination of Care

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

Hospitals are required to obtain prior authorization for transplants listed below prior to admission and procedure. WYhealth will complete prior authorization (6.13, Prior Authorization).

11.13.3 Covered Services

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

11.13.4 Reimbursement – Outpatient Stem Cell/Bone Marrow

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

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

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

11.13.5 Non-Covered Services

Transportation of organs is not covered.
11.14 Therapy Services

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

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

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

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

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

11.14.1 Physical Therapy and Occupational Therapy

Physical Therapy Revenue Codes: 0420 - 0429
Occupational Therapy Revenue Codes: 0430 – 0439

11.14.1.1 Covered Services

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

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

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

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

11.14.1.3 Documentation

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

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

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

11.14.1.5 Prior Authorization Once Threshold is Met

For Medicaid clients, dates of service in excess of twenty (20) per calendar year, providers will need to contact Comagine Health for prior authorization (6.9 Service Thresholds).

11.14.2 Speech Therapy

Revenue Codes: 0440 – 0449

11.14.2.1 Covered Services

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

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

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

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

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

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

11.14.2.2 Limitations

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

• For dates of service in excess of thirty (30) per calendar year, providers will need prior authorization
• Clients age 21 and over are limited to restorative services only. Restorative services are services that assist an individual in regaining or improving skills or strength
• Maintenance therapy can be provided for clients age 20 and under
• Self-correcting disorders (e.g., natural dysfluency or articulation errors that are self-correcting)
• Services that are primarily educational in nature and encountered in school settings (e.g., psychosocial speech delay, behavioral problems, attention disorders, conceptual handicap, 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.

11.14.2.3 Billing Requirements

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

NOTE: In cases where the client receives both occupational and speech therapy, treatments should not be duplicated and separate treatment plans and goals should be provided.
11.14.3 Prior Authorization Once Threshold is Met

For Medicaid clients, dates of service in excess of twenty (20) for physical therapy and occupational therapy and thirty (30) for speech therapy per calendar year, providers will need to contact Comagine Health for prior authorization (6.9 Service Thresholds).

11.14.4 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Comagine Health, including any additional clinical information that supports the request for services.
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Benefit Quality Control Manager, Brenda Stout (brenda.stout1@wyo.gov).
  - The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from Comagine Health’s system. The appeal will be reviewed in conjunction with the documentation uploaded into Comagine Health’s system.

11.15 Outpatient Non-Covered Services

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

- Acupuncture.
- Autopsies.
- Claims from outpatient hospitals for pharmaceuticals supplies only.
- Court ordered hospital services are only covered if:
  - Service is a Medicaid covered services.
  - Service does not exceed Medicaid limitations.
- Dietary supplements.
- Donor search expenses.
- Services that are not direct patient health care i.e. – missed or canceled appointments or preparation of medical or insurance reports.
- Exercise programs and programs that are primarily education, such as:
  - Cardiac rehabilitation exercise programs.
  - Independent exercise programs (e.g. pool therapy, swim programs, or health club memberships).
  - Nutritional programs.
  - Pulmonary rehabilitation programs.
- Homemaker services.
- Infertility services.
Outpatient Services

- Inmates – Services provided to a person who is an inmate of a public institution or agency are not covered.
- Massage services.
- Maternity services not provided in a licensed health care facility unless as an emergency service.
- Naturopath services.
- Outpatient hospital services provided outside the United States.
- Services considered experimental or investigational.

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

11.16 OPPS Reimbursement, Definitions, Billing Tips and Guidelines

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

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

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

11.16.1 Purpose and Objectives

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

11.16.2 Policy Notes
Outpatient Services

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

11.16.3 Coding Tips

- Always read the complete description and guidelines in the coding books.
- Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, don’t use 53899 (unlisted procedure of the urinary system) when a more specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have three (3) to five (5) levels. See the CPT coding book for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60-minutes with the client. The code choices are 45 to 50-minutes or 76 to 80-minutes. The provider must bill the code for 45 to 50-minutes.
- Revenue codes 025X (except for 0253) and 027X do not require CPT or HCPCS codes; however, providers are advised to place appropriate CPT or HCPCS Level II codes on each line. Providers are paid based on the presence of line item CPT and HCPCS codes. If these codes are omitted, the hospital may be under paid.
- Take care to use the correct “units” measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one (1) unit equals one (1) visit or one (1) procedure. For specific codes, however, one (1) unit may be “each 15 minutes”. Always check the long text of the code description published in the CPT-4 or HCPCS Level II coding books. For example, if a physical therapist spends 45 minutes working with a client (97110), and the procedure bills for “each 15 minutes,” it would be billed this way.

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<th>44 – Procedure Code</th>
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11.16.3.1 Using Modifiers

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

11.16.4 Coding, Billing and Edits

11.16.4.1 Bilateral Procedures

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

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11.16.4.2 Inpatient Only Procedure Codes

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

11.16.4.3 Patient Status Codes

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

11.16.4.4 Service on the Same Day

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

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

11.16.4.6  Recording Detailed ICD Diagnosis Codes

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

11.16.4.7  Recording Detailed CPT/HCPCS Codes

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

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

11.16.4.8  Type of Bill

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

11.16.4.9  Line Item Denial and Claim Denials

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

11.16.5.1 Drugs and Biologicals

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

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

11.16.5.2 Lab Services

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

11.16.5.3 Supplies

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

11.16.6 How Payment is Calculated

11.16.6.1 Outpatient Prospective Payment Systems (OPPS) Affected Providers and Claims Types

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

### 11.16.6.2 The Outpatient Prospective Payment System (OPPS)

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

### 11.16.6.3 Revenue Codes and Procedure Codes

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

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

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</tbody>
</table>

Refer to the OPPS fee schedule appropriate for the date of service to determine the payment when paid under the APC method. For Example:
Some revenue codes require a CPT/HCPCS code. Line item revenue codes indicated as “CPT/HCPCS required” will be denied if a CPT/HCPCS code is not present. This information is only found in the NUBC Official UB Data Specifications Manual.

11.16.7 Status Indicators

The IOCE assigns a status indicator to each procedure code. The status indicator directs payment of the line item. Each procedure code’s specific status indicator can be reviewed by using the APC online fee schedule on the website (2.1. Quick Reference). The status indicators used the DHCF are based on the indicators used by Medicare, with DHCF specific indicators:

<table>
<thead>
<tr>
<th>Status Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not Covered</td>
<td>Indicates a service that is not covered by Medicaid (e.g., a service that cannot be provided in an outpatient hospital setting or that is not a covered Medicaid benefit)</td>
</tr>
<tr>
<td>2</td>
<td>Paid a percentage of charges</td>
<td>Paid by multiplying billed charges by a hospital-specific cost-to-charge ratio</td>
</tr>
<tr>
<td>3</td>
<td>Other fee schedule</td>
<td>Indicates a service that is excluded from the APC-based methodology, e.g., laboratory and screening mammography’s</td>
</tr>
<tr>
<td>Status Code</td>
<td>Medicare Description</td>
<td>Wyoming use of Status Indicators</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>A</td>
<td>Services not Paid under OPPS; Paid under fee schedule or other payment system</td>
<td>Not paid under OPPS</td>
</tr>
<tr>
<td>B</td>
<td>Non-allowed item or service for OPPS</td>
<td>Not paid under OPPS</td>
</tr>
<tr>
<td>C</td>
<td>Inpatient procedure</td>
<td>Not paid under OPPS</td>
</tr>
<tr>
<td>D</td>
<td>Discontinued Codes</td>
<td>Not paid under any system</td>
</tr>
<tr>
<td>E1</td>
<td>Items and services not covered by Medicare</td>
<td>Not paid under any outpatient system</td>
</tr>
<tr>
<td>E2</td>
<td>Items and services for which pricing information and claims data are not available</td>
<td>Not paid under any outpatient system</td>
</tr>
<tr>
<td>F</td>
<td>Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines</td>
<td>Not paid under OPPS. Paid at reasonable cost</td>
</tr>
<tr>
<td>G</td>
<td>Pass-through drugs and biologicals</td>
<td>Paid under OPPS; Separate APC payment includes pass-through amount</td>
</tr>
<tr>
<td>H</td>
<td>(1) Pass-through device categories (2) Therapeutic Radiopharmaceuticals</td>
<td>Paid under OPPS; (1) separate cost-based pass-through payment; (2) separate cost-based non pass-through payment</td>
</tr>
<tr>
<td>J1</td>
<td>Hospital Part B services paid through a comprehensive APC</td>
<td>Paid under OPPS; (1) composite APC payment; (2) packaged if billed on the same date of service as other J1 services.</td>
</tr>
<tr>
<td>J2</td>
<td>Hospital Part B services that may be paid through a comprehensive APC</td>
<td>Paid under OPPS; (1) Comprehensive Observation; (2) If multiple visit codes with status indicator J2 are present, the visit code with the highest standard APC payment rate is chosen as the comprehensive observation APC; all other visit codes are packaged.</td>
</tr>
<tr>
<td>K</td>
<td>Non pass-through drugs and biological</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>L</td>
<td>Flu/PPV vaccines</td>
<td>Not paid under OPPS. Paid at reasonable cost</td>
</tr>
<tr>
<td>M</td>
<td>Services that are only billable to carriers and not to fiscal intermediaries</td>
<td>Not paid under OPPS</td>
</tr>
<tr>
<td>N</td>
<td>Items and services packaged into APC rates</td>
<td>Paid under OPPS; Payment is packaged into payment for other services.</td>
</tr>
<tr>
<td>P</td>
<td>Partial Hospitalization Service</td>
<td>Not Paid under OPPS</td>
</tr>
<tr>
<td>Q1</td>
<td>STVX-Packaged codes subject to separate payment under OPPS payment criteria.</td>
<td>Paid under OPPS; (1) Packaged APC payment if billed on the same date of service as a STVX procedure code; (2) separate APC payment.</td>
</tr>
<tr>
<td>Q2</td>
<td>T packaged codes subject to separate payment under OPPS Payment criteria.</td>
<td>Paid under OPPS; (1) Packaged APC payment if billed on the same date of service as a T procedure code; (2) separate APC payment.</td>
</tr>
<tr>
<td>Status Code</td>
<td>Medicare Description</td>
<td>Wyoming use of Status Indicators</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Q3</td>
<td>Codes that may be paid through a Composite APC</td>
<td>Paid under OPPS; (1) Composite APC payment based on composite criteria; (2) Paid through a separate APC; (3) Payment is packaged into payment for other services.</td>
</tr>
<tr>
<td>Q4</td>
<td>Conditionally packaged laboratory services</td>
<td>Paid under OPPS; (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3”.</td>
</tr>
<tr>
<td>R</td>
<td>Blood and Blood Products</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>S</td>
<td>Procedure or service, not discounted when multiple</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>T</td>
<td>Procedure or service, multiple reduction applies</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>U</td>
<td>Brachytherapy Sources</td>
<td>Paid under OPPS; pays at % of Charges.</td>
</tr>
<tr>
<td>V</td>
<td>Clinic or emergency department visit</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>Y</td>
<td>Non-implantable durable medical equipment (DME)</td>
<td>Not paid under OPPS.</td>
</tr>
</tbody>
</table>

### 11.16.8 Payment Calculators

The OPPS payment methodology strongly relies on the accurate coding of procedure codes for each service billed on the claim. These procedure codes are assigned a status indicator, which then identifies which type of Wyoming reimbursement methodology process will apply to the service line in question. Typically the payment methodology is the assignment of APC categories which determines the reimbursement rate for the procedure code.

### 11.16.8.1 Ambulatory Payment Classification (APC)

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

### 11.16.8.2 Composite APC

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

11.16.8.3 Relative Weight

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

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

11.16.8.4 Conversion Factor

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

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

11.16.8.5 Fee Calculation

In its simplest form, the calculation of an APC assigned procedure code is: (relative weight) x (conversion factor) = payment
4.3542 (relative weight) x $40.30 – Ambulatory Surgical Center (conversion factor) = $175.47 (payment)

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

### 11.16.8.6 Pass-Through Payments

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

### 11.16.8.7 Packaged Services

Services having a status indicator of N are considered packaged or bundled. The costs for these services are taken into account when relative weights are assigned for the other services, but are not paid separately. Medicare developed the relative weights for surgical, medical and other types of visits to reflect the packaged services in the APC methodology, i.e. lines with a status indicator of N will pay $0.00.

### 11.16.8.8 Wyoming Specific Non-APC Payments

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

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

### 11.16.9 Charge Caps (Maximum Payout on Line Item)

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

- This could mean that lines on the claim pay more than the submitted charge. When this occurs, the Remittance Advice/835 will reflect a negative write off amount.
Outpatient Services

- If a procedure code is priced using the Medicaid fee schedule, (status indicator 3) the line will price/pay the lesser of the Medicaid allowed amount or the billed amount.
- Package procedure codes will always price/pay at zero (status indicator N).
- Those procedure codes having a status indicator reflecting that they are paid a percentage of charges are paid at a percentage of the participating hospital’s charges for that service (e.g., status indicators 2 and H). The percentage paid is the participating hospital’s specific cost-to-charge ratio.
- Under Wyoming’s OPPS, select services are paid using a percentage of charges. The actual percentage used for payment varies by provider and is called a cost-to-charge ratio. For participating providers (providers that have reached a designated threshold of payments in the base year for rate setting) in Medicaid’s inpatient DRG system, Medicaid uses a Medicaid cost-to-charge ratio that is calculated annually. Hospital-specific Medicaid cost-to-charge ratios may not exceed 100 percent. Non-participating hospitals are reimbursed using the average Medicaid cost to charge ratio for their respective cost-to-charge ratio. Medicaid develops these cost-to-charge ratios from Medicare cost reports and Medicaid claims data.

11.16.10 Modifiers

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

11.16.10.1 Outpatient Services Modifiers

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

NOTE: Modifier Usage

Ch. 11 Index 198 Revision 04/01/20
• Modifier 51 is not accepted under OPPS.
• Modifier conflicts when billed on together on the same line:
  CT-FX or FX-CT
  PN-PO or PO-PN

11.16.11 Discounting

11.16.11.1 Discounted Procedures

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

11.16.11.2 Discounting for Type “T” Procedures (Significant Procedures Subject to Discounting)

• Multiple procedures – Medicaid will discount payment for certain procedures when a hospital performs two (2) or more type “T” procedures on the same-day for the same patient. The “T” procedure with the highest relative weight will not be discounted. The remaining “T” procedures will be multiple procedures discounted. If any of the following modifiers are present on the claim line item, the procedure will not be subject to multiple procedure discounting:
  o 76 Repeat procedure by same physician.
  o 77 Repeat procedure by another physician.
  o 78 Return to the operating room for a related procedure during the postoperative period.
  o 79 Unrelated procedure or service by the same physician during the postoperative period.

• Bilateral procedures – The first type “T” bilateral procedure, indicated by modifier 50 (bilateral procedure) will not be discounted. The remaining “T” bilateral procedures will be bilateral procedure discounted. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type “T” procedures.

• Discontinued procedures – Medicaid will discount type “T” procedures that a hospital discontinues before completion, indicated by modifier 52 (reduced services) or 73 (discontinued outpatient procedure prior to anesthesia administration). The “T” discontinued procedure with the highest relative weight will be discounted 50 percent of the payment rate. The remaining “T” discontinued procedures will be discontinued procedure discounted. Any applicable offset will be applied prior to selecting the type “T” procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount.
11.16.11.3 Discounting for Non-Type “T” Procedures

- Bilateral procedures – the first non-type “T” bilateral procedure, indicated by modifier 50 (bilateral procedure) will not be discounted. The remaining non-type “T” bilateral procedures will be bilateral procedure discounted. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type “T” procedures.

- Discontinued procedures – Medicaid will discount non-type “T” procedures that a hospital discontinues before completion, indicated by modifier 52 (reduced services) or 73 (discontinued outpatient procedure prior to anesthesia administration).

- Credit received from the manufacturer for a replaced medical device – When the credit for the device is 50% or more of the total cost of the device, the provider will need to indicate this on their claim by using a value code of “FD” and indicating the total amount of the credit.
11.16.12 Observation and Direct Admission Services

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

- Observation services are billed using revenue code 0762.
- Procedure code G0378 (hospital observation services, per hour) is appropriate for all conditions or types of admission to observation.
- The unit indicator for G0378 should be the total number of hours the client was in observation.
- Procedure code G0379 (direct admission of client for hospital observation care) is appropriate if the client was directly admitted to the hospital for observation such as a referral from a community physician, rather than admittance through the emergency room or clinic.
- The unit indicator for G0379 should be 1.

11.16.12.1 Reimbursement

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

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

OR

- No services with a status code of “T” were provided on the same date of services as the G0378; and
- Eight (8) or more units of procedure code G0378 are billed on the same date or the day after a high level emergency department visit or critical care service or an appropriate obstetric diagnosis code is billed along with at least one (1) unit of procedure code G0378; and
- One (1) or more of the following procedure codes are billed on the day of or the day prior to the observation services:
  - 99284 – Emergency department visit (Level 4)
  - 99285 – Emergency department visit (Level 5)
  - 99291 – Critical care, first hour
Observation services billed with one (1) of the listed visit procedure codes (99205, 99215, 99284, 99285, and 99291) but not meeting other criteria listed will be packaged.

11.16.12.2 Direct Admissions

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

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

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

11.16.12.3 NDC Billing Requirements

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

11.16.13 OPPS Quarterly Updates

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

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

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

11.16.14 Coding Tips

- Information related to the quarterly updates, and changes to OPPS policy and procedures as well as updated coding information will be published to the Medicaid web site with each quarterly update.
- The most accurate way to review information related to the current OPPS policy and coding procedures is to view the OPPS information on the web site (2.1, Quick Reference).
- There are a number of available references, resources and information sources available to assist with OPPS billing.
Chapter Twelve – Critical Access Hospital and General Hospital Inpatient

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12.1 General Coverage Principals and Definitions

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

12.1.1 Critical Access Hospital (CAH)

A hospital that meets the following CMS criteria:

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

12.1.1.1 General Acute Care Hospital

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

12.1.2 Psychiatric Hospital

Hospitals which specialize in the treatment of serious mental illnesses and have been certified by Medicare as a Psychiatric Hospital.
12.1.2.1 Inpatient Services

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

- For payment purposes, inpatient services require at least a 24 hour stay unless the stay falls under the less than 24 hour stay for transfers. ([Section 12.6.2, Outpatient Services Followed By Inpatient Services](#))

- Medically necessary inpatient hospital services are covered pursuant to written orders by a physician or staff under the supervision of a physician, a dentist or other appropriate practitioner.

- Facilities are required to send medications (either prescriptions or already filled) home with clients upon discharge.

- Services are considered inpatient services when the patient is admitted as an inpatient to the facility, regardless of the hour of admission, whether or not a bed is used and whether or not the patient remained in the hospital past midnight.
  - Inpatient stays are subject to the submission of Inpatient Monitoring Reports – refer to WYhealth for details.
  - When a client receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes. ([12.6, Inpatient Billing Guidelines](#))

12.2 Abortion

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

12.3 Psychiatric Services

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

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

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

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

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

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

12.3.1.1 Billing Requirements

Services, including involuntary psychiatric placements for Medicaid eligible clients, must be prior authorized within one (1) working day of admission through WYhealth. (2.1, Quick Reference and 6.13, Prior Authorizations).

12.4 Sterilization and Hysterectomies

12.4.1 Elective Sterilization

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

- Clients must complete and sign the Sterilization Consent Form at least 30 days, but not more than 180 days, prior to the sterilization procedure. There
are no exceptions to the 180-day limitation of the effective time period of the informed consent agreement (e.g., retroactive eligibility). This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly complete, payment will be denied. A complete Sterilization Consent Form must be obtained from the primary physician for all related services (6.15.1, Sterilization Consent Form and Guidelines).

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

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

Before performing sterilizations, the following requirements must be met:

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

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

12.4.1.1 Billing Requirements

**Diagnosis Code:** Z30.2

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

- The above surgical codes and diagnosis code must accompany one another on a claim. Anytime one (1) of the surgical sterilization procedure codes is present on an inpatient claim, the diagnosis code of Z30.2 (sterilization) must also be present. Likewise, if diagnosis Z30.2 is present on an inpatient claim, one (1) of the above surgical sterilization procedures must also be present. If only the surgical sterilization code or diagnosis code is present, the claim will deny.
- If both the above criteria are met then the system will verify that a delivery took place by identifying that a surgical obstetrical procedure is present, combined with a diagnosis code in the O20 – O92 range. If the obstetrical procedure and diagnosis code are not present the claim will deny.

12.4.2 Hysterectomies

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

- A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one (1) section (A, B or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client must sign and date section A of this form (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C apply. If this form is not properly completed, payment will be denied (6.15.2, Hysterectomy Acknowledgement of Consent).
  - If the surgery does not render the client sterile, operative notes can be submitted in place of the form indicating the reason for non-sterility.
- For clients that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one (1) of the following:
The client was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.

The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

12.5 Transplant Services

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

12.5.1 Eligibility

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

12.5.2 Coordination of Care

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

Hospitals are required to obtain prior authorization for transplants listed below prior to admission and procedure. WYhealth will complete prior authorizations (6.13, Prior Authorizations).

12.5.3 Covered Services

Medicaid covered transplants include:

<table>
<thead>
<tr>
<th>Transplant</th>
<th>Clients 20 years and under</th>
<th>Clients 21 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Marrow</td>
<td>Covered service</td>
<td>Covered service</td>
</tr>
<tr>
<td>Heart</td>
<td>Covered service</td>
<td>Not a covered service</td>
</tr>
<tr>
<td>Heart/Lung</td>
<td>Covered service</td>
<td>Not a covered service</td>
</tr>
<tr>
<td>Kidney</td>
<td>Covered service</td>
<td>Covered service</td>
</tr>
<tr>
<td>Pancreas</td>
<td>Covered service</td>
<td>Not a covered service</td>
</tr>
<tr>
<td>Lung</td>
<td>Covered service</td>
<td>Not a covered service</td>
</tr>
<tr>
<td>Liver</td>
<td>Covered service</td>
<td>Covered service</td>
</tr>
</tbody>
</table>

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

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

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

12.6  Inpatient Billing Guidelines

12.6.1  Present on Admission Indicator (POA)

Refer to Section 6.7, Provider Preventable Conditions (PPC)

12.6.2  Outpatient Services Followed by Inpatient Services

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

- Coverage period (FL 6) for the claim must be the date the client was first seen for outpatient services through the inpatient discharge date.
- The admit date (FL 12) must be the date the client was admitted to inpatient services.
- All outpatient services should be included on the claim, using the correct dates of service.
- The outpatient services will be considered in the APR DRG claims reimbursement calculations.

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

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

12.6.3 Reimbursement for Inpatient Hospital Claims

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

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

12.6.4 APR DRG Reimbursement for Inpatient Hospital Claims

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

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

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


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

12.6.5 Level of Care Reimbursement for Inpatient Hospital Claims

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

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

<table>
<thead>
<tr>
<th>Inpatient Category</th>
<th>LOC Criterion</th>
<th>Discharge prior to 2/1/19</th>
<th>Discharge 2/1/19 and after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney Transplant</td>
<td>• Prior authorized transplant services; AND &lt;br&gt; • ICD-10 surgical procedure code of 0TY00Z0-0TY10Z2</td>
<td>LOC 7</td>
<td>DRG Processing- Refer to 3M for payment details</td>
</tr>
<tr>
<td>Heart/Heart-Lung Transplant</td>
<td>• Prior authorized transplant services; AND &lt;br&gt; • ICD-10 surgical procedure code of 02YA0Z0-0BYM0Z2</td>
<td>LOC 8</td>
<td>DRG Processing- Refer to 3M for payment details</td>
</tr>
<tr>
<td>Liver Transplant</td>
<td>• Prior authorized transplant services; AND &lt;br&gt; • ICD-10 surgical procedure code of 0FY00Z0-0F700Z2</td>
<td>LOC 9</td>
<td>DRG Processing- Refer to 3M for payment details</td>
</tr>
<tr>
<td>Bone Marrow Transplant</td>
<td>• Prior authorized transplant services; AND &lt;br&gt; • ICD-10 surgical procedure code of 30230AZ to 30263Y1</td>
<td>LOC 10</td>
<td>DRG Processing- Refer to 3M for payment details</td>
</tr>
<tr>
<td>Lung Transplant</td>
<td>• Prior authorized transplant services; AND &lt;br&gt; • ICD-10 surgical procedure code of 0BYK0Z0-0BYM0Z2</td>
<td>LOC 16</td>
<td>DRG Processing- Refer to 3M for payment details</td>
</tr>
<tr>
<td>Inpatient Category</td>
<td>LOC Criterion</td>
<td>Discharge prior to 2/1/19</td>
<td>Discharge 2/1/19 and after</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Pancreas Transplant</td>
<td>• Prior authorized transplant services; AND • ICD-10 surgical procedure code of 0FYG0Z0-0FSG4ZZ</td>
<td>LOC 18</td>
<td>DRG Processing-Refer to 3M for payment details</td>
</tr>
<tr>
<td>Rehabilitation with ventilator</td>
<td>• Principal ICD-10 diagnosis codes: See List; AND • ICD-10 surgical procedure code: See List</td>
<td>LOC 30</td>
<td>LOC 30</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>• Principal ICD-10 diagnosis codes: See List; AND • ICD-10 surgical procedure code: See List</td>
<td>LOC 31</td>
<td>LOC 31</td>
</tr>
<tr>
<td>Maternity/Surgical</td>
<td>• Principal ICD-10 diagnosis codes: See List; AND • Major Surgery Procedure Code</td>
<td>LOC 32</td>
<td>DRG Processing-Refer to 3M for payment details</td>
</tr>
<tr>
<td>Maternity/Medical</td>
<td>• Principal ICD-10 diagnosis codes: See List</td>
<td>LOC 33</td>
<td>DRG Processing-Refer to 3M for payment details</td>
</tr>
<tr>
<td>NICU</td>
<td>• Revenue Code 0174</td>
<td>LOC 34</td>
<td>DRG Processing-Refer to 3M for payment details</td>
</tr>
<tr>
<td>ICU/CCU/Burn</td>
<td>• Revenue Code 0200-0205, 0207-0213, 0215-0219</td>
<td>LOC 35</td>
<td>DRG Processing-Refer to 3M for payment details</td>
</tr>
<tr>
<td>Surgery</td>
<td>• Revenue Code 0360-0369; AND • Major Surgery Procedure Code</td>
<td>LOC 36</td>
<td>DRG Processing-Refer to 3M for payment details</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>• Prior authorized psychiatric services;</td>
<td>LOC 37</td>
<td>DRG Processing-Refer to 3M for</td>
</tr>
<tr>
<td>Inpatient Category</td>
<td>LOC Criterion</td>
<td>Discharge prior to 2/1/19</td>
<td>Discharge 2/1/19 and after</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>AND</td>
<td>Principal ICD-10 diagnosis codes: See List</td>
<td>payment details</td>
<td>LOC 38 DRG Processing-Refer to 3M for payment details</td>
</tr>
<tr>
<td>Newborn Nursery</td>
<td>Principal ICD-10 diagnosis codes: See List</td>
<td>First date of service is &lt; 29 days of age</td>
<td>LOC 38 DRG Processing-Refer to 3M for payment details</td>
</tr>
<tr>
<td>Routine</td>
<td>All remaining discharges</td>
<td>LOC 39</td>
<td>DRG Processing-Refer to 3M for payment details</td>
</tr>
</tbody>
</table>

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

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

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

### 12.6.5.1 Level of Care Exceptions

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

The receiving hospital should use an admit source of 04 to indicate the patient was transferred in. Medicaid will reimburse for admit date regardless of admit time.

Transfers do not include movement of a patient from one hospital unit to another within a hospital, even if the hospital’s internal process includes a discharge and admission between the units. Example: A patient is treated in the acute care setting and later moved to the psychiatric unit of the same hospital – this is billed as one (1) complete stay, not two (2) claims.

- In the event that a claim’s dates of service cross two (2) different hospital-specific or statewide rate (typically updated annually) for the same level of care, the rates in effect on the admission date will be used to calculate payment.

- High cost outlier cases will receive additional payment. High cost outlier cases are defined as those cases for which allowable submitted charges exceed Level of Care threshold.

### 12.6.6 Level of Care High Cost Outlier Reimbursement

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

- Information required for calculation
- Total Billed Charges
- Admission Date
- Level of Care ([12.6.3, Level of Care Reimbursement for Inpatient Hospital Claims](#))
- Cost to Charge ratio (for the level of care and admission date)
- Outlier Threshold (for the level of care and admission date)
- Level of Care Payment (for the admission date)
- Capital Reimbursement

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

**Steps:**
1. Determine if the total billed charges are greater than the outlier threshold amount. If so, continue. If not – regular Level of care Methodology will be used to determine reimbursement (12.6.3, Level of Care Reimbursement for Inpatient Hospital Claims).

2. Multiply the cost to charge ratio by the total billed charges. Determine if this amount is greater than the outlier threshold amount. If so, continue. If not, regular level of care methodology will be used to determine reimbursement (12.6.3, Level of Care Reimbursement for Inpatient Hospital Claims).

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

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

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

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

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

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

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

   $125,000.00 > $12,000.50 – YES

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

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

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

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

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

   $36,737.00 X .75 = $27,327.75
5. Add the result of Step 4 to the level of care payment, and capital reimbursement to calculate the final reimbursement amount.

$27,327.75 + $5,500.00 + $277.87 = $33,105.62
Chapter Thirteen – Comprehensive Outpatient Rehabilitation Facility (CORF)

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13.1 Comprehensive Outpatient Rehabilitation Facility (CORF)

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

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

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

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

13.1.1 Billing Requirements

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

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Revenue Code</th>
<th>CPT or HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Therapy</td>
<td>041X</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>042X</td>
<td></td>
</tr>
</tbody>
</table>
### Comprehensive Outpatient Rehabilitation Facility (CORF)

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Revenue Code</th>
<th>CPT or HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
<td>043X</td>
<td></td>
</tr>
<tr>
<td>Speech Language Pathology</td>
<td>044X</td>
<td></td>
</tr>
<tr>
<td>Nursing Services</td>
<td>055X</td>
<td>HCPCS G0128</td>
</tr>
<tr>
<td>Immunizations</td>
<td>0636</td>
<td></td>
</tr>
<tr>
<td>Vaccine Administration</td>
<td>0771</td>
<td>CPT 90471</td>
</tr>
<tr>
<td>Behavioral Health Treatments/Services</td>
<td>090X, 091X</td>
<td>CPT 96152 Social &amp; Psychological Services</td>
</tr>
</tbody>
</table>

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

**NOTE:** Physical, occupational or speech therapy provided in the CORF will count towards the threshold for all clients.
Chapter Fourteen – End Stage Renal Disease (ESRD)

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14.1 End Stage Renal Disease (ESRD)

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

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

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

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

14.1.1 Billing Requirements

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

14.1.2.1 Coding Criteria Table

Bill Type 72X
Taxonomy 261QE0700X

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

14.1.3 ESRD Coding Additional Information

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

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15.1 Federally Qualified health Centers (FQHC)

Revenue Code: 0520 – 0528 Medical
Procedure Code: D8999 – Orthodontics & D9999 0 Dental

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

15.1.1 Covered Services

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

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

Medical visits can also consist of:

- Medical nutrition therapy
- Diabetes outpatient self-management training

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

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

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

15.1.2 Reimbursement Guidelines

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes, but is not limited to:
• Therapeutic services
• Diagnostic Services
• Tests
• Supplies
• Lab
• Radiology


Billing for Long Acting Reversible

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

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

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11981</td>
<td>Insertion, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11982</td>
<td>Removal, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11983</td>
<td>Removal with reinsertion, non-biodegradable drug delivery implant</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>520</td>
<td>T1015</td>
<td>$220.00</td>
</tr>
<tr>
<td>517</td>
<td>11981</td>
<td>$0.00</td>
</tr>
<tr>
<td>517</td>
<td>99215</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
• **Practitioner Group LARC Device Billing on the CMS 1500 Form/837P Claims Transaction**
  
  o Practitioner Group NPI as pay-to provider and enter the treating provider NPI (same as the attending on the encounter claim)
  o Date of service must be the same as the date on the encounter claim
  o LARC Device Covered Services/CPT Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>NDC Requirement</th>
<th>LARC Device Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7296</td>
<td>Required</td>
<td>Kyleena</td>
</tr>
<tr>
<td>J7297</td>
<td>Required</td>
<td>Liletta</td>
</tr>
<tr>
<td>J7298</td>
<td>Required</td>
<td>Mirena</td>
</tr>
<tr>
<td>J7300</td>
<td>Required</td>
<td>Paragard</td>
</tr>
<tr>
<td>J7301</td>
<td>Required</td>
<td>Skyla</td>
</tr>
<tr>
<td>J7307</td>
<td>Required</td>
<td>Nexplanon</td>
</tr>
</tbody>
</table>

**NOTE:** All LARC device codes require an NDC

  o **Device Billing Example:**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>NDC</th>
<th>Billed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7301</td>
<td>00000-00-000</td>
<td>340B acquisition cost OR if purchased outside 340B Program enter usual &amp; customary charge</td>
</tr>
</tbody>
</table>

**15.1.3 Billing Requirements**

• Multiple encounters within the FQHC, on the same day, with different practitioners are still considered one (1) encounter UNLESS the client suffers illness or injury requiring treatment unrelated to the first encounter or if the clients have both a medical visit and other health visit, as defined above.

• Claims must be billed with revenue and procedures codes for both the encounter and detail line items.

• All services provided during the encounter must be billed on a separate line.

• Claims must have a minimum of two (2) line items, the first would be the encounter line and the second line item is detail (both must include a revenue and procedure code combination).

• Encounter lines will be billed with a 0520 revenue code paired with:
  
  o Procedure code T1015 for a general encounter.
  o Procedure codes 99381-99385 or 99391-99395 for EPSDT encounter.
  o Use modifier 32 to indicate a health check encounter that results in a referral to a specialist.
  o Bill the total usual and customary charges for the visit.

• Detail line items will be billed with:
Any appropriate outpatient revenue code paired with any appropriate procedure code (for questions regarding appropriate pairing of revenue codes and procedure codes, use the current version of the NUBC Official UB Data Specifications Manual).
- Document each procedure that occurred during the encounter.
- Include a detailed line item for the office visit or health check procedure code if appropriate.
- Bill the detail line items at $0.00.

- **Appropriate Bill Type(s)**
  - 73X-77X

- **Pay-to Provider’s Taxonomy**
  - 261QF0400X

### 15.1.3.1 Billing Examples

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

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0520</td>
<td>T1015</td>
<td>$175.00</td>
</tr>
<tr>
<td>0517</td>
<td>99213</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0520</td>
<td>T1015</td>
<td>$220.00</td>
</tr>
<tr>
<td>0517</td>
<td>99381</td>
<td>$0.00</td>
</tr>
<tr>
<td>0300</td>
<td>87086</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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

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16.1 Home Health

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

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

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

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

16.1.1 Supervision

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

16.1.2 Criteria

Service must be:

- Ordered by a physician.
- Documented in a signed and dated Plan of Care/Medicare 485 Form that is reviewed and revised as medically necessary by the attending physician at least once every 60 days.
- Medically necessary.
• Three (3) or fewer encounters per day for any combination of home health aide and skilled nursing services.
  o An encounter is defined as all home health services provided in a single day that could be provided in a single visit to the client, regardless of how many actual visits to the client are actually completed. For example, shower, shampooing, nail care, and dressing CAN all be completed at the same time, so, even if the shower is in the morning and nail care is completed in the afternoon, this is one encounter. A separate encounter is not to be billed due to the convenience of the provider nor due to scheduling issues or conflicts. A separate encounter can be billed when services must be separated due to orders or medical necessity, such as wound dressings being changed multiple times per day, or medication being given in the morning or at bed time, or assistance with nutritional intake multiple times per day.
• Expected to last six months or less

16.2 Covered Services

• Skilled nursing services provided by a Registered Nurse (RN) for client’s condition while in the acute phase.

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

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

• Physical therapy services provided by a qualified licensed physical therapist.
• Speech therapy services provided by a qualified licensed therapist.
• Occupational therapy services provided by a qualified registered or certified therapist.
• Medical social services provided by a qualified licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW) -prepared person supervised by an MSW.

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

16.2.1 Limitations

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

16.2.2 Documentation Requirements

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

New clients ordered to home health care must have documentation of a face-to-face visit with the ordering practitioner within the 90 days preceding the beginning of home health. This face-to-face visit can be in the hospital, clinic, nursing home, or other clinical setting.

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

### Billing Requirements

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

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

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

<table>
<thead>
<tr>
<th>Home Health Revenue Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue Code</strong></td>
</tr>
<tr>
<td>0551</td>
</tr>
<tr>
<td>0421</td>
</tr>
<tr>
<td>0441</td>
</tr>
<tr>
<td>0431</td>
</tr>
<tr>
<td>0571</td>
</tr>
<tr>
<td>0561</td>
</tr>
</tbody>
</table>
NOTE: Do not place procedure codes on the claim.

16.2.3.1 Prior Authorizations

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

16.2.3.2 Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Comagine Health, including any additional clinical information that supports the request for services
- Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Benefit Quality Control Manager, Brenda Stout (brenda.stout1@wyo.gov).
  o The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from Comagine Health’s system. The appeal will be reviewed in
conjunction with the documentation uploaded into Comagine Health’s system
Chapter Seventeen – Hospice

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17.1 Hospice

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

Pay-to Provider’s Taxonomy: 251G00000X

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

17.1.1 Electing Hospice Services

Clients requesting coverage of hospice services under Wyoming Medicaid are locked-in to the hospice for all care related to their terminal illness. All services and supplies must be billed to the hospice provider, and the hospice provider will bill Wyoming Medicaid for covered services. For more information regarding client lock-in, refer to (4.4, Client Lock-In).

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

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

17.1.1.1 Hospice Benefit Election Form

![Hospice Benefit Election Form](image.png)

**NOTE:** Click image above to be taken to a printable version of this form.
17.1.1.2 Hospice Benefit Revocation Form

When a client chooses to revoke his/her hospice election, a copy of the Hospice Revocation Form must be submitted to Provider Relations. The hospice lock-in will be removed from the client’s file and they will be able to receive services as applicable. A copy of the revocation form must be sent to the Long Term Care Unit (2.1, Quick Reference).

NOTE: Only the WDH Hospice Revocation Form will be accepted by Medicaid.

17.1.1.3 Hospice Benefit Revocation Form

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

17.1.2 Covered Services

Hospice care program services will be available to Medicaid eligible clients of any age and may be provided in a home setting, nursing facility, or freestanding hospice facility when the client meets the following criteria:

- A client is certified by a physician as being terminally ill – meaning that a physician has certified that if the illness runs its normal course, the client’s life expectancy is six (6) months or less.
- The client has completed a Hospice Benefit Election Form (17.1.1.1 Hospice Benefit Election Form), which must be submitted to Medicaid along with the physician certification of terminal illness.
The hospice provider is responsible for medical care and services related to the terminal illness which are provided to the client who has elected palliative care. The hospice provider can bill for:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0651</td>
<td>G0162</td>
<td>Hospice last seven (7) days</td>
</tr>
<tr>
<td>0651</td>
<td>G0493</td>
<td>61 days and beyond – skilled services of a registered nurse (RN) for the observation and assessment of the patient’s condition</td>
</tr>
<tr>
<td>0651</td>
<td>G0494</td>
<td>61 days and beyond – skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient’s condition</td>
</tr>
<tr>
<td>0652</td>
<td></td>
<td>Continuous home care</td>
</tr>
<tr>
<td>0655</td>
<td></td>
<td>Inpatient respite care</td>
</tr>
<tr>
<td>0656</td>
<td></td>
<td>General inpatient care</td>
</tr>
<tr>
<td>0658</td>
<td></td>
<td>Nursing facility room and board</td>
</tr>
<tr>
<td>0659</td>
<td></td>
<td>Inpatient hospice room and board</td>
</tr>
</tbody>
</table>

Services provided in an inpatient setting must conform to the written plan of care. General inpatient hospital care may be required for procedures necessary for pain control and acute or chronic symptom management.

**NOTE:** Hospice clients under the age of 21 (Pediatric Hospice Election) are allowed concurrent care and reimbursement of medical care through the usual and customary billing procedures. All other provider and facility claims will be processed without the requirement of the Hospice Exemption Form (services unrelated to the client’s terminal illness.)

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Bill Type</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care</td>
<td>82X</td>
<td>0651</td>
</tr>
<tr>
<td>The hospice provider is to bill the routine home care rate for each day the client is under their care and another level of care is not reimbursed. The rate is a per diem rate. See billing information below table.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuous Home Care</td>
<td>82X</td>
<td>0652</td>
</tr>
<tr>
<td>Continuous home care is to be provided by the hospice only during a period of crisis. Bill the continuous home care rate when continuous home care is provided. Reimbursement is for every hour or part of an hour of care furnished up to a maximum of 24 hours a day. A minimum of at least eight (8) hours a day must be provided. One (1) unit equals one (1) hour of service. The rate is an hourly rate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Respite Care</td>
<td>81X</td>
<td>0655</td>
</tr>
</tbody>
</table>
### Level of Care

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Bill Type</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite care is reimbursed to an approved inpatient facility for a maximum of five (5) consecutive days at a time including the date of admission but not counting the date of discharge. The rate is a per diem rate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>81X</td>
<td>0656</td>
</tr>
<tr>
<td>The hospice is to bill the general inpatient rate when general inpatient care is provided. If the client is discharged from general inpatient care as deceased, the general inpatient rate is billed for that day. If they are discharged to home, the appropriate home care rate is billed on a separate claim form. The rate is a per diem rate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Hospice Room and Board</td>
<td>81X</td>
<td>0658</td>
</tr>
<tr>
<td>The hospice provider is to bill the nursing facility room and board component when the individual is a nursing facility resident. The hospice provider is responsible for paying the nursing facility. Use the provider number assigned to the hospice provider for nursing facility resident's room and board. The rate is a per diem rate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospice Room and Board</td>
<td>81X</td>
<td>0659</td>
</tr>
<tr>
<td>The hospice provider is to bill the inpatient hospice room and board rate for each day a client is in the hospice facility receiving care or in the inpatient hospice facility receiving respite care. Revenue codes 0652, 0656, and 0658 cannot be billed with revenue code 0659. The rate is a per diem rate. There is no client copay.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 17.1.2.1 Billing Examples

#### Routine Home Care Payments

- **Revenue code: 0651**

- **Procedure code: G0493 or G0494**

  Days 61 and beyond will be reimbursed at the lower “day 61 and beyond” rate

  - Billing examples
    - Bill on one line: 0651, G0493 or G0494, appropriate service dates & units, and total charges OR
    - Bill on two lines (service dates on the claim must be different):
      - Line 1: 0651, no procedure code, appropriate service dates & units, and total charges.
      - Line 2: 0651, G0493 or G0494, appropriate service dates & units, and total charges.

- Hospice client lifetime 60 day limit
  - A client’s hospice days will be calculated over a lifetime, meaning they will never reset.
  - On 3/1/2016, Medicaid will reprocess any paid hospice claims with dates of service 1/1/2016 and forward to calculate the client's lifetime days.
  - Once a client exceeds 60 days the provider must bill with the procedure code.
• Providers responsibility to track the number of days for each client.
• EOB code: 567: Client exceeded 60 days or received 60 or less of routine home care & procedure code G0493 or G0494 was not billed or was billed with rev code 0651.

Service Intensity Add-On (SIA) Payment

Revenue code: 0651

Procedure code: G0162

• This SIA service is reimbursable only when provided by a Registered Nurse or Social Worker in the last seven (7) days of the client’s life.
• The SIA service is limited to a maximum of 4 hours per day.
• For claims to process to payment Medicaid must have the client’s date of death on file and the dates of service are within the prior seven (7) days. Claims will be held as “in process” for 30 days pending the date of death and will deny after 30 days if no date of death is received.
• The SIA service is only billable in conjunction with routine home care (revenue code 0651).
  o A Medicaid hospice provider must have provided and received payment for the client’s routine home care services within the last 2-years. To clarify, the claims history will go back to dates of service 1/1/16 and forward, but in the year 2018 will eventually review a full two (2) years from dates of service 1/1/16.

Billing Examples:
• Bill on one line: 0651, G0162 (SIA), appropriate service dates & units, and total charges; OR
• Bill on two lines (service dates on the claim must be different):
  o Line 1: 0651, no procedure code (60 or less days), appropriate service dates & units, and total charges.
  o Line 2: 0651, G0162 (SIA), appropriate service dates & units, and total charges.
• Bill on two lines (service dates on the claim must be different):
  o Line 1: 0651, G0493 or G0494 (exceeds 60 days), appropriate service dates & units, and total charges.
  o Line 2: 0651, G0162 (SIA), appropriate service dates & units, and total charges.
• Bill on three lines (service dates on the claim must be different):
  o Line 1: 0651, no procedure code (60 or less days), appropriate service dates & units, and total charges.
  o Line 2: 0651, G0493 or G0494 (exceeds 60 days), appropriate service dates & units, and total charges.
  o Line 3: 0651, G0162 (SIA), appropriate service dates & units, and total charges.
17.1.3 Nursing Facility Residents

For clients residing in the nursing facility, the hospice provider is responsible for billing the room and board charges, and reimbursing the nursing facility for their portion of the care. The hospice provider must request prior authorization to establish a rate for nursing home care (6.13, Prior Authorization).

The hospice provider is responsible for the professional management of the individual’s hospice care, and the nursing facility will provide room and board.

Patient contribution is allocated across claims at 100% in the order the claims are received and processed. For example, if a client is a resident of a nursing facility and is receiving nursing facility hospice services in the same month, the patient contribution would be taken from total amount paid from the first provider (nursing facility or hospice provider) to bill and be paid until the patient contribution is satisfied. If payment to the first provider does not exhaust the client’s patient contribution, the remaining patient contribution will be applied to the next provider’s paid claim. This may mean that the provider who billed for the client for the second half of the month will be collecting the patient contribution and the provider billing for the first half of the month will receive a zero patient contribution assignment. For subsequent months, the full patient contribution will be applied to the hospice claim.

In both cases the providers need to determine the order in which claims should be billed, and how the patient contribution will be transferred between providers. Wyoming Medicaid cannot advise providers how to handle this business related transaction.

Nursing homes will receive pro-rated patient contribution letters; however, these are not for billing purposes. The facilities will use these letters to determine how the patient liability funds will be distributed between facilities.

If a claims adjustment is submitted with a pro-rated patient contribution letter, the adjustment will be returned.

The nursing home will not be able to submit any claims for a client who has elected hospice care. (19.2.2, Clients Under Hospice Care).

17.1.4 Reimbursement

In order for Medicaid to reimburse a hospice provider the following need to be completed as applicable:

- Received a physician certification statement of terminal illness certifying the client’s medical prognosis is a life expectancy of six (6) months or less if the terminal illness runs its normal course.
  - Copy sent to the Long Term Care Unit (2.1, Quick Reference).
- A Wyoming Medicaid Hospice Benefit Election Form (17.1.1.1 Hospice Benefit Election Form) has been completed. Only the WDH Medicaid Hospice Benefit Election Form will be accepted.
Clients who are eligible for both Medicare and Medicaid (dual eligible) must elect hospice under both programs.

Copy sent to Long Term Care Unit (2.1, Quick Reference).

- The hospice provider must request prior authorization to establish a rate for nursing home care when the client is residing in the nursing home. (6.13, Prior Authorizations).
  - The prior authorization number must be entered on the claim.
- Providers billing revenue code 0659 will need to provide a certification as a licensed inpatient hospice facility.

Reimbursement rates are determined specific to each hospice for each of the allowed revenue codes and will be re-determined on an annual basis. These rates are all inclusive and cover the services and supplies used in the care of the client, including:

- Drugs and biological.
- Home health aide or homemaker services.
- Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control.
- Durable medical equipment and supplies assisting in the use of durable medical equipment.

## 17.1.5 Services Unrelated to the Terminal Illness

For services unrelated to the client’s terminal illness, the hospice provider must provide the Hospice Exemption Form to the billing provider in order for the provider to be reimbursed. The service must be unrelated to the client’s terminal illness to qualify.

This form must be submitted with the claim or sent as an attachment (paper or electronic) if the claim is billed electronically. **Waiver Service providers will not need the exemption form.**

Dental treatment/services are limited to palliative treatment and emergency services.

**NOTE:** Providers may either upload the Hospice Benefit Election Form electronically or complete the Attachment Cover Sheet and mail the form (6.15, Submitting Attachments for Electronic Claims).
17.1.5.1 Hospice Exemption Form

Hospice Exemption Form

Date: ____________________________

Hospice Provider Name: ____________________________

Hospice Provider NPI: ____________________________

Re: Hospice Benefit - Approval for Charges Unrelated to a Medicaid Client’s Terminal Illness

The following client receiving Medicaid hospice benefits has or will soon have the following medical expenses. These expenses are not related to the terminal diagnosis and, therefore, are not the financial responsibility of the hospice provider. The hospice case manager has reviewed medical necessity and submitted payment to the provider who furnished the service.

Client Name: ____________________________

Client’s Medicaid ID: ____________________________

Date of Birth: ____________________________

Additional explanation: ____________________________

Provider: ____________________________

Service: ____________________________

Provider: ____________________________

Additional explanation: ____________________________

Hospice Provider Authorized Signature: ____________________________

Title: ____________________________

NOTE: Click image above to be taken to a printable version of this form.
Chapter Eighteen – Indian Health Services (IHS)

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18.1 Indian Health Services – Including 638 Tribal Facilities

Appropriate Bill Type(s): 13X
Pay-to Provider Taxonomy: 261QP0904X

Indian Health Services (IHS), an agency of the US Public Health Services within the Department of Health and Human Services, is the principal Federal health care provider for Native American people.

Paramount to the goals of IHS is raising the Native Americans’ health status to the highest possible level.

Indian Health Services provides comprehensive health care services, outpatient services including but not limited to: medical, vision, dental, and preventative services, etc.

18.1.1 Reimbursement

Indian Health Services are reimbursed through an encounter method.

An encounter is a face-to-face visit with an enrolled health care professional such as:

- Physician
- Physician’s assistant
- Nurse practitioner
- Nurse midwife
- Psychologist
- Social worker
- Dental professional
- Physical, Occupational, Speech therapist, Dietitian and Chiropractor
- Mental Health Professional
- Home Health service provider

18.1.1.1 Encounter Rate

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

- Therapeutic services
- Diagnostic services
- Tests
- Supplies
18.1.2 Billing Requirements

- Multiple encounters with one (1) or more professionals or multiple encounters with the same health professional on the same day in a single location should be billed as one (1) encounter, unless the patient suffers illness or injury which requires additional diagnosis or treatment.
- Starting April 1, 2017, claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.
- Each line (encounter and detail) must be billed with revenue and procedure codes.
- All services provided during the encounter must be billed on a separate line.
- Encounter lines will be billed with the appropriate revenue code (see 18.1.3 for covered services) paired with:
  - Procedure code T1015 for general encounter.
  - Bill the current encounter rate per calendar year.
- Detail line items will be billed with:
  - Any appropriate outpatient revenue code paired with an appropriate procedure code (for questions regarding appropriate pairing of revenue codes and procedure codes, use the current version of the NUBC Official UB Data Specifications Manual).
  - Include a detail line for the office visit or health check procedure if appropriate.
  - Document each procedure that occurred during the encounter.
  - Bill the detail line items at 0.00
- Pharmacy claims do not require a procedure code but need to be billed with an eleven (11) digit National Drug Code (NDC) (see section 6.8 for NDC instructions)

Each revenue code encounter line with detail lines must be billed on a separate claim.

NOTE: Do not bill with the encounter revenue code on the detail line item. For the detail line, bill with any appropriate revenue code paired with an appropriate procedure code.

18.1.2.1 Billing Examples

Client comes to the clinic for complaint of cough and sees a physician. No additional tests or treatments are administered.

- Claim #1 Date of Service 04/01/17

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0500</td>
<td>T1015</td>
<td>$391</td>
</tr>
<tr>
<td>0517</td>
<td>99213</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Client comes to the clinic for a medical appointment and a urine culture is run. The client then goes to the optometrist for an eye check.

- **Claim #1 Date of Service 03/17/17**

```
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0500</td>
<td>T1015</td>
<td>$391</td>
</tr>
<tr>
<td>0517</td>
<td>99213</td>
<td>$0.00</td>
</tr>
<tr>
<td>0520</td>
<td>87086</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
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- **Claim #2 Date of Service 03/17/17**

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<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0519</td>
<td>T1015</td>
<td>$391</td>
</tr>
<tr>
<td>0517</td>
<td>92012</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
```

Client goes to Substance Abuse and Recovery Center and goes to individual therapy. The client then works with a Peer Specialist on goals related to the treatment plan.

- **Claim #1 Date of Service 03/16/17**

```
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0914</td>
<td>T1015</td>
<td>$391</td>
</tr>
<tr>
<td>0517</td>
<td>H0047 (individual therapy)</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
```

- **Claim #2 Date of Service 03/16/17**

```
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0500</td>
<td>T1015</td>
<td>$391</td>
</tr>
<tr>
<td>0942</td>
<td>H2015 (peer specialist)</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
```

**NOTE:** These are only examples and the appropriate encounter and non-encounter codes and procedure codes should be used.
### 18.1.3 Covered Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description – within the IHS/638 Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>0300</td>
<td>Laboratory</td>
</tr>
<tr>
<td>0400</td>
<td>Imaging/Radiology</td>
</tr>
<tr>
<td>0421</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>0431</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>0441</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>0500</td>
<td>Medical Encounter</td>
</tr>
<tr>
<td>0512</td>
<td>Dental Encounter</td>
</tr>
<tr>
<td>0519</td>
<td>Optometric Encounter</td>
</tr>
<tr>
<td>0561</td>
<td>Medical Social Worker</td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide</td>
</tr>
<tr>
<td>0771</td>
<td>VFC Administration</td>
</tr>
<tr>
<td>0779</td>
<td>Health Check Screening</td>
</tr>
<tr>
<td>0821</td>
<td>ESRD Encounter</td>
</tr>
<tr>
<td>0914</td>
<td>Psychiatric/Psychological Services – Individual Therapy</td>
</tr>
<tr>
<td>0915</td>
<td>Psychiatric/Psychological Services – Group Therapy</td>
</tr>
<tr>
<td>0987</td>
<td>Hospital Encounter (IHS physician at the hospital)</td>
</tr>
</tbody>
</table>

### 18.1.3.1 Laboratory – Revenue Code 0300

Medicaid covers tests provided by independent (non-hospital) clinical laboratories when the following requirements are met:

- Services are ordered by physicians, dentists, or other providers licensed within the scope of their practice as defined by law.
- Services are provided in the facility.
- Providers must be Medicaid certified and must have a current Clinical Laboratory Improvement Amendments (CLIA) certification number.
- Providers may only bill for services they have performed. Medicaid does not pay for reference lab services.

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

### 18.1.3.2 Imaging/Radiology – Revenue Code 0400

Medicaid provides coverage of medically necessary radiology services which are directly related to the client’s symptom or diagnosis when provided by independent radiologists, hospitals and practitioners. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.
Radiology services must be ordered and provided by practitioners, dentists, or other providers licensed within the scope of their practice as defined by law. Radiology providers must be supervised by a practitioner licensed to practice within the state the services are provided.

18.1.3.3 Physical Therapy – Revenue Code 0421

All services provided in the clinic by a physical therapist are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.4 Occupational Therapy – Revenue Code 0431

All services provided in the clinic by the occupational therapist are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.5 Speech Therapy – Revenue Code 0441

All services provided in the clinic by a speech therapist are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.6 Medical Encounters (within IHS Clinic) – Revenue Code 0500

All professional services (including ancillary services and supplies) must be performed by or under the direct supervision of a licensed physician or doctor of osteopathy operating within the scope of his/her practice. This includes services rendered by a nurse practitioner, physical therapist, or other covered licensed health care professional performing services consistent with their scope of practice. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.
18.1.3.7 Dental Encounters (within IHS Clinic) – Revenue Code 0512

All professional services (including ancillary services and supplies) must be performed by or under the direct supervision of a licensed dentist operating within the scope of his/her practice. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.8 Optometric Encounters (within IHS Clinic) – Revenue Code 0519

All professional services (including ancillary services and supplies) performed by a licensed optometrist practicing within the scope of his/her practice. Routine eye examinations are not covered for clients age 21 and older. Treatment of eye diseases or eye injury continues to be covered when billed with the appropriate diagnosis code. The reason for the visit must be documented in the medical record. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.9 Medical Social Worker – Revenue Code 0561

Medical social services provided by a qualified licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW) -prepared person supervised by an MSW. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.10 VFC Administration – Revenue Code 0771

All services provided during the visit are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.11 Comprehensive Health Screening (Health Checks) – Revenue Code 0779

Indian Health Services is encouraged to participate in the Health Check (Well Child) program for Medicaid children under the age of 21. When an encounter meets the standards for a Health Check exam, use the Health Check encounter code(s) to assist the Medicaid program in tracking these services accurately. Individuals under age 21 are entitled to comprehensive health examinations. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

NOTE: This revenue code cannot be billed with any other revenue code on the same claim.
18.1.3.12 ESRD Encounter – Revenue Code 0821

All services provided during the ESRD visit are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.13 Mental Health (Individual) – Revenue Code 0914

All services provided during the encounter by the mental health professional are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.14 Mental Health (Group) – Revenue Code 0914

All services provided during the encounter by the mental health professional are included in the encounter. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.15 Hospital Visits by the Physician - Revenue Code 0987

All services provided in the hospital by the physician will be billed together under this revenue code. Claims must have a minimum of two (2) line items, the first would be an encounter line and the second line item is detail.

18.1.3.16 Home Health Agency (includes therapies) - Revenue Codes 0421, 0431, 0441, 0551, 0561 and 0571

When services are provided in the home, refer to Chapter 16, Home Health Services. Home health services cannot be paid the all-inclusive encounter rate because the services are not provided within the clinic.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description - provided in the client home</th>
</tr>
</thead>
<tbody>
<tr>
<td>0421</td>
<td>Home Health - Physical Therapy</td>
</tr>
<tr>
<td>0431</td>
<td>Home Health - Occupational Therapy</td>
</tr>
<tr>
<td>0441</td>
<td>Home Health - Speech Therapy</td>
</tr>
<tr>
<td>0551</td>
<td>Home Health - Skilled Nursing</td>
</tr>
<tr>
<td>0561</td>
<td>Home Health - Medical Social Worker</td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide</td>
</tr>
</tbody>
</table>
18.1.3.17 Non-Emergency Medical Transportation (NEMT)

Wyoming Medicaid provides non-emergency medical transportation (NEMT) services to clients who are in need of assistance traveling to and from medical appointments to enrolled providers to obtain covered services.

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

For the complete policy on travel services, please refer to the CMS 1500 Provider Manual, Chapter Twenty Three – Covered Services – Non-Emergency Medical Transportation.
Chapter Nineteen – Skilled Nursing Facility and Swing Bed Services

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19.1 Skilled Nursing Facility (SNF) and Swing Bed Services

Skilled Nursing Facilities provide long term care to clients who are unable to live independently safely, including room and board, dietary needs, laundry services, nursing services, minor medical services, surgical supplies, over the counter medications, and the use of the equipment and facilities.

Swing Bed services are those long term care services provided in the hospital setting in place of transferring the client to the skilled nursing facility, and are subject to the same policy as those services provided in the skilled nursing facilities.

19.1.1 Covered Services

Services provided in the skilled nursing facility or swing beds are reimbursed based on a per diem payment that is all inclusive of the care for the patient for the day. This care includes but is not limited to:

- All general nursing services, including but not limited to:
  - Administration of oxygen and related medication
  - Hand feedings
  - Incontinency care
  - Tray service
- Therapy services, including:
  - Physical Therapy
  - Speech Therapy
  - Occupational Therapy

**NOTE:** If the facility is unable to provide therapy in the facility or chooses to send the client to an external therapist, the facility is responsible for the therapy charges as part of the Medicaid per diem.

- Medical supply and drug items stocked at nursing stations or on the floor in gross supply and distributed individually in small quantities, such as:
  - Alcohol
  - Applicators
  - Cotton balls
  - Band-Aids
  - Gloves
  - Ostomy supplies
  - Tongue depressors
- Oxygen and over-the-counter drugs, which includes insulin.
- Items which are used by individual patients but which are reusable and expected to be available, such as:
  - Ice bags
Skilled Nursing Facility and Swing Bed Services

- Bed rails
- Canes
- Crutches
- Walkers
- Wheelchairs
- Traction equipment
- Other durable medical equipment

- Laundry services for routine nursing facility requirements and clients personal clothing.

- Over the counter nutritional supplements used for tube feeding or oral feeding, even if written prescription items by a physician.

**NOTE:** When reviewing the fee schedule on the Wyoming Medicaid website, the Nursing Home indicator will either be indicated as “Y”- Yes, this item is allowed outside of the NH per diem or “N”- No, this item is not allowed outside of the NH per diem.

19.1.1.1 Private Rooms

Medicaid reimburses for room and board for nursing home clients. Room and board in a semi-private room is included in the per diem – if a client wishes to stay in a private room within the nursing facility, the facility can bill Wyoming Medicaid as normal, and accept the reimbursed amount as payment in full for the private room, OR the responsible party for the nursing home client can pay the rate for the private room in full. The provider may not “balance bill” the client for the cost difference between a regular room and a private room within the facility.

19.1.2 Below is a list of items included in the per diem rate

- ABD Pads
- Adhesive tape
- Aerosol, other types
- Air Mattresses, Air P.R. Mattresses
- Airway-Oral
- Alcohol Plaster
- Alcohol Sponges
- Alternating Pressure Pads
- Applicators, Cotton-tipped
- Applicators, Swab-eez
- Aquamatic K Pads (Water-Heated Pad)
- Arm Slings
- Asepto Syringes
- Baby Powder
- Bandages
- Bandages-Elastic or Cohesive
- Band-Aids
- Basins
Skilled Nursing Facility and Swing Bed Services

- Bed Frame Equipment (for certain immobilized bed patients)
- Bed Rails
- Bedpans, All Types
- Beds; Manual, Electric, Clinitron
- Bedside tissues
- Bibs
- Blood Infusion Sets
- Bottle, Specimen Canes, All Types
- Cannula, All Types
- Cannula-Nasal
- Catheter-Indwelling
- Catheter Plugs
- Catheter Trays
- Catheter (any size)
- Colostomy Bags
- Combs
- Commodes, All Types
- Composite Pads
- Cotton Balls
- Crutches, All Types
- Decubitus Ulcer Pads/Dressings
- Denture Cleaner/Soak
- Denture Cups
- Deodorants
- Diapers
- Disposable Underpads
- Donuts
- Douche Bags
- Drain Tubing
- Drainage Bags
- Drainage Sets
- Drainage Tubes
- Dressing Tray
- Dressing, All Types
- Drugs (over the counter drugs as designated by the FDA)
- Enema Soap
- Enema Supplies
- Enema Unit
- Equipment and Supplies for Diabetic blood and urine testing
- Eye Pads
- Feeding Tubes
- Fingernail Clipping and Cleaning
- Flotation Mattress or Biowave mattress
- Flotation Pads and/or Turning Frames
- Foot Cradle, all types
- Gastric Feeding Unit, Including Bags
- Gauze Sponges
- Gloves, Unsterile and Sterile
- Gowns, Hospital
- Green Soap
- Hair Brushes
- Hair Care, Basic
- Hand Feeding
- Heat Cradle
- Heating Pads
- Heel Protector
- Hot Pack Machine
- Hydraulic Patient Lifts
- Hypothermia Blankets
- Ice Bags
- Incontinency Care
- Incontinency Pads and Pants
- Influenza Vaccine
- Infusion Arm Boards
<table>
<thead>
<tr>
<th>Skilled Nursing Facility and Swing Bed Services</th>
</tr>
</thead>
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<tr>
<td>• Infusion pumps, Enteral and Parenteral</td>
</tr>
<tr>
<td>• Inhalation Therapy Supplies</td>
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<tr>
<td>• Irrigation Bulbs</td>
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<td>• Irrigations Trays</td>
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<tr>
<td>• I.V. Needles</td>
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<tr>
<td>• I.V. Trays</td>
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<tr>
<td>• Jelly, Lubricating</td>
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<tr>
<td>• Lines, Extra</td>
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<tr>
<td>• Lotion, Soap and Oil</td>
</tr>
<tr>
<td>• Massages (by facility personnel)</td>
</tr>
<tr>
<td>• Mattresses, All Types</td>
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<tr>
<td>• Medical Social Services</td>
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<tr>
<td>• Medicine Dropper</td>
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<tr>
<td>• Medicine Cups</td>
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<tr>
<td>• Nasal Catheter</td>
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<td>• Nasal Catheter, Insertion and Tube</td>
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<tr>
<td>• Nasal Gastric Tubes</td>
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<tr>
<td>• Nasal Tube Feeding and feeding bags</td>
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<tr>
<td>• Nebulizer and Replacement kit</td>
</tr>
<tr>
<td>• Needles (various sizes)</td>
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<tr>
<td>• Needles – Hypodermic, Scalp Vein</td>
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<td>• Non-Legend Nutritional Products</td>
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<tr>
<td>• Nursing Services (all) regardless of level</td>
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<tr>
<td>including the administration of oxygen</td>
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<tr>
<td>and restorative nursing care</td>
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<td>• Nursing Supplies and Dressing</td>
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<tr>
<td>• Ostomy Supplies; Adhesive, Appliance,</td>
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<td>Belts, Fact Plates, Flanges, Gaskets,</td>
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<tr>
<td>Irrigation sets, Night Drains, Protective</td>
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<td>Dressings, Skin Barriers, Tail Closures</td>
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<tr>
<td>• Over-the-Counter Drugs, including insulin</td>
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<td>• Overhead Trapeze Equipment</td>
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<tr>
<td>• Oxygen, Gaseous and Liquid</td>
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<td>• Oxygen Concentrators</td>
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<td>• Oxygen Delivery Systems, Portable or</td>
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<td>Stationary</td>
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<td>• Oxygen Mask</td>
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<td>• Pads</td>
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<td>• Pitcher</td>
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<td>• Plastic Bib</td>
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<tr>
<td>• Pumps (Aspiration and Suction)</td>
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<td>• Pumps for Alternating Pressure Pads</td>
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<tr>
<td>• Respiratory Equipment; Ambu Bags, Cannulas,</td>
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<td>Compressors, Humidifier, IPPS Machines and</td>
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<tr>
<td>Circuits, Mouthpieces, Nebulizers, Suction</td>
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<tr>
<td>Catheters, Suction Pumps, Tubing, Etc.</td>
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<tr>
<td>• Restraints</td>
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<tr>
<td>• Room and Board (Semi-private or private if</td>
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<td>necessitated by a medical or social condition)</td>
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<td>• Sand Bags</td>
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<tr>
<td>• Scalpel</td>
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<td>• Shampoo</td>
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<td>• Shaves</td>
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<tr>
<td>• Shaving Cream</td>
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<tr>
<td>• Shaving Razors</td>
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<tr>
<td>• Sheepskin</td>
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</tbody>
</table>
• Side Rails
• Soap
• Special Diets
• Specimen Cups
• Sponges
• Steam Vaporizer
• Sterile Pads
• Sterile Saline for Irrigation
• Sterile Water for Irrigation
• Stomach Tubes
• Suction Catheter
• Suction machines
• Suction Tube
• Surgical Dressings (including sterile sponges)
• Surgical Pads
• Surgical Tape
• Suture Removal Kit
• Suture Trays
• Syringes (all sizes)
• Syringes, disposable
• Tape-for laboratory tests
• Tape (non-allergic or butterfly)
• Testing Sets and Refills (S&A)
• Therapy Services

NOTE: Therapy Services – If the facility is unable to provide therapy in the facility or chooses to send the client to an external therapist, the facility is responsible for the therapy charges as part of the Medicaid per diem.

• Toenail Clipping and Cleaning
• Tongue Depressors
• Toothbrushes
• Toothpaste
• Tracheostomy Sponges
• Transportation
• Trapeze Bars
• Tray Service
• Underpads
• Urinals, male and female
• Urinary Drainage Tube
• Urinary Tube and Bottle
• Urological Solutions
• Walkers, all types
• Water Circulating Pads
• Water Pitchers

For the most current list of covered items review Attachment A to Chapter 7 state of Wyoming rules at: https://rules.wyo.gov/

NOTE: Certain drugs and pharmaceutical products may be dispensed by a long-term care facility and are included in the facility’s per diem rate. Over-the-counter drugs, products, and medical supplies/equipment ordered by a
physician for use by person residing in a nursing facility are included in the nursing facility’s per diem rate and cannot be reimbursed separately, including insulin and diabetic supplies. This includes all over-the-counter drugs and products. Insulin and diabetic supplies are considered over-the-counter drugs and supplies.

Certain items are permitted to be billed outside of the per diem. These items include those that are customized or specialized for a specific client’s use that would not be functional or beneficial to any other client such as:

- Ambulance services – when medically necessary.
- Customized wheelchairs and seating systems.
- Dental
- Hearing Aids.
- Mental Health services.
- Medical Services including.
  - Laboratory, radiology, surgical procedures.
- Orthotics
- Physician and other practitioner services, excluding Physical, Occupational and Speech Therapy.
- Prosthetics

The fee schedule on the Medicaid website (2.1, Quick Reference) will document whether a specific procedure code is allowed outside of the per diem for a long term care resident. “Y” means it can be billed outside of the per diem. All charges must be billed by a provider outside of the nursing facility.

19.1.3 Nursing Facility / Swing Bed Transportation

The cost for non-ambulance patient transportation is included in the facilities per diem rate and includes:

- Patient return home after discharge from facility.
- Patient return to facility after discharge from hospital.
- To/from appointments outside the facility.
- Non-emergent transport to the hospital.

For ambulance services, refer to the Ambulance Services section in the CMS-1500 Provider manual.

The provider should make an effort to select the most efficient and cost effective mode of transportation for resident care which may include utilizing a facility owned vehicle or contracted outside service.
19.1.4 Prescription Drugs

Prescription drug services are handled through the pharmacy program, and all prescription drugs must be filled at an enrolled pharmacy. Skilled nursing facilities and swing bed units will not be reimbursed for the distribution of pharmacy drugs or products to clients, outside of the per diem. Please contact Change Healthcare for any pharmacy related questions (2.1, Quick Reference).

19.2 Patient Contributions

The Long Term Care Unit establishes the patient contribution upon admission to the nursing facility. Medicaid receives the initial patient contribution amount. Any adjustments made to the patient contribution must be reflected on the Patient Contribution Notice. The Long Term Care Unit will change or pro-rate the patient contribution as needed. They send the Patient Contribution Notice to the facility. The facility then submits an Adjustment Form along with the Patient contribution Notice to Medicaid to change the patient contribution.

A new Patient Contribution Notice is required for each calendar year, i.e., a Patient contribution Notice stating a change is for September forward is valid for September – December. For January a new Patient contribution Notice would be needed.

NOTE: Only paid claims can be adjusted. (6.17, Resubmitting Versus Adjusting Claims)

19.2.1 Multiple Facilities Billing and Patient Contribution

Nursing homes will receive pro-rated patient contribution letters; however, these are not for billing purposes. The facilities will use these letters to determine how the patient liability funds will be distributed between facilities.

- Nursing Facility vs. Nursing Facility

Patient contribution is allocated across claims at 100% in the order the claims are received and processed. For example, if a client is a resident of two (2) facilities in the same month, the patient contribution would be taken from total amount paid from the first facility to bill and be paid until the patient contribution is satisfied. If payment to the first facility does not exhaust the client’s patient contribution, the remaining patient contribution will be applied to the next facilities paid claim. This may mean that the provider who billed for the client for the second half of the month will be collecting the patient contribution and the provider billing for the first half of the month will receive a zero (0) patient contribution assignment.

- Nursing Facility vs. Hospice Services Provided with the Nursing Facility
Patient contribution is allocated across claims at 100% in the order the claims are received and processed. For example, if a client is a resident of a nursing facility and is receiving nursing facility hospice services in the same month, the patient contribution would be taken from total amount paid from the first provider (nursing facility or hospice provider) to bill and be paid until the patient contribution is satisfied. If payment to the first provider does not exhaust the client’s patient contribution, the remaining patient contribution will be applied to the next provider’s paid claim. This may mean that the provider who billed for the client for the second half of the month will be collecting the patient contribution and the provider billing for the first half of the month will receive a zero (0) patient contribution assignment. For subsequent months, the full patient contribution will be applied to the hospice claim.

In both cases the providers need to determine the order in which claims should be billed, and how the patient contribution will be transferred between providers. Wyoming Medicaid cannot advise providers how to handle this business related transaction.

If a claims adjustment is submitted with a pro-rated patient contribution letter, the adjustment will be returned.

### 19.2.2 Clients Under Hospice Care

For those clients receiving hospice care, no payment will be made to the skilled nursing facility or swing bed. Room and board is billed by the hospice and payment will be made to the hospice. The hospice is required to reimburse the nursing facility for the nursing facility’s contracted rate. (17.1.3, Nursing Facility Residents)

### 19.3 Evaluations That Must be Completed

The following two (2) evaluations must be completed prior to admission into skilled nursing or swing bed facilities:

- LT101
- PASRR - Pre Admission Screening and Resident Review

The following evaluation must be completed prior to admission into an ICF/ID:

- LT-MR-104

For all claims submitted after July 1, 2014 that are denied for one (1) of the following reasons, an Attestation for Admission Date Form (19.3.1, Attestation for Admission Date Form) must be completed and submitted with the claim form:

- Denied for no original admit claim on file with Wyoming Medicaid.
- Denied for no LT101 or PASRR on file with Wyoming Medicaid.
• Denied for no Attestation for Admission Date Form attached to the claim.
• Denied for the Attestation for Admission Date Form not completed appropriately.

This form can be attached to the claim form using one (1) of these methods:

• For electronic claim submissions
  o The attachment indicator must be a “Y” on the electronic claim submission, and the form can be uploaded electronically or submitted separate via paper. For a step by step tutorial on uploading the claim and attachment via the Secured Provider Web Portal, visit the Web Portal Tutorials section of the website and click on Institutional under the HIPAA 5010 Web Portal Tutorials, or view the WINASAP Tutorial under the WINASAP section of the website (2.1, Quick Reference).

19.3.1 Attestation for Admission Date Form

[Image of the Attestation for Admission Date Form]

NOTE: Click image above to be taken to a printable version of this form.
19.3.1.1 Instructions for Completing the Attestation Form Admission Date Form

- Read the form completely.
- Fill out all of the required information completely and accurately to ensure processing.
  - Facility NPI
  - Facility Name
  - Client Medicaid ID Number
  - Client Name
  - Original Admission Date (this is the date the client was first accepted into the nursing facility)
  - LT101 Review Date (the date of LT101 closest to the determination of Medicaid eligibility)
- Indicate why the admission claim is not on file as paid by Wyoming Medicaid by checking the appropriate box, or checking “Other” and providing explanation.
- Attest and complete remainder of form.

**NOTE:** For residents with a previous admit to the same skilled nursing facility, the previous stay must be billed through the date of discharge using the patient status code of "discharged". If not, future claims will deny for the client not being properly discharged. Claims in history can be adjusted and corrected to show the correct date of discharge.

19.3.2 LT101 (Medicaid Evaluation of medical Necessity)

- The LT101 is a functional assessment performed by a Public Health Nurse under contract with the Division of Healthcare Financing. The LT 101 assesses how someone functions independently and captures the burden of care or how much assistance the client needs in performing Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and social and cognitive functioning. This determines whether an applicant or client meets nursing facility level of care for Medicaid nursing facility services, swing bed services, Home and Community Based Services (HCBS); Community Choices Waiver (CCW), or PACE (Program of All-Inclusive Care for the Elderly) services.
- LT101s are valid for 90 days after completion.
- The Secured Provider Web Portal provides office administrators for skilled nursing facilities, swing bed units, hospitals and other appropriate providers with the ability to review a client’s LT101s that are on file with Wyoming Medicaid. This resource can be used to make sure that appropriate documents are in place with Wyoming Medicaid before billing is completed, to avoid denials of claims. (**2.1, Quick Reference**)
• Facilities must request an LT101 electronically through the Wyoming Department of Health Application Gateway: [https://gateway.health.wyo.gov/](https://gateway.health.wyo.gov/)
  If the facility does not have access, please email the Assessment Coordinator of Long Term Care/Community Based Services Unit (CBSU), Sherry Mitchell at [sherry.mitchell1@wyo.gov](mailto:sherry.mitchell1@wyo.gov) to request access. The WDH will not accept faxed LT101 requests.

**NOTE:** If corrections are needed after an LT101 has been submitted, contact Long Term Care, Sherry Mitchell at [sherry.mitchell1@wyo.gov](mailto:sherry.mitchell1@wyo.gov). Within the request, include what needs changed and why.

### 19.3.3 LT101s are Required Under the Following Conditions

- If there is not a valid LT101 on file. (LT101’s are valid for 90 days)
- Prior to Admission
  - No more than 90 days prior to admission
- Upon application for nursing facility admission. “Nursing Facility” includes hospital swing bed units. It does not include Medicare only Skilled Nursing Facilities that do not participate in Medicaid.
- Upon transfer to another nursing facility if the current LT101 on file is older than 90 days.
- Upon re-admission to a nursing facility after a previous discharge. “Discharge” does not include temporary absence from the facility for treatment in a hospital, home visit or a trial community stay, provided such a temporary absence is no longer than thirty consecutive days.
- Nursing facility residents shall receive continued stay reviews during the sixth (6th) month.
- Significant change in condition.
- Upon re-determination of Medicaid eligibility following a loss of eligibility for any reason.
- Medicaid shall not grant eligibility to a nursing facility resident unless the resident has an LT101 less than 90 days old.
- Upon referral for PASRR Level II evaluation for MI or MR or Categorical.

### 19.3.4 PASRR Pre-Admission Screening and Resident Review

PASRR process encompasses PASRR Level I and Level II (Pre Admission Screening).

PASRR Level I – The purpose of the Level I is to screen for potential diagnosis of mental illness or mental retardation. Such a determination will result in a referral for a Level II.

Routine annual Level I screenings are no longer required by Medicaid. If the Level I does not result in a referral to Level II, it need never be performed again unless a
significant change in the residents condition indicates that a Level II evaluation is advisable or if there is a transfer to another facility.

Mental status changes that result in a new diagnosis or that trigger a significant change to the total score on the Brief Interview for Mental Status (BIMS) or the Patient Health Questionnaire (PHQ9) on the Minimum Data Set (MDS) would result in a significant change of condition.

Please refer to http://pasrrassist.org/resources/mds-30/what-considered-significant-change-condition for more information on significant changes of condition.

PASRR Level II – The purpose of the Level II is to more accurately identify mental illness or intellectually disabled and assess whether the individual needs specialized services and nursing facility level of care.

NOTE: Dementia, including Alzheimer’s disease and other dementias, is excluded from the definition of serious mental illness for PASRR purposes. An individual is considered to have dementia if he or she has a primary diagnosis of dementia as described in the DSM (current edition), or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above. A primary diagnosis of a serious mental illness supersedes a secondary diagnosis of dementia and the individual must be referred for a Level II evaluation.

- Medicaid/Federal law requires all individuals, regardless of payment source, who apply as new admissions to Medicaid Facilities on or after January 1, 1989, must be screened prior to admission for mental illness and mental retardation
  - Individuals for whom respite care is provided (under LTC HCBS Waiver or the DD HCBS Waiver) in a nursing facility must be treated like any other nursing facility admission, therefore, all PASRR and LT101 requirements apply prior to admission
- Any individual who’s PASRR Level I screening indicates the presence or probability of mental illness or mental retardation must be referred to the State Mental Health Authority or the State Mental Retardation Authority. This authority has been delegated by contract to WYhealth. (2.1, Quick Reference)
- PASRR Level II must be determined prior to admission to be appropriate for nursing facility payment.
- If the individual is appropriate for nursing facility placement, the need for specialized services will be determined.
  - If an individual seeking admission to a nursing facility has Mental Illness or Mental Retardation and is found to be inappropriate for nursing facility placement, the nursing facility may not admit the individual.
  - If an individual already residing a nursing facility has Mental Illness or Mental Retardation and is found to be inappropriate for nursing facility
placement, the provider must cooperatively arrange with the state for the resident’s orderly discharge from the facility.

- Adverse determinations carry the right of appeal for the resident.

**NOTE:** If corrections are needed after a PASRR has been submitted, contact Benefits Quality Control Manager, Amy Guimond. Within the request, outline the details (client id, name, DOB, PASRR determination date, etc.). Once approved, the PASRR will be deleted and can be re-entered.

**NOTE:** PASRR is not a requirement for CHOW (Change of Ownership) completion. However, the skilled nursing facility will want to ensure that the admitted residents that need a PASRR evaluation have one on file and all residents are evaluated as appropriate.

### 19.4 New Admission

A Level I screening is required prior to admission for all new nursing facility admissions, regardless of payment source.

- A re-admission following hospitalization or therapeutic home leave is not considered a new admission for PASRR purposes and does not require a Level I screening unless a new diagnosis indicates the presence of MI or MR.
- An individual with MI or MR who has a Level II in the past and is being readmitted following hospitalization or therapeutic home leave is not considered a new admission.

#### 19.4.1 Transfer

A Level I is required upon transfer from one facility to another facility.

- In the case of a transfer of a resident with Mental Retardation or Mental Illness from the nursing facility to a hospital or to another nursing facility the transferring nursing facility is responsible for ensuring that copies of the most recent PASRR Level I and II (if applicable) and Resident Assessment reports accompany the transferring resident.

#### 19.4.2 Categorical Determinations that do Not Require a Level II Prior to Admission

Pursuant to Federal guidelines, the Division of Healthcare Financing has defined certain categories of conditions that automatically constitute appropriateness for nursing facility placement. The State may override the categorical determination and refer the individual for a Level II where appropriate.

- **Categorical 4 – Appropriate for nursing facility placement due to terminal illness** – Verified in writing by a physician. This constitutes a Level II determination of “appropriate specialized services not required”.
• **Categorical 5 – Appropriate for nursing facility placement due to severe medical conditions** – This determination may only be applied to an individual with Mental Illness or Mental Retardation who is comatose, ventilator dependent, functions at the brain stem level, OR has a diagnosis such as COPD, severe Parkinson’s disease, amyotrophic lateral sclerosis, congestive heart failure (CHF), cardiovascular accident (CVA), Huntington’s Disease, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end stage renal disease (ESRD), severe diabetic neuropathy or refractory anemia. The condition must result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. This constitutes a Level II determination of “appropriate, specialized services not required”.

• **Categorical 6 – Convalescent care for an acute physical illness** – This determination applies only to an individual with Mental Illness or Mental Retardation who has an acute physical illness which required hospitalization; AND does not meet all the criteria for an exempt hospital discharge (defined above). This categorical determination is limited to 120 days. When it becomes apparent the individual will require nursing facility placement longer than 120 days, the nursing facility must complete the Level II. A Level II determination must be rendered before permanent nursing facility placement can be made.

• **Categorical 7 – Provisional placements** – Pending further assessment in cases of delirium, where an accurate diagnosis cannot be made until the delirium clears, or for respite of caregivers. This categorical determination is limited to 14 days. The nursing facility must complete the Level II. A Level II determination must be rendered before permanent nursing facility placement can be made.

• **Categorical 8 – Emergency placement** – For an individual with Mental Illness or Mental Retardation for the individual’s protection. This categorical determination is limited to seven (7) days, at which time the nursing facility must complete the Level II. The determination must be rendered before permanent nursing facility placement can be made.

### 19.5 Medicaid Reimbursement

Medicaid will not reimburse a nursing facility for services provided to any individual who has not been screened at Level I.

- Payment will commence as of the Level I date or admission date, whichever is later.
- No retroactive payment will be made.

Medicaid will not reimburse a nursing facility for services provided to any individual with MI or MR who is admitted prior to completion of a PASRR Level II.
• Payment will commence upon the date of determination of appropriate placement.
• No retroactive payment will be made.
• The nursing facility may be subject to withdrawal of Medicaid certification if such a person is admitted to the facility before a Level II determination is rendered.

Medicaid will not reimburse a nursing facility for services provided to any individual who has previously been found to be inappropriate for nursing facility placement due to the need for specialized services.

• Any individual who has received such a determination must be re-evaluated and determined to be appropriate before any placement will be allowed.

NOTE: Medicaid does not accept paper copies of the PASRR screening forms. All PASRR forms must be entered on the Secured Provider Web Portal (2.1, Quick Reference). Please contact your office administrator if you are in need of a log on ID to access the secure web portal. If you do not know who your office administrator is contact EDI Services (2.1, Quick Reference) Refer to the Medicaid website for instructions on how to enter the PASRR online.

19.6  Billing Requirements

19.6.1  Nursing Facility

Revenue Code 0100 – Room & Board
Appropriate Bill Type: 21X, 23X
Pay-to Provider’s Taxonomy: 31400000X, 315P00000X, 283Q00000X (State Hospital Only)

19.6.2  Swing Bed

Revenue Code 0100- Room & Board
Appropriate Bill Type: 18X
Pay-to Provider’s Taxonomy: 275N00000X

• Enter one (1) unit for each day the client was a resident
• Medicaid does not pay for the date of discharge
  ○ Reduce units by one (1) in order to reflect this
  ○ Patient status on the claim is something other than 30 (still a patient) (6.4.1 Instructions for Completing the UB-04 Claim Form)
19.6.2.1 Swing Bed Exemption Letter

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

19.6.3 Reserve Bed Days

Reserve bed days during a resident's temporary absence are not covered unless the resident is absent from the facility for less than 24 hours. In these instances the absence should be billed to Medicaid as a normal covered day.

For days the resident is absent from the facility for 24 hours or more, bill these as non-covered days, using value code 81. Value codes and accommodation units must total the number of days within the coverage period.

Example:

- Coverage period is from 1/1/18-1/30/18, with a patient status of 30 (still a patient)
- Client went to the hospital for care from 1/5/18-1/10/18
- Total coverage period is 30 days
- Total non-covered days is 5 days
- Claim would show:
  - Room and board days revenue code (0100) billed for 25 units
  - Value code 81 (non-covered days) for 5 units

A provider may bill a client or the client's responsible party for reserved bed days if the facility has informed them in writing of their financial responsibility, before services are rendered.
19.7 Census Requirements

Effective April 1, 2019, nursing facilities are no longer required to submit a census report to Wyoming Medicaid or their contractor.

19.8 Wyoming Medicaid Client Death Report Form

Pursuant to Wyoming Department of Health, Division of Healthcare Financing (Wyoming Medicaid) rules, providers are required to notify the Department of Health, Division of Healthcare Financing of the death of any Wyoming Medicaid client in their facility within three (3) working days of the client’s death.

This form is located on the following page for the provider’s use to report this information. Send or fax it promptly to:

Sheila McInerney
Division of Healthcare Financing
6101 Yellowstone Road Suite 210
Cheyenne WY 82002

19.8.1 Medicaid Client Death Report Form

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

19.9 Extraordinary Care

Revenue Code 0101 – Room & Board (Prior Authorization is required)
Appropriate Bill Type: 21X, 23X
Pay-to Provider’s Taxonomy: 31400000X, 315P00000X

Extraordinary Care is for clients that require service beyond the average resident. They have an MDS Activities of Daily Living Sum score of ten (10) or more and require special or clinically complex care as recognized under the Medicare RUG-III classification system. Extraordinary Care requires a prior authorization from WYhealth (2.1, Quick Reference).

The extraordinary care client’s cost and service requirements must clearly exceed supplies and services covered under a facility’s per diem rate. The cost of clients’ extraordinary care shall not be included in the annual cost reports.

Patient contribution amounts will be applied to claims for approved Extraordinary Care clients. Please refer to section 19.2 Patient Contributions for more information regarding patient contribution.

19.9.1 Criteria

Extraordinary care clients services are covered when the below criteria is met, the services are individualized, specific, and consistent with symptoms or confirmed diagnosis, and not in excess of the client’s needs.

Medical conditions considered under extraordinary care criteria:

- Ventilator Dependence allows for automatic qualification without additional criteria being met.
- Tracheostomy requiring routine care that cannot be performed by the client because the submitted records provide documentation of cognitive or physical impairment that limits self-care of the tracheostomy with the potential to result in tracheostomy and related complications.
- Morbid Obesity (ICD 10 E66.01) documented BMI and extreme limitation in mobility as documented by recent PT/OT or MD evaluation of ambulation, ROM and deficiencies in ability to independently perform basic hygiene and other ADLs. Other limitations not addressed in these guidelines but documented by a medical professional will be considered.
- Psychiatric care for clients with significant behaviors that cannot otherwise be safely cared for in a standard nursing facility setting without increased staffing or special accommodations. This includes clients with significant physical aggression, delirium and/or psychosis. *Please see next section for additional information on psychiatric condition requirements.
- Other conditions where special care or clinically complex care is required will be evaluated on a case-by-case basis.

19.9.2 Documentation

- Completed Admission Certification Skilled Nursing Extraordinary Care form including clinical justification documentation. Form can be found at www.wyhealth.net.
• Completed Rate Request Form. (Part of Admission Certification Skilled Nursing Extraordinary Care Form)
• If the request is for behavioral health extraordinary care clients the documentation must include the following information:
  o A treatment plan that specifies both medical and behavioral strategy.
  o A stabilization plan to include both internal policies and plans for community based supports and if necessary transfer opportunities.
  o External resources, agreements, working partnerships for inpatient stabilization (if behavior escalates to a point where for their safety or those of the other patients or staff), with a written agreement to return client to resident location upon stabilization and recommendation plan in place.
  o List of primary care and psychiatric doctors.
  o Packet must include clinical justification and financial request as with any other extraordinary care client.

19.9.3 Additional Requirements

• Continued stay reviews must be completed at 15 days, 30 days, 90 days and yearly thereafter. If medical evaluation shows difference or change in services needed, notify WYhealth (2.1, Quick Reference).
• If a client has a change in services needed, the provider can submit new cost information for consideration of a rate adjustment. Incremental revenue of negotiated rates will offset against the applicable cost report. Notify Myers & Stauffer of changes for modification to reimbursement (800)336-7721.
• Include all costs for residents under extraordinary care negotiated rates; cost reports will be adjusted during rate setting.
• Forms can be found on the Medicaid website (2.1, Quick Reference).

19.9.4 Enhanced Psychiatric Conditions Considered Under Extraordinary Care Criteria

Adult recipients presenting with a Severe and Persistent Mental Illness (SPMI) with long term psychiatric and behavioral health needs, which exhibit challenging and difficult behaviors that is beyond traditional skilled nursing home care as recognized, may qualify under the Extraordinary Care Criteria. Extraordinary Care requires a prior authorization from WYhealth (2.1, Quick Reference).

Any requests for a behavioral health extraordinary care client must include the following prior to any review by the Division of Healthcare Financing:

• A treatment plan that specifies both medical and behavioral strategy.
• A stabilization plan to include both internal policies and plans for community based supports and if necessary transfer opportunities.
• External resources, agreements, working partnerships for inpatient stabilization (if behavior escalates to a point where for their safety or those of the other patients or staff), with a written agreement to return client to resident location upon stabilization and recommendation plan in place.
• List of primary care and psychiatric doctors.
• Packet must include clinical justification and financial request as with any other extraordinary care client.
• Other conditions where special care or clinically complex care is required will be evaluated on a case by case basis by WYhealth.
• Criteria are subject to change.

19.9.5 Specific Criteria

All criteria must be met:

• The client has an SPMI as defined by the following
  o The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders
  o Prior to admission (admission to hospital stabilization or nursing home), the Global Assessment of Functioning (GAF) score is 40 or lower.
• The level of impairment is confirmed by a Level II Pre-Admission Screening and Resident Review (PASRR) evaluation (42 CFR 483.128). (19.3.4, PASRR Pre-Admission Screening and Resident Review)
• The client is currently in a psychiatric hospital; or has had one (1) or more past hospitalizations; or is exhibiting behaviors that place him or her at risk of psychiatric hospitalization.
• The client exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care, including one (1) of the following:
  o Combative and assaulting behaviors (physical abuse toward staff, or self-abuse / self-injurious behaviors).
  o Sexually inappropriate behaviors (touching or grabbing others)
  o Other challenging and difficult behaviors related to the individual’s psychiatric illness
  OR

• Exhibits the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements.

19.9.6 Continued Eligibility Criteria

Continued stay is applicable when the client either:
• Exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care, including one (1) of the following:
  o Combative and assaulting behaviors (physical abuse toward staff, or self-abuse / self-injurious behaviors).
  o Sexually inappropriate behaviors (touching or grabbing others).
  o Other challenging and difficult behaviors related to the individual’s psychiatric illness.

OR

• Exhibits the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements.

19.9.7 Discharge from Extraordinary Care Criteria

Discharge from extraordinary care criteria is contingent upon the following:

• The consistent absence of unsafe behaviors as outlined in Section 19.9.5 Specific Criteria within consistently structured enhanced care; and

• The anticipation that the client will not exhibit the unsafe behavior if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements.

NOTE: These criteria must be closely observed and monitored during a continuous period of at least three (3) months (quarterly).

Additional determining criteria for discharge include the following:

• Monitoring of medication stability/consistency.
• Treatment compliance.
• Appropriate living arrangements upon discharge.
• Arrangement of aftercare for continued services.

19.9.8 Documentation

• New Requests must contain a completed packet, required documentation and cost review. Prior Authorization (PA) is required for all Medicaid clients. (6.13 Prior Authorization)
• Extraordinary Care client packets can be faxed to WYhealth. (2.1, Quick Reference)
• Continued Stay Reviews must contain a completed Continued Stay Form (19.11 Example Form Continued Stay) and all required documentation. Prior Authorization (PA) is required for all Medicaid clients.

• Annual Cost Reviews for extraordinary care clients rates will be done in conjunction with July 1 rate effective date reviews.

• Continued Stay Utilization Review must be completed at 15 days, 30 days, 90 days and yearly thereafter, or as needed if medical or psychiatric evaluation shows difference or change in services.

• If the client has a change in services needed, the provider can submit new cost information for consideration of a rate adjustment. Notify Myers & Stauffer of change for modification to reimbursement (800)336-7721.

• Include all costs for residents under extraordinary care negotiated rate; as incremental revenue of negotiated rate is offset against applicable cost repost.

19.10 Example Form – Admission Certification

NOTE:  Click image above to be taken to a printable version of this form.
19.11 Example Form – Continued Stay

NOTE: Click image above to be taken to a printable version of this form.
Chapter Twenty – Rural Health Clinics (RHC)

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20.1 Rural Health Clinics (RHC)

The purpose of an RHC program is to improve access to primary care in underserved rural areas. RHCs are required to use a team approach to provide outpatient primary care, and basic laboratory services.

Revenue Code: 0521

20.1.1 Covered Services

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

- Clinical psychologist
- Clinical social worker
- Nurse practitioner
- Nurse midwife
- Physician
- Physician’s assistant
- Visiting nurse

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

20.1.2 Reimbursement Guidelines

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

- Therapeutic services
- Diagnostic services
- Tests
- Supplies
- Lab
- Radiology

20.1.3 Billing Requirements

- The place of service must be the office, not the hospital, emergency room, home or nursing facility, etc.
• Multiple encounters within the same facility, on the same day, with different health professionals are still considered one (1) encounter UNLESS the patient suffers illness or injury requiring additional diagnosis or treatment after the first encounter.
• Claims must be billed with revenue and procedure codes for both the encounter information and detailed line item information.
• Claims will have a minimum of two (2) line items, the first would be the encounter line and the second line item is detail (both must include a revenue code and a procedure code combination).

20.1.3.1 Encounter Line Will be Billed with 0521 Revenue Code Paired With

• Procedure code T1015 for general encounter.
• Procedure codes in the range of 99381-99385 or 99391-99395 for health check encounter.
  o Use modifier 32 to indicate a health check encounter that results in a referral to a specialist.
• Bill the total usual and customary charges for visit.

20.1.3.2 Detailed Line Items Will be Billed With

• Any appropriate outpatient revenue code paired with any appropriate procedure code.
• Document each procedure that occurred during the encounter.
• Include a detailed line item for the office visit or health check procedure code if appropriate.
• Bill the detail line items at $0.00
• For questions regarding appropriate pairings of revenue codes and procedure codes, refer to the NUBC Official WB Data Specifications Manual.

NOTE: If billing Medicare as primary, bill the claim following Medicare’s rules (codes, etc.).

20.2 Billing Examples

Client comes to the RHC for complaint of a cough and sees a physician. No additional tests or treatments are administered. The client is given a prescription for antibiotics and released.
This client is a child who has come to the RHC for a health check visit. The health check is conducted, and in addition, a urine culture is run while the client is there.

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</table>
Chapter Twenty One – Psychiatric Residential Treatment Facility (PRTF)

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Psychiatric Residential Treatment Facility (PRTF)

21.1 Psychiatric Residential Treatment Facility (PRTF)

Appropriate Bill Type(s): 11X
Pay-to Provider’s Taxonomy: 323P00000X

Psychiatric Residential Treatment Facility (PRTF) is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents under age 21, who have long-term illnesses and/or serious emotional disturbance(s) that are not likely to respond to short-term interventions and have failed to respond to community based intervention(s).

PRTFs provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality, pro-active treatment. In addition to diagnostic and treatment services, PRTFs should also provide instruction and support toward attainment of developmentally appropriate basic living skills/daily living activities that will enable children and adolescents to live in the community upon discharge.

The focus of a PRTF is on improvement of a client’s symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; unless evidence shows family therapy would be detrimental to the client. Unless otherwise indicated, the program should facilitate family participation in the treatment planning, implementation of treatment planning, and timely, appropriate discharge planning, which includes assisting the family in accessing wrap-around services in the community.

Who should be admitted to a PRTF – A client may be appropriate for admission to a PRTF if he/she has a psychiatric condition which cannot be reversed with treatment in an outpatient treatment setting and the condition is characterized by severely distressing, disruptive and/or immobilizing symptoms which are persistent and pervasive.

Who should not be admitted to a PRTF – A client who is experiencing acute psychiatric behaviors is not appropriate to be admitted to a PRTF. PRTF services are not the entry point to accessing inpatient psychiatric services.

PRTF services must:

- Be provided under the direction of a physician.
- Provide active treatment.
- Be provided before the individual reaches age 21, per CFR 42§441.151, or if the individual was receiving services just prior to turning 21, the services must cease at the time the individual no longer requires services or the date at which the individual reaches age 22.
The PRTF must:

- Work closely with the appropriate school entity to ensure adherence to the youth’s Individual Education Plan (IEP).
- Ensure a smooth transition back to the home school or develop an alternative transition plan for those youth who are not returning to their home school.
- Ensure that there is an adequate number of multi-disciplinary staff to carry out the goals and objectives of the facility and to ensure the delivery of individualized treatment to each resident as detailed in their treatment plan.

### 21.1.1 PRTF Physical Layout

A PRTF is a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis. A PRTF that is a part of a hospital or other facility must be a distinct, stand-alone unit/building separate from the hospital or other type of facility.

Clients who meet the PRTF level of care are not to be co-mingled with clients who are not at a PRTF level of care at any time. For example: a client in a facility’s PRTF cannot co-mingle with another client (regardless of payment source) who may be in the facilities RTC unit (should they have both) during meals, schooling, therapies, or in living quarters.

### 21.1.2 Physical Separation

If more than one (1) type of program or facility is operated on the same piece of property, organizations should take steps to ensure that the programs or facilities can be easily identified as separate entities to those entering the property. Areas that providers are encouraged to consider include:

- **Documentation of Physical Separation** – the areas of the property occupied by the various programs should be clearly marked on campus maps and when buildings are shared, documentation of the parts of buildings occupied by different programs/facilities on floor plans should be clear and are readily available to surveyors or auditors.
- **Entrances and Signage** – when sharing a common property (i.e. same piece of land), the most ideal situation would be to have separate entrances, but when this is not feasible, the organization should use signage which clearly identifies and directs those entering the property or campus to the different facilities. Buildings should be clearly marked with signs that identify the programs or facilities that are located within them. For programs that must be open to the general public (outpatient clinic), there must not be physical barriers which prevent access or which would signal to those seeking services that the services would not be available to the general public (e.g. locked gate to the property).
- **Building Space** – Distinct buildings for each program or facility is best for maintaining separateness between programs and facilities. If building space is
shared, physical separation of the programs/facilities must be managed within the structure. Again, dividing the building space between programs in a manner that provides for clear and distinct separation of the programs and costs is the goal.

- Programs that share a building must be clearly separated by floors, wings, or other building sections. Living areas must not be shared and beds from different programs should not be intermixed or commingled within the same building section. “Swing” beds or units that are variously used by one program or another depending on census are not acceptable. For example, there cannot be beds that are sometimes utilized by an RTC and sometimes used by a PRTF.
- When a building is occupied by more than one (1) program or facility, utilization of separate building entrance for each program is preferable. When this is not possible, separate entrances to each program from a common building lobby could be used. Again, signage within the building should clearly identify the specific program or facility areas.

- Common Areas
  - Recreational Areas: If a PRTF and an RTC, for example, are operated on the same property, each program should have separate recreational space for its residents. If there are also common recreational spaces used by both programs (i.e. gyms or other indoor or outdoor sporting and recreation areas), the use of these common areas should be scheduled by the different programs or facilities for separate use and the individuals receiving services from distinct programs should not use the facilities at the same time.
  - Dining Areas: If a PRTF and RTC, for example, are operated on the same property, each program should have separate dining space for its residents. If common dining room areas are used by different programs/facilities, they should be used at separately scheduled times and the individuals receiving services from distinct programs/facilities should not use the same dining area at the same time.
  - Treatment Areas: When an organization is providing both PRTF and outpatient services, for example, on the same campus or facility, separate areas must be used for treatment.

## 21.2 PRTF Requirements

Pursuant to 42 CFR § 483.352, the PRTF must meet all the requirements identified in subpart D, which include: State accreditation (§441.151), certification of need for the services (§441.152), the team certifying need for services (§441.153), active treatment (§441.154), components of an individual plan of care (§441.155), and the team involved in developing the individual plan of care (§441.156). The way a PRTF organizes itself is critical to its success in complying with federal regulations.

All PRTFs must be accredited by one (1) of the organizations identified in 42 CFR §441.151(a)(2)(ii):
• Joint Commission, or
• The Commission on Accreditation of Rehabilitation Facilities, or
• The Council on Accreditation of Services for Families and Children.

Out of state PRTFs must be certified by The Center for Medicare and Medicaid Services (CMS), in conjunction with their state’s licensing and survey agency as a PRTF, in order to enroll as a PRTF provider with Medicaid.

In state PRTFs must be certified as a PRTF by the Division of Healthcare Financing, in conjunction with the Office of Healthcare Licensing and Surveys and CMS, should they meet all the PRTF criteria.

21.3 Letter of Attestation

Each PRTF that provides inpatient psychiatric services to individuals under 21 must attest, in writing, that the facility is in compliance with CMS’s standard governing the use of restraint and seclusion (42 CFR Subpart G-Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21). This attestation must be signed by the facility director, and is required for provider enrollment.

A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with Medicaid.

To download a copy of the attestation letter go to the Medicaid website under the Forms page.

21.4 Reporting of Serious Occurrences

The facility must report each serious occurrence to the Division of Healthcare Financing (State Medicaid Agency). Serious occurrences that must be reported include a resident’s death, a serious injury to a resident as defined in 42 CFR § 483.352, and resident’s suicide attempt.

All PRFT incidents and serious occurrences must be submitted electronically; faxed forms are no longer accepted. The link to the online form can be found here: https://health.wyo.gov/healthcarefin/medicaid/for-healthcare-providers/

42 CFR 483.374(b) states: In case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

42 CFR §483.374(c) states: “In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the CMS regional office. Staff must report the death of any resident to the CMS regional office.”
office by not later close of business the next business day after the resident’s death. Staff must document in the resident’s record that the death was reported to the CMS regional office.”

21.5 Covered Services

Services related to the client’s treatment plan and provided by a PRTF are included in the PRTF per diem. This includes room and board and licensed treatment. A practitioner or facility that is outside of the PRTF may bill for covered ancillary services to Medicaid as long as they are an enrolled Wyoming Medicaid provider.

Facilities are required to send medications (either prescriptions or already filled) home with clients upon discharge.

Medicaid does not cover any educational services or room and board in a Residential Treatment Center (RTC). Medicaid may pay for medically necessary treatment or therapy to an RTC client when the provider is an enrolled Wyoming Medicaid provider.

21.6 Revenue Code

0919 – Psychiatric/psychological services (room and board)

21.6.1 Prior Authorizations

- Prior authorization requests must be submitted three (3) days prior to the client’s planned admission.
- For prior authorizations requirements, review the WYhealth provider manual.
- For court ordered clients, a copy of the court order must be submitted as part of the prior authorization request. Court orders will be reviewed and must be in compliance with Wyoming Statute 14-3-429, 14-6-229 and 14-6-429.

21.7 PRTF Educational Services

Effective July 1, 2016, educational service payments will be authorized and made available by the Wyoming Department of Education for school services provided to all Wyoming Medicaid youth, regardless of court-order status.

There are several contingencies associated with the payment of educational services:

1. PRTF school programs must be certified by the Wyoming State Board of Education. To receive this certification, providers must make a formal application to the Wyoming Board of Education, undergo a formal on site survey, and be approved by the Board.
2. Educational service payment is contingent upon Medicaid’s determination of medical necessity for the PRTF admission. Once a youth is determined to no longer meet medical necessity for the placement, education funding ceases.

3. PRTFs receiving payment for educational services are required to comply with various provisions detailed in statute, including, but not limited to the following:
   a. Comply with the federal Family Education Rights and Privacy Act;
   b. Not later than ten (10) days after discharge, transfer all records via a secure method to the resident school district or the district in which the student enrolls;
   c. Create an individualized learning plan for the student that is appropriate for the learning capabilities of the student, monitors and measures the student’s progress toward meeting defined goals, facilitates necessary instructional support for the student, maintains the student’s permanent education records, and fulfills the state education program rules and regulations.

The current prior authorization request process with Wyoming Medicaid is not changing, and educational days will be authorized based on current criteria used for PRTF placements.

Please contact the Wyoming Department of Education for questions regarding payment for educational services or the Wyoming State Board of Education regarding the PRTF school program certification process.

21.8 Therapeutic Leave Days

Medicaid reimbursement is available for reserving beds in a PRTF for therapeutic leaves of absence of Medicaid clients less than 21 years of age at the regular per diem rate when all of the following conditions are present:

- A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the client’s habilitation plan.
- A physician’s order for therapeutic leave must be maintained in the client’s file at the facility.
- In a PRTF, the total length of time allotted for therapeutic leaves in any calendar year shall be 14 days per client. If the client is absent from the PRTF for more than 14 days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that client in that year.
- In no instance will Medicaid reimburse a PRTF for reserving beds for Medicaid clients when the facility has an occupancy rate of less than 90% (Based on licensed beds).

WYhealth must approve and prior authorize all therapeutic leave days. Approved therapeutic leave days should be billed as normal covered days. Therapeutic leave
days that are not approved by WYhealth, when the client does leave the facility, must be billed as non-covered days.

Refer to the WYhealth Manuals at: https://www.wyhealth.net/tpa-ap-web/?page=defaultRoot or contact WYhealth (2.1, Quick Reference) for PRTF prior authorization, PRTF referrals, admission criteria, continued stay review criteria, discharge planning, and other important PRTF information.

21.9 Onsite Compliance Review Process

21.9.1 Purpose and Goal

The purpose of an On-Site Compliance Review (OSCR) is to verify that the PRTF is in compliance with all applicable State and Federal requirements for mental health treatment, and to monitor the quality of treatment being provided to Wyoming Medicaid beneficiaries. This verification will include a review of adherence to all Federal and State guidelines restricting commingling should a level of care other than PRTF also be provided within the facility.

The goals of the OSCR are to:

- Access the program and services offered by the PRTF through direct observation, document review, and staff/resident interviews by experienced clinicians; and
- To provide clear, specific feedback regarding review findings to PRTF staff in order for services to be enhanced.

21.9.2 Review Team Composition

The review team will be comprised of at least two (2) but no more than five (5) Wyoming Medicaid staff and consultants. The participation of an appropriately credentialed child/adolescent psychiatrist is required. Optional team member may include any of the clinicians listed below:

- A registered nurse
- A licensed clinical social worker
- A licensed psychologist

Team members, in addition to the child/adolescent psychiatrist and Medicaid representative may be drawn from a variety of areas (i.e. Medicaid, contractor, Department of Family Services, private sector professionals) depending on availability, existing service contracts, and appropriated funding.

21.9.3 Pre-Review Notification
Written notification of an upcoming OSCR will be provided to the PRTF administrator 24 to 48 hours prior to the time the OSCR is scheduled to begin. The notification will include:

- The anticipated schedule for the OSCR.
- The names of the participating team members.
- A list of documents to be reviewed.
- A list of clinical records to be reviewed.

### 21.9.4 Overview of the OSCR Process

The OSCR is intended to monitor a PRTF’s overall operations for compliance with legal requirements and for quality of clinical programs and services. The review inquires into the PRTF’s operations in three (3) domains:

- **Administration** – This area comprises the organizational structure and management of the facility. The facility’s administrative functioning is evaluated through the review of such information as policy and procedure manuals, staff credentials, transfer agreements with hospitals, utilization review documents, incident reports, etc. The administrative area will account for 15% of the PRTF’s overall compliance rating.

- **Program** – This area comprises the philosophy and structure of the facility’s approach to treatment (what the facility believes constitutes good treatment and how they plan to carry it out). The facility’s program is evaluated through the review of documents (e.g. policy and procedure manuals, unit rules/regulations, unit level systems, schedules of unit activities, staff training schedules and agendas, seclusion/restraint logs, etc.), the facility tour, and staff interviews. The program area will account for 35% of the PRTF’s overall compliance rating.

- **Services** – This area comprises the manner in which a PRTF’s program translates into treatment of individual residents. The team particularly looks at whether or not services are delivered in such a manner as to provide maximum benefit to each child. The facility’s services are evaluated through the review of clinical records and resident interviews. The services area will account for 50% of the PRTF’s overall compliance rating.

The frequency with which routine reviews are scheduled is dependent upon the status of the facility at the time of its last review. Generally, the higher the facility’s rating, the longer the period of time between reviews. Refer to the PRTF Status Categories below for applicable time frames. Routine OSCRs will almost always be full scale reviews, with every aspect of the PRTF being evaluated. In most cases, a routine OSCR will be completed in two (2) to three (3) days.

Reviews are conducted utilizing the following Compliance Review Instruments (CRI) which can be viewed on the Wyoming Medicaid Provider website, UB Provider Manual within the PRTF section:
At the discretion of Wyoming Medicaid, an OSCR may be conducted at any time, and the OSCR may be conducted as a partial off-site (review of records) and partial on-site (facility tour and staff/resident interviews) compliance review. Regardless of when the next OSCR may be due, an interim review may be scheduled at any time at the discretion of Wyoming Medicaid to address specific concerns. Interim reviews may be full-scale or partial, depending upon the focus or scope of Wyoming Medicaid’s concerns. Interim reviews will typically be completed in one (1) to three (3) days.

21.9.4.1 General Outline of the OSCR Process

- **Entrance Interview** – At the beginning of the OSCR, the review team will meet with a small group (not to exceed six (6) people) of PRTF staff selected by the facility for an overview of the OSCR process. The group will typically consist of the PRTF Administrator, Medical Director, Risk Manager (where applicable), Clinical Director, and one (1) representative each from nursing, primary therapy and direct care staff. The entrance interview is the facility’s opportunity to meet the review team and inform the team of any changes, improvements, etc. that have occurred since the last review or to ask questions about the current proceedings. The review team will take this opportunity to interview the PRTF team on areas such as EBP used, average length of stay, etc. This phase will typically take about an hour.

- **Tour of the Facility** – The review team will tour all units of the PRTF and talk informally with staff and/or residents. They will note the physical layout and appearance/atmosphere of the units, review posted information, and observe interactions between staff and residents.

- **Review of Administrative and Program Records** – A review team member, usually the team leader, will review documents requested in the pre-OSCR notification. Information requested may include (but is not limited to) records pertaining to staff credentials and training, policy and procedure manuals, transfer agreements with hospitals, utilization review, staff training schedules and/or agendas, seclusion/restraint logs, treatment outcome data, etc. In addition, the facility must provide the review team with a roster of all staff who provide direct services to resident. The roster should be organized according to discipline and each name should be accompanied by the staff
member’s signature. All documents requested should be ready for review at the beginning of the OSCR.

- **Review of Clinical Records** – Resident records will be reviewed by the team to assess compliance with PRTF treatment requirements identified by Wyoming Medicaid policy. Charts will be selected from the census list of Wyoming Medicaid residents and all clients discharged in the previous 120 days. The PRTF must provide the review team with an organization guide to the resident record, which clearly identifies where specific documents may be found within the record.

- **Staff Interviews** – Staff to be interviewed will be identified as early in the review process as possible. When interviewing staff, review team members will want to know whether or not there are guiding treatment principles of which ALL STAFF (from psychiatrist to cafeteria worker to therapist to resident aide to facility administrator to maintenance worker) are aware and to which ALL STAFF adhere. The team is particularly interested in how well program guidelines are carried out in practice and whether or not staff work together collaboratively, functioning as a true team.

- **Resident Interviews** – Residents to be interviewed will be identified as early in the review process as possible. When interviewing residents, review team members will want to know whether or not residents feel they are active participants in their treatment, how knowledgeable they are about specific aspects of their treatment programs, and how they view the program and staff’s ability to help them. Refer to Provider Manual Section 18.36 for CRI-Clinical Services Section B: Resident Interviews policy.

- **Review Team Conference** – At the conclusion of the above components, the review team will meet to compile all information acquired and prepare for the Exit Interview.

- **Exit Interview** – The review team will meet with the PRTF staff (the same representatives who were present at the Entrance Interview unless changes have been discussed with the review team leader) to present an overview of the team’s findings. At this time, PRTF staff may ask questions, request examples of problems cited, etc. This phase typically will last one (1) hour or less.

- **Written Report** – Wyoming Medicaid will provide the PRTF with a written report of the review team’s findings within 30 days after the close of the OSCR.
21.9.5 PRTF Status Categories

At the time of the exit interview, the PRTF will be informed of its status ruling if that can be clearly determined. Star ratings will be published in the Wyoming Medicaid PRTF newsletter and website, as well as shared with other Judicial and Child Placement Agencies throughout Wyoming. The rating categories are as follows:

Three Star (★★★★) Commendation: Program and services consistently exceed standards. No problems were cited by the review team. The next OSCR will be scheduled within the next three (3) years.

Two Star (★★) Approved: Program and services consistently meet standards the majority of the time. No significant health and/or safety concerns were cited by the review team. The next OSCR will be scheduled in one (1) to two (2) years. A corrective action (CAP) may be requested at the State’s discretion for findings cited.

One Star (★) Review: Overall program and services are of acceptable quality with one (1) or more specific areas of health and/or safety risk or other substandard quality directly impacting the quality and effectiveness of services delivered. A CAP must be submitted to all address findings cited. The next OSCR will be scheduled within the next six (6) to 12 months after the implementation of an approved CAP.

21.9.6 OSCR Rating

21.9.6.1 Probation

- Program and services are of substandard quality OR
- The facility is already on Review Status and failed to show improvement in a follow-up OSCR OR
- An isolated, non-recurring condition exists which could jeopardize the safety or well-being of residents.

A CAP must be submitted to address all problems cited in the review. The next OSCR will be scheduled within the next three (3) to six (6) months after implementation of an approved CAP. Details of required elements within the CAP are detailed further in this document.

A facility receiving this rating will be subject to the following actions taken by Wyoming Medicaid:

- A hold on new admissions.
- Youth transfers will be considered.
- Guardian notifications of rating will be initiated for all Wyoming Medicaid clients receiving services from the facility.
- Notification of facility rating will be provided to the Facility’s licensing and survey authority and the Facility’s Board of Directors.
21.9.6.2 Suspension

Program and services are of unacceptable quality OR an ongoing pattern of recurring conditions exist which jeopardize the lives or well-being of residents OR the facility received probation status in any two (2) OSCRs and failed to show sufficient improvement in the next follow-up OSCR. The next OSCR will be scheduled as soon as possible (no later than 30 days) after the implementation of an approved corrective action plan. The CAP must be submitted to Wyoming Medicaid for review and approval no later than seven (7) days from the close of the OSCR.

A facility receiving this rating will be subject to the following actions taken by Wyoming Medicaid:

- A hold on new admissions.
- Child transfers will be initiated.
- Guardian notifications of rating will be initiated for all Wyoming Medicaid clients receiving services from the facility.
- Notification of facility rating will be provided to the Facility’s licensing and survey authority and the Facility’s Board of Directors.
- A facility receiving two (2) suspension ratings during its course of enrollment with Wyoming Medicaid (does not need to be consecutive compliance reviews) will be dis-enrolled as a Wyoming Medicaid provider. Petitions for re-enrollment will be considered on a case by case basis, no sooner than 24-months after dis-enrollment. Dis-enrollment could be considered by Wyoming Medicaid after one (1) suspension rating depending on the severity and scope of the findings.

21.9.6.3 Deferred

If the review team requires additional information or expert opinion in order to complete its determination, then the status ruling may be deferred. In cases of deferred status, Wyoming Medicaid must re-contact the PRTF within ten (10) days to:

- Request additional information or documentation, which must then be provided by the PRTF within ten (10) days of receiving the request; AND/OR
- Schedule a continuation of the OSCR, in which case additional team members may participate in further on-site review of the facility, OR
- Submit a final status ruling.

The ten (10) day request/submission response cycle will continue until a final status determination is made.
21.9.7 Corrective Action Plan

Any facility receiving a rating of Review, Probation or Suspension must submit a Corrective Action Plan (CAP). The CAP must be received by Wyoming Medicaid no later than ten (10) working days following the PRTF’s receipt of its status ruling.

The CAP must address separately each concern cited in the OSCR report by:

- Proposing specific measureable actions that will be taken to correct each identified problem.
- Specifying an implementation date for each corrective action.
- Including supporting documentation as appropriate, e.g. policy or procedural changes, new or revised forms, copies of schedules of training or staffing, etc.

Justifications or explanations for the cited problems have no place in the CAP. Although there may be good reasons for the existence of the problems, Wyoming Medicaid is interested only in the proposed solutions. The narrative of the CAP should be succinct and to-the-point. The following format is suggested for each separate element cited:

- Description of element
- Findings
- Plan of correction
- Implementation date
- Supporting documentation (attached to the CAP and referenced in the narrative response)

21.9.7.1 CAP Examples

- Description of element: Psychosocial assessment contains a developmental profile.
- Findings: Developmental profiles were missing from two (2) of the charts reviewed, were inadequate or incomplete in two (2) others.
- Plan of correction: Program Director will provide in-service training to therapy staff on developmental history-taking and documentation. Psychosocial assessments will be reviewed for completeness through record audits by Program Director.
- Implementation Date: January 1, 2008.
- Supporting documentation: Attachment A: Training Logs.

The CAP will include the name and telephone number of a PRTF staff member who will work with Wyoming Medicaid towards approval of the CAP.

Wyoming Medicaid must approve/disapprove of the PRTF’s proposed CAP within ten (10) days of its receipt by Wyoming Medicaid. The ten (10) day submission/ten
(10) day response cycle will continue until Wyoming Medicaid approves a CAP. The PRTF must implement the CAP within 30 days of its approval.

When notifying the PRTF of its CAP approval, Wyoming Medicaid will also inform the PRTF of the anticipated time of the next follow-up OSCR.

21.9.8 Appeals Process

If the PRTF disagrees with its status ruling or has a complaint regarding Wyoming Medicaid’s response to its proposed CAP, it may appeal the review team’s finding pursuant to the process outlined in Section 20 of Wyoming Medicaid Chapter 16 Rule. Wyoming Medicaid must receive the facility’s appeal in writing within 20 days of the date of the final status determination. If the reconsideration is not favorable, in accordance with Section 21 of Wyoming Medicaid Chapter 16 Rule, providers may request an administrative hearing pursuant to Chapter 4.
21.9.9 OSCR Forms

21.9.9.1 A: Administrative Section: Document Review

1. The facility is COA, CARF, or JCAHO-accredited.
   - Yes
   - No

2. The facility’s PRTF license is current.
   - Yes
   - No

3. The licenses of professional staff are current.
   - Yes
   - No

4. A roster of all staff, divided by discipline, who provide direct services to residents were provided with staff signatures.
   - Yes
   - No

5. The facility meets State-staffing requirements as outlined in 42 CFR, Part 441, Subpart D- Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs.
   - Yes
   - No

6. The facility has informed WDH of changes in PRTF administrator, Medical Director, or Clinical Director within 72 hours of the effective date of the change.
   - Yes
   - No

7. Records and documentation requested by WDH were provided at the time requested. An index or key was provided to locate required information.
   - Yes
   - No

8. The facility's policy and procedures are in accordance with WDH requirements.
   - Yes
9. The facility’s policy and procedures for transfer, discharge, and provision of services are the same for all residents, regardless of payment source.
   - Yes
   - No

10. The facility does not accept new residents who have attained the age of 21 or maintain residents who have attained the age of 22.
    - Yes
    - No

11. The facility has a signed transfer agreement with one or more general hospitals to provide any needed diagnostic and medical services to residents (Facility to provide an example of a chart note/documentation as evidence of arrangement).
    - Yes
    - No

12. The facility has arrangements with community providers to provide specialized medical care to residents when needed (Facility to provide an example of a chart note/documentation as evidence of arrangement).
    - Yes
    - No

13. Personnel records verify that all licensed and provisionally licensed staff/providers who participate in treatment planning have a minimum one-years’ experience in treating children and adolescents who are emotionally disturbed.
    - Yes
    - No

14. The facility has informed WDH in writing of the occurrence of any serious incidents as defined in Section 18.18 within one working day following their occurrence.
    - Yes
    - No

15. Records and documentation are maintained per the facility record retention policy.
    - Yes
    - No
16. The facility has a policy in place and a committee that meets regularly regarding policies on trauma informed care and bullying.
  o Yes
  o No

21.9.9.2 B: Facility Tour

1. The physical treatment environment is:

<table>
<thead>
<tr>
<th>Category</th>
<th>4</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td>Attractive (clean, pleasant décor).</td>
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<tr>
<td>Warm, child-friendly (pictures, plants, home-like atmosphere).</td>
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<tr>
<td>Treatment-oriented (educational/motivational posters, treatment reminders).</td>
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</tbody>
</table>

2. Program information (activity schedules, unit rules, requirements for level system) are posted in public spaces for resident reference.
  o 4
  o 3
  o 2
  o 1

3. Program information for residents (e.g., unit rules, behavior care plans, and other treatment information posted on units or given to children) is:

<table>
<thead>
<tr>
<th>Category</th>
<th>4</th>
<th>3</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td>Clear, specific.</td>
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<tr>
<td>In age-appropriate language.</td>
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<tr>
<td>Worded respectfully.</td>
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<tr>
<td>Expressed in positive terms.</td>
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</table>

4. Staff’s verbal communication with children is observed to be:

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<tr>
<th>Category</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
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<tbody>
<tr>
<td>Clear, specific.</td>
<td></td>
<td></td>
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<tr>
<td>In age-appropriate language.</td>
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<tr>
<td>Respectful.</td>
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<tr>
<td>Expressed in positive terms.</td>
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</tbody>
</table>
5. The physical arrangement of the units indicates a high level of staff/resident interaction (professional offices located on units or close to them, no unnecessary physical barriers between staff and residents).
   - 4
   - 3
   - 2
   - 1

6. Random checks of residents’ behavior program documentation (point sheets or similar documents) indicate that compliance feedback is being provided in a timely manner.
   - Yes
   - No

7. Effective safety precautions are in place for monitoring reactive children. There is a sensory room or other physical space (or items such as a sensory chart) to help children de-escalate.
   - Yes
   - No
   - Not applicable

8. Nighttime bed-monitoring procedures are established and documented. These are individualized to the needs of each resident.
   - Yes
   - No

9. Each unit has identified an appropriate place/procedure for responding to residents' physical/medical complaints.
   - Yes
   - No

10. Rules and schedules for the use of personal hygiene facilities provide adequately for the safety of residents.
    - Yes
    - No
11. Areas set aside for seclusion/restraint are clean, well-lighted/ventilated, and without doors.
   - Yes
   - No

12. All actions in each seclusion/restraint room can be continuously monitored.
   - Yes
   - No

13. The facility has adequate areas for indoor/outdoor recreation.
   - 4
   - 3
   - 2
   - 1

14. The facility provides an accredited school for residents.
   - Yes
   - No

15. There is a designated area for the provision of well-balanced meals. The menu is posted in public areas.
   - Yes
   - No

16. Areas designated for the provision of group therapy and community meetings are conducive to therapeutic interaction.
   - 4
   - 3
   - 2
   - 1

17. There is evidence of adequate facility security to minimize elopement risk.
   - 4
   - 3
   - 2
   - 1

18. Designated warm places where the residents can meet their families when they visit.
   - Yes
   - No
19. There is HIPAA compliant video conferencing availability with family for therapy sessions.
   ○ Yes
   ○ No

20. Evidence the facility follows their written policy/procedures was observed.
   ○ Yes
   ○ No

21.9.9.3 C: Program Section: Document Review

1. Behavior program used as a part of treatment is:

<table>
<thead>
<tr>
<th>Category</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear, specific.</td>
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<tr>
<td>Age-appropriate to the targeted group.</td>
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<tr>
<td>Reasonable and workable in the normal course of treatment.</td>
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<tr>
<td>Reflective of a trauma informed culture.</td>
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</tbody>
</table>

2. Adequate staff in-service training is provided, as evidenced by:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation and supervised on-the-job training is provided to new staff prior to their being assigned independent responsibilities.</td>
<td></td>
<td></td>
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<tr>
<td>A minimum of 20 hours of in-service training (excluding training described in item 3 below) are received by each staff member per year.</td>
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<tr>
<td>Training topics are appropriate to the needs of residential treatment staff.</td>
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<tr>
<td>Trainers are qualified in the area of training they provide.</td>
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<td></td>
</tr>
<tr>
<td>Reflect a trauma-informed care approach to treatment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. All direct care staff are trained and certified in a professionally recognized method of milieu management, de-escalating problem behaviors, applying physical restraints when necessary, and providing trauma-informed care.
   ○ Yes
   ○ No
4. There is documentation that adequate clinical supervision is provided. Therapists, nursing staff, and direct care staff receive a minimum of four (4) hours of clinical supervision per month, provided through a combination of individual supervision, group supervision, and participation in treatment team meetings. This requirement is not satisfied through training.
   o 4
   o 3
   o 2
   o 1

5. All occurrences of seclusion/restraint are documented in a facility-wide log and must be reported to the State through utilization review.
   o Yes
   o No
   o Not applicable

6. An interdisciplinary team that looks specifically at patterns and/or trends (for staff, shifts, etc.) reviews all occurrences of seclusion/restraint monthly. The team will then develop an appropriate action plan to address these occurrences, as an ongoing process.
   o Yes
   o No
   o Not applicable

7. Incident reports (accidents, injuries, allegations of staff misconduct) are maintained according to policy. Documentation indicates that incidents have been handled appropriately by the PRTF staff and are reported as required.
   o Yes
   o No

8. Child abuse allegations are reported to proper authorities.
   o Yes
   o No

9. Standards have been developed for evaluating the effectiveness of the facility’s program. The evaluation protocol includes, at a minimum:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A comparison of each resident’s pre- and post-treatment functional status.</td>
<td></td>
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<tr>
<td>There is a standardized process for discharge planning and development of an aftercare plan.</td>
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<tr>
<td>A comparison of prescribed medications, pre- and post-treatment.</td>
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<td></td>
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</tbody>
</table>
10. The therapeutic curriculum used by the facility is trauma-informed and evidence-based for the population and age range being served.
   o Yes
   o No

11. Documentation indicates that the facility follows its policies and procedures in practice
   o Yes
   o No

21.9.9.4 D: Staff Interviews

1. Staff can explain ways the facility’s culture and philosophy are trauma-informed.
   o 4
   o 3
   o 2
   o 1

2. Staff understands the facility’s behavior program and can explain it.
   o 4
   o 3
   o 2
   o 1

3. Staff participates regularly in community meetings with residents on the treatment unit.
   o 4
   o 3
   o 2
   o 1

4. Staff reports receiving adequate clinical supervision. Staff can identify their primary supervisor and at least two (2) other people with supervisory training and/or experience to whom they can turn for information, support, and guidance. Staff perceives supervision as helpful to them in improving the quality of services they provide to residents.
   o 4
   o 3
   o 2
   o 1
5. Staff reports receiving adequate in-service training. Staff can summarize the salient points of at least one (1) training provided within the last year. Staff perceives the training they have received as relevant to their job responsibilities.
   - 4
   - 3
   - 2
   - 1

6. Staff perceives professional working relationships as cooperative and collaborative.
   - 4
   - 3
   - 2
   - 1

7. Staff communication is timely, accurate, and works for the benefit of the residents.
   - 4
   - 3
   - 2
   - 1

8. Staff perceives the facility's administration as supportive of the clinical program and responsive to its needs and problems.
   - 4
   - 3
   - 2
   - 1

9. Staff understands the proper use and documentation of special procedures (seclusion and restraint), when and how they should be used, which staff is authorized to apply them, and what other less restrictive techniques might be attempted to de-escalate difficult situations or behavior.
   - 4
   - 3
   - 2
   - 1

10. Staff is aware of the proper procedure for handling medical/physical complaints of residents.
    - 4
    - 3
    - 2
    - 1

11. Staff believes that treatment units are adequately staffed, and a policy is in place to ensure there is coverage for individual and family therapy when staff is on leave.
    - 4
### 21.9.9.5 E: Resident Record Review

1. **Resident Record:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well organized and legible with a key identifying the location of all required documents.</td>
<td></td>
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<tr>
<td>Copies of documents verifying custody.</td>
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</table>

2. **Admission:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Documentation of MD recommendations and psychiatric evaluation for admission to PRTF within 30 days prior to admit.</td>
<td></td>
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<tr>
<td>If admission is for a Sexually Acting Out or SO program, then a current and independent Psychosocial Assessment should be completed in advance and the findings should be reflected in the Psychiatric Recommendations.</td>
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<tr>
<td>Parents or guardians were informed regarding medication policies (permission for medication changes, or any PRN changes), seclusion and restraint procedures, and requirements for family involvement.</td>
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</table>

3. **At admission, less restrictive treatment is not appropriate:**

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<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Resident failed to respond to less restrictive treatment.</td>
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<tr>
<td>Symptom severity warrants residential treatment.</td>
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<td>Resident is being stepped-down from acute</td>
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</table>
4. Assessment:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Psychiatric evaluation completed within seven (7) days of admit.</td>
<td></td>
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<tr>
<td>Medical history and physical exam provided within seventy-two (72)</td>
<td></td>
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<tr>
<td>hours of admission including medication history.</td>
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<tr>
<td>Escalation risk/safety plan, trauma assessment, risk of sexual offense,</td>
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<tr>
<td>and acting out behavior are addressed.</td>
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<tr>
<td>Psychosocial assessment per LOC.</td>
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<tr>
<td>Provisional discharge plan completed at intake.</td>
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5. Assessment: Required Elements

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<th>4</th>
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<tbody>
<tr>
<td>A complete clinical case formulation is documented in the record (e.g.,</td>
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<tr>
<td>primary diagnosis, medical conditions, psychosocial and environmental</td>
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<tr>
<td>factors and functional impairments).</td>
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<tr>
<td>Documentation of presence or absence of any current medical conditions.</td>
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<tr>
<td>A complete mental status exam, documenting the patient’s affect, speech,</td>
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<tr>
<td>mood, thought content, judgment, insight, attention or concentration,</td>
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<tr>
<td>memory, and impulse control.</td>
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<tr>
<td>Documentation of efforts to obtain collateral information from previous</td>
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<tr>
<td>treatment providers and parent/guardian.</td>
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<tr>
<td>Adequate information in the record to make a careful diagnostic</td>
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<tr>
<td>assessment or resolve differences in diagnostic impressions.</td>
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<tr>
<td>There is evidence that initial</td>
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</table>
6. Psychosocial assessment:

<table>
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<tr>
<th>Category</th>
<th>4</th>
<th>3</th>
<th>2</th>
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<tbody>
<tr>
<td>Includes developmental profile.</td>
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<tr>
<td>Includes behavioral assessment.</td>
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<tr>
<td>Includes details regarding onset of symptoms.</td>
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<tr>
<td>Assesses potential family resources.</td>
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<td></td>
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<tr>
<td>Trauma Assessment</td>
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<td></td>
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<tr>
<td>Risk of sexual offense and acting out behavior.</td>
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<tr>
<td>For patients 12 and older, a substance abuse screening occurs. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.</td>
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</table>

7. Treatment Planning: Team Composition

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Psychiatrist or PMH-MP/psychologist and physician separate PCP from psych.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LCSW, LPC, LMFT, LAT, Provisionally Licensed Staff/Providers, and Licensed Psychologists.</td>
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</tbody>
</table>

8. Treatment Planning: Time Lines Met

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial plan at intake.</td>
<td></td>
<td></td>
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<tr>
<td>Comprehensive plan within fourteen (14) days.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Reviews: once at end of first month of stay.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Reviews: once monthly after first month of stay.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment plans are updated within 24 hours following seclusion or restraint.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9. Treatment Planning: Required Elements

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If trauma and/or sexual acting out behavior has been identified, it is reflected in the treatment plan goals and interventions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both resident’s strengths and problem areas are addressed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both family's strengths and problem areas are addressed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The treatment plan is individualized and consistent with diagnosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short and long term goals are objective and measurable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment plan addresses each diagnosis separately.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment modalities and clinicians responsible are identified. Realistic and obtainable goals are put in place for kids with self-harm history.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family therapy goals/objectives are explained.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge plan and estimated discharge date are identified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a substance use disorder is identified, it is reflected in the treatment plan goals and interventions.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Treatment Planning: Reviews

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify changes in treatment, if needed, to address goals where progress is minimal.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The need for residential versus less-restrictive treatment is reassessed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The progress in relation to projected discharge date, as measured by meeting measurable goals/objectives, is assessed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals, measurable objectives, target dates for completion are incorporated into the treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. Evidence that resident and parent/guardian actively participate in treatment goals.
   - Yes
   - No

12. Evidence that psychiatrist directs treatment through comprehensive notes and participation in staffing.
   - Yes
   - No

13. Evidence of interdisciplinary collaboration in planning.
   - Yes
   - No

14. Treatment Documentation: Required Elements

<table>
<thead>
<tr>
<th>Category</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of content/process is detailed enough to provide an accurate clinical picture to those outside the treatment team.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sessions clearly have therapeutic focus.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome of session and plan for time between sessions and next session.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation that goals of treatment are communicated with all direct care staff.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

15. Treatment Documentation for all modalities:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist’s name and signature is present on treatment documentation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date/length of session.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Individual Therapy: Required Elements

<table>
<thead>
<tr>
<th>Category</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress towards treatment goals is identified.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress in relation to discharge</td>
<td></td>
<td></td>
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</tbody>
</table>
date and plan for future sessions is addressed at least monthly.

If trauma has been identified, there is evidence it is being addressed.

The progress notes document ongoing risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.

Treatment modalities are evidence-based and appropriate for the diagnoses.

Progress notes contain a level of detail sufficient for those not directly involved in treatment to have an accurate clinical picture.

Mental status and depression assessment.

| 17. Individual Therapy is provided a minimum of one hour per week. |
|---|---|---|---|
| o Yes | o No |

| 18. Family Therapy: Required Elements |
|---|---|---|---|
| Category: | 4 | 3 | 2 | 1 |
| Resident’s response to family. |  |  |  |  |
| Documentation supports family therapy focus on addressing presenting problems prior to admission and preparing for a successful transition home. |  |  |  |  |
| If family is not actively involved in treatment, therapeutic intervention is addressed. |  |  |  |  |
| Evidence of alternative treatment interventions when there is minimal or no progress. |  |  |  |  |
| If trauma has been identified, there is evidence it is being addressed. |  |  |  |  |

| 19. Family Therapy is provided a minimum of one hour per week. |
|---|---|---|---|
| o Yes | o No |
20. Group Therapy: Required Elements

<table>
<thead>
<tr>
<th>Category:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities are therapeutic in nature and relate to treatment goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is evidence of resident’s participation in groups.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. Group therapy is provided a minimum of 3 hours in at least 3 sessions per week.
   - Yes
   - No

22. Therapeutic milieu is provided 24 hours per day seven days per week.
   - Yes
   - No

23. Medication

<table>
<thead>
<tr>
<th>Category:</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>All orders are in chart.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of PRN orders routinely reviewed and updated (PRN follows WDH guidelines).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There was informed consent for meds properly executed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The resident was assessed for side effects.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration is timely and accurate (MAR).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is documentation of medical history.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasons for, and response to, PRN medication use is documented in MAR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is no evidence of chemical restraints being used.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. Medication Monitoring: Required Elements

<table>
<thead>
<tr>
<th>Category:</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale behind the medication plan is discussed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When medication does not appear</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
to be therapeutically effective, there is an aggressive plan to address.

Evidence the lab results were received and reviewed by the clinician.

Evidence of progress documented by the physician/addictionologist at regular intervals, appropriate to the rendered service.

Record of previous medication trials.

Documentation of monitoring for boxed warnings for medication.

Metabolic parameters obtained per best practice guidelines.

Rule out diagnoses confirmed or eliminated.

Record contains documentation of a differential diagnosis when medical conditions are present.

25. There is evidence that frequency of client visits with psychiatrist is appropriate to the intensity of treatment and current risk issues.
   o Yes
   o No

26. Care of the Whole Person

<table>
<thead>
<tr>
<th>Category:</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents have access to a primary care physician.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents have access to dental/vision.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRTF is ensuring resident is current with EPSDT.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRTF is providing health care education (STDs, birth control, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biometrics changes are addressed by the psychiatrist and/or dietitian.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
27. Therapeutic Pass:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals for pass are identified based on clinical need not programmatic standards.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence that goals were discussed with resident and family/guardian.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of evaluation of the pass.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. Therapeutic Leave:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized by physician’s or PMHNP’s orders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not taken during 14-day assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date/Time patient checked out/in is documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication instructions given using non-medical language.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic goals for leave are discussed with resident and family/guardian.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required time of return is identified and documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of person with whom leave will be spent with is documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident’s condition at check-out-in and mental status is documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name/signature of person with whom child is leaving/returning with is documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is documentation that goals were discussed with the child and their family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name/signature of staff checking child out/in is documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications provided/returned are noted and include number of doses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome of leave is assessed by therapist within 72 hours of return.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UDS completed upon return when clinically indicated.</td>
<td></td>
<td></td>
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</tbody>
</table>
29. Prior to seclusion/restraint, the least restrictive effective intervention was used:

<table>
<thead>
<tr>
<th>Category:</th>
<th>4</th>
<th>3</th>
<th>2</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Prior to seclusion/restraint, were less restrictive attempts to de-escalate behavior utilized.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of which less restrictive measures were used and how they failed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

30. Seclusion/Restraint: Required Elements

<table>
<thead>
<tr>
<th>Category:</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seclusion/restraint initiated and ended only by a state approved professional.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal seclusion/restraint administered by trained personnel.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Seclusion/restraints only used for imminent threat.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

31. Seclusion/Restraint: Documentation

<table>
<thead>
<tr>
<th>Category:</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date/Time procedure started/ended.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Names of staff involved in applying or monitoring seclusion/restraint.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the precipitating event for the escalating behavior identified.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order obtained from state approved professional within one hour.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orders for children under the age of 9 are no more than one hour, 9-17 year old children are two hours, and orders for 18-21 year olds are four hours.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order was renewed when original order expired and why a renewal was needed was documented.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear criteria for ending seclusion/restraint was identified.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Resident’s health/comfort was assessed every 15 minutes.
Vital signs were taken every hour.
In-person assessment conducted by physician, PMHNP, or RN within 1 hour, regardless of length of procedure.

32. Seclusion/Restraint: Assessment of Outcome

<table>
<thead>
<tr>
<th>Category</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident’s physical/psychological status.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident’s response to the restraint.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resulting complications.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seclusion/restraint ended at the earliest possible time.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

33. Seclusion/Restraint: Timelines

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The treatment plan was modified within one working day of incident as indicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents or guardian notified within 24 hours of the incident.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The incident was processed with the resident by staff within 24 hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resulting complications.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

34. Provisional discharge/aftercare plan developed at intake and updated throughout treatment episode to reflect resident progress.
- Yes
- No

35. Provisional Aftercare Plan: Required Elements

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated date of discharge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations for parents/caregivers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational summary and recommendations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations for mental health providers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
36. Final Aftercare Plan: Required Elements

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person/agency to who resident will be released.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address where resident will reside.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation that coordination of care was attempted by PRTF therapist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Names, addresses, and phone numbers of follow-up mental health care providers was documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations and briefing of safety plan with parents/caregivers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow up appointment with PCP, psychiatrist, and therapist including date, time, and provider name documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of functional impairments preventing completion of activities of daily living and ongoing risk.</td>
<td></td>
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</tr>
</tbody>
</table>

37. Final Aftercare Plan: Timelines Met

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up therapy appointment within 7 days of discharge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication management appointment scheduled within 30 days of discharge.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

38. Final Discharge Summary: Required Elements

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates of admission and discharge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress towards treatment goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary of reason(s) for discharge.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

39. Parents/Guardians Received:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum of one week supply of medications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written prescription for 30-day supply of medications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of aftercare plan.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
40. Documentation that educational summary and recommendations were mailed to the resident’s school within 24 hours post-discharge.
   o Yes
   o No

41. Documentation that aftercare plan and discharge summary were mailed to follow-up mental health care providers within 2 weeks post-discharge.
   o Yes
   o No

42. Documentation indicates that the facility follows its policies and procedures in practice.
   o Yes
   o No

21.9.9.6 F: Resident Interviews

1. Residents can explain how they are encouraged to participate freely in community meetings. Residents perceive open, collaborative communication between themselves and staff.
   o 4
   o 3
   o 2
   o 1

2. Residents feel like they can safely bring concerns and challenges to staff without fear of consequences.
   o 4
   o 3
   o 2
   o 1

3. Residents participate in treatment team meetings. They are knowledgeable about their treatment goals and have helped to set them.
   o 4
   o 3
   o 2
   o 1

4. Residents understand their behavior program(s). They know what phase they are on and what is required to reach the next phase.
   o 4
   o 3
   o 2
   o 1
5. Residents report receiving timely feedback on their progress towards treatment goals.
   - 4
   - 3
   - 2
   - 1

6. Residents are knowledgeable about their medications: names, strengths, frequency of dosages, and which symptoms are targeted. They can explain possible side effects of their medications.
   - 4
   - 3
   - 2
   - 1

7. Residents are aware of the goals they need to meet before going home, targeted discharge date, and current discharge date.
   - 4
   - 3
   - 2
   - 1

8. If residents have been secluded or restrained, they understand why the seclusion/restraint was used and understood their release criteria at the time the procedure was in progress.
   - 4
   - 3
   - 2
   - 1
   - Not applicable

9. A staff member helped them to process the incident after its conclusion.
   - Yes
   - No
   - Not applicable

10. Resident could name their triggers and at least two coping skills they can try in the future when feeling upset or out of control.
    - 4
    - 3
    - 2
    - 1

11. Does the resident feel safe when others are out of control?
    - 4
    - 3
12. Residents believe that medical complaints are handled in a timely and appropriate manner.
   - 4
   - 3
   - 2
   - 1

13. Residents have a positive perception of the facility’s program and how they are being treated. They perceive staff as genuinely interested in their welfare and capable of helping them.
   - 4
   - 3
   - 2
   - 1

14. Residents feel they are making progress in their treatment and can explain why.
   - 4
   - 3
   - 2
   - 1

15. Resident feels the facility is warm, safe, and comfortable.
   - 4
   - 3
   - 2
   - 1

16. Resident feels satisfied with how the facility reacts with their family and they are able to contact their family regularly.
   - 4
   - 3
   - 2
   - 1

17. Residents understand the grievance policy and how to submit a complaint if they have a grievance.
   - 4
   - 3
   - 2
   - 1
Appendix

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## APPENDIX A – Institutional Manual Version Control Table

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Change(s)</th>
</tr>
</thead>
</table>
| Chapter 2 – Getting Help When Needed  
2.1 Quick Reference – updated addresses for all DHCF and DPH listings | |
| Chapter 3 – Provider Responsibilities  
3.1.2.3 Inactivity – changed time given before inactive status from 1 year to 15 months | |
| Chapter 5 – Client Eligibility  
5.2.1 Children – updated DFS custody bullet  
5.2.4.3 Home and Community Based Waiver – “community choices” & “support” vs “community choice” & “Supports”  
5.2.5.1 Special Groups – changed FPL % for BCC & SSI Standard % for PACE  
5.2.5.2 Employed Individuals with Disabilities – changed SSI Standard %  
5.4.1 Applying for Medicaid – changed first bullet to say “Persons applying for Medicaid or Kid Care CHIP may complete the Streamlined Application” instead of “Persons applying for Children, Pregnant Women and/or Family MAGI Adult programs may complete the Application for Wyoming’s Healthcare Coverage, which is also used for the Kid Care CHIP program.”  
5.5 Client Identification Cards – Removed PDAP from list | |
| Chapter 6 – Common Billing Information  
6.14 Prior Authorization –  
- Removed BHD row  
- Removed ALF & LTC Waivers from DHCF  
- Added CCW, CDD, SDD waiver to DHCF  
- Removed specific surgeries and instead referenced the code range under WYhealth and Medical Policy rows  
6.14.4-6.14.5 PA Pending & PA Denial – swapped sections  
6.15 Submitting Attachments for Electronic Claims – reformatted  
6.17 Remittance Advice – RA no longer available via paper copy except in limited special circumstances  
6.24.2 Non-Covered [Telehealth] Services – moved group psychotherapy to a separate bullet point | 04/01/2020 |
| Chapter 7 – Third Party Liability  
7.1.1 Third Party Liability – removed info in () from first paragraph  
7.1.8 Exceptions – reformatted bullet points, removed non-bold parts of the first NOTE  
7.3 Billing Requirements –  
- corrected Dental box  
- added “or benefit plan year, if applicable” to “if a denial is obtained from the TPL…” bullet  
- added “Notify the Department for requests for information” bullet | |
| Chapter 11 – Outpatient Services | |

Institutional ICD 10  
325  
Revision 04/01/20
### APPENDIX A – Institutional Manual Version Control Table

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Change(s)</th>
</tr>
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<tbody>
<tr>
<td>11.1.4.1</td>
<td>Reimbursement – Now says “OPPS a Medicare based outpatient hospital...”</td>
</tr>
<tr>
<td>11.16</td>
<td>OPPS Reimbursement, Definitions, Billing Tips, and Guidelines – added Children’s Hospitals to list of providers</td>
</tr>
<tr>
<td>11.16.3</td>
<td>Coding Tips – changed 1st bullet point to only refer to ICD 10 CM coding books</td>
</tr>
<tr>
<td>11.16.4.6</td>
<td>Recording Detailed ICD Diagnosis Codes – changed to specify ICD 10</td>
</tr>
<tr>
<td>11.16.6.1</td>
<td>OPSS Affected Provider and Claims Types – added Children’s Hospitals to 1st bullet</td>
</tr>
<tr>
<td>11.16.8.2</td>
<td>Composite APC – added “composite APCs provide...”</td>
</tr>
<tr>
<td>11.16.9</td>
<td>Charge Caps (Maximum Payout on Line Item) – changed last bullet to say APR DRG instead of level of care system</td>
</tr>
<tr>
<td>Chapter 12 – Critical Access Hospital and General Hospital Inpatient</td>
<td></td>
</tr>
<tr>
<td>12.5.4</td>
<td>Reimbursement – unspecified the % of billed charge as it is provider dependent</td>
</tr>
<tr>
<td>12.6.2</td>
<td>Outpatient Services Followed by Inpatient Services – changed level of care to APR DRG</td>
</tr>
<tr>
<td>12.6.3</td>
<td>Reimbursement for Inpatient Hospital Claims – removed “Inpatient Rehab claims (LOC 30 &amp;31)...” sentence</td>
</tr>
<tr>
<td>12.6.6</td>
<td>Level of Care High Cost Outlier Reimbursement - previously High Cost Outlier Reimbursement</td>
</tr>
<tr>
<td>Chapter 15 – Federally Qualified Health Centers (FQHC)</td>
<td></td>
</tr>
<tr>
<td>15.1</td>
<td>Federally Qualified Health Centers (FQHC) – added rev code 0528 and Procedure Codes</td>
</tr>
<tr>
<td>15.1.2</td>
<td>Reimbursement Guidelines – added all information concerning Billing for Long Acting Reversible</td>
</tr>
<tr>
<td>Chapter 18 – Indian Health Services (IHS)</td>
<td></td>
</tr>
<tr>
<td>18.1.2.1</td>
<td>Billing Examples –</td>
</tr>
<tr>
<td></td>
<td>• Removed last sentence and Claim #2 from first example type.</td>
</tr>
<tr>
<td></td>
<td>• Removed middle sentence and Claim #3 from second example type.</td>
</tr>
<tr>
<td>18.1.3</td>
<td>Covered Services – removed 0259 rev code from table, changed WyVIP to VFC</td>
</tr>
<tr>
<td>18.1.3.1</td>
<td>Laboratory Rev Code 0300 – previously Pharmaceutical Encounters (within IHS clinic) Revenue Code 0259 which was removed</td>
</tr>
<tr>
<td>Chapter 21 – Psychiatric Residential Treatment Facility</td>
<td></td>
</tr>
<tr>
<td>21.4</td>
<td>Reporting of Serious Occurrences – added 42 CFR 483.374(b)</td>
</tr>
</tbody>
</table>
## APPENDIX B – Provider Notifications Log

<table>
<thead>
<tr>
<th>Active Date(s)</th>
<th>Notification Type</th>
<th>Title</th>
<th>Audience</th>
</tr>
</thead>
</table>
# APPENDIX B – Provider Notifications Log

<table>
<thead>
<tr>
<th>Active Date(s)</th>
<th>Notification Type</th>
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<th>Audience</th>
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<tbody>
<tr>
<td>1/30/2020</td>
<td>Bulletin</td>
<td>Medicare Crossover Policy Change</td>
<td>261QF0400X &amp; 261QR1300X</td>
</tr>
<tr>
<td>2/12/2020</td>
<td>Bulletin</td>
<td>LARC Billing and Reimbursement for FQHC/RHC Providers</td>
<td>261QE0400X &amp; 261QR1300X</td>
</tr>
</tbody>
</table>
# APPENDIX B – Provider Notifications Log

<table>
<thead>
<tr>
<th>Active Date(s)</th>
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<table>
<thead>
<tr>
<th>Active Date(s)</th>
<th>Notification Type</th>
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</tr>
</thead>
</table>
RA Banner – Reminder of Two Important Bulletins

ATTENTION MEDICAL PROVIDERS

BE AWARE THAT TWO IMPORTANT BULLETINS WERE SENT BY EMAIL ON 12/6/19 AND 12/9/19 REGARDING UPDATES TO THE PRIOR AUTHORIZATION VENDORS AND TO IMMUNIZATION POLICY. IF YOU HAVE NOT REVIEWED THE EMAIL NOTIFICATIONS, THEY ARE POSTED TO THE WEBSITE AT:

HTTPS://WYMEDICAID.PORTAL.CONDUENT.COM/MEDICAL.HTML

RA Banner Deployment

Active Dates: 12/19/19 – 1/9/20

ATTENTION PROVIDERS – UPDATED INFORMATION

UPDATED CHANGES TO NUTRITIONAL AND INCONTINENCE PRODUCTS

Effective January 1, 2020, nutritional products, which will now require prior authorization for enteral nutrition products, as well as incontinence supplies, will no longer be covered through the Wyoming Medicaid Pharmacy point-of-sale. These products will continue to be covered in accordance with Wyoming Medicaid DME policy when billed by DME providers through the medical billing system. Infant formula claims submitted through the Medicaid Pharmacy point-of-sale system will continue to be covered for members eligible for infant formula coverage through the pharmacy.

Medicaid DME policy for nutritional products:

Enteral Nutrition Codes: B4100, B4102, B4103, B4104 – B4162 (require prior authorization)

Please go to the fee schedule to determine how each HCPCS code is reimbursed. Some are by ml and some by calories.

https://wymedicaid.portal.conduen.com/fee_schedule.html

If enteral nutrition is taken orally, use modifier BO on the claim.
Appendix

Enteral nutrition may be covered for the following reasons:

1. When ordered by a physician who has seen the client within 30 days prior to ordering the therapy and has documented that the client cannot receive adequate nutrition by dietary adjustments and/or oral supplements, enteral therapy may be given by:
   A. Nasogastric
   B. Jejunostomy
   C. Gastrostomy tube
   D. Orally

2. **Enteral Nutrition Therapy** is considered reasonable and necessary for clients with:
   A. Functioning gastrointestinal tracts who, due to pathology or non-function of the structures that normally permit food to reach the digestive tract, cannot maintain weight, strength, and overall health status.

3. **Oral enteral nutrition therapy** is covered if the patient has a diagnosed medical condition such as, but not limited to:
   A. A mechanical inability to chew or swallow solid or pureed or blended foods;
   B. A malabsorption inability due to disease or infection;
   C. Weaning from Total Parenteral Nutrition or feeding tube;
   D. A significant weight lost over the past six (6) months or, for children under age 21, has experienced significantly less than expected weight; or
   E. If patient receives less that 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, a nutritionist, speech-language pathologist or a physician must write a detailed plan to decrease dependence on the supplement.

4. Enteral nutrition therapy is not covered:
   A. For clients whose nutritional deficiencies are due to a lack of appetite or cognitive problem; or
   B. For healthy newborns; or
   C. For individuals living in a nursing facility or residential facilities as this should be part of the per diem or room and board; or
   D. For clients whose need is nutritional rather than medical or is related to an unwillingness to consume solid or pureed foods; or
E. As a convenient alternative to preparing or consuming regular foods; or
F. Because of an inability to afford regular foods or supplements.

**Documentation:**

For all requests for authorization of enteral nutritional products, documentation must include the following:

A. Specific enteral product requested  
B. Average number of calories to be obtained per day from the enteral nutritional product  
C. Average number or calories to be obtained per day for other sources  
D. Medical condition that requires an enteral nutrition product  
E. Type of food preparation that have been tried (mechanically chopped, pureed or blended)  
F. Documentation if a swallowing study or swallowing evaluation has been completed with a history of aspiration  
G. Medical document to support the clinical need of the prescribed product  
H. Written order

Documentation of medical necessity must be kept on file by the provider and made available upon request.

**Prior Authorization:** PA required for oral enteral nutrition

Medicaid DME policy for **incontinence products:**

Covered for clients who are unable to control bladder or bowel function

**Equipment:**

**HCPCS Code Range:** A4310-A5200; T4521 – T4537; T4539 – T4544

Please check the HCPCS book for appropriate codes

**Indications/Limitations:**

Incontinence diapers/briefs and liners are not covered for clients under age three; limited to a
30-day supply. The below codes are limited as indicated:

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>T4521 – T4524:</td>
<td>390 per calendar month</td>
</tr>
<tr>
<td>T4525 – T4528:</td>
<td>210 per calendar month</td>
</tr>
<tr>
<td>T4529 – T4534:</td>
<td>390 per calendar month</td>
</tr>
<tr>
<td>T4535:</td>
<td>210 per calendar month</td>
</tr>
<tr>
<td>T4536 – T4537:</td>
<td>4 per calendar month</td>
</tr>
<tr>
<td>T4539 – T4540:</td>
<td>3 per calendar month</td>
</tr>
<tr>
<td>T4541 – T4544:</td>
<td>210 per calendar month</td>
</tr>
</tbody>
</table>

**Documentation:** Written Order

**Prior Authorization:** Not Required

For any questions related to these policies, please contact Amy Guimond at amy.guimond@wyo.gov.

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- [https://health.wyo.gov/healthcarefin/program-integrity/](https://health.wyo.gov/healthcarefin/program-integrity/)
- 1-855-846-2563

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

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

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

Date: 1/21/2020

Attention FQHC/RHC Providers

Medicare Crossover Pricing Policy Changes

Effective March 1, 2020

On January 1, 2017, the Wyoming Medicaid State Plan was approved to change how reimbursement was calculated for Medicare crossover claims for dual eligible clients. Dual eligible clients are persons/clients eligible for both Medicare and Medicaid. This change was to apply to all service providers. Not long after implementation of this reimbursement change the State determined the new crossover reimbursement methodology was not pricing FQHC/RHC encounter claims as expected. Since then Medicaid’s reimbursement to FQHC/RHC facilities has been 100% of the coinsurance and 100% of the deductible on Medicare crossover claims, as assigned by the coordination of benefits (COB).

Effective March 1, 2020, all FQHC/RHC crossover claims will be priced through the lesser of logic the same as all other service providers.

- Part B (FQHC only) – Part B crossovers are processed and paid at the line level (line by line)
- Part A (FQHC/RHC) – Part A outpatient crossovers, claims are priced at the line level (line by line) totaled, and then priced at the header level

Medicaid Covered Services
For services covered under the Wyoming Medicaid State Plan, the methodology considers the amount Medicaid would have paid, had it been the sole payer. Medicaid’s payment responsibility on the claim will be the lesser of the Medicare coinsurance and deductible, or the difference between the Medicare payment and Medicaid allowed charge(s).

If the reimbursement paid by Medicare exceeds the Medicaid allowable payment, Medicaid will pay nothing additional on the claim – resulting in a Medicaid payment of $0.00. This change will treat Medicare the same as Medicaid treats other types of primary insurance.

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

Billing Example:

Line 1: 0520 T1015 $295.55
Line 2: 0300 81003 $ 0.00

Medicaid Allowable: $295.55
Medicare Paid: $30.00
Medicare Deductible: $175.00
Medicare Coinsurance: $135.00

- First payment method option: (Medicaid Allowable) $295.55 – (Medicare Payment) $30.00 = $265.55
- Second payment method option: Deductible and Coinsurance = $310.00

Medicaid will pay the lesser of the Medicaid payment methodology or the coinsurance and deductible

- The reimbursement would be $265.55 since it is less than $310.00

**Medicaid Non-Covered Services**

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

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

Line 1: 0521 99214 $295.55
Line 2: 0300 81003 $ 0.00

Medicaid Allowable: Not covered $0.00
Medicare Allowable: $100.00
Medicare Paid: $30.00
Medicare Deductible: $100.00
Medicare Coinsurance: $ 0.00

- First payment method option: \[(\text{Medicare Allowable \$100.00} \div 2)\] - (Medicare Payment) $30.00 = $20.00
- Second payment method option: Deductible and Coinsurance = $100.00

Medicaid will pay the lesser of the Medicaid payment methodology or the coinsurance and deductible

- The reimbursement would be $20.00 since it is less than $100.00

FQHCs and RHCs are the last group of providers to transition to the change in reimbursement methodology for Medicare crossover claims.

**Effective March 1, 2020 this change will take effect for all FQHC/RHC claims regardless of the date of service, including adjustments.**

For the complete Medicare pricing policy, refer to the Institutional Manual, Section 7.4. Remember the Medicaid provider manuals are updated quarterly. The FQHC/RHC crossover “NOTE” will be removed with the April 2020 version, as this crossover exception will no longer apply as of March 1, 2020.

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

[https://health.wyo.gov/healthcarefin/program-integrity/](https://health.wyo.gov/healthcarefin/program-integrity/)

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[https://wymedicaid.portal.conduent.com/](https://wymedicaid.portal.conduent.com/)

**Deployment**

**Date:** 1/30/2020

**Audience:** FQHC/RHC Providers

**Taxonomies:** 261QF0400X & 261QR1300X
Clarification of Medicaid Behavioral Health Billing

New Modifier: HL – Intern

Reimbursement for Behavioral Health Residents and Student Interns

Medicaid providers who sponsor residents and student interns in their practice (per Medicaid policy), may bill for Medicaid-covered services provided by the resident and/or student intern utilizing the supervising clinical supervisor’s NPI and the HL modifier. Please submit billing for these services under the supervising clinician’s NPI and add the HL – Intern modifier to all of the claims where the intern was the treating provider.

Billing Clinical Assessments

If the clinical assessment takes multiple days to complete, it should be billed on the day of completion per CMS and AAPC guidelines.
<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Description</th>
<th>1 Unit Equals</th>
<th>Modifiers Allowed</th>
<th>Pay-to Providers with the appropriate Taxonomy Code</th>
<th>Treating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td>Clinical Assessment - Mental Health Assessment by non-physician</td>
<td>Per session</td>
<td>GT, UK, HL</td>
<td>CMHC, SATC, Clinical Psychologist, Neuropsychologist, LCSW, LPC, LMFT, LAT, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)</td>
<td>LPC, PPC, LCSW, CSW, PCSW, MSW, LMFT, PMFT, LAT, PLAT, CAP, Certified Mental Health Worker, Clinical Psychologist, Neuropsychologist, RN, Psychiatrist, APRN, Taxonomies beginning with 20 (Physicians)</td>
</tr>
</tbody>
</table>

**Reminder:**
Effective January 1, 2019, psychologists and neuropsychologists are required to use CPT codes that are specifically designated for report writing. ONLY PSYCHOLOGISTS AND NEUROPSYCHOLOGISTS providers are allowed to bill these codes. Wyoming Medicaid does not cover report writing for any other provider type.

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Deployment
Date: 1/30/2020

Audience: Behavioral Health Providers
Federally Qualified Healthcare Center (FQHC)/Rural Health Clinic (RHC) Update

LARC Billing & Reimbursement

Effective January 1, 2020, FQHCs and RHCs will be able to bill Wyoming Medicaid outside of the encounter rate for Long Acting Reversible Contraceptive (LARCs) Devices. FQHC/RHC Facilities will continue to submit a UB encounter claim for the LARC insertion/removal/reinsertion services AND the practitioner services location will now have the ability to submit a medical claim for the LARC devices.

The hope is to increase the access to LARCs and decrease the number of unintended pregnancies in addition to reimbursing the providers for the device.

Provider Action Steps:

- If a FQHC/RHC Facility does not have a practitioner location:
  - Obtain an additional provider number under the FQHC/RHC for a physician, family practice, etc. location, by completing a group enrollment. Within the enrollment application include the treating provider's names and NPIs to be lined to the new group: Web Enrollment Application.

- If the FQHC/RHC has an active practitioner group location:
  - Email the list of ORP/treating providers (name and NPI) that perform the LARC device insertion to amy.guimond@wyo.gov. These provider may need...
to be changes from an ORP to a treating provider and be linked to the practitioner group. Medicaid (Amy Guimond) will coordinate these updated from ORP to treating, re-enrollment is not required.

**LARC Billing & Reimbursement:**

- Billing for the LARC device will need to be completed on a CMS 1500 Claim Form/837P electronic claims transaction.
- Devices purchased under the 340B Program, providers are required to bill the actual acquisition cost for the device.
- Devices purchased outside the 340B Program, providers should bill their usual and customary charges.
- The group provider will be reimbursed the lesser of the provider’s billed amount or the Medicaid allowed amount.
- There should be correlating UB and CMS 1500 claims for the insertion and for the actual LARC device.
- Group providers should not submit a device claim when the encounter was for removal of a device only.
- **FQHC/RHC Facility Encounter Billing on the UB Form/837I Claims Transaction**
  - FQHC/RHC Facility NPI as the pay-to provider and enter an attending provider NPI
  - LARC Covered Services/CPT Codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11981</td>
<td>Insertion, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11982</td>
<td>Removal, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11983</td>
<td>Removal with reinsertion, non-biodegradable drug delivery implant</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0520</td>
<td>T1015</td>
<td>$220.00</td>
</tr>
</tbody>
</table>
Practitioner Group LARC Device Billing on the CMS 1500 Form/837P Claims Transaction

- Practitioner Group NPI as pay-to provider and enter the treating provider NPI (same as the attending on the encounter claim)
- Date of service must be the same as the date on the encounter claim
- LARC Device Covered Services/CPT Codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>NDC</th>
<th>LARC Device Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7296</td>
<td>Required</td>
<td>Kyleena</td>
</tr>
<tr>
<td>J7297</td>
<td>Required</td>
<td>Liletta</td>
</tr>
<tr>
<td>J7298</td>
<td>Required</td>
<td>Mirena</td>
</tr>
<tr>
<td>J7300</td>
<td>Required</td>
<td>Paragard</td>
</tr>
<tr>
<td>J7301</td>
<td>Required</td>
<td>Skyla</td>
</tr>
<tr>
<td>J7307</td>
<td>Required</td>
<td>Nezplanon</td>
</tr>
</tbody>
</table>

NOTE: LARC device codes require an NDC

- Device Billing Example:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>NDC</th>
<th>Billed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7301</td>
<td>00000-00-000</td>
<td>340B acquisition cost OR if purchased outside 340B Program enter usual &amp; customary charge</td>
</tr>
</tbody>
</table>

For additional assistance on billing LARC claims, please attend the following training:

"LARCs Billing: De-Coding the Paperwork for Center Reimbursement"
The training will be hosted by the WYPCA on March 24, 2020 from 12:00 - 1:00.

Please register for this training at the following link:
https://events.r20.constantcontact.com/register/eventReg?oeidk=a07egw4t5eq5f3908ea&oseq=&c=&ch=
If you have additional questions or concerns, please feel free to contact Amy Guimond at amy.guimond@wyo.gov or 307-777-3427.

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Deployment:
Date: 02/12/2020
Audience: FQHC/RHC Providers
Taxonomies: 261QE0400X & 261QR1300X
ATTENTION WY CANCER PROGRAM (WCP) PROVIDERS SERVING BREAST, CERVICAL, AND COLORECTAL CANCER SCREENING PROGRAM (BCC AND COLR) ELIGIBLE CLIENTS

ON 2/25/20, THE WCP MADE A SYSTEM UPDATE ALLOWING CLAIMS TO PROCESS FOR PAYMENT WHEN AT LEAST ONE (1) DIAGNOSIS CODE IS COVERED ON THE RELEVANT BCC OR COLR BENEFIT PLAN. IF YOU RECEIVED PREVIOUS CLAIM DENIALS WITH MEDICAID EOB 097, THE RECIPIENT IS NOT COVERED FOR THE TYPE OF SERVICE BILLED OR 835 REASON CODES N30, N52 OR PR96, PLEASE RESUBMIT THESE CLAIMS ELECTRONICALLY ASAP. THE BCC AND COLR PROGRAM REQUIRES SUPPORTING DOCUMENTATION FOR ALL DATES OF SERVICE.

THE WCP IS WAIVING TIMELY FILING BACK TO JULY 2018. MAIL ANY CLAIMS PAST TIMELY-FILING TO WYOMING MEDICAID, ATTENTION: FIELD REPRESENTATIVES, PO BOX 667, CHEYENNE, WY 82003.

IF YOU HAVE BILLED CLIENTS FOR DENIED BCC AND COLR SERVICES, REMOVE THIS BALANCE FROM PATIENT RESPONSIBILITY AND RESUBMIT CLAIMS. PROVIDERS CANNOT BILL CLIENTS FOR COVERED SERVICES.

CONTACT PROVIDER RELATIONS WITH ANY BILLING QUESTIONS- 1-800-251-1268.

Deployment
Date: 2/27/2020 – 3/12/2020
Audience: Wyoming Cancer Program Providers
Appendix

Bulletin Postcard – CMS COVID-19 Information & Guidance

WYOMING MEDICAID PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) have provided the following information to insure health care facilities have up-to-date information to adequately respond to COVID-19 concerns. See the below links:

- Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) by Hospice Agencies
- Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes

CMS has launched an additional resource page, Medicaid.gov Coronavirus Disease 2019 (COVID-19), that will be continually updated with relevant information.

Unsubscribe

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

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

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

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

Deployment:
Appendix

Date: 3/16/2020
Audience: Nursing Home, Hospice, and Hospital Providers
Taxonomies: 251G00000X, 282N00000X, 283X00000X, 283Q00000X, 31400000X
Email – Behavioral Health COVID-19 Group Therapy Telehealth

Attention Behavioral Health Providers:

In an effort to eliminate any barriers to care that might exist in relation to the COVID 19 virus, we are going to temporarily allow group therapy via telehealth, effective today, March 18, 2020 and forward. Group therapy will be limited to 2-10 unrelated clients and/or collaterals as necessary, for the purpose of implementing each client’s treatment plan. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a client’s mental health and/or substance abuse disorders.

Claims that are submitted for payment may be reviewed through our utilization management vendor. Please follow the telehealth policy in the CMS 1500 Provider Manual, https://wymedicaid.portal.conduent.com/manuals/Manual_CMS1500_01_01_20.pdf, using the GT modifier to identify the claims. For example, the H2019 HQ, GT will be billed for group therapy via telehealth.

Provider Communication Information:

- Emails sent directly to providers from the WYCUSTOMERSVC@conduent.com email.
- Email date: 3/18/20
- Approximate time: 4:30 pm MT
- Audience:
Email – Behavioral Health Providers COVID-19 Peer Specialist Telehealth

Attention Behavioral Health Providers:

In an effort to eliminate any barriers to care that might exist in relation to the COVID 19 virus, Wyoming Medicaid is going to temporarily allow peer specialist services via telehealth, effective today, March 19, 2020 and forward. Peer specialist services will be limited in a group setting to 2-5 unrelated clients and/or collaterals as necessary, for the purpose of implementing the portion of the client’s treatment plan that promotes the client to direct their own recovery and advocacy process or training to parents on how best to manage their child’s mental health and/or substance use disorder to prevent out-of-home placement; to teach and support the restoration and exercise of skills needed for management of symptoms; and for utilization of natural resources within the community. The skills and knowledge is provided to assist the client and/or parent to design and have ownership of their individualized plan of care. Services are person centered and provided from the perspective of an individual who has their own recovery experience from mental illness and/or substance use and is trained to promote hope and recovery, assist meeting the goals of the client’s treatment plan and to provide Peer Specialist services. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a client’s mental health and/or substance use disorder(s) as identified in the treatment plan. Services provided to family members must be for the direct benefit of the Medicaid client.

Claims that are submitted for payment may be reviewed through our utilization management vendor. Please follow the telehealth policy in the CMS 1500 Provider Manual, https://wymedicaid.portal.conduent.com/manuals/Manual_CMS1500_01_01_20.pdf, using the GT modifier to identify the claims. For example, the H0038 HQ, GT will be billed for peer specialist (group) services via telehealth and peer specialist with one client will be billed H0038 GT.

Wyoming Medicaid will allow providers to use telephonic services during this time. Please add the GT modifier to any services that are provided via telephone and please don’t forget to document the progress towards the client’s goals. All documentation requirements will still apply to all behavioral health services.

Provider Communication Information:
- Emails sent directly to providers from the WYCUSTOMERSVC@conduent.com email.
- Email date: 3/20/20
- Approximate time: 10:00 am MT
- Audience:
RA Banner – COVID-19 Testing Codes

ATTENTION HOSPITAL AND LABORATORY PROVIDERS
NEW COVID-19 TESTING CODES

EFFECTIVE APRIL 1, 2020 THE FOLLOWING CODES CAN BE BILLED BY ENROLLED
WY MEDICAID LABORATORY PROVIDERS FOR COVID-19 TESTING:

87635 - INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA);
SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2)
(CORONAVIRUS DISEASE [COVID-19]), AMPLIFIED PROBE TECHNIQUE -
EFFECTIVE 3/13/2020- $14.70
*U0001 - CDC 2019-NCOV REAL-TIME RT-PCR DIAGNOSTIC PANEL - $35.91
*U0002 - NON-CDC LABORATORY TESTS FOR COVID-19 - $51.31


ANY SERVICES THAT ARE CLINICALLY APPROPRIATE MAY BE BILLED VIA
TELEHEALTH. BE SURE TO MARK THE EMERGENCY INDICATOR FOR ANY COVID-19
SERVICES.

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Deployment:
Start Date: 3/19/2020
End Date: 4/30/2020
Audience: Hospitals & Laboratories
Taxonomies: 282N00000X, 282NR1301X, 283Q00000X, 283X00000X, 291U00000X,
367A00000X, 367500000X, 363L00000X, 363LA2200X, 363LF0000X,
363LG0600X, 363LX0001X, 363LP0200X, 364SP0808X, 207KA0200X,
207L00000X, 207SG0201X, 207N00000X, 2085R0202X, 207P00000X,
207Q00000X, 207R00000X, 207RC0000X, 207RE0101X, 207RG0100X,
207RG0300X, 207RX0202X, 207RN0300X, 207RP1001X, 207RR0500X,
207T00000X, 204D00000X, 207V00000X, 207VG0400X, 207VX0000X,
207W00000X, 207Y00000X, 207ZP0105X, 2080N0001X, 208100000X,
363A00000X, 208D00000X, 208000000X, 2083P0901X, 2084N0400X,
2084P0800X, 208600000X, 207X00000X, 2086S0120X, 2082S0099X,
208G00000X, 2086S0129X, 208800000X, 261QF0400X, 261QR0401X,
261QR1300X, 225X00000X, 225100000X, 235Z00000X
Email – FQHC/RHC and IHS/638 Tribal Facilities Telehealth

Attention FQHC/RHC and IHS/638 Tribal Facilities:

In an effort to eliminate any barriers to care that might exist in relation to the COVID 19 virus, Medicaid is going to temporarily allow providers to use telehealth and telephonic services during this time. Please add the GT modifier to any services that are provided via telehealth or telephone. All documentation and requirements still apply to services per the provider manuals.

Claims that are submitted for payment may be reviewed through our utilization management vendor. Please follow the telehealth policy in the CMS 1500 Provider Manual, https://wymedicaid.portal.conduent.com/manuals/Manual_CMS1500_01_01_20.pdf, using the GT modifier to identify the claims.

Provider Communication Information:

- Emails sent directly to providers from the WYCUSTOMERSVC@conduent.com email.
- Email date: 3/20/20
- Approximate time: 10:00 am MT
- Audience:
Bulletin – New WY Medicaid Pregnancy Reporting Code

Effective March 1, 2020, providers will be able to bill code 0500F to report the first prenatal visit for any pregnant woman. Wyoming Medicaid is asking for your support to identify pregnant clients in a timelier manner. It is Wyoming Medicaid’s hope that by gathering this information early on in the pregnancy will help both providers and clients.

A pregnant mother may not be identified as a member of this population, allowing outreach with additional resources to be initiated, until her delivery. This is due to the current practice of billing global maternity codes on the delivery date, potentially making this the first claim to reach Medicaid with a pregnancy diagnosis.

0500F Billing & Reimbursement:

- Code 0500F should be billed only one time per pregnancy.
- Bill when a woman has her first obstetrical visit using that first visit’s date as the date of service.
- This code will reimburse at $10.00.
- Providers should report this code for any woman they began seeing for obstetrical care on or after March 1, 2020.
- Bill as soon as possible after the first obstetrical visit in order for Wyoming Medicaid to be notified of the client’s pregnancy.
- Bill 0500F in addition to any other maternity codes, including cases where a provider intends to use global billing codes for maternity care after delivery.
Limitations:

- Billed only by the provider who is initiating the obstetrical care
- Providers only confirming pregnancy should NOT bill code 0500F.

If you are unsure if the code has been previously billed, contact Provider Relations 1-800-251-1268 to verify.

Desired Outcomes:

- Reporting of this code will allow Wyoming Medicaid to reach out to the client with additional resources available to them during their pregnancy in a timely manner.
- Clients will be placed on the correct eligibility programs with the correct benefits and co-pays.
- Providers and clients will benefit from other outreach programs such as care management through WYhealth for clients with complex pregnancies, and with referrals to other assistance sources such as WIC when appropriate.

Note: RHC/FQHC providers – although no additional payment will be made beyond the encounter rate for the visit, Medicaid would appreciate the code being billed as soon as possible as a detail line item for assistance in identifying that the client is pregnant as early as possible.

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

- https://health.wyo.gov/healthcarefin/program-integrity/
- 1-855-846-2563

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

Unsubscribe

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

Wyoming Medicaid, Provider Relations, PO Box 667, Cheyenne, WY 82003
Deployment:
Date: 3/23/2020
Audience: Maternity Care Providers
Email – Nursing Homes and Swing Bed Facilities COVID-19 PASRR Changes

ATTN: Nursing Homes and Swing Bed Facilities

In an effort to eliminate any barriers to care that might exist in relation to the COVID 19 virus, Wyoming Medicaid is temporarily suspending the requirement for PASRR Level I and PASRR Level II for seven (7) days beginning with dates of service March 1, 2020. After seven days, the PASRR Level I and PASRR Level II must be completed. This only applies to the time during this situation and will go back to the requirement on admission when it has passed. Resident reviews for significant changes should be completed as soon as time allows and resources are available.

For the safety of the clients and staff, the PASRR Level II can be conducted remotely by telehealth or telephonically. Please make sure the individual remains directly involved in the evaluation process to the fullest extent.

Medicaid is diligently working on making the necessary updates to the provider files impacted by the COVID-19 exceptions outlined above. We anticipate in having all the files updated no later than 4/6/2020, at that time providers may resubmit any denied claims meeting the criteria.

**Provider Communication Information**

- Emails sent directly to providers from the WYCUSTOMERSVC@conduent.com email.
- Email date: 3/31/20
- Approximate time: 9:55 AM MT
- Audience: