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

Overview

Thank you for your willingness to serve clients of the Medicaid Program and other medical assistance programs administered by the Division of Healthcare Financing. Medicaid has incorporated the former General Manual, Covered Services and Billing Module into one. This manual supersedes all prior versions.

Rule References

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

Procedure codes listed in the following Sections are subject to change at any time without prior notice. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedules on the website (Section 2.2, Quick Website Reference). Fee schedules list Medicaid covered codes, provide clarification of indicators, such as whether a code requires prior authorization and the number of days in which follow-up procedures are included. Not all codes are covered by Medicaid or are allowed for all taxonomy codes (provider types). It is the provider’s responsibility to verify this information. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current UB Editor, CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service.

Getting Questions Answered

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

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

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

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

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

1.1 How the Institutional UB-04 Manual is Organized .............................................................. 1-2
1.2 Updating the Manual ............................................................................................................... 1-3
1.3 State Agency Responsibilities .............................................................................................. 1-5
1.4 Fiscal Agent Responsibilities ............................................................................................... 1-5
1.1 How the Institutional UB-04 Manual is Organized

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

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two</td>
<td><strong>Getting Help When You Need It</strong> – telephone numbers and addresses for help and training. When and how to order forms.</td>
</tr>
<tr>
<td>Three</td>
<td><strong>Provider Responsibilities</strong> – obligations and rights as a Medicaid provider. The topics covered include enrollment changes, civil rights, group practices, provider-patient relationship, and record keeping requirements.</td>
</tr>
<tr>
<td>Four</td>
<td><strong>Utilization Review</strong> – fraud and abuse definitions, the review process, and the rights and responsibilities.</td>
</tr>
<tr>
<td>Five</td>
<td><strong>Client Eligibility</strong> – how to get eligibility information when a client presents their Medicaid card.</td>
</tr>
<tr>
<td>Six</td>
<td><strong>Common Billing Information</strong> – basic claim information, completing the UB-04 claim form, cap limits, newborn/unborn billing, working a Remittance Advice and completing adjustments.</td>
</tr>
<tr>
<td>Seven</td>
<td><strong>Third Party Liability (TPL)</strong> – explains what TPL is, how to bill it and exceptions to it.</td>
</tr>
<tr>
<td>Eight</td>
<td><strong>Electronic Data Interchange (EDI)</strong> – explains the advantages of exchanging documents electronically.</td>
</tr>
<tr>
<td>Nine</td>
<td><strong>Wyoming Specific HIPAA 5010 Electronic Specifications</strong> – this chapter covers the Wyoming Specific requirements pertaining to electronic billing.</td>
</tr>
<tr>
<td>Ten – Twenty One</td>
<td><strong>Covered Services</strong> – these chapters contain information regarding covered services.</td>
</tr>
<tr>
<td>Appendices</td>
<td><strong>Appendices</strong> – provide key information in an at-a-glance format. These include Social Security Administration (SSA) district office information, a list of Department of Family Services (DFS) offices, Medicaid and State Healthcare Benefit Plans.</td>
</tr>
</tbody>
</table>
1.2 Updating the Manual

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

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

**Attention EqualityCare Providers**

**Coming Soon: Online Entry of PASRR Level I Screenings and Online Access to LT101 Assessments**

Please share this bulletin with the following staff:

- Office Manager
- EqualityCare Biller
- Other

Exciting changes are coming to the EqualityCare website! Soon, eligible providers will be able to complete PASRR Level I screenings and access LT101 assessments using the secure Provider Web portal.

**New PASRR Level I Screening Process**

The current PASRR Level I form will phase out by July 31, 2009. Beginning August 1, 2009, providers will complete the PASSAR Level I screening online through the secure Web portal. The advantages of this process are:

- Improved turnaround time which reduces nursing facility claim denials.
- Immediate notification whether a PASRR Level II is required and additional online validation.
- Eliminates the need to mail the PASRR Level I which saves time and postage.

**Accessing LT101 Assessments**

The advantages to making the LT101s available on the secure portal are:

- Providers will have 24x7 access to a client’s most recent 25 LT101s.
- As providers become more comfortable with the process, there should be less need to maintain a hardcopy paper trail.
**Example RA Banner:**

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

**THE WEEK OF FEBRUARY 20TH:**

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

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

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

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

HTTP://WYMEDICAID.ACS-INC.COM

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

### 1.3 State Agency Responsibilities

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

### 1.4 Fiscal Agent Responsibilities

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

Chapter Two ....................................................................................................................................... 2-1
2.1 Quick Address and Telephone Reference................................................................................... 2-2
2.2 Quick Website Reference............................................................................................................ 2-5
2.3 How to Call for Help.................................................................................................................. 2-6
2.4 How to Write for Help................................................................................................................ 2-6
2.5 How to Get On-Site Help........................................................................................................... 2-8
2.6 How to Get Help Online............................................................................................................. 2-8
2.7 Training Seminars..................................................................................................................... 2-8
2.8 Ordering Forms......................................................................................................................... 2-9
## 2.1 Quick Address and Telephone Reference

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

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

NOTE: The client’s Medicaid ID number or social security number is required for accessing client information. |
| Claims | 8-5pm MST M-F | N/A | • Claims adjustment requests  
• Hardcopy claims processing  
• Returning Medicaid checks |
| Dental Services | 1-888-863-5806 9-5pm MST M-F | (307) 772-8405 | • Bulletin/manual inquiries  
• Claim inquiries  
• Claim submission problems  
• Client eligibility  
• How to complete forms  
• Payment inquiries  
• Request field representative visit  
• Training seminar questions  
• Timely filing inquiries  
• Verifying validity of procedure codes  
• Claim void/adjustment inquiries  
• WINASAP training  
• Web Portal training |
| EDI Services | 1-800-672-4959 OPTION 3 9-5pm MST M-F | (307) 772-8405 | • EDI Enrollment Form  
• Trading Partner Agreement  
• WINASAP software  
• Technical support for WINASAP  
• Technical support for vendors, billing agents and clearing houses  
• Web Portal registration  
• Technical support for Web Portal |
| Medical Policy | 1-800-251-1268 OPTION 1,1,4,3 9-5pm MST M-F (Voice Mail Available) | (307) 772-8405 | Prior authorization requests for:  
• Out-of-State Home Health  
• Surgeries requiring prior authorization  
• Hospice Services: Limited to clients residing in a nursing home  
• Status of a pending prior authorization  
• Cap limit Waiver requests |
<table>
<thead>
<tr>
<th>Agency Name &amp; Address</th>
<th>Phone Numbers And Hours</th>
<th>Fax</th>
<th>Contact For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td>1-800-251-1268 Call Center Agents are available - 9-5pm MST M-F Touchtone phone required</td>
<td>(307) 772-8405</td>
<td>• Bulletin/Manuals inquiries • Cap limits • Claim inquiries • Claim submission problems • Client eligibility • How to complete forms • Payment inquiries • Request Field Representative visit • Training seminar questions • Timely filing inquiries • Troubleshooting prior authorization problems • Verifying validity of procedure codes • Claim void/adjustment inquiries • WINASAP training</td>
</tr>
<tr>
<td>Third Party Liability (TPL)</td>
<td>1-800-251-1268 OPTION 2 9-5pm MST M-F Select Option 2 if you need Medicare or Estate and Trust recovery assistance THEN Select Option 2 if you are with an insurance company, attorney’s office or child support enforcement OR Select Option 3 for Medicare and Medicare Premium Payments OR Select Option 4 for Estate and Trust Recovery inquires</td>
<td>(307) 772-8405</td>
<td>• Medicare Buy-In status • Client accident covered by liability or casualty insurance or legal liability is being pursued • Estate and Trust Recovery • New insurance coverage • Policy no longer active • Problems getting insurance information needed to bill • Questions or problems regarding third party coverage or payers • WHIPP program</td>
</tr>
<tr>
<td>Transportation Call Center</td>
<td>1-800-595-0011 9-5pm MST M-F (Voicemail Available 24 hours/day)</td>
<td>(307) 772-8405</td>
<td>Client inquiries: • Prior authorize transportation arrangements • Verify that transportation is reimbursable</td>
</tr>
<tr>
<td>KePRO (DME)</td>
<td>1-855-294-1196</td>
<td>(855) 294-1197</td>
<td>• Prior authorization request for Durable Medical Equipment (DME)</td>
</tr>
<tr>
<td>Agency Name &amp; Address</td>
<td>Phone Numbers And Hours</td>
<td>Fax</td>
<td>Contact For:</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------------------------</td>
<td>----------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Xerox Care and Quality Solutions (Utilization and Care</td>
<td>1-888-545-1710</td>
<td>For PASRRs Only</td>
<td>Prior authorization for:</td>
</tr>
<tr>
<td>Management)</td>
<td></td>
<td>(888) 245-1928</td>
<td>- Extraordinary care</td>
</tr>
<tr>
<td>PO Box 49</td>
<td></td>
<td>Attn: PASRR Processing</td>
<td>- Gastric Bypass</td>
</tr>
<tr>
<td>Cheyenne, WY 820030-0049</td>
<td></td>
<td>Specialist</td>
<td>- Inpatient rehabilitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Acute Psych</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Extended Psych</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Psychiatric Residential Treatment Facility (PRTF)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Transplants</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Vagus Nerve Stimulator</td>
</tr>
<tr>
<td>ADAP Aids Drug Assistance Program</td>
<td>(307) 777-5800</td>
<td>(307) 777-7382</td>
<td>Prescription medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MFH Children Special Health</td>
<td>(307) 777-6921 or</td>
<td>(307) 777-7215</td>
<td>Children’s Special Health</td>
</tr>
<tr>
<td></td>
<td>(800) 438-5795</td>
<td></td>
<td>- High Risk Maternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Newborn intensive care</td>
</tr>
<tr>
<td>MDP Marginal Dental</td>
<td>(307) 777-7945</td>
<td></td>
<td>Eligibility for Marginal Dental Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>1-800-633-4277</td>
<td><a href="http://www.cms.gov">www.cms.gov</a></td>
<td>General information regarding Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Division of Healthcare Financing</td>
<td>(307) 777-7531</td>
<td></td>
<td>Health Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Health Check</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medicaid State Rules</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plans of Treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Utilization of Services</td>
</tr>
<tr>
<td>Division of Healthcare Financing Program Integrity</td>
<td>1-855-846-2563</td>
<td></td>
<td>Provider and Client fraud</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Division of Healthcare Financing Pharmacy Program</td>
<td>1-800-438-5785</td>
<td>(307) 777-8623</td>
<td>General questions</td>
</tr>
<tr>
<td></td>
<td>1-877-207-1126 (Goold</td>
<td></td>
<td>Pharmacy prior authorization questions</td>
</tr>
<tr>
<td></td>
<td>Health Systems, Inc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6101 Yellowstone Rd. Ste. 210</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheyenne, WY 82002</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.2 Quick Website Reference

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Web Address</th>
<th>Phone Number</th>
<th>Reference for</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS EDI Gateway</td>
<td><a href="http://www.acs-gcro.com">http://www.acs-gcro.com</a></td>
<td>1-800-672-4959</td>
<td>• WINASAP software</td>
</tr>
<tr>
<td>Wyoming Medicaid (Medicaid)</td>
<td><a href="http://wymedicaid.acs-inc.com">http://wymedicaid.acs-inc.com</a></td>
<td>N/A</td>
<td>• Billing Manuals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• HIPAA electronic transaction data exchange</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Fee schedules</td>
</tr>
<tr>
<td>Division of Healthcare</td>
<td><a href="http://www.health.wyo.gov/healthcarefin/equalitycare/index.html">http://www.health.wyo.gov/healthcarefin/equalitycare/index.html</a></td>
<td>(307) 777-7531</td>
<td>• EDI enrollment form</td>
</tr>
<tr>
<td>Financing</td>
<td></td>
<td></td>
<td>• Trading Partner Agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Frequently asked questions (FAQs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Forms (e.g., Claim Adjustment/Void Request Form)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• HIPAA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• IVR Navigation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Outpatient Perspective Payment System (OPPS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Publications</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Remittance Advice Retrieval</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• WINASAP software</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Secure Provider Web Portal</td>
</tr>
<tr>
<td>Division of Healthcare</td>
<td><a href="http://www.wyequalitycare.org/">http://www.wyequalitycare.org/</a></td>
<td>(800) 438-5785</td>
<td>• Pharmacy Manual</td>
</tr>
<tr>
<td>Financing Pharmacy Program</td>
<td></td>
<td></td>
<td>• FAQs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Prior Authorizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.3 **How to Call for Help**

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

2.4 **How to Write for Help**

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

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provider Name and Address</td>
<td>2. Provider/NPI Number</td>
<td>3. Telephone Number</td>
</tr>
<tr>
<td>4. Person to contact in Provider’s Office</td>
<td>5. Date of Inquiry</td>
<td></td>
</tr>
<tr>
<td>6. Client Name: Last, First, MI.</td>
<td>7. Medicaid ID Number</td>
<td>8. Dates of Service</td>
</tr>
<tr>
<td>12. MED Record Number</td>
<td>13. Transaction Control Number</td>
<td></td>
</tr>
<tr>
<td>14. Nature of Inquiry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Fiscal Agent Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Client Name: Last, First, MI.</td>
<td>7. Medicaid ID Number</td>
<td>8. Dates of Service</td>
</tr>
<tr>
<td>12. MED Record Number</td>
<td>13. Transaction Control Number</td>
<td></td>
</tr>
<tr>
<td>14. Nature of Inquiry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Fiscal Agent Response</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mail completed form to:**

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

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

2.6 How to Get Help Online

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

- Answers to your frequently asked Medicaid questions
- Claim, prior authorization, and other forms for download
- Free download of latest WINASAP software and latest WINASAP updates
- Free download of WINASAP Training Manuals and Tutorials
- Medicaid publications, such as provider handbooks and bulletins

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

- **278 Electronic Prior Authorization Requests** – ability to submit and retrieve prior authorization requests and responses electronically via the web
- **Data Exchange** – upload and download of electronic HIPAA transaction files
- **Remittance Advice Reports** – retrieve recent Remittance Advices
- **User Administration** – add, edit, and delete users within your organization who can access secure Web Portal
- **837 Electronic Claim Entry** – interactively enter dental, institutional and medical claims without buying expensive software

2.7 Training Seminars

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

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

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

PLEASE ENTER THE QUANTITY DESIRED FOR EACH FORM

ASSISTED LIVING FACILITY
___ WAIVER PLAN OF CARE FORM (C-501C)

LTC WAIVER PLAN OF CARE FORM
___(C-501A)

___ LT101 SCREENING FORM

LTC CONSUMER DIRECTED PLAN OF
___ CARE FORM (C-501B)

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

FROM: Wyoming Medicaid
Attn: Mail Room
PO Box 547
Cheyenne, Wyoming 82003-0547

TO:
____________________________________
____________________________________
____________________________________
Chapter Three
Provider Responsibilities

Chapter Three..................................................................................................................................... 3-1
3.1 Enrollment ..................................................................................................................................... 3-2
3.2 Accepting Medicaid Clients .......................................................................................................... 3-3
3.3 Medical Necessity .......................................................................................................................... 3-5
3.4 Medicaid Payment is Payment in Full ........................................................................................ 3-5
3.5 Out-of-State Service Limitations .................................................................................................. 3-6
3.6 Medicare Covered Services ........................................................................................................... 3-8
3.7 Usual and Customary Charges .................................................................................................... 3-8
3.8 Record Keeping, Retention, and Access ...................................................................................... 3-8
3.9 Tamper Resistant Rx Pads ......................................................................................................... 3-10
3.1 **Enrollment**

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

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

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

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

3.1.1 **Notifying Medicaid of Updated Provider Information**

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

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

3.1.2 **Re-Certification**

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

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

3.2 Accepting Medicaid Patients

3.2.1 Compliance Requirements

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

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

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

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

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

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

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

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

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

3.2.3 Do Not Bill Before Services Are Provided

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

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

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

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

Additionally, the service must be:

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

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

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

3.4 Medicaid Payment is Payment in Full

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

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

- If you have not billed Medicaid, the service provided is not covered by Medicaid, and prior to providing service, you informed the client in writing that the service is non-covered and he/she is responsible for the charges.
- If the client is not Medicaid eligible at the time you provide the services or on a plan that does not cover those particular services. (Section A.5, Medicaid and State Healthcare Benefit Plans).
- If the client has exceeded the Medicaid limits on physical therapy, occupational therapy, prescriptions, and/or office/outpatient hospital visits. You may contact Provider Relations or the Interactive Voice Response System to receive this information (Section 2.1, Quick Address and Telephone Reference).

### 3.5 Out-of-State Service Limitations

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

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

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

**Utah**

- Salt Lake City
- Ogden

**NOTE:** The cities of Greeley, Fort Collins, and Denver, Colorado are excluded from the WMSA and are not considered border cities.
Medicaid compensates out-of-state providers within the WMSA when:

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

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

- Emergency Care – when a client is traveling and an emergency arises due to accident or illness.
- Other Care – when a client is referred by a Wyoming physician to a provider outside the WMSA for services not available within the WMSA. The referral must be documented in the provider’s records. Prior authorization is not required unless the specific service is identified as requiring prior authorization (Section 6.10).
- Children in out-of-state placement

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

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

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

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

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

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

Questions concerning a client’s Medicare eligibility should be directed to the Social Security Administration office (Section A.1) closest to the client’s permanent place of residence.

3.7 Usual and Customary Charges

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

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

3.8 Record Keeping, Retention, and Access

3.8.1 Requirements

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

- The record must be typed or legibly written.
- The record must identify the client on each page.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- The record must indicate the observed medical condition of the client, the progress at each visit, any change in diagnosis or treatment, and the client’s response to treatment. Progress notes must be written for every office, clinic, nursing home, or hospital visit billed to Medicaid.
- Total treatment minutes of the client, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented, to include beginning time and ending time for services billed.
3.8.2 Retention of Records

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

3.8.3 Access to Records

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

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

3.8.4 Audits and On-Site Visits

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

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

- Examination of records;
- Interviews of providers, their associates, and employees;
- Interviews of program clients;
- Verification of the professional credentials of providers, their associates, and their employees;
- Examination of any equipment, stock, materials, or other items used in or for the treatment of program clients;
- Examination of prescriptions written for program clients;
- Determination of whether the healthcare provided was medically necessary;
- Random sampling of claims submitted by and payments made to providers; and/or
- Audit of facility financial records for reimbursement.
You must grant the State and its representative’s access during regular business hours to examine medical and financial records related to healthcare billed to the program. Medicaid notifies you before examining such records.

Medicaid reserves the right to make unscheduled visits under extraordinary circumstances, i.e., when the client’s health may be endangered, when criminal/fraud activities are suspected, etc. Medicaid is authorized to examine all your records in that:

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

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

- Immediate suspension of all Medicaid payments.
- All Medicaid payments made to the provider during the six-year record retention period for which records supporting such payments are not produced shall be repaid to the Division of Healthcare Financing after written request for such repayment is made.
- Suspension of all Medicaid payments furnished after the requested date of service.
- Reimbursement will not be reinstated until adequate records are produced or are being maintained.

### 3.9 Tamper Resistant Rx Pads

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

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

- **Written Prescriptions:** As of April 1, 2008 must contain one, and as October 1, 2008, must contain all three of the following characteristics:
  1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement all written prescriptions must contain:
     - Some type of “void” or illegal pantograph that appears if the prescription is copied.
May also contain any of the features listed within category one or that meets the standards set forth in this category.

2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. **This requirement applies only to prescriptions written for controlled substances.** In order to meet this requirement all written prescriptions must contain:
   - Quantity check-off boxes **PLUS** numeric form of quantity values OR alpha and numeric forms of quantity value.
   - Refill Indicator (circle or check number of refills or “NR”) **PLUS** numeric form of refill values OR alpha AND numeric forms of refill values.
   - May also contain any of the features listed within category one or that meets the standards set forth in this category.

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all written prescriptions must contain:
   - Security features and descriptions listed on the **FRONT** of the prescription blank.
   - May also contain any of the features listed within category three or that meets the standards set forth in this category.

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

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

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

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

Chapter Four...................................................................................................................................... 4-1

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

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

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

4.2 Complaint Referral

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

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

4.3 Release of Medical Records

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

The Division of Healthcare Financing will not reimburse for the copying of medical records when the agency or its agent requests records.
4.4 Client Lock-In

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

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

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

In cases where lock-in restrictions are indicated, it is the responsibility of each provider to determine whether he/she may bill for services provided to a lock-in client. Contact Provider Relations in circumstances where coverage of a lock-in client is unclear. Refer to the Medicaid Pharmacy Provider Manual (Section 2.2, Quick Website Reference).

4.5 Fraud and Abuse

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

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, documents or concealment of material facts may be prosecuted as a felony in either Federal or State court. The program has processes in place for referral to the Medicaid Fraud Control Unit (MFCU) when suspicions of fraud and abuse arise.
Medicaid has the responsibility, under Federal Regulations and Medicaid Rules, to refer all cases of suspected fraud and abuse to the MFCU. In accordance with 42 CFR Part 455, and Medicaid Rules, the following definitions of fraud and abuse are used:

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

4.6 Provider Responsibilities

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

4.7 Referral of Suspected Fraud and Abuse

If a provider becomes aware of possible fraudulent or program abusive conduct/activity by another provider, or eligible client, the provider should notify the Program Integrity Unit in writing. Return a completed Report of Suspected Abuse of the Medicaid Healthcare System (Section 4.7.1) to:

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

NAME(s) OF MEDICAID CLIENT/PROVIDER:_______________________________
ADDRESS OF MEDICAID CLIENT/PROVIDER:_______________________________
TELEPHONE NUMBER OF MEDICAID CLIENT/ PROVIDER:_____________________

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

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

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

Signature of Person Reporting Abuse _______________________________ Date __________

ADDRESS:_________________________________________________ Telephone ______________

__________________________________________________________________________

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

RETURN THIS FORM TO:

Program Integrity Unit
Division of Healthcare Financing
6101 Yellowstone Rd., Suite 210
Cheyenne, WY 82002
4.8 Sanctions

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

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

4.9 Adverse Actions

Providers and clients have the right to request an administrative hearing regarding an adverse action, after reconsideration, taken by the Division of Healthcare Financing. This process is defined in Wyoming Medicaid Rule, Chapter 1, entitled “Rules for Medicaid Administrative Hearings”.
Chapter Five
Client Eligibility

Chapter Five ....................................................................................................................................... 5-1
5.1  What is Medicaid?........................................................................................................................................ 5-2
5.2  Who is Eligible? ....................................................................................................................................... 5-2
5.3  Maternal and Family Health (MFH)........................................................................................................ 5-4
5.4  Eligibility Determination .................................................................................................................... 5-5
5.5  Client Identification Cards .................................................................................................................. 5-6
5.6  Other Types of Eligibility Identification ............................................................................................ 5-7
5.7  Clients without Cards............................................................................................................................ 5-7
5.8  Freedom of Choice................................................................................................................................... 5-8
5.9  Verification of Client Eligibility........................................................................................................... 5-8
5.10 Verification Options................................................................................................................................ 5-9
5.1 What is Medicaid?

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

5.2 Who is Eligible?

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

- Children;
- Pregnant women;
- Family Care Adults; and
- Aged, Blind, and Disabled

Childless adults who do not fit into one of these categories are not covered regardless of income or assets.

NOTE: For a complete listing of Medicaid and State Healthcare Benefit Plans refer to Section A.5.

5.2.1 Children

- Newborns are automatically eligible if the mother is Medicaid eligible at the time of the birth
- Low Income Children are eligible if family income is less than or equal to 100% federal poverty level (FPL) or 133% FPL, dependent on age of the child
- Family Care Children are eligible when a caretaker is determined eligible based on family that is less than or equal to income below the 1996 Family Care Standard
- Foster Care Children in Department of Family Services (DFS) custody are eligible in different income levels including some who enter subsidized adoption or who age out of foster care until they are age twenty-one (21)
5.2.2 Pregnant Women

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

5.2.3 Family Care Adult

- Family Care Adults (caretaker relatives with a dependent child) are eligible if family income is less than or equal to the 1996 Family Care Standard

5.2.4 Aged, Blind, and Disabled

5.2.4.1 Supplemental Security Income (SSI) and SSI Related

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

5.2.4.2 Institution

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

- Nursing Home
- Hospital
- Hospice
- ICF MR – State Training School
- INPAT-PSYCH – WY State Hospital – are 65 and older

5.2.4.3 Home and Community Based Waiver

All waiver groups are income eligible up to 300% of the SSI Payment Standard.

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

5.2.5.1 Special Groups

- Breast and Cervical Cancer Treatment Program – Uninsured women diagnosed with breast or cervical cancer are income eligible when income is less than or equal to 250% FPL.
- Tuberculosis (TB) Program – Individuals diagnosed with tuberculosis are eligible based on the TB Standard.

5.2.5.2 Employed Individuals with Disabilities

- Employed Individuals with Disabilities are income eligible under 300% of the SSI payment standard using unearned income and must pay a premium.

5.2.5.3 Medicare Savings Programs

- Qualified Medicare Beneficiaries are income eligible when their income is less than or equal to 100% FPL. Benefits include payment of Medicare premiums, deductibles, and cost sharing.
- Specified Low Income Beneficiaries are income eligible when their income is less than or equal to 135% FPL. Benefits include payment of Medicare premiums only.

5.2.5.4 Non-Citizens with Medical Emergencies

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

5.3 Maternal and Family Health (MFH)

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

- A client may be eligible only for a MFH program or may be dually eligible for a MFH program for other Medicaid programs. Care coordination for both MFH only and dually eligible clients is provided through the Public Health Nurse’s office.
- MFH has a dollar cap and service limits on some services that apply to clients who are eligible for MFH only. Refer to the provider manual issued by CSH. The
CSH provider manual is provided by CSH when a provider enrolls with the CSH program.

- Contact MFH for the following information:
  - The nearest Public Health Nurse
  - A replacement CSH provider manual
  - Questions related to eligibility determination or the type of services authorized by MFH.

Maternal & Family Health
6101 N. Yellowstone Rd., Ste. 420
Cheyenne, WY 82002
(800) 438-5795 or Fax: (307) 777-7215

Providers must be enrolled with Medicaid and MFH to receive payment for MFH services. Claims for both programs are submitted to and processed by the fiscal agent for Wyoming Medicaid (Section 2.1, Quick Address and Telephone Reference). Medical records for visits, which result from MFH referrals, must be sent directly to MFH for appointment tracking and case management. An optional form is available from CSH, which may be used to submit the medical information. Providers are asked to submit the record as soon after the visit as possible to assure timely coordination of referrals and services.

5.4 Eligibility Determination

5.4.1 Applying for Medicaid

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

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

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

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

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

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

5.5 Client Identification Cards

A Medicaid ID Card is mailed to clients upon enrollment in the Medicaid Program or the AIDS Drug Assistance Program (ADAP), Children’s Special Health (CSH), Prescription Drug Assistance Program (PDAP), and Marginal Dental Program (MDP). A complete listing of ways to check client eligibility is provided later in this chapter. An example of the Medicaid ID Card is shown below:
5.6 Other Types of Eligibility Identification

5.6.1 Notice of Award

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

5.7 Clients without Cards

5.7.1 Responsibility for Provider Payment

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

- Require the client to return with the card; or
- Verify the client’s eligibility for Medicaid and ID number by using a variety of free or fee-for-service eligibility inquiry options (Section 2.2, Quick Website Reference).

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

If, initially, a provider does not accept a patient as a Medicaid client (because they cannot produce a Medicaid ID card or because they did not inform the provider they are eligible), but the provider agrees at a later date to accept Medicaid benefits:

- The provider must refund the entire amount paid by the client prior to billing Medicaid; and
- The twelve-month timely filing deadline will not be waived (Section 6.19, Timely Filing).

In cases of retroactive eligibility when a provider agrees to bill Medicaid for services provided during the retroactive eligibility period:
- The provider must refund the entire amount paid by the client prior to billing Medicaid; and
- The twelve-month timely filing deadline will be waived.

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

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

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

5.9  **Verification of Client Eligibility**

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

5.9.1  **Medicaid ID Card**

It is each provider’s responsibility to verify the person receiving services is the same person listed on the card. If necessary, providers should request additional materials to confirm identification. It is illegal for anyone other than the person named on the Medicaid ID Card to obtain or attempt to obtain services by using the card. Providers who suspect misuse of a card should report the occurrence to the Program Integrity Unit or complete the Report of Suspected Abuse of the Medicaid Healthcare System Form (Section 4.7.1).

5.9.2  **Verification of Client Age**

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

Routine services may be covered through the month of the client’s twenty-first birthday.
5.10 Verification Options

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

5.10.1 Free Services

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

- Contact Provider Relations. There is a limit of three (3) verifications per call but no limit on the number of calls.
- Fax a list of identifying information to Provider Relations for verification. Send a list of beneficiaries for verification and receive a response within ten (10) business days.
- Call the Interactive Voice Response (IVR). The IVR is available 24 hours a day, seven days a week.
- (Section 2.1, Quick Address and Telephone Reference)
- Use the Ask EqualityCare feature on the Secure Provider Web Portal (Section 2.2, Quick Website Reference)

Note: For a complete listing of Medicaid and State Healthcare Benefit Plans refer to Section A.5.

5.10.2 Fee-for-Service

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

Chapter Six ......................................................................................................................................... 6-1

6.1 Basic Claim Information .................................................................................................... 6-2

6.2 Completing the UB-04 Claim Form .................................................................................... 6-4

6.3 Medicare Crossovers ........................................................................................................... 6-8

6.4 Examples of Billing .............................................................................................................. 6-9

6.5 Cap Limits ............................................................................................................................ 6-20

6.6 Reimbursement Methodologies .......................................................................................... 6-23

6.7 Co-Payment Schedule ........................................................................................................ 6-24

6.8 How to Bill for Newborns .................................................................................................. 6-24

6.9 No Show Appointments ...................................................................................................... 6-24

6.10 Prior Authorization ............................................................................................................ 6-25

6.11 Submitting Attachments for Electronic Claims ................................................................. 6-33

6.12 Sterilization, Hysterectomy, and Abortion Consent Forms ............................................... 6-35

6.13 The Remittance Advice .................................................................................................... 6-43

6.14 Resubmitting Verses Adjusting Claims ............................................................................. 6-50

6.15 Returning a Medicaid Check ............................................................................................ 6-55

6.16 Credit Balances .................................................................................................................. 6-56

6.17 Third Party Payments Received after Medicaid’s Payment .............................................. 6-56

6.18 Timely Filing ....................................................................................................................... 6-56

6.19 Important Information Regarding Retroactive Eligibility Decisions .............................. 6-58

6.20 Failure to Notify a Provider of Eligibility ....................................................................... 6-59

6.21 Billing Tips to Avoid Timely Filing Denials .................................................................... 6-59

6.22 Telehealth ........................................................................................................................... 6-59
6.1 Basic Claim Information

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

The following is a list of tips to aid providers in avoiding paper claims processing problems with OCR:

- Use an original, standard, red-dropout form [CMS-1500 (08/05) and UB04]
- Use typewritten print; for best results use a laser printer
- Use a clean, non-proportional font
- Use black ink
- Print claim data within the defined boxes on the claim form
- Print only the information asked for on the claim form
- Use all capital letters
- Use correction tape for corrections

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

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

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

NOTE: The fiscal agent and the Division of Healthcare Financing are prohibited by federal law from altering a claim.
Billing errors detected after a claim is submitted cannot be corrected until after Medicaid has made payment or notified the provider of the denial. Providers should not resubmit or attempt to adjust a claim until it is reported on their Remittance Advice (Section 6.15, Resubmitting Versus Adjusting Claims).

**NOTE:** Claims are to be submitted only after service(s) have been rendered, not before.
6.2 Completing the UB-04 Claim Form

6.2.1 UB-04 Claim Form

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT NAME</strong></td>
<td><strong>PATIENT ADDRESS</strong></td>
</tr>
<tr>
<td><strong>DATE OF BIRTH</strong></td>
<td><strong>SEX</strong></td>
</tr>
<tr>
<td><strong>ADMISSION</strong></td>
<td><strong>DISCHARGE</strong></td>
</tr>
<tr>
<td><strong>OCURRENCE CODE</strong></td>
<td><strong>OCURRENCE DATE</strong></td>
</tr>
<tr>
<td><strong>CPT CODE</strong></td>
<td><strong>CPT DESCRIPTION</strong></td>
</tr>
<tr>
<td><strong>ADMISSION CODE</strong></td>
<td><strong>ADMISSION DATE</strong></td>
</tr>
<tr>
<td><strong>DISCHARGE CODE</strong></td>
<td><strong>DISCHARGE DATE</strong></td>
</tr>
<tr>
<td><strong>VALUE COVERED AMOUNT</strong></td>
<td><strong>VALUE COVERED AMOUNT</strong></td>
</tr>
<tr>
<td><strong>VALUE COVERED AMOUNT</strong></td>
<td><strong>VALUE COVERED AMOUNT</strong></td>
</tr>
</tbody>
</table>

**PAGE** **OF** **CREATION DATE** **TOTALS**

**10 PAYOR NAME** **11 HEALTH PLAN ID** **14 PROVIDER NAME** **17 GROUP NAME** **20 EMPLOYER NAME**

**12 PROVIDER NUMBER** **13 CHARGE** **15 BENEFIT** **18 TOTAL CHARGES** **21 NON-COVERED CHARGES**

**16 SERVICES PERFORMED** **19 SERVICES PERFORMED** **22 REMARKS** **25 SIGNATURE** **28 APPROVED CODE NUMBER**

**MUE**

THE CERTIFICATIONS ON THE INVOICE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
### 6.2.2 Instructions for Completing the UB-04 Claim Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Item Description</th>
<th>Required</th>
<th>Required</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name and Address and Telephone</td>
<td>X</td>
<td>X</td>
<td>Enter the name of the provider submitting the bill, complete mailing address and telephone number.</td>
</tr>
<tr>
<td>2</td>
<td>Pay-To Name and Address</td>
<td>X</td>
<td>X</td>
<td>Enter the Pay-To Name and Address if different from 1.</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Control Number</td>
<td>X</td>
<td>X</td>
<td>(Optional) Enter your account number for the client. Any alpha/numeric character will be accepted and referenced on the R.A. No special characters are allowed.</td>
</tr>
<tr>
<td>3b</td>
<td>Medical Record Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>X</td>
<td>X</td>
<td>Enter the three-digit code indicating the specific type of bill. The code sequence is as follows:</td>
</tr>
<tr>
<td></td>
<td>First Digit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Skilled Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Home Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(ESRD,FQHC,RHC, or CORF)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 Special Facility (Hospital, CAH)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>** See Appendix C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax Number</td>
<td>X</td>
<td>X</td>
<td>Refers to the unique identifier assigned by a federal or state agency.</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period From/Through Dates</td>
<td>X</td>
<td>X</td>
<td>For services rendered on a single day, enter that date (MMDDYY) in both the “FROM” and “THROUGH” fields.</td>
</tr>
<tr>
<td></td>
<td>Inpatient:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enter the date of admission through the date of discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enter the date or dates of services that are being billed on the claim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient/Inpatient Combined:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enter the date the client was first seen for outpatient services through the inpatient discharge date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>Patient ID</td>
<td></td>
<td></td>
<td>Enter client’s Medicaid number.</td>
</tr>
<tr>
<td>8b</td>
<td>Patient Name</td>
<td>X</td>
<td>X</td>
<td>Enter the client’s name as shown on the front of the Medicaid card.</td>
</tr>
<tr>
<td>9</td>
<td>Patient Address</td>
<td>X</td>
<td>X</td>
<td>Enter the full mailing address of client.</td>
</tr>
<tr>
<td>10</td>
<td>Patient Birthdate</td>
<td>X</td>
<td>X</td>
<td>Enter client’s birthdate (MMDDYY)</td>
</tr>
<tr>
<td>11</td>
<td>Patient Sex</td>
<td>X</td>
<td>X</td>
<td>(Optional) Enter appropriate code</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>X</td>
<td>X</td>
<td>Enter the date the patient was admitted as an inpatient or the date of outpatient care.</td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour</td>
<td>X</td>
<td>X</td>
<td>0-24 hour of Admit (use 24 hour clock)</td>
</tr>
<tr>
<td>Field</td>
<td>Item Description</td>
<td>Inpatient Required</td>
<td>Outpatient Required</td>
<td>Action</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------</td>
<td>--------------------</td>
<td>---------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 14    | Type of Admission/Visit           | X                  | N/A                 | Enter appropriate code Inpatient:  
1 = Emergency  
2 = Urgent Care  
3 = Elective  
4 = Newborn  
Home Health Codes same as Inpatient |
| 15    | Source of Admission               | X                  | X                   | Enter the Source of Admission Code                                    |
| 16    | Discharge Hour                    | X                  | N/A                 | (When applicable) Enter the Hour the client was discharged.            |
| 17    | Patient Discharge Status          | X                  | X                   | Enter the two-digit Code indicating the status of the patient as noted below:  
<p>|       | Code                              | Description       |
| 18-28 | Condition Codes                   | X                  | X                   | Enter if Applicable                                                    |
| 29    | Accident State                    |                    |                     | If claim is for auto accident, enter the state the accident occurred in. |
| 30    | Future Use                        | N/A                | N/A                 |                                                                      |
| 31-34 | Occurrence Code and Dates         | X                  | X                   | Enter if Applicable                                                    |
| 35-36 | Occurrence Span Codes and Dates   | X                  | X                   | Enter if Applicable                                                    |
| 37    | Future Use                        | N/A                | N/A                 |                                                                      |
| 38    | Subscriber Name and Address        | X                  | X                   | Enter client’s name and address.                                       |
| 39-41 | Value Codes and Amounts           | X                  | X                   | Enter if Applicable                                                    |
| 42    | Revenue Codes                     | X                  | X                   | Enter the appropriate revenue codes                                    |
| 43    | Revenue Code Description          | X                  | X                   | Enter appropriate revenue code descriptions                            |
| 44    | HCPCS/Rates                       | X                  | X                   | Enter if Applicable                                                    |
| 45    | Service Date                      | X                  | X                   | Enter date(s) of service.                                              |
| 46    | Units of Service                  | X                  | X                   | Enter the units of services rendered for each detail line. A unit of service is the number of time a procedure is performed. If only one service is performed, the numeral 1 must be entered. |
| 47    | Total Charges (By Revenue Code)   | X                  | X                   | Enter the charge for each line item.                                    |</p>
<table>
<thead>
<tr>
<th>Field</th>
<th>Item Description</th>
<th>Inpatient Required</th>
<th>Outpatient Required</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>Non-Covered Charges</td>
<td>X</td>
<td>X</td>
<td>Enter if applicable</td>
</tr>
<tr>
<td>49</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Payer Identification (Name)</td>
<td>X</td>
<td>X</td>
<td>Enter name of Payor</td>
</tr>
<tr>
<td>51</td>
<td>Health Plan Identification Number</td>
<td></td>
<td></td>
<td>(Optional) Enter Health Plan ID for Payor</td>
</tr>
<tr>
<td>52</td>
<td>Release of Info Certification</td>
<td>X</td>
<td>X</td>
<td>Enter Y for release on file</td>
</tr>
<tr>
<td>53</td>
<td>Assignment of Benefit Certification</td>
<td>X</td>
<td>X</td>
<td>Y marked in this box indicates provider agrees to accept assignment under the terms of the Medicare program.</td>
</tr>
<tr>
<td>54</td>
<td>Prior Payments</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>55</td>
<td>Estimated Amount Due</td>
<td>X</td>
<td>X</td>
<td>Enter remaining total is prior payment was made.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>X</td>
<td>X</td>
<td>Enter Pay-To NPI</td>
</tr>
<tr>
<td>57</td>
<td>Other Provider IDs</td>
<td>Optional</td>
<td>Optional</td>
<td>Enter legacy ID’s if required</td>
</tr>
<tr>
<td>58</td>
<td>Insured’s Name</td>
<td>X</td>
<td>X</td>
<td>Enter client or insured’s name.</td>
</tr>
<tr>
<td>59</td>
<td>Patient’s Relation to the Insured</td>
<td>X</td>
<td>X</td>
<td>Enter appropriate relationship to insured.</td>
</tr>
<tr>
<td>60</td>
<td>Insured’s Unique ID</td>
<td>X</td>
<td>X</td>
<td>Enter client’s Medicaid ID.</td>
</tr>
<tr>
<td>61</td>
<td>Insured Group Name</td>
<td></td>
<td></td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>62</td>
<td>Insured Group Name</td>
<td></td>
<td></td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>64</td>
<td>Document Control Number</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>65</td>
<td>Employer Name</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>66</td>
<td>Diagnosis/Procedure Code Qualifier</td>
<td>X</td>
<td>X</td>
<td>Enter Appropriate qualifier.</td>
</tr>
<tr>
<td>67</td>
<td>Principal Diagnosis Code/Other Diagnosis Codes</td>
<td>X</td>
<td>X</td>
<td>Enter all applicable diagnosis codes.</td>
</tr>
<tr>
<td>68</td>
<td>Present on Admission Indicator (shaded area)</td>
<td>X</td>
<td></td>
<td>Enter the appropriate POA indicator on each required diagnosis in the shaded area to the right of the diagnosis box.</td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis Code</td>
<td>X</td>
<td>X</td>
<td>Outpatient only if applicable</td>
</tr>
<tr>
<td>70</td>
<td>Patient’s Reason for Visit Code</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>71</td>
<td>PPS Code</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>72</td>
<td>External Cause of Injury Code</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>73</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Principal Procedure Code/Date</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>75</td>
<td>Future Use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Attending Name/ID-Qualifier 1-G</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>77</td>
<td>Operating ID</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>78-79</td>
<td>Other ID</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>X</td>
<td>X</td>
<td>Enter if Applicable</td>
</tr>
<tr>
<td>81</td>
<td>Code/Code Field Qualifiers *B3 Taxonomy</td>
<td>X</td>
<td>X</td>
<td>Enter B3 to indicate taxonomy and follow with the appropriate taxonomy code.</td>
</tr>
</tbody>
</table>
6.3 **Medicare Crossovers**

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

6.3.1 **General Information**

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

6.3.2 **Billing Information**

- Medicare is primary and must be billed first. Direct Medicare claims processing questions to the Medicare carrier.
- When posting the Medicare payment, the EOMB (Explanation of Medicare Benefits) may state that the claim has been forwarded to Medicaid. **No further action is required**, it has automatically been submitted.
- Medicare transmits electronic claims to Medicaid daily.
- The time limit for filing Medicare crossover claims to Medicaid is twelve months from the date of service or six months from the date of the Medicare payment, whichever is later.
- **If payment is not received from Medicaid after 45 days of the Medicare payment, submit a paper claim to Medicaid.** The line items on the paper claim being submitted to Medicaid must be exactly the same as the claim submitted to Medicare and have the Medicare EOMB attached.

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

6.4.1 Client Has Medicaid Coverage Only
6.4.2 Client has Medicaid and Medicare

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Occurrence Code</th>
<th>Occurrence Date</th>
<th>Occurrence Time</th>
<th>Final Diagnosis Code</th>
<th>Final Diagnosis Date</th>
<th>Final Diagnosis Time</th>
<th>Final Diagnosis Occurrence Date</th>
<th>Final Diagnosis Occurrence Time</th>
<th>Final Diagnosis Occurrence Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>Pharmacy</td>
<td></td>
<td>7-1-08</td>
<td>10</td>
<td>450</td>
<td>0</td>
<td>4886</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0270</td>
<td>Supplies</td>
<td></td>
<td>7-1-08</td>
<td>84</td>
<td>1150</td>
<td>0</td>
<td>4886</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0360</td>
<td>OR Services</td>
<td>30140</td>
<td>7-1-08</td>
<td>50</td>
<td>1184</td>
<td>50</td>
<td>4886</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0360</td>
<td>OR Services</td>
<td>30520</td>
<td>7-1-08</td>
<td>3</td>
<td>1185</td>
<td>50</td>
<td>4886</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0370</td>
<td>Anesthesia</td>
<td></td>
<td>7-1-08</td>
<td>5</td>
<td>750</td>
<td>0</td>
<td>4886</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0636</td>
<td>N4 00409298703</td>
<td>J0295</td>
<td>7-1-08</td>
<td>1</td>
<td>87</td>
<td>0</td>
<td>4886</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTALS: 4886

Wyoming Medicaid: Y
Medicare: Y

Provider: Smith, Jonas A
Address: 88 West 5th Street, My Town, WY 82000

ICN: 3282N00000X

Provider: Jackson Anthony

ICN: 109112232
6.4.3 Client has Medicaid and TPL (Third Party Liability)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Occurrence Date</th>
<th>Code</th>
<th>Occurrence Date</th>
<th>Occurrence From</th>
<th>Occurrence Through</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>Pharmacy</td>
<td>7-1-08</td>
<td>0270</td>
<td>Supplies</td>
<td>7-1-08</td>
<td>84</td>
<td>1150</td>
</tr>
<tr>
<td>0360</td>
<td>OR Services</td>
<td>7-1-08</td>
<td>0360</td>
<td>OR Services</td>
<td>7-1-08</td>
<td>3</td>
<td>1185</td>
</tr>
<tr>
<td>0370</td>
<td>Anesthesia</td>
<td>7-1-08</td>
<td>0636</td>
<td>00409298703</td>
<td>J0295</td>
<td>7-1-08</td>
<td>750</td>
</tr>
</tbody>
</table>

**WY Medicaid**
- Y

**BCBS**
- Y

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jonas A Smith</td>
<td>06000123456</td>
<td></td>
</tr>
<tr>
<td>Smith Anna</td>
<td>0479123586</td>
<td></td>
</tr>
</tbody>
</table>

The Company

<table>
<thead>
<tr>
<th>Code</th>
<th>Occurrence Date</th>
<th>Occurrence From</th>
<th>Occurrence Through</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>47819</td>
<td>7-1-08</td>
<td>470</td>
<td>4739</td>
<td></td>
</tr>
<tr>
<td>1091112232</td>
<td>7-1-08</td>
<td>1091112232</td>
<td>7-1-08</td>
<td></td>
</tr>
<tr>
<td>282N000000X</td>
<td>7-1-08</td>
<td>282N000000X</td>
<td>7-1-08</td>
<td></td>
</tr>
</tbody>
</table>
6.4.4  Client has Medicaid, TPL (Third Party Liability) and Medicare

My Hospital
123 Main Street
My Town, WY 82000-1111
307-555-1111

Smith, Jonas A
88 West 5th Street
My Town, WY 82000

0250 Pharmacy
0270 Supplies
0360 OR Services
0360 OR Services
0370 Anesthesia
0636 N4 00409298703

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Occurrence Date</th>
<th>Occurrence Code</th>
<th>Occurrence Start</th>
<th>Occurrence End</th>
<th>Occurrence Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>Pharmacy</td>
<td>7-1-08</td>
<td>1030</td>
<td>7-1-08</td>
<td>1050</td>
<td>450 00</td>
</tr>
<tr>
<td>0270</td>
<td>Supplies</td>
<td>7-1-08</td>
<td>1030</td>
<td>7-1-08</td>
<td>1050</td>
<td>1150 00</td>
</tr>
<tr>
<td>0360</td>
<td>OR Services</td>
<td>7-1-08</td>
<td>1030</td>
<td>7-1-08</td>
<td>1050</td>
<td>1184 50</td>
</tr>
<tr>
<td>0360</td>
<td>OR Services</td>
<td>7-1-08</td>
<td>1030</td>
<td>7-1-08</td>
<td>1050</td>
<td>1185 50</td>
</tr>
<tr>
<td>0370</td>
<td>Anesthesia</td>
<td>7-1-08</td>
<td>J0295</td>
<td>7-1-08</td>
<td>1050</td>
<td>87 00</td>
</tr>
</tbody>
</table>

Page 1 of 1
Creation Date: 7-5-08
Total: 4806 00

Medicaid: Y Y
Medicare: Y Y
BCBS Supplement: Y Y

Smith Jonas A
06000123456
Smith Anna
520111222A
Smith Jonas A
091234831

47819 4780 27801 4019 496 4169

470 4739

Jackson Anthony
1091112232
Jackson Anthony
1091112232
Jackson Anthony
1091112232
6.4.5 Provider Preventable Conditions (PPC)

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

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

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

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

6.4.5.3 Providers included in the PPC Review

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

6.4.5.4 Present on Admission (POA) Indicator

Wyoming Medicaid requires POA indicators on all inpatient hospital for all hospital types participating in Wyoming Medicaid. Wyoming Medicaid has adopted Medicare’s list of exempt ICD-9 diagnosis codes. The list of diagnosis codes exempt from the POA requirement can be found at:

http://www.cms.gov/HospitalAcqCond/05_Coding.asp#TopOfPage
6.4.5.4.1 Wyoming’s Health Care-Acquired Condition Inpatient Payment Adjustment Process

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

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

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

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

NOTE: The number “1” is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for diagnosis codes exempt from POA reporting.

4. For all claims with a POA indicator of “N”, request that the hospital submit an adjusted claim which identifies all charges associated with the HAC as “non-covered” and all charges not associated with the HAC as “covered.”

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

6. Request medical records for all claims identified in Step 3 with a POA indicator of “U” and for a sample of claims with a POA indicator of “Y” (no more than five from each hospital).

   a. For claims with a POA indicator of “Y,” review medical record documentation to validate the accuracy of the assignment of the “Y” indicator by verifying that the condition was present on admission. If the review determines that the indicator should be “N”, then proceed to Steps 4 and 5. Further, based on the results of the review, Wyoming Medicaid may request additional claims.

   b. For claims with a POA indicator of “U”, review the medical record to determine whether the use of the “U” indicator is appropriate. If the review determines that the indicator should be “N,” then proceed to Steps 4 and 5. If the review determines that the indicator should be “Y,” then the claim is not a HAC. Drop from the HAC adjustment consideration.

   c. Wyoming Medicaid will monitor the results and increase or decrease the sample size in each subsequent quarter, as necessary. Wyoming Medicaid may also drop hospitals from future sampling, depending on the results of the first year of reviews.

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

6.4.6 National Drug Code (NDC) Billing Requirement

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

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

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

<table>
<thead>
<tr>
<th>Labeler Code</th>
<th>Product Code</th>
<th>Package Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>(5 Digits)</td>
<td>(4 Digits)</td>
<td>(2 Digits)</td>
</tr>
</tbody>
</table>
General Provider Information                                      Common Billing Information

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

6.4.6.1 Converting 10-Digit NDCs to 11 Digits

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

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

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

6.4.6.2 Documenting and Billing the Appropriate NDC

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

6.4.6.3 Rebateable NDCs

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

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

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

### 6.4.6.4 Procedure Code / NDC Combinations

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

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

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

### 6.4.6.5 Billing Requirements

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

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

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

6.4.6.7 Submitting Multiple NDCs per Procedure Code

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

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

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

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

6.4.6.8 OPPS Packaged Services (Critical Access and General Hospitals Only)

The NDC requirement does not apply to services considered packaged under OPPS. These services are assigned status indicator N. For a list of packaged services, consult the APC-Based Fee Schedule located on the Medicaid website (Section 2.2, Quick Website Reference).
6.4.6.9  UB-04 Billing Instructions

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

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

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

**UB-04 - One NDC per Procedure Code**

<table>
<thead>
<tr>
<th>42 REV. CD.</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS/ RATE / HIPS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NON-COVERED CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0636</td>
<td>N460574411101</td>
<td>90378</td>
<td>030107</td>
<td>2</td>
<td>500.00</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>42 REV. CD.</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS/ RATE / HIPS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NON-COVERED CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0636</td>
<td>N460574411101</td>
<td>90378 KQ</td>
<td>030107</td>
<td>1</td>
<td>250.00</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:**  Medicaid’s instructions follow the National Uniform Billing Committee’s (NUCC) recommended guidelines for reporting the NDC on the UB-04 claim form. Provider claims that do not adhere to these guidelines will be returned unprocessed.
6.5 Cap Limits

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

<table>
<thead>
<tr>
<th>Codes</th>
<th>Limits</th>
<th>Does not apply to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Codes: 99281-99285, 99201-99215</td>
<td>12 combined visits per calendar year</td>
<td>• Clients Under Age 21</td>
</tr>
<tr>
<td>Revenue Codes: 450-459, 510-519</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Codes</th>
<th>Limits</th>
<th>Does not apply to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure codes: 97010-97039; 97110-97546 (all modalities on same date of service count as 1 visit)</td>
<td>20 physical therapy visits per year</td>
<td>• Clients Under Age 21</td>
</tr>
<tr>
<td>Revenue codes: 420, 421, 422, 424, 430, 431, 432, 434, 439, 440, 441, 442, 444 and 449 (each unit counts as 1 visit)</td>
<td>20 occupational therapy visits per year</td>
<td>• Medicare Crossovers</td>
</tr>
<tr>
<td></td>
<td>20 speech therapy visits per year</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

![Wyoming Department of Health Logo]( wyoming-health-department-logo.png)

<table>
<thead>
<tr>
<th>WYOMING MEDICAID CAP LIMIT WAIVER REQUEST FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client Name:</td>
</tr>
<tr>
<td>2. Client ID:</td>
</tr>
<tr>
<td>3. Pay-to Provider or Facility Name &amp; Address:</td>
</tr>
<tr>
<td>4. NPI Number:</td>
</tr>
<tr>
<td>5. Which calendar year are you requesting the cap limit waiver for?</td>
</tr>
<tr>
<td>6. Instructions: In the space below, please document reason for waiver request (must be medically necessary):</td>
</tr>
<tr>
<td>7. Physician’s Signature:</td>
</tr>
</tbody>
</table>

 Wyoming Medicaid
 Attention: Medical Policy
 PO Box 667
 Cheyenne, WY 82003-0667
 Fax – 307.772.8405

Revision 8/1/14
6.5.3 Cap Limit Waiver Request Form Instructions

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Title</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Client Name</td>
<td>Client’s name as it appears on their WY Medicaid card; if you know there has been a name change, include both names.</td>
</tr>
<tr>
<td>2</td>
<td>Client ID</td>
<td>Client’s WY Medicaid number</td>
</tr>
<tr>
<td>3</td>
<td>Pay-To Provider Name &amp; Address</td>
<td>Pay-To Providers name and address, the pay to provider is the provider that submits the claims and may be different than the treating provider.</td>
</tr>
<tr>
<td>4</td>
<td>Pay-To Provider NPI Number</td>
<td>Pay-To Provider NPI Number</td>
</tr>
<tr>
<td>5</td>
<td>Calendar Year for Request</td>
<td>The year the waiver is for. If you need to submit cap limit waivers for more than one year at a time, submit on separate forms.</td>
</tr>
<tr>
<td>6</td>
<td>Conditions</td>
<td>Note the conditions the client is being treated for that caused them to go over the cap limit; conditions must be written out. Diagnosis codes alone will not be accepted.</td>
</tr>
<tr>
<td>7</td>
<td>Provider Signature</td>
<td>The form needs to be signed and dated by the entity requesting the cap waiver.</td>
</tr>
</tbody>
</table>

6.6 Reimbursement Methodologies

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

- Medicaid fee schedule
- By report pricing
- Billed charges
- Invoice charges
- Negotiated rates
- Per diem
- RBRVS
- Outpatient Prospective Payment System (OPPS)
- Level of Care (LOC)

6.6.1 Invoice Charges

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

6.7 Co-Payment Schedule

<table>
<thead>
<tr>
<th>Procedure and Revenue Code(s)</th>
<th>Description</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015 and 0521 Revenue Code</td>
<td>Rural Health Clinic encounters</td>
<td>Co-payment requirements do not apply to:</td>
</tr>
<tr>
<td>T1015 and 0520 Revenue Code</td>
<td>Federally Qualified Health Center encounters</td>
<td>• Clients under age 21</td>
</tr>
<tr>
<td>450-459 and 510-519</td>
<td>Outpatient hospital visits (non-emergency)</td>
<td>• Nursing Facility Residents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pregnant Women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family planning services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Emergency services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hospice services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare Crossovers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inpatient Hospital stays</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Members of a Federally recognized tribe</td>
</tr>
</tbody>
</table>

6.8 How to Bill for Newborns

When a mother is eligible for Medicaid, at the time the baby is born, the newborn is automatically eligible for Medicaid for one year. However, DFS must be notified of the newborn’s name and date of birth for a Medicaid ID Card to be issued. A provider will need to have the newborn client ID in order to bill newborn claims.

6.9 No Show Appointments

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

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

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

Selected services and equipment requiring prior authorization include, but are not limited to, the following:

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Phone</th>
<th>Services Requiring PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Healthcare Financing (DHCF)</td>
<td>Contact case manager</td>
<td>• Assisted Living Facility (ALF) Waiver</td>
</tr>
<tr>
<td></td>
<td>Case manager will contact the DHCF</td>
<td>• Long Term Care (LTC) Waiver</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-State Home Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-State Placement for LTC Facilities</td>
</tr>
<tr>
<td>Dental Health Services</td>
<td>1-307-777-7945</td>
<td>• Severe Malocclusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Marginal Dental Program</td>
</tr>
<tr>
<td>Behavioral Health Division</td>
<td>Contact case manager</td>
<td>• Acquired Brain Injury (ABI) Waiver Services</td>
</tr>
<tr>
<td></td>
<td>Case manager will contact the Behavioral Health Division</td>
<td>• Developmentally Disabled Adult Waiver Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Developmentally Disabled Children Waiver Services</td>
</tr>
<tr>
<td>Goold Health Systems Inc (GHS)</td>
<td>1-877-207-1126</td>
<td>• Pharmacy</td>
</tr>
<tr>
<td>Division of Healthcare Financing (DHCF)</td>
<td>Contact case manager</td>
<td>• Children’s Mental Health Waiver Services</td>
</tr>
<tr>
<td></td>
<td>Case manager will contact - DHCF</td>
<td></td>
</tr>
<tr>
<td>Medical Policy</td>
<td>1-800-251-1268</td>
<td>• Hospice Services: Limited to clients residing in a nursing home</td>
</tr>
<tr>
<td></td>
<td>Option 1, 1, 4, 3</td>
<td>• Out-of-State Home Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgeries Requiring PA (not listed in this table)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tysabri IV Infusion Treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Contact Lenses</td>
</tr>
<tr>
<td>KePRO (DME)</td>
<td>1-855-294-1196</td>
<td>• Durable Medical Equipment (DME)</td>
</tr>
<tr>
<td>Xerox Care and Quality Solutions, Inc. (Utilization and Care Management)</td>
<td>1-888-545-1710</td>
<td>• Acute Psych</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Extended Psych</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Extraordinary Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gastric Bypass</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inpatient Rehabilitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PRFT – Psychiatric Residential Treatment Facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transplants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vagus Nerve Stimulator</td>
</tr>
</tbody>
</table>
6.11.1 Requesting Prior Authorization from Medical Policy

NOTE: This section only applies to providers requesting PA for out-of-state Home Health, certain surgeries and hospice services (limited to client’s residing in a nursing home). For all other types of PA requests, contact the appropriate authorizing agencies listed above for their written PA procedures.

Providers have three ways to request and receive a PA:

- Prior Authorization Form (Section 6.11.1.1). A hardcopy form for requesting a PA by mail or fax. For a copy of the form and instructions on how to complete it, refer to (Section 6.11.1.2).
- X12N 278 Prior Authorization Request and Response. A standard electronic file format used to transmit PA requests and receive responses. For additional information, refer to Chapter 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications; or
- Web-Based Entry. A web-based option for entering PA requests and receiving responses via Medicaid’s secure Provider Web Portal. For direction on entering a PA request through the Secure Provider Web Portal, view the Web Portal Tutorial found on the website. (Section 2.2, Quick Website Reference) For additional information, refer to Chapter 8, Electronic Data Interchange (EDI) and Chapter 9, Wyoming Specific HIPAA 5010 Electronic Specifications.
## 6.11.1.1 Medicaid Prior Authorization Form

### General Provider Information

<table>
<thead>
<tr>
<th>1. DBB</th>
<th>2. AGB</th>
<th>3. MEDICAID ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. PATIENT NAME (Last, First, M.I.)</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STREET ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITY, STATE, ZIP CODE</td>
</tr>
<tr>
<td>TELEPHONE</td>
</tr>
<tr>
<td>CONTACT NAME</td>
</tr>
</tbody>
</table>

### Service Information

<table>
<thead>
<tr>
<th>12. PROPOSED DATES OF SERVICE</th>
<th>12a. FROM</th>
<th>12b. TO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SERVICE DESCRIPTION</th>
<th>PROC CODE</th>
<th>MODIFIER(S)</th>
<th>UNITS</th>
<th>ESTIMATED COST</th>
<th>TREATING PROVIDER NPI NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes

19. PLEASE ATTACH SUPPORTING DOCUMENTATION SHOWING MEDICAL NECESSITY
   Applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the prescribed service. Additional documentation may be attached when necessary.

20. PLEASE NOTE BELOW WHICH MODIFICATIONS ARE REQUESTED

21. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCurate AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

### Signature

<table>
<thead>
<tr>
<th>SIGNATURE OF PROVIDER</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Authorization (For Fiscal Agent Use Only)

<table>
<thead>
<tr>
<th>AUTHORIZATION IS VALID FOR SERVICES</th>
<th>FROM DATE</th>
<th>TO DATE</th>
<th>PRIOR AUTHORIZATION #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comments / Explanation

The form includes sections for patient and provider information, service description, dates, and authorizations. It emphasizes the importance of accurate and complete documentation.
### 6.11.1.2 Instructions for completing the Medicaid Prior Authorization Form

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Title</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Date of Birth</td>
<td>Enter MMDDYY of client’s date of birth</td>
</tr>
<tr>
<td>2</td>
<td>Age</td>
<td>Enter client’s age</td>
</tr>
<tr>
<td>3*</td>
<td>Medicaid ID Number</td>
<td>Enter the client’s ten-digit Medicaid ID number</td>
</tr>
<tr>
<td>4*</td>
<td>Patient Name</td>
<td>Enter Last Name, First Name and Middle Initial exactly as it appears on the Medicaid ID card</td>
</tr>
<tr>
<td>5*</td>
<td>Pay-To Provider NPI #</td>
<td>Enter the Pay to Provider NPI Numbers</td>
</tr>
<tr>
<td>6*</td>
<td>Pay To Provider Taxonomy</td>
<td>Enter the Pay To Provider Taxonomy</td>
</tr>
<tr>
<td>7*</td>
<td>Pay To Provider Name</td>
<td>Enter the Pay To Provider Name</td>
</tr>
<tr>
<td>8</td>
<td>Street Address</td>
<td>Enter the Pay To Provider Street Address</td>
</tr>
<tr>
<td>9</td>
<td>City, State, Zip Code</td>
<td>Enter the Pay To Provider City, State and Zip Code</td>
</tr>
<tr>
<td>10*</td>
<td>Telephone – Contact Person</td>
<td>Enter phone number of the contact person for this prior authorization</td>
</tr>
<tr>
<td>11*</td>
<td>Contact Name</td>
<td>Enter the name of the person that can be contacted regarding this Prior Authorization</td>
</tr>
<tr>
<td>12*</td>
<td>Proposed Dates of service</td>
<td>Enter to the best of your ability what dates of service are you looking for. It can be one day or a date range.</td>
</tr>
<tr>
<td>13*</td>
<td>Service Description</td>
<td>Enter the service that you are requesting</td>
</tr>
<tr>
<td>14*</td>
<td>Procedure Code</td>
<td>Procedure Code for the service(s) being requested</td>
</tr>
<tr>
<td>15*</td>
<td>Modifier(s)</td>
<td>Modifier needed to bill the procedure on the claim – If no modifiers needed – put N/A</td>
</tr>
<tr>
<td>16*</td>
<td>Unit(s)</td>
<td>Enter number of each service requested</td>
</tr>
<tr>
<td>17*</td>
<td>Estimated Cost</td>
<td>Enter dollar amount times the unit(s) for each service requested</td>
</tr>
<tr>
<td>18*</td>
<td>Treating Provider NPI Number</td>
<td>Enter the Treating Provider NPI Number – Needs to be a Wyoming Medicaid Provider</td>
</tr>
<tr>
<td>19*</td>
<td>Supporting Documentation</td>
<td>Please attach all documentation to support medical necessity. Applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the prescribed service. Additional documentation may be attached when necessary.</td>
</tr>
<tr>
<td>20</td>
<td>Modifications</td>
<td>This is the entry of changes that are needed by the provider from the original request.</td>
</tr>
<tr>
<td>21*</td>
<td>Signature</td>
<td>The form needs to be signed and dated by the entity requesting the prior authorization of services.</td>
</tr>
<tr>
<td>22</td>
<td>Pending Authorization</td>
<td>If called in for a verbal authorization, put the name of the provider giving the PA number and date.</td>
</tr>
</tbody>
</table>

**NOTE:** The Prior Authorization Request Form needs to match the lines on the claim that are being billed.
6.11.2 Requesting an Emergency Prior Authorization

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

NOTE: Contact the other appropriate authorizing agencies for their pending/emergency PA procedures (Section 6.10).

6.11.3 Prior Authorization Approval/Denial Letter

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

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

6.11.3.1 Prior Authorization Approved

Once a PA is approved, an approval letter (Section 6.11.3.1.1) is mailed that includes the PA number. The PA number must be entered in box 63 of the UB-04 claim form. (For placement in an electronic X12N 837 Institutional Claim, consult the Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at http://www.wpc.edi.com.)
6.11.3.1.1 Prior Authorization Notice Approved

HCF-01

02/26/10
SAMPLE PROVIDER OF WYOMING
LTC WAIVER SERVICES
1234 SAMPLE STREET
SAMPLE WY 82001

MEDICAID PRIOR AUTHORIZATION NOTICE

Client : Sample Client
Client ID: 0000062141

PA-NUMBER 0012900194

Waiver Case Manager:

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

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

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

02/01/10-02/28/10 T2041 - SUPPORTS BROKERAGE, SELF DIRECTED, 15 MIN APPROVED
APPR UNITS: 300 UNIT PRICE $ 3.32 USED UNITS: 0

CODE EXPLANATIONS:

NO DENIAL REASON PROVIDED

COMMENT:

A8200RB1

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

PA-NUMBER 0012900194
A8200RB1

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

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

6.11.3.2.1 Prior Authorization Notice - Denied

---

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

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

6.11.3.3.1 Prior Authorization Notice - Pending

![Image of the MEDICAID PRIOR AUTHORIZATION NOTICE]

01/19/10 MEDICAID PRIOR AUTHORIZATION NOTICE

SAMPLE PROVIDER OF WYOMING
1234 SAMPLE STREET
SAMPLE WY 82001
Client: SAMPLE CLIENT
Client ID: 000062141

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

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

01/18/10-01/18/11 V2715 - PRISM, PER LENS PENDING
APPR UNITS: 2 UNIT PRICE:$ 9.32 USED UNITS: 0

CODE EXPLANATIONS:

NO DENIAL REASON PROVIDED

COMMENT:

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

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

PA-Number: 0019800002
A1500RB2
6.12 Submitting Attachments for Electronic Claims

- **Steps for submitting paper attachments**
  - Medicaid has created a process that allows providers to submit paper attachments for electronic claims. Providers need only follow these two simple steps:
    - Mark the attachment indicator on the electronic claim and indicate by mail as the submission method. For more information on the attachment indicator, consult your software vendor or clearinghouse, or the X12N 837 Institutional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at http://www.wpc.edi.com.
    - Complete Attachment Cover Sheet (Section 6.12.1) and mail it with the attachment to Wyoming Medicaid Attn: Claims.

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

- **Steps for submitting electronic attachments**
  - Medicaid has created a process that allows providers to submit paper attachments for electronic claims. Providers need only follow these two simple steps:
    - Mark the attachment indicator on the electronic claim. For more information on the attachment indicator, consult your software vendor or clearinghouse, or the X12N 837 Institutional Electronic Data Interchange Technical Report Type 3 (TR3). The TR3 can be accessed at http://www.wpc.edi.com.
    - Log onto the Secure Provider Web Portal
    - Under the submissions menu select Electronic Attachments
    - Complete required information
    - Select Browse
    - Navigate to the location of the electronic attachment on your computer
    - Click Upload
    - For support and additional information refer to Chapters 8 and 9 or contact EDI Services (Section 2.1, Quick Address and Telephone Reference)
6.12.1 Attachment Cover Sheet

Wyoming Medicaid Program

Attachment Cover Sheet

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this cover sheet. If this cover sheet is not attached to your documentation, your request CANNOT be processed. You MUST submit one cover sheet for each type of document. Documents sent without a cover sheet will be shredded.

Provider
Name ____________________________________________

Provider or NPI Number

Client
Name ____________________________________________

Client Medicaid ID Number

Date of Service (MMDDYY) ____________

Type of Document – One must be checked

☐ C – Consent Form (Abortion, Hysterectomy, Sterilization)
☐ H – Hospice Waiver
☐ I – Invoice
☐ M – Medicare EOMB
☐ O – Operative Reports
☐ P – Prior Authorization Form and/or Documentation
☐ S – Swing Bed Exemption Letter
☐ T – Third Party Liability Documentation (EOB’s, Denial Letters, Letters attempting to collect)

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

Attachment Control Number – For Office Use Only

6-34
6.13 Sterilization, Hysterectomy, and Abortion Consent Forms

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

- Sterilization Consent Form (Section 6.13.1.2)
- Hysterectomy Consent Form (Section 6.13.2.2)
- Abortion Certification Form (Section 6.13.3.2)
6.13.3 Sterilization Consent Guidelines

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

The Sterilization Consent Form (Section 6.13.1.2) may be obtained from Medicaid or copied from this manual. As mandated by Federal regulations, the consent form must be attached to all claims for sterilization-related procedures.

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

---

**FEDERAL GUIDELINES**

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

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

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

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

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

The physician statement on the consent form must be signed and dated by the physician who will perform the sterilization on the date of the sterilization or after the sterilization procedure was performed. The date on the sterilization claim form must be identical to the date and type of operation given in the physician’s statement.
6.13.1.1 **Instructions for Completing the Sterilization Consent Form**

Important tips for completing the Sterilization Consent Form

- Fields 7, 8 and 15, 16 must be completed prior to the procedure. Fields 7 and 15 cannot be corrected.
- All other fields may be corrected however corrections must be made with one line through the error and must be initialied.
  - The person that signed the line is the only person that can make the alteration
  - “Whiteout” will not be accepted when making corrections
- Every effort should be taken to complete the form correctly without any changes.

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

CONSENT TO STERILIZATION

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

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

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

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

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

I am at least 21 years or age and was born on _____________________________.

41. ____________________________, hereby consent of my own free will to be sterilized by 5. _________________________________, (specify type of operation) the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: ____________________________, (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation ____________________________, (specify type of operation) the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

After ____________________________, (name of individual) signed the consent form, I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

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

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

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

15. ____________________________     16. ____________________________

STATEMENT OF PERSON OBTAINING CONSENT

PHYSICIAN'S STATEMENT

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

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

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

Before ____________________________, (name of individual) signed the consent form, I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary.

I explained to him/her the nature of the sterilization operation ____________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

Physician ____________________________ Date: ____________________________

6.13.2 Hysterectomy Acknowledgment of Consent
The Hysterectomy Acknowledgment of Consent Form (Section 6.13.2.2) must accompany all claims for hysterectomy-related services; otherwise, Medicaid will not cover the services. The originating physician is required to supply other billing providers (e.g., hospital, surgeon, anesthesiologist, etc.) with a copy of the completed consent form.

6.13.2.1 Instructions for Completing the Hysterectomy Acknowledgment of Consent Form

6.13.2.2 Hysterectomy Consent Form

HYSTERECTOMY ACKNOWLEDGMENT OF CONSENT

Complete PART A if consent is obtained PRIOR to surgery

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

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

2  Diagnosis:_______________________________________________________________________________

3  Signature of Patient:____________________________________    Date:_____________________________

4  Signature of Person Explaining Hysterectomy:__________________________________    Date:_____________________________
Complete **PART B** if consent is obtained **AFTER** surgery

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

6 Diagnosis: ____________________________

7 Signature of Patient: ____________________________ Date: ____________________________

8 Signature of Person Explaining Hysterectomy: ____________________________ Date: ____________________________

---

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

9 Diagnosis: ____________________________

10 Check which is applicable:

[ ] Other reason for sterility: ______________________________________________

[ ] Previous tubal Date: ____________________________

[ ] Emergency situation (describe) ____________________________________________

11 Physician Signature ____________________________ Date ____________________________

HCF-03
6.13.3 Abortion Certification Guidelines

The Abortion Certification Form (Section 6.13.3.2) must accompany claims for abortion-related services; otherwise, Medicaid will not cover the services. This requirement includes, but is not limited to, claims from the attending physician, assistant surgeon, anesthesiologist, pathologist, and hospital.

6.13.3.1 Instructions for completing the Abortion Certification Form

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

I, Doctor 1 ____________________________________________, certify that:

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

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

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

3 Patient Name: _____________________________________

Address:   _____________________________________

Physician Signature:              _________________________________     4

Address:            _________________________________     5

________________________
6.14 The Remittance Advice

After claims have been processed, Medicaid distributes a Remittance Advice (RA) (Section 6.14.1) to providers.

The Remittance Advice (RA) plays an important communication role between providers and Medicaid. It explains the outcome of claims submitted for payment. Aside from providing a record of transactions the RA assists providers in resolving potential errors. Typically, the claims processing time from receipt to payment is five (5) to ten (10) business days. Providers receiving manual checks will receive their check and RA in the same mailing.

The RA is organized in the following manner:

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

- Claim Number
- Type of Document (0=new claim, 1=credit, 2=adjustment)
- Batch Number
- Imager Number
- Year/Julian Date
- Claim Input Medium Indicator
  - 0=Paper Claim
  - 1=Point of Sale
  - 2=Electronic Medicare Cross Overs
  - 3=Electronic (example, WINASAP)
  - 4=Computer generated (Adjustment)
  - 5=Special Batch

• The RA Summary Section reports the number of claim transactions, and total payment or check amount.
6.14.1 Sample Institutional Remittance Advice

<table>
<thead>
<tr>
<th>TRANS-CONTROL NUMBER</th>
<th>1ST-LAST DATE</th>
<th>PROC/MOD</th>
<th>REV</th>
<th>UNITS</th>
<th>BILLED</th>
<th>OTHER</th>
<th>PAID BY</th>
<th>COPAY</th>
<th>WRITE</th>
<th>DIS</th>
<th>PROVIDER NUMBER: 1234567890</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REMITTANCE ADVICE**

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

**ORIGINAL CLAIMS:**

* Gore  
  ALBERT  
  RECIP ID: 0600123456  
  PATIENT ACCT #: 00001  
  3-08241-00-029-0000-08  
  797.00  
  0.00  
  0.00  
  0.00  
  0.00  
  HEADER  
  EOB(S): 682  
  LI: 001 08/19/08 08/19/08 0270 3 24.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 K DDCW M01  
  LINE EOB(S): 690  
  LI: 002 08/19/08 08/19/08 0272 2 54.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 K DDCW M01  
  LINE EOB(S): 690  
  LI: 003 08/19/08 08/19/08 44310 0320 1 541.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 K DDCW M01  
  LINE EOB(S): 661  
  LI: 004 08/19/08 08/19/08 0621 1 178.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 K DDCW M01  
  LINE EOB(S): 690

**REMITTANCE ADVICE**

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

**TOTALS**

<table>
<thead>
<tr>
<th>PAID ORIGINAL CLAIMS</th>
<th>0 -------</th>
<th>0.00</th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAID ADJUSTMENT CLAIMS</td>
<td>0 -------</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>DENIED ORIGINAL CLAIMS</td>
<td>0 -------</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>DENIED ADJUSTMENT CLAIMS</td>
<td>0 -------</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>PENDED CLAIMS (IN PROCESS)</td>
<td>0 -------</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**AMOUNT OF CHECK:**  
0.00

---

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

**COUNT:**

- 690 SERVICE ON SAME DAY AS INPATIENT PROCEDURE CODE  
  COUNT: 3  
- 661 INPATIENT PROCEDURES AND INPATIENT SEPARATE PROCEDURES NOT PAID  
  COUNT: 1
6.14.2  How to Read Your Remittance Advice

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

<table>
<thead>
<tr>
<th>FIELD NAME</th>
<th>HEADER DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>To</td>
<td>Provider Name</td>
</tr>
<tr>
<td>R.A. Number</td>
<td>Remittance Advice Number assigned.</td>
</tr>
<tr>
<td>Date Paid</td>
<td>Payment date</td>
</tr>
<tr>
<td>Provider Number</td>
<td>Medicaid provider number/NPI number</td>
</tr>
<tr>
<td>Page</td>
<td>Page Number</td>
</tr>
<tr>
<td>Last, MI, and First</td>
<td>The client’s name as found on the Medicaid ID Card.</td>
</tr>
<tr>
<td>Recip ID</td>
<td>The client’s Medicaid ID Number.</td>
</tr>
<tr>
<td>Patient Acct #</td>
<td>The patient account number reported by the provider on the claim.</td>
</tr>
<tr>
<td>Trans Control Number</td>
<td>Transaction Control Number: The unique identifying number assigned to each claim submitted.</td>
</tr>
<tr>
<td>Billed Amt.</td>
<td>Total amount billed on the claim</td>
</tr>
<tr>
<td>Mcare Paid</td>
<td>Amount paid by Medicare</td>
</tr>
<tr>
<td>Copay Amt.</td>
<td>The amount due from the client for their co-payment.</td>
</tr>
<tr>
<td>Other Ins.</td>
<td>Amount paid by other insurance</td>
</tr>
<tr>
<td>Deductible</td>
<td>Medicare deductible amount</td>
</tr>
<tr>
<td>Coins Amt.</td>
<td>Medicare coinsurance amount</td>
</tr>
<tr>
<td>Mcaid Paid</td>
<td>The amount paid by Medicaid</td>
</tr>
<tr>
<td>Write off</td>
<td>Difference between Medicaid paid amount and the provider’s billed amount.</td>
</tr>
<tr>
<td>Header EOB(s)</td>
<td>Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA</td>
</tr>
<tr>
<td>Li</td>
<td>The line item number of the claim</td>
</tr>
<tr>
<td>Svc date</td>
<td>The date of service</td>
</tr>
<tr>
<td>Proc / Mods</td>
<td>The procedure code and applicable modifier.</td>
</tr>
<tr>
<td>Units</td>
<td>The number of units submitted.</td>
</tr>
<tr>
<td>Billed Amt.</td>
<td>Total amount billed on the line</td>
</tr>
<tr>
<td>Mcare Paid</td>
<td>Amount paid by Medicare</td>
</tr>
<tr>
<td>Copay Amt.</td>
<td>The amount due from the client for their co-payment.</td>
</tr>
<tr>
<td>Other Ins.</td>
<td>Amount paid by other insurance</td>
</tr>
<tr>
<td>Deductible</td>
<td>Medicare deductible amount</td>
</tr>
<tr>
<td>Coins Amt.</td>
<td>Medicare coinsurance amount</td>
</tr>
<tr>
<td>Mcaid Paid</td>
<td>The amount paid by Medicaid</td>
</tr>
<tr>
<td>Write off</td>
<td>Difference between Medicaid paid amount and the provider’s billed amount.</td>
</tr>
<tr>
<td>Treating Provider</td>
<td>The treating provider’s NPI number</td>
</tr>
<tr>
<td>S</td>
<td>How the system priced each claim. For example, claims priced manually have a distinct code. Claims paid according to the Medicaid fee schedule have another code. Below is a table which describes these pricing source codes:</td>
</tr>
<tr>
<td>A=</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>B=</td>
<td>Billed Charge</td>
</tr>
<tr>
<td>C=</td>
<td>Percent-of-Charges</td>
</tr>
<tr>
<td>D=</td>
<td>Inpatient Per Diem Rate</td>
</tr>
<tr>
<td>E=</td>
<td>EAC Priced Plus Dispensing Fee</td>
</tr>
<tr>
<td>F=</td>
<td>Fee Schedule</td>
</tr>
<tr>
<td>G=</td>
<td>FMAC Priced Plus Dispensing Fee</td>
</tr>
<tr>
<td>H=</td>
<td>Encounter Rate</td>
</tr>
<tr>
<td>I=</td>
<td>Institutional Care Rate</td>
</tr>
<tr>
<td>K=</td>
<td>Denied</td>
</tr>
<tr>
<td>L=</td>
<td>Maximum Suspend Ceiling</td>
</tr>
<tr>
<td>M=</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>N=</td>
<td>Provider Charge</td>
</tr>
<tr>
<td>O=</td>
<td>Relative Value Units TC</td>
</tr>
<tr>
<td>P=</td>
<td>Prior Authorization Rate</td>
</tr>
<tr>
<td>R=</td>
<td>Relative Value Unit Rate</td>
</tr>
<tr>
<td>S=</td>
<td>Relative Value Unit PC</td>
</tr>
<tr>
<td>T=</td>
<td>Fee Schedule TC</td>
</tr>
<tr>
<td>X=</td>
<td>Medicare Coinsurance and Deductible</td>
</tr>
<tr>
<td>Y=</td>
<td>Fee Schedule PC</td>
</tr>
<tr>
<td>Z=</td>
<td>Fee Plus Injection</td>
</tr>
</tbody>
</table>

Plan

The Medicaid and State Healthcare Benefit Plan the client is eligible for (Section A.3).

Line EOB(s)

Explanation of Benefits: A denial code. A description of each code is provided at the end of the RA.
6.14.3 Remittance Advice Replacement Request Policy

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

- Print the Remittance Advice (RA) replacement request form (Section 6.14.3.1)
- For replacement of a complete RA contact Provider Relations (Section 2.1, Quick Address and Telephone Reference) to obtain the RA number, date and number of pages
- Replacements of a specific page of an RA (containing a requested specific claim/TCN) will be 3 pages (the cover page, the page containing the claim, and the summary page for the RA)
- Review the below chart to determine the cost of the replacement RA (based on the total number of pages requested – for multiple RAs requested at the same time, add total pages together)
- Send the Completed form and payment as indicated on the form
  - Make checks to Division of Healthcare Financing
    - Mail to Provider Relations (Section 2.1, Quick Address and Telephone Reference)

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

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

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

Remittance Advice Replacement Request Policy

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

- Print the Remittance Advice (RA) Replacement Request Form
- For replacement of a complete RA - contact Provider Relations at 800-251-1268, options 1, 5, 0 - to obtain the RA number, date, and number of pages
- Replacements of a specific page of an RA (containing a requested specific claim/TCN) will be 3 pages (the cover page, the page containing the claim, and the summary page for the RA)
- Review the below chart to determine the cost of the replacement RA (based on total number of pages requested - for multiple RAs requested at the same time, add total pages together)
- Send the completed form and payment as indicated on the form
  - Make checks to Division of Healthcare Financing
  - Mail to: Provider Relations, PO Box 667, Cheyenne, WY 82003-0667

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

RAs less than 24 weeks old can always be obtained from the Secure Provider Web Portal, once a provider has registered for access. For assistance with accessing the Secure Provider Web Portal, contact the EDI Call Center at 800-672-4959, option 3.

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

<table>
<thead>
<tr>
<th>Provider Name (as enrolled with Wyoming Medicaid):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider NPI: ____________________________ Provider Taxonomy: ____________________________</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>Wyoming Medicaid Provider ID: ____________________</td>
</tr>
</tbody>
</table>

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

To request a complete RA:

RA Number: ____________________________
RA Date: ____________________________
RA Amount: ____________________________

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

Specific Claim TCN: ____________________________
Specific Claim Client ID and Date of Service: ____________________________

Delivery Method (select one):

__ Email Address (preferred): ____________________________
__ Fax Number (over 10 pages cannot be faxed): ____________________________
__ Mailing Address: ____________________________

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

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

Enclosed Check Info:
Total Amount: ____________________________
Check Number: ____________________________

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

6.14.4 Obtain Your RA from the Web

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

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

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

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

6.15 **Resubmitting Verses Adjusting Claims**

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

The deadlines for resubmitting and adjusting claims are different:

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

Adjustment requests for overpayments are accepted indefinitely. However, the Provider Agreement requires you to notify Medicaid within 30 days of learning of an overpayment. When Medicaid discovers an overpayment during a claims review, the provider is notified in writing of the error and has 30 days to either refund the overpayment by check or have it deducted from future payments. While either option is acceptable, refund checks are not encouraged. Refund checks are not reflected on the Remittance Advice. However, deductions from future payments are reflected on the Remittance advice, providing a hardcopy record of the repayment.

6.15.2 Resubmitting a Claim

Resubmitting is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned unprocessed or denied. Claims are often returned to providers before processing because key information such as an authorized signature or required attachment is missing or unreadable.

6.14.3.2 How to Resubmit

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

6.15.2.2 When to Resubmit to Medicaid

- Claim Denied. Providers can resubmit to Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the explanation of benefits (EOB) code on the RA, make the appropriate corrections, and resubmit the claim on the appropriate claim form.
- Line Denied. Providers can submit individually denied lines.
- Claim Returned. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed. Correct the information as directed and resubmit your claim.
6.15.3 Adjustments

If you believe a claim has been paid incorrectly, contact Provider Relations for verification. Once the incorrect payment has been verified, you may submit an Adjustment/Void Request Form (Section 6.15.3.1). If the incorrect payment was the result of the fiscal agents keying error, contact Provider Relations to have the claim corrected (Section 2.1, Quick Address and Telephone Reference).

When adjustments are made to previously paid claims, Medicaid reverses the original payment and processes a replacement claim. The result of the adjustment appears on the RA as two transactions. The reversal of the original payment will appear as a credit (negative) transaction. The replacement claim will appear as a debit (positive) transaction and may or may not appear on the same RA as the credit transaction. The replacement claim will have nearly the same TCN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. Adjustments are processed in the same time frame as original claims.
## 6.15.3.1 ADJUSTMENT/VOID REQUEST FORM

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

- 1a) **CLAIM ADJUSTMENT**: Attach a copy of the claim with corrections made in **BLUE ink**.
  
  **DO NOT USE HIGHLIGHTER**

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

  Complete Sections B and C.

  If attaching a check, the check should be payable to **Division of Healthcare Financing (DHCF)**.

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

  Complete Section C only.

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

**SECTION B**

TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:

1. 17-DIGIT TCN:  

2. PAYMENT DATE:  

3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER:  

4. PROVIDER NAME:  

5. 10-DIGIT CLIENT NUMBER:  

6. 10-DIGIT PA NUMBER:  

7. REASON FOR ADJUSTMENT OR VOID:  

**SECTION C: SIGNATURE AND DATE REQUIRED**

**PROVIDER SIGNATURE:** ___________________________ **DATE:** ____________

RETURN ALL REQUESTS TO:  
Wyoming Medicaid  
Attn: Claims  
PO BOX 547  
Cheyenne, WY 82003-0547

**REMARKS/STATUS:** ___________________________ 
(FOR FISCAL AGENT USE ONLY)

**CASH CONTROL NUMBER:** ___________________________  
**ADJUSTED BY:** ___________________________ **DATE:** ____________
6.15.3.2 How to request an adjustment/void

To request an adjustment, use the Adjustment/Void Request Form (Section 6.15.3.1). The requirements for adjusting/voiding a claim are as follows:

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

6.15.3.3 How to Complete the Adjustment/Void Request Form

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

• When a claim was overpaid or underpaid.
• When a claim was paid, but the information on the claim was incorrect (such as client ID, date of service, procedure code, diagnoses, units, etc.)

6.15.3.5 When to Request a Void

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

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

To request a cancellation of an entire RA, complete the Adjustment/Void Request Form (Section 6.15.3.1) and attach a copy of the RA and the Medicaid check. All claims listed on the RA will be voided from the system. If, at a later date, the claims need to be reprocessed, then they must be resubmitted by the provider.

6.16 Returning a Medicaid Check

Return a check issued by Medicaid only when every claim listed on the Remittance Advice (RA) is not correct. Return the Remittance Advice and check to Wyoming Medicaid Attn: Claims with the Adjustment/Void Request Form (Section 6.15.3.1) attached and Section A, box 2 marked.

If you receive a Remittance Advice that lists some correct payments and some incorrect payments, do not return the Medicaid check. Deposit the check and file an adjustment request for each individual claim paid incorrectly.
6.17 **Credit Balances**

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

**Credit balances can be resolved in two ways:**

1) Working off the credit balance. By taking no action, remaining credit balances will be deducted from future claim payments. The deductions appear as credits on the provider’s RA(s) until the balance owed to Medicaid has been paid.

2) Sending a check payable to the “Division of Healthcare Financing” for the amount owed. This method is typically required for providers who no longer submit claims to Medicaid. A notice is typically sent from Medicaid to the provider requesting the credit balance be paid. The provider is asked to attach the notice, a check and a letter explaining the money is to pay off a credit balance. Include your provider number to ensure the money is applied correctly.

6.18 **Third Party Payments Received after Medicaid’s Payment**

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

Complete the Adjustment/Void Request Form (Section 6.15.3.1), attach a corrected claim showing the insurance payment and attach a copy of the insurance EOB if the payment is less than 40% of the total claim charge.

6.19 **Timely Filing**

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

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

<table>
<thead>
<tr>
<th>Exceptions Beyond the Control of the Provider</th>
<th>The time limit is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Crossover</td>
<td>A claim must be submitted within twelve months of the date of service or within six months from the payment date on the Explanation of Medicare Benefits (EOMB), whichever is later.</td>
</tr>
<tr>
<td>Client is determined to be eligible on appeal, reconsideration, or court decision.</td>
<td>Claims must be submitted within six-months of the date of the determination of retroactive eligibility. If a claim exceeds timely filing, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing. The notice of retroactive eligibility may be a SSI award notice or a notice from DFS.</td>
</tr>
<tr>
<td>Client is determined to be eligible due to agency corrective actions.</td>
<td>Claims must be submitted within six-months of the date of the determination of retroactive eligibility. If a claim exceeds timely filing, a copy of the notice must be attached to the claim with a cover letter requesting an exception to timely filing.</td>
</tr>
<tr>
<td>Provider finds their records to be inconsistent with filed claims, regarding rendered services. This includes dates of service, procedure/revenue codes, tooth codes, modifiers, admission or discharge dates/times, treating or referring providers or any other item which makes the records/claims non-supportive of each other.</td>
<td>Although there is no specific time limit for correcting errors, the corrected claim must be submitted in a timely manner from when the error was discovered. If the claim exceeds timely filing, the claim must be sent with a cover letter requesting an exception to timely filing.</td>
</tr>
</tbody>
</table>

**NOTE:** The notice of retroactive eligibility may be a SSI award notice or a notice from DFS.
6.19.2 Appeal of Timely Filing

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

- The claim was originally filed within twelve-months of the date of service; and
- The provider made at least one attempt to resubmit the claim within twelve-months of the date of service; or
- A Medicaid computer or policy problem beyond the provider’s control prevented the provider from finalizing the claim within twelve months of the date of service.

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

6.19.2.1 How to Appeal

The provider should appeal directly to Provider Relations (Section 2.1, Quick Address and Telephone Reference) and should include the following:

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

6.20 Important Information Regarding Retroactive Eligibility Decisions

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

A provider is responsible for billing Medicaid only if:

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

In the event of retroactive eligibility, claims must be submitted within six months of the date of determination of retroactive eligibility.
NOTE: Inpatient Hospital Certification: A hospital may seek admission certification for a client found retroactively eligible for Medicaid benefits after the date of admission for services that require admission certification. The hospital must request admission certification within thirty days after the hospital receives notice of eligibility. To obtain certification, contact Xerox Care and Quality Solutions (Utilization and Care Management) (Section 2.1, Quick Address and Telephone Reference).

6.21 Failure to Notify a Provider of Eligibility

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

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

6.22 Billing Tips to Avoid Timely Filing Denials

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

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

6.23 Telehealth

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

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

Each site will be able to bill for their own services as long as they are an enrolled Medicaid provider (this includes out-of-state Medicaid providers).

6.23.1 Covered Services

Originating Sites (HUB Site)

The originating site or HUB site is the location of an eligible Medicaid client at the time the service is being furnished via telecommunications system occurs. Authorized originating sites are:

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

Distant Site Providers (Spoke Site)

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

Physician/practitioners eligible to bill for professional services are:

- Physician
- Advanced Practice Nurse with specialty of Psychiatry/Mental Health
- Physician’s Assistant (billed under the supervising physician)
- Psychologist or Neuropsychologist
- Licensed Mental Health Professional (LCSW, LPC, LMFT, LAT) – Licensed mental health professional cannot bill Medicaid directly. Services must be provided through an appropriate supervising provider. Services provided by non-physician practitioners must be within their scope(s) of practice and according to Medicaid policy.
For Medicaid payment to occur, interactive audio and video telecommunications must be used permitting real-time communication between the distant site physician or practitioner and the patient with sufficient quality to assure the accuracy of the assessment, diagnosis, and visible evaluation of symptoms and potential medication side effects. All interactive video telecommunication must comply with HIPAA patient privacy regulations at the site where the patient is located, the site where the consultant is located, and in the transmission process. If distortions in the transmission make adequate diagnosis and assessment improbable and a presenter at the site where the patient is located is unavailable to assist, the visit must be halted and rescheduled. It is not appropriate to bill for portions of the evaluation unless the exam was actually performed by the billing provider.

6.23.1.1 Non-Covered Services

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

6.23.1.2 Billing Requirements

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

- The services must be medically necessary and follow general accepted standards of care.
- The service must be a service covered by Medicaid.
- Claims must be made according to Medicaid billing instructions.
- The same procedure codes and rates apply as for services delivered in person.
- Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented, and monitored.
- Providers need to develop and document evaluation processes and patient outcomes related to the telehealth program, visits, provider access, and patient satisfaction.
- All service providers are required to develop and maintain written documentation in the form of progress notes the same as is originated during an in-person visit or consultation with the exception that the mode of communication (i.e. teleconference) should be noted.
- Medicaid will not reimburse for the use or upgrade of technology, for transmission charges, for charges of an attendant who instructs a patient on the use of the equipment or supervises/monitors a patient during the Medicaid encounter, or for consultations between professionals.

➢ The modifier to indicate a telehealth service is “GT” which must be used in conjunction with the appropriate procedure code to identify the professional telehealth services provided by the distant site provider (e.g., procedure code
90805 billed with modifier GT). Using the GT modifier does not change the reimbursement fee.

- When billing for the originating site facility fee, use procedure code Q3014. A separate or distinct progress note isn’t required to bill Q3014. Validation of service delivered would be confirmed by the accompanying practitioner’s claim with the GT modifier indicating the practitioner’s service was delivered via telehealth. Medicaid will reimburse the originating site provider the lesser of charge or the current Medicaid Fee.

- Additional services provided at the originating site on the same date as the telehealth services may be billed and reimbursed separately according to published policies and the national correct coding initiative guidelines.

- For ESRD-related services, at least one face-to-face, “hands on” visit (not telehealth) must be furnished each month to examine the vascular access site by a qualified provider.

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

<table>
<thead>
<tr>
<th>Spoke Sites Billing Code(s) (site without patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT-4 and HCPCS Level II Codes</strong></td>
</tr>
<tr>
<td>99241 - 99255</td>
</tr>
<tr>
<td>99201 – 99215</td>
</tr>
<tr>
<td>90832 – 90838</td>
</tr>
<tr>
<td>90791-90792</td>
</tr>
<tr>
<td>96116</td>
</tr>
<tr>
<td>90951, 90952, 90954, 90955, 90957, 90958, 90960 and 90961</td>
</tr>
<tr>
<td>G0270</td>
</tr>
<tr>
<td>H0031, H2019, T1007, T1017, H0006, G9012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hub Site Billing Code (site with patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCPCS Level II Code</strong></td>
</tr>
<tr>
<td>Q3014</td>
</tr>
</tbody>
</table>

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

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

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

7.2 **When Clients Have Third Party Liability (TPL)**

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

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

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

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

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

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

7.4 Exceptions to Billing Third Party Payers First

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

7.4.1 Preventive Pediatric Care

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

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

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

7.4.3 Health Insurance Policies Held by Absent Parents

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

7.4.4 100% Federally Funded Programs

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

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

7.5 Billing Third Party Payers

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

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

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

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

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

5) **If payment is received from the other payer.** Compare the amount received per procedure code with Medicaid’s maximum fee for the same procedure code.
   - **If the payment from the other payer is less than Medicaid’s maximum payment for a procedure.** Indicate the payment in the appropriate box on the claim form. If the insurance paid less than 40% of the total bill, attach a copy of the Explanation of Benefits (EOB) from the other payer.
   - **If payment is received from the other payer after Medicaid has already paid the claim.** Medicaid’s payment must be refunded for either the amount of the Medicaid payment or the amount of the insurance payment, whichever is less (Section 6.15, Resubmitting Verses Adjusting Claims). A copy of the EOB from the other payer must be included with the refund showing the reimbursement amount.

**NOTE:** Contact Provider Relations before timely filing becomes a problem (Section 2.1, Quick Address and Telephone Reference). Waivers of timely filing will not be granted due to unresponsive third party payers.
Wyoming Medicaid,

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

Thank you.

Sincerely,

Authorized Representative of ____________________________ (Billing Facility)

Name of Insurance Company billed: ____________________________

Date billing attempts made: ____________________________

Policyholder’s name: ____________________________

Policyholder’s policy number: ____________________________

Comments: _______________________________________

______________________________________

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

August 14, 2014
7.6 Coordination of Benefits

Coordination of benefits (COB) is the process of determining which source of coverage is the primary payer in a particular situation. COB information must be complete and indicate the payer, payment date, and payment amount. (Electronic COB information may be submitted as a part of the 837 transaction.)

Attachments may be sent indicating denial/payment of TPL to accompany an electronic claim (Section 6.11, Submitting Attachments for Electronic Claims).

7.7 Questions about TPL

Below answers to three common questions providers have about TPL.

1) Why is TPL important to my practice?

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

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

- If a policy is no longer in effect, Medicaid will not require the policy to be billed if it has expired;
- If a client has a new insurance carrier;
- If a client has been in an accident which may be covered by liability or casualty insurance or legal liability is being pursued; or
- If a request for medical information has been received from an insurance company, attorney, or another third party.
2) **Can I refuse to accept Medicaid clients who have other insurance if my office doesn’t bill other insurance?**

A provider **cannot** refuse to see a client because he/she has other insurance. A provider may limit the number of Medicaid clients he/she is willing to admit in his/her practice. The provider may not discriminate in establishing the limit. 42 (Code of Federal Regulations) C.F.R. 447.20 states:

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

3) **What if I do not participate with a health insurance company?**

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

4) **Why does Medicaid need my help?**

Pursuing third party payers allows Medicaid to save money without denying access to quality healthcare. It also benefits providers since third party payers may reimburse at a higher rate than Medicaid.

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

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

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

FISCAL AGENT USE ONLY

AUTHORIZED BY: ____________________  DATE: ____________

INPUT BY: _________________________  DATE: ____________
Chapter Eight
Electronic Data Interchange (EDI)

Chapter Eight ...................................................................................................................................8-10
8.1 What is Electronic Data Interchange (EDI)? ........................................................................... 8-11
8.2 Benefits......................................................................................................................................... 8-11
8.3 Standard Transaction Formats.................................................................................................. 8-12
8.4 Sending and Receiving Transactions........................................................................................ 8-13
8.5 EDI Services................................................................................................................................ 8-15
8.6 Additional Information Sources ................................................................................................ 8-18
8.7 Scheduled Web Portal Downtimes ............................................................................................8-10
8.1 What is Electronic Data Interchange (EDI)?

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

8.2 Benefits

Several immediate advantages can be realized by exchanging documents electronically:

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

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

- X12N 270/271 Eligibility Benefit Inquiry and Response
- X12N 276/277 Claims Status Request and Response
- X12N 278 Request for Prior Authorization and Response
- X12N 824 Implementation Guide Error Reporting  
  ➢ Will change to X12N 277CA with HIPAA 5010 implementation
- X12N 835 Claim Payment/Remittance Advice
- X12N 837 Dental, Professional and Institutional Claims
- X12N 997 Functional Acknowledgement  
  ➢ Will change to X12N 999 with HIPAA 5010 implementation

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

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

<table>
<thead>
<tr>
<th>EDI Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Method</strong></td>
</tr>
<tr>
<td>Bulletin Board System (BBS)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Method</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Web Portal</td>
</tr>
<tr>
<td>WINASAP 2003</td>
</tr>
</tbody>
</table>
8.5 EDI Services

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

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

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

What can you do with Web Portal?
• Submit claims
• Upload claim attachments (Section 6.12, Submitting Attachments for Electronic Claims)
• Retrieve Remittance Advices (stores the last 24 RAs)
• Submit Ask EqualityCare questions
• Submit and retrieve Prior Authorization requests and responses
• Perform LT101 Inquires
• Enter PASRR
• The Office Administrator can set up additional users and give them only the access that they need
• Build Claims Templates to save standard information such as
  ➢ NPI numbers
  ➢ Procedure Codes
  ➢ Fees

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

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

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

8.5.2.2 Creating an Office Administrator
Your Office Administrator will be the person responsible for adding and deleting new users as necessary for your organization along with any other privileges selected.

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

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

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

8.5.2.3 Creating additional users
1. Return to the home page and choose manage users
   a. Follow the steps as listed above

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

- Pentium processor
- CD-ROM drive
- 25 Megabytes of free disk space
- 128 Megabytes of RAM
- Monitor resolution of 800 x 600 pixels
- Hayes compatible 9600 baud asynchronous modem
- Telephone connectivity

WINASAP Start-up

1. Download program from the Medicaid Website or install the program from the CD you requested.
   a. When the welcome screen appears click next
   b. Read and accept the terms of the Software License Agreement
   c. Enter User Information
   d. Choose Destination Location
   e. Confirm your current settings and choose next
   f. Check Yes, launch the program file and finish

2. Creating a WINASAP login
   a. The user ID auto fills as ADMIN
   b. Tab to password and type asap
      1. The user ID and password are the same for everyone using WINASAP, we suggest that you do not change them
   c. After successfully logging in choose ok

3. Steps that must be completed
   a. The screen will automatically open the first time you run the program that says Open Payer
      i. Select Wyoming Medicaid and choose ok
   b. Choose File and Trading Partner – Enter the following
      i. Primary Identification: Enter your Trading Partner ID from the EDI welcome letter
      ii. Secondary Identification – Re-enter your Trading Partner ID (primary and secondary identification will be the same)
   c. Trading Partner Name:
      i. Entity Type: select person or non-person.
         1. Choose person if you are an individual such as; a waiver provider, physician, therapist, or nurse practitioner
2. Choose non-person if you are a facility such as; a hospital, pharmacy or nursing home.
   ii. Enter your last name, first name and middle initial (optional) OR
       the organization name

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

4. The following criteria must be completed:
   a. WINASAP2003 Communications:
      i. Host Telephone Number: This phone number is listed as the
         Submission Telephone Number on the EDI Welcome Letter.
         Enter it with no spaces, dashes, commas, or other punctuation
         marks.
      ii. User ID Number: Enter your Password/User ID exactly as it
          appears.
      iii. User Name: Enter your User Name exactly as it appears.
      iv. Choose Save

8.6 Additional Information Sources

For more information regarding EDI, please refer to the following websites:
- Centers for Medicare and Medicaid Services:  www.cms.gov/hipaa2/default.asp. This is the official HIPAA website of the Centers for Medicare & Medicaid Service).
- Washington Publishing Co.: www.wpc-edi.com/hipaa/HIPAA_40.asp. This website is the official source of the implementation guides for each of the ASC X12 N transactions.
- Workgroup for Electronic Data Interchange: www.wedi.org. This industry group promotes electronic transactions in the healthcare industry.
- Designated standard maintenance organizations: www.hipaa-dsmo.org. This website explains how changes are made to the transaction standards.
## 8.7 Scheduled Web Portal Downtime

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

Chapter Nine ...................................................................................................................................... 9-1

9.1  Wyoming Specific HIPAA 5010 Electronic Specifications....................................................... 9-2
9.2  Transaction Definitions.............................................................................................................. 9-2
9.3  Transmission Methods and Procedures................................................................................... 9-2
9.4  Acknowledgement and Error Reports....................................................................................... 9-7
9.5  Testing....................................................................................................................................... 9-9
9.6  270/271 Eligibility Request and Response.................................................................................. 9-10
9.7  276/277 Claim Request and Response....................................................................................... 9-12
9.8  278 Request for Review and Response...................................................................................... 9-13
9.9  835 Claim Payment/Advice....................................................................................................... 9-14
9.10 837 Professional Claims Transactions...................................................................................... 9-15
9.11 837 Institutional Claims Transactions....................................................................................... 9-19
9.12 837 Dental Claims Transactions............................................................................................... 9-20
9.1 **Wyoming Specific HIPAA 5010 Electronic Specifications**

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

9.2 **Transaction Definitions**

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

Acknowledgement Transaction Definitions
- TA1 – Interchange Acknowledgement
- 999 – Implementation acknowledgement for Health Care Insurance
- 277CA – Health Care Claim Acknowledgement

9.3 **Transmission Methods and Procedures**

9.3.1 **Asynchronous Dial-up**

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

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

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

9.3.1.1 **Communication Protocols:**

The EDI Clearinghouse currently supports the following communication options:

- XMODEM
- YMODEM
- ZMODEM
- KERMIT
9.3.1.2 Teleprocessing Requirements:

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

9.3.1.3 Transmission Protocol:

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

9.3.1.4 Teleprocessing Settings:

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

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

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

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

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

Enters Password/User ID (From the EDI Welcome Letter) <CR>

**Prompt: “Please Select from the Menu Options Below=>”**

Enters Desired Selection <CR>

1. **Electronic File Submission:**
   - Assigns and sends the transmission file name then waits for ZMODEM (by default) file transfer to be initiated by the Trading Partner.

2. **View Submitter Profile**

3. **Select File Transfer Protocol:**
   - Allows you to change the protocol for the current submission only. The protocol may be changed to (k) ermit, (x) Modem, (y) Modem, or (z) Modem.
   - Enter selection [k, x, y, z]:

4. **Download Confirmation**

9. **Exit & Disconnect:** Terminates connection.

Enters “1” to send file <CR>

**Prompt: “Please Select from the Menu Options Below=>”**

- Receives ZMODEM (or other designated protocol) file transfer. Upon completion, initiates file confirmation. Sends file confirmation report. Sends HOST selection menu followed by a user prompt=>
9.3.2 Web Portal

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

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

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

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


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

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

Diagram 3. MOVEit Managed File Transfer
9.4 Acknowledgement and Error Reports

The following acknowledgement reports are generated and delivered to trading partners:
- TA1 – Will be used to report invalid Trading Partner Relationship Validation – to Provider/Trading Partner
- 999 – Will be used to acknowledge Syntax Validation (Positive, Negative or Partial) – to Provider/Trading Partner
- 277CA – Claims Acknowledgement will be used to provide accept/reject information regarding submitted claims/request – to Provider/Trading Partner

9.4.1 Confirmation Report

When a trading partner submits an X12N transaction, a receipt is immediately sent to the trading partner to confirm that EDI Clearinghouse received a file, and shows a unique file number for each submission. The Host System will forward a Confirmation Report to the trading partner indicating:
- Verification of file receipt
- If the file is accepted or rejected
- Identified as an X12N at a high level

If a file fails this preliminary check, it will not continue processing. The Confirmation Report includes the following information:
- Date and time file was received
- File number
- Payor code (Wyoming Medicaid 77046)
- Submission format
- Type of transaction
- Number of claims and batches
- Status of Production or Test
- Additional messages that can be added as a communication to trading partners or may indicate the reason the file is invalid.

9.4.2 Interchange Level Errors and TA1 Rejection Report

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

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

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

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

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

- If the trading partner information is valid, the data continues processing for complete X12N syntax validation.

9.4.3 999 Implementation Acknowledgement

The 999 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group and the TR3 compliance.

For more information on the relationship between the 999 transaction set and other response transaction sets, refer to the ASC X12N Standards for Electronic Data Interchange Technical Report Type3 (TR3).

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

9.4.3.1 Batch and Real-Time Usage

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

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

- **Real-Time** - In real-time mode the sender remains connected while the receiver processes the transactions and returns a response transaction to the sender.

### 9.4.4 Data Retrieval Method

**Secure Web Portal**

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

### 9.5 Testing

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

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

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

### 9.5.1 Testing Requirements

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

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

Testing with EDI Clearinghouse

- The call center will have you submit a test file.
- After 24 hours contact the call center for test file results.
- Make corrections based on the TR3s and Wyoming Specific HIPAA 5010 Specifications.
- Resubmit test files as necessary.
- Successful completion of the testing process is required before a submitter will be approved for production.

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

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

9.6 270/271 Eligibility Request and Response

Health Care Eligibility Benefit Inquiry Request and Response for Wyoming Medicaid

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

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

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

9.6.2 GS Functional Group Header

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

9.6.3 The following are access methods supported by Wyoming Medicaid:

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

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

9.6.4 270 Eligibility Request

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

No Wyoming Specific Requirement

### 9.7 276/277 Claim Request and Response

**Health Care Claim Status Request and Response for Wyoming Medicaid**

This section is for use along with the ANSI ASC X12 Health Care Claim Status Request and Response 276/277. It should not be considered a replacement for the TR3s, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

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

#### 9.7.1 ISA Interchange Control Header

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

#### 9.7.2 GS Functional Group Header

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C</td>
<td>Header</td>
<td>GS</td>
<td>03</td>
<td>Enter 77046</td>
</tr>
</tbody>
</table>
9.7.3 276 Claim Status Request

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 46</td>
<td>2100B</td>
<td>NM1</td>
<td>09</td>
<td>Note: Enter the 9-digit Wyoming Medicaid Provider ID when a Wyoming Provider is an Atypical Provider/non-medical.</td>
</tr>
<tr>
<td>Page 51</td>
<td>2100C</td>
<td>NM1</td>
<td>08</td>
<td>Note: SV should be used only when a Wyoming Provider is an Atypical Provider/non-medical.</td>
</tr>
<tr>
<td>Page 73</td>
<td>2210D</td>
<td>REF</td>
<td>01</td>
<td>The Line Item Control Number inquiry is not supported by Wyoming Medicaid. The Claim Status Response will return all claim line items.</td>
</tr>
<tr>
<td>Page 73</td>
<td>2210D</td>
<td>REF</td>
<td>02</td>
<td>The Line Item Control Number inquiry is not supported by Wyoming Medicaid. The Claim Status Response will return all claim line items.</td>
</tr>
</tbody>
</table>

9.7.4 277 Claim Status Response

No Wyoming Specific Requirement

9.8 278 Request for Review and Response

Health Care Services Request for Review/Response for Wyoming Medicaid

This section is for use along with the ANSI ASC X12 Health Care Prior Authorization Request and Response 278. It should not be considered a replacement for the TR3s, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

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

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C</td>
<td>Interchange Control Header</td>
<td>ISA</td>
<td>08</td>
<td>Enter 100000 followed by spaces</td>
</tr>
</tbody>
</table>

9.8.2 GS Functional Group Header

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

9.8.3 278 Prior Authorization Request – Data Clarifications Inbound

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 73</td>
<td>2010A</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046</td>
</tr>
</tbody>
</table>

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

9.9 835 Claim Payment/Advice
Health Care Claim Payment Advice for Wyoming Medicaid

9.9.1 Payment/Advice

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

### 9.10 837 Professional Claims Transactions

**Wyoming Medicaid Professional Claims**

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

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

#### 9.10.1 ISA Interchange Control Header

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C Page C.3</td>
<td>Header</td>
<td>ISA</td>
<td>01</td>
<td>Enter 00</td>
</tr>
<tr>
<td>Appendix C Page C.4</td>
<td>Header</td>
<td>ISA</td>
<td>03</td>
<td>Enter 00</td>
</tr>
<tr>
<td>Appendix C Page C.4</td>
<td>Header</td>
<td>ISA</td>
<td>06</td>
<td>Enter Trading Partner ID</td>
</tr>
<tr>
<td>Appendix C Page C.5</td>
<td>Header</td>
<td>ISA</td>
<td>08</td>
<td>Enter 100000 followed by spaces</td>
</tr>
</tbody>
</table>
### 9.10.2 GS Functional Group Header

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C Page C.7</td>
<td>Functional Group Header</td>
<td>GS</td>
<td>02</td>
<td>Enter Trading Partner ID</td>
</tr>
<tr>
<td>Appendix C Page C.7</td>
<td>Functional Group Header</td>
<td>GS</td>
<td>03</td>
<td>Enter 77046</td>
</tr>
</tbody>
</table>

### 9.10.3 837 Professional

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 72</td>
<td>Header</td>
<td>BHT</td>
<td>06</td>
<td>Wyoming Medicaid only accepts the CH code.</td>
</tr>
<tr>
<td>Page 80</td>
<td>1000B</td>
<td>NM1</td>
<td>03</td>
<td>Enter Wyoming Medicaid</td>
</tr>
<tr>
<td>Page 80</td>
<td>1000B</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046</td>
</tr>
<tr>
<td>Page 83</td>
<td>2000A</td>
<td>PRV</td>
<td>03</td>
<td>If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.</td>
</tr>
<tr>
<td>Page 115</td>
<td>2000B</td>
<td>HL</td>
<td>04</td>
<td>Enter 0. The subscriber is always the patient; therefore, the dependent level will not be utilized.</td>
</tr>
<tr>
<td>Page 116-117</td>
<td>2000B</td>
<td>SBR</td>
<td>01</td>
<td>Enter P (Primary-Payer Responsibility Sequence Number Code) Client has only Medicaid coverage</td>
</tr>
<tr>
<td>Page 123</td>
<td>2010BA</td>
<td>NM1</td>
<td>09</td>
<td>Enter the 10-digit Wyoming Medicaid Client ID</td>
</tr>
<tr>
<td>Page 134</td>
<td>2010BB</td>
<td>NM1</td>
<td>03</td>
<td>Enter Wyoming Medicaid</td>
</tr>
<tr>
<td>Page 134</td>
<td>2010BB</td>
<td>NM1</td>
<td>08</td>
<td>Enter PI (Payor Identification)</td>
</tr>
<tr>
<td>Page 134</td>
<td>2010BB</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046</td>
</tr>
<tr>
<td>Page 140</td>
<td>2010BB</td>
<td>REF</td>
<td>01</td>
<td>If 'XX' is used to pass the NPI number in 2010AA, NM109, then Medicaid Provider Number is no longer allowed do not submit this segment. If no NPI was submitted then submit ‘G2’ (provider Commercial Number) in 2010BB REF01, and submit the Wyoming Medicaid Provider number in 2010BB REF02.</td>
</tr>
<tr>
<td>TR3 Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Reference Description</td>
<td>Wyoming Requirements</td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
<td>---------</td>
<td>-----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Page 140-141</td>
<td>2010BB</td>
<td>REF</td>
<td>02</td>
<td>If ‘XX’ is used to pass the NPI number in 2010AA, NM109, Then Medicaid Provider Number is no longer allowed, do no submit this segment. If no NPI was submitted then submit ‘G2’ (Provider Commercial Number) in 2010BB REF01, and submit the Wyoming Medicaid Provider Number in 2010BB REF02.</td>
</tr>
<tr>
<td>Page 262-263</td>
<td>2310A</td>
<td>REF</td>
<td>01</td>
<td>If ‘XX’ is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in Ref01 and the Wyoming Medicaid Provider ID in REF02.</td>
</tr>
<tr>
<td>Page 262-263</td>
<td>2310A</td>
<td>REF</td>
<td>02</td>
<td>If ‘XX’ is used to pass the NPI number in NM109, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
</tr>
<tr>
<td>Page 269-270</td>
<td>2310B</td>
<td>Ref</td>
<td>01</td>
<td>If ‘XX’ is used to pass the NPI number in NM09, then Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
</tr>
<tr>
<td>Page 269-270</td>
<td>2310B</td>
<td>REF</td>
<td>02</td>
<td>If ‘XX’ is used to pass the NPI Number is NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and</td>
</tr>
<tr>
<td>TR3 Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Reference Description</td>
<td>Wyoming Requirements</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
<td>---------</td>
<td>------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Page 300</td>
<td>2320</td>
<td>SBR</td>
<td>09</td>
<td>Do not use code MC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enter the 11-digit National Drug Code (NDC). NDCs less than 11-digits will cause the service line to be denied by Wyoming Medicaid. Do not enter hyphens or spaces with the NDC. Note: Only the first iteration of Loop 2410 will be used for claims processing. If two or more NDCs need to be reported for the same claim, the procedure code must be repeated on a separate service line with the first iteration of Loop 2410 used to report each unique NDC. For more information, consult the Wyoming Medicaid website (<a href="http://wymedicaid.acs-inc.com">http://wymedicaid.acs-inc.com</a>)</td>
</tr>
<tr>
<td>Page 427</td>
<td>2410</td>
<td>LIN</td>
<td>03</td>
<td>If the NPI is registered with Wyoming Medicaid, the Taxonomy Code is required.</td>
</tr>
<tr>
<td>Page 436</td>
<td>2420A</td>
<td>PRV</td>
<td>03</td>
<td>If ’XX’ is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
</tr>
<tr>
<td>Page 437</td>
<td>2420A</td>
<td>REF</td>
<td>01</td>
<td>If ’XX’ is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
</tr>
<tr>
<td></td>
<td>471</td>
<td>2420F</td>
<td>REF</td>
<td>01</td>
</tr>
<tr>
<td>Page 472</td>
<td>2420F</td>
<td>REF</td>
<td>02</td>
<td>If ’XX’ is used to pass the NPI number in NM109, Medicaid Provider Number is no longer allowe</td>
</tr>
<tr>
<td>TR3 Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Reference Description</td>
<td>Wyoming Requirements</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
<td>---------</td>
<td>-----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Provider Number is no longer allowed, do not submit this segment. If no NPI was submitted then enter ‘G2’ (Provider Commercial Number) in REF01 and the Wyoming Medicaid Provider ID in REF02.</td>
</tr>
</tbody>
</table>

### 9.11 837 Institutional Claims Transactions

**Wyoming Medicaid Institutional Claims**

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

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

### 9.11.1 ISA Interchange Control Header

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C Page C.4</td>
<td>Header</td>
<td>ISA</td>
<td>06</td>
<td>Enter Trading Partner ID</td>
</tr>
<tr>
<td>Appendix C Page C.5</td>
<td>Header</td>
<td>ISA</td>
<td>08</td>
<td>Enter 100000 followed by spaces</td>
</tr>
</tbody>
</table>
9.11.2 GS Functional Group Header

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C Page C.7</td>
<td>Functional Group Header</td>
<td>GS</td>
<td>02</td>
<td>Enter Trading Partner ID</td>
</tr>
<tr>
<td>Appendix C Page C.7</td>
<td>Functional Group Header</td>
<td>GS</td>
<td>03</td>
<td>Enter 77046</td>
</tr>
</tbody>
</table>

9.11.3 837 Institutional

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 77</td>
<td>1000B</td>
<td>NM1</td>
<td>03</td>
<td>Enter Wyoming Medicaid</td>
</tr>
<tr>
<td>Page 77</td>
<td>1000B</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046</td>
</tr>
</tbody>
</table>

9.12 837 Dental Claims Transactions

Wyoming Medicaid Dental Claims

This section is for use along with the ANSI ASC X12 Health Care 837 Claims Transactions. It should not be considered a replacement for the TR3’s, but rather used as an additional source of information. This section contains data clarifications derived from specific business rules that apply exclusively to Wyoming Medicaid.

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

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C</td>
<td>Header</td>
<td>ISA</td>
<td>06</td>
<td>Enter Trading Partner ID</td>
</tr>
<tr>
<td>Page C.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix C</td>
<td>Header</td>
<td>ISA</td>
<td>08</td>
<td>Enter 100000 followed by spaces</td>
</tr>
<tr>
<td>Page C.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.12.2 **GS Functional Group Header**

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix C</td>
<td>Functional Group Header</td>
<td>GS</td>
<td>02</td>
<td>Enter Trading Partner ID</td>
</tr>
<tr>
<td>Page C.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix C</td>
<td>Functional Group Header</td>
<td>GS</td>
<td>03</td>
<td>Enter 77046</td>
</tr>
<tr>
<td>Page C.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.12.3 **Dental**

<table>
<thead>
<tr>
<th>TR3 Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Reference Description</th>
<th>Wyoming Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 75</td>
<td>1000B</td>
<td>NM1</td>
<td>03</td>
<td>Enter Wyoming Medicaid</td>
</tr>
<tr>
<td>Page 75</td>
<td>1000B</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046</td>
</tr>
<tr>
<td>Page 125</td>
<td>2010BB</td>
<td>NM1</td>
<td>03</td>
<td>Enter Wyoming Medicaid</td>
</tr>
<tr>
<td>Page 125</td>
<td>2010BB</td>
<td>NM1</td>
<td>08</td>
<td>Enter PI (Payor Identification)</td>
</tr>
<tr>
<td>Page 125</td>
<td>2010BB</td>
<td>NM1</td>
<td>09</td>
<td>Enter 77046</td>
</tr>
<tr>
<td>Page 126</td>
<td>2010BB</td>
<td>N3</td>
<td>01</td>
<td>Enter PO Box 547</td>
</tr>
<tr>
<td>Page 127</td>
<td>2010BB</td>
<td>N4</td>
<td>01</td>
<td>Enter Cheyenne</td>
</tr>
<tr>
<td>Page 128</td>
<td>2010BB</td>
<td>N4</td>
<td>02</td>
<td>Enter WY</td>
</tr>
<tr>
<td>Page 128</td>
<td>2010BB</td>
<td>N4</td>
<td>03</td>
<td>Enter 82003</td>
</tr>
</tbody>
</table>
Chapter Ten

Important Information

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

10.1 Claims Review.................................................................10-2
10.2 Coding........................................................................10-2
10.3 Importance of Fee Schedules........................................10-2
10.4 Interpretation Services...................................................10-3
10.1 Claims Review

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

10.2 Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Division of Healthcare Financing cannot suggest specific codes to be used in billing services. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current version of the Uniform Billing Editor.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend coding classes offered by certified coding specialists.
- Use the correct unit of measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II coding books. One (1) unit may equal “one visit” or “15 minutes.” Always check the long version of the code description.

10.3 Importance of Fee Schedules

Procedure codes and revenue codes listed in the following chapters are subject to change at any time without prior notice. The most accurate way to verify coverage for a specific service is to review the Medicaid fee schedules on the Medicaid website (Section 2.2, Quick Website Reference). Fee schedules list Medicaid covered codes, provide clarification of indicators such as whether a code requires prior authorization and the number of days in which follow-up procedures are included. Not all codes are covered by Medicaid or are allowed for all taxonomy codes (provider types). It is the provider’s responsibility to verify this information. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Remember to use the fee schedule and coding books that pertain to the appropriate dates of service.
10.4 Interpretation Services

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

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

- Interpretation between English and a foreign language is a covered service for Medicaid clients who have LEP. LEP is defined as “the inability to speak, read, write, or understand the English language at a level that permits an individual to interact effectively with healthcare providers.”
- Interpretation between sign language or lip reading and spoken language is a covered service for Medicaid clients who are deaf or hard of hearing. Hard of hearing is defined as “limited hearing which prevents an individual from hearing well enough to interact effectively with healthcare providers.”
### Chapter 11
**Outpatient Services**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>General Coverage Principles and Definitions</td>
<td>11-2</td>
</tr>
<tr>
<td>11.2</td>
<td>Abortion</td>
<td>11-4</td>
</tr>
<tr>
<td>11.3</td>
<td>Ambulance Services</td>
<td>11-5</td>
</tr>
<tr>
<td>11.5</td>
<td>Diabetic Training</td>
<td>11-6</td>
</tr>
<tr>
<td>11.6</td>
<td>Durable Medical Equipment</td>
<td>11-6</td>
</tr>
<tr>
<td>11.7</td>
<td>Emergency Department Services</td>
<td>11-7</td>
</tr>
<tr>
<td>11.8</td>
<td>Laboratory Services</td>
<td>11-8</td>
</tr>
<tr>
<td>11.9</td>
<td>Obstetrical Ultrasounds</td>
<td>11-11</td>
</tr>
<tr>
<td>11.10</td>
<td>Preventative Medicine - Over 21</td>
<td>11-11</td>
</tr>
<tr>
<td>11.11</td>
<td>Radiology Services</td>
<td>11-11</td>
</tr>
<tr>
<td>11.12</td>
<td>Sterilization and Hysterectomies</td>
<td>11-12</td>
</tr>
<tr>
<td>11.13</td>
<td>Surgical Services</td>
<td>11-14</td>
</tr>
<tr>
<td>11.14</td>
<td>Transplant Policy</td>
<td>11-15</td>
</tr>
<tr>
<td>11.15</td>
<td>Therapy Services</td>
<td>11-16</td>
</tr>
<tr>
<td>11.16</td>
<td>Non-Covered Services</td>
<td>11-20</td>
</tr>
<tr>
<td>11.17</td>
<td>OPPS Reimbursement, Definitions, Billing Tips and Guidelines</td>
<td>11-21</td>
</tr>
</tbody>
</table>
11.1 **General Coverage Principles and Definitions**

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

11.1.1 **Ambulatory Surgical Center (ASC)**

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

11.1.1.1 **Covered Services**

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

- Nursing, technical, and other related services involved in client care
- Use of surgical facility, including operating and recovery room, client preparation area, waiting room, and other facility areas used by the client
- Drugs, medical equipment, oxygen, surgical dressings, and other supplies directly related to the surgical procedure
- Splints, casts, and equipment directly related to the surgical procedures
- Administrative, record keeping, and housekeeping items and services
- Anesthesia materials
- Diagnostic procedures directly related to the surgical procedure, including those procedures performed before the surgery
- Blood and blood products

**NOTE:** ASCs must bill the same procedure codes as the practitioner. Providers should code all services using standard coding guidelines and the rules established by the American Medical Association. **Medicare crossover claims can be billed using the CMS 1500 form only when Medicare pays.**
11.1.2 **Critical Access Hospital (CAH)** – A hospital that meets the following CMS criteria:

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

11.1.3 **General Acute Care Hospital** – a hospital that is certified with CMS as a hospital but not a Critical Access hospital, to provide inpatient and outpatient services.

11.1.4 **Outpatient Services**

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

- Medically necessary outpatient hospital services are covered pursuant to written orders by a physician or staff under the supervision of a physician, a dentist or other appropriate practitioner.
- Services are considered outpatient services when the treatment is expected to keep the patient less than 24 hours regardless of the hour of admission, whether or not a bed is used and whether or not the patient remained in the hospital past midnight.
- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes. For inpatient information (Chapter 12, Critical Access Hospital and General Hospital Inpatient).
- When a patient receives outpatient services from a different facility each facility bills as appropriate. Services that were rendered in the outpatient services are billed outpatient by that facility and the inpatient services are billed as inpatient by that facility.
11.1.4.1 Reimbursement:

The three categories of outpatient services listed above (Ambulatory Surgical Centers, Critical Access Hospitals and General Hospitals) are based off of OPPS – a Medicare base outpatient hospital reimbursement methodology which is used by Wyoming Medicaid to reimburse for outpatient services. (Section 11.17, OPPS Reimbursement, Billing Tips, and Guidelines)

11.2 Abortion

11.2.1 Covered Services

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

- The client suffers from a physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed
- The pregnancy is the result of a sexual assault as defined in W.W. 6-2-301 which was reported to a law enforcement agency within five days after the assault or within five days after the time the victim was capable of reporting the assault
- The pregnancy is the result of incest

11.2.2 Billing Requirements

An Abortion Certification form (Section 6.13.3.2) must accompany all claims from the attending practitioner, assistant surgeon, anesthesiologist, and hospital. The attending practitioner is required to supply all other billing providers with a copy of the consent form.

- In cases of sexual assault, submission of medical records is not required prior to payment; however documentation of the circumstances of the case must be maintained in the client’s medical records
- Other abortion related procedures, including spontaneous, missed, incomplete, septic, and hydatiform mole, do not require the certification form; however, all abortion related procedure codes are subject to audit, and all pertinent records must substantiate the medical necessity and be available for review

NOTE: Reimbursement is available for those induced abortions performed during periods of retroactive eligibility only if the Abortion Certification Form (Section 6.13.3.2) was completed prior to performing the procedure.
11.3 **Ambulance Services**

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

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

Ambulance services must be billed using the CMS-1500 and must follow the policy defined for those programs. Refer to CMS-1500 Provider Manual Section 10.5.

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

11.4 **Diabetic Training**

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

Revenue Code Range: 0942

Procedure Code Range: G0108-G0109

11.4.1 **Covered Services**

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

- Medication education
- Dietetic/nutrition counseling
- Weight management
- Glucometer education
- Exercise education
- Foot/skin care
- Individual plan of care services received by the client
11.4.2 Billing Requirements

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

11.4.3 Documentation

- Documentation should reflect an overview of relative curriculum and any services received by the client.
- The Diabetic Education Certificate is not required to be submitted with each claim.

11.5 Durable Medical Equipment

Durable Medical Equipment must be billed using the CMS-1500 form and must follow the policy defined for that program. Refer to the Medicaid website for a copy of the Durable Medical Equipment General and Covered Services Manual (Section 2.2, Quick Website Reference).

11.6 Emergency Department Services

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

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

The facility must be available twenty-four hours a day.

Emergency department services provide evaluation, management, treatment and prevention of unexpected illness or injuries.

“Per visit” means all occurrences of a service provided on the same date of service during a separate visit. If more than one visit to an emergency room or clinic takes place on the same date of service, the second or subsequent visits to the emergency room must be for medically necessary services. Any same-day subsequent visits to the ER must have medical documentation, of all visits, attached to receive reimbursement.

NOTE: Clients who regularly present themselves to an outpatient department of a hospital for primary non-emergency services should be reported to the
Program Integrity Manager at the Division of Health Care Financing  
(Section 2.2, Quick Website Reference)

Revenue Codes: 0450 – 0459  
Procedure Codes: 99281 - 99285

NOTE: If a significant surgery is performed in the emergency room, enter a HCPCS surgery code in Field 44. Otherwise a CPT Evaluation / Management code can be reported.

11.6.1 Covered Services

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

11.6.2 Limitations

- If a significant surgery is performed in the emergency room, enter a HCPCS surgery code in Field 44. Otherwise, a CPT Evaluation/Management code can be reported.
- The twelve visits per calendar year limit for clients age 21 and older will continue to apply to non-emergency visits to the emergency room. Ancillary charges will be paid. Clients can be billed for denied visits that exceed limits. (Section 6.5, Cap Limits)
- A co-payment of $3.65 is also required for non-emergency visits to the emergency room. This amount will be automatically deducted from the emergency room payment. (Section 6.7, Co-Payment Schedule)
- When a patient receives outpatient services and is afterwards admitted as an inpatient of the same hospital within 24 hours, the outpatient services are treated as inpatient services for billing purposes. (Chapter 12, Critical Access Hospital and General Hospital Inpatient)
- When a patient receives outpatient services from a different hospital each facility bills as appropriate. Services that were rendered in the outpatient services are billed outpatient by that facility and the inpatient services are billed as inpatient by that facility.
- Physician services are billed on the CMS-1500 and are paid separately.
11.7 Laboratory Services

Revenue Codes: 30X - 31X

Procedure Codes: 80000 - 89999

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

- Services are ordered by physicians, dentists, or other providers licensed within the scope of their practice as defined by law
- Hospitals must have a current Clinical Laboratory Improvement Amendments (CLIA) number on file

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

11.7.1 CLIA Requirements

The type of CLIA certificate required to cover specific codes is listed in the table below. These codes are identified by Center for Medicare and Medicaid Services (CMS) as requiring CLIA certification; however, Medicaid may not cover all of the codes listed. Refer to the fee schedule located on Medicaid website for actual coverage and fees. Content is subject to change at any time, without notice (Section 2.2, Quick Website Reference).

<table>
<thead>
<tr>
<th>CLIA CERTIFICATE TYPE</th>
<th>ALLOWED TO BILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>REGISTRATION, COMPLIANCE, OR ACCREDITATION (LABORATORY) (1)</td>
<td>78110</td>
</tr>
<tr>
<td></td>
<td>78191</td>
</tr>
<tr>
<td>PROVIDER-PERFORMED MICROSCOPY PROCEDURES (PPMP) (4)</td>
<td>Q0111</td>
</tr>
<tr>
<td></td>
<td>Q0113</td>
</tr>
<tr>
<td></td>
<td>Q0115</td>
</tr>
<tr>
<td></td>
<td>81000</td>
</tr>
<tr>
<td></td>
<td>81020</td>
</tr>
<tr>
<td></td>
<td>G0027</td>
</tr>
<tr>
<td>AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)</td>
<td></td>
</tr>
</tbody>
</table>
### General Provider Information

#### WAIVER (2)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>81002</td>
<td>81025</td>
<td>82270</td>
<td>82272</td>
<td>82962</td>
<td>83026</td>
<td>84830</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85013</td>
<td>85651</td>
<td>80047QW</td>
<td>82330QW</td>
<td>82374QW</td>
<td>82435QW</td>
<td>82565QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82947QW</td>
<td>82950QW</td>
<td>82951QW</td>
<td>82952QW</td>
<td>84132QW</td>
<td>84295QW</td>
<td>84520QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85014QW</td>
<td>80048QW</td>
<td>80051QW</td>
<td>80053QW</td>
<td>80061QW</td>
<td>82465QW</td>
<td>83718QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>84478QW</td>
<td>84460QW</td>
<td>84450QW</td>
<td>80069QW</td>
<td>80178QW</td>
<td>81003QW</td>
<td>82044QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82570QW</td>
<td>84703QW</td>
<td>81007QW</td>
<td>82010QW</td>
<td>82040QW</td>
<td>82150QW</td>
<td>82247QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82310QW</td>
<td>82977QW</td>
<td>84075QW</td>
<td>84155QW</td>
<td>82043QW</td>
<td>82055QW</td>
<td>82120QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>83986QW</td>
<td>82271QW</td>
<td>82274QW</td>
<td>80301QW</td>
<td>83037QW</td>
<td>83065QW</td>
<td>83655QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>83880QW</td>
<td>84443QW</td>
<td>85018QW</td>
<td>85576QW</td>
<td>85610QW</td>
<td>86294QW</td>
<td>86308QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>86318QW</td>
<td>86618QW</td>
<td>86701QW</td>
<td>86803QW</td>
<td>87077QW</td>
<td>87210QW</td>
<td>87449QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>87804QW</td>
<td>87807QW</td>
<td>87808QW</td>
<td>87809QW</td>
<td>87880QW</td>
<td>87899QW</td>
<td>89300QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>89321QW</td>
<td>AND ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (REFER TO TABLE BELOW)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### NO CERTIFICATION

ALL CODES EXCLUDED FROM CLIA REQUIREMENTS (SEE BELOW)

---

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>80103</td>
<td>80500</td>
<td>80502</td>
<td>81050</td>
<td>82075</td>
<td>83013</td>
<td>83014</td>
<td>83987</td>
<td>84061</td>
</tr>
<tr>
<td>86078</td>
<td>86079</td>
<td>86485</td>
<td>86490</td>
<td>86510</td>
<td>86580</td>
<td>86891</td>
<td>86910</td>
<td>86911</td>
</tr>
<tr>
<td>86927</td>
<td>86930</td>
<td>86931</td>
<td>86932</td>
<td>86945</td>
<td>86950</td>
<td>86960</td>
<td>86965</td>
<td>86985</td>
</tr>
<tr>
<td>87900</td>
<td>88305(TC)</td>
<td>88311</td>
<td>88312(TC)</td>
<td>88313(TC)</td>
<td>88314(TC)</td>
<td>88329</td>
<td>88720</td>
<td>88738</td>
</tr>
<tr>
<td>88304(TC)</td>
<td>88741</td>
<td>89049</td>
<td>89220</td>
<td>89398</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** The Integrated Outpatient Code Editor has numerous edits that verify combinations of lab codes billed on the same claim to determine if they are on the NCCI Table 1 and Table 2 documents as invalid combinations of codes. Please review these documents on Medicare’s website if you have questions regarding denials for mutually exclusive lab codes.


---

**11.7.2 Genetic Testing**

**Revenue Codes:** 30X - 31X

**Procedure Codes:** 83891 and 88385 - 88386
11.7.3 Covered Services
Medicaid covers genetic testing under the following conditions:
- There is reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists; and
- Test results will influence decisions concerning disease treatment or prevention; and
- Genetic testing of children might confirm current symptomatology or predict adult onset diseases and findings might result in medical benefit to the child or as the child reaches adulthood.

11.7.4 Billing Requirements

Facility Laboratory
- The following documents must be attached to the claim:
  - The physician’s letter justifying the genetic testing must be attached to the claim. The letter must document the necessity for the genetic testing by meeting the covered service conditions mentioned above.
- No prior authorization is required.

Contracted Laboratory
- The following billing requirements must be followed when the enrolled facility agrees to act as a third party agent for a non-enrolled laboratory:
  - The physician’s letter justifying the genetic testing must be attached to the claim. The letter must document the necessity for the genetic testing by meeting the covered service conditions mentioned above.
  - Manufacturer’s invoice (Reimbursement will be invoice plus 15%)
- No prior authorization is required.

11.8 Obstetrical Ultrasounds

Revenue Codes: 32X – 35X, 40X, 61X

Procedure Codes: 76801-76828

Medicaid covers obstetrical ultrasounds during pregnancy when medical necessity is established for one (1) or more of the following conditions:
- Establish date of conception
- Discrepancy in size versus fetal age
- Early diagnosis of ectopic or molar pregnancy
- Fetal Postmaturity Syndrome
- Guide for amniocentesis
- Placental localization associated with abnormal vaginal bleeding (placenta previa)
- Polyhydramnios or Oligohydramnios
- Suspected congenital anomaly
• Suspected multiple births
• Other conditions related directly to the medical diagnosis or treatment of the mother and/or fetus.

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

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

• Determining gender
• Baby pictures
• Elective
• Observation for any signs of abuse
• Observation of any physical abnormality

11.9 Preventative Medicine - Over 21

11.9.1 Covered Services

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

11.10 Radiology Services

Revenue Code: 32X - 35X, 40X, 61X

Procedure Code: 70000 - 79999 and 90000 - 99999

Radiology services are ordered and provided by practitioners, dentists, or other providers licensed within the scope of their practice as defined by law. Imaging providers must be supervised by a practitioner licensed to practice medicine within the state the services are provided. Radiology providers must meet state facility licensing requirements. Facilities must also meet any additional federal or state requirements that apply to specific tests (e.g., mammography). All facilities providing screening and diagnostic mammography services are required to have a certificate issued by the Federal Food and Drug Administration (FDA).
11.10.1.1 Medicaid provides coverage of medically necessary radiology services, which are directly related to the client’s symptom or diagnosis when provided by independent radiologists, hospitals and practitioners.

11.10.2 Billing Requirements

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

11.10.3 Limitations:

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

11.11 Sterilization and Hysterectomies

Revenue Codes: 36X or 49X

11.11.1 Elective Sterilization

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

- Clients must complete and sign the Sterilization Consent Form at least 30 days, but not more than 180 days, prior to the sterilization procedure. There are no exceptions to the 180-day limitation of the effective time period of the informed consent agreement (e.g., retroactive eligibility). This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly completed, payment will be denied. A complete Sterilization Consent Form must be obtained from the primary physician for all related services (Section 6.13.1, Sterilization Consent Guidelines).

The 30-day waiting period may be waived for either of the following reasons:

- Premature Delivery - The Sterilization Consent Form must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
- Emergency Abdominal Surgery - The Sterilization Consent Form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.
  - Clients must be at least 21 years of age when signing the form.
Clients must not have been declared mentally incompetent by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.

Clients must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing sterilizations, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent any time before the sterilization without being subject to retribution or loss of benefits.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks, which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits associated with the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the client has been informed (Section 10.4, Interpretation Services).

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

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

### 11.11.2 Hysterectomies

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

- A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one section (A, B or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client must sign and date Section A of this form (see 42 CFR 441.250 for the Federal policy on hysterectomies and sterilizations).
The client does not need to sign this form when Sections B or C apply. If this form is not properly completed, payment will be denied (Section 6.13.2, Hysterectomy Acknowledgement of Consent).

- If the surgery does not render the client sterile, operative notes can be submitted in place of the form indicating reason for non-sterility.

- For clients that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one of the following:
  - The client was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing
  - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

11.12 Surgical Services

Revenue Codes: 36X or 49X

Procedure Codes 10000 - 69999

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

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

11.12.1 Billing Requirements

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

11.12.2 Limitations

- Medicaid covers cosmetic services only when it is medically necessary (e.g., restore bodily function or correct a deformity). Before cosmetic services are performed, they must be prior authorized.
- Surgical procedure codes that can only be done as an inpatient, are cosmetic or non-covered, or are an unlisted procedure will be denied.
- Any outpatient surgeries which are denied as only allowed in the inpatient setting can be appealed.
- Durable medical equipment must be billed as appropriate per DME Manual (2.2, Quick Website Reference).
- Medical/surgical supplies used in actual treatment of an outpatient are covered. A limited supply (two day maximum) may be provided to a patient only if a
prescription for the supply cannot be filled at a retail pharmacy or medical supplies provider within the two day time frame.

- Prescriptions for medications used in actual treatment of an outpatient are covered. A limited supply (two day maximum) may be prescribed to a patient only if a prescription for the medication cannot be filled at a retail pharmacy within the two day time frame.

11.13 Transplant Policy

11.13.1 Eligibility

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

11.13.2 Coordination of Care

Coordination of care will be provided by the case manager and Xerox Care and Quality Solutions (Utilization and Care Management) (Section 2.1, Quick Address and Telephone Reference).

Hospitals are required to obtain pre-certification/prior authorization for transplants listed below prior to admission and procedure. Xerox Care and Quality Solutions (Utilization and Care Management) will complete pre-certification/prior authorization (Section 6.10, Prior Authorization).

11.13.3 Covered Services

Outpatient transplants cover bone marrow only for clients 20 and under. Refer to inpatient services Section 12.5 for all other transplant services.

11.13.4 Reimbursement – Outpatient Stem Cell/ Bone Marrow

Medicaid reimburses for outpatient bone marrow transplantation services provided by specialized transplant physicians and facilities. Transplant services will be reimbursed, after discharge, at fifty-five percent (55%) of billed charges. Transplant services include:

- Initial evaluation
- Procurement/Acquisition (included on facility claim)
- Facility fees
- If the physician is employed by the hospital bill under facility charges. If physicians are not employed by the hospital they need to be enrolled with Medicaid and have their own agreement with Medicaid to bill appropriately.

11.13.5 Non-Covered Services

Transportation of organs is not covered under travel reimbursement.
11.14 Therapy Services

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

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

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

11.14.1 Physical Therapy and Occupational Therapy

Physical Therapy Revenue Codes: 420 - 429
Occupational Therapy Revenue Codes: 430 - 439

11.14.1.1 Covered Services

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

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

11.14.1.2 Limitations

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

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

11.14.1.3 Documentation
The practitioner’s and licensed physical therapist’s treatment plan must contain the following:
• Diagnosis and date of onset of the client’s condition
• Client’s rehabilitation potential
• Modalities
• Frequency
• Duration (interpreted as estimated length of time until the client is discharged from physical therapy)
• Practitioner signature and date of review
• Physical therapist’s notes and documented measurable progress and anticipated goals
• Initial orders certifying the medical necessity for therapy
• Practitioner’s renewal orders (at least every 30 days) certifying the medical necessity of continued therapy and any changes. The ordering practitioner must certify that:
  ➢ The services are medically necessary.
  ➢ A well-documented treatment plan is established and reviewed by the practitioner at least every 30 day.

11.14.1.4 Billing Requirements
• Therapy visits may be span billed in the ‘From’ and ‘To’ fields at the claim header, but the dates of each visit should be listed separately on the line items.

11.14.2 Speech Therapy

Revenue Codes: 440 - 449

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

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

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

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

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

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

11.14.2.2 Limitations

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

• Maintenance therapy, with the exception of clients age 20 and under
• Restorative therapy is for clients 21 and older
• Self-correcting disorders (e.g., natural dysfluency or articulation errors that are self-correcting)
• Services that are primarily educational in nature and encountered in school settings (e.g., psychosocial speech delay, behavioral problems, attention disorders, conceptual handicap, mental retardation, developmental delays, stammering and stuttering)
• Services that are not medically necessary
• Treatment of dialect and accent reduction
• Treatment whose purpose is vocationally or recreationally based
• Diagnosis or treatment in a school-based setting

Maintenance therapy consists of drills, techniques, and exercises that preserve the present level of function so as to prevent regression of the function and begins when therapeutic goals of treatment have been achieved and no further functional progress is apparent or expected.

11.14.2.3 Billing Requirements

• Therapy visits may be span billed in the 'From' and 'To' fields at the claim header, but the dates of each visit should be listed separately on the line items.

NOTE: In cases where the client receives both occupational and speech therapy, treatments should not be duplicated and separate treatment plans and goals should be provided.

11.14.2.4 Cap Limits

Medicaid clients age 21 and over will be limited to 20 occupational therapy, 20 physical therapy and 20 speech therapy visits per year. If the client has exceeded the Medicaid limits on therapy visits, the provider may bill him/her, or request the cap limit be waived, as long as the services are still medically necessary. For additional Cap Limit waiver information refer to Section 6.5 Cap Limits.

11.15 Outpatient Non-Covered Services

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

• Acupuncture
• Autopsies
• Chiropractic services
• Claims from outpatient hospitals for pharmaceuticals supplies only
• Court ordered hospital services are only covered if:
  ➢ Service is a Medicaid covered services
  ➢ Service does not exceed Medicaid limitations
• Dietary supplements
• Dietician/nutritional services
• Donor search expenses
• Medicaid does not cover services that are not direct patient health care i.e. – missed or canceled appointments or preparation of medical or insurance reports
• Exercise programs and programs that are primarily education, such as:
  ➢ Cardiac rehabilitation exercise programs
General Provider Information

11.16 OPPS Reimbursement, Definitions, Billing Tips and Guidelines

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

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

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

11.16.1 Purpose and Objectives

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

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

11.16.3 Coding Tips

- Use current CPT-4, HCPCS Level II and ICD-9-CM coding books
- Always read the complete description and guidelines in the coding books
- Relying on short descriptions can result in inappropriate billing
- Attend classes on coding offered by certified coding specialists
- Use specific codes rather than unlisted codes. For example, don’t use 53899 (unlisted procedure of the urinary system) when a more specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have three (3) to five (5) levels. See your CPT coding book for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the client. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.
- Revenue codes 25X (except for 253) and 27X do not require CPT or HCPCS codes; however, providers are advised to place appropriate CPT or HCPCS Level II codes on each line. Providers are paid based on the presence of line item CPT and HCPCS codes. If these codes are omitted, the hospital may be under paid.
- Take care to use the correct “units” measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be “each 15 minutes”. Always check the long text of the code description published in the CPT-4 or HCPCS Level II coding books. For example, if a physical therapist spends 45 minutes working with a client (97110), and the procedure bills for “each 15 minutes,” it would be billed this way.

<table>
<thead>
<tr>
<th>UB Field</th>
<th>42 – Rev Code</th>
<th>44 – Procedure Code</th>
<th>45 – Date of Service</th>
<th>46 – Units</th>
<th>47 – Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0420</td>
<td>97110</td>
<td>1/1/10</td>
<td>3</td>
<td>$75.00</td>
</tr>
</tbody>
</table>
11.16.3.1 **Using Modifiers**

- Review the guidelines for using modifiers in the most current CPT 4 coding book, HCPCS Level II book, and other help resources (e.g., CPT assistant, APC Answer Letter, and others)

- Always read the complete description for each modifier, some modifiers are described in the CPT coding book while others are in the HCPCS Level II book

- Medicaid accepts the same modifiers as Medicare for the purposes of OPPS billing (this is not true when the procedure code is priced from the Medicaid fee schedule rather than through OPPS methodology)

11.16.3.2 **Span Bills**

Outpatient providers may include services for more than one day on a single claim; however, each date of service must be billed on a separate line and must fall within the covered services date span at the header of the claim.

11.16.4 **Coding, Billing and Edits**

11.16.4.1 **Bilateral Procedures** - When billing bilateral procedures, bill the procedure code only once and bill with modifier 50.

<table>
<thead>
<tr>
<th>UB Field</th>
<th>42 – Rev Code</th>
<th>44 – Procedure Code</th>
<th>45 – Date of Service</th>
<th>46 – Units</th>
<th>47 – Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0360</td>
<td>27301 50</td>
<td>1/1/10</td>
<td>1</td>
<td>$2500.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UB Field</th>
<th>42 – Rev Code</th>
<th>44 – Procedure Code</th>
<th>45 – Date of Service</th>
<th>46 – Units</th>
<th>47 – Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>27301 50</td>
<td>7/1/14</td>
<td>1</td>
<td>$2500.00</td>
<td></td>
</tr>
</tbody>
</table>

11.16.4.2 **Inpatient Only Procedure Codes** – Certain procedure codes have been designated by Medicare and accepted by Medicaid as being valid in an inpatient setting only. The presence of one of these procedures on the claim without the appropriate modifiers may cause the claim to deny. A complete list of the current inpatient only procedure codes can be reviewed on the Medicaid website. (Section 2.2, Quick Website Reference)

11.16.4.3 **Patient Status Code** – Bill the appropriate patient status code. Medicaid accepts patient status codes that are not reserved for national assignment.
11.16.4.4 **Service on the same day** – All services provided to the Medicaid client by the hospital on the same day must be billed on a single claim. This requirement does not apply to reference labs, billing only for lab tests, with type of bill 14X.

11.16.4.5 **Line Item Date of Service** – All line items must show a valid date of service and must be within date of the header dates.

11.16.4.6 **Recording Detailed ICD-9 Diagnosis Codes** – ICD-9 diagnosis codes should be recorded to the greatest level of specificity using the fourth or fifth digit when required. Under the OPPS Pricing Program, the claim will deny if the principal diagnosis field is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid for the dates of service.

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

<table>
<thead>
<tr>
<th>UB Field</th>
<th>42 – Rev Code</th>
<th>44 – Procedure Code</th>
<th>45 – Date of Service</th>
<th>46 – Units</th>
<th>47 – Total Charges</th>
<th>Payment Method</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td></td>
<td>3/6/09</td>
<td>4</td>
<td>$913.13</td>
<td>Packaged</td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

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

11.16.4.8 **Type of Bill** – Type of Bill (TOB) acceptable on outpatient claims are 12X, 13X, 14X, 83X or 85X. (Section A-4 Appendix C)

11.16.4.9 **Line Item Denials and Claim Denials** – The claim will not necessarily be denied if an edit causes a line item to deny. When a hospital can correct a line item that has denied, the hospital should submit an adjustment to Wyoming Medicaid (Section 2.1, Quick
Address and Telephone Reference). The claims processing system will then re-price the entire claim and adjust payment to the hospital as appropriate.

11.16.5 Billing Tips for specific services

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

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

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

11.16.5.3 Supplies – Supplies are generally packaged so they usually do not need to be billed individually. A few especially expensive supplies are paid separately by Medicaid. Review the APC fee schedule available on the website to see which codes are paid separately. (Section 2.2 Quick Website Reference)

11.16.6 How payment is Calculated

11.16.6.1 Outpatient Prospective Payment System (OPPS) affected providers and claim types

- Critical Access and General Hospitals (taxonomies which begin with 282N)
- Ambulatory Surgical Centers (taxonomy 261QA1903X)
- In and out of state providers
- Outpatient claims only
- Does NOT impact Medicare secondary claims
11.16.6.2 The Outpatient Prospective Payment System (OPPS)

Most services in the outpatient setting are paid using the Ambulatory Payment Classification (APC) system developed by Medicare. The DHCF has adopted Medicare definitions and weights for APCs and those codes paid through the APC method. (See Section 11.16.9.9 for non-APC payments).

11.16.6.3 Revenue Codes and Procedure Codes

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

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

Refer to the OPPS fee schedule appropriate for the date of service to determine the payment when paid under the APC method. For Example:

<table>
<thead>
<tr>
<th>UB Field</th>
<th>42 – Rev Code</th>
<th>44 – Procedure Code</th>
<th>45 – Date of Service</th>
<th>46 – Units</th>
<th>47 – Total Charges</th>
<th>Payment Method</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0270</td>
<td></td>
<td>1/2/10</td>
<td>8</td>
<td>$149.36</td>
<td>Packaged</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>0300</td>
<td>80053</td>
<td>1/2/10</td>
<td>1</td>
<td>$84.71</td>
<td>Medicaid Fee Schedule</td>
<td>$13.29</td>
</tr>
<tr>
<td></td>
<td>0300</td>
<td>80101</td>
<td>1/2/10</td>
<td>7</td>
<td>$211.19</td>
<td>Medicaid Fee Schedule</td>
<td>$121.24</td>
</tr>
<tr>
<td></td>
<td>0450</td>
<td>9928425</td>
<td>1/2/10</td>
<td>1</td>
<td>$516.96</td>
<td>APC</td>
<td>$164.02</td>
</tr>
<tr>
<td></td>
<td>0730</td>
<td>93005</td>
<td>1/2/10</td>
<td>1</td>
<td>$100.65</td>
<td>APC</td>
<td>$19.52</td>
</tr>
<tr>
<td></td>
<td>0490</td>
<td>48102</td>
<td>7/14/14</td>
<td>1</td>
<td>$616.00</td>
<td>APC</td>
<td>$417.08</td>
</tr>
</tbody>
</table>
Some revenue codes require a CPT/HCPCS code. Line item revenue codes indicated as “CPT/HCPCS required” will be denied if a CPT/HCPCS code is not present. This information is only found in the Uniform Billing Editor, The Ultimate Guide to Accurate Facility Claims Submission.

### 11.16.7 Status Indicators

The IOCE assigns a status indicator to each procedure code. The status indicator directs payment of the line item. Each procedure code’s specific status indicator can be reviewed by using the online Fee Schedule on the website (Section 2.2, Quick Website Reference). The status indicators used the DHCF are based on the indicators used by Medicare, with DHCF specific indicators:

**Wyoming-Specific Status Indicators**

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

<table>
<thead>
<tr>
<th>Status Code</th>
<th>Medicare Description</th>
<th>Wyoming use of Status Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Services not Paid under OPPS; Paid under fee schedule or other payment system</td>
<td>Not paid under OPPS.</td>
</tr>
<tr>
<td>B</td>
<td>Non-allowed item or service for OPPS</td>
<td>Not paid under OPPS.</td>
</tr>
<tr>
<td>C</td>
<td>Inpatient procedure</td>
<td>Not paid under OPPS.</td>
</tr>
<tr>
<td>Column</td>
<td>Description</td>
<td>Payment Methodology</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D</td>
<td>Discontinued Codes</td>
<td>Not Paid under any system</td>
</tr>
<tr>
<td>E</td>
<td>Non-allowed item or Service</td>
<td>Not Paid under any outpatient system</td>
</tr>
<tr>
<td>F</td>
<td>Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines</td>
<td>Not paid under OPPS. Paid at reasonable cost</td>
</tr>
<tr>
<td>G</td>
<td>Pass-through drugs and biologicals</td>
<td>Paid under OPSS; Separate APC payment includes pass-through amount.</td>
</tr>
<tr>
<td>H</td>
<td>(1) Pass-through device categories</td>
<td>Paid under OPSS; (1) separate cost-based pass-through payment; (2) separate cost-based non pass-through payment</td>
</tr>
<tr>
<td>K</td>
<td>Non pass-through drugs and biological</td>
<td>Paid under OPSS; separate APC payment</td>
</tr>
<tr>
<td>L</td>
<td>Flu/PPV vaccines</td>
<td>Not paid under OPSS. Paid at reasonable cost</td>
</tr>
<tr>
<td>M</td>
<td>Services that are only billable to carriers and not to fiscal intermediaries</td>
<td>Not paid under OPPS</td>
</tr>
<tr>
<td>N</td>
<td>Items and services packaged into APC rates</td>
<td>Paid under OPSS; Payment is packaged into payment for other services.</td>
</tr>
<tr>
<td>P</td>
<td>Partial Hospitalization Service</td>
<td>Not Paid under OPPS</td>
</tr>
<tr>
<td>Q1</td>
<td>STVX-Packaged codes subject to separate payment under OPPS payment criteria.</td>
<td>Paid under OPPS; (1) Packaged APC payment if billed on the same date of service as a STVX procedure code; (2) separate APC payment</td>
</tr>
<tr>
<td>Q2</td>
<td>T packaged codes subject to separate payment under OPPS Payment criteria.</td>
<td>Paid under OPPS; (1) Packaged APC payment if billed on the same date of service as a T procedure code; (2) separate APC payment</td>
</tr>
<tr>
<td>Q3</td>
<td>Codes that may be paid through a Composite APC</td>
<td>Paid under OPPS; (1) Composite APC payment based on composite criteria; (2) Paid through a separate APC; (3) Payment is packaged into payment for other services</td>
</tr>
<tr>
<td>R</td>
<td>Blood and Blood Products</td>
<td>Paid under OPSS; separate APC payment</td>
</tr>
<tr>
<td>S</td>
<td>Procedure or service, not discounted when multiple</td>
<td>Paid under OPSS; separate APC payment</td>
</tr>
<tr>
<td>T</td>
<td>Procedure or service, multiple reduction applies</td>
<td>Paid under OPSS; separate APC payment</td>
</tr>
<tr>
<td>U</td>
<td>Brachytherapy Sources</td>
<td>Paid under OPSS; pays at % of Charges</td>
</tr>
<tr>
<td>V</td>
<td>Clinic or emergency department visit</td>
<td>Paid under OPSS; separate APC payment</td>
</tr>
<tr>
<td>X</td>
<td>Ancillary services</td>
<td>Paid under OPSS; separate APC payment</td>
</tr>
<tr>
<td>Y</td>
<td>Non-implantable durable medical equipment (DME)</td>
<td>Not paid under OPPS</td>
</tr>
</tbody>
</table>

### 11.16.8 Payment Calculations

The OPPS payment methodology strongly relies on the accurate coding of procedure codes for each service billed on the claim. These procedure codes are assigned a status indicator, which then identifies which type of Wyoming reimbursement methodology process will apply to the service line in question. Typically the payment methodology is the assignment of APC categories which determines the reimbursement rate for the procedure code.
11.16.8.1 **Ambulatory Payment Classification (APC)** – The main payment method for the OPPS system is the APC method which is used by Medicare. The Division of Health Care Financing has adopted the IOCE with APC.

11.16.8.2 **Composite APC** – An APC fee calculation that takes into consideration the presence of multiple procedures performed on the same date of service, and may discount the total payment due to the procedures being performed in combination rather than in separate situations.

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

11.16.8.4 **Conversion Factor** – A conversion factor is a standard dollar amount that is used to translate relative weights into payment. For current conversion factors review the APC fee schedule available on the website. (Section 2.2, Quick Website Reference) Medicaid has designated three (3) conversions for the following facility types:

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

11.16.8.5 Medicare calculates the relative weight for each procedure code based on historical claims costs and charges. Medicaid adopts Medicare’s relative weights.

11.16.8.6 **Fee Calculation** – In its simplest form, the calculation of an APC assigned procedure code is: (relative weight) x (conversion factor) = payment

\[ 4.0416 \times 40.00 = 161.66 \]

4.0416 (relative weight) x $40.00 – Ambulatory Surgical Center (conversion factor) = $161.66 (payment)
4.0416 (relative weight) x $45.45 – General Hospitals (conversion factor) = $183.69 (payment)

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

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

11.16.8.9 **Wyoming Specific Non-APC Payments** – Certain procedures are not assigned an APC category but are instead referred back to the Medicaid fee schedule for pricing.

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

11.16.9 **Charge Caps (Maximum payout on line item)**

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

- Due to the above, this could mean that lines on the claim pay more than the submitted charge. When this occurs, the Remittance Advice will reflect a negative write off amount.

11.16.9.1 If a procedure code is priced using the Medicaid fee schedule, (status indicator 3) the line will price/pay the lesser of the Medicaid allowed amount or the billed amount.

11.16.9.2 Package procedure codes will always price/pay at zero (status indicator N).
11.16.9.3 Those procedure codes having a status indicator reflecting that they are paid a percentage of charges are paid at a percentage of the participating hospital’s charges for that service (e.g., status code indicators 2 and H). The percentage paid is the participating hospital’s specific cost-to-charge ratio.

10.16.10.3.1 Under Wyoming’s OPPS, select services are paid using a percentage of charges. The actual percentage used for payment varies by provider and is called a cost-to-charge ratio. For participating providers (providers that have reached a designated threshold of payments in the base year for rate setting) in Medicaid’s inpatient level of care system, Medicaid uses a Medicaid cost-to-charge ratio that is calculated annually. Hospital-specific Medicaid cost-to-charge ratios may not exceed 100 percent. Non-participating hospitals are reimbursed using the average Medicaid cost to charge ratio for their provider type (children’s hospital, critical access hospital and general acute care hospital). Medicaid develops these cost-to-charge ratios from Medicare cost reports and Medicaid claims data.

11.16.10 Modifiers

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

11.16.10.1 Outpatient Services Modifiers

<table>
<thead>
<tr>
<th>Level I (CPT) Modifiers</th>
<th>Level II (HCPCS) Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 50 63 73 91 BL CA EA FA GA J1 KG LC Q0 P1 RC TA</td>
<td>CR EB F1 GG J2 KK LD Q1 P2 RT T1</td>
</tr>
<tr>
<td>27 52 74</td>
<td></td>
</tr>
<tr>
<td>33 58 76</td>
<td></td>
</tr>
<tr>
<td>59 77</td>
<td></td>
</tr>
<tr>
<td>78</td>
<td></td>
</tr>
<tr>
<td>79</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: OPPS does not accept the use of the 51 Modifier
11.16.11 Discounting

11.16.11.1 Discounted Procedures

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

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

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

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

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

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

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

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

11.16.12 Observation and Direct Admission Services

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

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

11.16.12.1 Reimbursement

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

- 8 or more units of procedure code G0378 are billed or an appropriate obstetric diagnosis code is billed along with at least 1 unit of procedure code G0378 and

- No services with a status code of “T” were provided on the same date of services as the G0378 and
• One or more of the following procedure codes are billed on the day of or the day prior to the observations services:
  ➢ 99205 – Office/outpatient visit, new
  ➢ 99215 – Office/outpatient visit, established

OR

• No services with a status code of “T” were provided on the same date of services as the G0378 and
• 8 or more units of procedure code G0378 are billed on the same date or the day after a high level emergency department visit or critical care service or an appropriate obstetric diagnosis code is billed along with at least 1 unit of procedure code G0378 and
• One or more of the following procedure codes are billed on the day of or the day prior to the observation services:
  ➢ 99284 – Emergency department visit (Level 4)
  ➢ 99285 – Emergency department visit (Level 5)
  ➢ 99291 – Critical care, first hour

Observation services billed with one of the listed visit procedure codes (99205, 99215, 99284, 99285, and 99291) but not meeting other criteria listed will be packaged.

11.16.12.2 Direct Admissions

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

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

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

11.16.13 NDC Billing Requirements

Review Chapter 6 for requirements on billing NDC codes with certain drug related procedure codes.
11.16.14 OPPS Quarterly Updates

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

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

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

11.16.15 Coding Tips

- Information related to the quarterly updates, and changes to OPPS policy and procedures as well as updated coding information will be published to the Medicaid web site with each quarterly update
- The most accurate way to review information related to the current OPPS policy and coding procedures is to view the OPPS information on the web site (Section 2.2, Quick Website Reference)
- There are a number of available references, resources and information sources available to assist with OPPS billing
Chapter 12
Critical Access Hospital and General Hospital Inpatient

Chapter Twelve ............................................................................................................................................. 12-1
12.1 General Coverage Principles and Definitions ................................................................................ 12-36
12.2 Abortion ............................................................................................................................................ 12-37
12.3 Psychiatric Services ........................................................................................................................... 12-37
12.4 Sterilization and Hysterectomies ........................................................................................................ 12-38
12.5 Transplant Services ............................................................................................................................ 12-40
12.6 Inpatient Billing Guidelines ............................................................................................................. 12-42
12.1 **General Coverage Principals and Definitions**

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

12.1.1 **Critical Access Hospital (CAH) - A hospital that meets the following CMS Criteria:**

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

12.1.1.1 **General Acute Care Hospital** – A hospital that is certified with CMS as a hospital but not a Critical Access Hospital, to provide inpatient and outpatient services.

12.1.2 **Psychiatric Hospital** – Hospitals which specialize in the treatment of serious mental illnesses and have been certified by Medicare as a Psychiatric Hospital.

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

- For payment purposes, inpatient services require at least a 24 hour stay unless the stay falls under the less than 24 hour stay for transfers. (Section 12.6.2, Outpatient Services Followed By Inpatient Services)
• Medically necessary inpatient hospital services are covered pursuant to written
orders by a physician or staff under the supervision of a physician, a dentist or other
appropriate practitioner.
• Facilities are required to send medications (either prescriptions or already filled)
home with clients upon discharge.
• Services are considered inpatient services when the patient is admitted as an
inpatient to the facility, regardless of the hour of admission, whether or not a bed is
used and whether or not the patient remained in the hospital past midnight
  ➢ Inpatient stays are subject to the submission of Inpatient Monitoring Reports –
  refer to Xerox Care and Quality Solutions for details
  ➢ When a client receives outpatient services and is afterwards admitted as an
  inpatient of the same hospital within 24 hours, the outpatient services are
treated as inpatient services for billing purposes. (Section 12.6, Inpatient
Billing Guidelines)

**12.2 Abortion**

Abortions are only allowed to be billed on an outpatient basis. (Section 11.2, Abortion)

**12.3 Psychiatric Services**

For Clients 21 and over Medicaid will reimburse for acute stabilization provided in
acute care general or critical access hospitals.

For Clients 20 and under Medicaid will reimburse for acute stabilization and extended
psychiatric care provided in acute care general or critical access hospitals.

**12.3.1 Acute Psychiatric Admissions Requirement**

Inpatient psychiatric admission requirements for the stabilization of acute conditions
are covered when the following medical necessity is met:

• The client must have been diagnosed with a psychiatric illness by a licensed mental
  health professional
• Symptoms of the illness must be in accord with those described in the Diagnostic
  Statistical Manual of Mental Disorders, Edition IV (DSM-IV)
• One or more of the following must be present:
  ➢ Client presents with suicidal ideation and intention, which represents
    significant risk of harm, medically significant self-mutilation, and/or recent
    lethal attempt to harm self, such that 24-hour/day hospitalization and
    observation are necessary for the patient’s safety
Client presents with a recent history of grossly disruptive/delusional and/or violent behavior representing clear and present danger of serious harm to others.

- The client’s psychiatric condition severely impairs his/her basic functional capacity as evidenced by disorganized, uncontrolled thinking/behavior that represents a genuine and proximal risk of danger to self-such that 24-hour/day nursing and medical treatment is required.

- Diagnosis and/or treatment is/are clearly unsafe or impossible to be provided in an ambulatory setting and can only be accomplished with 24-hour intensive nursing and medical care.

### 12.3.1.1 Billing Requirements

Services must be prior authorized within one working day of admission through Xerox Care and Quality Solutions. (Section 2.1, Quick Reference Guide and Section 6.10, Prior Authorizations)

### 12.4 Sterilization and Hysterectomies

**Procedure Codes:** 58150-58294, 58541-58554 and 58600-58720

#### 12.4.1 Elective Sterilization

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

- Clients must complete and sign the Sterilization Consent Form at least 30 days, but not more than 180 days, prior to the sterilization procedure. There are no exceptions to the 180-day limitation of the effective time period of the informed consent agreement (e.g., retroactive eligibility). This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly complete, payment will be denied. A complete Sterilization Consent Form must be obtained from the primary physician for all related services (Section 6.14.1, Sterilization Consent Guidelines)

The 30 day waiting period may be waived for either of the following reasons:

- Premature Delivery – The Sterilization Consent Form must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.

- Emergency Abdominal Surgery – the Sterilization Consent Form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.

- Clients must be at least 21 years of age when signing the form
• Clients must not have been declared mentally incompetent by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization

• Clients must not be confined under civil or criminal status in a correctional rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill

Before performing sterilizations, the following requirements must be met:

• The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction

• The client must be informed of his/her right to withdraw or withhold consent any time before the sterilization without being subject to retribution or loss of benefits

• The client must understand the sterilization procedure being considered is irreversible

• The client must be made aware of the discomforts and risks, which may accompany the sterilization procedure being considered

• The client must be informed of the benefits associated with the sterilization procedure

• The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized

• An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the client has been informed

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

• If the client is in labor or childbirth

• If the client is seeking or obtaining an abortion

• If the client is under the influence of alcohol or other substances which may affect his/her awareness

12.4.1.1 Billing Requirements

**Diagnosis Code:** V25.2

**Surgical Code:** 66.2X and 66.3X

• The above surgical codes and diagnosis code must accompany one another on a claim. Anytime one of the surgical sterilization procedure codes is present on an inpatient claim, the diagnosis code of V25.2 (sterilization) must also be present. Likewise, if diagnosis V25.2 is present on an inpatient claim, one of the above surgical sterilization procedures must also be present. If only the surgical sterilization code or diagnosis code is present, the claim will deny.

• If both the above criteria are met then the system will verify that a delivery took place by identifying that a surgical obstetrical procedure of 72.xx, 73.xx, or 74.xx is
present, combined with a diagnosis code in the 640-676 range. If the obstetrical procedure and diagnosis code are not present the claim will deny.

12.4.2 **Hysterectomies**

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

- A complete Hysterectomy Acknowledgement of Consent Form must be obtained from the primary practitioner for all related services. Complete only one section (A, B or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client must sign and date section A of this form (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C apply. If this form is not properly completed, payment will be denied (Section 6.13.2, Hysterectomy Acknowledgement of Consent).
  - If the surgery does not render the client sterile, operative notes can be submitted in place of the form indicating the reason for non-sterility.
- For clients that become retroactively eligible for Medicaid, the practitioner must verify in writing that the surgery was performed for medical reasons and must document one of the following:
  - The client was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing
  - The client was already sterile at the time of the hysterectomy and the reason for prior sterility

12.5 **Transplant Services**

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

12.5.1 **Eligibility**

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

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

Hospitals are required to obtain pre-certification/prior authorization for transplants listed below prior to admission and procedure. Xerox Care and Quality Solutions (Utilization and Care Management) will complete pre-certification/prior authorizations. (Section 6.10, Prior Authorizations)

12.5.3 Covered Services

Medicaid covered transplants include:

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

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

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

12.5.4 Reimbursement

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

- Initial evaluation
- Procurement/Acquisitions (included on facility claim)
- Facility fees

➢ If the physician is employed by the hospital, bill under facility charges. If the physician is not employed by the hospital they need to be enrolled with Medicaid and have their own agreement with Medicaid to bill appropriately.

- Follow-up care for inpatient transplants using Medicare’s standard global period. This period refers to the time frame during which all services integral to the surgical procedure are covered by a single payment.
12.6 Inpatient Billing Guidelines

12.6.1 Present on Admission Indicator (POA)

See Section 6.4.5, Provider Preventable Conditions (PPC)

12.6.2 Outpatient Services Followed By Inpatient Services

When a client is initially seen in an outpatient setting and later admitted as an inpatient of the same facility within 24 hours of the outpatient services, the services must be combined and billed as one claim. The outpatient services will be considered part of the inpatient stay and will not be reimbursed separately.

- Coverage period (box 6) for the claim must be the date the client was first seen for outpatient services through the inpatient discharge date
- The admit date (box 12) must be the date the client was admitted to inpatient services
- All outpatient services should be included on the claim, using the correct dates of service
- The outpatient services will be considered in the level of care claims reimbursement calculations

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

- According to the UB Editor and Medicare guidance, the "admission date" and "from" dates are not required to match however, when the number in fields 18-41 is added to the number of days represented in the covered days, the sum must equal the total number of days reflected in the statement covers period field. (FL 6). Use of value code 81 (non-covered days) to account for OP days will satisfy this requirement.

12.6.3 Level of Care Reimbursement for Inpatient Hospital Claims

The level of care reimbursement system is based on a per discharge Level of Care (LOC) methodology that recognizes differences in the costs for treating patients. Payment is based on the principal diagnosis, which can be found in box 67 on the UB-04 (the first diagnosis listed on a claim) for the patient. Medicaid uses 10 levels of care with rates based on either hospital-specific or statewide rates. Participating hospitals are reimbursed at Level of Care, plus a statewide capital reimbursement fee. If your facility is not given a capital reimbursement fee, then the LOC amount will be considered the total reimbursement. The Levels of Care and their criteria are as follows:
## Rebased LOC | Level of Care | Criterion |
|----------------|----------------|-----------|
| 30             | Rehabilitation with ventilator | • Prior authorized rehabilitation services; AND  
• Principal diagnosis codes: V57-V57.99; AND  
• ICD-9 procedure code of 9670,9671, or 9672 |
| 31             | Rehabilitation | • Prior authorized rehabilitation services; AND  
• Principal diagnosis codes: V57-V57.99; |
| 32             | Maternity/Surgical | • Principal Diagnosis codes 640-699.99; AND  
• Major Surgery Procedure Code |
| 33             | Maternity/Medical | Principal Diagnosis codes 640-669.99 |
| 34             | NICU            | Revenue Code 174 |
| 35             | ICU/CCU/Burn    | Revenue Code 200-205, 207-213, 215-219 |
| 36             | Surgery         | • Revenue Code 360-369; AND  
• Major Surgery Procedure Code |
| 37             | Psychiatric     | • Prior authorized psychiatric services; AND  
• Principal Diagnosis code 290-314.99 |
| 38             | Newborn Nursery | • Principal Diagnosis codes: V30-V39.99, 773-773.29, 764-765.99 or 774.00-774.99; AND  
• First date of service is < 29 days of age |
| 39             | Routine         | All remaining discharges |

- Valid diagnosis codes are required. All diagnosis codes will be validated against the current ICD-9 CM-coding book for the dates of service on the claim
- All inpatient claims must be submitted for the complete stay - admit through discharge. A claim cannot be submitted prior to the patient’s discharge
- UB-04 claims field 18-21 (Admit hour, admit type, admit source and discharge hour) must be complete and valid
- As LOC is based on the principal diagnosis code, the claim will be reimbursed as a whole; however, each line item will be edited for validity. Any error on a line item may cause the whole claim to deny.

### 12.6.3.1 Level of Care Exceptions

- Less than 24 hour inpatient stays will be reviewed. Admissions determined to be appropriate will receive a Level of Care per-diem rate, rather than the complete Level of Care amount
- Patient transfers (both the transferring and the receiving hospital) will receive a Level of Care per-diem rate for each day of care provided to the client, with a
maximum payment of the full Level of Care payment, unless the claim qualifies for a high cost outlier payment

- The transferring hospital should use a patient status of 02 or 05 to indicate a transfer. Medicaid does not reimburse for the date of discharge regardless of discharge time.
- The receiving hospital should use an admit source of 04 to indicate the patient was transferred in. Medicaid will reimburse for admit date regardless of admit time.
- Transfers do not include movement of a patient from one hospital unit to another within a hospital, even if the hospital’s internal process includes a discharge and admission between the units. Example: A patient is treated in the acute care setting and later moved to the psychiatric unit of the same hospital – this is billed as one complete stay, not two claims.

- In the event that a claim’s dates of service cross two different hospital-specific or statewide rate (typically updated annually) for the same level of care, the rates in effect on the admission date will be used to calculate payment.
- High cost outlier cases will receive additional payment. High cost outlier cases are defined as those cases for which allowable submitted charges exceed Level of Care threshold.

12.6.4 High Cost Outlier Reimbursement

When the total charges on a claim exceed the established Outlier Threshold for a given level of care, an increased payment may be calculated to compensate for the additional cost of care to the patient. In order to determine if additional payment will be made, the hospital will need a completed claim and their rates calculated for their specific hospital for the dates of service on the claim. If the hospital does not have hospital-specific rates, the state wide rates will be used.

Information required for calculation

Total Billed Charges
Admission Date
Level of Care (See table Section 12.6.3)

Cost to Charge ratio (for the level of care and admission date)
Outlier Threshold (for the level of care and admission date)
Level of Care Payment (for the admission date)
Capital Reimbursement

NOTE: This information can be found on the rate letter sent to the hospital by the Division of Healthcare Financing
Steps:

1. Determine if the total billed charges are greater than the outlier threshold amount. If so, continue. If not, regular Level of care Methodology will be used to determine reimbursement. (Section 12.6.3)

2. Multiply the cost to charge ratio by the total billed charges. Determine if this amount is greater than the outlier threshold amount. If so, continue. If not, regular level of care methodology will be used to determine reimbursement. (Section 12.6.3)

3. Subtract the outlier threshold amount from your results in Step 2.

4. Multiply your result from Step 3 by .75.

5. Add the result of Step 4 to the level of care payment, and capital reimbursement to calculate the final reimbursement amount.

Example:
The hospital assumes hospital specific rates for a surgical level of care claim.

Total Billed Charges: $125,000.00
Admission Date: 10/29/09
Level of Care: 36 – Surgery

Cost to charge ratio (for the level of care and admission date): .3875
Outlier threshold (for the level of care and admission date): $12000.50
Level of care payment (for the admission date): $5500.00
Capital reimbursement: $277.87

Steps:

1. Determine if the total billed charges are greater than the outlier threshold amount. If so, continue. If not, regular level of care methodology will be used to determine reimbursement.

   $125,000.00 > $12,000.50 – YES

2. Multiply the cost to charge ratio by the total billed charges. Determine if this amount is greater than the outlier threshold amount. If so continue. If not, regular level of care methodology will be used to determine reimbursement.

   $125,000.00 X .3875 = $48,437.50 – YES

3. Subtract the outlier threshold amount from your results in Step 2.

   $48,437.50 - $12,000.50 = $36,437.00

4. Multiply your result from Step 3 by .75.
$36,737.00 \times 0.75 = $27,327.75

5. Add the result of Step 4 to the level of care payment, and capital reimbursement to calculate the final reimbursement amount.

$27,327.75 + $5,500.00 + $277.87 = $33,105.62
Chapter 13
Comprehensive Outpatient Rehabilitation Facility (CORF)

Chapter Thirteen .............................................................................................................................................13-1

13.1 Comprehensive Outpatient Rehabilitation Facility (CORF)............................................................ 13-2

13.1.1 Billing Requirements:...................................................................................................................... 13-2
13.1 **Comprehensive Outpatient Rehabilitation Facility (CORG)**

A Comprehensive Outpatient Rehabilitation Facility (CORG) provides coordinated comprehensive outpatient rehabilitation services at one fixed location. A CORF must provide at least these three components of rehabilitation services to qualify for certification as a CORF:

- Physician Supervision
- Provide physical therapy
- Provide social or psychological services
  - This is a core CORF service and must be reasonable and medically necessary and directly related to the Physical Therapy, Occupational Therapy, Speech Language Pathology or Respiratory Therapy plan of treatment

In addition, the CORF may also provide any of the following services:

- Behavioral Health treatments/services
- Drugs and biologicals which cannot be self-administered
- Occupation therapy (restorative)
- Speech therapy
- Orthotics and prosthetics
- Medical supplies and equipment
  - CORFs may not bill for the supplies they furnish except for those cast and splint supplies that are used in conjunction with the corresponding current CPT codes the 29XXX series
- Nursing services
- Respiratory Therapy
  - Services must be provided by a Respiratory Therapist not a Respiratory Technician

13.1.1 **Billing Requirements:**

13.1.1.1 All CORF providers must bill using taxonomy 261QR0401X and bill type 75X. A CORF **must** also bill using CPT/HCPCS codes to report their full range of services.

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Revenue Code</th>
<th>CPT or HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Therapy</td>
<td>41X</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>42X</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>43X</td>
<td></td>
</tr>
<tr>
<td>Speech Language Pathology</td>
<td>44X</td>
<td></td>
</tr>
<tr>
<td>Nursing Services</td>
<td>55X</td>
<td>HCPCS G0128</td>
</tr>
<tr>
<td>Immunizations</td>
<td>636</td>
<td></td>
</tr>
<tr>
<td>Vaccine Administration</td>
<td>771</td>
<td>CPT 90471</td>
</tr>
<tr>
<td>Behavioral Health Treatments/Services</td>
<td>90X, 91X</td>
<td>CPT 96152 Social &amp; Psychological Services</td>
</tr>
</tbody>
</table>
13.1.1.2  CORF services must be specific to the needs of the client and must be directed toward the restoration of safe, functional independence. Maintenance or general conditioning is not considered appropriate in the CORF setting.

**NOTE:** Physical, occupational or speech therapy provided in the CORF will count towards the cap limits for clients over the age of 21.
Chapter 14
End Stage Renal Disease (ESRD)

Chapter Fourteen........................................................................................................................................14-1

14.1 End Stage Renal Disease (ESRD).....................................................................................................14-2

14.1.1 Billing Requirements.....................................................................................................................14-2

14.1.2 ESRD Coding Criteria....................................................................................................................14-3

14.1.3 ESRD Coding Additional Information..........................................................................................14-3
14.1 End Stage Renal Disease (ESRD)

ESRDs may be a freestanding facility or a hospital based facility, which provides inpatient, outpatient and / or home dialysis.

Revenue Code: 82X, 83X, 84X, 85X or 88X

Procedure Code: 90951 to 90970 – Other procedure codes are billable under this program but at least one of these must be present to be considered a dialysis claim.

NOTE: For the purpose of this policy this chapter refers to freestanding clinics.

14.1.1 Billing Requirements

- ESRD providers are responsible for the procurement, delivery and maintenance of the equipment and supplies.
- The facility may bill for all medically necessary services for home dialysis.
- Services provided outside the ESRD scope must be billed under other applicable programs and guidelines.
- Personal attendants are not covered
- Claim should be billed with an appropriate bill type – see ESRD Coding Criteria table below.
- NDC numbers must be billed with certain J-codes
- Medicaid will reimburse ESRD services based on the services that Medicare includes in its composite rate for ESRD (as listed in the Medicare Benefit Policy Manual – Chapter 11 – End Stage Renal Disease (ESRD)).
- Medicaid will reimburse ESRD services at 9% of billed charges resulting in a Medicare-like payment.
14.1.2  ESRD Coding Criteria

14.1.2.1  Coding Criteria Table

Bill Type 72X
Taxonomy 261QE0700X

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Coding Criteria</th>
<th>Date of Service Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis</td>
<td>All claims must include a revenue code 82X, 83X, 84X, 85X, or 88X with a procedure code in the range 90951 to 90970</td>
<td>01/01/2014 9 % of billed charges.</td>
</tr>
<tr>
<td>Lab</td>
<td>80000-89999</td>
<td>01/01/2014 9 % of billed charges</td>
</tr>
<tr>
<td>All other services</td>
<td>36400-36420; 90658; 90732; 90740; 90747; A4206 to A4259; A4265; A4300 to 5200; G0008; G0010; J0120 to J9999; Q4081</td>
<td>01/01/2014 9 % of billed charges.</td>
</tr>
</tbody>
</table>

14.1.3  ESRD Coding Additional Information

- The above criterion does not apply to Medicare crossover claims, claims for any other bill type or for denied lines
- Claims or claim lines that are billed with a CPT code not on the coding criteria list will be denied
- Codes within the above ranges that aren’t normally covered by Medicaid will not be covered for ESRD claims either
Chapter 15
Federally Qualified Health Centers (FQHC)

Chapter Fifteen ................................................................................................................................ 15-1
15.1 Federally Qualified Health Centers (FQHC) ........................................................................... 15-2
  15.1.1 Covered Services .................................................................................................................. 15-2
  15.1.2 Reimbursement Guidelines ................................................................................................ 15-2
  15.1.3 Billing Requirements: ........................................................................................................ 15-3
15.1 Federally Qualified Health Centers (FQHC)

An FQHC is a community-based organization that provides comprehensive primary and preventative care, including medical, dental and mental health/substance abuse services to persons of all ages, regardless of their ability to pay.

Revenue Code: 520

15.1.1 Covered Services

A medical visit is a face-to-face encounter between a client and:

- Dental Professional
- Nurse Practitioner
- Nurse Midwife
- Physician
- Physician’s Assistant
- Visiting Nurse

Medical visits can also consist of:

- Medical nutrition therapy
- Diabetes outpatient self-management training

Other health visits are a face to face encounter between a client and:

- Clinical Psychologist
- Clinical Social Worker
- Other health professional for mental health services

NOTE: When a practitioner is performing services outside the FQHC facility services cannot be billed under the FQHC NPI number.

15.1.2 Reimbursement Guidelines

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes, but is not limited to:

- Therapeutic services
- Diagnostic Services
- Tests
- Supplies
- Lab
- Radiology

NOTE: For dental treatment refer to the Dental Manual
15.1.3 Billing Requirements:

- Multiple encounters within the FQHC, on the same day, with different practitioners are still considered one encounter UNLESS the client suffers illness or injury requiring treatment unrelated to the first encounter or if the clients have both a medical visit and other health visits, as defined above.
- Claims must be billed with revenue and procedures codes for both the encounter and detail line items.
- All services provided during the encounter must be billed on a separate line.
- Claims must have a minimum of two (2) line items, the first would be the encounter line and the second line item is detail (both must include a revenue and procedure code combination.
- Encounter lines will be billed with a 520 revenue code paired with:
  - Procedure code T1015 for a general encounter
  - Procedure codes 99381-99385 or 99391-99395 for EPSDT encounter
  - Use modifier 32 to indicate a health check encounter that results in a referral to a specialist
  - Bill the total usual and customary charges for the visit
- Detail line items will be billed with:
  - Any appropriate outpatient revenue code paired with any appropriate procedure code (for questions regarding appropriate pairing of revenue codes and procedure codes, see the Universal Billing Editor)
  - Document each procedure that occurred during the encounter
  - Include a detailed line item for the office visit or health check procedure code if appropriate
  - Bill the detail line items at $0.00

15.1.3.1 Billing Examples

- Client comes to the FQHC for complaint of cough and sees a physician. No additional tests or treatments are administered. The client is given a prescription for antibiotics and released

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>520</td>
<td>T1015</td>
<td>$175.00</td>
</tr>
<tr>
<td>517</td>
<td>99213</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

- This client is a child who has come to the FQHC for a health check visit. The health check is conducted, and in addition, a urine culture is run while the client is there.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>520</td>
<td>99381</td>
<td>$220.00</td>
</tr>
<tr>
<td>517</td>
<td>99381</td>
<td>$0.00</td>
</tr>
<tr>
<td>300</td>
<td>87086</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

For further information refer to EPSDT Appendix or CMS-1500 Provider Manual
Chapter 16
Home Health

Chapter Sixteen................................................................................................................................16-1

16.1  Home Health................................................................................................................................16-2

16.2  Home Health Exemption Letter.................................................................................................16-5
16.1 **Home Health**

Medicare certified or State Licensed Home Health agencies can provide Home Health services. These agencies may be independent or based in a hospital, nursing home, Senior Center, or Public Health agency. Agencies that are not Medicare certified must continue to meet the Conditions of Participation for Medicare and will need to be licensed by the Division of Healthcare Licensing and Survey.

Home Health agencies are unable to bill for the sale or rental of Durable Medical Equipment unless they are separately enrolled as a DME provider. For specific billing instructions refer to the DME General and DME Covered Services Provider Manuals on the Medicaid website (Section 2.2., Quick Website Reference).

**NOTE:** All claims are subject to post payment review, ensuring home health policy has been adhered to.

16.1.1 **Criteria**

- Ordered by a physician
- Documented in a signed and dated Plan of Treatment/Medicare Form 485 that is reviewed and revised as medically necessary by the attending physician at least once every 60 days.
- Medically necessary

16.2 **Covered Services**

- Intermittent – Three or fewer visits a day for home health aide and/or skilled nursing services, where each visit does not exceed four (4) hours.
- Skilled nursing services
- Home health aide services delegated and supervised by a Registered Nurse
  - Each Home Health Aide visit **MUST** include personal care of at least one or more of the following. Personal care is defined as:
    - Bath (bed, sponge, tub, shower, or shampooing hair)
    - Nail or skin care (applying lotion does not constitute personal care)
    - Oral hygiene
    - Toileting and elimination
    - Safe transfers / assisted ambulation
    - Assist with dressing (not grooming alone)
    - Assisted range of motion / positioning
    - Assisted nutrition or fluid intake (meal set-up or prep or feeding assist / supervision)
- Physical therapy services provided by a qualified licensed physical therapist
- Speech therapy services provided by a qualified licensed therapist
- Occupational therapy services provided by a qualified registered or certified therapist
Medical social services provided by a qualified licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW) -prepared person supervised by an MSW.

16.2.1 Limitations

The following services are not covered through home health:

- Homemaker services
- Respite care
- Home delivered meals
- Services for clients who are hospital patients or residents of skilled nursing facilities.
- Services for clients that are clearly inappropriate in the client’s home setting.
- Services for clients that are extensive or long periods and/or are not cost effective.
- Services for clients where the desired outcome could be better and faster accomplished in another setting.
- Services for clients where the client must be compliant to achieve measured success and the client is not compliant.

16.2.2 Documentation Requirements

- Each visit note must specify what the purpose of the visit is, i.e.: Home Health (Medicaid), or HCBS Waiver (LTC, ALF, DD, ABI, etc.), as some clients are receiving waiver services in addition to home health.

  - The 485 form must list all services the client is receiving, regardless of pay source. This includes waiver, private duty nursing, etc. and frequency of the services to portray a clear picture of all services the client is receiving.
  - Adequate documentation justifying medical necessity must be kept. Any claims extending past 120 days (two consecutive 60 day plan periods) will be reviewed.

16.2.3 Billing Requirements

In-State Requirements

- Bill using appropriate revenue codes
- Do not bill with procedure codes
- Bill using appropriate units
- Plans of Treatment, Physician Orders, Home Health Exemption (Section 16.2), and Prior Authorization Forms (for out of state providers only) must be signed, dated, and kept on file and submitted to Medicaid upon request. (Section 6.10, Prior Authorization)
  - Questions regarding Plans of Treatment or Utilization of Services should be addressed to the Home Health Program Manager at the Division of Healthcare Financing (Section 2.1, Quick Address and Telephone Reference Guide).
Out of State Requirements

- Prior authorizations are required for all services (Section 6.10, Prior Authorization)
- Prior authorization number must be placed in box 63 of the UB 04 claim Form (Section 6.2.2, Instructions for Completing the UB-04 Form).
- Plans of Treatment, Physician Orders, Home Health Exemption (Section 16.2) must accompany all prior authorization requests when submitted to Medical Policy (Section 2.1, Quick Address and Telephone Reference Guide).

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0551</td>
<td>Skilled Nursing</td>
<td>Per visit</td>
</tr>
<tr>
<td>0421</td>
<td>Physical Therapy</td>
<td>Per visit</td>
</tr>
<tr>
<td>0441</td>
<td>Speech Therapy</td>
<td>Per visit</td>
</tr>
<tr>
<td>0431</td>
<td>Occupational Therapy</td>
<td>Per visit</td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide</td>
<td>Per visit</td>
</tr>
<tr>
<td>0561</td>
<td>Medical Social Worker</td>
<td>Per visit</td>
</tr>
</tbody>
</table>
16.3 Home Health Exemption Letter

Home Health Exemption Letter

Thomas O. Forslund, Director  Governor Matthew H. Mead

(Agency Name)

(Address)

(Address)

(City, State and Zip)

I certify that ______________ continues to not meet Medicare Home Health criteria because of the chronic state of his/her condition or because of his/her homebound status. I also certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

(Signature)                                (Title)                                (Date)

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

Mail To:
Wyoming Medicaid
Attn: Claims
PO Box 547
Cheyenne, WY 82003

Division of Healthcare Financing Medicaid Home Care Service Unit
6101 Yellowstone Road, Suite 210 · Cheyenne WY 82002
FAX (307) 777-1913 · (307) 777-7366
## Chapter 17
### Hospice

### Chapter One

- **17.1 Hospice**
- **17.2 Hospice Benefit Election Form**
- **17.3 Hospice Benefit Revocation Form**
- **17.4 Wyoming Department of Health Hospice Exemption Form**
17.1 Hospice

Hospice care is provided by a public agency or a private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A participating hospice provider must meet the Medicare conditions of participation for hospices to be enrolled. Hospice care is an interdisciplinary approach to caring for the psychological, social, spiritual, and physical needs of dying clients. This service is a special way of caring for a client whose disease cannot be cured. It is primarily a program of care delivered in a person’s home that provides reasonable and necessary medical and support services for the management of a terminal illness.

17.1.1 Covered Services

Hospice care program services will be available to Medicaid eligible clients of any age and may be provided in a home setting, nursing facility, or freestanding hospice facility when the client meets the following criteria:

- A client is certified by a physician as being terminally ill – meaning that a physician has certified that if the illness runs its normal course, the client’s life expectancy is six (6) months or less
- The client has completed a Hospice Benefit Election Form (Section 17.2), which must be submitted to Medicaid along with the Certification of Terminal Illness.

The hospice provider is responsible for medical care and services related to the terminal illness which are provided to the client who has elected palliative care. The hospice provider can bill for:

- Routine Home Care (Revenue Code 651)
- Continuous Home Care (Revenue Code 652)
- Inpatient Respite Care (Revenue Code 655)
- General Inpatient Care (Revenue Code 656)
- Nursing Facility Room and Board (Revenue Code 658)
- Inpatient Hospice Room and Board (Revenue Code 659)

Services provided in an inpatient setting must conform to the written Plan of Care. General inpatient hospital care may be required for procedures necessary for pain control and acute or chronic symptom management.
17.1.2 Nursing Facility Residents

For clients who are residents in the nursing facility, the hospice provider will be responsible for billing the room and board charges, and reimbursing the nursing facility for their portion of the care.

The hospice provider will be responsible for the professional management of the individual’s hospice care, and the nursing facility will provide room and board.

Patient liability will apply as normal.
17.1.3 Reimbursement
In order for Medicaid to reimburse claims to a hospice provider for a client, the client must first have elected hospice care and appropriate paperwork must be sent to Wyoming Medicaid (Section 2.1, Quick Address and Telephone Reference), including:

- Physician Certification statement certifying that the client’s medical prognosis is a life expectancy of six (6) months or less if the terminal illness runs its normal course.
- A Hospice Benefit Election Form (Section 17.2.1, Instructions for Completing the Hospice Benefit Election Form)
- The hospice provider must request Prior Authorization to establish a rate for nursing home care. (Section 6.10, Prior Authorizations).
- The prior authorization number must be entered into box 63 of the UB-04 claim form.
- Copies of the paperwork should also be submitted to DFS.
- Clients who are eligible for both Medicare and Medicaid (dual eligible) must elect hospice under both programs.
- The nursing home will not be able to submit any claims for a client who has elected hospice care. (Section 19.2.2, Clients Under Hospice Care).
- Providers billing revenue code 659 will need to provide a certification as a licensed inpatient hospice facility.

If a client chooses to revoke his or her hospice election, a copy of the hospice revocation form must be submitted to Client Relations (Section 2.1, Quick Address and Telephone Reference), to allow the client to receive full services again. A copy of the revocation form should be submitted to DFS.

Reimbursement rates are determined specific to each hospice for each of the allowed revenue codes and will be re-determined on an annual basis. These rates are all inclusive and cover the services and supplies used in the care of the client, including

- Drugs and biological
- Home health aide or homemaker services
- Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control.
- Durable medical equipment and supplies assisting in the use of durable medical equipment.

17.1.4 Services Unrelated to the Terminal Illness
For services unrelated to the client’s terminal illness, the hospice provider must provide the Hospice Exemption Form to the billing provider in order for the provider to be reimbursed. The service must be unrelated to the client’s terminal illness to qualify (Section 17.1.4, Hospice Exemption Form).
This form must be submitted with the claim or sent as an attachment (paper or electronic) if the claim is billed electronically (Section 6.12, Submitting Attachments for Electronic Claims). Waiver Service providers will not need the exemption form.

Dental treatment/services are limited to palliative treatment and emergency services.
17.2 Hospice Benefit Election Form

Hospice Benefit Election Form

Name of Hospice Provider: ____________________________________________
Provider Address: ____________________________________________________
Provider Number: _____________________________________________________
Client Name: _________________________________________________________
Client ID Number: _____________________________________________________
Date of Hospice Election: ___________________ 

The client has been given a full understanding of Hospice care, that with the exception of home and community-based waiver services and independent physician services, other Medicaid services related to their terminal illness are waived for the duration of the election of Hospice care.

______________________________
Client Signature

OR

______________________________
Client Representative’s Signature

NOTE: Please attach the Physician Certification Statement, signed by the physician, and include a statement that the individual’s medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course.

Mail both Election and Physician Certification forms to:

Wyoming Medicaid
Attn: Client Relations
PO Box 667
Cheyenne, WY 82003

Copies of these forms need be submitted to your local DFS Office.
17.2.1 Instructions for Completing the Hospice Benefit Election Plan

- An Election Statement must include:
  - The hospice provider number, name and address that will provide care to the client
  - Client Name and Medicaid ID Number
  - The effective date of the election of hospice care
  - The client (or his/her representative’s) signature
  - If the client is a resident in a nursing facility, the name and address of the facility where they are a resident.

- Mail copies of the Hospice Benefit Election form and physician certification to Wyoming Medicaid (Section 2.1, Quick Address and Telephone Reference) and your local DFS Office (Appendix B, County DFS Offices).
Hospice Benefit Revocation Form

Name of Hospice Provider: ___________________________________________________________
Provider Number: ________________________________________________________________
Client Name: ______________________________________________________________________
Client ID Number: ________________________________________________________________
Diagnosis: ______________________________________________________________________
Attending Physician: ______________________________________________________________
I, _____________________________, hereby revoke my election to Hospice Care for the remainder of the current election period.
Election Period Number 1 2 3 4
Date Election Period Began _____________________________
Date of Revocation _____________________________
Number of Days Remaining _____________________________
I understand that I am no longer covered under Hospice benefit for hospice services. If covered by Medicare/Medicaid/Champus, I may resume regular benefits previously waived.
I understand that I may again elect to receive hospice benefits for any additional hospice election periods for which I am eligible.

Client Signature _____________________________ Date _____________________________
Witness Signature _____________________________ Date _____________________________

Mail form to:
Wyoming Medicaid
Attn: Client Relations
PO Box 667
Cheyenne, WY 82003
A copy of this form needs to be submitted to your local DFS Office
17.4 Wyoming Department of Health Hospice Exemption Form

Wyoming Department of Health
Hospice Exemption Form

Date: ________________________________

Hospice Provider Name: ________________________________
Hospice Provider Number: ____________________________ Phone # __________________________

RE: Hospice Benefit - Approval for Charges Unrelated to Client's Terminal Illness

The following client receiving Medicaid hospice benefits has or will soon have the following medical expenses. These expenses are not relative to the terminal diagnosis and therefore, are not the financial responsibility of the hospice provider/program. The hospice case manager has reviewed medical necessity and is authorizing payment to the provider who furnished the service.

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

Client Name: ________________________________
Client ID Number: ____________________________ Date of Birth __________________________

Non Hospice Benefit Diagnosis (es) (Valid ICD-9-CM diagnosis codes only) (Dental providers are not required to enter a diagnosis but must provide medical necessity or procedures being performed, in the addition to explanation “section” below):
________________________________________________________________________

Provider Providing Service: ________________________________ Date of Service: __________________________
Procedure(s) Being Performed:
(Use valid CPT-4 procedure codes)
________________________________________________________________________

Additional explanation:
________________________________________________________________________

Hospice Provider Signature: ________________________________
Printed Name: ________________________________ Title: __________________________

Mail To:
Wyoming Medicaid
Attn: Client Relations
PO Box 667
Cheyenne, WY 82003

CTEC-750
Chapter 18
Indian Health Services (IHS)

Chapter Eighteen..................................................................................18-1
18.1 Indian Health Services........................................................................18-2
18.1 **Indian Health Services**

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

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

18.1.1 **Reimbursement**

Indian Health Services are reimbursed through an encounter method.

An encounter is a face-to-face visit with an enrolled health care professional such as:

- Physician
- Physician’s assistant
- Nurse practitioner
- Nurse midwife
- Psychologist
- Social worker
- Dental Professional

18.1.1.2 **Encounter Rate**

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes, but is not limited to:

- Therapeutic services
- Diagnostic services
- Tests
- Supplies
- Lab
- Radiology

Multiple encounters with one or more professionals or multiple encounters with the same health 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.
18.1.2 Covered Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0779</td>
<td>Health Check Screening</td>
</tr>
<tr>
<td>0500</td>
<td>Medical Encounter (within IHS clinic)</td>
</tr>
<tr>
<td>0512</td>
<td>Dental Encounter (within IHS clinic)</td>
</tr>
<tr>
<td>0519</td>
<td>Optometric Encounter (within IHS clinic)</td>
</tr>
<tr>
<td>0259</td>
<td>Pharmaceutical Encounter (within IHS clinic)</td>
</tr>
<tr>
<td>0771</td>
<td>WyVip Administration</td>
</tr>
<tr>
<td>0987</td>
<td>Hospital Encounter (IHS physician at the hospital)</td>
</tr>
</tbody>
</table>

18.1.2.2 Comprehensive Health Screenings (Health Check) use Revenue Code 779

Indian Health Services is encouraged to participate in the Health Check (Well Child) program for Medicaid children under the age of twenty-one (21). When an encounter meets the standards for a Health Check exam, use the Health Check encounter code(s) to assist the Medicaid program in tracking these services accurately. Individuals under age twenty-one (21) are entitled to comprehensive health examinations.

NOTE: This revenue code cannot be billed with any other revenue code on the same claim.

18.1.2.3 Medical Encounters (within IHS Clinic) use Revenue Code 500

All professional services (including ancillary services and supplies) must be performed by or under the direct supervision of a licensed physician or doctor of osteopathy operating within the scope of his/her practice. This includes services rendered by a nurse practitioner, physical therapist, or other covered licensed health care professional performing services consistent with their scope of practice.

18.1.2.4 Dental Encounters (within IHS Clinic) use Revenue Code 512

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.

18.1.2.5 Optometric Encounters (within IHS Clinic) use Revenue Code 519

All professional services (including ancillary services and supplies) performed by a licensed optometrist practicing within the scope of his/her practice. Routine eye examinations are not covered for clients age twenty one (21) and older. Treatment of eye diseases or eye injury continues to be covered when billed with the appropriate diagnosis code. The reason for the visit must be documented in the medical record.

18.1.2.6 Pharmaceutical Encounters (within IHS Clinic) use Revenue Code 259

All prescription drugs, over the counter drugs and medical supplies are covered by Medicaid and are not included in the medical, dental, or optometric encounter.
18.1.2.7 Hospital Visits by the Physician, use Revenue Code 987
All services provided in the hospital by the physician will be billed together under this revenue code.

18.1.2.8 VFC Administration, use Revenue Code 771
All services provided during the visit are included in the encounter. Do not bill each procedure separately.
Chapter 19
Skilled Nursing Facility and Swing Bed Services

Chapter One ..................................................................................................................................... 19-1

19.1 Skilled Nursing Facility (SNF) and Swing Bed Services......................................................... 19-2

19.2 Patient Contributions ............................................................................................................. 19-8

19.3 Evaluations that must be completed ..................................................................................... 19-9

19.4 Medicaid Reimbursement ....................................................................................................... 14

19.5 New Admission ....................................................................................................................... 19-14

19.6 Categorical determinations that do not require a Level II prior to Admission ................... 19-15

19.7 Billing Requirements ................................................................................................................. 19-16

19.8 Census Requirements ................................................................................................................ 19-18

19.9 Reserve Bed Days Billing Requirements ............................................................................... 19-18

19.10 Billing Examples: .................................................................................................................... 19-19

19.11 Extraordinary Care .................................................................................................................. 19-20

19.12 Example Form – Admission Certification............................................................................... 19-25

19.13 Example Form - Continued Stay ........................................................................................... 19-24
19.1 Skilled Nursing Facility (SNF) and Swing Bed Services

Skilled Nursing Facilities provide long term care to clients who are unable to live independently safely, including room and board, dietary needs, laundry services, nursing services, minor medical services, surgical supplies, over the counter medications, and the use of the equipment and facilities.

Swing Bed services are those long term care services provided in the hospital setting in place of transferring the client to the skilled nursing facility, and are subject to the same policy as those services provided in the skilled nursing facilities.

19.1.1 Covered services

Services provided in the skilled nursing facility or swing bed are reimbursed based on a per diem payment that is all inclusive of the care for the patient for the day. This care includes but is not limited to:

- All general nursing services, including but not limited to:
  - Administration of oxygen and related medication
  - Hand feedings
  - Incontinency care
  - Tray service

- Therapy services, including:
  - Physical Therapy
  - Speech Therapy
  - Occupational Therapy

- Medical supply and drug items stocked at nursing stations or on the floor in gross supply and distributed individually in small quantities, such as:
  - Alcohol
  - Applicators
  - Cotton balls
  - Band-Aids
  - Gloves
  - Ostomy supplies
  - Tongue depressors

- Oxygen and over-the-counter drugs, which includes insulin.

- Items which are used by individual patients but which are reusable and expected to be available, such as:
  - Ice bags
  - Bed rails
  - Canes
  - Crutches
  - Walkers
  - Wheelchairs
➢ Traction equipment
➢ Other durable medical equipment

- Laundry services for routine nursing facility requirements and clients personal clothing
- Over the counter nutritional supplements used for tube feeding or oral feeding, even if written prescription items by a physician

19.1.1 Private rooms

Medicaid reimburses for room and board for nursing home clients. Room and board in a semi-private room is included in the per diem – if a client wishes to stay in a private room within the nursing facility, the facility can bill Wyoming Medicaid as normal, and accept the reimbursed amount as payment in full for the private room, OR the responsible party for the nursing home client can pay the rate for the private room in full. The provider may not “balance bill” the client for the cost difference between a regular room and a private room within the facility.

19.1.2 Below is a list of items included in the per diem rate

➢ ABD Pads
➢ Adhesive tape
➢ Aerosol, other types
➢ Air Mattresses, Air P.R. Mattresses
➢ Airway-Oral
➢ Alcohol Plaster
➢ Alcohol Sponges
➢ Alternating Pressure Pads
➢ Applicators, Cotton-tipped
➢ Applicators, Swab-eez
➢ Aquamatic K Pads (Water-Heated Pad)
➢ Arm Slings
➢ Asepto Syringes
➢ Baby Powder
➢ Bandages
➢ Bandages-Elastic or Cohesive
➢ Band-Aids
➢ Basins
➢ Bed Frame Equipment (for certain immobilized bed patients)
➢ Bed Rails
➢ Bedpans, All Types
➢ Beds; Manual, Electric, Clinitron
➢ Bedside tissues
➢ Bibs
➢ Blood Infusion Sets
➢ Bottle, Specimen
➢ Canes, All Types
➢ Cannula-Nasal
- Catheter-Indwelling
- Catheter Plugs
- Catheter Trays
- Catheter (any size)
- Colostomy Bags
- Combs
- Commodes, All Types
- Composite Pads
- Cotton Balls
- Crutches, All Types
- Decubitus Ulcer Pads/Dressings
- Denture Cleaner/Soak
- Denture Cups
- Deodorants
- Diapers
- Disposable Underpads
- Donuts
- Douche Bags
- Drain Tubing
- Drainage Bags
- Drainage Sets
- Drainage Tubes
- Dressing Tray
- Dressing, All Types
- Drugs (over the counter drugs as designated by the FDA)
- Enema Soap
- Enema Supplies
- Enema Unit
- Equipment and Supplies for Diabetic blood and urine testing
- Eye Pads
- Feeding Tubes
- Fingernail Clipping and Cleaning
- Flotation Mattress or Biowave mattress
- Flotation Pads and/or Turning Frames
- Foot Cradle, all types
- Gastric Feeding Unit, Including Bags
- Gauze Sponges
- Gloves, Unsterile and Sterile
- Gowns, Hospital
- Green Soap
- Hair Brushes
- Hair Care, Basic
- Hand Feeding
- Heat Cradle
- Heating Pads
 Heel Protector
 Hot Pack Machine
 Hydraulic Patient Lifts
 Hypothermia Blankets
 Ice Bags
 Incontinency Care
 Incontinency Pads and Pants
 Influenza Vaccine
 Infusion Arm Boards
 Infusion pumps, Enteral and Parenteral
 Inhalation Therapy Supplies
 Irrigation Bulbs
 Irrigations Trays
 I.V. Needles
 I.V. Trays
 Jelly, Lubricating
 Lines, Extra
 Lotion, Soap and Oil
 Massages (by facility personnel)
 Mattresses, All Types
 Medical Social Services
 Medicine Dropper
 Medicine Cups
 Nasal Catheter
 Nasal Catheter, Insertion and Tube
 Nasal Gastric Tubes
 Nasal Tube Feeding and feeding bags
 Nebulizer and Replacement kit
 Needles (various sizes)
 Needles – Hypodermic, Scalp Vein
 Non-Legend Nutritional Products
 Nursing Services (all) regardless of level including the administration of oxygen and restorative nursing care
 Nursing Supplies and Dressing
 Ostomy Supplies; Adhesive, Appliance, Belts, Fact Plates, Flanges, Gaskets, Irrigation sets, Night Drains, Protective Dressings, Skin Barriers, Tail Closures
 Over-the-Counter Drugs, including insulin
 Overhead Trapeze Equipment
 Oxygen, Gaseous and Liquid
 Oxygen Concentrators
 Oxygen Delivery Systems, Portable or Stationary
 Oxygen Mask
 Pads
 Pitcher
 Plastic Bib
- Pumps (Aspiration and Suction)
- Pumps for Alternating Pressure Pads
- Respiratory Equipment; Ambu Bags, Cannulas, Compressors, Humidifier, IPPS Machines and Circuits, Mouthpieces, Nebulizers, Suction Catheters, Suction Pumps, Tubing, Etc
- Restraints
- Room and Board (Semi-private or private if necessitated by a medical or social condition)
- Sand Bags
- Scalpel
- Shampoo
- Shaves
- Shaving Cream
- Shaving Razors
- Sheepskin
- Side Rails
- Soap
- Special Diets
- Specimen Cups
- Sponges
- Steam Vaporizer
- Sterile Pads
- Sterile Saline for Irrigation
- Sterile Water for Irrigation
- Stomach Tubes
- Suction Catheter
- Suction machines
- Suction Tube
- Surgical Dressings (including sterile sponges)
- Surgical Pads
- Surgical Tape
- Suture Removal Kit
- Suture Trays
- Syringes (all sizes)
- Syringes, disposable
- Tape-for laboratory tests
- Tape (non-allergic or butterfly)
- Testing Sets and Refills (S&A)
- Therapy Services
- Toenail Clipping and Cleaning
- Tongue Depressors
- Toothbrushes
- Toothpaste
- Tracheostomy Sponges
- Transportation
- Trapeze Bars
- Tray Service
- Underpads
- Urinals, male and female
- Urinary Drainage Tube
- Urinary Tube and Bottle
- Urological Solutions
- Walkers, all types
- Water Circulating Pads
- Water Pitchers
- Wheelchairs: Amputee, Geriatric, Heavy Duty, Hemi, Lightweight, One Arm Drive, Reclining Roll-about, Semi-Reclining, Standard, Etc

For the most current list of covered items review attachment A to Chapter 7 state of Wyoming rules at: http://soswy.state.wy.us/rules/rule_search_main.asp

**NOTE:** Certain drugs and pharmaceutical products may be dispensed by a long-term care facility and are included in the facility’s per diem rate. Over-the-counter drugs, products, and medical supplies/equipment ordered by a physician for use by person residing in a nursing facility are included in the nursing facility’s per diem rate and cannot be reimbursed separately, including insulin and diabetic supplies. This includes all over-the-counter drugs and products. Insulin and diabetic supplies are considered over-the-counter drugs and supplies.

**19.1.3** Certain items are permitted to be billed outside of the per diem. These items include those that are customized or specialized for a specific client’s use that would not be functional or beneficial to any other client such as:

- Ambulance services – when medically necessary
- Customized wheelchairs and seating systems
- Dental
- Hearing Aids
- Mental Health services
- Medical Services including
  - Laboratory, radiology, surgical procedures
- Orthotics
- Physician and other practitioner services, excluding Physical, Occupational and Speech Therapy
- Prosthetics

**19.1.4** The cost for non-ambulance patient transportation is a covered cost and the cost can be reported as an allowable cost. Ambulance services are not an allowable cost per Section 12 (a) (i).

The allowable cost for patient transportation includes the costs incurred to transport patients to medical appointments/treatment not available in the facility (e.g., dialysis treatment), as well as when the facility arranges for services to be provided at the facility (e.g., hearing aid dealer).
Ambulance services which are defined as a service not included in the per diem rate per Section 12 (a) (i), should not be reported as allowable costs on Schedule E of the cost reports. Ambulance services include:

- **Ground ambulance** – Ground ambulance is any land motor vehicle maintained, operated or advertised for the medical care and transportation of patients upon any street, highway or public way, or any land motor vehicle owned and operated on a regular basis by the State of Wyoming or any agency, municipality, city, town, county, or political subdivision of Wyoming for medical care and transportation of patients upon any street, highway or public way.
- **Air ambulance** – Air ambulance services are fixed-wing aircraft or helicopter licensed to provide ambulance services.

The provider should make an effort to select the most efficient and cost effective mode of transportation for resident care which may include utilizing a facility owned vehicle or contracted outside service so that the cost incurred can be in conformity with Section 4 (b) (iii).

The fee schedule on the Medicaid website (Section 2.2, Quick Website Reference) will document whether a specific procedure code is allowed outside of the per diem for a long term care resident. Y means it can be billed outside of the per diem. All charges must be billed by a provider outside of the nursing facility.

### 19.1.5 Prescription Drugs

Prescription drug services are handled through the pharmacy program, and all prescription drugs must be filled at an enrolled pharmacy. Skilled nursing facilities and swing bed units will not be reimbursed for the distribution of pharmacy drugs or products to clients, outside of the per diem. Please contact Goold Health Systems Inc (Section 2.1, Quick Address and Telephone Reference).

### 19.2 Patient Contributions

The Department of Family Services (DFS) establishes the patient contribution upon admission to the nursing facility. Medicaid receives the initial patient contribution amount. Any adjustments made to the patient contribution must be reflected on the Notice to LSC (Licensed Shelter Care) Facility Form (DFS-411). DFS will change or pro-rate the patient contribution as needed. They send the Notice to LSC Facility. The facility then submits an Adjustment Form along with the Notice to LSC Facility Form to Medicaid to change the patient contribution.

A new DFS-411 is required for each calendar year, i.e., a DFS-411, stating a change is for September forward is valid for September – December. For January a new DFS-411 would be needed.

**NOTE:** Only paid claims can be adjusted. (Section 6.15.3, Adjustments)

### 19.2.1 Multiple Facilities Billing and Patient Contribution

Patient contribution is allocated across claims at 100% in the order the claims are received and processed. For example if a client is a resident of two (2) facilities, the patient contribution
would be taken from total amount paid from the first facility to bill and be paid until the patient contribution is satisfied. If payment to the first facility does not exhaust the client’s patient contribution, the remaining patient contribution will be applied to the next facilities paid claim. This may mean that the provider who billed for the client for the second half of the month will be collecting the patient contribution and the provider billing for the first half of the month will receive a zero patient contribution assignment.

19.2.2 Clients Under Hospice Care

For those clients receiving hospice care, no payment will be made to the skilled nursing facility or swing bed. Room and board is billed by the hospice and payment will be made to the hospice. The hospice is required to reimburse the nursing facility for the nursing facility’s contracted rate. (Section 17.1.2, Nursing Facility Residents)

19.3 Evaluations that must be completed

The following two evaluations must be completed prior to admission into skilled nursing or swing bed facilities:

- LT101
- PASRR - Pre Admission Screening and Resident Review

For all claims submitted after July 1, 2014 that are denied for one of the following reasons, an Attestation for Admission Date Form (Section 19.3.1) must be completed and submitted with the claim form:

- Denied for no original admit claim on file with Wyoming Medicaid
- Denied for no LT101 or PASRR on file with Wyoming Medicaid
- Denied for no Attestation for Admission Date Form attached to the claim
- Denied for the Attestation for Admission Date Form not completed appropriately

This form can be attached to the claim form using one of these methods:

- For electronic claim submissions
  - The attachment indicator must be a “Y” on the electronic claim submission, and the form can be uploaded electronically or submitted separate via paper. For a step by step tutorial on uploading the claim and attachment via the Secured Provider Web Portal, visit the Web Portal Tutorials section of the website and click on Institutional under the HIPAA 5010 Web Portal Tutorials, or view the WINASAP Tutorial under the WINASAP section of the website. (Section 2.2, Quick Website Reference)

- For paper claim submissions
  - The claim form can be submitted via paper claim, and the attachment can be sent in with the claim form
19.3.1 Attestation for Admission Date Form

ATTESTATION FOR ADMISSION DATE

Effective July 1, 2014, Wyoming Medicaid will require this form be completed when clients whose original admission claim was prior to Medicaid eligibility, or whose original admit claim is not on file as paid with Wyoming Medicaid.

This form is not to replace the submission of a Medicaid eligible admission claim.

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

LT101s are required under the following conditions:

<table>
<thead>
<tr>
<th>LT101s Required</th>
<th>No more than 90 days prior to admission</th>
<th>Upon application for facility admission</th>
<th>Upon transfer to another facility</th>
<th>Upon re-admission to a facility after previous discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Continued stay review at six months</td>
<td>Significant change in condition</td>
<td>Upon determination and re-</td>
<td>Upon referral for PASRR Level II evaluation for MI or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>determination of Medicaid</td>
<td>MR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>eligibility.</td>
<td></td>
</tr>
</tbody>
</table>

THE FOLLOWING INFORMATION IS REQUIRED TO AVOID CLAIM DENIALS:

Providers who receive a denial for one of the following reasons will need to complete the below information and return it with a copy of the claim receiving the denial. This can be done by submitting an electronic attachment to the claim, by submitting both the claim and form via paper, or by sending the claim electronically and the form paper:

- No original admit claim on file or admit claim was not paid by Wyoming Medicaid
- No LT101 or PASRR on file with Wyoming Medicaid
- This form was not completed appropriately or not attached to the claim

<table>
<thead>
<tr>
<th>Facility NPI:</th>
<th>Facility Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Original Admission Date:</th>
<th>PASRR Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LT101 Review Date for Medicaid Eligibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Indicate why the admission claim is not on file as paid by Wyoming Medicaid:

- Paid by Medicare
- Paid as private pay
- Paid by another insurance
- LT101 and/or PASRR not completed appropriately (please explain):

<table>
<thead>
<tr>
<th>LT101 and/or PASRR not completed appropriately (please explain):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

19-10
☐ Other (please explain):

☐ In signing this document I attest that the above information was completed as required by Wyoming Medicaid Policy, and that the information furnished is true and accurate.

Signature: ___________________________  Date: ___________________________

Printed Name: _______________________

Return completed form with denied claim to:

Wyoming Medicaid
Claims Department
PO Box 547
Cheyenne, WY 82003

Fiscal Agent Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
19.3.1.1 Instructions for Completing the Attestation For Admission Date Form

- Read the form completely.
- Fill out all of the required information completely and accurately to ensure processing.
  - Facility NPI
  - Facility Name
  - Client Medicaid ID Number
  - Client Name
  - Original Admission Date (this is the date the client was first accepted into the nursing facility)
  - PASRR Date
  - LT101 Review Date (the date of LT101 closest to the determination of Medicaid eligibility)
- Indicate why the admission claim is not on file as paid by Wyoming Medicaid by checking the appropriate box, or checking “Other” and providing explanation.
- Attest and complete remainder of form.

19.3.2 LT101 (Medicaid determination of Medical Necessity)

- The LT101 is a functional assessment performed by a Public Health Nurse under contract to the Division of Healthcare Financing.
- It is a state requirement for the determination of medical necessity for nursing facility level of care.
- The Department of Family Services (DFS) cannot approve nursing facility eligibility to any client who is not clinically eligible based on the LT101 assessment.
- LT101s are valid for 90 days after completion.

19.3.2.1 The Medicaid Secure Provider Web Portal provides office administrators for skilled nursing facilities, swing bed units, hospitals and other appropriate providers with the ability to review a client’s LT101s that are on file with Wyoming Medicaid. This resource can be used to make sure that appropriate documents are in place with Wyoming Medicaid before billing is completed, to avoid denials of claims. (Section 2.2, Quick Website Reference)

19.3.3 LT101s are required under the following conditions:

- Prior to Admission
  - No more than 90 day prior to admission
- Upon application for nursing facility admission. “Nursing Facility” includes hospital swing bed units. It does not include Medicare only Skilled Nursing Facilities that do not participate in Medicaid.
- Upon transfer to another nursing facility.
- Upon re-admission to a nursing facility after a previous discharge. “Discharge” does not include temporary absence from the facility for treatment in a hospital, home visit or a trial community stay, provided such a temporary absence is no longer than thirty consecutive days.
• Nursing facility residents shall receive continued stay reviews during the sixth month.
• Significant change in condition
• Upon re-determination of Medicaid eligibility following a loss of eligibility for any reason.
• DFS shall not grant Medicaid eligibility to a nursing facility resident unless the resident has an LT101 less than 90 days old.
• Upon referral for PASRR Level II evaluation for MI or MR.

19.3.4 PASRR Pre-Admission Screening and Resident Review

PASRR process encompasses PASRR Level I and Level II (Pre Admission Screening)

PASRR Level I – The purpose of the Level I is to screen for potential diagnosis of mental illness or mental retardation. Such a determination will result in a referral for a Level II.

Routine annual Level I screenings are no longer required by Medicaid. If the Level I does not result in a referral to Level II, it need never be performed again unless a significant change in the resident’s condition indicates that a Level II evaluation is advisable or if there is a transfer to another facility.

PASRR Level II – The purpose of the Level II is to more accurately identify mental illness or intellectually disabled and assess whether the individual needs specialized services and nursing facility level of care.

NOTE: Dementia, including Alzheimer’s disease and other dementias, is excluded from the definition of serious mental illness for PASRR purposes. An individual is considered to have dementia if he or she has a primary diagnosis of dementia as described in the DSM (current edition), or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above. A primary diagnosis of a serious mental illness supersedes a secondary diagnosis of dementia and the individual must be referred for a Level II evaluation.

• Medicaid/Federal law requires all individuals, regardless of payment source, who apply as new admissions to Medicaid Facilities on or after January 1, 1989, must be screened prior to admission for mental illness and mental retardation
  ➢ Individuals for whom respite care is provided (under LTC HCBS Waiver or the DD HCBS Waiver) in a nursing facility must be treated like any other nursing facility admission, therefore, all PASRR and LT101 requirements apply prior to admission

• Any individual who’s PASRR Level I screening indicates the presence or probability of mental illness or mental retardation must be referred to the State Mental Health Authority or the State Mental Retardation Authority. This authority has been delegated by contract to Xerox Care and Quality Solutions (Utilization and Care Management).

• PASRR Level II must be determined prior to admission to be appropriate for nursing facility payment
• If the individual is appropriate for nursing facility placement, the need for specialized services will be determined
If an individual seeking admission to a nursing facility has Mental Illness or Mental Retardation and is found to be inappropriate for nursing facility placement, the nursing facility may not admit the individual.

If an individual already residing a nursing facility has Mental Illness or Mental Retardation and is found to be inappropriate for nursing facility placement, the provider must cooperatively arrange with the state for the resident’s orderly discharge from the facility.

Adverse determinations carry the right of appeal for the resident.

### 19.4 Medicaid Reimbursement

Medicaid will not reimburse a nursing facility for services provided to any individual who has not been screened at Level I:

- Payment will commence as of the Level I date or admission date, whichever is later
- No retroactive payment will be made

Medicaid will not reimburse a nursing facility for services provided to any individual with MI or MR who is admitted prior to completion of a PASRR Level II:

- Payment will commence upon the date of determination of appropriate placement
- No retroactive payment will be made
- The nursing facility may be subject to withdrawal of Medicaid certification if such a person is admitted to the facility before a Level II determination is rendered

Medicaid will not reimburse a nursing facility for services provided to any individual who has previously been found to be inappropriate for nursing facility placement due to the need for specialized services:

- Any individual who has received such a determination must be re-evaluated and determined to be appropriate before any placement will be allowed

**NOTE:** Medicaid does not accept paper copies of the PASRR screening forms. All PASRR forms must be entered on the Medicaid Secure Provider Web Portal (Section 2.2, Quick Website Reference). Please contact your office administrator if you are in need of a log on ID to access the secure web portal. If you do not know who your office administrator is contact EDI (Section 2.1, Quick Address and Telephone Reference) Refer to the Medicaid web site for instructions on how to enter the PASRR online.

### 19.5 New Admission

A Level I screening is required prior to admission for all new nursing facility admissions, regardless of payment source.
• A re-admission following a discharge, hospitalization or therapeutic home leave is not considered a new admission for PASRR purposes and does not require a Level I screening unless a new diagnosis indicates the presence of MI or MR.

• An individual with MI or MR who has a Level II in the past and is being readmitted following hospitalization or therapeutic home leave is not considered a new admission.

19.5.1 **Exception hospital discharge:**

An exemption may be made for an individual who:

• Is admitted to any nursing facility directly from a hospital after receiving acute inpatient care at the hospital AND

• Requires nursing facility services for the condition for which he or she received care in the hospital AND

• Attending physician certified before admission to the facility that the individual is likely to require less than thirty days of nursing facility care, a Level I must be initiated no later than thirty days after admission

19.5.2 **Transfer/Inter-facility**

A Level I is required upon transfer from one facility to another facility.

An inter-facility transfer is not considered a “new admission” for PASRR purposes.

• In the case of a transfer of a resident with Mental Retardation or Mental Illness from the nursing facility to a hospital or to another nursing facility the transferring nursing facility is responsible for ensuring that copies of the most recent PASRR Level I and II (if applicable) and Resident Assessment reports accompany the transferring resident

19.6 **Categorical determinations that do not require a Level II prior to admission**

Pursuant to Federal guidelines, the Division of Healthcare Financing has defined certain categories of conditions that automatically constitute appropriateness for nursing facility placement. The State may override the categorical determination and refer the individual for a Level II where appropriate.

19.6.1.1 **Appropriate for nursing facility placement due to terminal illness**, verified in writing by a physician. This constitutes a Level II determination of “appropriate specialized services not required”.

19.6.1.2 **Appropriate for nursing facility placement due to severe medical conditions.** This determination may only be applied to an individual with Mental Illness or Mental Retardation who is comatose, ventilator dependent, functions at the brain stem level, OR has a diagnosis such as COPD, severe Parkinson’s disease, amyotrophic lateral sclerosis, congestive heart failure (CHF), cardiovascular accident (CVA), Huntington’s Disease, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end stage renal disease (ESRD), severe diabetic neuropathy or refractory anemia. The condition must result in a level of impairment so severe
that the individual could not be expected to benefit from specialized services. This constitutes a Level II determination of “appropriate, specialized services not required”.

19.6.1.3 Convalescent care for an acute physical illness. This determination applies only to an individual with Mental Illness or Mental Retardation who has an acute physical illness which Required hospitalization; AND does not meet all the criteria for an exempt hospital discharge (defined above). This categorical determination is limited to 120 days. When it becomes apparent the individual will require nursing facility placement longer than 120 days, the nursing facility must complete the Level II. A Level II determination must be rendered before permanent nursing facility placement can be made.

19.6.1.4 Provisional placements pending further assessment in cases of delirium, where an accurate diagnosis cannot be made until the delirium clears, or for respite of caregivers. This categorical determination is limited to fourteen (14) days. The nursing facility must complete the Level II. A Level II determination must be rendered before permanent nursing facility placement can be made.

19.6.1.5 Emergency placement for an individual with Mental Illness or Mental Retardation for the individual’s protection. This categorical determination is limited to seven (7) days, at which time the nursing facility must complete the Level II. The determination must be rendered before permanent nursing facility placement can be made.

19.7 Billing Requirements

19.7.1 Nursing Facility

Revenue Code 0100 – Room & Board
Bill Type 21X, 23X

19.7.1.1 Swing Bed

Revenue Code 0100- Room & Board
Bill Type 18X

- Enter one unit for each day the client was a resident
- Medicaid does not pay for the date of discharge
  - Reduce your units by 1 in order to reflect this
  - Patient status on the claim is something other than 30 (still a patient) (Section 6.2.2, Instructions for Completing the UB-04)
19.7.1.2 Swing Bed Exemption Letter

Facility Name: ________________________________________ certifies that Medicare or other third party liability has been billed for this Medicaid client.

To receive payment from Medicaid without an EOMB from the third party one or more of the following situations must be met and this letter must accompany a 18X UB-04 claim:

(Check one box)

1. The client did not complete a 3 day hospital stay and is therefore not eligible for Medicare benefits. The hospital stay dates were _____/_____/_____ to _____/_____/_____. This must be reviewed if the patient returns to the hospital after any nursing facility stay, and for interim, continuing claims.

2. This client has exhausted the Medicare and/or other insurance benefit period. The date of the Medicare and/or other insurance benefits period was/is _____/_____/_____ to _____/_____/_____.

3. This client did complete a 3 day hospital stay. Medicare was billed for _____ days and an EOMB for that period was previously submitted. After the first claim for the first benefit period, the T19 EOB Exempt letter may be attached for succeeding claims.

4. Medicare and/or other insurance denied payment of the swing-bed benefit. A copy of the EOMB is attached. After the first claim for the first benefit period, the T19 EOB Exempt letter may be attached to succeeding claims.

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

_________________________________   __________________________    _______________
Signature        Title             Date

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

Nursing Facilities may receive the per diem rate for reserved bed days during a resident’s temporary absence if an appropriate bed is not otherwise available during the time for which reimbursement is sought. “Appropriate bed” is defined as a bed in an empty room or a vacant bed in a room occupied by a person of the same sex as the temporarily absent client.

Reimbursement for temporary absences is limited to fourteen (14) days per client per calendar year.

If a nursing facility maintains an average occupancy of ninety percent (90%) or more within the month of the leave, the nursing facility may receive the per diem rate for reserved bed days during temporary absences. Occupancy is calculated as total patient days (period of service rendered to a patient not including any day that a patient was temporarily absent) divided by licensed beds multiplied by the number of calendar days in the period being measured.

A provider may not bill a client or the client’s family for reserved bed days that are not reimbursed by Medicaid unless the facility has informed the client in writing. A client may pay the Nursing Facility to hold the bed if the temporary absence exceeds the fourteen (14) day annual maximum.

19.8 Census Requirements

Each provider is to submit to Xerox Care and Quality Solutions (Section 2.1, Quick Address & Telephone Reference) a census report of all Medicaid residents for the previous month. The census report is due the 15th of the month for the previous month’s census. Failure to submit a census report could result in Medicaid withholding payment or a reduction in payment.

19.9 Reserve Bed Days Billing Requirements

Bill with the appropriate revenue codes, and indicated the number of days as the total number of units.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0180</td>
<td>Leave of absence, General Class</td>
<td>Limited to a total of 14 leave days per calendar year, per client. Facility must be considered 90% of full occupancy, meaning there would not be an appropriate bed for this client to return to without hold their bed for their return.</td>
</tr>
<tr>
<td>0181</td>
<td>Leave of absence, Reserved</td>
<td></td>
</tr>
<tr>
<td>0182</td>
<td>Leave of absence, Patient Convenience</td>
<td></td>
</tr>
<tr>
<td>0183</td>
<td>Leave of Absence, Therapeutic Leave</td>
<td></td>
</tr>
<tr>
<td>0184</td>
<td>Leave of absence, ICF/MR – Any reason</td>
<td></td>
</tr>
<tr>
<td>0185</td>
<td>Leave of absence, Hospitalization</td>
<td></td>
</tr>
<tr>
<td>0189</td>
<td>Leave of absence, other reason</td>
<td></td>
</tr>
</tbody>
</table>
19.10 Billing Examples:

- Client was admitted on 01/12/09 and was still a resident on 01/31/09. Claim is for the month of January:

<table>
<thead>
<tr>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Coverage Period</th>
<th>Patient Status</th>
<th>Revenue Code</th>
<th>Date</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/09</td>
<td>N/A</td>
<td>01/12/09-01/31/09</td>
<td>30 (still a patient)</td>
<td>0100 Room &amp; Board</td>
<td>01/12/09-01/31/09</td>
<td>18</td>
</tr>
</tbody>
</table>

- Client was admitted on 03/15/08 and was discharged on 01/22/09. Claim is for the month of January:

<table>
<thead>
<tr>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Coverage Period</th>
<th>Patient Status</th>
<th>Revenue Code</th>
<th>Date</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/15/08</td>
<td>01/22/09</td>
<td>01/01/09-01/22/09</td>
<td>01 (discharged to home)</td>
<td>0100 Room &amp; Board</td>
<td>01/01/09-01/22/09</td>
<td>21</td>
</tr>
</tbody>
</table>

- Client was admitted on 12/05/09 and passed away on 01/03/10. Claim is for the month of January:

<table>
<thead>
<tr>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Coverage Period</th>
<th>Patient Status</th>
<th>Revenue Code</th>
<th>Date</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/05/09</td>
<td>01/03/10</td>
<td>01/01/10-01/03/10</td>
<td>20 (expired)</td>
<td>0100 Room &amp; Board</td>
<td>01/01/10-01/03/10</td>
<td>2</td>
</tr>
</tbody>
</table>

NOTE: If there are leave days involved refer to Section 19.9 for appropriate revenue codes

- Client is a resident for the month of January, however went to the hospital from 01/03/09-01/05/09. The facility is full enough to bill for leave days.

<table>
<thead>
<tr>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Coverage Period</th>
<th>Patient Status</th>
<th>Revenue Code</th>
<th>Date</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Admit Date</td>
<td>N/A</td>
<td>01/01/09-01/31/09</td>
<td>30 (still a patient)</td>
<td>0100 Room &amp; Board</td>
<td>01/01/09-01/02/09</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0185 Leave of absence, hospitalization</td>
<td>01/03/09-01/04/09</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0100 Room &amp; Board</td>
<td>01/05/09-01/31/09</td>
<td>27</td>
</tr>
</tbody>
</table>
• Client is a resident for the month of January, however went to the hospital from 01/03/09-01/05/09. The facility is NOT full enough to bill for leave days.

<table>
<thead>
<tr>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Coverage Period</th>
<th>Patient Status</th>
<th>Non-Covered Days</th>
<th>Revenue Code</th>
<th>Date</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Admit Date</td>
<td>N/A</td>
<td>01/01/09 – 01/31/09</td>
<td>30 (still a patient)</td>
<td>2</td>
<td>0100 (Room &amp; Board)</td>
<td>01/01/09-01/02/09</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0100 (Room &amp; Board)</td>
<td>01/05/09-01/31/09</td>
<td>27</td>
</tr>
</tbody>
</table>

• Client is a resident for the month of January however went to the hospital for 01/03/09 - 01/28/09. The facility is full enough to bill for leave days.

<table>
<thead>
<tr>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Coverage Period</th>
<th>Patient Status</th>
<th>Non-Covered Days</th>
<th>Revenue Code</th>
<th>Date</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Admit Date</td>
<td>N/A</td>
<td>01/01/09-01/31/09</td>
<td>30 (still a patient)</td>
<td>11</td>
<td>0100 (Room &amp; Board)</td>
<td>01/01/09-01/02/09</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0185 (Leave of absence, hospitalization)</td>
<td>01/03/09-01/16/09</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0100 (Room &amp; Board)</td>
<td>01/28/09-01/31/09</td>
<td>4</td>
</tr>
</tbody>
</table>

19.11 Extraordinary Care

Extraordinary Care is for clients that require service beyond the average resident. They have an MDS Activities of Daily Living Sum score of ten (10) or more and require special or clinically complex care as recognized under the Medicare RUG-III classification system. Extraordinary Care requires a prior authorization from Xerox Care and Quality Solutions (Utilization and Care Management). (Section 2.1, Quick Address and Telephone Reference)

The extraordinary care client’s cost and service requirements must clearly exceed supplies and services covered under a facility’s per diem rate. The cost of clients’ extraordinary care shall not be included in the annual cost reports.

19.11.1 Criteria

Extraordinary care clients services are covered when the below criteria is met, the services are individualized, specific, and consistent with symptoms or confirmed diagnosis, and not in excess of the client’s needs.
Medical conditions considered under extraordinary care criteria

- Ventilator Dependence allows for **automatic qualification** without additional criteria being met
- Cerebral Palsy (ICD-9 343) must have additional criteria below met
- Morbid Obesity (ICD-9 278.01) must have additional criteria below met
- Multiple Sclerosis (ICD-9 340) must have additional criteria below met
- Quadriplegia (ICD-9 344.00, 344.01, 344.02, 344.03, 344.04, or 344.09) must have additional criteria below met
  - **Must have one** of the following
    - Ventilator dependence
    - Tracheostomy
    - Coma
    - Seizures
    - Disease process involving five (5) or more functional areas of visual, motor, sensory, cognitive, coordination and/or bowel and bladder (Multiple Sclerosis only)
    - Spastic Quadriplegia (Cerebral Palsy only)
  - **AND must have three** of the following:
    - Skin care could include Stage 3 or 4 ulcer/turning every two hours
    - Foley incontinence care could include urinary tract infections/diarrhea/constipation/bowel and bladder training
    - Tube feeding/aphasia could include dehydration/weight loss/aspiration pneumonia
    - Physical therapy could include wound care/range of motion exercises
    - Special equipment used only by this resident that is clearly above and beyond what is covered in the per diem rate
- Other conditions where special care or clinically complex care are required will be evaluated on a case by case basis by Xerox Care and Quality Solutions.
- Criteria are subject to change

19.11.2 Documentation

- New Requests must contain a completed packet, required documentation and cost review.
- Continued Stay Reviews must contain a completed Continued Stay Form (Section 19.13, Example Form) and all required documentation.
- Annual Cost Reviews for extraordinary care clients rates will be done in conjunction with October 1 rate effective date reviews.
19.11.3 Additional requirements

- Continued stay reviews must be completed at 15 days, 30 days, 90 days and yearly thereafter. If medical evaluation shows difference or change in services needed, notify Xerox Care and Quality Solutions (Utilization and Care Management) (Section 2.1, Quick Address and Telephone Reference).

- If a client has a change in services needed, the provider can submit new cost information for consideration of a rate adjustment. Incremental revenue of negotiated rates will offset against the applicable cost report. Notify Myers & Stauffer of changes for modification to reimbursement 800-336-7721.

- Include all costs for residents under extraordinary care negotiated rates; cost reports will be adjusted during rate setting.

- Forms can be found on the Medicaid website (Section 2.2, Quick Website Reference).

19.11.4 Enhanced Psychiatric Conditions Considered Under Extraordinary Care Criteria

Adult recipients presenting with a Severe and Persistent Mental Illness (SPMI) with long term psychiatric and behavioral health needs, which exhibit challenging and difficult behaviors that is beyond traditional skilled nursing home care as recognized. Extraordinary Care requires a prior authorization from Xerox Care and Quality Solutions (Utilization and Care Management). (Section 2.1, Quick Address and Telephone Reference)

Any requests for a behavioral health extraordinary care client must include the following prior to any review by the Division of Healthcare Financing:

- A treatment plan that specifies both medical and behavioral strategy
- A stabilization plan to include both internal policies and plans for community based supports and if necessary transfer opportunities
- External resources, agreements, working partnerships for inpatient stabilization (if behavior escalates to a point where for their safety or those of the other patients or staff), with a written agreement to return client to resident location upon stabilization and recommendation plan in place
- List of primary care and psychiatric doctors
- Packet must include clinical justification and financial request as with any other extraordinary care client
- Other conditions where special care or clinically complex care are required will be evaluated on a case by case basis by Xerox Care and Quality Solutions (Utilization and Care Management).
- Criteria are subject to change
19.11.5 Specific Criteria

All criteria must be met
- The client has an SPMI as defined by the following
  - The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders
  - Prior to admission (admission to hospital stabilization or nursing home), the Global Assessment of Functioning (GAF) score is 40 or lower.
- The level of impairment is confirmed by a Level II Pre-Admission Screening and Resident Review (PASRR) evaluation (42 CFR 483.128). (Section 19.3.3, PASRR Pre-Admission Screening and Resident Review)
- The client is currently in a psychiatric hospital; or has had one or more past hospitalizations; or is exhibiting behaviors that place him or her at risk of psychiatric hospitalization.
- The client exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care, including one of the following:
  - Combative and assaulting behaviors (physical abuse toward staff, or self-abuse / self-injurious behaviors)
  - Sexually inappropriate behaviors (touching or grabbing others)
  - Other challenging and difficult behaviors related to the individual’s psychiatric illness

19.11.6 Continued Eligibility Criteria

Continued stay is applicable when the client either:
- Exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care, including one of the following:
  - Combative and assaulting behaviors (physical abuse toward staff, or self-abuse / self-injurious behaviors)
  - Sexually inappropriate behaviors (touching or grabbing others)
  - Other challenging and difficult behaviors related to the individual’s psychiatric illness
- OR Exhibits the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements.

19.11.7 Discharge from Extraordinary Care Criteria

Discharge from extraordinary care criteria is contingent upon the following:
- The consistent absence of unsafe behaviors as outlined in Section 19.11.5, Specific Criteria within consistently structured enhanced care; and
- The anticipation that the client will not exhibit the unsafe behavior if moved from the enhanced services available in the nursing facility, as evidence by exploratory visits without enhancements.

NOTE: These criteria must be closely observed and monitored during a continuous period of at least three months (quarterly).
Additional determining criteria for discharge include the following:

- Monitoring of medication stability / consistency
- Treatment compliance
- Appropriate living arrangements upon discharge
- Arrangement of aftercare for continued services

19.11.8 Documentation

- New Requests must contain a completed packet, required documentation and cost review. Prior Authorization (PA) is required for all Medicaid clients.
- Extraordinary Care client packets can be faxed to Xerox Care and Quality Solutions (Utilization and Care Management) (Section 2.1, Quick Address and Telephone Reference)
- Continued Stay Reviews must contain a completed Continued Stay Form (Section 19.13, Example Form) and all required documentation. Prior Authorization (PA) is required for all Medicaid clients
- Annual Cost Reviews for extraordinary care clients rates will be done in conjunction with October 1 rate effective date reviews
- Continued Stay Utilization Review must be completed at 15 days, 30 days, 90 days and yearly thereafter, or as needed if medical or psychiatric evaluation shows difference or change in services.
- If the client has a change in services needed, the provider can submit new cost information for consideration of a rate adjustment. Notify Myers & Stauffer of change for modification to reimbursement 800-336-7721.
- Include all costs for residents under extraordinary care negotiated rate; as incremental revenue of negotiated rate is offset against applicable cost repost.
19.12 Example Form – Admission Certification

ADMISSION CERTIFICATION
SKILLED NURSING EXTRAORDINARY CARE

Extraordinary Recipients: MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

Required Documentation:
1) PASRR & Date
2) LT 101 less than 45 days old
3) MDS assessment
4) History & Physical (<1 yr old)
5) Drug history
6) Nursing Care Plan
7) Progress notes
8) Itemized cost
9) MD statement w/Dx & expected LOS

Ventilator Dependent? Y / N

Note: Preadmission certification DOES NOT guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date requested</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission date</td>
<td>Date received</td>
</tr>
<tr>
<td>Facility</td>
<td>Approved</td>
</tr>
<tr>
<td>Facility NPI#</td>
<td>Certified Through</td>
</tr>
<tr>
<td>Facility UR rep</td>
<td>Denied</td>
</tr>
<tr>
<td>Phone #</td>
<td>Reviewed By</td>
</tr>
<tr>
<td>Fax #</td>
<td>Authorization #</td>
</tr>
</tbody>
</table>

Attending/referring physician (first and last name)
Physician Wyoming Medicaid ID #

Address

PATIENT INFORMATION

Name
Medicaid ID #

Address
Phone #

DOB
SS#
Sex: Male Female

ICD-9-CM code(s) (provide ALL code numbers as well as diagnosis names)
1. 4.
2. 5.
3. 6.

HCPCS code(s) (provide ALL code numbers as well as diagnosis names)
1. 4.
2. 5.
3. 6.

Fax form to Xerox Care and Quality Solutions (CQS) toll-free @ 1-888-245-1928

Forms can be found on-line at http://wyequalitycare.acs-inc.com/cqs

9/26/12 gb
### General Provider Information

**Skilled Nursing Facility and Swing Bed Services**

---

**Wyoming Nursing Facility**

**Extraordinary Care Rate Request Form**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projected Time Period:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Per Wyoming Medicaid Rules, Chapter 7, Section 22 (a), the negotiated rate determined is to cover the cost of medically necessary services and supplies that are not included in the Nursing Facility per diem rate.**

---

**Requested Negotiated Rate:**

<table>
<thead>
<tr>
<th>Services under Fee Schedule:</th>
<th>Negotiated Rate per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator Care</td>
<td>Check box if applies:</td>
</tr>
</tbody>
</table>

**Additional Staffing:**

- **Staff Time (list number of 1:1 hours required per day that is above standard care):**
  - RN: $29.84
  - LPN: $20.52
  - CNA: $13.37

**Additional Services required (Invoices must accompany request to be considered):**

- **Equipment (list type and cost/day):**
  - $ (variable)

- **Medical Supplies (list items and cost/day):**
  - $ (variable)

- **Wound Care (list item):**
  - Wound VAC rental: Cost/day=
  - Wound VAC supplies:
    - Dressing Kits: Cost for 15 kits=
    - Canisters: Cost of 10 canisters=
  - Other (specify): Cost/day=
  - Other (specify): Cost/day=

  **Sub-total Negotiated Rate** $ (variable)

**Current Nursing Facility Per Diem Rate** $ (variable)

**Net Extraordinary Care Rate** $ (variable)

---

1 Maximum coverage of 15 kits per month

2 Maximum coverage of 10 canisters per month

---

9/26/12 gb
19.13  Example Form – Continued Stay

CONTINUED STAY
SKILLED NURSING EXTRAORDINARY CARE

Extraordinary Recipients: MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

Note: Certification DOES NOT guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date requested</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission date</td>
<td>Date received</td>
</tr>
<tr>
<td>Facility</td>
<td>Approved</td>
</tr>
<tr>
<td>Facility NPI#</td>
<td>Approved YTD</td>
</tr>
<tr>
<td>Facility UR Rep</td>
<td>Denied</td>
</tr>
<tr>
<td>Phone #</td>
<td>Certified Through</td>
</tr>
<tr>
<td>Fax #</td>
<td>Reviewed By</td>
</tr>
<tr>
<td></td>
<td>Authorization#</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of authorization with the member.

PATIENT INFORMATION

Name
Medicaid ID #

Please include current: 1) MDS assessment  2) Progress notes  3) Nursing Care Plan  4) MD orders

Ventilator Dependent? Y / N

New ICD-9-CM code(s) (provide ALL code numbers as well as diagnosis names)
1. 4.
2. 5.
3. 6.

HCPCS code(s) (provide ALL code numbers as well as diagnosis names)
1. 4.
2. 5.
3. 6.

Fax form to Xerox Care and Quality Solutions (CQS) toll-free @ 1-888-245-1928

Forms can be found on-line at http://wyequalitycare.acs-inc.com/cqs

9/26/12 gb
Chapter 20
Rural Health Clinics (RHC)

Chapter One ..................................................................................................................................... 20-1

20.1 Rural Health Clinics (RHC) ..................................................................................................... 20-2
20.1 **Rural Health Clinics (RHC)**

The purpose of an RHC program is to improve access to primary care in underserved rural areas. RHCs are required to use a team approach to provide outpatient primary care, and basic laboratory services.

**Revenue Code:** 521

20.1.1 **Covered Services**

A visit is a face-to-face encounter between a client and:

- Clinical psychologist
- Clinical social worker
- Nurse practitioner
- Nurse midwife
- Physician
- Physician’s assistant
- Visiting nurse

20.1.2 **Reimbursement Guidelines**

The encounter rate established by Medicaid includes all services provided during the encounter regardless of actual charges. The encounter rate is considered to be all-inclusive. The rate includes, but is not limited to:

- Therapeutic services
- Diagnostic services
- Tests
- Supplies
- Lab
- Radiology

20.1.3 **Billing Requirements:**

- The place of service must be the office, not the hospital, emergency room, home or nursing facility, etc.
- Multiple encounters within the same facility, on the same day, with different health professionals are still considered one encounter UNLESS the patient suffers illness or injury requiring additional diagnosis or treatment after the first encounter.
- Claims must be billed with revenue and procedure codes for both the encounter information and detailed line item information.
- Claims will have a minimum of two (2) line items, the first would be the encounter line and the second line item is detail (both must include a revenue code and a procedure code combination).
20.1.3.1 Encounter lines will be billed with 521 Revenue Code paired with:

- Procedure code T1015 for general encounter
- Procedure codes in the range of 99381-99385 or 99391-99395 for health check encounter
  - Use modifier 32 to indicate a health check encounter that results in a referral to a specialist.
- Bill the total usual and customary charges for visit.

20.1.3.2 Detailed line items will be billed with:

- Any appropriate outpatient revenue code paired with any appropriate procedure code.
- Document each procedure that occurred during the encounter.
- Include a detailed line item for the office visit or health check procedure code if appropriate.
- Bill the detail line items at $0.00
- For questions regarding appropriate pairings of revenue codes and procedure codes, see the Universal Billing Editor.

20.2 Billing Examples:

Client comes to the RHC for complaint of a cough and sees a physician. No additional tests or treatments are administered. The client is given a prescription for antibiotics and released.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>521</td>
<td>T1015</td>
<td>$175.00</td>
</tr>
<tr>
<td>517</td>
<td>99213</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

This client is a child who has come to the RHC for a health check visit. The health check is conducted, and in addition, a urine culture is run while the client is there.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>521</td>
<td>99381</td>
<td>$220.00</td>
</tr>
<tr>
<td>517</td>
<td>99381</td>
<td>$0.00</td>
</tr>
<tr>
<td>300</td>
<td>87086</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
21.1 PRTF

Psychiatric Residential Treatment Facility (PRTF) is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents under age 21, who have long-term illnesses and/or serious emotional disturbance(s) that are not likely to respond to short-term interventions and have failed to respond to community based intervention(s).

PRTFs provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality, proactive treatment. In addition to diagnostic and treatment services, PRTFs should also provide instruction and support toward attainment of developmentally appropriate basic living skills/daily living activities that will enable children and adolescents to live in the community upon discharge.

The focus of a PRTF is on improvement of a client’s symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; unless evidence shows family therapy would be detrimental to the client. Unless otherwise indicated, the program should facilitate family participation in the treatment planning, implementation of treatment planning, and timely, appropriate discharge planning, which includes assisting the family in accessing wrap-around services in the community.

Who should be admitted to a PRTF – A client may be appropriate for admission to a PRTF if he/she has a psychiatric condition which cannot be reversed with treatment in an outpatient treatment setting and the condition is characterized by severely distressing, disruptive and/or immobilizing symptoms which are persistent and pervasive.

Who should not be admitted to a PRTF – A client who is experiencing acute psychiatric behaviors is not appropriate to be admitted to a PRTF. PRTF services are not the entry point to accessing inpatient psychiatric services.

PRTF services must:

- Be provided under the direction of a physician
- Provide active treatment
- Be provided before the individual reaches age 21, per CFR 42§441.151, or if the individual was receiving services just prior to turning 21, the services must cease at the time the individual no longer requires services or the date at which the individual reaches age 22.

The PRTF must:

- Work closely with the appropriate school entity to ensure adherence to the youth’s Individual Education Plan (IEP).
- Ensure a smooth transition back to the home school or develop an alternative transition plan for those youth who are not returning to their home school.
- Ensure that there is an adequate number of multi-disciplinary staff to carry out the goals and objectives of the facility and to ensure the delivery of individualized treatment to each resident as detailed in their treatment plan.
21.1.2 PRTF Physical Layout

A PRTF is a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis. A PRTF that is a part of a hospital or other facility must be a distinct, stand-alone unit/building separate from the hospital or other type of facility.

Clients who meet the PRTF level of care are not to be co-mingled with clients who are not at a PRTF level of care at any time. For example: a client in a facility’s PRTF cannot co-mingle with another client (regardless of payment source) who may be in the facilities RTC unit (should they have both) during meals, schooling, therapies, or in living quarters.

21.1.3 Physical Separation

If more than one type of program or facility is operated on the same piece of property, organizations should take steps to ensure that the programs or facilities can be easily identified as separate entities to those entering the property. Areas that providers are encouraged to consider include:

- Documentation of Physical Separation – the areas of the property occupied by the various programs should be clearly marked on campus maps and when buildings are shared, documentation of the parts of buildings occupied by different programs/facilities on floor plans should be clear and are readily available to surveyors or auditors.
- Entrance and Signage – when sharing a common property (i.e. same piece of land), the most ideal situation would be to have separate entrances, but when this is not feasible, the organization should use signage which clearly identifies and directs those entering the property or campus to the different facilities. Buildings should be clearly marked with signs that identify the programs or facilities that are located within them. For programs that must be open to the general public (outpatient clinic), there must not be physical barriers which prevent access or which would signal to those seeking services that the services would not be available to the general public (e.g. locked gate to the property).
- Building Space – Distinct buildings for each program or facility is best for maintaining separateness between programs and facilities. If building space is shared, physical separation of the programs/facilities must be managed within the structure. Again, dividing the building space between programs in a manner that provides for clear and distinct separation of the programs and costs is the goal.
  - Programs that share a building must be clearly separated by floors, wings, or other building sections. Living areas must not be shared and beds from different programs should not be intermixed or commingled within the same building section. “Swing” beds or units that are variously used by one program or another depending on census are not acceptable. For example there cannot be beds that are sometimes utilized by an RTC and sometimes used by a PRTF.
  - When a building is occupied by more than one program or facility, utilization of separate building entrance for each program is preferable. When this is not possible, separate entrances to each program from a common building lobby could be used. Again, signage within the building should clearly identify the specific program or facility areas.
• Common Areas-
  ➢ Recreational Areas: If a PRTF and an RTC, for example, are operated on the same property, each program should have separate recreational space for its residents. If there are also common recreational spaces used by both programs (i.e. gyms or other indoor or outdoor sporting and recreation areas), the use of these common areas should be scheduled by the different programs or facilities for separate use and the individuals receiving services from distinct programs should not use the facilities at the same time.
  ➢ Dining Areas: If a PRTF and RTC, for example, are operated on the same property, each program should have separate dining space for its residents. If common dining room areas are used by different programs/facilities, they should be used at separately scheduled times and the individuals receiving services from distinct programs/facilities should not use the same dining area at the same time.
  ➢ Treatment Areas: When an organization is providing both PRTF and outpatient services, for example, on the same campus or facility, separate areas must be used for treatment.

21.2 PRTF Requirements

Pursuant to 42 CFR § 483.352, the PRTF must meet all the requirements identified in subpart D, which include: State accreditation (§441.151), certification of need for the services (§441.152), the team certifying need for services (§441.153), active treatment (§441.154), components of an individual plan of care (§441.155), and the team involved in developing the individual plan of care (§441.156). The way a PRTF organizes itself is critical to its success in complying with federal regulations.

All PRTFs must be accredited by one of the organizations identified in 42 CFR §441.151(a)(2)(ii):
• Joint Commission, or
• The Commission on Accreditation of Rehabilitation Facilities, or
• The Council on Accreditation of Services for Families and Children

Out of state PRTFs must be certified by The Center for Medicare and Medicaid Services (CMS), in conjunction with their state’s licensing and survey agency as a PRTF, in order to enroll as a PRTF provider with Medicaid.

In state PRTFs must be certified as a PRTF by the Division of Healthcare Financing, in conjunction with the Office of Healthcare Licensing and Surveys and CMS, should they meet all the PRTF criteria.

21.3 Letter of Attestation

Each PRTF that provides inpatient psychiatric services to individuals under 21 must attest, in writing, that the facility is in compliance with CMS’s standard governing the use of restraint and seclusion (42 CFR Subpart G-Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21). This attestation must be signed by the facility director, and will be sent out annually by the Division of Healthcare Financing.
A facility with a current provider agreement with Medicaid must provide its attestation to the Division of Healthcare Financing and the fiscal agent annually by July 21st.

A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with Medicaid.

To download a copy of the Attestation Letter go to the Medicaid website (Section 2.2, Quick Website Reference).

### 21.4 Reporting of serious occurrences

The facility must report each serious occurrence to the Division of Healthcare Financing (State Medicaid Agency). Serious occurrences that must be reported include a resident’s death, a serious injury to a resident as defined in 42 CFR § 483.352, and resident’s suicide attempt. The Division of Healthcare Financing (State Medicaid Agency) contact is:

Division of Healthcare Financing  
State Medicaid Agent  
6101 Yellowstone Rd., Ste. 210  
Cheyenne, WY 82002  
(307) 777-7531

42 CFR §483.374(c) states: “In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the CMS regional office. Staff must report the death of any resident to the CMS regional office by not later close of business the next business day after the resident’s death. Staff must document in the resident’s record that the death was reported to the CMS regional office.” The contact for CMS Region XIII is Michael Bishop, (303) 844-7032.

### 21.5 Covered Services

All services provided for a PRTF client are included in the PRTF per diem, including room and board and licensed treatment. A provider who is outside of the PRTF cannot bill for any ancillary services to Medicaid. Payment for these ancillary services will need to be made by the PRTF to the outside provider. If the client is discharged from the PRTF, the enrolled outside provider may then bill Medicaid for any covered ancillary services.

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

Medicaid does not cover any Educational Services.

### 21.6 Revenue Codes

919 – Psychiatric/psychological services (room and board)
21.7 **Therapeutic Leave Days**

Medicaid reimbursement is available for reserving beds in a PRTF for therapeutic leaves of absence of Medicaid clients less than 21 years of age at the regular per diem rate when all of the following conditions are present:

- A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the client’s habilitation plan.
- A physician’s order for therapeutic leave must be maintained in the client’s file at the facility.
- In a PRTF, the total length of time allotted for therapeutic leaves in any calendar year shall be fourteen (14) days per client. If the client is absent from the PRTF for more than fourteen (14) days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that client in that year.
- In no instance will Medicaid reimburse a PRTF for reserving beds for Medicaid clients when the facility has an occupancy rate of less than ninety percent (90%) (Based on licensed beds).

Xerox Care and Quality Solutions must approve and prior authorize all therapeutic leave days. Approved therapeutic leave days should be billed as normal covered days. Therapeutic leave days that are not approved by Xerox Care and Quality Solutions, when the client does leave the facility, must be billed as non-covered days.

Refer to the Xerox Care and Quality Solutions Manuals at: http://wyequalitycare@acs-inc.com/cqs/ or contact Xerox Care and Quality Solutions (Section 2.1, Quick Address and Telephone Reference) for PRTF prior authorization, PRTF referrals, admission criteria, continued stay review criteria, discharge planning, and other important PRTF information.

**All PRTF stays must be prior authorized by Xerox Care and Quality Solutions in order to be reimbursable by Medicaid.**
Appendices

A.1 Appendix A – Social Security Administration
A.2 Appendix B – County DFS Offices
A.3 Appendix C – Pay-to Provider Taxonomy Table
A.4 Appendix D – Sample Claims
A.5 Appendix E – Medicaid & State Health Care Benefit Plan
### A.1 APPENDIX A – Social Security Administration

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>LOCATION/MAILING ADDRESS</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casper</td>
<td>100 East B St., Room 1008</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Casper, WY 82601</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Areas Covered: 040 Converse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>120 Natrona</td>
<td></td>
</tr>
<tr>
<td></td>
<td>130 Niobrara</td>
<td></td>
</tr>
<tr>
<td></td>
<td>210 Washakie</td>
<td></td>
</tr>
<tr>
<td></td>
<td>307-261-5360</td>
<td></td>
</tr>
<tr>
<td></td>
<td>800-772-1213</td>
<td></td>
</tr>
<tr>
<td>Cheyenne</td>
<td>5353 Yellowstone Rd. Room 210</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cheyenne, WY 82009</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Areas Covered: 001 Albany</td>
<td></td>
</tr>
<tr>
<td></td>
<td>030 Carbon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>070 Goshen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100 Laramie</td>
<td></td>
</tr>
<tr>
<td></td>
<td>150 Platte</td>
<td></td>
</tr>
<tr>
<td></td>
<td>307-772-2135</td>
<td></td>
</tr>
<tr>
<td></td>
<td>800-773-2144</td>
<td></td>
</tr>
<tr>
<td>Cody</td>
<td>1285 Sheridan Ave., Ste. 265</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cody, WY 82414</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Areas Covered: 010 Big Horn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>140 &amp; 141 Park</td>
<td></td>
</tr>
<tr>
<td></td>
<td>307-587-8155</td>
<td></td>
</tr>
<tr>
<td></td>
<td>800-770-2652</td>
<td></td>
</tr>
<tr>
<td>Riverton</td>
<td>215 Big Bend Ave.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Riverton, WY 82501</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Areas Covered: 060 &amp; 061 Fremont</td>
<td></td>
</tr>
<tr>
<td></td>
<td>080 Hot Springs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>110 &amp; 111 Lincoln</td>
<td></td>
</tr>
<tr>
<td></td>
<td>307-856-7737</td>
<td></td>
</tr>
<tr>
<td></td>
<td>800-305-6919</td>
<td></td>
</tr>
<tr>
<td>Rock Springs</td>
<td>79 Winston Dr., Suite 131</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rock Springs, WY 82901</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Areas Covered: 170 Sublette</td>
<td></td>
</tr>
<tr>
<td></td>
<td>180 Sweetwater</td>
<td></td>
</tr>
<tr>
<td></td>
<td>190 Teton</td>
<td></td>
</tr>
<tr>
<td></td>
<td>200 &amp; 201 Uinta</td>
<td></td>
</tr>
<tr>
<td></td>
<td>307-362-4634</td>
<td></td>
</tr>
<tr>
<td></td>
<td>877-593-3952</td>
<td></td>
</tr>
<tr>
<td>Sheridan</td>
<td>909 Long Dr., Ste. A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sheridan, WY 82801</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Areas Covered: 020 Campbell</td>
<td></td>
</tr>
<tr>
<td></td>
<td>050 Crook</td>
<td></td>
</tr>
<tr>
<td></td>
<td>090 Johnson</td>
<td></td>
</tr>
<tr>
<td></td>
<td>160 Sheridan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>220 Weston</td>
<td></td>
</tr>
<tr>
<td></td>
<td>307-672-5390</td>
<td></td>
</tr>
<tr>
<td></td>
<td>877-593-3952</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX B – County DFS Offices

<table>
<thead>
<tr>
<th>County DFS</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany County DFS</td>
<td>3817 Beech Street, Suite 200</td>
<td>Laramie WY 82070 307-745-7324</td>
</tr>
<tr>
<td>Carbon County DFS</td>
<td>PO Box 2409</td>
<td>Rawlins WY 82301 307-328-0612</td>
</tr>
<tr>
<td>Big Horn County DFS</td>
<td>616 Second Ave., North Greybull WY 82426 307-765-9453</td>
<td></td>
</tr>
<tr>
<td>Campbell County DFS</td>
<td>1901 Energy Court suite 300</td>
<td>Gillette WY 82716 307-682-7277</td>
</tr>
<tr>
<td>Crook County DFS</td>
<td>PO Box 57</td>
<td>Sundance, WY 82729 307-283-2014</td>
</tr>
<tr>
<td>Converse County DFS</td>
<td>219 North Russell</td>
<td>Douglas WY 82633 307-358-3138</td>
</tr>
<tr>
<td>Converse County DFS (physical)</td>
<td>925 W Birch</td>
<td>Glenrock WY 82637 307-436-9068</td>
</tr>
<tr>
<td>Northern Arapahoe</td>
<td>PO Box 9334</td>
<td>#9 Great Plains Rd Arapahoe, WY 82510</td>
</tr>
<tr>
<td>Eastern Shoshone</td>
<td>PO Box 1150</td>
<td>Ft Washakie, WY 82514</td>
</tr>
<tr>
<td>Hot Springs County DFS</td>
<td>403 Big Horn</td>
<td>Thermopolis WY 82443 307-864-2158</td>
</tr>
<tr>
<td>Johnson County DFS</td>
<td>381 N. Main</td>
<td>Buffalo WY 82834 307-684-5513</td>
</tr>
<tr>
<td>Laramie County DFS</td>
<td>1510 E. Pershing</td>
<td>Cheyenne WY 82002 307-777-7921</td>
</tr>
<tr>
<td>Lincoln County DFS</td>
<td>PO Box 470</td>
<td>Kemmerer WY 83101 307-877-6670</td>
</tr>
<tr>
<td>Lincoln County DFS</td>
<td>PO Box 1336</td>
<td>Afton WY 83110 307-886-9232</td>
</tr>
<tr>
<td>Natrona County DFS</td>
<td>851 Werner Court, Ste. 200</td>
<td>Casper WY 82601 307-473-3900</td>
</tr>
<tr>
<td>Niobrara County DFS</td>
<td>PO Box 389</td>
<td>Lusk WY 82225 307-334-2153</td>
</tr>
<tr>
<td>Park County DFS</td>
<td>1301 Rumsey</td>
<td>Cody WY 82414 307-587-6246</td>
</tr>
<tr>
<td>Park County DFS (physical)</td>
<td>109 W. 14th</td>
<td>Powell WY 82435 307-754-2245</td>
</tr>
<tr>
<td>Platte County DFS</td>
<td>975 Gilchrist</td>
<td>Wheatland WY 82201 307-322-3790</td>
</tr>
<tr>
<td>Sheridan County DFS</td>
<td>111 E Works</td>
<td>Sheridan WY 82801 307-672-2404</td>
</tr>
<tr>
<td>Sublette County DFS</td>
<td>111 N Sublette B. 1070</td>
<td>Pinedale WY 82941 307-367-4124</td>
</tr>
<tr>
<td>Sweetwater County DFS</td>
<td>2451 Foothill Blvd Suite 103</td>
<td>Rock Springs WY 82901 307-362-5630</td>
</tr>
<tr>
<td>Teton County DFS</td>
<td>PO Box 547</td>
<td>Jackson WY 83001 307-733-7757</td>
</tr>
<tr>
<td>Uinta County DFS</td>
<td>1109</td>
<td>Mountain View WY 82939 307-786-4011</td>
</tr>
<tr>
<td>Washakie County DFS</td>
<td>1700 Robertson</td>
<td>Worland WY 82401 307-347-6181</td>
</tr>
<tr>
<td>Weston County DFS</td>
<td>2013 West Main Suite #101</td>
<td>Newcastle WY 82701 307-746-4657</td>
</tr>
</tbody>
</table>
A.3 APPENDIX C – Bill Type for Pay-to Provider Taxonomy Table

<table>
<thead>
<tr>
<th>Appropriate Bill Type(s)</th>
<th>Pay-to Provider’s Taxonomy</th>
<th>Taxonomy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X-14X</td>
<td>282N000000X, 283Q000000X, 283X000000X</td>
<td>General and Specialty Hospitals, Medical Assistance Facilities, Long Term Hospitals, Rehabilitation Hospitals, Children’s Hospitals, Psychiatric Hospitals</td>
</tr>
<tr>
<td>73X, 77X</td>
<td>261QF0400X</td>
<td>FQHC</td>
</tr>
<tr>
<td>11X-14X, 85X</td>
<td>282NR1301X</td>
<td>Critical Access Hospitals (CAH)</td>
</tr>
<tr>
<td>81X-82X</td>
<td>251G00000X</td>
<td>Hospice</td>
</tr>
<tr>
<td>83X</td>
<td>261QA1903X</td>
<td>Ambulatory Surgical Centers</td>
</tr>
<tr>
<td>72X</td>
<td>261QE0700X</td>
<td>Hospital Based Renal Dialysis Facility, Independent Renal Dialysis Facility, Independent Special Purpose Renal Dialysis Facility, Hospital Based Satellite Renal Dialysis Facility, Hospital Based Special Purpose Renal Dialysis Facility</td>
</tr>
<tr>
<td>33X</td>
<td>251E00000X</td>
<td>Home Health Agencies</td>
</tr>
<tr>
<td>75X</td>
<td>261QR0401X</td>
<td>CORF</td>
</tr>
<tr>
<td>71X</td>
<td>261QR1300X</td>
<td>Freestanding or Provider Based RHC</td>
</tr>
<tr>
<td>21X, 23X</td>
<td>314000000X, 315P000000X, 283Q000000X (State Hospital Only)</td>
<td>SNF-ICF/MR,</td>
</tr>
<tr>
<td>18X</td>
<td>275N00000X</td>
<td>Hospital Swing Bed</td>
</tr>
<tr>
<td>11X</td>
<td>323P00000X</td>
<td>PRTF</td>
</tr>
<tr>
<td>13X</td>
<td>261QP0904X, 261QR0400X</td>
<td>Indian Health Services (IHS), National Jewish Health Asthma Day Program</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Description</td>
<td>Occurrence Date</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>0258</td>
<td>IV SOLUTIONS</td>
<td>09/22/2010</td>
</tr>
<tr>
<td>0258</td>
<td>N400074795309UN1</td>
<td></td>
</tr>
<tr>
<td>0272</td>
<td>STERILE SUPPLY</td>
<td></td>
</tr>
<tr>
<td>0300</td>
<td>COMPREHENSIVE METABOLIC</td>
<td></td>
</tr>
<tr>
<td>0300</td>
<td>UV-ASSAY BLOOD LDH ENZYM</td>
<td></td>
</tr>
<tr>
<td>0300</td>
<td>ASSAY BLOOD URIC ACID</td>
<td></td>
</tr>
<tr>
<td>0300</td>
<td>AUTOMATED HEMOGRAM</td>
<td></td>
</tr>
<tr>
<td>0301</td>
<td>ASSAY OF PROTEIN, URINE</td>
<td></td>
</tr>
<tr>
<td>0636</td>
<td>N4000850566050UN1</td>
<td></td>
</tr>
<tr>
<td>0636</td>
<td>N64332306402UN6</td>
<td></td>
</tr>
<tr>
<td>0721</td>
<td>OFFICE VISIT ESTAB PATIENT</td>
<td>09/22/2010</td>
</tr>
<tr>
<td>0761</td>
<td>FETAL NON-STRESS TEST</td>
<td></td>
</tr>
</tbody>
</table>

**Creation Date:** 12/23/10

**Total:** 1798.80
<table>
<thead>
<tr>
<th>0420</th>
<th>THERAPEUTIC EXERCISES</th>
<th>97110</th>
<th>GP</th>
<th>122210</th>
<th>1</th>
<th>65 00</th>
</tr>
</thead>
<tbody>
<tr>
<td>0420</td>
<td>NEUROMUSCULAR EX 2</td>
<td>97112</td>
<td>GP</td>
<td>122210</td>
<td>2</td>
<td>13000</td>
</tr>
<tr>
<td>0420</td>
<td>REML TISSUE WOUND LESS</td>
<td>97597</td>
<td>GP</td>
<td>122310</td>
<td>1</td>
<td>80 00</td>
</tr>
<tr>
<td>0420</td>
<td>THERAPEUTIC EXERCISES</td>
<td>97110</td>
<td>GP</td>
<td>122310</td>
<td>2</td>
<td>13000</td>
</tr>
<tr>
<td>0420</td>
<td>GAIT TRAINING</td>
<td>97116</td>
<td>GP</td>
<td>122810</td>
<td>2</td>
<td>13000</td>
</tr>
</tbody>
</table>

**TOTALS** 595 00

**WYOMING MEDICAID**

PO BOX 667
Cheyenne, WY 82003-0667
<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>VALUE CODES</th>
<th>AMOUNT</th>
<th>VALUE CODES</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>ADMIN NON-ROUTINE DRUGS</td>
<td>A8</td>
<td>68</td>
<td>A9</td>
<td>167</td>
</tr>
<tr>
<td>0634</td>
<td>EPOGEN 1,000 UNITS</td>
<td>O4081</td>
<td>10</td>
<td>16</td>
<td>800</td>
</tr>
<tr>
<td>0635</td>
<td>EPOGEN &gt; 10,000 UNITS</td>
<td>O4081</td>
<td>10</td>
<td>16</td>
<td>3500</td>
</tr>
<tr>
<td>0636</td>
<td>ZEMPLAR PER 5 MCG</td>
<td>J2501</td>
<td>10</td>
<td>16</td>
<td>830</td>
</tr>
<tr>
<td>0637</td>
<td>FERRLECIT 62.5 MG</td>
<td>J2916</td>
<td>2</td>
<td>16</td>
<td>258</td>
</tr>
<tr>
<td>0821</td>
<td>HEMODIALYSIS</td>
<td>90999 G3</td>
<td>10</td>
<td>16</td>
<td>5000</td>
</tr>
<tr>
<td>0004</td>
<td>PRINCIPAL PROCEDURE CODE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0005</td>
<td>PRINCIPAL PROCEDURE DATE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0006</td>
<td>OTHER PROCEDURE CODE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0007</td>
<td>OTHER PROCEDURE DATE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0008</td>
<td>OTHER PROCEDURE CODE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0009</td>
<td>OTHER PROCEDURE DATE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS** 10448.00
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Occurrence Date</th>
<th>Occurrence Code</th>
<th>Occurrence Span From</th>
<th>Occurrence Span Through</th>
<th>VA2C3</th>
<th>VA2C4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0520</td>
<td>MEDICAL ENCOUNTER</td>
<td>T1015</td>
<td>011311</td>
<td>1</td>
<td>244 00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0520</td>
<td>DESTRUCTION OF LESIONS</td>
<td>17110 25</td>
<td>011311</td>
<td>1</td>
<td>0 00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0730</td>
<td>ELECTROCARDIGRAM</td>
<td>93005</td>
<td>011311</td>
<td>1</td>
<td>0 00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Creation Date:** 012411

**TOTALS:** 244 00

**WYOMING MEDICAID**

**PAGE 1 OF 1**

**SAMPLE, CLIENT**

<table>
<thead>
<tr>
<th>RECORD</th>
<th>A444444</th>
<th>B455555</th>
<th>C466666</th>
<th>D477777</th>
<th>E488888</th>
<th>F499999</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
<td>F</td>
<td>G</td>
</tr>
<tr>
<td>07812</td>
<td>4019</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### A.4 Appendix D

#### Sample Claims

**Sample Home Health Care**  
123 Sample Avenue  
Sample Town, WY 12345  
(123) 456-5678

**Sample, Client**  
1234 Sample Lane  
Cheyenne, WY 12345

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Address</th>
<th>Sample City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>04301980</td>
<td>M 120109</td>
<td></td>
<td>WY</td>
</tr>
<tr>
<td>27</td>
<td>112610</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Wyoming Medicaid**  
PO Box 667  
Cheyenne, WY 82003-0667

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Occurrence Code</th>
<th>Occurrence Date</th>
<th>Occurrence Span From</th>
<th>Occurrence Span Through</th>
<th>Occurrence Amount</th>
<th>Value Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0551</td>
<td>Skilled Nurse Visit</td>
<td>123110</td>
<td></td>
<td></td>
<td>1</td>
<td>125</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
<td>121610</td>
<td></td>
<td></td>
<td>2</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
<td>121710</td>
<td></td>
<td></td>
<td>2</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
<td>121810</td>
<td></td>
<td></td>
<td>2</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
<td>121910</td>
<td></td>
<td></td>
<td>2</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
<td>122010</td>
<td></td>
<td></td>
<td>2</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
<td>122110</td>
<td></td>
<td></td>
<td>2</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
<td>122210</td>
<td></td>
<td></td>
<td>2</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
<td>122310</td>
<td></td>
<td></td>
<td>2</td>
<td>91</td>
<td></td>
</tr>
</tbody>
</table>

**Creation Date**: 01052011  
**Total**: 853 00

**WYOMING MEDICAID**  
**PAYMENT**:  
**Claim ID**: 1234567890

**Sample, Client**:  
18 0612345678

**Remarks**: B3 251E000000X
<table>
<thead>
<tr>
<th>HCPCS/HCPCS CODE</th>
<th>DESCRIPTION</th>
<th>CHARS</th>
<th>DUR</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0651</td>
<td>ROUTINE HOME CARE</td>
<td>0</td>
<td>20</td>
<td>33800</td>
</tr>
<tr>
<td>0656</td>
<td>GENERAL INPATIENT CARE</td>
<td>0</td>
<td>7</td>
<td>463400</td>
</tr>
</tbody>
</table>

**Creation Date:** 112410

**TOTALS:** 8014 00

**PAYER NAME:** WYOMING MEDICAID

**INSURED'S UNIQUE ID:** 0612345678

**ATTENDING:**

```
A
B
C
D
E
F
G
H
I
J
K
L
M
N
O
P
Q
R
S
T
U
V
W
X
Y
Z

183.0
```

```
B3 251E00000X
```

**CERTIFICATIONS:**

The certificates on the reverse apply to this bill and are made a part hereof.
WYOMING MEDICAID
PO BOX 667
Cheyenne, WY 82003-0667

0658 HOSPICE ROOM AND BOARD - NURSING
27  5340  60
<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>VALUE CODES AMOUNT</th>
<th>VALUE CODES AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0120</td>
<td>ROOM-BOARD/SEMI</td>
<td>97900</td>
<td></td>
</tr>
<tr>
<td>0250</td>
<td>PHARMACY</td>
<td>2</td>
<td>1958 00</td>
</tr>
<tr>
<td>0260</td>
<td>IV THERAPY</td>
<td>46</td>
<td>1172 42</td>
</tr>
<tr>
<td>0270</td>
<td>MED-SUR SUPPLIES</td>
<td>1</td>
<td>88 10</td>
</tr>
<tr>
<td>0272</td>
<td>STERILE SUPPLY</td>
<td>31</td>
<td>1404 04</td>
</tr>
<tr>
<td>0300</td>
<td>LABORATORY OR LAB</td>
<td>1</td>
<td>235 62</td>
</tr>
<tr>
<td>0310</td>
<td>PATH LAB</td>
<td>6</td>
<td>270 80</td>
</tr>
<tr>
<td>0310</td>
<td>PATH LAB</td>
<td>2</td>
<td>130 60</td>
</tr>
<tr>
<td>0370</td>
<td>ANESTHESIA</td>
<td>3</td>
<td>157560</td>
</tr>
<tr>
<td>0410</td>
<td>RESPIRATORY SVC</td>
<td>4</td>
<td>153830</td>
</tr>
<tr>
<td>0710</td>
<td>RECOVERY ROOM</td>
<td>1</td>
<td>33 00</td>
</tr>
<tr>
<td>0720</td>
<td>LAB/DEL/REC</td>
<td>5</td>
<td>1422 30</td>
</tr>
<tr>
<td>0760</td>
<td>TREATMENT ROOM</td>
<td>1</td>
<td>135 00</td>
</tr>
</tbody>
</table>

**TOTALS** 11093 28
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Billable Description</th>
<th>Billable Date</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>RURAL HEALTH</td>
<td>112310</td>
<td>126.00</td>
</tr>
<tr>
<td>0510</td>
<td>CLINIC HOSP</td>
<td>112310</td>
<td>1</td>
</tr>
<tr>
<td>0300</td>
<td>LABORATORY SERVICES</td>
<td>112310</td>
<td>1</td>
</tr>
</tbody>
</table>

**WYOMING MEDICAID**

PO BOX 667
Cheyenne, WY 82003-0667
**WYOMING MEDICAID**
PO BOX 667
Cheyenne, WY 82003-0667

<table>
<thead>
<tr>
<th>CODE</th>
<th>VALUE CODES</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0100 ROOM AND BOARD

<table>
<thead>
<tr>
<th>0001</th>
<th>PAGE 1 OF 1</th>
<th>CREATION DATE</th>
<th>020411</th>
<th>TOTALS</th>
<th>1020 00</th>
</tr>
</thead>
</table>

ワイミン メディケアID

SAMPLE, CLIENT

<table>
<thead>
<tr>
<th>18</th>
<th>0612345678</th>
</tr>
</thead>
</table>

**A.4 Appendix D**

Sample Claims

<table>
<thead>
<tr>
<th>2</th>
<th>1234</th>
</tr>
</thead>
</table>
Ambulatory Surgical Center
123 Sample Avenue
Sample Town, WY 12345
(123) 456-5678

Sample, Client
Sample City, WY 12345

11171976 F 070114 10 3 1 10 01
10 020910 11 092210

WYOMING MEDICAID
PO BOX 667
Cheyenne, WY 82003-0667

490 64483 7-1-2014 1 1798 80

50 PAYER NAME 53 HEALTH PLAN ID
51 BILLING ID 54 PRORATED PAYMENTS
55 EST. AMOUNT DUE 56 NPI
57 OTHER PAY ID

WYOMING MEDICAID Y Y 1798 80

58 INSURED'S NAME 60 INSURED'S UNIQUE ID
61 GROUP NAME 62 INSURANCE GROUP NO.

SAMPLE, CLIENT 18 0612345678

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

722.10 724.2 724.4

64243

78 ATTENDING 1234567891 QUAL
77 OPERATING NPI QUAL
76 LAST FIRST
75 OTHER NPI QUAL
74 LAST FIRST
73 OTHER NPI QUAL
72 FIRST
71 PRINCIPAL PROCEDURE CODE
70 PATIENT REASON CODE
69 ADMIT RX

68 REMARKS

B3 261QA1903X

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay</th>
<th>Coverage Types *</th>
<th>Cap Limits *</th>
<th>Covered Services</th>
<th>Limitations</th>
<th>ID Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABIW</td>
<td>Acquired Brain Injury</td>
<td>Y</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x 20 20 20 12</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>This plan does not cover nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
<td>Y</td>
</tr>
<tr>
<td>ADAP</td>
<td>Aids Drug Assistance Program</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td>This plan covers specific prescriptions only.</td>
<td></td>
</tr>
<tr>
<td>ADSS</td>
<td>Aged/Disabled SSI Related (Additional Information: Clients under 21 - no co-pay and no cap limits)</td>
<td>Y</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x 20 20 20 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALEN</td>
<td>Emergency Services for Non-Citizens</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid and State Healthcare Benefit Plans

#### Provider Eligibility Job Aid

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay*</th>
<th>Coverage Types *</th>
<th>Cap Limits*</th>
<th>Covered Services</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCC</td>
<td>Breast and Cervical Cancer</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers outpatient hospital and medical services for providers who are enrolled with the Breast and Cervical Cancer Program. In addition, coverage is limited to specific screening and diagnostic services. For more information contact the BCC Program at 800-264-1296.</td>
<td>N</td>
</tr>
<tr>
<td>CASI</td>
<td>Child &amp; Adolescent Service Intensity Instrument (CASII Evaluations)</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers CASII evaluations only</td>
<td>N</td>
</tr>
<tr>
<td>CHPR</td>
<td>CHIPRA Care Management</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers clients who are eligible for CHIPRA services. For additional information contact Wyoming Access at 1-855-883-8740 or Wyoaccess.net</td>
<td>N</td>
</tr>
<tr>
<td>CMHW</td>
<td>Children’s Mental Health Waiver</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers dental, medical, vision, outpatient hospital and waiver services, prescriptions, inpatient hospital stays and pays co-insurance and deductibles on Medicare claims. This plan does not cover nursing home services.</td>
<td>Y</td>
</tr>
<tr>
<td>COAW</td>
<td>Comprehensive Adult Waiver</td>
<td>Y</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>20 20 12</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services. This plan does not cover nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or eye injury. Glasses and Contacts are not covered under this plan.</td>
<td>Y</td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Description</td>
<td>Copay*</td>
<td>Coverage Types</td>
<td>Cap Limits*</td>
<td>Covered Services</td>
<td>Limitations</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------</td>
<td>--------</td>
<td>----------------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>COCW</td>
<td>Comprehensive Child Waiver</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers dental, medical, vision, outpatient hospital and waiver services, prescriptions, inpatient hospital stays and pays co-insurance and deductibles on Medicare claims. This plan does not cover nursing home services.</td>
<td></td>
</tr>
<tr>
<td>COLR</td>
<td>Colorectal Cancer Screening Program</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers outpatient hospital and medical services related to specific screening and diagnostic services. The medical provider must be enrolled with the Colorectal Cancer Screening Program. For more information contact the CRC Program at 1-866-205-5292.</td>
<td></td>
</tr>
<tr>
<td>CSH1</td>
<td>Children's Special Health - Special Needs Children</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers services for specific diagnoses or conditions as approved by the CSH Program. For additional information contact CSH at 1-800-438-5795.</td>
<td></td>
</tr>
<tr>
<td>CSH2</td>
<td>Children's Special Health - Moms and Babies</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td></td>
<td>This plan covers services for specific diagnoses or conditions as approved by the CSH Program. For additional information contact CSH at 1-800-438-5795.</td>
<td></td>
</tr>
<tr>
<td>DDAW</td>
<td>DD Adult Waiver</td>
<td>Y</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>20 20 20 12</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services. No nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
<td></td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Description</td>
<td>Copay*</td>
<td>Coverage Types *</td>
<td>Cap Limits*</td>
<td>Covered Services</td>
<td>Limitations</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------</td>
<td>--------</td>
<td>------------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>DDCW</td>
<td>DD Children's Waiver</td>
<td>N</td>
<td>D Rx I O M V W</td>
<td>T OT ST ST</td>
<td>This plan covers dental, medical, vision, outpatient hospital and waiver services, prescriptions, inpatient hospital stays and pays co-insurance and deductibles on Medicare claims.</td>
<td>This plan does not cover nursing home services.</td>
</tr>
<tr>
<td>DDP</td>
<td>Disability Determination</td>
<td>N</td>
<td></td>
<td></td>
<td>This plan covers a physician consultation and diagnostic screening and testing for SSI determination only.</td>
<td>This plan does not cover abortion, infertility services and/or treatments, or sterilization reversals.</td>
</tr>
<tr>
<td>FPW</td>
<td>Pregnant By Choice</td>
<td>N</td>
<td></td>
<td></td>
<td>This plan receives Dental coverage only, with a maximum of 1,000 dollars total payment limitation per year and receives 85% of billed charges, the client is responsible for remaining 15%. Eligibility is determined annually. For additional information contact the Marginal Dental Program at (307)777-7945.</td>
<td>No waiver or nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
</tr>
<tr>
<td>MDP</td>
<td>Marginal Dental Program</td>
<td>N</td>
<td></td>
<td></td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td></td>
</tr>
<tr>
<td>EID</td>
<td>Employed Individual Disabled</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Description</td>
<td>Copay*</td>
<td>Coverage Types *</td>
<td>Cap Limits*</td>
<td>Covered Services</td>
<td>Limitations</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------</td>
<td>--------</td>
<td>------------------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HSPC</td>
<td>Hospice Only</td>
<td>N</td>
<td>Rx I O M V W N</td>
<td>T OT PT ST OV</td>
<td>This plan covers services provided by physicians and the attending hospice provider. Prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, co-insurance and deductibles on Medicare claims and limited dental and vision services are covered when not related to the client's terminal illness and approved by the hospice provider.</td>
<td>No nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
</tr>
<tr>
<td>IP65</td>
<td>Inpatient Psychology</td>
<td>Y</td>
<td>Rx I O M V W N</td>
<td>T OT PT ST OV</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and nursing home services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>No waiver services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.</td>
</tr>
<tr>
<td>KIDA</td>
<td>Standard Full Coverage</td>
<td>N</td>
<td>Rx I O M V W N</td>
<td>T x x x x x</td>
<td>This plan covers dental, medical, vision, outpatient hospital and waiver services, prescriptions, inpatient hospital stays and pays co-insurance and deductibles on Medicare claims.</td>
<td>This plan does not cover waiver or nursing home services.</td>
</tr>
<tr>
<td>LTCS</td>
<td>Long Term Care Screening</td>
<td>N</td>
<td></td>
<td></td>
<td>This plan covers LT101 and PASRR screenings only.</td>
<td></td>
</tr>
</tbody>
</table>
### A.5 Appendix E

#### Medicaid and State Healthcare Benefit Plans

**Provider Eligibility Job Aid**

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay</th>
<th>Coverage Types *</th>
<th>Cap Limits *</th>
<th>Covered Services</th>
<th>Limitations</th>
<th>ID Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>MATR</td>
<td>Maternity</td>
<td></td>
<td></td>
<td></td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>This plan does not cover waiver or nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
<td>Y</td>
</tr>
<tr>
<td>MCAD</td>
<td>Standard Full Coverage</td>
<td>Y</td>
<td></td>
<td></td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>This plan does not cover waiver or nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
<td>Y</td>
</tr>
<tr>
<td>MMRX</td>
<td>Renal Program</td>
<td>N</td>
<td></td>
<td></td>
<td>This plan covers specific renal prescriptions only.</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>MQIB</td>
<td>Medicare Qualified</td>
<td>N</td>
<td></td>
<td>X</td>
<td>This plan pays Medicare Part B premiums only.</td>
<td></td>
<td>N</td>
</tr>
<tr>
<td>MQIP</td>
<td>Individual - B Premium</td>
<td>N</td>
<td></td>
<td></td>
<td>This plan covers 3 prescriptions per month, pays Medicare Part B premiums.</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Individual - B Premium and Prescriptions</td>
<td>Y</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>
### Medicaid and State Healthcare Benefit Plans

#### Provider Eligibility Job Aid

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay*</th>
<th>Coverage Types *</th>
<th>Cap Limits*</th>
<th>Covered Services</th>
<th>Limitations</th>
<th>ID Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH</td>
<td>Nursing Home</td>
<td>N</td>
<td>D Rx I O M V W N</td>
<td>T OT PT ST OT</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and nursing home services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>No waiver services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
<td>Y</td>
</tr>
<tr>
<td>NONH</td>
<td>No Nursing Home or Wavier</td>
<td>Y</td>
<td>D Rx I O M V W N</td>
<td>T OT PT ST OT</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>No waiver or nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
<td>Y</td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Description</td>
<td>Copay*</td>
<td>Coverage Types*</td>
<td>Cap Limits*</td>
<td>Covered Services</td>
<td>Limitations</td>
<td>ID Card</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
<td>--------</td>
<td>-----------------</td>
<td>-------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>PACE</td>
<td>Program of All-Inclusive Care for the Elderly</td>
<td>N</td>
<td>D Rx I O M V W N</td>
<td>C/D T OT PT ST OV</td>
<td>This plan covers Medicaid eligible medical services as well as home and community based services for participants 55 years of age and older who meet nursing home level of care. All services must be provided by a PACE provider in Wyoming. For additional information contact Wyoming Medicaid at (307)777-7531.</td>
<td>This plan covers Medicaid eligible medical services as well as home and community based services for participants 55 years of age and older who meet nursing home level of care. All services must be provided by a PACE provider in Wyoming. For additional information contact Wyoming Medicaid at (307)777-7531.</td>
<td>Y</td>
</tr>
<tr>
<td>PDAP /MMP</td>
<td>Prescription Drug Assistance Program</td>
<td>Y</td>
<td>x x</td>
<td></td>
<td>This plan covers 3 prescriptions per month.</td>
<td>This plan does not cover inpatient hospital stays, waiver, nursing home or dental services. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
<td>Y</td>
</tr>
<tr>
<td>PE</td>
<td>Presumptive Eligibility</td>
<td>N</td>
<td>x x x x x</td>
<td>20 20 20 12</td>
<td>This plan covers prescriptions, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited vision services.</td>
<td>This plan covers prescriptions, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited vision services.</td>
<td>Y</td>
</tr>
<tr>
<td>POUT</td>
<td>Project Out</td>
<td>N</td>
<td>x</td>
<td></td>
<td>This plan is limited to providers who are enrolled with the Project Out Program and coverage is limited specific medical services. For more information contact the Project Out Program at 800-442-2766.</td>
<td>This plan is limited to providers who are enrolled with the Project Out Program and coverage is limited specific medical services. For more information contact the Project Out Program at 800-442-2766.</td>
<td>N</td>
</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
<td>N</td>
<td>x x</td>
<td></td>
<td>This plan pays Medicare Part B premiums and co-insurance and deductibles on Medicare claims only.</td>
<td>This plan pays Medicare Part B premiums and co-insurance and deductibles on Medicare claims only.</td>
<td>Y</td>
</tr>
<tr>
<td>QMBP</td>
<td>Qualified Medicare Beneficiary with Prescriptions</td>
<td>Y</td>
<td>x x</td>
<td></td>
<td>This plan covers 3 prescriptions per month, pays co-insurance and deductibles on Medicare claims, pays Medicare Part B premiums.</td>
<td>This plan covers 3 prescriptions per month, pays co-insurance and deductibles on Medicare claims, pays Medicare Part B premiums.</td>
<td>Y</td>
</tr>
<tr>
<td>QWDI</td>
<td>Qualified Working Disabled Individual</td>
<td>N</td>
<td>x</td>
<td></td>
<td>This plan pays Medicare Part A premiums only.</td>
<td>This plan pays Medicare Part A premiums only.</td>
<td>N</td>
</tr>
</tbody>
</table>
### A.5 Appendix E

**Medicaid and State Healthcare Benefit Plans**

**Provider Eligibility Job Aid**

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay*</th>
<th>Coverage Types</th>
<th>Cap Limits*</th>
<th>Covered Services</th>
<th>Limitations</th>
<th>ID Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCM</td>
<td>Targeted Case Management</td>
<td>N</td>
<td>D Rx I G M V W N AP BP C/D T OT</td>
<td>x</td>
<td>This plan covers screening services for the Developmentally Disabled Waiver Program only.</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>SHPS</td>
<td>State Licensed Shelter Care</td>
<td>N</td>
<td>D Rx I G M V W N AP BP C/D T OT</td>
<td>x</td>
<td>This plan covers nursing home services only and pays co-insurance and deductibles on Medicare claims.</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>SLMB</td>
<td>Special Low-Income Medicare Beneficiaries</td>
<td>N</td>
<td>D Rx I G M V W N AP BP C/D T OT</td>
<td>x</td>
<td>This plan pays Medicare Part B premiums only.</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>SLMP</td>
<td>Special Low-Income Medicare Beneficiaries with Prescriptions</td>
<td>Y</td>
<td>D Rx I G M V W N AP BP C/D T OT</td>
<td>x</td>
<td>This plan covers 3 prescriptions per month, pays Medicare Part B premiums.</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>SUAW</td>
<td>Supports Adult Waiver</td>
<td>Y</td>
<td>D Rx I G M V W N AP BP C/D T OT</td>
<td>x x x x x x x x x</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>This plan does not cover nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or eye injury. Glasses and Contacts are not covered under this plan.</td>
<td>Y</td>
</tr>
<tr>
<td>SUCW</td>
<td>Supports Child Waiver</td>
<td>N</td>
<td>D Rx I G M V W N AP BP C/D T OT</td>
<td>x x x x x x x</td>
<td>This plan covers dental, medical, vision, outpatient hospital and waiver services, prescriptions, inpatient hospital stays and pays co-insurance and deductibles on Medicare claims.</td>
<td>This plan does not cover nursing home services.</td>
<td>Y</td>
</tr>
</tbody>
</table>
### Medicaid and State Healthcare Benefit Plans

#### Provider Eligibility Job Aid

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay*</th>
<th>Coverage Types</th>
<th>Cap Limits*</th>
<th>Covered Services</th>
<th>Limitations</th>
<th>ID Card</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>D Rx I O M V N AP BP C/D T OT PT ST OV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TBI</td>
<td>Tuberculosis Infected</td>
<td>Y</td>
<td>x x x x x</td>
<td>x x</td>
<td>20 20 20 12</td>
<td>This plan covers prescriptions, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.</td>
<td>Y</td>
</tr>
<tr>
<td>TBRX</td>
<td>Tuberculosis State Only Program</td>
<td>N</td>
<td>x</td>
<td></td>
<td></td>
<td>This plan covers specific prescriptions only</td>
<td>Y</td>
</tr>
</tbody>
</table>
## Medicaid and State Healthcare Benefit Plans

### Provider Eligibility Job Aid

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Copay*</th>
<th>Coverage Types *</th>
<th>Cap Limits*</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>WLTC</td>
<td>Waiver Long Term Care</td>
<td>N</td>
<td>D Rx I O M V W N AP BP C/D T OT PT ST OV</td>
<td>x x x x x x x x x 20 20 20 12</td>
<td>This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services. This plan does not cover nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.</td>
</tr>
</tbody>
</table>

### *Key*

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

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

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

Revision Date: 6.27/14