SEPTEMBER 1986

ATTACHMENT 3.1-B

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OMB No. 0938-0193

State/Territo	ory:	
· · · · · · · · · · · · · · · · · · ·	DURATION AND SCOPE OF SERVICES PROVIDED NEEDY GROUP(S):	

The following ambulatory services are provided.

*Description provided on attachment.

TN No. 86-6 Supersedes TN No.

Approval Date 2/9/87 Effective Date 2/1/86

HCFA ID: 0140P/0102A

/_/ Not provided. Revision: HCFA-PM-91- (BPD) 1991	ATTACHMENT 3.1-B Page 2 OMB No. 0938-
State/Territory: <u>WYC</u> AMOUNT, DURATION, MEDICALLY NEEDY GR	OMING AND SCOPE OF SERVICES PROVIDED OUP(S): NOT APPLICABLE
1. Inpatient hospital services of institution for mental disease	
//Provided: //No li	mitations / / With limitations*
2.a.Outpatient hospital services	5 .
b.Rural health clinic services	mitations / /With limitations* s and other ambulatory services clinic (which are otherwise covered under the
c.Federally qualified health of services that are covered und	mitations / With limitations* center (FQHC) services and other ambulatory der the plan and furnished by an FQHC in of the State Medicaid Manual (HCFA-Pub. 45-
Provided: No]	imitations // With limitations*
3. Other laboratory and X-ray s	services.
$\sqrt{/}$ Provided: $\sqrt{/}$ No	limitations / / With limitations*
4.a.Nursing facility services (comental diseases) for individu	ther than services in an institution for lals 21 years of age or older.
b. Early and periodic screening	tations //With limitations* , diagnostic and treatment services for fage, and treatment of conditions found.*
/// Provided c.Family planning services and childbearing age.	supplies for individuals of
$\frac{1}{\sqrt{1}}$ Provided: $\frac{1}{\sqrt{1}}$ No limit	ations /_/With limitations*
*Description provided on attachm	ment.
TN No. <u>92-02</u> S rsedes Approval Date S). <u>91-13</u>	
-14M	HCFA ID: 7986E

Revision:	HCFA-PM-93-5 (MB) May 1993	ATTACHMENT Page 2a OMB NO:	3.1-B
	State/Territory: WYOMING		
	AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED GROUPS(s):	MEDICALLY	NEEDY
	NOT APPLICABLE		
5.a.	Physicians' services, whether furnished in the office, to a hospital, a nursing facility, or elsewhere.	he patient's	home,
	Provided: No limitations With limitations*		
b.	Medical and surgical services furnished by a dentist (i section $1905(a)(5)(B)$ of the Act).	n accordance	e with
	Provided: No limitations With limitations:		

TN # 95-003'				
Supersedes	Approval Date _	06/21/95	Effective Date	01 <i>/\$\\</i> 95
TN # 92-013				

^{*} Description provided on attachment

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		State/Terr	itory:		· · · · · · · · · · · · · · · · · · ·				
		AMOUN MEDICAI	T, DURA	ATION AND DY GROUP(SCOPE O	F SERV	CES PR	OVIDED	
6.	law	ical care ar , furnished ctice as def	by lic	ensed pra	ctitione	nedial ors with	care re	cognized scope of	under State their
a.	Pod	iatrists' Se	rvices						
	<u>/</u> /	Provided:	<u></u>	No limi	tations	<u></u>	With	limitatio	ons*
b.	Opto	ometrists' S	ervice	8					
		Provided:		No limi	tations	<u>/</u> /	With	limitatio	ns*
c.	Chir	copractors'	Servic	8 8					
		Provided:		No limi	tations	<u></u>	With	limitatio	ns*
đ.	Othe	er Practitio	ners'	Services					
		Provided:	<u>/</u> /	No limi	tations	<u></u>	With	limitatio	ns≭
7.	Home	Health Ser	vices						
a.	agen	rmittent or cy or by a area.	part-	ime nurs	ing serv e when n	ice pro o home	vided health	by a home agency e	health xists in
		Provided:	<u></u>	No limit	tations		With :	limitatio	ns*
b.	Home	health aid	e servi	ces provi	ided by	a home	health	agency.	
•	<u></u>	Provided:	<u>_</u>	No limit	tations	<u></u>	With 1	limitatio	ns*
c.	Medi home	cal supplie	s, equi	.pment, ar	nd appli	ances s	uitable	for use	in the
	<i></i>	Provided:	<u>/</u> /	No limit	ations	<u> </u>	With 1	imitatio	ns*
d.	audi	ical therap ology service bilitation	ces pro	vided by	therapy a home 1	, or sp health	eech pa agency	thology or medic	and al
		Provided:		No limit	ations		With 1	imițatio	ns*
*Descr	riptio	n provided o	on atta	chment.					
TN No.	. 86	-6							
Supers			Approv	al Date	2/9/8	7	Effect	ive Date	12/1/86
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		State/Terr	itory:				
		AMOUN MEDICAL	T, DURA	ATION AND SCOPE DY GROUP(S):	OF SERVI	CES PROVIDED	
8.	Priv	vate duty no	ursing	services.			
	<u></u>	Provided:		No limitations		With limitations*	
9.	Clir	nic services	ı.				
		Provided:	<u></u>	No limitations		With limitations*	
10.	Dent	al services	١.				
	<u></u>	Provided:		No limitations		With limitations*	
11.	Phys	ical therap	y and	related services	ı.		
a.	Phys	ical therap	y.				
	<u></u>	Provided:	<u></u>	No limitations	<u> </u>	With limitations*	
b.	Occu	pational th	erapy.			1	
	<i></i>	Provided:		No limitations		With limitations*	
c.	Serv prov	ices for in	dividu: under :	als with speech, supervision of a	hearing speech	, and language disorders pathologist or audiologi	st.
		Provided:	<i></i>	Wo limitations		With limitations*	
12.	pres	cribed drug cribed by a metrist.	s, deni	tures, and prost cian skilled in	hetic de diseases	evices; and eyeglasses s of the eye or by an	
a.	Pres	cribéd drug	s .				
	乊	Provided:	<u> </u>	No limitations		With limitations*	
b.	Dent	ures.				•	
	<u></u>	Provided:		No limitations	<u></u>	With limitations*	
*Descr	iptio	n provided	on atta	chment.			
TN No. Supers	edes		Approv	val Date 2/9/	187	Effective Date 2/1/	<u>'8</u> 6
18 NO.		_				tiant en actes too	

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	State/Territory:	
	AMOUNT, DURATION AND SCOPE OF S MEDICALLY NEEDY GROUP(S):	
c.	Prosthetic devices.	
	// Provided: // No limitations	// With limitations*
đ.	Eyeglasses.	
	/// Provided: // No limitations	// With limitations*
13.	Other diagnostic, screening, preventive, i.e., other than those provided elsewhere	
a.	Diagnostic services.	
	// Provided: // No limitations /	// With limitations*
b.	Screening services.	
	// Provided: // No limitations /	
c.	Preventive services.	
	// Provided: // No limitations /	_/ With limitations*
d.	Rehabilitative services.	
	// Provided: // No limitations /	
14.	Services for individuals age 65 or older diseases.	in institutions for mental
a.	Inpatient hospital services.	
	// Provided: // No limitations /	_/ With limitations*
b.	Skilled nursing facility services.	
Descr	// Provided: // No limitations / iption provided on attachment.	_/ With limitations
Supers	86-6 sedes Approval Date 2/9/87	Bffective Date <u>12/1/86</u> HCFA ID: 0140P/0102A

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		State/Terr	itory:	4		
		AMOUR MEDICA	IT, DUR LLY NEI	ATION AND SCOPE CEDY GROUP(S):	F SERV	ICES PROVIDED
c.	Int	ermediate c	are fac	ility services.		
		Provided:		No limitations		With limitations*
15. a	TIID	CICACTOU LOI	. menta	l Ciseases) for t	ergong	han such services in an determined in accordance e in need of such care.
		Provided:		No limitations		With limitations*
b.	Inc.	luding such reof) for th	servic e ment	es in a public in ally retarded or	stitut. person:	ion (or distinct part s with related conditions.
	<i>二</i>	Provided:		No limitations	<i></i>	With limitations*
16.	Inpa of a	itient psych ige.	iatric	facility service	s for	individuals under 22 years
		Provided:		No limitations	<u></u>	With limitations*
17.	Nurs	e-midwife s	ervices	3.		
		Provided:		No limitations		With limitations*
l 8 .	Новр	ice care (i	accor	dance with section	on 1905	(o) of the Act).
		Provided:	<u></u>	No limitations		With limitations*
		•				
Descri	ption	n provided o	n atta	chment.		
N No. Superse			Approv	al Date <u>2/9/8</u>	32	Rffective Date 12/1/86
		-				HCFA ID: 0140P/0102

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

		STATE/TERRITORY: WYOMING
		AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): NOT APPLICABLE
19.	Case	management services and Tuberculosis related services
		a. Case management services as defined in, and to the growspecified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
		Provided: With limitations*
i		Not provided.
!		 Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.
		Provided: With limitations*
		Not provided.
20.	Exten	ded services for pregnant women
		a. Pregnant-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the montion which the 60th day fails.
		Provided:+ Additional coverage ++ .
		b. Services for any other medical conditions that may complicat pregnancy.
		Provided:+ Additional coverage ++ Not provided
21.	Certi	ied pediatric or family nurse practitioners' services.
		Provided: No limitations With limitations
		Not provided.
	+	Attached is a list of major categories of services (e.g., inpatien hospital, physician, etc.) and limitations on them, if any, that ar available as pregnancy-related services or services for any othe medical condition that may complicate pregnancy.
	++	Attached is a description of increases in covered services beyon limitations for all groups described in this attachment and/or an additional services provided to pregnant women only.
*Des	cription	provided on attachment.
N No Supe	o. <u>95-</u> rsedes	008 Approval Date 07/24/95 Effective Date 07/01/95
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Revision:

HCFA-PM-01-01-02

June 2001

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State/Territory: WYOMING

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Not Applicable

		MEDICA	LET NEEDT GROOF(S). No	t Applicable
22.	Respir	atory care services (in	accordance with section 1902(e)	(9)(A) through (C) of the Act.)
	// Pr	rovided: /	No limitations /_/ With	limitations*
	/_/ N	lot provided.		
23.		ther medical care and a cretary.	any other type of remedial care re	ecognized under State law, specified by
b	. Trans	sportation.		
	//	Provided:	/_/ No limitations	/_/ With limitations*
	/_/	Not provided.		
	b. Se	ervices provided in Rel	igious Nonmedical Health Care	Institutions.
	/_/	Provided:	/_/ No limitations	/_/ With limitations*
	//	Not provided.		
c.	Reser	ved		
d	. Nursi	ing facility services for	patients under 21 years of age.	
	//	Provided:	/_/ No limitations	/_/ With limitations*
	//	Not provided.		
e.	Emer	gency hospital service	S	
	//	Provided:	/_/ No limitations	/_/ With limitations*
	//	Not provided.		
f.			cipient's home, prescribed in according to the control of a register on under supervision of a register	ordance with a plan of treatment and ered nurse.
	/_/	Provided:	/_/ No limitations	/_/ With limitations*
4	· /_/	Not provided.		
* Desc	cription p	provided on attachmen	t	
TNI NIA	01.00)5		
Supers	<u>v 01-00</u> edes	<u>is</u> Annroval D	ate <u>07/31/01</u> Effective I	Date 7/1/01
	. <u>87-0</u> 0	06	O 1 1 0 1 DIRECTIVE I	- // I/O1

ATTACHMENT 3.1-B Revision: HCFA-PM-94-9 (MB) Page 9 DECEMBER 1994 WYOMING State/Territory: AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): Home and Community Care for Functionally Disabled Elderly Individuals, as 24. defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A. Not Provided Provided 25.

Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home. Provided: State Approved (Not Physician) Service Plan Allowed

Services Outside the Home Also Allowed Limitations Described on Attachment Not provided.

NOT APPLICABLE