## Chapter Nine

**Covered Services/Limitations**

<table>
<thead>
<tr>
<th>Section Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview of Service Coverage and Limitations</strong></td>
<td>9-4</td>
</tr>
<tr>
<td>Covered Services</td>
<td>9-4</td>
</tr>
<tr>
<td>Service Limitations</td>
<td>9-7</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>9-8</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>9-8</td>
</tr>
<tr>
<td>Copayment</td>
<td>9-8</td>
</tr>
<tr>
<td>Incentive Payment Program</td>
<td>9-8</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>9-11</td>
</tr>
<tr>
<td>Covered Services</td>
<td>9-11</td>
</tr>
<tr>
<td>Service Levels</td>
<td>9-11</td>
</tr>
<tr>
<td>Limitations</td>
<td>9-12</td>
</tr>
<tr>
<td>Reimbursement Guidelines</td>
<td>9-13</td>
</tr>
<tr>
<td><strong>Ambulatory Surgical Centers</strong></td>
<td>9-14</td>
</tr>
<tr>
<td>Covered Procedures</td>
<td>9-14</td>
</tr>
<tr>
<td>Facility Services</td>
<td>9-14</td>
</tr>
<tr>
<td>Professional Services</td>
<td>9-14</td>
</tr>
<tr>
<td>Limitations</td>
<td>9-15</td>
</tr>
<tr>
<td>Reimbursement Guidelines</td>
<td>9-15</td>
</tr>
<tr>
<td><strong>Children’s Health Services</strong></td>
<td>9-16</td>
</tr>
<tr>
<td>Codes for pediatric evaluations and follow up of Complex Disorder</td>
<td>9-16</td>
</tr>
<tr>
<td>CHS Local Procedure Codes</td>
<td>9-17</td>
</tr>
<tr>
<td>Third Party Billing</td>
<td>9-17</td>
</tr>
<tr>
<td><strong>Community Mental Health Center and Substance Abuse Center Services</strong></td>
<td>9-17</td>
</tr>
<tr>
<td>Program Requirements</td>
<td>9-17</td>
</tr>
<tr>
<td>Covered Services</td>
<td>9-18</td>
</tr>
<tr>
<td>Covered Services for recipients Under Age 21</td>
<td>9-18</td>
</tr>
<tr>
<td>Psychiatrist Services</td>
<td>9-18</td>
</tr>
<tr>
<td>Reimbursement Guidelines</td>
<td>9-19</td>
</tr>
<tr>
<td>Limitations</td>
<td>9-19</td>
</tr>
<tr>
<td><strong>Developmental Centers</strong></td>
<td>9-20</td>
</tr>
<tr>
<td>Covered Services</td>
<td>9-20</td>
</tr>
<tr>
<td>Treatment and Documentation</td>
<td>9-21</td>
</tr>
<tr>
<td>Reimbursement Guidelines</td>
<td>9-22</td>
</tr>
<tr>
<td><strong>Family Planning Clinics</strong></td>
<td>9-24</td>
</tr>
<tr>
<td>Covered Clinic Services</td>
<td>9-24</td>
</tr>
<tr>
<td>Limitations</td>
<td>9-24</td>
</tr>
<tr>
<td>Reimbursement Guidelines</td>
<td>9-25</td>
</tr>
</tbody>
</table>
Federally Qualified Health Care Centers (FQHC) .......................................................... 9-27
  Reimbursement Guidelines ........................................................................................ 9-27
Health Check- EPSDT .................................................................................................. 9-28
  Components of a HEALTH CHECK Physical .......................................................... 9-29
  HEALTH CHECK Periodicity Schedules ................................................................ 9-36
  Treatment and Referral Services .............................................................................. 9-37
  Expanded HEALTH CHECK Services .................................................................... 9-38
Hearing Services .......................................................................................................... 9-43
  Hearing Aid Examination ....................................................................................... 9-44
  Hearing Aid Services .............................................................................................. 9-45
  Covered Services ..................................................................................................... 9-45
  Reimbursement Guidelines ..................................................................................... 9-45
Indian Health Services ................................................................................................. 9-47
  Reimbursement Guidelines under Wyoming's Medicaid Program ....................... 9-47
Laboratory Services ...................................................................................................... 9-49
  Covered Services ..................................................................................................... 9-49
  Limitations ................................................................................................................ 9-49
  Reimbursement Guidelines ..................................................................................... 9-49
Medical Supplies - Durable Medical Equipment ........................................................ 9-50
  Limitations ................................................................................................................ 9-50
  Documentation .......................................................................................................... 9-51
  Certification of Medical Necessity ........................................................................... 9-51
  Medical Records ....................................................................................................... 9-51
Nurse Midwife/Nurse Practitioner ................................................................................ 9-53
Nutritional Services ....................................................................................................... 9-54
  Covered Services ..................................................................................................... 9-54
Pharmaceutical Services ............................................................................................... 9-56
  Coverage .................................................................................................................... 9-56
  Limitations ................................................................................................................ 9-57
  Provider Guidelines .................................................................................................. 9-57
Physical Therapy ......................................................................................................... 9-59
  Covered Services ..................................................................................................... 9-59
  Limitations ................................................................................................................ 9-60
Physician Services ........................................................................................................ 9-60
  Abortion ...................................................................................................................... 9-61
  Allergy and Clinical Immunotherapy ..................................................................... 9-63
  Anesthesia Services ................................................................................................. 9-64
  Consultation Services ............................................................................................... 9-66
  Dermatology .............................................................................................................. 9-68
  Home Visits ............................................................................................................... 9-69
  Hospital Services ..................................................................................................... 9-70
  Hysterectomies ........................................................................................................... 9-75
  Injections .................................................................................................................... 9-77
  Locum Tenens ............................................................................................................ 9-81
  Maternity Care ......................................................................................................... 9-82
  Medical Supplies Furnished by a Physician/Practitioner's Office ......................... 9-84
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility Visits</td>
<td>9-84</td>
</tr>
<tr>
<td>Office and Outpatient Services</td>
<td>9-87</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>9-89</td>
</tr>
<tr>
<td>Preventive Medicine</td>
<td>9-90</td>
</tr>
<tr>
<td>Psychiatric Services</td>
<td>9-91</td>
</tr>
<tr>
<td>Sterilizations</td>
<td>9-92</td>
</tr>
<tr>
<td>Surgery</td>
<td>9-96</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>9-102</td>
</tr>
<tr>
<td>Coverage</td>
<td>9-102</td>
</tr>
<tr>
<td>Supervision and Interpretation</td>
<td>9-102</td>
</tr>
<tr>
<td>Limitations</td>
<td>9-103</td>
</tr>
<tr>
<td>Reimbursement Guidelines</td>
<td>9-103</td>
</tr>
<tr>
<td>Rural Health Clinics</td>
<td>9-104</td>
</tr>
<tr>
<td>Covered Services</td>
<td>9-104</td>
</tr>
<tr>
<td>Physician Direction Requirements</td>
<td>9-104</td>
</tr>
<tr>
<td>Reimbursement Guidelines</td>
<td>9-104</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>9-105</td>
</tr>
<tr>
<td>Vision Services</td>
<td>9-106</td>
</tr>
<tr>
<td>Coverage</td>
<td>9-106</td>
</tr>
<tr>
<td>Reimbursement Guidelines</td>
<td>9-107</td>
</tr>
<tr>
<td>Waiver Programs</td>
<td>9-108</td>
</tr>
<tr>
<td>Developmentally Disabled Adult</td>
<td>9-108</td>
</tr>
<tr>
<td>Developmentally Disabled Children</td>
<td>9-108</td>
</tr>
<tr>
<td>Long-Term Care (LTC)/Home and Community-Based Waiver Services</td>
<td>9-109</td>
</tr>
</tbody>
</table>
Overview of Service Coverage and Limitations

Wyoming Medicaid reimburses for services mandated by Title XIX as well as several optional services. The general categories of service coverage are briefly described below. For details regarding a specific service, refer to the appropriate provider manual, or section of this manual.

Administrative transportation services: payment for travel to obtain medical services, which is arranged through field offices of the Department of Family Services.

Ambulatory surgical center services: outpatient surgery, which is performed in a freestanding facility.

Ambulance services: emergency ground and air transportation and limited non-emergency Ground transportation.

Community Mental Health Center services: mental health and substance abuse services for all ages.

Dental services: comprehensive services for children and young adults under the age of 21. Orthodontia is covered for crippling malocclusion through Dental Health Services. A maximum of two emergency visits to a dentist per calendar year is covered for recipient’s age 21 and older.

Developmental Center services: developmental assessments and therapy services for recipients under the age of 21 with chronic conditions.

Developmental Disabilities Waiver Programs: specific services provided by a variety of providers in the client’s home or community to prevent institutional care.

End Stage Renal Disease (ESRD) services: outpatient dialysis services provided by a freestanding facility.

Family planning services: services furnished to individuals of childbearing age which are provided by a physician, nurse practitioner or a Family Planning Clinic. Contraceptive supplies are covered through a Family Planning Clinic or a pharmacy. Norplant is covered. Infertility services are not covered.

Federally Qualified Health Center services (FQHC): primary care services provided by a clinic designated as a FQHC.

HEALTH CHECK services: comprehensive well-child screening, diagnostic and treatment services for recipients under the age of 21 which are provided by a physician, a nurse practitioner or a Public Health nurse.

Hearing services: services of an audiologist and hearing aids.

Home Health services: skilled nursing services and therapies provided by a Home Health
Agency to patients in their home under a physician's plan of care.

**Hospice services:** medical and support services for patients with terminal illness.

**Hospital services:** inpatient and outpatient hospital services are covered with some exceptions. Alcohol and chemical rehabilitation services are not covered, except for acute detoxification. Psychiatric care is limited to acute care stabilization. Extended inpatient psychiatric services for recipients under age 21 are covered through contracted facilities. Level III neonatal intensive care and high risk maternal/fetal admission facility reimbursement is only covered through contracted facilities. Outpatient emergency room visits for recipient's age 21 and older are limited.


**Laboratory and X-ray services:** services, which are ordered by a physician or nurse practitioner. Annual routine Pap tests and screening mammography are covered.

**Long Term Care/Home and Community Based Waiver Services:** specific services which can be provided by a variety of providers in a client's home or community to prevent institutional care.

**Medical Supplies/Equipment:** medical supplies and equipment, which are medically necessary for use in the home, are covered with a physician's prescription. These services/items may be obtained from a pharmacy or a medical supplier and may require prior authorization.

**Mental Hospital services:** services provided to Medicaid eligible recipients age 65 and older in freestanding psychiatric hospitals.

**Nurse practitioner and nurse midwife services:** services, which are permitted by, state law when provided by nurse-midwives and adult, pediatric, OB/GYN, and geriatric nurse practitioners.

**Nursing facility services:** long term care in nursing facilities for patients with medical needs who are unable to live independently. Services are subject to preadmission screening.

**Organ transplants:** cornea transplants are covered without prior authorization. Other medically necessary transplants are limited to recipients under the age of 21, require prior authorization and must be performed at a contract facility.

**Orthotics and prosthetics:** most services are covered. Prior authorization is required in some cases.

**Physician services:** most services provided by physicians are covered. Cosmetic procedures, transsexual surgery, and weight reduction surgery are not covered. Surgical procedures may require prior authorization or consent forms. The number of office visits per calendar year is limited for recipient age 21 and older.
Physical therapy: restorative physical therapy is covered when provided through a hospital, physician's office or by an independent physical therapist. The number of visits per calendar year is limited for recipient’s age 21 and older.

Prescription drugs: most legend drugs are covered. Some over the counter drugs are covered. A prescription is required for all drugs.

Rehabilitation services: services provided in comprehensive outpatient rehabilitation facilities.

Rural Health Clinic services: primary care services provided by a clinic designated as a rural health clinic.

Vision services: comprehensive services including eyeglasses for recipients under the age of 21 when provided by an ophthalmologist, an optometrist or an optician. Vision services for recipients age 21 and older are limited to eye examinations for treatment of disease or injury.
Service Limitations

Services not covered by Wyoming Medicaid are listed below in general terms. For details regarding a particular service refer to the appropriate provider manual or section of this manual.

- Abortion, except as specified by Federal Law
- Acupuncture
- Alcohol and chemical rehabilitation services are not covered. Treatment for alcohol and chemical dependency is limited to detoxification and/or stabilization of acute conditions.
- Autopsies
- Biofeedback therapies and equipment
- Canceled or missed appointments
- Chronic pain rehabilitation
- Community mental health services furnished outside of Wyoming
- Custodial care in a hospital
- Educational supplies and equipment
- Examinations or reports required for legal purposes or not specifically related to medical care
- Experimental procedures
- Hysterectomies, except as specified by Federal Law
- Infertility services, including counseling, reverse sterilization and artificial insemination
- Personal comfort items
- Podiatrist services, except when Medicare is primary
- Private duty nursing services
- Routine health examinations other than annual cancer examinations, school, work, camp physicals or those obtained through the HEALTH CHECK program.
- Services provided outside the United States
- Services provided to an individual in emergency detention
- Services provided to an individual who is an inmate of a public institution or an individual that is in the custody of state, local, or federal law enforcement agency
- Services rendered by an independently practicing:
  - Occupational therapist,
  - Psychologist,
  - Social Worker, or
  - Speech Therapist
- Services which are not medically necessary
- Services without the consent of the recipient’s legal guardian, except in an emergency
- Sleep disorder clinic services
- Sterilizations, except as specified by Federal Law
- Telephone calls
- Transplants
- Transsexual surgery
- Weight reduction surgery
- Weight reduction treatment
Payment

Reimbursement

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

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

A schedule of Medicaid fees is available upon written request to:

Consultec
P.O. Box 667
Cheyenne, WY  82003-0667

Copayment

A copayment from the recipient is required on specific services as outlined in the "Benefit Limits Chart”.

Incentive Payment Program

An Incentive Payment Program is available for primary care physicians who serve a disproportionate share of Wyoming Medicaid recipients. For more information regarding this program, contact:

Health Care Financing, Provider Services
6101 Yellowstone Road, Room 259B
Cheyenne, WY  82002
(307) 777-7531
# BENEFIT LIMITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limits</th>
<th>Does not apply to:</th>
</tr>
</thead>
</table>
| OFFICE VISITS/OUTPATIENT HOSPITAL | 12 combined total per calendar year | - Under age 21  
- Emergency visits  
- Family Planning  
- Medicare Crossover  
- Under age 21  
- Emergency visits  
- Family Planning  
- Medicare Crossover |
| Office visits to a physician/optometrist  
Codes: 99201-99215 |  | |
| Outpatient Hospital Visits  
Revenue Codes:  
450-459  
510-519 |  | |
| **NOTE:** Ancillary service provided during visits which exceed the limits will be reimbursed: e.g., lab, x-ray |
| PHYSICAL THERAPY | 20 combined visits per calendar year  
All modalities same date of service count as 1 visit | - Under age 21  
- Medicare Crossover |
| Physical therapy visits MD or IPT codes: 97010-97039 97110-97139 |  | |
| Outpatient Hospital Physical Therapy  
Revenue Codes:  
420, 421, 422, 424, each count as 1 visit. |  | |
| HOSPICE |  | |
| Hospice services related to terminal illness are reimbursed through Hospice.  
Any services not related to the terminal illness must be approved through the Hospice. |  | |
| EMERGENCY DENTAL SERVICE | 2 visits per calendar year | - Under age 21 |
| Adult visits to a dentist |  | |
| VISION SERVICES | Coverage limited to treatment of eye disease and/or injury | - Under age 21  
- Medicare Crossover |
| Eye examination codes: 92002, 92004, 92012, 92014  
Non-covered diagnoses: V72.00, 367.00, 367.10, 367.20, 367.21, 367.22, and 367.40 |  | |
| Eyeglasses/contact lenses | Not covered | |
## COPAYMENT SCHEDULE

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$2.00</strong></td>
<td>Office Visits 99201-99215</td>
<td><strong>EXCEPTIONS</strong>&lt;br&gt;Copayment requirements do not apply to:&lt;br&gt;- Recipients under age 21&lt;br&gt;- Nursing Facility Residents&lt;br&gt;- LTC Waiver recipients (pharmacy only)&lt;br&gt;- Pregnant Women&lt;br&gt;- Family planning services&lt;br&gt;- Emergency services&lt;br&gt;- Hospice services&lt;br&gt;- Medicare Crossovers</td>
</tr>
<tr>
<td></td>
<td>(The $2.00 copayment only applies to these office visit codes when the place of service code is 11.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Visits 99341-99350</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eye Examinations 92002, 92004, 92012, 92014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical psychotherapy 90804-90815</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(The $2.00 copayment only applies to these medical psychotherapy codes when the place of service code is 11.)</td>
<td></td>
</tr>
<tr>
<td><strong>$2.00</strong></td>
<td>Rural Health Clinic encounters&lt;br&gt;Federally Qualified Health Care encounters</td>
<td></td>
</tr>
<tr>
<td><strong>$6.00</strong></td>
<td>Outpatient hospital visits (non-emergency)&lt;br&gt;Revenue Codes - 450-459 and 510-519</td>
<td></td>
</tr>
<tr>
<td><strong>$2.00</strong></td>
<td>Prescriptions</td>
<td></td>
</tr>
</tbody>
</table>
Ambulance Services - Independent Ambulance or Hospital-Based Ambulance

Covered Services

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

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

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

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

Non-Emergency Transportation - is covered when any other mode of transportation would endanger the health or life of a recipient and at least one of the following criteria are met:

1. Continuous dependence on oxygen
2. Continuous confinement to bed
3. Cardiac disease resulting in the inability to perform any physical activity without discomfort
4. Receiving intravenous treatment
5. Heavily sedated
6. Comatose
7. Post pneumoencephalogram, myelogram, spinal tap, or cardiac catheterization
8. Hip spicas and other casts that prevent flexion at the hip
9. Requirement for isolette in perinatal period
10. State of unconsciousness or semi-consciousness

Service Levels

Basic Life Support Ambulance Services

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

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

Air Ambulance Services

Wyoming Medicaid covers both conventional air and helicopter ambulance services. These services are only covered under the following conditions:

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

Limitations

Wyoming Medicaid does not reimburse for the following ambulance services:

1. Transportation to receive services which does Wyoming Medicaid not cover
2. Transportation, which does not involve transporting a recipient (i.e., no-load trips), including life-support transportation in response to an emergency call
3. Transportation of a recipient pronounced dead before medical transportation is called
4. Transportation of family members to visit a recipient or to consult with their physician
5. Transportation to pick up drugs at a pharmacy
6. Return transportation to a recipient's home if ambulance transportation is not medically necessary
7. Transportation of a nursing home resident to a physician's office or outpatient hospital department if the care can be furnished in the recipient’s care facility
8. Transportation to a hospital or other health service facility for the purpose of detention ordered by a court or law enforcement agency
9. Stand-by time
10. Special attendants
11. Unloaded mileage
12. Services based on standing orders
Reimbursement Guidelines

Billing Procedure Codes - Following are the procedure codes accepted for ambulance services:

**GROUND/Basic Life Support (BLS)**

- **A0362** BLS, Emergency Transport, Mileage and Disposable supplies billed separately.
- **A0360** BLS, Non-Emergency Transport, Mileage and Disposable supplies billed separately.
- **A0380** BLS, Ground Mileage (per mile).
- **A0422** BLS or ALS, Oxygen
- **A0382** BLS, Disposable supplies

**GROUND/Advanced Life Support (ALS)**

- **A0370** ALS, Emergency Transport (Specialized ALS Services Rendered) Mileage and Disposable supplies billed separately.
- **A0390** ALS, Ground Mileage (per mile) billed separately.
- **A0398** ALS, Disposable supplies

**Additional Ground/ALS Codes**

- **A0366** ALS, Non-Emergency Transport (Specialized ALS services rendered), Mileage and Disposable supplies billed separately.
- **A0368** ALS, Emergency Transport, (No Specialized ALS services rendered),

**Air Ambulance**

- **A0030** Conventional, base rate, one-way, loaded. Oxygen and Disposable supplies billed separately.
- **A0040** Helicopter, base rate, one-way, loaded. Oxygen and Disposable supplies billed separately.
- **A0221** Air ambulance mileage, per mile, one way, loaded. Nautical miles only.
- **A0398** ALS, Disposable supplies.
- **A0422** ALS, Oxygen.

**AN AMBULANCE TRIP REPORT MUST BE ATTACHED TO ALL CLAIMS**
Ambulatory Service Centers (ASC)

Covered Procedures

Wyoming Medicaid will reimburse those surgical procedures, which are authorized for coverage under Medicare. Other surgical procedures which are performed in ambulatory surgical centers may also be covered.

Facility Services - Facility services include items and services furnished by an ASC in connection with a procedure normally covered on an inpatient or outpatient basis in a hospital. ASC facility services include the following:

- Nursing, technical, and other related services involved in patient care
- Use of surgical facility, including operating and recovery room, patient preparation area, waiting room, and other facility areas used by the patient
- Drugs, medical equipment, oxygen, surgical dressings, and other supplies directly related to the surgical procedure
- Splints, casts, and equipment directly related to the surgical procedure
- 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

Professional Services - Services furnished by physicians, surgeons, or anesthesiologists in an ambulatory surgical center are billed and reimbursed separately from the ambulatory facility services. Professional services include the administration of anesthesia to ASC patients, routine pre and/or postoperative services, and the actual surgical procedure.

These services are subject to all applicable Wyoming Medicaid coverage rules, such as informed consent, medical necessity, prior authorization, and documentation requirements and provider enrollment.
Limitations

The following services are not covered when billed by an ASC or physician performing the services in an ASC:

- Take-home supplies
- Prosthetic devices
- Leg, arm, back and neck braces
- Ambulance services
- Equipment for use in patient’s home
- Cosmetic procedures

Reimbursement Guidelines

Wyoming Medicaid uses the current levels of payment established by Medicare for covered surgical procedures. If a procedure is not covered by Medicare, a level of payment is established for the procedure by comparison to a similar procedure.

ASC facility charges are billed with CPT surgery codes.

Modifiers are not accepted, with the exception of bilateral procedures.

Bilateral procedures which are not designated as bilateral in CPT are billed on two detail lines with a -50 modifier on the second detail line.

Multiple procedures: the primary surgical procedure must be billed on the first line, the secondary surgical procedure on the following line.

Dental extraction/restoration is billed with local code X5840.

Practitioners who provide services in an ambulatory surgical center must be enrolled in the Wyoming Medicaid program as an individual practitioner to receive reimbursement.
Children’s Health Services (CHS)

The CHS program provides services for high-risk pregnant women and newborns who require Level III hospital care and children with special health care needs. The purpose of the program is to identify these patients, assure diagnostic and treatment services, provide payment for authorized specialty care and provide tracking and care coordination services. CHS DOES NOT COVER PRIMARY, ACUTE OR EMERGENCY CARE.

Questions related to CHS eligibility determination or the type of services authorized by CHS should be directed to:

Children's Health Services
Hathaway Building, 4th Floor
Cheyenne, WY  82002
307-777-7941 FAX: 307-777-5402

A patient may be eligible only for the CHS program or may be dually eligible for the CHS program and for Medicaid. Care coordination for both CHS only and dually eligible patients is provided through the PHN office.

Providers must be enrolled with Medicaid and CHS to receive payment for CHS services. Claims for services for both programs are submitted to and processed by Consultec. Medical records for visits which result from CHS referrals must be sent directly to CHS for appointment tracking and case management. An optional form is available from CHS which may be used to submit the medical information. Providers are asked to submit the record as soon after the visit as possible to assure timely coordination of referrals and services.

Provider Manual: A CHS provider manual is provided by CHS when a provider enrolls with the CHS program and a replacement manual may be ordered at any time from CHS.

Covered Services: CHS has a dollar caps and service limits on some services which apply to clients who are eligible for CHS and not for Medicaid. Please refer to the CHS manual.

Procedure Coding for the HCFA 1500: All services, with the exception of pediatric evaluations discussed below, are to be billed with routine CPT procedure coding and will be paid using the Medicaid fee schedule. When billing for Evaluation and Management Consultation Codes, you may use WY0000 or Children’s Health Services in field locator 17.

Local codes for pediatric evaluations and follow up of complex disorder:

Because CHS policy allows for a higher reimbursement for these evaluations than is available with CPT codes, local codes were developed in cooperation with the medical community for billing pediatric consultations for complex disorders for CHS eligible children (including those who are also Medicaid eligible). These codes are reserved for initial comprehensive evaluation, diagnosis and management of children with complex disorders or multiple complex disorders and follow-up of these disorders. Local codes are based on factors such as time, medical
complexity, special testing, intensive coordination, extensive patient education, complex social situations and other factors related to children with special health care needs.

These codes are reserved for pediatric evaluations by CHS-approved pediatricians, specialists and pediatric sub-specialists.

Examples of conditions that qualify for these special codes include new onset Juvenile Diabetes, significant Learning and Behavior Disorders such as ADHD and Autism, Developmental Delay, Growth Disorders, Failure to Thrive, pediatric/genetic syndromes, new onset or uncontrolled seizure concerns. Note: Some diagnostic evaluations are limited to two visits. See CHS Provider Manual for specific policies. Surgical evaluations are included IF performed for a complex condition/congenital anomaly that requires coordination’s with multiple providers.

<table>
<thead>
<tr>
<th>CHS Local Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Comprehensive pediatric Complex disorder</strong></td>
</tr>
<tr>
<td>X5907 - 30 minutes</td>
</tr>
<tr>
<td>X5908 - 45 minutes</td>
</tr>
<tr>
<td>X5909 - 60 minutes</td>
</tr>
<tr>
<td>X5910 - 90 minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Established pediatric follow up, consultation, complex disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>X5911 - 10 minutes</td>
</tr>
<tr>
<td>X5912 - 20 minutes</td>
</tr>
<tr>
<td>X5913 - 30 minutes</td>
</tr>
<tr>
<td>X5914 - 45 minutes</td>
</tr>
</tbody>
</table>

These procedure codes may only be used for services authorized by CHS and provided in an office.

**Third Party Billing**

When billing other insurance, use an appropriate CPT code and when payment or denial is received, submit a claim to Consultec with the appropriate local code and the insurance EOB. Payment will be made up to the CHS allowed fee or billed charge whichever is less.

**Community Mental Health Center and Substance Abuse Center Services**

**Program Requirements**

Community Mental Health Center and Substance Abuse Center Providers should refer to the Division of Behavioral Health Medicaid Policies and Procedures Manual for Mental Health/Substance Abuse Rehabilitative Option, EPSDT Child and Adolescent Mental Health Services, and Targeted Case Management Option Services (July 1, 1995 edition) for detailed information regarding provider qualifications and requirements, covered services and their definition, and quality assurance/utilization review standards.

**The Wyoming Board of Medicine has determined that the use of the terms "medical" or**
"medical necessity" are within the scope of practice of licensed doctors of medicine only. The board has determined that Community Mental Health and Substance Abuse Centers would be operating outside of their statutory authority if they continued to present themselves as providing "medical" care. Therefore, in every case where the word "medical" is used in this manual, the term "mental health/substance abuse therapeutic" is substituted. In every case where the term "medically necessary" is used in this manual, the term "therapeutically essential for the reduction of mental health/substance abuse disability" is substituted. In every case where the term "medical necessity" is used in this manual, the term "being therapeutically essential for the reduction of mental health/substance abuse disability" is substituted. Licensed practitioners of the healing arts who are eligible under Section 204(4)(b) of this manual to refer and sign for services being therapeutically essential for the reduction of mental health/substance abuse disability must sign and date the clients clinical assessment and treatment plans with the following statement, "I certify that the services in this treatment plan are therapeutically essential for the reduction of a mental health (or substance abuse) disability." Providers should refer to this manual for complete service descriptions.

Covered Services

- X2801 - Clinical Assessment
- X2841 - Agency Based Individual\Family Therapy
- X2853 - Group Therapy
- X2892 - Community Based Individual\Family Therapy
- X2893 - Individual Rehabilitative Services
- X2895 - Intensive Individual Rehabilitative Services
- X2899 - Day Treatment
- X2912 - Adult Targeted Case Management

Covered Services for recipients under age 21:

- X2905 - On-going Case Management
- X2903 - Transitional Case Management
- X2901 - Intensive Child Treatment Services

Psychiatrist Services

Community Mental Health Centers will be reimbursed for psychiatric services at the same fee currently set for psychiatrists in private practices. Community Mental Health Centers must use current CPT codes when billing for these services.

CPT codes for psychiatric services in the range 90801-90899 are covered with the exception of 90875, 90876, 90880, 90882, 90885, 90887 and 90889. These codes are reserved for billing services provided directly by a psychiatrist only and should not be used to bill for the services of other mental health professionals and counselors.
Reimbursement Guidelines

When billing for services with the local codes listed below, it is necessary to combine charges for the same procedure for the same date of service onto one line, with multiple units. If the procedure is listed on more than one line for the same date of service, on the same claim form or a different claim form, it will be denied as a duplicate.

\[
\begin{array}{ccc}
X2801 & X2892 & X2899 \\
X2841 & X2893 & X2905 \\
X2853 & X2895 & X2912 \\
\end{array}
\]

This denial is consistent for all Wyoming Medicaid covered procedures and all claim types. Refer to Chapter Four in this manual if you have any questions regarding submitting a claim form.

A $2.00 copay applies to 90804-90815. Refer to Copayment Requirements Table for exceptions.

Limitations

Wyoming Medicaid does not cover the following services or activities:

- Hospital liaison
- Consultation and education
- Emergency services not provided through face-to-face contact with the recipient
- Residential room, board, and care
- Substance abuse and mental health prevention services
- Recreation and socialization services
- Vocational services, including:
  - Vocational assessments and evaluation of work skills and aptitude
  - Trial work, whether paid or volunteer, including work readiness evaluation and work skills evaluation
  - Sheltered work, whether paid or volunteer
  - Job coaching, crews and enclaves
  - Groups in which the specific task is job support for employed recipients
  - Job clubs
- Missed appointments
- Day care
- Psychological testing for educational diagnosis or school placement
- Remedial education
- Travel time
- Record keeping time
- Time spent in telephone calls regarding the recipient, except as part of EPSDT On-Going or Transitional Case Management Services and Adult Targeted Case Management Services
- Time spent writing test reports and other reports with the exception of two hours allowed for report writing by a licensed psychologist for the purpose of compiling a
formal report of test findings

- Time spent in consultation with other persons or organizations on behalf of a recipient unless:
  - The consultation is a face-to-face contact with a collateral to implement the treatment plan of a client receiving Rehabilitative Option services; or
  - The consultation is a face-to-face contact or telephone contact to implement the treatment plan of a client receiving EPSDT Mental Health Services and Adult Targeted Case Management Services.
- Groups such as AA, NA, and other self-help groups
- DUI classes
- Progress or status reports made on behalf of a specific recipient.

**Developmental Centers**

Medicaid covered services provided by Developmental Centers, except DD Waiver authorized services shall be provided only with written referral by a licensed physician. Copies of all physician orders/referrals must be part of each individual patient's permanent developmental center clinical record and must be renewed at least every six (6) months. Each physician referral or order must be signed and dated by the physician.

**Covered Services**

**Diagnostic Evaluations/Assessments**

*Limitations and Requirements:* This service is limited to children 5 years of age and under. Diagnostic evaluation services shall be provided only after written referral by a licensed physician. This referral must list areas of concern. Areas to be assessed will include: physical development including fine and gross motor skills, cognitive development, speech development, and social and emotional development. Based on the individual needs of the child, the evaluation may take place in a Regional Developmental Center, a child's primary placement (if other than a Developmental Center) or the child's home. The evaluation is to be done using standardized assessment tools. If no standardized instruments are available based on the child's chronological age or suspected developmental age, criterion based assessments will be used. A comprehensive multi-disciplinary evaluation performed by the appropriate Wyoming certified or licensed professional is required for all children referred and all areas will be evaluated to gain a complete developmental overview of the child. A written report indicating assessment tools used, procedures followed and findings of the evaluation / assessment shall be developed, with a copy provided to the referring physician and a copy maintained in the child's permanent treatment record. (This service is not required in order for a recipient to be prescribed physical, occupational or speech therapy).

**Physical, Occupational and Speech Therapy**

*Limitations and Requirements:* This service is limited to children 20 years of age and under. Therapy shall be provided only after a written order is received from a licensed physician. Wyoming Medicaid will only reimburse those services provided by a licensed physical therapist.
Medical Services                                                                                          March 1, 1999

or licensed physical therapy assistant working under the direct supervision of a licensed physical therapist; or a licensed occupational therapist or a certified occupational therapy assistant working under the direct supervision of a licensed occupational therapist; or, a certified speech therapist. Services provided by speech therapy assistants are not covered by Wyoming Medicaid.

Wyoming Medicaid will reimburse Developmental Centers for providing restorative and maintenance services:

Restorative services are services, which assist an individual in regaining or improving skills or strength.

Maintenance services are those, which prevent conditions from worsening or the development of additional health problems.

*Group physical, occupational and speech therapy are limited to a maximum of three children per group.*

Documentation

Prior to the provision of any therapy services, the following must occur and be documented in the patient's permanent clinical record:

1. A comprehensive medical diagnostic examination by a licensed physician as well as a multi-disciplinary comprehensive evaluation must be completed as part of the Individual Education Plan/Individual Family Services Plan (IEP/IFSP). The IFSP must be completed for children ages 0-36 months.

2. Services must:
   - Be determined, in writing, to be medically necessary by a licensed physician;
   - Appear on the physician's plan of treatment/care; and
   - Have original and subsequent renewal physician written orders, which shall be for no more than six months duration.

3. The physician's plan of treatment/care shall contain:
   - Diagnosis and onset date of patient's condition;
   - Patient's rehabilitation potential;
   - Restorative and/or maintenance program goals;
   - Therapy modalities determined to be medically necessary to attain the program goals;
   - Therapy duration (not to exceed six months); and
   - Physician's signature and date signed.

4. Each therapy ordered, either independently or in combination with another, must
be described in a separate Medicaid treatment plan which shall:

- State treatment goals in terms of specific outcomes associated with referral diagnosis;
- Outline each therapy regime relative to stated goals, including modalities, frequency of each treatment session and duration of each treatment session;
- Be updated with every change or renewal of physician orders (not to exceed 6 months);
- Be signed, including professional title, and dated by each appropriate therapist; and
- Be attached to the client's IEP/IFSP

Ongoing documentation of services provided (progress notes) is required by each discipline billing Medicaid for services provided and shall include each of the following:

- Identification of the patient on each page of the treatment record;
- Identification of the type/discipline of therapy being documented on each entry (i.e., speech vs. physical vs. occupational therapy);
- Date and time(s) spent in each therapy session;
- Description of therapy activities, client reaction to treatment and progress being made to stated goals/outcomes; and
- Full signature or counter signature of the licensed therapist, professional title and date that entry was made, and the signature of the therapy assistant and date the entry was made. Licensed therapist must sign progress notes of assistants within 30 days.

Reimbursement Guidelines

Diagnosis Codes

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

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

The diagnosis code 783.4 Lack of Development, shall only be used if a more specific diagnosis code is not applicable.

Procedure Codes for Billing

X3100 - Comprehensive multi-disciplinary evaluation
X3125 - Individual speech, language or hearing evaluation
X3131 - Individual speech, language or hearing re-evaluation
X3126 - Individual speech, language or hearing therapy
X3128 - Group speech, language or hearing therapy (not to exceed 3 patients)
X3129 - Group occupational therapy (not to exceed 3 patients)
X3130 - Individual occupational therapy, excluding initial or periodic evaluation
X3132 - Individual occupational therapy evaluation
X3133 - Individual occupational therapy reevaluation
X3134 - Individual physical therapy evaluation
X3135 - Individual physical therapy reevaluation
X3136 - Individual physical therapy - direct one-on-one patient contact by the provider,
        (use of dynamic activities to improve functional performance)
X3137 - Group physical therapy (not to exceed 3 patients)
X3138 - Physical performance test or measurement with written report (i.e.,
         musculoskeletal, functional capacity)
Family Planning Clinics

Family Planning Clinics are programs receiving Title X funding and/or Maternal Child Health (MCH) funding which provide family planning services.

Family planning services are those services which are prescribed to individuals of childbearing age for the purpose of enabling them to freely determine the number and spacing of their children.

Covered Services

- Comprehensive visits - initial and annual
- Brief/Limited Visits
- Contraceptive supplies and devices
- Pap Smear
- Pregnancy Test

Comprehensive visits include the following services:

- Evaluation of medical history or update
- Patient education
- Patient counseling
- Weight
- Blood Pressure
- Urinalysis; routine
- Hematocrit
- Physical Examination
- Collection of Pap smear
- GC culture
- Wet mount, when indicated
- VDRL, when indicated
- Rubella titer, if indicated

Limited Visits include the following services:

- Evaluation of medical history or update
- Patient education
- Patient counseling
- Any other service listed under comprehensive visit which is indicated for presenting a problem

Brief visit includes the following services:

- Patient Evaluation
- Patient Counseling

Limitations

Wyoming Medicaid does not reimburse for infertility services, including counseling, artificial insemination and reversal of sterilizations.
Reimbursement Guidelines

Diagnosis Codes

These codes should be used for visits when any type of contraceptive management is provided:

- V24.9 Unspecified contraceptive management
- V25.0 General counseling and advice
- V25.01 Prescription of oral contraceptives
- V25.02 Initiation of other contraceptive measures (fitting of diaphragm;
- V25.09 Other Family planning advice
- V25.1 Insertion of intrauterine contraceptive device
- V25.4 Surveillance of previously prescribed contraceptive methods
  Checking, reinsertion, or removal of contraceptive device, Repeat
  prescription for contraceptive method, Routine examination in
  connection with contraceptive maintenance Excludes: presence of
  intrauterine contraceptive device as incidental finding V45.5)
- V25.40 Contraceptive surveillance, unspecified
- V25.41 Contraceptive pill
- V25.42 Intrauterine contraceptive device (Checking, reinsertion, or removal
  of Intrauterine device)
- V25.43 Implantable, subdermal contraceptive
- V25.49 Other contraceptive method
- V25.5 Insertion of implantable subdermal contraceptive
- V25.8 Other specified contraceptive management - post

These codes should be used for visits when contraceptive management is not provided:

- V72.3 Gynecological examination (Pap smear as part of general
  gynecological examination, pelvic examination (annual) (periodic)
- V76.2 Cervical Pap smear without general gynecological

This code should be used for visits when billing pregnancy test X5666

- V72.4 Pregnancy examination or test, pregnancy unconfirmed (Possible
  pregnancy, not (yet) confirmed Excludes: pregnancy examination
  with immediate confirmation (V22.0-V22.1)
This code should be used for visits when billing pap smear handling X5661, and chlamydia kit X5956.

V68.89 Other specified administrative purpose

Procedure Codes

A4261 Cervical Cap for contraceptive use.
J1050 Depo Provera Aq. injection 100 mg
J1055 Depo Provera injection 150 mg
X5600 Female Condom
X5601 Initial Comprehensive Visit
X5606 Annual Comprehensive Visit
X5611 Brief Visit
X5616 Limited Visit
X5621 Cervical Cap
X5626 Oral Contraceptives - per cycle
X5631 IUD - invoice required
X5636 Sponge or contraceptive film
X5641 Foam with applicator
X5646 Condoms - dozen
X5651 Diaphragm
X5656 Jelly or Cream - per tube
X5661 Pap Smear Handling
X5666 Pregnancy Test
X5956 Chlamydia Kit

The number of units must be specified in field 24G of the HCFA-1500 claim form for contraceptive supplies and devices. A three-month supply of oral contraceptives is allowed.
Federally Qualified Health Care Centers (FQHC)

Wyoming Medicaid will reimburse encounters to Federally Qualified Health Centers. An encounter is a face to face visit with an enrolled health care professional (physician, physician assistant, nurse practitioner, nurse midwife, psychologist or social worker). The place of service may be the office, emergency room, home or nursing facility. Multiple encounters with one or more health professional that take place on the same day and at a single location, constitute a single visit except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

HEALTH CHECK (well child) Encounter:

The Wyoming Medicaid Program encourages FQHC's to participate in the HEALTH CHECK program as outlined in the Consultec Medical billing manual. When an encounter meets the criteria for a HEALTH CHECK exam or if a referral is made, use the appropriate HEALTH CHECK encounter code.

Reimbursement Guidelines

Providers are required to use the following local codes when billing an encounter on the HCFA-1500.

- X5855 Federally Qualified Health Center Encounter
- X5515 HEALTH CHECK Encounter
- X5515 RE HEALTH CHECK Encounter w/referral

An encounter will be paid at a facility specific encounter rate established by Medicaid. This rate will cover all services provided during the encounter regardless of what the actual charges are.
HEALTH CHECK - EPSDT

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program was enacted by Congress mandating that states provide eligible children with well-child screening, diagnostic and treatment services through their Medicaid programs. EPSDT in Wyoming is referred to as HEALTH CHECK. A HEALTH CHECK examination includes:

1. A comprehensive health and developmental history including:
   a developmental screen;
   a nutritional screen; and
   a mental health screen.

2. An unclothed physical examination.

3. Appropriate immunizations.

4. Appropriate laboratory tests including lead toxicity assessment;

5. Age appropriate health education, including anticipatory guidance.

6. Vision screening and direct referral as medically indicated.

7. Hearing screening and direct referral as medically indicated.

8. Dental screening and initial referral when appropriate.

These components are discussed in more detail on the following pages.

Note: A comprehensive EPSDT Screening examination is referred to as a "HEALTH CHECK." "Screening" is defined as a quick and simple procedure by a HEALTH CHECK practitioner to determine the need for a full assessment by a qualified specialist, i.e. a dental screening during a routine HEALTH CHECK could result in a direct referral to a dentist.
COMPONENTS OF A HEALTH CHECK PHYSICAL

The following minimum components of a comprehensive physical must be performed during each HEALTH CHECK:

Health and Developmental History

The purpose of a health and developmental history is to gather information about those diseases and health problems for which no single standard screening test has been developed and to compile historical information about the child and the child's family. Answers to a standard set of questions can serve to identify those children who may be at substantial risk of having a significant health problem. The health and developmental history should also provide information on: the child's brothers and sisters, growth history, conditions suffered by blood relatives, previous medication, immunizations, allergies, and developmental histories of the patient and other family members.

Developmental Screening:

A developmental screening is defined as the range of activities surrounding the examination of the child, adolescent, and young adult in order to determine whether they fall within the normal range of achievement for the patient's age group and cultural background. The developmental screening is performed during the HEALTH CHECK for all ages. Information from the parent or other person who has knowledge of the patient, observation, and talking to the patient are utilized in assessing the patient's behavior.

The following elements are recommended to be included in the developmental screening of children of all ages:

- Gross motor development, focusing on strength, balance, locomotion.
- Fine motor development, focusing on eye-hand coordination.
- Communication skills or language development, focusing on expression, comprehension and speech articulation.
- Self-help and self-care skills.
- Social-emotional development, focusing on the patient's ability to engage in social interaction with other children, adolescents, parents and other adults.
- Cognitive skills, focusing on problem solving or reasoning.

As the child grows through school age, the focus of the screening should be on visual-motor integration, visual-special organization, visual sequential memory, attention skills, auditory processing skills, and auditory sequential memory.

For adolescents, the orientation should encompass areas of special concern such as the potential presence of learning disabilities, peer relations, psychological/psychiatric problems and vocational skills.
Children determined to be in need of further assessment as a result of the developmental screening should be referred to appropriate state and community resources.

**Nutritional Screening:**

The child's nutritional status, eating habits, and the use of alcohol and tobacco, are to be screened at the time of the physical examination. Evaluation is also suggested for the following groups:

- Children who demonstrate weight loss or no weight gain over a period of time.
- Children who are considerably overweight in proportion to their height or greater than the 95th percentile weight for height.
- Other variations from expected growth parameters such as weight for age and height for age below the 5th percentile.
- Diseases in which nutrition plays a key role such as cardiovascular disease, hyperlipidemia, gastrointestinal disorders, hypertension, metabolic disorder, physical and mental handicaps affecting feeding, allergies, surgery and burns.

**Mental Health Screening:**

Mental health and anticipatory guidance on normal growth and development must be included during each comprehensive examination.

No list of specified tests and instruments is prescribed for identifying mental health problems in order to avoid any connotation that only certain tests or instruments satisfy state and federal requirements. However, during the assessment the HEALTH CHECK screener should consider the patient's social interaction, behavior, thinking patterns, feelings and physical problems such as problems sleeping, etc.

In the event that a referral for a complete mental health assessment is indicated, Medicaid covers services provided through Community Mental Health Centers and physician providers of psychiatric services.

**Unclothed Physical Examination**

The unclothed physical examination includes specific elements as appropriate for the child's age and health history, including:

1. Body measurements;
2. Blood pressure;
3. Pulse;
4. General appearance;
5. Skin evaluation;
6. Facial features evaluation;
7. Ears, eyes, nose and throat inspection;
8. Pulmonary evaluation/auscultation of lungs, chest configuration and respiratory movements;
9. Auscultation of heart and palpation of femoral arteries;
10. Abdominal evaluation of musculature, organs, masses;
(11) Urogenital evaluation;
(12) Neurological evaluation including gross/fine motor coordination;
(13) Vocalization and speech appropriate for age; and,
(14) Orthopedic evaluation including muscle tone and scoliosis.

Documentation of the results of all screening components must be retained in the medical record.

**IMMUNIZATIONS**

Immunizations appropriate to age and health history are required components of a HEALTH CHECK visit. The recommended childhood immunization schedule for the United States in 1999 as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) is included in this section.

Medicaid reimburses for administration of vaccine in addition to the reimbursement for the screening examination. The Wyoming Vaccine for Children Program (VFC) supplies provider with some vaccines free of charge and Medicaid reimburse an administration fee of $7.00 for these vaccines. For detailed information on billing for vaccines refer to the Injection section in Chapter 9.
**Laboratory Tests**

The provision of laboratory tests appropriate for the individual's age and population group are required under the HEALTH CHECK Program. Practitioners providing screening services under the HEALTH CHECK Program use their medical judgment in determining the applicability of the laboratory tests or analyses to be performed. If any laboratory tests or analyses are medically contraindicated at the time of screening, provide them when no longer medically contraindicated.

*Blood Lead Level Assessment:*

Wyoming Medicaid, in a joint effort with the Wyoming Department of Health, has issued revised recommendation for blood lead testing as required by the Health Care Financing Administration:

- All Medicaid children are required to receive capillary or venous blood lead test at 12 months and 24 months of age. A blood lead test is also required for any Medicaid child 36 to 72 months of age who has not been previously screened.

- The Wyoming Department of Health (WDH) provides phlebotomy equipment, mailers, postage, expenses of the laboratory blood lead analysis and also maintains a blood lead registry. Blood lead testing supplies can be obtained at no charge by calling the Wyoming Department of Health at 1-800-458-5847 or 777-6951 in Cheyenne.

- Wyoming Medicaid pays for the administration of initial capillary or venous blood lead tests. Wyoming Medicaid also pays for required venous confirmation of initial capillary blood leasd results ≥ 10 ug/dL. The provider who performs the capillary or venipuncture draws may bill Wyoming Medicaid for the blood draw using CPT code 36415.

- The Wyoming Department of Health laboratory performs the analysis of the specimens and therefore Medicaid will not reimburse for this service with the following exception:

  Wyoming Medicaid will reimburse for physician based blood lead analysis using the FDA approved ESA LeadCare Blood Lead Testing when the physician’s office is CLIA certified for the test and the results are reported to the Wyoming Department of Health.
Treatment of Lead Poisoning:

Children with lead poisoning require diagnosis and treatment, which may include periodic re-evaluation, nutritional and educational interventions, pharmacologic treatment and chelation therapy.

Environmental Investigation for Lead:

If the blood lead level persists, environmental investigation to identify the source(s) of the lead is indicated. For further information please contact your county health office or the State of Wyoming Department of Health, Lead Program at (307) 777-6951.

Tuberculin Test:

There are several high-risk categories of people in Wyoming, members of which may be under age 21 and who are candidates for TB screening using the Mantoux PPD Test. These include: (1) persons who have had close contact with an infectious TB case; (2) persons with known or suspected HIV infection; (3) persons with medical risk factors (e.g. silicosis, diabetes mellitus, prolonged corticosteroid therapy, immunosuppressive therapy, leukemia, Hodgkin's disease, end-stage renal disease, chronic malabsorption syndromes, and cancer of the oropharynx or upper GI tract) known to substantially increase the risk of TB once infection has occurred; (4) foreign born persons from high prevalence countries such as Africa, Asia, Latin America and Mexico; (5) Native Americans; (6) intravenous drug users; and (7) other locally identified populations (e.g. the homeless).

All children with positive tuberculin tests should be considered for preventive therapy after active tuberculosis disease is ruled out. If a child (0-15 years) is living in a household with an individual diagnosed with tuberculosis disease, preventive therapy is recommended even if the child's skin test is initially negative.

A single view PA chest x-ray is employed to rule out active pulmonary tuberculosis. Persons with abnormal chest x-rays, who are symptomatic, require sputum smears and cultures to determine the presence or absence of Mycobacterium tuberculosis. Once active tuberculosis disease is ruled out, liver function laboratory tests may be required to provide a baseline before preventive therapy with Isoniazid is begun. Liver profiles may need to be repeated during the six to twelve month course of preventive therapy.

The above guidelines are consistent with the recommendations of the Centers for Disease Control and Prevention, as presented in the Core Curriculum on Tuberculosis, Third Edition, 1994.
HEALTH EDUCATION AND COUNSELING

Health education and counseling, including anticipatory guidance, are required components of the HEALTH CHECK Program. At the outset, the physical examination and the dental screening give providers the initial context for providing health education. Health education and counseling to parents (or guardians) and children should be designed to assist them in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyle practices as well as accident and disease prevention. Literature to assist in the provision of health education and anticipatory guidance is available from the American Academy of Pediatrics, i.e. The Injury and Prevention Program (TIPP), the American Academy of Family Practitioners and the Wyoming Department of Health.

Providers should encourage the parent(s)/guardian(s) and the patient (if age appropriate) to take advantage of the well-child, dental, vision and hearing services covered by Medicaid under the HEALTH CHECK Program.

THE STANDARDIZED TESTING METHODS FOR VISION AND HEARING SCREENING ARE INTENDED TO BE SUGGESTIONS AND ARE NOT INTENDED TO CONNOTE THAT ONLY THESE TESTS OR INSTRUMENTS SATISFY STATE AND FEDERAL REQUIREMENTS.

VISION SCREENING

Administration of age-appropriate vision screening is a required component of the HEALTH CHECK Program. At a minimum, HEALTH CHECK’s should include:

- General external examination and evaluation of ocular motility.
- Visual acuity examination.
- Testing light sense with pupillary light reflex test.
- Intraocular examinations with ophthalmoscope.

Standardized testing methods include:

Visual acuity for distance should be tested separately for each eye. The Broken Wheel test is recommended. However, the Illiterate E test, the STYCAR (Screening Test for Young Children and Retardates) or the Lippman Matching Symbol Chart - HOTV may be utilized. Children 4 and 5 years of age should be tested at 10 to 15 feet.

To determine muscle balance, a cover test and the Hirschberg test (corneal light reflex) should be given. Parents should be asked whether they notice the child's eyes ever turning in or out.

All individuals ages 5 through 20 years should be evaluated for distance visual acuity utilizing
the Illiterate E of the Snellen letters for a linear fashion. The testing should be at 20 feet.

Individuals who wear glasses should be tested while wearing their glasses.

It is recommended that children have their first full eye health and vision exam by an eye care practitioner at age 3, and yearly thereafter to ensure proper development. HEALTH CHECK providers are asked to encourage children wearing prescription eyeglasses to be examined yearly by their eye care practitioner. Abnormalities detected during a HEALTH CHECK screen should be directly referred to an appropriate eye care practitioner.

**HEARING SCREENING**

Administration of age-appropriate hearing screening is required.

Children should be tested using an appropriate test such as the Weber, Rinne, or Puretone Audiometric Evaluation along with history from the parent or guardian. Where behavioral responses are not possible, more objective tests (such as a brainstem audiometric assessment or otacoustic emissions testing) could be used instead.

**Abnormalities detected should be directly referred to an audiologist, ENT or other specialist as appropriate.**

HEALTH CHECK providers are asked to encourage children wearing hearing devices to be examined periodically by their hearing specialist. A general rule of thumb would be every six months after the child has become accustomed to wearing the hearing aid.

**DENTAL ASSESSMENT**

An oral assessment should be completed by the screening provider during each HEALTH CHECK. For children 3 years and under, this assessment should include visual evaluation of the palate and dental ridge including any erupting teeth. Any evidence of infection, inflammation, discoloration, malformation of the dental ridge or palate, or malformation or decay of erupting and/or erupted teeth should be referred to a dentist.

A direct dental referral is recommended for every child three years of age and older, **OR** earlier as medically indicated. The referral must be for an office visit with a dentist, or a professional dental hygienist under the supervision of a dentist. The referral is made by providing the recipient with a dental resource within the local geographic area.

Providers should continue to screen children between the ages of 3 and 21 for obvious abnormalities, such as dental diseases or caries, or abnormalities in the teeth or dental ridge and to encourage them to seek regular appointments for preventive care and dental health education.
HEALTH CHECK Periodicity Schedules

Comprehensive Physicals:

Wyoming recommends the following periodicity schedules as published by the National Center for Education in Maternal and Child Health Bright Futures; Guidelines for Health Supervision of Infants, Children and Adolescents.

Infancy: Prenatal, newborn, first week, 1 month, 2 months, 4 months, 6 months, 9 months

Early Childhood: 1 year, 15 months, 18 months, 2 years, 3 years, 4 years

Middle Childhood Schedule: 5 years, 6 years, 8 years, 10 years

Adolescence: Ages 11-20 each year.

Dental Examinations:

Following the initial referral at age 3*, subsequent examinations by a dental professional are recommended every six months, or more frequently as prescribed by a dentist or other authorized provider.

Hearing Screens:

Standardized testing:

All neonates should be screened in the hospital prior to departure. A standard method of pure tone testing should also be employed by HEALTH CHECK screening providers at ages 4-10, 12 and 18 years of age, or more frequently as prescribed by an authorized provider.

Subjective testing:
Hearing testing may be subjective, by history, through 3 years, as well as at 11, 13-17 and 20+ years of age.

Abnormalities should be directly referred to an appropriate hearing specialist.

Vision Screens:

Vision testing is to be both objective (observation, cover test, Hirshberg light reflex) and subjective (by history) from birth through 3 years, at 10 years and at 16 years of age.

Standardized vision testing should be done on newborns at risk for vision loss in the hospital prior to departure. It is recommended that children have their first full eye health and vision exam by an eye care practitioner at age 3* and yearly thereafter to ensure proper development.

Abnormalities should be directly referred to an appropriate vision specialist.
*Screening providers should use their best judgment in determining if the child is able to behave appropriately at age 3. If not, the referral may be delayed until such time as the child is able to cooperate during the exam.

Interperiodic Examinations

An interperiodic HEALTH CHECK examination is defined as one that is conducted outside the guidelines given in the Periodicity Schedule (Page 16). For example, an eight-year-old child, according to the periodicity schedule, would not require a HEALTH CHECK until age nine. However, if this child has not previously had a HEALTH CHECK, the examination should be completed at age eight.

Interperiodic HEALTH CHECKs and vision, hearing and dental services may also be provided whenever medically necessary to evaluate a suspected physical, developmental or mental problem. A health, developmental, or education professional who comes into contact with the child outside of the formal health care system may refer a child to a HEALTH CHECK provider for an interperiodic HEALTH CHECK if a problem is suspected.

Wyoming Medicaid expects that all components of a HEALTH CHECK exam will be completed for every interperiodic examination.

School and Sports Physicals

HEALTH CHECK providers who have been requested to do a school or sports physical should first determine when the last periodic HEALTH CHECK was completed. If the time elapsed since the last comprehensive examination is less than 12 months and after June 1 of the current school year, the school and sports physical forms should be completed and signed without an office visit. The HEALTH CHECK provider may bill for laboratory work as needed.

If the time elapsed since the last HEALTH CHECK is less than 12 months, but prior to June 1 of the current school year, the provider may bill for a limited routine physical examination, code X5957.

If the time elapsed since the last comprehensive examination is greater than 12 months, a comprehensive HEALTH CHECK should be completed, even though it doesn't fall within the guidelines given in the Periodicity Schedule.

Treatment and Referral Services

Under federal regulations Medicaid must provide for medically necessary (see definition below) treatment services diagnosed as a result of a HEALTH CHECK. Once the patient is examined and referred for treatment, any further diagnosis and/or treatment is then provided through the individual treatment service program. For example, if a patient is found to have an abnormal laboratory test result, such as the tuberculin (TB) skin test, any further referral, diagnosis and treatment is considered diagnostic treatment under physician services.
Many of the HEALTH CHECK referrals may be for conditions that children's Health Services (CHS) covers. CHS and Medicaid have a cooperative agreement and work together to provide appropriate specialty medical care for children identified with special health care needs. CHS provides local care coordination services through Public Health Nursing and assures medical follow-up for Medicaid eligible children with special health care needs. CHS can offer Medicaid families per diem for travel expenses to tertiary care centers. Medicaid eligible special needs children are automatically financially eligible for CHS.

Children identified with possible or diagnosed chronic health problems or disabilities should be referred as usual to CHS. HEALTH CHECK should not change your referral habits. To refer a family to CHS you may send the Public Health Nurse a copy of the medical record, CHS Physician's Referral Form or a copy of the HEALTH CHECK referral form. Call your local Public Health Nursing Office or CHS (777-7941) for more information.

A HEALTH CHECK examination should not be completed on an obviously ill child, as the illness may distort the results. Sound professional judgment should be exercised in determining the appropriateness of examining an ill child. If screening results could be questionable, treatment should be provided and the comprehensive physical rescheduled. If, however, a mild illness is detected during an examination, the exam may be completed and treatment provided on the same date, billing the treatment on a separate HCFA-1500 claim form. Billing for treatment on the same day, as the comprehensive physical examination should be done only when a detected illness or condition requires SIGNIFICANT time and procedures in addition to the time usually spent for a comprehensive physical evaluation.

"Medically necessary" or "medical necessity" is defined as a health service that is required to diagnose, treat, cure or prevent an illness, injury or disease which has been diagnosed or is reasonably suspected; to relieve pain; or to improve and preserve health and be essential to life. The service must be:

- Consistent with the diagnosis and treatment of the recipient's condition
- In accordance with the standards of good medical practice among the provider's peer group
- Required to meet the medical needs of the recipient and undertaken for reasons other than the convenience of the recipient and the provider
- Performed in the least costly setting required by the recipient's condition.

HEALTH CHECK Referral Form:

When an abnormal condition is detected during a HEALTH CHECK, which requires referral to another provider, the HEALTH CHECK Referral Notification Card (Exhibit9.2) must be completed. This form will enable the HEALTH CHECK Program and the DFS to assist the patient in obtaining the referred services (a Federal requirement) and to track abnormal referrals for reporting purposes. The card will be supplied by HCF to enrolled HEALTH CHECK providers. Requests for resupply of these forms should be directed to Consultec at (307)777-5501 or the forms may be copied by providers. **Its use is not optional.**
Expanded HEALTH CHECK Services

OBRA 89 also included a mandate to reimburse all federally allowable diagnostic and treatment services needed to correct or ameliorate a condition detected during an HEALTH CHECK screening examination, even if these services are not otherwise reimbursed under a state's Medicaid Plan. These are called expanded services and include transplants, occupational and speech therapy, private duty nursing, etc. HEALTH CHECK provides medically necessary expanded EPSDT services for children. These services must be referred by a physician and must be prior authorized.

Coverage Limitations

Specific limitations for HEALTH CHECK treatment services are those not approved by the FDA, those that are considered educational, those that are considered experimental and those that are not considered accepted medical practice. The services provided must be medically necessary and provided in the most cost effective manner.
Exhibit 9.2
Medical Referral Notification Card for HEALTH CHECK program

THIS SECTION INTENTIONALLY LEFT BLANK
Billing Procedures

When billing HEALTH CHECK exams, always use diagnosis code V20.2 and the appropriate local procedure code:

- **X5501**: HEALTH CHECK Exam by Physician/Nurse Practitioner
- **X5501RE**: HEALTH CHECK Exam by Physician/Nurse Practitioner with referral to another provider
- **X5511**: HEALTH CHECK Exam by a Public Health Nurse
- **X5511RE**: HEALTH CHECK Exam by a Public Health Nurse with a referral to another provider
- **X5504**: HEALTH CHECK Exam at Indian Health Services (IHS)
- **X5504RE**: HEALTH CHECK Exam at IHS with referral
- **X5514**: HEALTH CHECK at a Rural Health Clinic (RHC)
- **X5514RE**: HEALTH CHECK at a RHC with referral
- **X5515**: HEALTH CHECK Exam at a Federally Qualified Health Center (FQHC)
- **X5515RE**: HEALTH CHECK at a FQHC with referral

The HEALTH CHECK procedure code must appear on the first line of block 24-D of the 1500 claim form or it will not be considered a HEALTH CHECK exam for statistical purposes.

When an abnormality is detected during the HEALTH CHECK exam that requires the patient to be referred to another provider, the "RE" modifier must be added to the appropriate local procedure code (see above).

> **When billing the "RE" modifier, the pre-addressed, postage paid HEALTH CHECK Notification card (described above) must be mailed to Medicaid.**

**BILL X----RE ➤ SEND REFERRAL CARD!**

It is not necessary to use the "RE" modifier when a child is referred for x-rays or lab work, or when billing for the examination of a child with an identified, chronic problem which was previously treated and for which the child is currently receiving treatment.

**THE PROCEDURE FOR THE HEALTH CHECK EXAM MUST BE BILLED ON THE FIRST LINE OF THE CLAIM. BILL ONLY THE EXAM AND ANCILLARY SERVICES PROVIDED ON ONE DATE OF SERVICE ON A CLAIM.**

ANCILLARY SERVICES SUCH AS LAB TESTS AND IMMUNIZATIONS MAY BE BILLED ON THE HCFA-1500 WITH THE HEALTH CHECK PROCEDURE. IF MORE THAN 6 PROCEDURES ARE PERFORMED BILL ADDITIONAL PROCEDURES
SEPARATELY ON AN ADDITIONAL HCFA-1500 FORM.

NOTE: X5957 - Limited Routine Physical - should be used only when an additional examination is required because the most recent HEALTH CHECK exam was performed prior to June 1 of the current school year.

It is appropriate to bill for a HEALTH CHECK exam and an office visit ONLY when all components of the exam have been provided AND a SIGNIFICANT amount of additional time was spent providing other services, i.e. counseling that takes an additional 15 minutes. The HEALTH CHECK EXAM AND THE OFFICE VISIT, WITH APPROPRIATE DIAGNOSIS CODE, MUST BE BILLED ON SEPARATE CLAIM FORMS.

HEALTH CHECK Providers

Wyoming Medicaid believes, as does the American Academy of Pediatrics, "that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, and compassionate. It should be delivered, or directed, by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The provider should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them" (PEDIATRICS Vol. 90 No. 5, Nov., 1992). These characteristics define the "medical home" and describe the care that is expected of HEALTH CHECK Providers.

The following providers may enroll to provide comprehensive HEALTH CHECK examinations: Physicians, nurse practitioners, nurse midwives, and public health nurses.

Ancillary personnel in a physician's office may assist with provision of screening testing and anticipatory guidance.

Physician's assistants and nurse practitioners who are not independently enrolled, but who work under the direct supervision of an enrolled physician, may conduct HEALTH CHECK examinations and bill under the supervising physician's provider number.

Transportation and Scheduling Assistance

Recipients requiring assistance in scheduling appointments or obtaining necessary transportation should contact their local Department of Family Services office.
Hearing Services

Diagnostic or treatment services usually included in a comprehensive evaluation or office visit are integrated in that visit. Special services may be billed separately with procedures codes 92502 - 92599.

Audiologist Services: 92541 - 92599

Audiology services as defined by Medicaid are those tests referred by a physician for a Medicaid recipient and provided by a licensed audiologist to include audioligic function tests with a medical diagnostic evaluation and hearing aid examination.

Audiologic Function Tests

Requirements of Covered Services include:

- Physician orders, diagnostic, and evaluative reports must be current and maintained in the patient's record.
- Basic audio assessment MUST include at a minimum a speech discrimination test, a speech reception threshold, a pure tone air threshold, a pure tone bone threshold, tympanogram, and acoustic reflex testing.

Reporting Standards - Audiologic Function Tests

The audiologist report for Medicaid recipients shall contain the following information:

- Recipients name, date of birth, and Medicaid identification number.
- The results of the audiometric tests performed
- The date the audiometric exam was performed.
- The audiologist's name, address, and license number, in typed or reprinted form.
- Report must be signed and dated by the audiologist.

The audiologist is required to send a copy of this report to the referring physician and maintain a copy in the patient’s medical record.
Hearing Aid Examination

Coverage Requirements

- Physician referral is required.
- The physician must indicate on the referral that there is no medical reason a hearing aid would not be effective in correcting the patient's hearing loss.
- Hearing aid examination should be in a sound attenuated room in a free field setting to determine those acoustical specifications most appropriate for the patient's hearing loss, and will include at least one follow-up visit.

Reporting Standards of Hearing Aid Dispensing

- The audiologist report for services rendered to a Medicaid recipient must contain the following information:
  - Recipient's name, date of birth, and Medicaid identification number.
  - The results of the audiometric tests for each ear.
  - The date the audiometric exam was performed.
  - A summary of the results indicating whether a hearing aid is required, the type of hearing aid, and whether monaural or binaural aids are required.
  - Report shall indicate the audiologist's name, address, and license number in typed or reprinted form.
  - Report MUST be signed and dated by the audiologist.
- The audiologist must provide a copy of the report to the recipient in order for the recipient to obtain a hearing aid. The recipient is allowed to use the hearing aid dispenser of his/her choice.
- The dispenser must retain a copy of the report in the patient's record.
- A copy of the report must be submitted with the claim.

Refer to Medical Supplies/DME section for policy related to purchase of hearing aids.
Hearing Aid Services

"Hearing Aid" is defined as any wearable instrument or device designed for, offered for the purpose of, or represented as aiding persons with or compensating for impaired hearing.

"Hearing Aid Dispenser" is defined as any person, partnership, corporation, or association engaged in the sale, lease, or rental of hearing aids and licensed by the appropriate licensing agency within the state where the business is located.

Covered Services

Medicaid payment for hearing aids will be made only to a licensed hearing aid dispenser.

Medicaid recipients must be referred by a physician for audiologic function tests with medical diagnostic evaluation, and the physician must indicate that there is no medical reason a hearing aid would not be effective in correcting the patient's hearing loss.

A hearing aid will be covered if the examination by the licensed audiologist results in a determination that a hearing aid or aids are needed when there is an average pure tone hearing loss of at least forty (40) decibels over the frequency at 1000, 2000, 3000, and 4000 hertz.

Medicaid reimburses standard hearing aid insurance - per aid, annual fee. Use local code X5612

Reimbursement Guidelines

Dispensing: Medicaid will pay a dispensing fee for the hearing aid which will consist of the initial ordering, fitting, orientation, counseling, two return visits for the services listed and the insurance for loss or damage covered under an extended warranty. A copy of the warranty must be submitted to HCF upon request. These services are billed with HCPCS Level II-V procedure codes.

Hearing Aids: Payment will consist of the manufacturer’s invoice price. A copy of the invoice must be attached to the claims and must contain the model and serial number of the aid.

Repair: Repairs covered under warranty are not billable to Medicaid. V5014 is used to bill for repair which is not covered by warranty.

The following Wyoming Medicaid specific local codes are used to bill for services not covered by V codes:

X5607 Hearing aid batteries, per cell
X5608 Hearing aid rental, per day

X5609 Earplugs, custom made with fitting

X5610 Re-dispensing fee, after repair

Hearing aid insurance for services not covered under warranty or when warranty expires:

X5612 Standard hearing aid insurance, per aid, annual fee.
X5613 Advanced hearing aid insurance, per aid, annual fee.
Indian Health Services

Indian Health Services (IHS), an agency of the U.S. Public Health Services within the Department of Health and Human Services, is the principal federal health care provider for Indian people. Paramount to the goals of IHS is raising the American Indians’ health status to the highest possible level.

The Indian Health Services provides comprehensive health care services, ambulatory medical care and preventative services through its service unit located at Fort Washakie on the Wind River Reservation.

Reimbursement Guidelines under Wyoming’s Medicaid Program

*Definition:* An encounter is a face-to-face visit with a covered health care professional. Multiple encounters with more than one professional or multiple encounters with the same professional on the same day in a single location should be billed as one encounter unless the patient suffers illness or injury which requires additional diagnosis or treatment.

Billing Procedures: Wyoming Medicaid has assigned local codes for billing an encounter on the HCFA-1500. These local codes are paid at the outpatient encounter rate published each year in the Federal Register.

**X5860 Medical Encounter (Within IHS Clinic)**

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. Includes services rendered by a nurse practitioner, physical therapist, or other covered licensed health care professional performing services consistent with their scope of practice.

**X5864 Physician Services (Not within IHS Clinic)**

Visits performed by a licensed physician or doctor of osteopathy to a hospital, nursing facility or the patient’s home within the scope of his/her practice.

**X5861 Dental Encounter (Within IHS Clinic)**

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.

**X5862 Optometric Encounter (Within IHS Clinic)**

All professional (including ancillary services and supplies) performed by a licensed optometrist practicing within the scope of his/her practice.
Routine eye examinations are non-covered for recipient’s age 21 and older. Treatment of eye diseases or eye injury continues to be covered when billed with appropriate diagnosis coding. The reason for the visit must be documented in the medical record.

**X5863 Pharmaceutical Encounter (Within IHS Clinic)**

All prescription drugs, over the counter drugs and medical supplies covered by the Wyoming Medicaid program and not included in the medical, dental, or optometric encounter.

**X5865 Multi-Specialty Encounter (Within IHS Clinic)**

If a patient obtains more than one type of encounter per day (exclusive of Physician’s Services not within an Indian Health Services), consider the encounter a Multi-specialty encounter.

**X5504 Comprehensive Health Screenings (HEALTH CHECKS)**

Indian Health Services is encouraged to participate in the HEALTH CHECK (well child) program for Medicaid children under the age of twenty-one. HEALTH CHECK policy is outlined in this chapter. When an encounter meets the standards for a HEALTH CHECK exam, please use the following HEALTH CHECK encounter codes to assist the Medicaid program in tracking these services more accurately.

**X5504RE Comprehensive Health Screening Referrals (HEALTH CHECKS)**

When a HEALTH CHECK examination indicates the need for a diagnosis/treatment of a suspected abnormality, the physician’s notes must indicate this. The recipient may be referred for a type of service (e.g., dental care) or to a particular physician/specialist. Individuals under age 21 are entitled to comprehensive health examinations.
Laboratory Services

Covered Services

Medically necessary laboratory services are covered when a laboratory is licensed according to the state law in which the services are performed. The Federal Clinical Laboratory Improvement Amendment of 1988 (CLIA) applies to all laboratory services performed in a independent clinical laboratory and those laboratory tests performed in a physician's office.

Requirements

Tests must be ordered by a physician/practitioner for a specific patient.

Tests must be billed by the laboratory performing the test.

Specimen collection fees are allowed when drawing a blood sample through venipuncture (36415) or collecting a urine sample through catherization (53670). Only one collection fee is allowed for each patient encounter.

All of the tests in the panel must be performed in order to use the CPT code for the panel. If the laboratory is not performing all of the required tests listed in the panel code, then the panel code should not be reported. Rather, the individual CPT codes should be reported for tests performed. Panel codes that have similar lab tests should not be billed at the same time, i.e.: CPT code 80049 Basic metabolic panel should not be billed with 80051 Electrolyte panel. Refer to current CPT for specific lab tests included in each panel.

Limitations

Routine handling charges
Stat fees
Post-mortem examination
Specimen collection fees for throat culture or Pap smears

Reimbursement Guidelines

Medicaid fees for clinical laboratory tests are based on amounts allowed by the state Medicare program.

Payment for professional components with a -26 modifier are limited to anatomic pathology.
Medical Supplies and Equipment

Coverage - For detailed information about medical supplies and equipment please refer to the Medical Supplies and Equipment (DME) Manual, or the Physician Services section of this manual.

Durable Medical Equipment is defined as equipment that:

- can withstand repeated use;
- is used to serve a medical purpose;
- is generally not useful to a person in the absence of illness or injury;
- is appropriate for use in the home; and
- will not be used by any other member of the household.

The following medical supplies and equipment may be covered if prescribed by a physician for home use and all medical necessity criteria and guidelines are met. Some supplies and equipment codes may require prior authorization. The medical equipment and supplies provider may need to obtain more detailed information from the prescribing physician before a particular supply or piece of equipment is approved by Medicaid. The objective is to provide supplies and equipment to reduce physical disability and restore the patient to his or her functional level.

Ambulation Devices
Bathroom Equipment
Bedroom Equipment
Diabetic Supplies (not to include insulin and insulin syringes which are billed through the pharmacy program).
Lifts
Orthopedic Devices
Ostomy Care Products
Respiratory Care Accessories, Supplies and Related Devices
Oxygen Contents and Cylinders
Stockings and Elastic Supports
Syringes and Needles
Transcutaneous and/or Neuromuscular Electrical Nerve Stimulators
Urinary Care
Wheelchairs and Scooters

Limitations

Medical supplies should be prescribed in quantities limited to one month’s supply.
Documentation

Documentation which substantiates that the client’s condition meets the coverage criteria must be on file with the provider. The following requirements indicate what documentation must be maintained in the client’s file for all equipment and supplies provided to a Medicaid client:

Written order (physician order/ prescription) For most items or services billed, a written order must be obtained from the physician. Written orders:

- must include the physician’s printed name and be signed by the physician’s own hand (stamps or other substitutes may not be used) and dated; using the date the order is signed; These orders must be on the physician’s personalized prescription pad or letterhead, and in hand by the supplier prior to providing the equipment to the beneficiary.

- must include the diagnosis code (ICD-9-CM) and/or conditions necessitating the item(s) and an estimate of the total length of time the equipment will be needed, in months and years.

- must be sufficiently detailed, including all options or additional features which will be separately billed or which will require an upgraded HCPCS code.

- for supplies provided on a periodic basis, must include appropriate information on the quantity used, frequency of change and duration of need

- must be current to the patient’s condition and must be renewed at intervals of no longer than one year or when requesting a change or addition in services. A new order is required when there is a change in the prescription for supplies.

Certification of Medical Necessity

A certificate of medical necessity (CMN) may be required in addition to the physician’s order, for equipment such as wheelchairs, hospital beds and ventilators, in order to determine whether certain types of equipment, devices or other items are medically necessary.

Medical Records

A physician must maintain a medical record that includes sufficient documentation of the patient’s condition to substantiate the need for the items ordered. This information includes the patient’s diagnosis and other pertinent information including; duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of the functional limitations, other therapeutic interventions and results, and past experience with related items. It is recommended that a copy of the CMN be kept in the patient record; however, the CMN by itself does not provide sufficient documentation of medical necessity. There must be additional clinical information in the medical record. The physician must also retain a copy of the order or have equivalent information in the record.
A patient’s medical record is not limited to the physician’s office records. They may include hospital or nursing home records and records from other professionals including: nurses, physical therapists, prosthetist, orthotist and dieticians. This documentation is not sent to the supplier or Medicaid; however, it may be requested in certain cases.
Nurse Midwife/Nurse Practitioner

Independent nurse midwife and nurse practitioner services are covered when they are in compliance with state laws or regulations in the state in which the service is performed. A nurse midwife must have completed a program of study and gained clinical experience for the management and care of mothers and their newborn infants through the maternity cycle.

The following Independent Nurse Practitioner specialties are covered:

  Pediatric
  Family
  OB/GYN
  Adult
  Geriatric

Wyoming Medicaid does not reimburse the services of independent practicing clinical psychiatric nurse practitioners. These services can only be reimbursed if they are employed by or work under contract with a physician who is enrolled as a provider of psychiatric services, and who have oversight of the patient's care.

All services are billed with procedure codes covered by Medicaid for the specific services. Special modifiers are not required.
Nutritional Services

Covered Services

Enteral Nutrition Therapy

Enteral Nutrition Therapy is considered reasonable and necessary for a patient with a functioning gastrointestinal tract who, due to pathology or nonfunctioning of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength and overall health status. Enteral therapy may be given by nasogastric, jejunostomy or gastrostomy tubes.

General guidelines:

1. Must be ordered by a physician who has seen the patient within 30 days prior to ordering therapy.
2. Patient must have a permanent impairment. (Permanence = > than 90 days)
3. Must have a condition involving the GI tract somewhere between the mouth and the duodenum.
4. Patient must require tube feeding to sustain life.
5. Adequate nutrition must not be possible by dietary adjustments and/ or oral supplements.
6. Enteral therapy is not covered for patients whose nutritional deficiencies are due to a lack of appetite or cognitive problem.
7. Enteral therapy must provide sufficient nutritional benefits.
8. Enteral nutrition is considered a food and is not separately reimbursable to Medicaid outside of the nursing facilities per diem for a recipient residing in a nursing facility.

Documentation:

1. Physician order must include in detail: the nutrients ordered, quantity for administration, the dosing frequency, and the duration of therapy.
2. Documentation of medical necessity (in accordance with the above “Guidelines”) must be kept on file by the provider and made available upon request.

Refer to the Medical Supplies (DME) Manual for further information on enteral nutrition.

Parenteral Nutrition Therapy

Parenteral Nutrition Therapy is considered reasonable and necessary for a patient with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight, strength and general health status. Parenteral therapy is given intravenously.
General Guidelines:

1. Must be ordered by a physician who has seen the patient within 30 days prior to ordering the therapy.
2. Patient must have a permanent impairment. (Permanence = > 90 days).
3. Patient must have a condition of the GI tract that prevents absorption of sufficient nutrients.
4. Patient must require IV feedings to sustain life.
5. Adequate nutrition must not be possible by dietary adjustments, oral supplements, or tube feedings with enteral nutrition.
6. Parenteral therapy is not covered for patients whose nutritional deficiencies are due to a lack of appetite or cognitive problem.
7. Parenteral therapy must provide sufficient nutritional benefits.
8. Parenteral therapy is covered in a nursing facility if the patient meets all the general guidelines, documentation and prior authorization guidelines.

Documentation:

1. Physician order must include in detail: the nutrients ordered, quantity for administration, the dosing frequency and duration of therapy.
2. Documentation of medical necessity (in accordance with the “Guidelines” listed above).
3. Prior Authorization is required for most parenteral codes. The medical supplies/DME provider may need detailed medical history information from the physician to submit to Medicaid to obtain prior authorization for Parenteral Nutrition Therapy.

Medical Supplies used in conjunction with Enteral/Parenteral Nutrition Therapy:

IV poles, pumps, cassettes, etc. may be covered when ordered by a physician and when all medical necessity criteria and other required documentation is present.
Pharmaceutical Services

Coverage

Legend Medications

Legend medications may be covered if:

1. they are ordered by a licensed prescribing practitioner; and
2. the manufacturer has signed a rebate agreement with HCFA; and
3. the product has been assigned an NDC number; and
4. the manufacturer has submitted all product data to First Data Bank; and
5. the medication is not a DESI drug as determined by the FDA; and
6. the medication does NOT fall into one of the restricted categories.

Over-The-Counter (OTC) Drugs and Supplies

Wyoming Medicaid reimburses for over-the-counter products in certain therapeutic classes when, in the judgment of the prescriber, such drugs and products may be indicated for the condition being treated, precluding the need for a legend product.

OTC drugs and products may be covered if:

1. they are ordered by a licensed prescribing practitioner; and
2. furnished to a recipient NOT residing in a nursing facility (OTC’s are covered in the nursing facility per diem and are not separately reimbursable through Medicaid); and
3. the medication or product has been assigned an NDC number or UPC code; and
4. the manufacturer has submitted all product data to First Data Bank; and
5. the medication falls into one of the categories listed below.

The OTC therapeutic classes covered by Medicaid are:

- Analgesics
- Antacids (including H-2 Antagonists)
- Antidiarrheals
- Antihistamines
- Antitussives
- Contraceptive products
- Food thickeners
- Insulin
- Laxatives
- Nutritional products (enteral nutrition)
- Pediatric and prenatal vitamins
- Sodium Chloride for nebulizer use
- Supplements (calcium and iron)
Topical antibiotics, antifungals, antiparasitics
Vaginal antifungals

Nutritional Services

Refer to page (?) for general guidelines regarding prescribing and providing enteral and parenteral nutrition therapy, or for more detailed information refer to the Medical Supplies Manual.

Limitations

Legend Drug Restrictions

Wyoming Medicaid WILL NOT COVER the following products:

- Anorexiants which are not indicated for narcolepsy or hyperkinesis
- Agents used for weight gain
- Agents used to promote fertility
- Retin-A, when used for cosmetic purposes
- Agents used for the stimulation of hair growth
- Agents used for smoking cessation
- Drug products classified as DESI by the FDA

Provider Guidelines

Selection of Brand Name or Generic Drug Products

Physicians and pharmacists are encouraged to use generic drug products. However, if the prescriber perceives that the use of a brand name drug product is a medical necessity for a Medicaid recipient, the prescriber must write "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" on the face of the prescription order AND sign on the “Dispense as Written” line of the prescription. The physician must write “BRAND NECESSARY” or “BRAND MEDICALLY NECESSARY” in his or her own handwriting. Prescriptions for “BRAND MEDICALLY NECESSARY” may not be called into the pharmacy. The pharmacy will not be reimbursed for the brand name drug product per federal law if the above guidelines are not followed.

Maintenance Medications

Although most prescriptions for Medicaid recipients may be dispensed for a 34 day supply or 100 quantity, whichever is greater, prescriptions for maintenance medications should be ordered and dispensed in a 90-day supply. Do not order a 90-day supply for a maintenance medication until the patient’s dosage has been stabilized to avoid costly waste of medication. Medications for MMP (Minimum Medical
Program) recipients are still limited to a 30 day supply.

The therapeutic classes of covered maintenance drugs are:

- Anti-arrhythmic medications
- Anti-asthmatic medications
- Anti-convulsant medications
- Anti-diabetic medications
- Anti-Parkinsons medications
- Cardiac medications
- Diuretics
- Hormones (estrogens, progestins, thyroid)

Prescription Limits

Medicaid has eliminated prescription limits to promote patient care. All prescriptions must be medically necessary and the most cost effective. **A limit of 3 prescriptions per month still applies for recipients of MMP (Minimum Medical Program).**

Copay for Prescriptions

With the exception of MMP recipients, all recipients are required to pay a $2.00 copay per prescription at the pharmacy unless:

1. they are under 21 years of age; or
2. they are pregnant (exception ends on day of delivery); or
3. they are living in a nursing facility; or
4. they are receiving family planning services (copay exception applies to
5. they are receiving Long Term Care Home and Community Based Waiver Services.

**MMP (Minimum Medical Program) recipients are required to pay a $25.00 copay per prescription.**
Physical Therapy

Covered Services

Wyoming Medicaid covers restorative physical therapy services when provided by or under the direct supervision of a licensed physical therapist upon written orders of a licensed physician. If services are provided by unlicensed personnel, the licensed physical therapist must be in constant attendance.

Covered physical therapy services must relate directly and specifically to an active treatment plan established by the physician. Independent physical therapy services are only covered in an office or home setting. They are not covered in a Nursing Facility.

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:

1. prescribed during an inpatient stay continuing on an outpatient basis; or
2. as a direct result of outpatient surgery or injury.


Covered when a physician or physical therapist applies physical therapy and/or rehabilitation techniques to improve the patient’s functioning. These techniques or therapy may include mobilization/manipulation, manual lymphatic drainage (massage), traction or other types of manipulation in one or more regions for 15 minutes of direct patient to physician/therapist contact.

Physician's Renewal Orders

The ordering physician must certify that:

1. The services are medically necessary
2. A well documented treatment plan is established and reviewed by the physician at least every 30 days.
3. Outpatient physical therapy services are furnished while the patient is under their care.

Documentation Requirements

The physician’s treatment plan must contain the following:

1. Diagnosis and date of onset of patient's condition
2. Patient's rehabilitation potential
3. Modality(ies)
4. Frequency
5. Duration (interpreted as estimated length of time until the patient is discharged)
from physical therapy)
6. Physician signature and date of review are required
7. Physical therapist's notes documenting measurable progress and anticipated goals
8. Renewal orders (at least every 30 days) certifying the need for continued therapy and any changes.

Limitations

Wyoming Medicaid covers manipulative therapy, 97140, only when provided by a physician.

The following CPT codes are not covered:

97535
97537
97545
97546

CPT procedure codes that are not listed in the PHYSICAL MEDICINE section ARE NOT covered by Wyoming Medicaid.

Restorative and maintenance physical therapy is covered for recipients under the age of 21 who have chronic disabilities, through Developmental Centers or the school system.

Supplies

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

Evaluation Code

Physical therapy evaluations are covered using code Q0086
Physician and Other Practitioner Services:

Wyoming Medicaid covers services furnished by physicians and other practitioners as specified in this section. Services provided in a physician office, under the direct supervision of a physician, by a physician's assistant, licensed clinical psychologist, licensed clinical social worker and board certified master's level counselor are billed with the supervising physician's Medicaid provider number. Refer to the service descriptions within this section for additional information on specific requirements.

Refer to sections on Nurse Practitioners, Laboratory, Radiology, Hearing Services, and Physical Therapy for information applicable to these specific services when provided in a physician or practitioner’s office.
Abortion

Covered Services

Legal (therapeutic) abortions and abortion services will only be paid by Wyoming Medicaid under the following conditions:

A physician certifies in writing that:

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

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

3. the pregnancy is the result of incest.

The reporting requirements associated with sexual assault are defined in W.S. 35-6-117.

Reimbursement Requirements

A Wyoming Medicaid Abortion Certification Form must accompany all claims for abortion and abortion related services. This requirement includes claims from the attending physician, assistant surgeon, anesthesiologist, pathologist and hospital. The attending physician is required to supply all other billing providers with a copy of the consent form. Chapter 4 of this manual contains a sample Abortion Certification Form (Exhibit 4.10 on page 91) as well as instructions for completing the form (Exhibit 4.5 on pages 80-81).

- Submission of medical records is not required prior to payment; however, documentation of the circumstances of the case must be maintained in the medical records and records of agencies to which a sexual assault is reported.

- Therapeutic abortions must be billed using CPT codes 59840 through 59866. 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.

Retroactive Eligibility

Reimbursement is available for those induced abortions performed during periods of retroactive eligibility ONLY IF the Abortion Certification Form is completely filled out prior to performing the induced abortion to certify that the above condition has been met.
Allergy and Clinical Immunotherapy

Coverage

Allergy testing must be performed under the direct supervision of a physician and must include observation and interpretation of the tests' significance in relation to the history and physical examination.

Limitations

Wyoming Medicaid does not cover sublingual, intracutaneous, and subcutaneous provocative and neutralization therapy for food allergies.

Reimbursement Guidelines

An evaluation and management service code is allowed to obtain the history and conduct a physical examination. Subsequent evaluation and management may be billed when SIGNIFICANT services are performed in addition to testing or immunotherapy.

Allergy Sensitivity Testing 95004 Through 95078

The actual number of tests performed must be entered as units in the unit’s column of the HCFA-1500 claim form.

Allergy Immunotherapy 95115 Through 95199

When billing code 95125, specify the number of injections. Codes 95144 requires that the number of vials be specified in the units column.

Professional services for immunotherapy which do not include the extract should be billed with CPT codes:

95115       Single injection
95117       Multiple injection
Anesthesia Services

Coverage

Anesthesia services include pre and postoperative visits, anesthesia care during the procedure, administration of fluids and/or blood incident to the anesthesia or surgery, and the usual monitoring procedure. Medicaid covers those anesthesia services which are rendered by a licensed anesthesiologist or Certified Registered Nurse Anesthetist (CRNA).

Procedure code 99360 should be used only by physicians for standby anesthesia services. Do not use this code in addition to charges for anesthesia, or multiply it by anesthesia time units. Standby anesthesia services are covered when the physician is physically present in the operating suite and performing the following functions:

1. Monitoring the patient's condition
2. Making medical judgments regarding the patient's anesthesia needs
3. Standing ready to furnish anesthesia services as necessary to a specific patient who is known to be in potential need of such services

Anesthesia Consultations - rendered as a result of any direct or indirect patient care are included in the basic fee for anesthesia services and are not reimbursable separately. However, if an anesthesiologist is requested to consult with another physician or hospital anesthetist, or if a physician examines a patient to determine the appropriate agent and does not furnish direct anesthesia services, then the anesthesiologist may bill for a separate consultation.

Intrathecal Injection for Labor and Delivery - The CPT code 62274, injection of anesthetic substance (including narcotics), diagnostic or therapeutic, subarachnoid or subdural, single, will be the code accepted by Wyoming Medicaid for intrathecal injection for labor and delivery. This injection is not included in the global obstetric rate. Limitations are as follows:

The maximum number of billable units will be 1. Additional units will require documentation for review. No time will be billable for this procedure.

The code cannot be billed with any other anesthesia code unless supporting documentation is sent for review.

Physicians, anesthesiologists, and CRNAs will be covered by Wyoming Medicaid to perform the intrathecal injection.

Limitations

Medicaid will not reimburse for anesthesia services which are performed in conjunction with a non-covered surgical procedure, or a procedure requiring recipient consent (hysterectomy or sterilization) when proper consent was not obtained. Any procedure requiring informed consent must have a copy of the surgeon's consent form attached to the claim, (i.e.: hysterectomy, sterilizations and abortions).
Charges for starting IV’s or patient intubation are included in the basic anesthesia fee and will not be paid as separate charges.

**Reimbursement Guidelines**

*CPT 00100 - 01999 Anesthesia*
Medicalai*d reimburses for anesthesia services, CPT codes 00100 - 01999, based on the units of the anesthesia procedure and the time units allowed. The total units (base units and time units) are multiplied by a conversion factor to determine the allowed amount. Medical supervision is not reimbursed.

*Time Units* - Anesthesia time which will be reimbursed by Medicaid begins when the anesthesiologist starts to prepare for the induction of the anesthesia and ends when the anesthesiologist is no longer in personal attendance. Submit claim for anesthesia time as the total number of **minutes of anesthesia time** for the surgery(ies) performed. Minutes are automatically converted by the system to reflect one unit for each 15-minute period.

*Base Units* - Relative Value Units for anesthesia services are based on McGraw Hill Relative Value Guide for physicians.

*CPT Surgery Codes 10040-69979*
CPT procedures codes 20550, 36405 - 36410, 36420 - 36425, 36481, 62289, 64400 - 64530, 62270 - 62282, 62350 - 62368, 63780, 36400, 36488, 36489, 36490, 36600-36660 and 31500 may be used for introduction/injection of anesthetic agent (nerve block) diagnostic or therapeutic. Time units are not billable for surgery codes in the CPT section 10040 - 69979.

CPT procedures codes used to identify qualifying circumstances (patient age, physical status) are not covered.

Modifiers are not accepted.

When multiple procedures are performed during the same period of anesthesia administration, both procedures can be billed and supporting documentation must be attached to the claim.
Consultation Services

Covered Services

Wyoming Medicaid's coverage and limitations for medically necessary consultation services are in accordance with AMA CPT Coding guidelines:

Medicaid covers consultation services rendered by a physician whose opinion or advice is sought by a physician or other appropriate source for further evaluation and/or management of a patient for a specific problem.

The request for a Consultation from the attending physician or other appropriate source and the need for the consultation must be documented in the patient's medical record.

The consultant's opinion and any service that was ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source.

Reimbursement Guidelines

A consultation initiated by a patient and/or family, and not requested by a physician, is NOT reported using the initial consultation code but may be reported using the codes for confirmatory consultation or office visits, as appropriate.

If, subsequent to the completion of a consultation, the consultant assumes responsibility for management of all or a portion of the patient's condition(s), the follow-up consultation codes should NOT be used.

In the hospital the physician receiving the patient for partial or complete transfer of care should use the appropriate inpatient hospital consultation code for the initial encounter and the subsequent hospital care codes. In the office setting, use the appropriate established patient code.

There are four subcategories of consultations:

1. office 99241 - 99245
2. initial inpatient 99251 - 99255
3. follow-up inpatient 99261 - 99263
4. confirmatory 99271 - 99275

A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice ONLY. Services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care if the physician has taken over the management of the patient.

If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.
When billing for a consultation, the UPIN number of the referring physician must be entered in field 17A or if the referring provider does not have a UPIN then the provider name must appear in field 17 of the claim form.

Wyoming Medicaid requires Documentation of Medical Necessity (Exhibit 4.11) be attached to a claim submitted by the consulting physician when a recipient is seen for an additional consultation within one (1) year of an initial consultation.

Medical Necessity will be reviewed in accordance with the following policy:

* Documentation that a referring physician has requested an additional consultation.  
* Documentation of the medical condition and/or complications of care requiring an additional opinion or advice.  
* Claims submitted without the Documentation of Medical Necessity will be returned for the required attachment  
* Documentation that does not support the use of consultative services will be denied. The provider can resubmit the claims with supporting documentation for use of the consultative codes or re-code for the appropriate level of evaluation/management services.
Dermatology

Covered Services

Medicaid covers consultative dermatological procedures, as well as medically necessary services rendered in the treatment of dermatological illnesses.

Acne surgery is a covered service; for those recipients who have a disfiguring acne condition. The recipient's medical records MUST document the medical necessity of the procedure.

There are limitations on removal of lesions not suspected to be precancerous. If a physician finds it medically necessary to remove a benign lesion, ganglion cyst, skin tag, keloid, or wart, the recipient's medical records must clearly document the medical necessity and condition present that will support the procedure performed:

- Restoration of a body area affected by the lesion, cyst, keloid or wart
- Recurring infections, bleeding or irritation at the site
- Suspicious lesions or changes in any lesions causing physician concern
- Destruction of cutaneous vascular lesions for the treatment of hemangiomas and vascular malformations, i.e.: port wine stains
- Documentation supporting clinical evidence that significant medical complications may occur if treatment is not rendered

Limitations:

- Services performed primarily for cosmetic reasons
- Services which are not medically necessary
- Services which are done for patient convenience

If, prior to rendering the service, the provider and the recipient mutually agree in writing to have services performed which are not covered, and the recipient is informed of their financial responsibility, then the recipient may be billed for the services rendered.
Home Visits

Covered Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99341 - 99345</td>
<td>New patient</td>
</tr>
<tr>
<td>99347 - 99350</td>
<td>Established patient</td>
</tr>
</tbody>
</table>

In a continuing effort to assure continuity of care for pregnant women and children the following policy became effective September 1, 1997:

Wyoming Medicaid covers home care visits, billed by a physician, for pregnancy related conditions, infant and child related medical services provided by a registered nurse employed by the ordering physician. This benefit is not intended to replace those services available in the community through other agency programs, (Best Beginnings, PHN, Home Health, etc.) But to offer the attending physician another alternative to care for children and pregnant women in the home setting. Home visits are a covered service for the following situations:

1. episodic acute care
2. high risk pregnancy monitoring
3. premature birth monitoring
4. failure to thrive
5. cases determined by the physician to need limited home monitoring

The physician is required to establish and keep on file, protocols necessary to monitor the services performed in the home setting. Care rendered by the registered nurse must be within their scope of practice and be countersigned by the physician who ordered the visit.

Services provided must be billed by the physician using the physician provider number. The following documentation must be included in the recipient's medical record.

1. Documentation of physician order and treatment plan of care
2. Documentation of observed medical condition, progress at each visit, any change in treatment, and recipient's response to treatment
3. Documentation of coordination of care between office and home visit
Hospital Services

Covered Services

Medicaid covers physician visits furnished in hospitals when the hospital admission meets the certification requirements of Medicaid admissions guidelines and/or prior authorization requirements.

Limitations

Medicaid will reimburse the admitting physician for only one initial visit per recipient for each hospital stay. A comprehensive inpatient hospital visit is not allowed within 30 days of a previous Hospital admission with the same diagnosis.

Medicaid will not reimburse a comprehensive hospital inpatient exam on the same day as an office visit or nursing home visit or ER visit by the same provider.

For initial inpatient encounters by physicians other than the admitting physician use initial inpatient consultation codes or subsequent hospital care codes.

Reimbursement Guidelines

Initial Hospital Care - New or Established Patient  99221-99223

All evaluation and management services related to and provided on the same date as an inpatient admission are considered part of that hospital admission. They are NOT reported separately. This applies regardless of the setting in which the services are provided, (e.g., observation status, physician's office, or hospital emergency department, etc.).

Subsequent Hospital Care  99231 - 99233

Subsequent visits are limited to one visit per day unless a Documentation of Medical Necessity form is attached and approved by Medicaid. All subsequent hospital care visits are to include reviewing the medical record and the results of diagnostic studies and changes in the patient's status since the last assessment by the physician.

Observation or Inpatient Care Services 99234 - 99236

These codes are used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. For patients admitted to observation or inpatient care and discharged on a different date, see codes 99218-99220 and 99217, or 99221-99223 and 99238-99239.
Hospital Discharge Services 99238 - 99239

The physicians may bill for the final day of hospital care of a multiple day stay if they provide a final examination, discussion of the stay, instructions for continuing care and preparation of discharge records. These codes are NOT allowed when an initial or subsequent hospital visit is billed on the day of discharge. These codes are only to be used to report services provided to the patient on the date of discharge from a multiple day stay. Only one code may be used.

Hospital Observation Services 99218 - 99220

These codes are used to report evaluation and management services provided to patients admitted to observation status in a hospital. It is not required that the patient be located in an observation area designated by the hospital as a separate unit. These codes are to be used based on the level of care the patient receives rather than location.

To report services provided to a patient admitted to the hospital after receiving hospital observation care services on the same date, refer to the hospital inpatient billing instructions. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission is reported using the appropriate initial hospital care codes. Do not report the observation discharge in conjunction with the hospital admission.

All evaluation and management services related to and provided on the same day as an admission to observation status are considered part of that admission. Do not report them separately. This applies regardless of the setting in which the services are provided (e.g., a hospital emergency department, a physician's office, or a nursing facility, etc.).

These codes apply to all physician services provided on the same date of patient admission to observation status. Do not use these codes for postoperative recovery if the procedure is considered a global surgical procedure.

Observation Care Discharge Services 99217

This code is to be utilized by the physician to report all services (final examination of patient, discussion of hospital stay, instructions on continuing care, and preparation of discharge records) provided to a patient on discharge from “observation status” if the discharge is on a date other than the initial date of “observation status”.

Concurrent Care

Defined as inpatient hospital care by two or more physicians to the same patient at the same time. Physicians who are providing concurrent care should use the subsequent hospital care billing codes. Medicaid will reimburse for these services when ALL of the following circumstances are met:
1. The physicians have different specialties or subspecialties;
2. The condition or injury involves more than one body system;
3. The condition or injury is so severe or complex that one physician alone cannot handle the patient's care; and
4. The physicians are actively co-managing the patient's treatment.

If physicians of the same or similar specialty render care to the same patient for the same condition for the same time, only the services of the attending physicians are covered.

Critical Care Visits 99291, 99292

Critical care is the treatment of critically ill patients experiencing a variety of medical emergencies requiring the constant attendance of the physician. Critical care is usually, but not always, given in a critical care area. The use of these codes includes:

1. the interpretation of cardiac output measurements,
2. chest x-rays
3. blood gases
4. data stored in computers
5. gastric intubation
6. temporary transcutaneous pacing
7. ventilator management and vascular access procedures

Any services performed which are not listed above should be reported separately.

The critical care codes are used to report the total duration of time spent by a physician providing constant attention to a critically ill patient. Code 99291 is used to report the first hour of critical care on a given day. It should be used only once per day even if the time spent by the physician is not continuous that day. Code 99292 is used to report each additional 30 minutes (30 minutes = 1 unit) beyond the first hour.

Services for a patient who is not critically ill but happens to be in a critical care area are to be reported using subsequent hospital care codes not critical care.

Prolonged Service 99354 - 99359

Prolonged services that exceed three hours on the same date of service require Documentation of Medical Necessity attached to the claim. Documentation must also be accurately recorded in the patient's medical record, including the purpose and actual time the physician was detained.

Physician Standby Service 99360

A physician required to "standby" (e.g. operative standby, standby frozen section, for c-section/high risk delivery for newborn care, for monitoring EKG) may charge for services in addition to the regular medical service each 30 minutes. This code may not be reported in
addition to CPT code 99436 (attendance at delivery).

**Emergency Room Services**  99281 - 99288

Medicaid covers physician services performed in the emergency department of a hospital when furnished by:

1. a hospital-based emergency room physician;
2. a private physician who furnishes emergency room services through arrangement with the hospital; or
3. a private physician who is called to the hospital to treat an emergency.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled, episodic services to patients who present themselves for immediate attention. The facility must be available 24 hours a day.

Medicaid reimburses for physician direction of emergency care systems and advanced life support when the physician is located in a hospital emergency department or critical care department and is in two-way voice communication with ambulance or rescue personnel outside the hospital. These physician-directed services include but are not limited to:

- Telemetry of cardiac rhythm
- Cardiac and/or pulmonary resuscitation
- Endotracheal or esophageal obturator airway intubation
- Administration of intravenous fluids and/or intramuscular, intratracheal, or subcutaneous drugs
- Electrical conversion of arrhythmia

In all cases the physician must document in the patient's medical record if the patient's visit to the emergency room was actually an emergency situation. Physicians are requested to report any potential abuse of emergency room visits to Medicaid Quality Management and Utilization Review Unit. No distinction is made between new and established patients in the emergency department.

**Neonatal Intensive Care**  99295 - 99297

These codes are used to report services provided by physicians directing the care of a neonate or infant in a neonatal intensive care unit (NICU). The codes represent care starting with the date of admission to the NICU and may be reported only once per day, per patient. Once the neonate is no longer considered to be critically ill, the codes for subsequent hospital care should be utilized.

Care rendered includes management; monitoring treatment of the patient including nutritional, metabolic and hematologic maintenance; parent counseling; and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

The following procedures are also included as part of the global descriptors: umbilical, central or
peripheral vessel catheterization, endotracheal intubation, lumbar puncture and suprapubic bladder aspiration. In addition, specific services are included in the parenthetic note following each NICU code. Any services which are not listed above or not listed with each NICU code should be reported separately.

Newborn Care  99431 - 99440

These codes are used to report the services provided to normal or high risk newborns in several different settings.

NICU Code - 99298

This new code to CPT 1999 covers the procedures of evaluating, managing and helping in the recovering of a very low birth weight infant (less than 1500 grams or about 3.3 pounds). These procedures apply to infants who are no longer critically ill but continue to require intensive care under the constant observation of a healthcare team supervised by a physician. This care may include cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen. Infants in this category of low birth weight are expected to require infrequent changes in respiratory, cardiovascular and/or fluid and electrolyte therapy.

CPT code 99436 - Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn. This code may be reported in addition to CPT code 99431 (History and examination code) but may not be reported in addition to 99440 (Newborn resuscitation code).
Hysterectomies

Covered Services

Hysterectomies are covered in the following circumstances:

Medically Necessary - A medically necessary hysterectomy will be covered when the physician or physician's representative securing the authorization to perform the hysterectomy has informed the patient verbally and in writing PRIOR to the surgery being performed that the hysterectomy will render the individual permanently incapable of bearing children. The patient must sign the written acknowledgment that she has been provided this information and does fully understand the information. It is required that the physician or physician's representative sign the written acknowledgment in ink. Signature stamps will not be accepted and may result in the claim being denied. Documentation of medical necessity must be in the patient’s record.

NOTE: The written acknowledgment of consent statement is acceptable if the patient signs the statement before or after the hysterectomy is performed.

Emergency - When a hysterectomy is performed on an emergency basis because of life-threatening circumstances and the physician determines that prior acknowledgment of consent is not possible, the physician must certify in writing that prior acknowledgment was not possible and describe the nature of the emergency.

Sterility - A hysterectomy performed on a patient who was already sterile before the surgery is not subject to the written acknowledgment requirement; however, the physician must certify in writing that the patient was sterile at the time of the hysterectomy and must state the cause of the sterility.

Limitations

Federal regulations which are established as the guideline for Wyoming Medicaid do not consider hysterectomy to be a sterilization procedure. Therefore, hysterectomies performed solely or primarily for the purpose of rendering an individual incapable of reproducing are not covered by Wyoming Medicaid.

A copy of the COMPLETED Hysterectomy Acknowledgment Consent Form must be attached to each provider's claim. Refer to Chapter Four for an example of the Hysterectomy Acknowledgment Consent Form. It is the responsibility of the originating physician to supply other billing providers with a completed copy of this form. The Sterilization Consent Form WILL NOT BE accepted as a substitute for the Hysterectomy Acknowledgment of Consent Form.
Retroactive Eligibility

Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the physician who performed the hysterectomy certifies in writing that the recipient was informed prior to the operation that the hysterectomy would render her permanently incapable of bearing children and that the procedure was medically necessary.

The physician's written certification or a copy must accompany all claims submitted by the providers. It is the performing physician's responsibility to provide the written certification to other billing providers.
Injections

Immune Globulins - 90281-90399

These codes identify the immune globulin product only and are reported in addition to the administration codes 90780-90784 as appropriate.

RespiGam, an immunoglobulin intravenous antibody for the prevention of respiratory syncitial virus (RSV) is covered only when billed by a hospital and when administered in an outpatient hospital setting due to the monitoring requirements during the infusion therapy and the risk for adverse reactions. RespiGam is covered for the prevention of serious lower respiratory tract infection caused by RSV in children under 24 months of age with bronchopulmonary dysplasia (BPD) or a history or premature birth (under 35 weeks of gestation).

Synagis (palivizumab) may be billed by a physician’s office, an outpatient hospital clinic, or a retail pharmacy. Retail pharmacies may not have Synagis in stock; however, it can be ordered. Use X1565 - Synagis - 100 mg vial. If a vial is shared with more than one patient, charge accordingly. Synagis is covered for:

a. the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus, (RSV) when administered by intramuscular injection at 15 mg/kg given once a month during the anticipated period of RSV prevalence in the community;

b. children under 24 months of age with bronchopulmonary dysplasia (BPD) or a history of premature birth (less than 35 weeks gestation). If Synagis is prescribed outside of the normal prescribing guidelines, the physician should have sufficient medical necessity documentation in the patient’s file to support prescribing this medication.

Vaccines, Toxoids - 90471 - 90749

Procedure codes 90476-90748 identify the vaccine product only and are reported in addition to the immunization administration codes 90471, 90472 unless the vaccine is supplied by the VFC program. The exact vaccine product administered needs to be reported.

Separate codes are available for combination vaccines. It is inappropriate to code each component of a combination vaccine separately.

Vaccine for Children (VFC) Program

The following vaccines are distributed through the Wyoming Immunization Program free of charge, and VFC vaccines purchased on the open market are not reimbursed by Medicaid. An administrative fee of $7 for VFC vaccines is allowed when the appropriate CPT code for the vaccine is billed. The fee for administration of a VFC vaccine is allowed in addition to the fee paid for a Health Check/Well Child examination or other evaluation and management visit.
Questions regarding enrollment should be addressed to the Wyoming Immunization Program at (307) 777-7173.

Vaccines available for children 0 to 18 which are distributed by the VFC Program are:

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>90645</td>
<td>Hib - Hemophilus influenza b vaccine, HbOC conjugate (4 dose schedule), for intramuscular use.</td>
</tr>
<tr>
<td>90646</td>
<td>Hib - Hemophilus influenza b vaccine, PRP-D conjugate, for booster use only, intramuscular.</td>
</tr>
<tr>
<td>90647</td>
<td>Hib - Hemophilus influenza b vaccine, PRP-OMP conjugate (3 dose schedule, for intramuscular use.</td>
</tr>
<tr>
<td>90700</td>
<td>DtaP - Diphtheria, tetanus toxoids, and acellular pertussis vaccine for intramuscular use.</td>
</tr>
<tr>
<td>90702</td>
<td>DT - Diphtheria and tetanus toxoids (DT) adsorbed for pediatric use, for intramuscular use.</td>
</tr>
<tr>
<td>90707</td>
<td>MMR - Measles, mumps, and rubella virus vaccine, live, for subcutaneous or jet injection use.</td>
</tr>
<tr>
<td>90712</td>
<td>OPV - Poliovirus vaccine, (any types), live, for oral use.</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella (chicken pox) Varicella virus vaccine, live, for subcutaneous use.</td>
</tr>
<tr>
<td>90720</td>
<td>DTP-Hib - Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine, for intramuscular use.</td>
</tr>
<tr>
<td>90721</td>
<td>DtaP-Hib - Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine, for intramuscular use.</td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use.</td>
</tr>
<tr>
<td>90745</td>
<td>Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use.</td>
</tr>
</tbody>
</table>

Bill vaccines not supplied by the VFC program with an appropriate CPT code for the vaccine product in addition to the appropriate immunization administration code, 90471 or 90472.

Refer to the section on Health Check for the most current recommended childhood immunization schedule.
Rotashield Vaccine

90680 - Rotavirus vaccine, tetravalent, live. For oral use is covered for the prevention of gastroenteritis caused by rotavirus. The recommended dosing schedule for ORAL immunization with RotaShield in infants is at 2, 4 and 6 months of age. The first dose may be administered as early as 6 weeks of age; with subsequent doses at least 3 weeks apart.

Influenza and Pneumococcal Vaccines

Medicaid covers influenza vaccine and pneumococcal vaccine for patients considered at risk. When a Medicaid recipient is a resident of a long-term care facility, the vaccine and administration are included in the nursing home per diem rate, and NOT paid separately.

Therapeutic or Diagnostic Infusions (Excludes Chemotherapy) - 90780, 90781

These procedures encompass prolonged intravenous injections. These codes require the presence of the physician during the infusion. These codes are not to be used for intradermal, subcutaneous or intramuscular or routine IV drug injections. These codes may not be used in addition to prolonged service codes.

Therapeutic or Diagnostic Injections

Medicaid will cover therapeutic injections if the following conditions are met:
- the drug cannot be given orally, and
- the drug cannot be self administered, and
- the drug is reasonable and necessary for the diagnosis and/or treatment of the illness or injury for which it was prescribed.

Non-covered:
- Appetite suppressants
- Vitamin injections, except for Vitamin B-12, which is limited to recipients with one of the following diagnoses:

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>040.2</td>
<td>Whipple's disease</td>
</tr>
<tr>
<td>094.0</td>
<td>Tabes Doraslis</td>
</tr>
<tr>
<td>123.0-123.9</td>
<td>Cestode infestations</td>
</tr>
<tr>
<td>140.0-239.9</td>
<td>Cancer</td>
</tr>
<tr>
<td>250.6</td>
<td>Diabetic Neuropathies</td>
</tr>
<tr>
<td>266.2</td>
<td>Postlateral Sclerosis</td>
</tr>
<tr>
<td>266.9</td>
<td>Vitamin B Complex Deficiency</td>
</tr>
<tr>
<td>280.0-280.9</td>
<td>Iron deficiency anemias</td>
</tr>
<tr>
<td>281.0-281.9</td>
<td>Other deficiency anemias</td>
</tr>
<tr>
<td>285.9</td>
<td>Normocytic Anemia</td>
</tr>
<tr>
<td>334.0</td>
<td>Friedreich's ataxia</td>
</tr>
<tr>
<td>340</td>
<td>Multiple Sclerosis</td>
</tr>
</tbody>
</table>
| 560.0-560.9| Intestinal obstruction without mention of
Frequency of Vitamin B-12 injections is limited to the following schedule:

- One injection per day for the first week
- One injection per week for the next four weeks;
- One injection per month until the condition is stabilized

**Reimbursement Guidelines**

The appropriate J code MUST be used when submitting claims. (Refer to Appendix D). Reimbursement for J Codes includes an allowance for administration.

Reimbursement for therapeutic injections INCLUDES the cost of administration. This cost is already calculated into the fee for each code.

If multiple drugs are included in a single injection, separate codes may be billed for the drugs, however, the administration fee should be included with only one code.

Injection codes 90788 and 90782 are NOT paid in addition to a J-code. The only exception is when the patient supplies the medication, which must be documented on the claim.

CPT Codes 90782 and 90788 for therapeutic injections will be reimbursed for administration of injection only.

CPT Code J3490 should be used when a J-code for a specific drug is not listed in Appendix D. Documentation of the medication and dosage administered must be listed on the claim. An administration fee will be added to the material fee in pricing and may not be billed separately.

J Code fees are reviewed and updated on an annual basis. If a fee for a specific drug does not cover the provider’s cost in purchasing the drug, the fee may be updated more frequently.
Chemotherapy

Medicaid covers chemotherapy services rendered in an inpatient, outpatient, or office setting for the treatment of cancer.

Covered procedures include:

- Procedures for administration 96400-96549
- Chemotherapy drugs as listed in this manual
- Physicians may bill for professional office or hospital visits in addition to the administration of the chemotherapy and the cost of the drugs.

Limitations

- Preparation of the chemotherapy agent(s) is included in the service for administration of the agent.

Locum Tenens

Wyoming Medicaid may issue a separate provider number to a physician (individual or group) to use in billing for locum tenens services. This option is generally needed when a provider routinely utilizes one or more locum tenens. Payment is made to the provider to whom the locum tenens number is issued.

It is also permissible for a provider to bill for the services of a locum tenens by using their own provider number, except when the locum tenens is assisting a surgeon. When services are billed with a locum tenens number, the medical records will need to substantiate the service that was provided by a locum tenens with an employment agreement.
Maternity Care and Delivery

Covered Services

Wyoming Medicaid covers services normally provided in uncomplicated maternity cases, according to guidelines set forth in the current edition of CPT.

Routine Care Billing Requirements

Wyoming Medicaid accepts total/global care OR individual service billing for routine care.

Billing Total/Global Care: 59400, 59510, 59610, 59618

Billing for total/global care must include at least five antepartum visits, delivery and scheduled postpartum care. Charges are billed on or after the delivery using the date of delivery as the date of service. If a physician or clinic has an agreement with another physician to cover the delivery procedure, the primary physician may utilize global billing and must then reimburse the attending physician for the delivery. Without such an agreement, each physician must bill only for the actual services provided.

Billing Individual Services: Antepartum Care, Delivery, Postpartum Care

The following codes may be used when billing for individual service.

Antepartum Care:

Initial examination and the second and third visit may be billed with the For the fourth, fifth or sixth visit(s) use 59425. Enter first and last dates and

For the seventh visit and any visit(s) thereafter use 59426. Enter first and last

Delivery Only - 59409, 59514, 59612, 59620

Postpartum Care - 59430
Do not bill with a delivery code, which includes postpartum care, (ie: 59400,

Reimbursement Guidelines

• If the physician meets the patient at the emergency room or admits the patient to the hospital for observation, in the instance of false labor, the appropriate ER visit code should be used.

• Pregnancies, which terminate in abortion in any trimester, must be billed using the appropriate abortion procedure code. Prenatal visits and any additional services must be billed separately.

• If sterilization is being considered by the patient, it is suggested that consent should
be obtained at or about the twenty-fourth week of pregnancy thereby ensuring compliance with all Federal and State guidelines. When a sterilization is performed at the time of delivery, it should be billed as a separate procedure. Sterilizations are reimbursed in addition to the delivery only if consent has been obtained using Wyoming Medicaid forms and requirements.

- When billing for the services of an assistant surgeon at a delivery, use the procedure code for delivery only with a -80 modifier, (59409, 59514, 59612, 59620).

- An examination to determine if the patient is pregnant is not considered an initial maternity visit unless a review of the total body system is included. It is general practice that a limited office exam for a perceived condition would be charged at the time of the pregnancy test.

- Do not use the newborn diagnosis and procedure codes with the mother’s recipient identification number. See Chapter 4, page 25 re: newborn billing.

**Intrathecal Injection for Labor and Delivery - 62274**

Injection of anesthetic substance (including narcotics), diagnostic or therapeutic, subarachnoid or subdural, single, will be the code accepted by Wyoming Medicaid for intrathecal injection for labor and delivery. This injection is not included in the global obstetric rate. Limitations are as follows:

1. The maximum number of billable units will be 1 unit. Additional units will require documentation for review. No time will be billable for this procedure.

2. This code cannot be billed with any other anesthesia code unless supporting documentation is sent for review.

3. Wyoming Medicaid will only reimburse physicians, anesthesiologists, and CRNAs for performing the intrathecal injection.
Medical Supplies Furnished by a Physician/Practitioner's Office

A separate manual is available to address in detail the requirements for providers of medical supplies and the coverage issue for these supplies. In general, providers must be enrolled as a medical supply provider to bill for medical supplies and equipment. However, it is not necessary for a physician office to enroll as a medical supply provider in order to bill for medical supplies incident to physician services.

Covered Services

Disposable medical supplies - A medical supply or equipment that is intended for one-time use and not for re-use and specifically related to the active treatment or therapy of the client for a medical illness or physical condition. These supplies have a medical purpose, are consumable and/or expendable and non-durable. This does not include personal care items. Following is a list of disposable medical supplies and appropriate billing codes:

- **A4550** Major surgical tray: Reimbursement may be allowed for a surgical tray if physician's office. Examples of procedures requiring a major tray and will not be reimbursed as such. Reimbursement is NOT provided when the surgery is performed in a hospital.
- **A4460** Ace bandage
- **A4565** Sling
- **A4572** Rib Belt
- **A4580** Cast Supplies
- **A4590** Special cast materials (D: Hexcelite)
- **A4351** Straight Catheter kit
- **L-Codes**
  - **Z4410** Bandages, eye bubbles, per box
  - **99070** Supplies and materials which are not listed above and are beyond those routinely included in an office visit may be billed with this code. Claims for more than $10.00 require an attached invoice. Claims billed with this code will be reviewed to determine if they should have been billed with a specific CPT code. If 99070 appears to be appropriate, claims will be paid at invoice cost, plus shipping and handling, plus 15%.

Limitations

Expendable medical supplies normally used in the physician's office, such as gauze, dressings, syringes and culture plates, are INCLUDED in Medicaid's reimbursement rate for the office visit or test performed. Only the actual cost of disposable medical supplies, such as listed above will be reimbursed separately.

Covered supplies and equipment prescribed by a physician and furnished by an enrolled Medical Supplier for use in the patient's home are reimbursed through the Medical Supply Program, and are subject to the limitations and policies detailed in the Medical Supply Manual.
Nursing Facility Visits

Coverage

Physician visits to patients in a nursing facility are covered when they are medically necessary and are performed to meet the requirements of continued long-term care.

Limitations

When a patient is admitted to the nursing facility in the course of an encounter in another site of service, such as office or emergency room, all evaluation and management services in conjunction with the admission are considered part of the initial nursing facility care if performed on the same date, and will not be reimbursed separately. Initial patient care may be billed only once per long term care stay unless patient has moved to a different facility. Evaluation and management codes billed in addition to code 99303 are not reimbursed when performed on the same date as the admission.

Hospital discharge or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately.

Reimbursement Guidelines

Two subcategories of nursing facility services are recognized. Both subcategories apply to new or established patients.

**Comprehensive Nursing Facility Assessments (99301-99303)**

- **Initial Assessment: 99303** - Evaluation and Management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility.

- **Annual Assessment: 99301** - Evaluation and Management of a new or established patient involving an annual nursing facility assessment.

- **Intermediate Assessment: 99302** - Evaluation and Management of new or established patient involving an intermediate assessment when a patient has had a major change in status, and requires a new plan of care.

**Subsequent Nursing Facility Care per day (99311-99313)**

- **99311** Subsequent nursing facility care, per day, for the evaluation and Management of a new or established patient. *Problem focused.*
99312  Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient. *Expanded problem focused.*

99313  Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient. *Detailed history and exam.*

**Domiciliary Rest Home or Custodial Care**

The following codes are covered for evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component.

99231-99233  New Patient  
99331-99333  Established Patient

**Nursing Facility Discharge Services**

Nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a patient.

99315  Nursing Facility discharge day management; 30 minutes or less.  
99316  Nursing Facility discharge day management; more than 30 minutes.
Office and Outpatient Services

Covered Services

Office Visits

99201 - 99205 New Patient Procedures
99211 - 99215 Established Patient Procedures

99050, 99052, 99054, 99058 may be used in addition to the above codes when services are provided in a physician or practitioner's office for emergency care after scheduled routine office hours.

New Patient
Medicaid considers a new patient to be a patient who is new to the physician or group practice and whose medical and administrative records need to be established. A new patient visit should be submitted once per recipient lifetime per provider. An exception may be allowed when a patient has been absent for a period of three (3) years.

Established Patient
Medicaid considers a routine office visit for an established patient to be a limited service, CPT code 99213. If a provider furnishes services at a higher level, documentation supporting the medical necessity for such services must be maintained in the patient's medical record.

Complex Examinations for Child Protection
Medicaid utilizes the following Medicaid assigned local codes for specific office services:

X5870 Child protection examination, limited
X5874 Child protection examination, intermediate
X5878 Child protection examination, comprehensive

Psycho-social Counseling

X3001 Individual or family counseling per 15 minute unit
X3003 Group counseling per 15 minute unit

These codes are to be used if the physician is not a psychiatrist. These codes may not be billed in addition to other services.

These codes are to be used if the physician is not a psychiatrist. These codes may not be billed in addition to other services.
Case Management

99361 - 99362  Medical team conferences to coordinate patient care when a patient is not present. Coordination of care with other providers or agencies is a component of evaluation and management codes and should not be billed separately.

Care Plan Oversight

99374 - 99380  Physician developing and/or revising of care plan, review of the medical treatment plan and/or adjustment of medical therapy, within a 30 day period; 15-29 minutes and 30 minutes or more.

Telephone Consultations

Separate charges for telephone consultation services will NOT be covered. Charges should be included in the examination or medical service fee.

Diet Instruction

Medicaid has established the following guidelines for diet instructions when performed by a physician, nurse or nurse practitioner:

1. Services must be a required part of treatment for a well established diagnosis such as hypertension, cardiac disease, and diabetes.

2. Services must be performed by a licensed nurse or registered dietitian under physician orders, and must be billed by the physician.

3. If the sole purpose of the visit was for diet instruction, the service must be coded as a routine visit using CPT code 99212.

4. If obesity is the primary or only diagnosis, diet instruction is not covered.

Osteopathic Manipulative Treatment

Medicaid will reimburse a physician for OMT Codes 98925, 98926, 98927 and 98929. These codes cannot be billed with an E/M Code on the same day of the manipulation unless the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual pre-service and post-service work associated with the OMT procedure.
Organ Transplants

Medicaid covers cornea transplants. Prior authorization is not required. V2785 - processing, preserving and transporting of corneal tissue is a covered service.

Wyoming Medicaid covers the following transplants, for recipients under the age of 21, if medically necessary:

- Heart
- Kidney
- Bone marrow
- Liver

Prior authorization MUST be obtained before services are rendered.
Preventive Medicine

Preventive health services for recipients under age 21 are covered through HEALTH CHECK.

Medicaid does NOT cover other routine services or examination when the procedure is performed in the absence of an illness or complaint. EXCEPTIONS to this policy are:

- Newborn care furnished in the hospital
- Immunizations
- Cancer screening services
- Screening mammography’s are limited to a baseline mammography between ages 35 and 39; one screening mammography per year after age 40. All mammograms require a referral by a physician.
- Annual gynecological exam including a PAP smear. One per year following the onset of menses. This should be billed using an extended office visit (E&M) 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.

Limitations

Refer to the HealthCheck section for information on school or sports physicals.
Psychiatric Services

Covered Services  90801 - 90899

Wyoming Medicaid covers psychiatric services if provided by a psychiatrist, or when provided by one of the following mental health practitioners who are employed by or work under contract with a psychiatrist.

* a licensed clinical psychologist; or
* a licensed clinical social worker; or
* a licensed master's level counselor; or
* a licensed psychiatric clinical nurse practitioner; or
* a licensed physician's assistant;

* Providers must work under the direct supervision of the primary care psychiatrist; or be employed by or under contract with a Community Mental Health Center.

Reimbursement Guidelines

All services must be provided on-site at the psychiatrist’s office, billed by the psychiatrist, using their provider number.

Psychosocial counseling services performed by physicians other than psychiatrists should be billed using appropriate local office visit codes listed in the “Office and Outpatient Services” section of this manual.

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

A $2.00 copay applies to 90804 - 90815. Refer to Co-payment Requirements Table for exceptions.

Limitations

Services provided by independent mental health practitioners are not covered.

Wyoming Medicaid does not cover CPT codes: 90875, 90876, 90880, 90882, 90885, 90887, 90889.

Psychological testing (96100) is reimbursed on a per hour basis not to exceed three hours total.
Sterilizations

Sterilization is defined by Medicaid as: *any elective medical procedure, treatment, or operation performed for the primary purpose of rendering an individual, (male or female), PERMANENTLY incapable of reproducing. Sterilizations that are performed because pregnancy would be life threatening are subject to all conditions of coverage.*

Coverage

1. Sterilization procedures must conform to Federal Regulation in either inpatient or outpatient settings.

2. A sterilization will be covered under the program only if the following conditions are met:
   
   a. The individual is at least 21 (twenty one) years old at the time the consent for sterilization is obtained. This is a Federal requirement for sterilizations provided under the Federal Title XIX program and is not affected by any other Wyoming state law regarding the ability to give consent to medical treatment in general. There are no exceptions.
   
   b. The individual is mentally competent. For Medicaid purposes, a mentally declared competent for purposes that include the ability to consent to sterilization. The are no exceptions.
   
   c. The individual is able to understand the content and nature of the informed consent process as required by Medicaid regulations. A patient considered mentally ill or mentally retarded may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilization procedure, which includes the concept of permanent sterility.
   
   d. The individual is not institutionalized. For purposes of Wyoming Medicaid, an institutionalized individual is a person who is:

      Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility which renders care and treatment of mental illness; or

      Confined under voluntary commitment in a mental hospital or other facility which renders care and treatment of mental illness.

   
   e. The individual has VOLUNTARILY given informed consent in accordance with all requirements of the Medicaid regulations.
   
   f. At least 30 (thirty) days, but not more than 180 days, have passed since the date
the informed consent was signed and the date of sterilization. (The day the recipient signs the consent form and the surgical date should not be included in the 30 day waiting period. In determining a surgical date, do not count the day that the consent was obtained or the day of sterilization.

There are no exceptions to the 180-day limitation of the effective time period of the informed consent agreement.

Exceptions to the 30 (thirty) day waiting period are as follows:

Sterilization may be performed at the time of emergency abdominal surgery if at least 72 (seventy-two) hours have passed since the time written informed consent was given and the emergency surgery was performed. The patient's medical record must document the medical necessity for emergency surgery.

Sterilization may be performed at the time of a premature delivery if the informed consent was given at least 30 (thirty) days before the expected date of delivery, and at least 72 (seventy-two) hours have passed since the written informed consent was signed.

g. A completed consent form must accompany all claims for sterilization services, including attending physicians, surgeons, anesthesiologists, and facilities. Only claims related to sterilization surgery require consent documentation to be attached. Claims for presurgical visits, tests, or services related to post-surgical complications, do not require consent documentation at the time of submission for reimbursement.

Treatment which is not for the purpose of, but results in, sterility will not require the completion of the STERILIZATION CONSENT form. Hysterectomies require the HYSTERECTOMY ACKNOWLEDGMENT OF CONSENT.

h. A sterilization performed during a routine scheduled C-section performed for non-emergency reasons must meet the minimum 30 day waiting period requirements.

Informed Consent Process of Sterilization

The informed consent process may be conducted by the physician or by the physician's designee and must comply with the following guidelines:

1. Offer to answer any questions the individual may have had concerning the sterilization procedure.

2. Provide the individual with a copy of the consent form.

3. Verbally provide the following information PRIOR to the sterilization procedure:
a Counseling the individual that they are free to withhold or without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled.

b Advise the individual of the available alternative methods of family planning and birth control.

c Informe the individual that the sterilization procedure is considered to be irreversible and permanent.

d Provide a thorough explanation of the specific sterilization procedure to be performed on the individual.

e Furnish the individual with a complete description of the discomforts and risks that may accompany or follow the procedure. This must include an explanation of the type and possible effects of any anesthetic to be utilized during the procedure.

f Supply the individual with a complete description of the benefits or advantages that may be expected as a result of the sterilization procedure.

g Advise the individual that the sterilization will not be performed until after the 30 (thirty) day waiting period, except under the circumstance of premature delivery or emergency abdominal surgery, in which the 72 (seventy-two) hours must have passed between the informed consent and the surgery. Also advise the individual that in the case of premature delivery, consent must have been given at least 30 (thirty) days prior to the expected date of delivery.

h Make suitable arrangement to ensure that the information specified above has been effectively communicated to the blind, deaf, or otherwise handicapped individual to be sterilized.

i Permit the individual to be sterilized to have a witness of their choice present when the consent is obtained.

j Certify that the sterilization operation was requested without fraud, duress, or undue influence.

k Comply with all other State and local requirements.

l Certify that the Medicaid Consent form was properly filled out and signed as outlined in Medicaid guidelines.
May not obtain informed consent while the individual to be sterilized is:

- In labor or within 24 (twenty four) hours postpartum or post abortion.
- Under the influence of alcohol or other substances that affect the individual’s state of awareness.
- Seeking to obtain or obtaining an abortion.

“Seeking to obtain” is defined by Wyoming abortion are being made.

“Obtaining an abortion” is defined by Wyoming Medicaid as the period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered.

Wyoming Medicaid DOES NOT cover sterilization procedures for individual under age 21 (twenty one), for mentally incompetent or institutionalized individuals, or for cases in which the procedure is court ordered.
Surgery-General

Covered Services

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

Limitations

Surgical procedures that meet *any one* of the following conditions are NOT COVERED by Medicaid.

1. Performed for cosmetic reasons
2. An alternative non-operative treatment exists
3. Performed based on inadequate diagnostic indications
4. Experimental or investigative in nature
5. Performed for the convenience of the patient
6. Not proven effective
7. Do not restore a bodily function

Cosmetic Surgery

Medicaid does not cover surgical procedures performed exclusively for cosmetic purposes. Cosmetic surgical procedures are defined as those surgical procedures intended solely to improve the physical appearance of an individual, which do not restore bodily function or correct deformity.

The following procedures are considered cosmetic and are not covered by Medicaid:

Tattooing to cover or create a decorative tattoo

Subcutaneous injection of filling material to augment small, but otherwise, normal breasts

Dermabrasion and/or superficial chemosurgery for wrinkling or the removal or treatment of decorative or self-induced tattoos
Blepharoplasty of lower eyelids or blepharoplasty of upper eyelids without documented evidence of visual impairment
Rhytidectomy solely for aging and/or wrinkling skin or to correct glabella frown lines or submental fat pad

Lipectomy of the leg, hip, buttocks, or forearms or lipectomy elsewhere

Augmentation mammoplasty to augment small or correct asymmetrical, but otherwise, normal breasts

Removal of mammary implant material when the original insertion was for cosmetic purposes

Reconstruction of the nipple and/or areola when asymptomatic

Rhinoplasty for external nasal deformity without functional breathing impairment

Injection of a sclerosing solution into spider varicose veins

Hairplasty or hair transplant or implant, even though there may be a medical reason for the hair loss

Ear piercing or removal of keloids following ear piercing

Electrolysis

Gastric or intestinal bypass services including the gastric bubble and stapling

Under certain circumstances, Medicaid may cover reconstructive surgical procedures. Reconstructive surgical procedures are defined as those surgical procedures intended to improve function and appearance of any body area which has been altered by disease, trauma, congenital or developmental anomalies, or previous surgical processes.

**Reimbursement Guidelines**

1. Reconstructive surgery must be prior authorized by Medicaid. The request must include precise documentation, including a description of any impaired function, congenital anomaly, developmental abnormality, previous surgery, or injury. Photographic documentation is beneficial and may be required.

2. Medicaid will not cover cosmetic surgeries performed at the same operative session as a covered service, and reimbursement in such cases will be limited to the allowable fee for the covered service only.

3. Medicaid covers Contigen Implants for Type III stress urinary incontinence. The CPT Code 51715 - endoscopic injection of the implant material into the submucosal tissues of the
urethra and/or bladder neck, would be the HCPCS procedure code. Code L8603 would be billable for The Collagen implant, per 2.5 cc syringe, inclusive of shipping and necessary supplies, CPT Code 95028 would be billable for the skin test procedure.

4. Medicaid will reimburse physicians, in Wyoming, who are treating Medicaid recipients post operatively when surgical procedures are performed out-of-state. The local code X5000 - post op follow-up for out-of-state surgery.

5. CPT code 30420: Rhinoplasty, primary including major septal repair

   PA required prior to service

   The nasal surgery request would not be covered if performed solely to improve the patient's appearance in the absence of any signs and/or symptom's of functional abnormalities, the procedure would be considered cosmetic.

   The request for reconstructive surgery is reviewed to ensure that it will:

   a  improve nasal respiratory function (relieve airway obstruction or stricture), or

   b  repair defects caused by trauma (septal deviation, dislocated nasal bone fractures), or

   c  treat congenital anatomic abnormalities or deformities, or

   d  replace nasal issue lost after tumor ablative surgery.

6. Operating Microscope

   This new CPT code, 69990, is reported if a physician uses a surgical microscope when services are performed using the techniques of microsurgery, except when the microscopy is part of the procedure; (15756-15758, 19364, 19368, 20955-20962, 20969-20973, 26551-26554, 26556, 31561, 31571, 43116, 43496, 49906, 61548, 63075-63078, 64727, 65091-68850). This code is reported in addition to the primary procedure.
Surgical Packages

Coverage

Normal preoperative and postoperative care included as part of surgical package includes:

a office examinations,

b emergency room visits, and hospital visits, including discharge management.

c Routine postoperative care. The number of postoperative days for each procedure is listed within the surgical fees schedule.

d Consultations and hospital admission (when a history and physical exam have not been performed in the office) are not considered part of the surgical package.

Limitations

Services provided to diagnose or treat conditions unrelated to the surgery may be billed with a separate examination code if the primary diagnosis code reflects a different complaint or service.

Medicaid will reimburse for surgical trays when minor surgery necessitates local anesthesia and other supplies (i.e., gauze, sterile equipment, suturing material, etc.) if the surgical procedure is performed in a physician's office. For example, procedures requiring a surgical tray would include diagnostic biopsies, wound closures, and removal of cysts or other lesions. Reimbursement is not provided when the surgery is performed in a hospital, with the exception of trays supplied by the physician, which are not billed by the hospital.

Starred (*) Procedures - Exceptions to Surgical Packages - Refer to guidelines in CPT.

Separate Procedures

Certain procedures are commonly performed as an integral part of a total service and may not be billed separately. When such a procedure is performed independently of, and is not immediately related to, other services, it may be reported separately under its unique procedure code. When a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered a separate procedure. For example, an arthrotomy performed as part of a meniscectomy should not be billed separately. An arthrotomy performed as the principal procedure, however, may be billed separately.

Incidental Procedures

Incidental procedures are those procedures performed subsequent to surgery which do not add significantly to the major surgery or are rendered incidentally and performed at the same time as the major surgery (e.g., incidental appendectomies, incidental scar excisions).

Medicaid will not reimburse separately for incidental surgical procedures which are performed at the same time as other major surgery.
Surgical Destruction

Surgical destruction is a part of a surgical procedure, and different methods of destruction are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate codes.

Multiple Procedures

A multiple procedure is an additional, medically necessary, surgical procedure which is performed at the time of a primary medical procedure (for example, a liver biopsy performed at the time of a splenectomy). When multiple procedures are performed at the same operative session, the major procedure is billed with the appropriate CPT code. The secondary, additional, or lesser procedure(s) must be identified by adding a -51 modifier to the CPT code for the secondary procedure(s).

Bilateral Procedures

Bilateral procedures are those procedures requiring a separate incision that are performed at the same operative session on both sides of the body. Bilateral procedures should be billed on two claim lines by billing the first line item with the base code and the second line item by attaching the modifier -50 to the procedure code.

Assistant Surgeons

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

- When a physician assistant or a registered nurse who is employed by a physician assists with surgery, the fee is billed with an -AS modifier using the same procedure code billed by the primary surgeon.

Reimbursement Guidelines

All surgical claims submitted for reimbursement for multiple surgical procedures must have an operative report attached. The following methodology applies to reimbursement for surgical procedures:

Multiple Procedures (Same Incision)

The primary surgical procedure is reimbursed at 100 percent of the allowed fee.

The second and subsequent surgical procedures through same incision (bill with a -51 modifier at 50 percent of the allowed fee).
Multiple Procedures (Two or More Incisions)

First incision - The primary surgical procedure is reimbursed at 100 percent of the allowed fee.

Second incision - The primary surgical procedure is reimbursed at 100 percent of the allowed fee.

Additional procedures through each incision are reimbursed at 50 percent of the allowed fee.

Bilateral Procedures

Bill the first line with the base code and the second line with the base code and modifier of -50. The base code will be reimbursed at 100 percent of the allowable fee for the first incision and 75 percent of the allowable fee for the other incision.

Modifiers

Medicaid recognizes the following list of modifiers when used in conjunction with CPT surgical procedure codes. No other modifiers will be accepted for reimbursement by the Medicaid Program.

-22 Unusual Procedural Services - An operative report is required.

-50 Bilateral Procedure

-51 Multiple Procedure

-62 Two Surgeons - Under certain circumstances, two surgeons (with different skills) may be required in the management of a specific surgical procedure. Under such circumstances the separate services may be identified by adding the modifier “-62” to the procedure number by each surgeon for reporting this services. An operative report is required.

-80 Assistant Surgeon

-AS Physician Assistant/Registered Nurse - Surgical assistant services
Radiology Services

Coverage

Medicaid provides coverage of medically necessary radiology services which are directly related to the patient's symptom or diagnosis when provided by independent radiologists, hospitals, and physicians. Radiology and nuclear medicine services include:

- Diagnostic radiology
- Diagnostic ultrasound
- Radiation therapy
- Oncology
- Nuclear medicine services.

Medicaid will reimburse physicians only for radiology services performed personally by the physician or under supervision of a physician.

Radiology and nuclear medicine services include a professional component and a technical component. The total radiology procedure may be divided into the professional and technical component for billing and payment when appropriate. Certain radiology procedures are designated as complete procedures and can only be billed as such.

The professional component is the performing, interpreting, and reporting of the radiological exam.

The technical component is the provision for equipment, facility, and personnel to perform the services.

The total (complete) procedure is interventional radiologic procedure or diagnostic study involving injection of contrast media. This includes all usual pre-injection and post-injection services, supervision of the study, and interpretation of the results by a radiologist.

Supervision and Interpretation

When a procedure is performed by two physicians, the radiologic portion of the procedure is designated as "radiologic supervision and interpretation." If all services are not performed by a single physician, the radiologist may bill using the supervision and interpretation codes, and the clinician may bill for the separate injection procedure using the appropriate surgical procedure codes.
Computerized Tomography (CT scans) is covered for diagnostic examination of the head and of certain other parts of the body when the patient's medical record documents that the scan is medically necessary based on the patient's symptoms and preliminary diagnosis.

Limitations

Screening mammographies are limited to a baseline mammography between ages 35 and 39; one screening mammography per year after age 40. All mammograms require a referral by a physician.

X-rays performed as a screening mechanism or based on standing orders

Separate consultations, procedures unless ordered by the attending physician

Reinterpretations, unordered X-rays, and second opinions

Reimbursement Guidelines

Modifiers

Medicaid will only accept:

-26 professional component
-TC technical component.

MRI codes may be billed with -52, -22 to indicate level of service; however, reimbursement will be the same.

Multiple procedures performed on the same day must be billed with two units to avoid denial as a duplicate service.

Contract media should be billed with procedure codes A4641 - A4647.
Rural Health Clinics

Covered Services

Wyoming Medicaid covers medically necessary visits to a rural health clinic. A visit is a face-to-face encounter between a clinic patient and a health professional.

Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Encounters are considered to be all-inclusive. They include therapeutic and diagnostic services and all test and supplies incidental to a clinic visit.

Physician Direction Requirements

Federal regulations limit coverage of clinic services to situations in which services are furnished under the direction of a physician. This requirement does not mean that the physician must necessarily be an employee of the clinic, be utilized on a full-time basis, or be present in the facility during all hours that services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the clinic.

To meet the above requirements, a physician must see the patient at least once, prescribe the type of care provided and if the services are not limited by the prescription, periodically review the need for continued care. The physician does not have to be on the premises when their patient is receiving covered services, however, they must assume professional responsibility for the services provided and ensure that the services are medically appropriate.

For a physician to be affiliated with a rural health clinic, there must be a contractual agreement or some type of formal agreement between the physician and facility by which the physician is obligated to supervise the care provided to the clinic's patients.

Reimbursement Guidelines

Wyoming Medicaid has assigned local codes for billing an encounter on the HCFA-1500. These local codes are paid at the encounter rate established by Medicaid for ALL services provided during the encounter regardless of actual charges.

X5850 Rural Health Encounter
*X5514 HEALTH CHECK Encounter
*X5514 RE HEALTH CHECK Encounter w/ referral

* RHCs are encouraged to participate in the HEALTH CHECK (well child) program for Medicaid Children. HEALTH CHECK policy is outlined in this beginning of this chapter. When an encounter meets the standards for a HEALTH CHECK exam, use the HEALTH CHECK encounter codes.
Inpatient Services:

Inpatient services are not considered RHC/FQHC services and cannot be billed using your RHC/FQHC provider number. Enrollment to provide "physician services" is required to bill inpatient services. These services are reimbursed based on Medicaid fee schedule. A place of service code of 21 is required in field 24b on the HCFA 1500 when billing for these services.

Prenatal services delivered at the RHC/FQHC are billed as encounter services. A delivery only procedure code (59409, 59514, 59612, 59620) should be used when billing for the hospital delivery. Global procedures codes which include prenatal visits should never be used.
Vision Services

Vision services may be provided by a licensed ophthalmologist, optometrist, or optician, who is considered appropriate within the Scope of Practice Act within their respective profession.

Coverage

Medicaid covers the following vision services for recipients age 21 and over:

1. Treatment of eye disease or eye injury, based on the appropriate ICD-9 diagnosis code
2. Payment of deductible and/or coinsurance due on Medicare cross-over claims for post surgical contact lenses and/or eyeglasses.
3. Contact Lenses: Contact lenses are NOT covered for routine correction of vision Lenses are covered only for correction of pathological conditions when useful vision cannot be obtained with regular lenses (i.e. Keratoconus). Prior Authorization is not required at this time; however, the medical record should document why the patient cannot be satisfactorily fitted with conventional lenses.

Medicaid covers the following vision services for recipients UNDER age 21:

1. Routine eye examination with determination of refractive state:
   
   92002 - 92004 eye examination codes include determination of refractive state.

   92015 - Determination of refractive state - should ONLY be billed when an eye examination is not performed.

2. Office exams as medically necessary for the treatment of eye disease or eye injury.
3. Eyeglasses: one pair and additional replacement pairs as medically necessary are covered. Patient records must reflect the need for replacement pairs. Multiple pairs issued at the same time are not covered.
4. Repair to eyeglasses must follow the warranty. Upon expiration of the warranty, repair of the eyeglasses can be billed to Medicaid.
5. Specialized transmissivity, e.g. tints, UV lenses, scratch resistant coating are covered when medically necessary and documented by applicable diagnosis on the claim. If a recipient requests these services for cosmetic purpose, the recipient must be advised in writing that this is a non-covered service and they will be responsible for the charge.
6. Frames; Standard frames are a covered service. Medicaid allows up to $60.00 for
standard frames (V2020). When a provider bills Medicaid for these services, Medicaid payment will not exceed $60.00 and the payment must be considered payment in full. The recipient CANNOT be billed for the difference between billed charges and the Medicaid payment. If the recipient desires to order frames which exceed the allowed amount (and the provider will not accept Medicaid allowance as payment if full) an arrangement MUST be made in writing between the recipient and the provider stating the recipient will be responsible for the ENTIRE cost of the frames. Medicaid cannot be billed in this instance for any cost associated the frames.

7. Contact Lenses: Contact lenses are NOT covered for routine correction of vision however, the medical record should document why the patient cannot be satisfactorily fitted with conventional lenses.

8. Vision Therapy: Vision therapy (procedure code 92065) is a covered service which requires Prior Authorization. The authorization request must document the appropriate diagnosis of the condition to be treated and the diagnosis for any complication. The request should estimate the number of visits required to treat the condition and the estimated range of dates for completion of the therapy.

Reimbursement Guidelines

Providers should only use appropriate HCPCS codes for material when billing Medicaid.

Reimbursement for dispensing of frames, frame parts, and/or lenses is not allowed in addition to reimbursement for dispensing of total eyeglasses.

Providers must use the order date as the date of dispensing.

Eyeglasses for cosmetic purposes are NOT covered.
Waiver Programs

Developmentally Disabled Adult Home and Community-Based Services Waiver

The purpose of the Developmentally Disabled Adult Home and Community-Based Services waiver is to provide services to eligible adults who require the level of care provided in an Intermediate Care Facility for the Mentally Retarded, the cost of which would be reimbursed under the approved Medicaid State Plan. This waiver is limited to a target group of mentally retarded and developmentally disabled individuals age 21 and over. Waiver services will not be furnished to recipients while they are inpatients of a hospital, nursing facility, or an intermediate care facility for the mentally retarded. An individual written plan of care will be developed for each recipient under this waiver. This plan of care will describe the services to be furnished, their frequency, and the type of provider who will furnish each service. All services will be furnished pursuant to a written plan of care, subject to the approval of the Medicaid agency. For more information, contact the Division of Developmentally Disabled at (307) 777-7115.

Developmentally Disabled Children's Home and Community-Based Services Waiver

The purpose of the Developmentally Disabled Children's Home and Community-Based Services waiver is to provide services to eligible children who require the level of care provided in an Intermediate Care Facility for the Mentally Retarded, the cost of which would be reimbursed under the approved Medicaid State Plan. This waiver is limited to serving a target group of mentally retarded and developmentally disabled individuals from birth through 20 years of age. Waiver services will not be furnished to recipients while they are inpatients of a hospital, nursing facility, or an intermediate care facility for the mentally retarded. An individual written plan of care will be developed for each recipient under this waiver. This plan of care will describe the medical and other services to be furnished, their frequency, and the type of provider who will furnish each service. All services will be furnished pursuant to a written plan of care, subject to the approval of the Medicaid agency. For more information, contact the Division of Developmentally Disabled at (307) 777-7115.
Long-Term Care (LTC) / Home and Community-Based Waiver Services

The purpose of the LTC/Home and Community-Based Service Waiver is to offer an option for people who would otherwise have to go to a Nursing Home. If the client/recipient chooses the LTC/HCBS Waiver services, they are also able to utilize other Medicaid services. This is a statewide program although there may not be providers in certain areas of the state to provide these specific services. The waiver is limited to a target group of people, age 19 and older, who require the level of care of a nursing facility. There are a limited number of available sites and there may be a waiting list. Waiver services will not be furnished to clients while they are inpatients of a hospital, nursing facility, or other institutions.

This program offers Nursing Facility level of services in the community, so that it is not necessary for a person to go to a Nursing Home. Recipients may stay in their own home and get specialized care. The client may exercise their freedom of choice in deciding which services and providers to use.

The services are limited by a monthly dollar amount and are listed below:

Case Management: The Home and Community-Based waiver operates under a case management system. The case manager submits a plan of care to Health Care Financing for approval. If indicated in the plan of care and available in the community, the following services are provided but limited by a monthly dollar amount:

  Adult Day Care: This is a structured program in a protective setting that provides a variety of healthy, social and related programs for part of the day, but less than 24 hours.

  Home-Delivered Meals: This service allows the recipient to receive one or two meals in the home or at a day facility.

  Non-Medical Transportation: This service allows transportation for non-medical reasons which are not purely diversionary in nature, and cannot be arranged by any other means.

  Personal Care: This service provides care in the recipient's home by a Certified Nurse's Aid, who is employed by an agency. The Nurse's Aid provides assistance with activities of daily living such as bathing, shampooing, meal preparation, grocery shopping, etc. Consumer directed care is a personal care option for LTC/HCBS Waiver clients who have the capacity to direct their own care.

  Personal Emergency Response System: This service provides an electronic alarm system, such as Lifeline, worn by the recipient which allows him to summon help in case of emergency.

  Respite: Respite care is provided to relieve a regular caregiver for a short period of time, either in the home or in an institution. Home service must be provided by a Certified Nurse's Aid employed by an agency.

All services will not be provided to all clients. Clients will receive only those services which the Case Manager and the interdisciplinary team determines are necessary. The client or a member of their family are included as members of this team.

For information, contact Vereen Bebo, Home Care Services Program Manager at (307)777-7366 or refer to the Home and Community-Based Services Manual.