

WYOMING OUTPATIENT HOSPITAL REIMBURSEMENT SYSTEM

ATTACHMENT 4.19B

Section 1. Purpose and Applicability.

This Attachment shall apply to and govern the reimbursement of inpatient and outpatient hospital services provided on or after July 1, 1993. Hospital services are also subject to the provisions of Chapters III, VIII and IX of the Wyoming Medicaid rules, except as otherwise specified in this Attachment.

Section 2. General provisions.

(a) Terminology. Except as otherwise specified, the terminology used in this Attachment is the standard terminology and has the standard meaning used in accounting, health care, Medicaid and Medicare.

(b) General methodology. The Department reimburses providers of outpatient hospital services using Medicare's retrospective reasonable cost reimbursement principles, subject to the limits established by Section 1886(b) of the Social Security Act, except as otherwise specified by this Attachment.

Section 3. Definitions.

(a) "Admission." The act by which an individual is admitted to a hospital as an outpatient. "Admission" does not include a new born child or an individual that is transferred from one unit of a hospital to another unit in the hospital or to a distinct part hospital unit.

(b) "Allowable costs." Medicare allowable costs, except as otherwise specified by this Attachment.

(c) "Base year." A hospital's first 12 month cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(d) "Chapter I." Chapter I, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid rules.

(e) "Claim." A request by a provider for Medicaid payment for services provided to a recipient.

(f) "Cost report." An itemized statement of a hospital's costs for its most recently completed fiscal year, including an audited or unaudited financial statement, prepared in accordance with GAAP and the instructions of the Department. A cost report must include the information and be prepared in the form specified by the Department and the intermediary, and must be submitted in hardcopy and on computer disc using software designated by the Department. "Cost report" includes any

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supplemental request by the Department for additional information relating to the hospital's costs and the hospital's efforts to achieve efficiencies or other cost savings.

(g) "Covered service." A health service or supply eligible for Medicaid reimbursement pursuant to the rules and policies of the Department. "Covered service" does not include nursing facility services.

(h) "Credit balance." Medicaid funds received by a hospital that are owed to the Department for any reason.

(i) "Department." The Wyoming Department of Health, its designee, agent or successor.

(j) "Desk review." A review by the Department of a hospital's cost report to determine: (i) if the cost report has been prepared and submitted in compliance with this Attachment; (ii) that costs have been properly allocated; and (iii) that costs are allowable.

(k) "Director." The Director of the Department or the Director's designee.

(l) "Distinct part hospital unit." A distinct part hospital unit excluded from the Medicare prospective payment system pursuant to 42 C.F.R. 412.20(b)(1), which is incorporated by this reference.

(m) "Division." The Division of Health Care Financing of the Department, its agent, designee or successor.

(n) "Excess payments." Medicaid funds received by a provider which exceed the Medicaid allowable payment established by the Department.

(o) "Extraordinary circumstances." A catastrophic occurrence, beyond the control of a provider, which results in substantially higher costs and which meets the criteria set forth in (i) through (v). "Extraordinary circumstances" include, but are not limited to, labor strikes, fire, earthquakes, floods or similar circumstances which result in substantial cost increases, and which:

- (i) Is a one-time occurrence;
- (ii) Could not have reasonably been predicted;
- (iii) Is not insurable;
- (iv) Is not covered by federal or state disaster relief; and

- (v) Is not the result of intentional, reckless or negligent actions or inactions by any director, officer, employee or agent of the provider.
- (p) "Field audit." An examination, verification and review of a hospital's financial records and any supporting or related documentation conducted by employees, agents or representatives of the Department or HHS.
- (q) "Financial records." All records, in whatever form, used or maintained by a hospital in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the hospital's cost reports.
- (r) "Generally accepted accounting principles (GAAP)." Accounting concepts, standards and procedures established by the American Institute of Certified Public Accountants.
- (s) "Generally accepted auditing standards (GAAS)." Auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.
- (t) "HCFA." The Health Care Financing Administration of HHS, its agent, designee or successor.
- (u) "HHS." The United States Department of Health and Human Services, its agent, designee or successor.
- (v) "Hospital." An institution that: (i) is approved to participate as a hospital under Medicare; (ii) is maintained primarily for the treatment and care of patients with disorders other than mental diseases or tuberculosis; (iii) has a provider agreement; (iv) is enrolled in the Medicaid program; and (v) is licensed to operate as a hospital by the State of Wyoming or, if the institution is out-of-state, licensed by the state in which the institution is located.
- (w) "Interim rate." The interim reimbursement rate established pursuant to Section 4.
- (x) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and the Wyoming Medical Assistance and Services Act.
- (y) "Medical record." All documents, in whatever form, in the possession of or subject to the control of the hospital which describe the recipient's diagnosis, condition or treatment, including, but not limited to, the plan of care for the recipient.
- (z) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.

(aa) "Medicare allowable costs." Costs incurred by a hospital which are allowable under Medicare principles of cost reimbursement.

(bb) "Medicare intermediary." The intermediary for Medicare Part A appointed pursuant to 42 U.S.C. § 1395u.

(cc) "Medicare principles of cost reimbursement." The inpatient hospital reimbursement principles established by Medicare as set forth in the Provider Reimbursement Manual and HCFA's instructions for administering the Manual, which are incorporated by reference. The Provider Reimbursement Manual and the HCFA instructions are published by HCFA and are available from that agency. The Provider Reimbursement Manual is also published in the CCH Medicare and Medicaid Guide, beginning at ¶ 7227, and is available from Commerce Clearing House, 4025 West Peterson Avenue, Chicago, Illinois 60646.

(dd) Most recently settled Medicare cost report." A facility's most recent cost report which has been (i) submitted to Medicare, in accordance with Medicare standards and procedures; (ii) cost settled by the Medicare intermediary using Medicare principles of cost reimbursement; and (iii) for which a notice of program reimbursement has been issued. A cost report is considered settled notwithstanding a request to reopen.

(ee) "New hospital." A hospital which has not filed an audited Medicare cost report with the Department.

(ff) "Nonallowable costs." Costs which are not related to covered services. Nonallowable costs include, but are not limited to:

(i) Costs related to other services as described in Section 7; and

(ii) As otherwise specified in this Attachment and the rules of the Department.

(gg) "Notice of Medicaid Program Reimbursement." Written notice from the Department to a hospital, sent by certified mail, which includes, if available, the hospital's Medicaid allowable costs, cost to charge ratio and interim reimbursement rate.

(hh) "Notice of Program Reimbursement." Written notice from the Medicare intermediary to the Department of a hospital's Medicaid allowable costs, cost to charge ratio and interim reimbursement rate.

(ii) "Outpatient." An outpatient as defined by 42 C.F.R. § 440.2(a), which is incorporated by this reference.

(jj) "Outpatient hospital service." "Outpatient hospital services" as defined in 42 C.F.R. § 440.20(a), which is incorporated by this reference.

(kk) "Overpayments." The amount by which the interim rate a hospital received exceeds the final cost-settled amount determined pursuant to Section 6.

(ll) "Provider." A hospital which has a current provider agreement, is licensed to provide services and is enrolled with the Department as a provider.

(mm) "Provider agreement." A written contract between a provider and the Department in which the provider agrees to comply with the provisions of the contract and applicable federal and State statutes and regulations as a prerequisite to receiving Medicaid funds for services provided to recipients.

(nn) "Recipient." A person who has been determined eligible for Medicaid.

(oo) "Reopen." A request by a hospital, the intermediary or the department, pursuant to the procedures and standards established by Medicare, to re-examine or review the correctness of a cost settlement determination or decision made by or on behalf of Medicare.

(pp) "Request for TEFRA target rate adjustment." A request, pursuant to Section 13, for a rate adjustment. "Request for TEFRA target rate adjustment" does not include any request to reopen a provider's cost report or any request for a change in a provider's Medicaid rate based on Medicare principles of cost reimbursement; any such requested change must be handled pursuant to the procedures and standards established by Medicare.

(qq) "TEFRA target rate adjustment." A change in a hospital's Medicaid rate based on extraordinary circumstances or the criteria specified in subsection 13(c), other than a change based on Medicare principles of cost reimbursement.

Section 4. Medicaid allowable payment for outpatient hospital services.

(a) In general. Except as otherwise specified in this Attachment, the Department reimburses hospitals providing outpatient hospital services to recipients using Medicare principles of cost reimbursement. The Medicaid allowable payment shall be the lower of the hospital's usual and customary charges and the allowable payment determined pursuant to this section.

(b) Interim rate. The interim rate for outpatient hospital services shall be the interim rate established for inpatient services reduced by twenty percent.

(c) Negotiated rate. A hospital may negotiate an interim rate which is lower than the interim rate which would otherwise be in effect pursuant to this Section.

(d) New hospitals. A new hospital shall receive an initial rate equal to the lowest rate for outpatient services established for a hospital located in Wyoming pursuant to paragraph (e)(i) until the hospital files its most recently settled Medicare cost report.

(e) Hospitals located in Wyoming.

(i) Interim rate. The Department shall establish an interim rate for outpatient hospital services based on the most recently settled cost report submitted by the hospital to the Medicare intermediary.

(A) Rate effective date. The interim rate shall be effective for all outpatient hospital services provided on or after December 1, 1992;

(B) Rate period. The interim rate shall remain in effect for all outpatient hospital services until redetermined pursuant to this Section;

(C) Except as otherwise specified by this Attachment, the interim rate shall be applied to all claims submitted by the provider.

(ii) Cost settlement. The Department shall cost settle, pursuant to Section 6, Medicaid reimbursement for outpatient hospital services provided during each rate period.

(f) Hospitals located outside Wyoming.

(i) Reimbursement rate. The Department shall determine a reimbursement rate for outpatient hospital services provided by hospitals located outside the State of Wyoming pursuant to paragraphs (ii) and (iii). Such rate shall remain in effect for all outpatient hospital services until redetermined pursuant to this subsection.

(ii) Hospitals which submit cost reports.

(A) Submission and preparation of cost reports. Except as otherwise specified by this subsection, hospitals which submit cost reports shall prepare and submit them pursuant to Section 5.

(B) Time of submission. A hospital shall submit its most recently settled Medicare cost report on or before October 31st of each year.

(I) The cost report must not have been previously submitted or used for a previous rate period, and it must be for a year subsequent to the year reported in the hospital's most recently submitted cost report.

(II) If the hospital cannot submit a cost report which meets the requirements of this subparagraph because of delay caused by the intermediary, the hospital must submit verification of the delay from the intermediary on or before October 31st of the relevant year. If there is a verifiable delay caused by the intermediary, the hospital shall receive a rate equal to the lowest cost to charge ratio established for a hospital located in Wyoming pursuant to paragraph (f)(i) of this Section for the current State of Wyoming fiscal year. The hospital must submit its cost report promptly after it becomes available, and in no event later than 9 months after the October 1st due date. The Department shall determine the hospital's cost to charge ratio and shall adjust the hospital's rate retroactively to the original rate effective date. A hospital which fails to submit a cost report within 9 months after the due date shall receive no retroactive adjustment to its rate.

(C) Determination of reimbursement rate. The Department shall establish a reimbursement rate for each hospital which submits a cost report using Medicare principles of cost reimbursement, as modified by this Attachment, based on the most recently settled Medicare cost report submitted by the hospital to the Department. The reimbursement rate shall be the hospitals' cost to charge ratio for combined inpatient and outpatient services.

(D) Rate effective date. Reimbursement rates for hospitals which submit cost reports shall be effective for services provided on or after July 1, 1992. The rate shall be adjusted each December 1 thereafter, assuming the hospital submits a cost report pursuant to (B).

(E) Duration of reimbursement rate. Rates determined pursuant to this paragraph shall remain in effect for services provided during the twelve months following the rate effective date.

(F) Cost settlement. The Department shall cost settle, pursuant to Section 6, unless the Department determines that it is not cost-effective to do so.

(iii) Hospitals which do not submit cost reports. The reimbursement rate for hospitals which elect not to submit cost reports pursuant to (ii) shall be the lesser of the hospital's submitted charges and the lowest cost to charge ratio established for a hospital located in Wyoming pursuant to paragraph (f)(i) for the current State of Wyoming fiscal year. The rate shall be effective for all services provided on after July 1, 1992. The rate shall be adjusted each December 1 thereafter to correspond

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with the then current lowest cost to charge ratio established pursuant to paragraph (f)(i).

Section 5. Submission and preparation of cost reports.

(a) Time of submission. Each hospital must submit a complete cost report to the Medicare intermediary in accordance with Medicare requirements.

(b) Preparation of cost reports. Each hospital shall prepare its cost report in conformance with Medicare requirements.

(c) Submission of additional information. The Department may request, in writing, that a hospital submit information to supplement its cost report. The hospital shall submit the requested information within thirty days after the date of the request.

(d) Failure to comply with this Section. The failure of a hospital to comply with the provisions of this Section shall result in the immediate suspension of all Medicaid payments to the hospital and all Medicaid payments under review shall be repaid to the Department within ten days after written request for such payment. The suspension of payments shall continue until the hospital complies with this Section. Upon the Department's receipt of all information required by this Section, payments will be reinstated, without interest. This remedy does not affect the Department's right to withhold payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules.

Section 6. Cost settlement.

(a) Cost settlement methodology. Cost reports shall be cost settled by the Medicare intermediary using Medicare principles of cost reimbursement as modified by this Attachment and using data provided by the Department.

(b) Notice of Medicaid Program Reimbursement. The Department shall, within sixty days after receipt of the Notice of Program Reimbursement, send a Notice of Medicaid Program Reimbursement to the hospital.

(c) Repayment of overpayments. A hospital shall reimburse the Department for overpayments within thirty days after the date of the Notice of Medicaid Program Reimbursement, even if the provider has requested reconsideration or an administrative hearing regarding the determination of overpayments. If a hospital does not timely reimburse the Department, overpayments may be recovered pursuant to Section 11. Notice of overpayments must include the hospital's right to request reconsideration of the cost-settlement pursuant to Section 14. The reconsideration

shall be limited to whether the Department has complied with the provisions of this Attachment.

(e) Payment of underpayments. The Department shall request the issuance of a payment warrant to reimburse the hospital for underpayments within fifteen days after the date of the Notice of Medicaid Program Reimbursement.

Section 7. Medicaid allowable payment for other services.

All costs relating to services provided to recipients which are reimbursed pursuant to a fee schedule or other methodology established by the Department shall be deducted from the hospital's cost report prior to cost settlement.

Section 8. Record retention

(a) Period of retention. A hospital which receives or has received Medicaid funds shall retain financial records for six (6) years following the date of submission of the applicable cost report to the Department. Such records may be maintained in hard-copy, on micro-fiche or micro-film.

(b) Record keeping requirements.

(i) Financial records. A provider must keep financial records in accordance with GAAP and maintain sufficient control and documentation to satisfy the requirements of this Attachment, including accommodating GAAS and reasonable requests by the Department for additional information. The provider must maintain adequate documentation for all line items on the cost report.

(ii) Medical records. A provider must maintain medical records.

(c) Availability of records. A provider shall make financial or medical records available upon request to representatives of the Department or the United States Department of Health and Human Services and pursuant to Chapter XVI, Medicaid Program Integrity.

(d) Refusal to produce records. The refusal of a provider to make financial or medical records available upon request pursuant to this section shall result in the immediate suspension of all Medicaid payments to the provider and all Medicaid payments under review shall be repaid to the Department within ten days after written request for such payment. The suspension of payments shall continue until the requested records are provided.

(e) Explanation of records. In the event of a field audit, the provider shall have available at the field audit location one or more knowledgeable persons who can explain the provider's

financial records, the accounting and control system and cost report preparation, including attachments and allocations, to the auditors.

(f) Failure to maintain records. A provider unable to satisfy one or more of the requirements of this Section shall be given a written notice of deficiency and shall have sixty days after the date of the written notice to correct such deficiency. If, at the end of the sixty days, the Department determines that the deficiency has not been corrected, the Department shall withhold twenty-five percent (25%) of the provider's claims for services provided on or after the sixtieth day. If, at the end of one hundred and twenty days after the mailing of the written notice of deficiency, the Department determines that the deficiency has not been corrected, the Department shall suspend all Medicaid payments for services provided after such date. The suspension of payments shall continue until the the Department determines that adequate records are being maintained. At such time, payments will be reinstated, without interest. This remedy does not affect the Department's right to withhold payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules.

(g) Out of state records. If a provider maintains financial or medical records out of state, the provider shall either transfer the records to an in-state location that is suitable for the Department to perform the field audit or reimburse the Department for reasonable costs, including travel, lodging and meals, incurred in performing the field audit in an out-of-state location.

Section 9. Audits.

(a) Field audits. The Department or HCFA may perform a field audit of a provider at any time to determine the accuracy and reasonableness of cost reports, the accuracy of cost settlements or whether the hospital has received excess payments.

(b) Desk review. The Department or HCFA may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports, the accuracy of cost settlements or whether the hospital has received excess payments.

(c) The Department or HCFA may perform field audits or desk reviews through employees, agents, or through a third party. Audits shall be performed in accordance with GAAS.

(d) Disallowances. If a field audit or desk review discloses nonallowable costs, overpayments or excess payments, the Department shall adjust the final cost settlement and recover any excess payments pursuant to Section 11.

(e) Notice of excess payments. After determining that a provider has received excess payments, the Department shall send

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written notice to the provider, by certified mail, return receipt requested, stating the amount of the excess payments, the basis for the determination of excess payments and the provider's right to request reconsideration of that determination pursuant to Section 14. The reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

(f) Recovery of excess payments. A provider must reimburse the Department for excess payments within fifteen days after the provider receives written notice from the Department pursuant to subsection (e), even if the provider has requested reconsideration or an administrative hearing regarding the determination of excess payments. If the provider fails to timely repay excess payments, the Department may recover the excess payments pursuant to Sections 11.

Section 10. Repayment of credit balance.

(a) Quarterly request. The Department shall quarterly request the repayment of any credit balance. Such request shall be made in writing and mailed by certified mail, return receipt requested. The hospital shall repay the credit balance within sixty days after the date of receipt of the request for repayment.

(b) A hospital shall repay any credit balance within sixty days after the date such credit balance is identified by the Department, the hospital or the intermediary.

(c) Lump sum adjustment. If a credit balance identified pursuant to paragraphs (a) or (b) is not timely paid to the Department, the Department may recover the credit balance pursuant to Section 11.

Section 11. Recovery of overpayments, excess payments or credit balance. If a provider does not timely reimburse the Department for overpayments pursuant to subsection 6(d), excess payments pursuant to subsection 9(f), or a credit balance pursuant to Section 10, the Department may recover the overpayments, excess payments or credit balance, even if the provider has appealed the Department's determination, by:

(a) Withholding all or part of Medicaid payments until the overpayments are recovered;

(b) Initiating a civil lawsuit against the provider; or

(c) Any other method of collecting a debt or obligation permitted by law.

Section 12. Request to Reopen.

(a) Medicare standards and procedures. A request to reopen shall be made in the manner specified by Medicare, directed to

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the entity specified by Medicare, and shall be disposed of pursuant to the methods and standards specified by Medicare.

(b) Sole remedy. A provider which has an issue which may be resolved through a request to reopen may not request a rate adjustment or reconsideration pursuant to this Attachment or an administrative hearing pursuant to Chapter I.

Section 13. Request for TEFRA target rate adjustment.

(a) Request for TEFRA target rate adjustment. A provider may request a rate adjustment by mailing a written request to the Department by certified mail within sixty days after the date of the Notice of Medicaid Program Reimbursement provided pursuant to subsection 6(c). The request must include the information included in subparagraphs (i) through (iii). A request for rate adjustment shall be dismissed with prejudice if the provider does not comply with the requirements of this subsection.

(i) The nature of the rate adjustment sought;

(ii) The amount of the requested rate adjustment, the methodology used to calculate the requested rate adjustment, the specific calculation for the requested rate adjustment, and documentation which supports the above; and

(iii) The specific reasons, including references to applicable federal and State law, that justify the rate adjustment.

(b) Department's responsibilities.

(i) The Department shall acknowledge, in writing, receipt of the request for rate adjustment within fifteen days after receipt;

(ii) The Department may request, in writing, additional information from the provider. The provider must mail the requested information to the Department, by certified mail, within sixty days after receipt of the request. Failure to timely provide the requested information shall result in the dismissal, with prejudice, of the request for rate adjustment.

(iii) The Department shall review the request for rate adjustment to determine whether the request meets any of the criteria set forth in subsection (c).

(iv) Burden of proof. Except as otherwise provided by this Attachment, the provider requesting a rate adjustment shall bear the burden of proving by a preponderance of the evidence that it is entitled to a rate adjustment.

(v) Notice of final decision. The Department shall send written notice to the provider, by certified mail, of its

final decision within one-hundred eighty days after the receipt of the request for rate adjustment or the receipt of any additional information requested by the Department pursuant to (ii), whichever is later. The provider may request an administrative hearing regarding the decision of the Department pursuant to (g).

(c) Bases for rate adjustment. The Department may grant a request for rate adjustment if the provider demonstrates that:

(i) There has been a significant increase in the acuity of care provided by the hospital since the base year and the failure to make a rate adjustment will result in recipients not having reasonable access to inpatient hospital services of adequate quality;

(ii) Extraordinary circumstances occurring since the base year have caused the provider to incur substantially higher costs;

(iii) There has been an error in the calculation of the provider's TEFRA cost per discharge target amount;

(iv) The provider is rendering atypical services;

(v) The provider is located in an area with a significant change in the Medicaid population during the year;

(vi) The provider is engaged in an approved medical or paramedical education program that has resulted in increased costs;

(vii) For cost reporting periods beginning before October 1982, the provider is rendering more intensive routine care resulting in a shorter length of stay and higher per unit costs than in comparable hospitals;

(viii) Application of the limit would render a hospital insolvent, thereby depriving the community of essential services (the hospital must have exceeded the limit by more than fifteen percent);

(ix) The provider is newly established home health agency (an agency certified for Medicare less than three full years); or

(x) The provider has labor costs that vary by more than ten percent from the labor costs that were used in promulgating the limits.

(d) In determining whether to grant a rate adjustment pursuant to subsection (c), the Department shall consider:

(i) Whether the provider has demonstrated that its unreimbursed costs are caused by factors generally not shared by other Wyoming hospitals;

(ii) Whether the provider has taken every reasonable step to control costs; and

(iii) Whether the provider's costs may be controlled through good management practices or cost containment measures. In determining whether the provider's costs may be so controlled, the Department may consider:

(A) Efforts to reduce or contain employee benefits;

(B) Efforts to consolidate or centralize personnel or departmental functions;

(C) Efforts to review departmental staffing levels and use lesser-skilled employees or reduce full-time equivalent employees, without adversely affecting the quality of patient care;

(D) Efforts to affect physicians' order patterns, e.g., through use of drug formularies, standardizing supplies, and reducing unnecessary tests;

(E) Efforts to reduce reliance on agency or registry personnel;

(F) Efforts to expedite billing;

(G) Use of volunteers and fund-raising;

(H) Efforts to control costs;

(I) Efforts to reduce the incidence of employee injuries;

(K) Efforts to reduce employee turnover;

(L) Efforts to improve efficiency through improved scheduling;

(M) Equipment sharing arrangements; and

(N) The use of information or management systems and procedures.

(e) Calculation of rate adjustment. If the Department determines pursuant to subsection (d) that a hospital is entitled to a rate adjustment for one of the reasons specified in subsection (c), the rate adjustment shall be calculated as follows:

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(i) The Department shall recalculate the provider's target amount using the rate year for which the rate adjustment was requested, unless the rate adjustment is based on extraordinary circumstances.

(ii) If the rate adjustment is based on extraordinary circumstances, the Department may increase the per discharge ceiling by the amount necessary to meet the Medicaid share of the net additional allowable costs incurred as a result of the extraordinary circumstances.

(f) Effect of rate adjustments.

(i) Rate adjustments resulting from extraordinary circumstances shall be limited to the fiscal period in question.

(ii) Rate adjustments other than adjustments resulting from extraordinary circumstances shall be limited to the fiscal period in question unless the facility shows, for each succeeding rate period, that the conditions which resulted in the rate adjustment still exist.

(g) Administrative hearing. A provider may request an administrative hearing regarding the final agency decision pursuant to Chapter I of these rules by mailing by certified mail or personally delivering a request for hearing to the Department within twenty days after the date the provider receives notice of the final agency decision.

(h) Failure to request rate adjustment. A provider which fails to request a rate adjustment pursuant to this section may not subsequently request an administrative hearing pursuant to Chapter I regarding the decision to recover overpayments.

(i) Matters not subject to rate adjustment or reconsideration. The following matters are not subject to a rate adjustment pursuant to this section, reconsideration pursuant to Section 14, or an administrative hearing pursuant to Chapter I:

(i) A recovery of overpayments caused by a change in the reimbursement methodology as the result of a change in state or federal law, including a change in this Attachment; or

(ii) The use or reasonableness of the reimbursement methodology set forth in this Attachment.

Section 14. Reconsideration.

(a) Request for reconsideration. A provider may request that the Department reconsider a decision to recover overpayments pursuant to Section 6 or a decision to recover excess payments pursuant to Section 11. Such request must be mailed to the Department by certified mail within twenty days of the date the facility receives notice pursuant to subsections 6(c) or 11(f).

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The request must state with specificity the reasons for the request. Failure to provide such a statement shall result in the dismissal of the request with prejudice. The reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

(b) Reconsideration. The Department shall review the decision and send written notice, by certified mail, to the provider of its final decision within forty-five days after receipt of the request for reconsideration. The Department may request additional information from the provider as part of the reconsideration process.

(c) Administrative hearing. A provider may request an administrative hearing regarding the final decision pursuant to Chapter I of these rules by mailing by certified mail or personally delivering a request for hearing to the Department within twenty days of the date the provider receives notice of the final decision.

(d) Failure to request reconsideration. A provider which fails to request reconsideration pursuant to this section may not subsequently request an administrative hearing regarding the decision to recover overpayments pursuant to Chapter I.

(e) A provider may not request reconsideration or an administrative hearing regarding a denial or reduction of payment or recovery of overpayments or excess payments caused by a change in the reimbursement methodology or any change in state or federal law.

Section 15. Severability. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.

STATE: Wyoming

REIMBURSEMENT OF OUTPATIENT HOSPITAL SERVICES

Section 1. Authority

This Attachment is prepared and submitted to HCFA for approval pursuant to 42 U.S.C. § 42 1396a(b) and 45 C.F.R. Part 201, Subpart A.

Section 2. Purpose and Applicability.

(a) This Attachment shall apply to and govern Medicaid reimbursement of outpatient hospital services furnished to individuals admitted on or after its effective date. Outpatient hospital services are also subject to the provisions of Chapters 3, 9, and 24 of the Wyoming Medicaid rules, except as otherwise specified in this Attachment.

(b) The Department may issue Provider Manuals, Provider Bulletins, or both, to providers and/or other affected parties to interpret the provisions of this Attachment. Such Provider Manuals and Provider Bulletins shall be consistent with and reflect the policies contained in this Attachment. The provisions contained in Provider Manuals or Provider Bulletins shall be subordinate to the provisions of this Attachment.

Section 3. General Provisions.

(a) Terminology. Except as otherwise specified, the terminology used in this Attachment is the standard terminology and has the standard meaning used in accounting, health care, Medicaid and Medicare.

(b) General methodology. The Department reimburses providers of outpatient hospital services on a fee for service.

Section 4. Definitions.

(a) "Admission" or "admitted." The act by which an individual is admitted to a hospital as an outpatient. "Admission" or "admitted" does not include an individual that is transferred from one unit of a hospital to another unit in the hospital or to a distinct part hospital unit.

(b) "Certified." Approved by the survey agency as in compliance with applicable statutes and rules.

(c) "Chapter 1." Chapter 1, Rules for Medicaid

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Administrative Hearings, of the Wyoming Medicaid rules.

(d) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(e) "Chapter 4." Chapter 4, Third Party Liability, of the Wyoming Medicaid Rules.

(f) "Chapter 9." Chapter 9, Hospital Services, of the Wyoming Medicaid Rules.

(g) "Chapter 24." Chapter 24, Wyoming Hospital Reimbursement System, of the Wyoming Medicaid Rules.

(h) "Claim." A request by a provider for Medicaid payment for covered services provided to a recipient.

(i) "Covered service." A health service or supply eligible for Medicaid reimbursement pursuant to the Wyoming Medicaid State Plan.

(j) "Department." The Wyoming Department of Health, its agent, designee or successor.

(k) "Director." The Director of the Department or the Director's designee.

(l) "Division." The Division of Health Care Financing of the Department, its agent, designee or successor.

(m) "Emergency services." Outpatient hospital services designated by the Division based on ICD-9-CM codes and disseminated by Provider Manuals or Provider Bulletins.

(n) "Emergency." The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(o) "Enrolled." Enrolled as defined in Chapter 3, which definition is incorporated by this reference.

(p) "Excess payments." Medicaid funds received by a provider which exceed the Medicaid allowable payment established by the

Department.

(q) "HCFA." The Health Care Financing Administration of the United States Department of Health and Human Services, its agent, designee or successor

(r) "HHS." The United States Department of Health and Human Services, its agent, designee or successor.

(s) "Hospital." An institution that: (i) is approved to participate as a hospital under Medicare; (ii) is maintained primarily for the treatment and care of patients with disorders other than mental diseases or tuberculosis; (iii) has a provider agreement; (iv) is enrolled in the Medicaid program; and (v) is licensed to operate as a hospital by the State of Wyoming or, if the institution is out-of-state, licensed as a hospital by the state in which the institution is located.

(t) "ICD-9-CM." The International classification of Diseases, 9th Clinical Modification. The ICD-9-CM is published by HCFA and is available from the United States Government Printing Office, Washington, D.C. 20402.

(u) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program enacted by Congress and/or the Wyoming Legislature.

(v) "Medicaid fee schedule." The Medicaid fee schedule as established pursuant to Chapter 3, as in effect on the effective date of this Attachment, and as modified pursuant to that Chapter.

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

(i) Consistent with the diagnosis and treatment of the recipient's condition;

(ii) In accordance with the standards of good medical practice among the provider's peer group;

(iii) Required to meet the medical needs of the recipient and undertaken for reasons other than the convenience of the recipient and the provider; and

(iv) Performed in the least costly setting required by

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the recipient's condition.

(x) "Outpatient." An outpatient as defined by 42 C.F.R. § 440.2(a), which is incorporated by this reference.

(y) "Outpatient hospital services." Outpatient hospital services as defined by 42 C.F.R. § 440.20(a), which is incorporated by this reference.

(z) "Patient." An individual admitted to a hospital or other provider of outpatient hospital services.

(aa) "Physician." A person licensed to practice medicine or osteopathy by the Wyoming State Board of Medical Examiners or a comparable agency in another state, or a person licensed to practice dentistry by the Wyoming Board of Dental Examiners or a comparable agency in another state.

(bb) "Prior authorized." Approval by the Division pursuant to Chapter 3, Section 9, which is incorporated by this reference.

(cc) "Provider." A provider as defined by Chapter 3, Section 3(y), which is incorporated by this reference.

(dd) "Readmission." The act by which an individual is:

(i) Admitted to a provider from which the individual had been discharged;

(ii) On or before the thirty-first day after the previous discharge; and

(iii) For treatment of any diagnosis.

(ee) "Recipient." A person who has been determined eligible for Medicaid.

(ff) "Survey agency." The Health Facilities Survey, Certification and Licensure Office of the Department, its agent, designee or successor, or a comparable agency in another state.

(gg) "Third party liability." Third party liability as determined pursuant to Chapter 4, which is incorporated by this reference.

(hh) "Usual and customary charge." A provider's charge to the general public for the same service.

Section 5. Provider Participation.

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(a) Payments only to providers. No provider that furnishes outpatient hospital services to a recipient shall receive Medicaid funds unless the provider is certified, has signed a provider agreement and is enrolled.

(b) Compliance with Chapter 3. A provider that wishes to receive Medicaid reimbursement for outpatient hospital services furnished to a recipient must meet the requirements of Chapter 3, Sections 4 through 6, which are incorporated by this reference.

Section 6. Provider Records. A provider must comply with Chapter 3, Section 7, which is incorporated by this reference.

Section 7. Verification of recipient data. A provider must comply with Chapter 3, Section 8, which is incorporated by this reference.

Section 8. Medicaid allowable payment for outpatient hospital services.

(a) Generally. Medicaid allowable payments for outpatient hospital services are made according to one of the following fee schedules depending on the type of service. Facilities receiving payment for outpatient hospital services are provider based according to 42 CFR, Section 413.65. State-developed fee schedule rates for services described in Section 8 are the same for public and private providers. The fee schedule and any periodic adjustments to the fee schedule are published at the State's fiscal agent's website.

- (i) Medicaid Ambulatory Payment Classification (APC) fee schedule. The Medicaid APC fee schedule is based on services that are included in Medicare's outpatient prospective payment system as published in the Federal Register Vol. 69, No. 219 (November 15, 2004) and Federal Register Vol. 69, No. 250 (December 30, 2004).

(A) Services included under the APC fee schedule:

- a. Significant outpatient procedures, e.g., a procedure or surgery provided to a patient that constitutes the primary reason for the visit to the hospital;
- b. Ancillary;
- c. Emergency;
- d. Observation;
- e. Drugs;
- f. Laboratory services not included in Medicare's clinical laboratory fee schedule;

- g. Durable medical equipment, prosthetics and orthotics;
 - h. Radiology;
 - i. Vaccines and immunizations.
- (B) Ambulatory Payment Classification relative weights. The State uses Medicare's APC relative weights.
- (C) State-specific Medicaid conversion factors. The State uses a Wyoming-specific Medicaid conversion factor for each of the following three hospital groups: children's hospitals, critical access hospitals, and general acute care hospitals as follows:
- a. For each group of hospitals, the State divided the estimated costs of APC-based services by the sum of the relative weights for the hospital group.
 - i. For each hospital, the State calculated estimated costs by dividing SFY 2005 estimated Medicaid costs by SFY 2005 Medicaid billed charges (paid claims).
 - ii. The State calculated estimated SFY 2005 Medicaid costs by multiplying SFY 2005 billed charges by hospital-specific outpatient hospital cost-to-charge ratios calculated from provider fiscal year end 2004 as-filed cost reports.
 - b. The State adjusted the conversion factors so that projected payments for all hospitals equaled total payments under the previous outpatient hospital prospective payment system.
 - c. For each group of hospitals, the State calculated the conversion factor percentage of Medicare's final CY 2006 conversion factor as published in the Federal Register Vol. 70, No. 217 (November 10, 2005). The State divided the Wyoming-specific Medicaid conversion factor by Medicare's final CY 2006 conversion factor:
 - i. The Wyoming-specific Medicaid conversion factor for children's hospitals is 171% of Medicare's final CY 2006 conversion factor.
 - ii. The Wyoming-specific Medicaid conversion factor for critical access hospitals is 196% of Medicare's final CY 2006 conversion factor.

- iii. The Wyoming-specific Medicaid conversion factor for general acute care hospitals is 75% of Medicare's final CY 2006 conversion factor.
- (D) Fee schedule payment calculation. The fee schedule is established by multiplying the state-specific Medicaid conversion factor by the Medicare APC relative weight.
- (E) Discounting. Payment amounts will be discounted for services reimbursed using the Medicaid Ambulatory Payment Classification fee schedule when a hospital performs certain procedures.
 - a. The State will reimburse procedures subject to discounting a percentage of the fee schedule amount.
 - b. The discount percentage will vary depending if the discounted procedure is a terminated procedure, a reduced services procedure or a procedure otherwise subject to discounting.
- (ii) Medicaid physician fee schedule. The Medicaid allowable payment is based on the reported procedure code and is the lesser of charges or the fee schedule amount. The following outpatient hospital services are reimbursed using the physician fee schedule, which is described in additional detail in Attachment 4.19 B, Number 5:
 - (A) Physical, occupational and speech therapy;
 - (B) Radiology, including mammography screening and diagnostic mammography;
 - (C) Vaccines and immunization.
- (iii) The Medicaid durable medical equipment, prosthetics and orthotics fee schedule. For those durable medical equipment, prosthetics and orthotics not included in the Wyoming Medicaid APC fee schedule, the Medicaid allowable payment is based on the reported procedure code and is the lesser of charges or the fee schedule amount. The durable medical equipment, prosthetics and orthotics fee schedule is described in additional detail in Attachment 4.19 B, Number 12c.
- (iv) The Medicaid laboratory fee schedule. For those laboratory services not included in the Wyoming Medicaid APC fee schedule, the Medicaid allowable payment is based on the reported procedure code and is the lesser of charges or the fee schedule amount. The laboratory fee schedule is described in additional detail in Attachment 4.19 B, Number 3.

- (v) Percent of charges. Certain services are reimbursed based on a percent of allowed charges. The Medicaid payments will not exceed Medicare upper payment limits according to 42 CFR, Section 447.321. These services include the following:
 - (A) Transplants. Reimbursed at 55 percent of billed charges, not to exceed the upper payment limits described in Section 1903(i) of the Social Security Act;
 - (B) Corneal tissue. Reimbursed using the hospital-specific Medicaid cost-to-charge ratio calculated annually for Wyoming Medicaid's inpatient level of care participating providers. 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);
 - (C) Medical devices that are paid transitional pass-through payments under Medicare's outpatient prospective payment system according to Social Security Act Section 1833(t) (6). Reimbursed using the hospital-specific Medicaid cost-to-charge ratios used in Section 8(v)(B);
 - (D) Dental. Reimbursed using the hospital-specific Medicaid cost-to-charge ratios used in Section 8(v)(B).

(b) Upper payment limits. The Medicaid payments will not exceed Medicare upper payment limits according to 42 CFR, Section 447.321. Reimbursement for laboratory services complies with Federal upper limits for laboratory services (1903(i) of the Social Security Act).

(c) Medicaid reimbursement is not available for services that are not medically necessary.

(d) Services that require prior authorization. The Division may, from time to time, designate outpatient hospital services that require prior authorization. In designating such services, the Division shall consider the cost of the service, the potential for over-utilization of the service, and the availability of lower cost alternatives. The Division shall disseminate a current list of services that require prior authorization to providers through Provider Manuals or Provider Bulletins. The failure to obtain prior authorization shall result in denials of Medicaid payment for the service.

(e) Claims for outpatient and inpatient hospital services. A claim seeking reimbursement for outpatient hospital services provided to a recipient within twenty-four hours before the recipient received inpatient hospital services for the same or similar diagnosis shall be denied.

(f) Updates. The APC conversion factors and relative weights is reviewed annually. Considerations for update include adequate provider participation, beneficiary access and the reduction of inequities in the system.

Section 9. Third party liability.

(a) Submission of claims. Claims for which third party liability exists shall be submitted in accordance with Chapter 4, which is incorporated by this reference.

(b) Medicaid payment. The Medicaid payment for a claim for which third party liability exists shall be the difference between the Medicaid allowable payment and the third party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Chapter.

Section 10. Payment of Claims. Payment of claims shall be pursuant to Chapter 3, Section 11, which is incorporated by this reference.

Section 11. Audits.

(a) The Department or Centers for Medicare and Medicaid Services (CMS) may audit a provider at any time to determine whether the hospital has received excess payments.

(b) The Department or CMS may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.

(c) Disallowances. If an audit discloses excess payments, the Department shall recover any excess payments pursuant to Section 12.

(d) Notice of excess payments. After determining that a provider has received excess payments, the Department shall send written notice to the provider, by certified mail, return receipt requested, stating the amount of the excess payments, the basis for the determination of excess payments and the provider's right to request reconsideration of that determination pursuant to Section 13. The reconsideration shall be limited to whether the Department has complied with the provisions of this Chapter.

(e) Recovery of excess payments. A recovery of excess payments from a provider will result in the Department returning the appropriate Federal Financial Participation (FFP) to CMS. A provider must reimburse the Department for excess payments within thirty days after the

provider receives written notice from the Department pursuant to subsection (d), even if the provider has requested reconsideration or an administrative hearing regarding the determination of excess payments. If the provider fails to timely repay excess payments, the Department shall recover the excess payments pursuant to Section 12.

(f) Reporting audit results. If at anytime during a financial audit or a medical audit, the Division discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Division's final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit of the Wyoming Attorney General's Office.

Section 12. Recovery of excess payments. The Department shall recover excess payments pursuant to Chapter 3, Section 12, which is incorporated by this reference.

Section 13. Reconsideration.

(a) Request for reconsideration. A provider may request reconsideration of a request to recover excess payments. Such a request must be mailed to the Department, by certified mail, return receipt requested, within twenty days after the date the provider receives notice pursuant to Section 11. The request must state with specificity the reasons for the request. Failure to provide such a statement shall result in the dismissal of the request with prejudice.

(b) Reconsideration. The Department shall review the matter and send written notice by certified mail, return receipt requested, to the provider of its final decision within forty-five days after receipt of the request for reconsideration or the receipt of any additional information requested pursuant to (c), whichever is later.

(c) Request for additional information. The Department may request additional information from the provider as a part of the reconsideration process. Such a request shall be made in writing by certified mail, return receipt requested. The provider must provide the requested information within the time specified in the request. Failure to provide the requested information shall result in the dismissal of the request with prejudice.

(d) Matters subject to reconsideration. A provider may request reconsideration of a decision to recover excess payments.

(e) Reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

(f) Informal resolution. The provider or the Department may request an informal meeting before the final decision on reconsideration to determine whether the matter may be resolved. The substance of the discussions and/or settlement offers made pursuant to an attempt at informal resolution shall not be admissible as part of a subsequent administrative hearing or judicial proceeding.

(f) Administrative hearing. A provider may request an administrative hearing regarding the final agency decision pursuant to Chapter 1 of the Department's Medicaid rules by mailing by certified mail, return receipt requested or personally delivering a request for hearing to the Department within twenty days after the date the provider receives notice of the final agency decision. At the hearing, the burden shall be on the provider to show that the agency's final decision does not comply with this Attachment.

(g) Failure to request reconsideration. A provider which fails to request reconsideration pursuant to this Section may not subsequently request an administrative hearing pursuant to Chapter 1.

(h) Confidentiality of settlement agreements. If the Division and a provider enter into a settlement agreement as part of a reconsideration or an administrative hearing, such agreement shall be confidential, except as otherwise required by law. A breach of confidentiality by the provider shall, at the Division's option, result in the settlement agreement becoming null and void.

Section 14. Interpretation of Attachment

(a) The order in which the provisions of this Attachment appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Attachment shall control the titles of various provisions.

Section 15. Superseding effect. This Attachment supersedes all prior Attachments or policy statements issued by the Department, including provider manuals and provider bulletins, which are inconsistent with this Attachment, except as otherwise specified in this Attachment.

Section 16. Severability. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Wyoming Medicaid meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4 19(B)

 X 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

Wyoming Medicaid will adopt the baseline for other provider-preventable conditions as described above. The following reimbursement changes will apply

Payment will be denied for these conditions in any Health Care Setting as identified in Attachment 4 19(B) and any other settings where these events may occur. For any Wyoming Medicaid claims with dates of service after July 1, 2012, Wyoming Medicaid will follow the minimum CMS regulations in 42 CFR §447 and deny payment for all of the OPPCs identified in 42 CFR §447

In compliance with 42 CFR 447.26(c), Wyoming Medicaid provides

1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider

2) That reductions in provider payment may be limited to the extent that the following apply

- (i) The identified provider-preventable conditions would otherwise result in an increase in payment

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- (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions

3) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursements according to the methodology above. Denial of payment shall be limited to the additional care required by the provider preventable condition. Wyoming Medicaid shall review from time to time the list of OPPCs and add to the list in the event that Wyoming Medicaid makes a medical finding using evidence-based guidelines. In such an event, the Department shall disseminate to providers, through manuals or bulletins, a current list of provider preventable conditions pursuant to this Attachment.

____ Additional Other Provider-Preventable Conditions Identified below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4 19(d) nursing facility services, 4 19(b) physician services*) of the plan

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-New. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Service 2a.

Outpatient Hospital Services

Qualified Rate Adjustment (QRA) Payments

A hospital located in Wyoming may be eligible for an outpatient Qualified Rate Adjustment (QRA) payment if:

1. It is owned or operated by a non-state governmental entity; and
2. Its calculated outpatient Medicaid costs for the payment period are greater than its projected pre-QRA outpatient Medicaid payments for the same period.

A hospital's calculated Medicaid costs for the payment period are determined by applying the cost-to-charge ratios developed from the hospital's most recently available Medicare cost report to the hospital's billed charges for outpatient services for Medicaid claims paid during the most recently ended State fiscal year (inflated to the midpoint of the payment period). Reimbursable costs are calculated using Medicare payment principles. Billed charges are inflated using the most currently available CMS Prospective Payment System Hospital Input Price Index.

A hospital's projected pre-QRA Medicaid payments for the payment period are the total of Medicaid payments to the hospital for claims paid during the most recently ended State fiscal year.

The QRA payment is an annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's calculated Medicaid costs for the payment period and its pre-QRA Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. Qualified Rate Adjustment payments are made after the qualifying hospital's data for the most recently ended state fiscal year become available. For purposes of the first QRA payments calculated under this provision, the first fiscal year treated as the most recently ended state fiscal year is the July 1, 2003 – June 30, 2004 fiscal year. QRA payments will not be subject to cost settlement. The Medicaid payments and the QRA payments will not exceed Medicare Upper Payment Limits according to 42 CFR, Section 447.321.

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PEDIATRIC PRACTITIONER SERVICES

Evaluation and Management

Office or Outpatient or Other Ambulatory Facility (Visit)

New Patient

* 99201	Physicians typically spend 10 minutes	\$ 23.90
* 99202	Physicians typically spend 20 minutes	\$ 37.73
* 99203	Physicians typically spend 30 minutes	\$ 50.98
* 99204	Physicians typically spend 45 minutes	\$ 74.59
* 99205	Physicians typically spend 60 minutes	\$ 92.74

Established Patient

* 99211	Typically 5 minutes are spent supervising or performing these services	\$ 12.38
* 99212	Physicians typically spend 10 minutes	\$ 20.74
* 99213	Physicians typically spend 15 minutes	\$ 28.80
* 99214	Physicians typically spend 25 minutes	\$ 43.78
* 99215	Physicians typically spend 40 minutes	\$ 67.39

Office or Other Outpatient Consultations

New or Established Patient

99241	Physicians typically spend 15 minutes	\$ 37.15
99242	Physicians typically spend 30 minutes	\$ 58.18
99243	Physicians typically spend 40 minutes	\$ 75.17
99244	Physicians typically spend 60 minutes	\$105.41
99245	Physicians typically spend 80 minutes	\$139.97

Confirmatory Consultations

New or Established Patient

99271	Usually the presenting problem(s) are self limited or minor	\$ 34.85
99272	Usually the presenting problem(s) are of low severity	\$ 50.40
99273	Usually the presenting problem(s) are of moderate severity	\$ 66.82
99274	Usually the presenting problem(s) are moderate to high severity	\$ 90.14
99275	Usually the presenting problem(s) are of moderate to high severity	\$118.66

Home Services

New Patient

99341	Usually the presenting problem(s) are of low severity	\$ 45.50
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99342	Usually the presenting problem(s) are of moderate severity	\$ 57.60
99343	Usually the presenting problem(s) are of high severity	\$ 74.59

Established Patient

99351	Usually the patient is stable, recovering or improving	\$ 35.14
99352	Usually the patient is responding inadequately to therapy or has developed a minor complication	\$ 46.37
99353	Usually the patient is unstable or has developed a significant complication or a significant new problem	\$ 58.18

Prolonged Services

Prolonged Physician Service with Direct (Face-to-Face) Patient Contact

99354	Prolonged physician serviced in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	\$ 60.00
99355	Each additional 30 minutes	\$ 30.00

Prolonged Physician Services without Direct (Face-to-Face) Patient Contact

99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	\$ 60.00
99359	Each additional 30 minutes	\$ 30.00

Preventive Medicine Services

New Patient

* 99381	Initial evaluation and management of a healthy individual requiring a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)	N/C
* 99382	Early childhood (age 1 through 4 years)	N/C
* 99383	Late childhood (age 5 through 11 years)	N/C
* 99384	Adolescent (age 12 through 17 years)	N/C

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Established Patient

- | | | |
|---------|--|-----|
| * 99391 | Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; new patient; infant (age under 1 year) | N/C |
| * 99392 | Early childhood (age 1 through 4 years) | N/C |
| * 99393 | Late childhood (age 5 through 11 years) | N/C |
| * 99394 | Adolescent (age 12 through 17 years) | N/C |

Local Codes

New Patient or Established Patient

- | | | |
|---------|----------------------|----------|
| * X5501 | Physician EPSDT exam | \$ 45.00 |
|---------|----------------------|----------|

Counseling and/or Risk Factor Reduction Intervention

New or Established Patient

Preventive Medicine, Individual Counseling

- | | | |
|-------|--|-----|
| 99401 | Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes | N/C |
| 99402 | Approximately 30 minutes | N/C |
| 99403 | Approximately 45 minutes | N/C |
| 99404 | Approximately 60 minutes | N/C |

Preventive Medicine, Group Counseling

- | | | |
|-------|--|-----|
| 99411 | Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting | N/C |
| 99412 | Approximately 60 minutes | N/C |

Other Preventive Medicine Services

- | | | |
|-------|--|-----|
| 99420 | Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal) | N/C |
| 99429 | Unlisted preventive medicine services | N/C |

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Newborn Care

99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)	\$100.00
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Immunizations

90700	Immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTP)	\$ 7.00
* 90701	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	\$ 7.00
90702	Diphtheria and tetanus toxoids (DT)	\$ 7.00
90703	Tetanus toxoid	\$ 13.00
90704	Mumps virus vaccine, live	\$ 7.00
90705	Measles virus vaccine, live	\$ 7.00
90706	Rubella virus vaccine, live - state supplied	\$ 7.00
* 90707	Measles, mumps and rubella virus, live	\$ 7.00
90708	Measles and rubella virus vaccine, live	\$ 7.00
90709	Rubella and mumps virus vaccine, live	\$ 17.00
90710	Measles, mumps, rubella, and varicella vaccine	\$ 41.00
90711	Diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine	\$ 50.00
* 90712	Poliovirus vaccine, live, oral (any type(s))	\$ 7.00
90713	Poliomyelitis vaccine - state supplied	\$ 7.00
90714	Typhoid vaccine	BR
90716	Varicella (chicken pox) vaccine	\$ 7.00
90717	Yellow fever vaccine	BR
* 90718	Tetanus and diphtheria toxoids absorbed	\$ 5.00
90719	Diphtheria toxoid	BR
90720	Diphtheria, tetanus, and pertussis (DTP) and hemophilus influenza b (HIB) vaccine	\$ 7.00
90721	Diphtheria, tetanus, toxoids, and acellular pertussis vaccine (DTAP) and Hemophilus influenza B(HIB) vaccine	\$ 7.00
90724	Influenza virus vaccine	\$ 9.00
90725	Cholera vaccine	BR
90726	Rabies vaccine	BR
90727	Plague vaccine	BR
90728	BGC vaccine	BR

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90730	Hepatitis A vaccine	\$ 13.00
90732	Pneumococcal vaccine, polyvalent	\$ 12.00
90733	Meningococcal polysaccharide vaccine (any group(s))	\$ 20.00
* 90737	Hemophilus influenza B - state supplied	\$ 7.00
90741	Immunization, passive; immune serum globulin, human (ISG)	\$ 12.00
90742	Specific hyperimmune serum globulins (e.g., hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicella-zoster)	BR
90744	Immunization, active, hepatitis B vaccine; new Newborn to 11 years	\$ 7.00
90745	Immunization, active, hepatitis B vaccine; new 11 - 19 years	\$ 7.00
90749	Unlisted immunization procedure	BR
X5951	HIB conjugate	\$ 7.00

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OBSTETRICAL PRACTITIONER SERVICES

Maternity Care and Delivery

Incision

59000	Amniocentesis, any method	\$ 63.00
59012	Cordocentesis (intrauterine), any method	\$ 252.00
59015	Chorionic villus sampling, any method	\$ 189.00
59020	Fetal contraction stress test	\$ 63.00
59025	Fetal non-stress test	\$ 63.00
59030	Fetal scalp blood sampling	\$ 63.00
59050	Fetal monitoring during labor by consulting physician with written report (separate procedure); supervision and interpretation	\$ 113.40
59051	Interpretation only	\$ 88.20

Excision

59100	Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)	\$1008.00
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	\$ 882.00
59121	Tubal or ovarian, without abdominal pregnancy	\$ 882.00
59130	Abdominal pregnancy	\$ 913.50
59135	Interstitial, uterine pregnancy requiring total hysterectomy	\$1102.50
59136	Interstitial, uterine pregnancy with partial resection of uterus	\$1260.00
59140	Cervical, with evacuation	\$ 882.00
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	\$ 693.00
59151	With salpingectomy and/or oophorectomy	\$1134.00
59160	Curettage, postpartum (separate procedure)	\$ 264.60

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Introduction

59200	Insertion of cervical dilator	\$ 151.20
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Repair

59300	Episiotomy or vaginal repair, by other by other than attending physician	\$ 132.30
59320	cerclage or cervix, during pregnancy; vaginal	\$ 226.80
59325	Abdominal	\$ 378.00
59350	Hysterorrhaphy of ruptured uterus	\$ 945.00

Vaginal Delivery, Antepartum or Postpartum Care

* 59400	Routine obstetric care including antepartum care, vaginal delivery	\$1260.00
* 59409	Vaginal delivery only (with or without episiotomy and/or forceps)	\$ 787.50
* 59410	Vaginal delivery only (with or without episiotomy and/or forceps) including postpartum care	\$ 787.50
* 59412	External cephalic version, with or without tocolysis	\$ 220.50
* 59414	Delivery of placenta (separate procedure)	\$ 157.50
* 59420	Antepartum visit (separate procedure)	\$ 42.95
* 59425	Antepartum care only; 4-6 visits	N/C
* 59426	7 or more visits	N/C
* 59430	Postpartum care only (separate procedure)	\$ 42.95
* X5901	Initial visit	\$ 70.00

Cesarean Delivery

* 59510	Routine obstetric care including ante- partum care, cesarean delivery, and postpartum care	\$1575.00
* 59514	Cesarean delivery only	\$1102.50
* 59515	Cesarean delivery only including post- partum care	\$1102.50
* 59525	Subtotal or total hysterectomy after initial visit cesarean delivery	\$ 535.50

Abortion

59812	Treatment of spontaneous abortion, any trimester, completed surgically	\$ 252.00
59820	Treatment of missed abortion, completed surgically; first trimester	\$ 283.50

TN NO. <u>97-05</u>			
Supersedes	Approval Date <u>05/21/97</u>	Effective Date <u>07/01/97</u>	
TN NO. <u>96-003</u>			

STATE: WYOMING

59821	Second trimester	
59830	Treatment of septic abortion, completed	\$ 315.00
59840	Induced abortion, by dilation and curettage	\$ 315.00
59841	Induced abortion, by dilation and evacuation	\$ 283.50
59850	Induced abortion, by one or more intra- amniotic injections	\$ 283.50
59851	With dilation and curettage and/ or evacuation	\$ 447.30
59852	With hysterotomy (failed intra-amniotic injection)	\$ 567.00
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria)	\$ 756.00
59856	With dilation and curettage and/or evacuation	\$ 529.20
59857	With hysterotomy (failed medical evaluation)	\$ 648.90
		\$ 837.90

Other Procedures

59870	Uterine evacuation and curettage for hydatidiform mole	\$ 315.00
59899	Unlisted procedure, maternity care and delivery	BR

TN NO. 97-05
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TN NO. 96-003

STATE: WYOMING

Medicaid reimburses all practitioners using the fees listed in Attachment 4.19-B, Attachment 1, Pages 1-8 regardless of specialty.

Wyoming has no HMO providers.

Incentive payments:

Providers who are certified as disproportionate share providers are allowed a 10% increase in the calculated allowed fee as listed below for the following procedures:

<u>Code</u>	<u>Incentive Payment</u>
99201	\$ 26.29
99202	41.51
99203	56.08
99204	82.05
99205	102.02
99211	13.62
99212	22.82
99213	31.68
99214	48.16
99215	74.13
X5901	77.00
59400	1386.00
59409	866.25
59410	866.25
59420	47.25
59430	47.25
59510	1732.50
59514	1212.75
59515	1212.75
59610	1386.00
59612	866.25
59614	866.25
59618	1732.50
59620	1212.75
59622	1212.75
X5501	49.50
X5501 RE	49.50
99431	110.00
99433	33.00

TN NO. 97-05
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STATE: WYOMING

AVERAGE MEDICAID PAYMENT
FOR LISTED OBSTETRIC SERVICES

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
59400	\$1356.95	\$1359.28	\$1380.64
59409	801.03	856.58	866.25
59410	823.75	866.25	840.00
59412	220.50	0.00	220.50
59414	157.50	0.00	0.00
59420	49.48	57.34	55.90
59425	0.00	0.00	0.00
59426	0.00	0.00	0.00
59430	43.19	45.56	36.00
59510	1688.81	1677.38	1732.50
59514	1101.42	847.18	1212.75
59515	1144.03	1157.63	0.00
59525	0.00	0.00	0.00

TN NO. 97-05

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Approval Date

05/21/97

Effective Date

07/01/97

STATE: WYOMING

ATTACHMENT 4.19-B
ATTACHMENT 2, PAGE 2

AVERAGE MEDICAID PAYMENT
FOR LISTED OBSTETRIC SERVICES (OB/GYN)

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
59400	\$1360.49	\$1335.78	\$1386.00
59409	796.06	859.69	866.25
59410	820.17	0.00	840.00
59412	220.50	0.00	220.50
59414	157.50	0.00	0.00
59420	46.98	52.18	47.24
59425	0.00	0.00	0.00
59426	0.00	0.00	0.00
59430	43.02	45.00	0.00
59510	1691.06	1641.05	1732.50
59514	1108.00	847.18	1212.75
59515	1137.71	1102.50	0.00
59525	0.00	0.00	0.00

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STATE: WYOMING

ATTACHMENT 4.19-B
ATTACHMENT 2, PAGE 3

AVERAGE MEDICAID PAYMENT
FOR LISTED OBSTETRIC SERVICES (OTHER)

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
59400	\$1350.84	\$1375.60	\$1370.92
59409	822.62	844.17	866.25
59410	830.12	866.25	840.00
59412	0.00	0.00	0.00
59414	157.50	0.00	0.00
59420	54.58	57.89	58.34
59425	0.00	0.00	0.00
59426	0.00	0.00	0.00
59430	43.97	45.90	36.00
59510	1672.53	1716.21	0.00
59514	1051.43	0.00	0.00
59515	1160.87	1212.75	0.00
59525	0.00	0.00	0.00

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STATE: WYOMING

AVERAGE MEDICAID PAYMENTS FOR LISTED PEDIATRIC SERVICES

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
90701	\$6.46	\$6.05	\$6.13
90707	6.54	5.91	6.71
90712	5.88	3.85	6.41
90737	6.32	6.01	5.64
90744	0.00	0.00	0.00
90745	0.00	0.00	0.00
99201	24.47	24.82	24.69
99202	38.64	38.76	38.68
99203	51.45	51.25	51.66
99204	69.99	67.39	70.68
99205	83.09	86.20	91.79
99211	12.50	12.06	12.27
99212	21.70	22.28	21.40
99213	30.36	29.75	30.48
99214	44.62	46.34	43.93
99215	64.47	66.21	66.25
99381	0.00	0.00	0.00
99382	0.00	0.00	0.00
99383	0.00	0.00	0.00
99384	0.00	0.00	0.00
99391	0.00	0.00	0.00
99392	0.00	0.00	0.00
99393	0.00	0.00	0.00
99394	0.00	0.00	0.00

TN NO. 97-05
Supersedes Approval Date 05/21/97 Effective Date 07/01/97
TN NO. 96-003

STATE: WYOMING

ATTACHMENT 4.19-B
ATTACHMENT 2, PAGE 5

AVERAGE MEDICAID PAYMENTS FOR LISTED PEDIATRIC SERVICES (OTHER)

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
90701	\$6.19	\$5.90	\$6.11
90707	6.18	5.39	6.44
90712	5.04	2.41	5.60
90737	6.10	5.73	5.64
90744	0.00	0.00	0.00
90745	0.00	0.00	0.00
99201	24.44	24.82	24.44
99202	38.43	38.79	38.12
99203	51.20	51.26	51.47
99204	71.09	66.78	69.71
99205	82.70	85.92	88.51
99211	12.50	12.00	12.21
99212	21.70	22.39	21.29
99213	29.92	29.83	29.63
99214	43.94	46.25	41.19
99215	62.35	65.16	59.94
99381	0.00	0.00	0.00
99382	0.00	0.00	0.00
99383	0.00	0.00	0.00
99384	0.00	0.00	0.00
99391	0.00	0.00	0.00
99392	0.00	0.00	0.00
99393	0.00	0.00	0.00
99394	0.00	0.00	0.00

TN NO. 97-05
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TN NO. 96-003

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STATE: WYOMING

ATTACHMENT 4.19-B
ATTACHMENT 2, PAGE 6

AVERAGE MEDICAID PAYMENTS FOR LISTED PEDIATRIC SERVICES (PEDS)

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
90701	\$6.89	\$6.68	\$7.00
90707	6.97	6.93	7.00
90712	6.85	6.95	7.00
90737	6.82	6.74	0.00
90744	0.00	0.00	0.00
90745	0.00	0.00	0.00
99201	25.22	0.00	26.29
99202	39.83	38.15	41.50
99203	52.01	51.19	55.52
99204	66.80	74.39	80.98
99205	84.12	92.74	95.90
99211	12.54	12.65	13.61
99212	21.69	21.13	22.76
99213	30.95	29.54	31.66
99214	46.07	46.60	47.84
99215	68.85	68.06	71.58
99381	0.00	0.00	0.00
99382	0.00	0.00	0.00
99383	0.00	0.00	0.00
99384	0.00	0.00	0.00
99391	0.00	0.00	0.00
99392	0.00	0.00	0.00
99393	0.00	0.00	0.00
99394	0.00	0.00	0.00

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STATE: WYOMING

Health Care Financing conducted an annual analysis of all licensed physicians engaged in primary care in Wyoming, by county, to determine their status with regard to participation in the Medicaid program. The definition of primary care for the sake of this analysis included physician specialties of general practice (GP), family practice (FP), obstetrics and gynecology (OG), and pediatrics (PD). There were 291 licensed primary care physicians in Wyoming in March 1997 of which 100% participated in Medicaid during the past year. Participation was defined as having at least one paid claim. These statistics are depicted below.

	Licensed/ Participating				Licensed Non-Participating			
	FP	GP	OG	PD	FP	GP	OG	PD
ALBANY	6	--	3	5	--	--	--	--
BIG HORN	2	2	--	--	--	--	--	--
CAMPBELL	6	2	4	3	--	--	--	--
CARBON	4	3	--	1	--	--	--	--
CONVERSE	1	3	--	--	--	--	--	--
CROOK	0	0	--	--	--	--	--	--
FREMONT	7	4	6	3	--	--	--	--
GOSHEN	4	2	--	--	--	--	--	--
HOT SPRINGS	4	--	--	--	--	--	--	--
JOHNSON	4	--	--	--	--	--	--	--
LARAMIE	47	2	6	9	--	--	--	--
LINCOLN	8	2	--	1	--	--	--	--
NATRONA	43	2	5	6	--	--	--	--
NIOBRARA	--	3	--	--	--	--	--	--
PARK	7	2	2	2	--	--	--	--
PLATTE	1	--	1	--	--	--	--	--
SHERIDAN	5	1	3	4	--	--	--	--
SUBLETTE	3	0	--	--	--	--	--	--
SWEETWATER	9	1	3	3	--	--	--	--
TETON	4	1	4	4	--	--	--	--
UINTA	5	--	2	3	--	--	--	--
WASHAKIE	3	2	--	--	--	--	--	--
WESTON	3	--	--	--	--	--	--	--
TOTALS	176	32	39	44	0	0	0	0

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STATE: WYOMING

FAMILY PRACTITIONERS/GENERAL PRACTITIONERS PERFORMING OBSTETRICS

	Licensed		Providing OB			Providing Medicaid OB	
	FP	GP	FP	GP		FP	GP
ALBANY	6	--	4	--		4	--
BIG HORN	2	2	00	1		--	1
CAMPBELL	6	2	4	--		4	--
CARBON	4	3	1	0		1	0
CONVERSE	1	3	1	3		1	3
CROOK	0	0	--	0		--	0
FREMONT	7	4	5	1		5	1
GOSHEN	4	2	3	2		3	2
HOT SPRINGS	4	--	3	--		3	--
JOHNSON	4	--	4	--		4	--
LARAMIE	47	2	27	1		27	1
LINCOLN	8	2	6	2		6	2
NATRONA	43	2	27	1		27	1
NIOBRARA	--	3	--	0		--	0
PARK	7	2	7	1		7	1
PLATTE	1	--	1	--		1	--
SHERIDAN	5	1	--	--		--	--
SUBLETTE	3	0	--	--		--	--
SWEETWATER	9	1	--	1		--	1
TETON	4	1	1	--		1	--
UINTA	5	--	3	--		3	--
WASHAKIE	3	2	2	1		2	1
WESTON	3	--	3	--		3	--
TOTAL	176	32	102	14		102	14

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Effective Date 07/01/97

STATE: WYOMING

FAMILY PRACTITIONERS/GENERAL PRACTITIONERS/PEDIATRIC NURSE PRACTITIONERS
PROVIDING PEDIATRIC SERVICES

		LICENSED				PROVIDING PED				PROVIDING MEDICAID PED		
		FP	GP	PNP		FP	GP	PNP		FP	GP	PNP
ALBANY		6	--	--		6	--	--		6	--	--
BIG HORN		2	2	--		2	2	--		2	2	--
CAMPBELL		6	2	--		6	2	--		6	2	--
CARBON		4	3	--		4	3	--		4	3	--
CONVERSE		1	3	--		1	3	--		1	3	--
CROOK		0	0	--		0	0	--		0	0	--
FREMONT		7	4	--		7	4	--		7	4	--
GOSHEN		4	2	--		4	2	--		4	2	--
HOT SPRINGS		4	--	--		4	--	--		4	--	--
JOHNSON		4	--	--		4	--	--		4	--	--
LARAMIE		47	2	--		47	2	--		47	2	--
LINCOLN		8	2	--		8	2	--		8	2	--
NATRONA		43	2	--		43	2	--		43	2	--
NIOBRARA		--	3	--		--	3	--		--	3	--
PARK		7	2	--		7	2	--		7	2	--
PLATTE		1	--	--		1	--	--		1	--	--
SHERIDAN		5	1	1		5	1	1		5	1	1
SUBLETTE		3	0	--		3	0	--		3	0	--
SWEETWATER		9	1	--		9	1	--		9	1	--
TETON		4	1	--		4	1	--		4	1	--
UINTA		5	--	--		5	--	--		5	--	--
WASHAKIE		3	2	--		3	2	--		3	2	--
WESTON		3	--	--		3	--	--		3	--	--
TOTAL		176	32	1		176	32	1		176	32	1

TN NO. 97-05

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STATE: Wyoming

Selective contracting of outpatient services. The Division may identify outpatient services to be reimbursed as speciality services pursuant to Attachment 4.19A, Part 3. In evaluating services for reimbursement as speciality services, the Department shall consider:

- (1) The cost of services and the potential savings from selective contracting;
- (2) The potential to control over-utilization of services;
- (3) Methods of ensuring recipient access to services; and
- (4) Methods of ensuring quality.

Selective contracting of outpatient services shall be pursuant to Attachment 4.19A, Part 3.

TN No.: 97-06
Supersedes
NEW

Approved Date 06/24/97 Effective Date 02/18/97 TN No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

2b. RURAL HEALTH CLINIC SERVICES.

Payment for Rural Health Clinic (RHC) services conforms to Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA).

All covered RHC services furnished on or after January 1, 2001 and each succeeding Federal Fiscal Year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse RHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the RHC's reasonable costs of providing Medicaid-covered services during RHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during RHC Fiscal Year 2001.

The baseline per visit rate is determined for each RHC by (1) calculating a per visit rate for RHC Fiscal Year 1999 and RHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two.

Beginning with Federal Fiscal Year 2002 and for each Federal Fiscal Year thereafter, the per visit payment rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the RHC during that RHC Fiscal Year. The RHC is responsible for supplying the needed documentation to the State regarding increases or decreases in the RHC's scope of services.

The Medicaid allowable payment for a provider that qualifies as a Rural Health Clinic (RHC) after September 30, 1999, shall be equal to 100 percent of the reasonable costs used in calculating the rates of RHC's with similar caseloads located in the state during the same facility fiscal year. If there are no RHC's located in Wyoming with a similar caseload, the Department shall calculate the rate for the new RHC based on projected costs after applying tests of reasonableness.

The per visit payment for out-of-state RHC's is the statewide average Medicaid allowable payment in effect in the State as of October 1st of that year.

TN# 01-011

Supersedes

TN# 01-003

Approval Date 11/29/01Effective Date October 1, 2001

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

2c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Payment for Federally Qualified Health Center (FQHC) services conforms to Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA).

All covered FQHC services furnished on or after January 1, 2001 and each succeeding Federal Fiscal Year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse FQHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the FQHC's reasonable costs of providing Medicaid-covered services during FQHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during FQHC Fiscal Year 2001.

The baseline per visit rate is determined for each FQHC by (1) calculating a per visit rate for FQHC Fiscal Year 1999 and FQHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two.

Beginning with Federal Fiscal Year 2002 and for each Federal Fiscal Year thereafter, the per visit payment rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the FQHC during that FQHC Fiscal Year. The FQHC is responsible for supplying the needed documentation to the State regarding increases or decreases in the FQHC's scope of services.

The Medicaid allowable payment for a provider that qualifies as a Federally Qualified Health Center (FQHC) after September 30, 1999, shall be equal to 100 percent of the reasonable costs used in calculating the rates of FQHC's with similar caseloads located in the state during the same facility fiscal year. If there are no FQHC's located in Wyoming with a similar caseload, the Department shall calculate the rate for the new FQHC based on projected costs after applying tests of reasonableness.

The per visit payment for out-of-state FQHC's is the statewide average Medicaid allowable payment in effect in the State as of October 1st of that year.

TN# 01-011

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE
OF CARE PROVIDED

3. OTHER LABORATORY AND X-RAY SERVICES

Laboratory Services

Reimbursement for all outpatient laboratory services is the lessor of charges or the Medicaid fee schedule amount. The fee schedule for laboratory services complies with the Federal upper limits of payments for laboratory services.

X-ray Services

Reimbursement is the lessor of charges or the physician fee schedule amount.

TN # 89-09
Supersedes
TN # 87-7

Approval Date 1/31/90 Effective Date 7/1/89

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

4.b. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES

Medical Screening Examination, Dental and Optometric services are reimbursed at the lesser of charges or the established Medicaid fee schedule amount.

Reimbursement for expanded EPSDT services is based on a rate negotiated with the provider, not to exceed the rate paid for a comparable covered Medicaid service or 70% of the usual and customary charge.

TN # 95-004

Supersedes

TN # 89-09

Approval Date 05/02/95

Effective Date 01/01/95

ATTACHMENT 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE
OF CARE PROVIDED

4.c. FAMILY PLANNING SERVICES AND SUPPLIES

Refer to appropriate services for reimbursement data,
i.e., inpatient and outpatient hospital and physician
services.

TN # 89-09
Supersedes
TN # NEW Approval Date 1/31/90 Effective Date 7/1/89

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

5. PHYSICIAN SERVICES

Reimbursement for physician services is the lesser of charges or the Medicaid fee schedule amount. A maximum allowable fee is established by procedure code regardless of provider location. All public and private providers are reimbursed according to the same fee schedule. Providers may access the fee schedule on the agency website or upon request by calling the fiscal agent.

Physician fees were determined by an RBRVS analysis of customary charges, prevailing charges, and average commercial rates. Charges were inflated to the SFY 2007 rate year using the Medicare Economic Index. The reasonable charge was identified as the lower of the inflated charges or the newly computed rate under each of the three approaches. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rate for these services, for dates of service on or after July 1st 2010 are on the official Web site of the Department of Health at <http://wdh.state.wy.us> or <http://wyequalitycare.acs-inc.com>

New procedures or by report procedures are reimbursed at 70% of billed charges until sufficient data (consultant recommendations or profiling of charges) is available to establish a relative value or allowable fee. Fee for specific procedures are adjusted when a significant number of claims or fees are defined as outliers. The modification may be performed by adjusting the relative value and conversion factor or by establishing a specific fee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

5.b. MEDICAL AND SURGICAL SERVICES FURNISHED BY A DENTIST

Reimbursement for medical and surgical services furnished by a dentist is the lessor of charges or the Medicaid fee schedule amount.

TN # 95-004

Supersedes

TN # NEW

Approval Date 05/02/95

Effective Date 01/01/95

Reimbursement-Physician Services**Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415****Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- ☐ The rates reflect all Medicare site of service and locality adjustments.
- ☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- ☐ The rates reflect all Medicare geographic/locality adjustments.
- ☒ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: Deloitte Fee Schedule Tool , no other changes in rates are anticipated.

Method of Payment

- ☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- ☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☒ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

- ☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
- ☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

TN No. 13-002

Supersedes

TN No. NEW

CMS ID: _____

Approval Date 05/15/13 Effective Date 01/01/13

99339, 99340, 99363, 99364, 99368, 99375, 99378, 99386, 99387, 99396, 99397, 99408, 99409, 99411, 99412, 99420, 99444, 99450, 99455, 99456, 99485, 99486, 99487, 99488, 99489, 99495, 99496 and 99499

(Primary Care Services Affected by this Payment Methodology – continued)

☐ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

- ☒ Medicare Physician Fee Schedule rate
- ☒ State regional maximum administration fee set by the Vaccines for Children program
- ☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: \$11.81.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

TN No. 13-002

Supersedes

TN No. NEW

CMS ID: _____

Approval Date 05/15/13

Effective Date 01/01/13

☐ Alternative methodology to calculate the vaccine administration rate in effect
7/1/09: _____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at <http://wyequalitycare.acs-inc.com/index.html>.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at (<http://wyequalitycare.acs-inc.com/index.html>).

TN No. 13-002

Supersedes

TN No. NEW

CMS ID: _____

Approval Date 05/15/13

Effective Date 01/01/13

ATTACHMENT 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE
OF CARE PROVIDED

6.b. OPTOMETRISTS

Professional fees are reimbursed at the lessor of charges
or the established physicians' fee schedule amount.
Materials are reimbursed at the lessor of charges or the
Medicaid fee schedule amount.

TN # 89-09
Supersedes
TN # 87-7

Approval Date 1/31/90

Effective Date 7/1/89

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

7. HOME HEALTH SERVICES

Home Health Agency

Reimbursement for home health services other than disposable medical supplies is the lesser of charges or the established fee schedule amount. Disposable medical supplies are reimbursed at charges.

Medical Supplier

For HCPCS codes subject to Section 1903(i)(27) of the Social Security Act:

Reimbursement for DMEPOS is set at the lower of the following, excluding oxygen, oxygen related equipment, and oxygen related supplies:

1. Ninety seven and a half percent (97.5%) of the Medicare DMEPOS fee schedule rate for Wyoming geographic areas, set as of January 1 each year, and updated on an annual basis as needed;
2. The provider's charge; or
3. Actual acquisition cost plus shipping plus a percentage of billed charges.

For HCPCS codes not subject to Section 1903(i)(27) of the Social Security Act, codes for which Medicare does not have an assigned rate, and oxygen, oxygen related equipment, and oxygen related supplies:

Reimbursement for DMEPOS is set at the lower of the following:

1. The Wyoming Medicaid Fee Schedule amount;
2. The provider's charge; or
3. Actual acquisition cost plus shipping plus a percentage of billed charges.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2021 and is effective for services provided on or after that date. All rates are published on the Medicaid Web site at https://wymedicaid.portal.conduent.com/fee_schedule.html.

TN NO. WY-21-0003

Approval Date 4/15/21

Effective Date: January 1, 2021

Supersedes

TN NO. 18-0003

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

6.d. OTHER PRACTITIONERS

Certified Registered Nurse Anesthetist (CRNA)

Reimbursement for CRNA services is the lessor of the charges or the Medicaid fee schedule amount allowed for anesthesia services.

TN # 90-17
Supersedes
TN # NEW

Approval Date 2/13/91 Effective Date 10/1/90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED.

42 CFR 447.321

9. CLINIC SERVICES

- a.) Payment for clinic services will not exceed the upper limits of payment specified in 42 CFR 447.321.
- b.) Family Planning Clinics - Reimbursement is the lessor of the charges or the fee schedule amount.
- c.) End Stage Renal Disease Centers (ESRD) – ESRD clinics will be reimbursed at the lessor of the Medicare rate for services in the state where the facility is located or billed charges.
- d.) County Health Departments – Payment is made at the lessor of charges or the established fee schedule amount.
- e.) Tribal Health Programs

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of clinic services.

The Agency's fee schedule was last updated January 1, 2014 and is effective for dates of service provided on or after that date. All rates are published on the Medicaid provider website located at:
https://wyequalitycare.acs-inc.com/fee_schedule.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED.

CLINIC SERVICES (continued)

(e). Payments to Indian Health Services and any 638 tribal health facility that is federally recognized and tribally-operated or operated by the Indian Health Service shall be made according to the following:

Clinic Categories of Service – Payment for multiple encounters on the same date of service will be allowed only if the services are categorically different and/or are provided for distinct and separate diagnoses. Different categories of allowable services shall include but are not limited to practitioner services, mental health services, optometric services, dental services, physical therapy, occupational therapy, and speech therapy. Any services provided outside of the clinic shall be reimbursed according to the fee schedule.

Pharmacy encounters will be paid at the federal OMB clinic encounter rate and will not be limited to a certain number of prescriptions per day.

End Stage Renal Disease (ESRD) clinics will be paid up to one (1) encounter per day if medically necessary.

Nursing Home Reimbursement is located in section 4.19-D of the State Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

POLICY AND METHODS OF ESTABLISHING PAYMENT/PER VISIT RATES FOR INDIAN HEALTH SERVICES

Alternative Payment Methodology for Tribal Facilities Recognized as FQHCs

Under section 1905(I)(2)(B) of the Social Security Act and the Indian Self Determination Act (Public Law 93-638), facilities operated by a Tribe or Tribal organization are, by definition, FQHCs. A Tribal FQHC may bill Wyoming Medicaid for services on a per visit basis whether those services are furnished at the facility, outside the facility, by telehealth (when the practitioner is in the facility and client is off-site) or provided by off-site providers under contract to the Tribal FQHC.

Under the authority of section 1902(bb)(6) of the Social Security Act, Tribal facilities that have chosen to be designated as a Tribal FQHC to be paid using an Alternative Payment Methodology (APM). Tribal FQHCs who agree to receive this APM will receive reimbursement equivalent to the AIR for in-scope FQHC services.

Wyoming Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal FQHCs so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to the PPS rate that is currently paid to non-tribal FQHCs to determine if the all-inclusive rate is higher. Tribal FQHCs are not required to report their costs for the purposes of establishing a PPS rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

DENTAL SERVICES

Reimbursement is the lesser of charges or the established fee schedule amount. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of dental services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Medicaid website: <http://wyequalitycare.acs-inc.com>

Effective June 1, 2015, for dental procedures, Wyoming will set a fee at 70% of the fee determined by the National Dental Customized Fee Analyzer and fee data from average billed charges of Wyoming dental providers. For procedures that do not have sufficient data to set a fee, reimbursement will be determined by report and reimbursed at 70% of billed charge until sufficient data is available to establish an allowable fee. Fees for specific procedures are adjusted and set when a significant number of claims or fees are defined as outliers, or there is a comparable CPT code with a set fee. CPT fees are determined using the Resource-Based Relative Value Scale (RBRVS). This fee will be utilized to price the dental code.

TN No. WY-15-0002

Supersedes

Approval Date 8/11/15Effective Date June 1, 2015

TN No.

CMS ID: 06-009

ATTACHMENT 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE
OF CARE PROVIDED

11.a. PHYSICAL THERAPY

Reimbursement is the lessor of charges or the fee
schedule amount. Refer to physician services.

TN # 89-09
Supersedes
TN # 88-09

Approval Date

1/31/90

Effective Date

7/1/89

STATE PLAN ATTACHMENT 4.19 B

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

11.B. OCCUPATIONAL THERAPY

Reimbursement is the lesser of charges or the fee schedule amount. The Office of Medicaid utilizes the Resource Based Relative Value Scale (RBRVS) for fee schedule development.

WYOMING
03-004
01/29/04
07/01/03
NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

- 11.c. SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING AND LANGUAGE DISORDERS (PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR AUDIOLOGIST).

Reimbursement is the lessor of charges or the fee schedule amount. Refer to Physician Services.

TN #91-11
Supersedes
TN # NEW

Approval Date 7/8/91 Effective Date 4/1/91

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

11.d. SPEECH PATHOLOGY

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of speech pathology services. The agency's fee schedule rate for speech therapy services was set as of July 1, 2009 and is effective for services provided on or after that date. All rates are published at wyequalitycare.acs-inc.com.

TN#: 09-003

Supersedes

TN#: NEW

Approval Date 8/27/09

Effective Date: July 1, 2009

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

12.a. PHARMACY PROVIDERS

1. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
- c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
- d) The Federal Upper Limit (FUL);
- e) The State Maximum Allowable Cost (SMAC);
- f) The Ingredient Cost submitted;
- g) The Gross Amount Due (GAD); or
- h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional \$10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

2. Payment for specialty drugs not dispensed by a retail community pharmacy but dispense primarily through the mail will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
- c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
- d) The Federal Upper Limit (FUL);
- e) The State Maximum Allowable Cost (SMAC);
- f) The Ingredient Cost submitted;
- g) The Gross Amount Due (GAD); or
- h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional \$10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

3. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;

TN No. 17-0002Approval Date 10/06/2017Effective Date April 1, 2017

Supersedes

TN No. 01-004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

- c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
- d) The Federal Upper Limit (FUL);
- e) The State Maximum Allowable Cost (SMAC);
- f) The Ingredient Cost submitted;
- g) The Gross Amount Due (GAD); or
- h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional \$10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

4. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
- c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
- d) The Federal Upper Limit (FUL);
- e) The State Maximum Allowable Cost (SMAC);
- f) The Ingredient Cost submitted;
- g) The Gross Amount Due (GAD); or
- h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional \$10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

5. Entities that purchase products under Section 340B of the Public Health Service Act must request, in writing, to use these drugs for Wyoming Medicaid clients. 340B entities that request and are granted such an arrangement shall bill Medicaid no more than their actual acquisition cost (AAC) for the drug and will be reimbursed no more than the AAC plus a \$10.65 dispensing fee. 340B entities that fill Wyoming Medicaid client prescriptions with drugs not purchased under the Section 340B of the Public Health Services Act will be reimbursed in accordance with section 1 of this State Plan Amendment plus the \$10.65 professional dispensing fee.

5.1. Drugs acquired through the federal 340B drug price program and dispensed by 340B contract pharmacies are not covered.

6. Facilities purchasing drugs through the Federal Supply Schedule (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than 340B drug pricing program will be

TN No. 17-0002 Approval Date 10/06/2017 Effective Date April 1, 2017

Supersedes

TN No. 01-004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee.

7. Facilities purchasing drugs a Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee. Nominal Price as defined in §447.502 of the Code of Federal Regulation, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

8. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 100 percent of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at an aggregate Wholesale Acquisition Cost (WAC) + 0% for the pertinent HCPCS code. PADs without an ASP or WAC will be reimbursed at an aggregate AWP for the HCPCS code. If it is clearly demonstrated by the provider that reimbursement at the ASP, WAC, or AWP rate will negatively impact a provider's ability to continue service delivery, the DHCF may reimburse for PADs up to 100% of the established Medicare rate for the same PAD. In accordance with section 5 above, covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (AAC).

9. Payment to all Indian Health Service, tribal, and urban Indian pharmacies shall be at the All Inclusive Rate (AIR) published annually in the Federal Register. One AIR reimbursement shall be made for each pharmacy claim paid by the Department. The applicable AIR shall be determined by the date of service submitted on the pharmacy claim. Pharmacies reimbursed using the AIR will not be eligible for a dispensing fee.

10. Investigational drugs are not a covered service under the Wyoming Medicaid program.

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TN No. 17-0002Approval Date 10/06/2017Effective Date April 1, 2017

Supersedes

TN No. 01-004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

12.c. PROSTHETIC APPLIANCES, ORTHOTICS AND DURABLE MEDICAL EQUIPMENT

Reimbursement for prosthetic appliances, orthotics and durable medical equipment that are not reimbursed using the Wyoming Medicaid Ambulatory Payment Classification (APC) fee schedule which is described in the outpatient hospital reimbursement section of Attachment 4.19B shall be the lower of the fee assigned to the code or reimbursed at invoice cost, plus fifteen percent handling fee, plus shipping costs. The fee schedule for prosthetic appliances, orthotics and durable medical equipment is derived from an historical analysis of providers' charges, while taking into consideration the Medicare fee schedule. Fees were determined to assure access to services and adequate provider participation.

Updates to the schedule may be targeted to specific procedure codes or ranges of procedure codes. Considerations for update are to assure adequate provider participation and to eliminate inequities in the system.

TN NO. 05-005Approval Date 3/29/07Effective Date: October 1, 2005

Supersedes

TN NO. 95-005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

13d. REHABILITATIVE SERVICES – MENTAL HEALTH & SUBSTANCE ABUSE

Outpatient mental health and substance abuse treatment services are reimbursed on a fee-for-service basis utilizing the American Medical Association's Current Procedural Terminology, HCPCS Level I (CPT) and HCPCS Level II codes. Reimbursement will be the lesser of charges or a percentage of the physician fee schedule amount. All public and private providers are reimbursed according to the same fee schedule. A maximum allowable fee is established by procedure code regardless of provider location.

Providers bill rehabilitation services using either a HCPCS Level I (CPT) or HCPCS Level II code, not both. Physician fees were determined by an RBRVS analysis of customary charges, prevailing charges, and average commercial rates. Charges were inflated to the SFY2007 rate year using the Medicare Economic Index. The reasonable charge was identified as the lower of the inflated charges or the newly computed rate under each of the three approaches. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of mental health and substance abuse illnesses. The agency's fee schedule rate was set as of 1/1/2021 and is effective for services provided on or after that date. All rates are published (<https://wymedicaid.portal.conduent.com>). The rates for HCPCS Level II codes will be paid at or below 90% of the Medicare fee schedule rates for Wyoming. Rates do not include the cost of room and board and include only Medicaid allowable costs. Payment made by Medicaid will not duplicate payments made to other public agencies or private entities under other program authorities for this same purpose.

TN# 21-0002
Supersedes
TN# 16-006

Approval Date 4/6/21 Effective Date January 1, 2021

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**Policy and Methods of Establishing Payment Rate for Each Type of Care Provided.****14 Ambulatory Surgical Center –**

(a) Medicaid allowable payments for ambulatory surgical center services are made consistently with outpatient hospital services according to Section 8 of Attachment 4.19B with the following exceptions

(1) State specific Ambulatory Surgical Center Medicaid conversion factor

(11) Percent of charges. Certain services are reimbursed based on a percent of allowed charges as indicated in the APC fee schedule. These services include corneal tissue medical devices and dental (i.e., procedure code 41899)

(b) Updates. The APC conversion factor and relative weights are reviewed annually

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician services

The agency's fee schedule rate was set as of July 1, 2014 and is effective for services provided on or after that date. All rates are published at <http://wymedicaid.acs-inc.com>.

TN No. 13-009

Supersedes

TN No New

Approval Date 04/23/14

Effective Date 07/01/14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

17. NURSE-MIDWIFE SERVICES

Reimbursement will be the lesser of charges or a percentage of the physician fee schedule amount. All public and private providers are reimbursed according to the same fee schedule. A maximum allowable fee is established by procedure code regardless of provider location. Providers may access the fee schedule on the agency website or upon request by calling the fiscal agent.

Physician fees were determined by an RBRVS analysis of customary charges, prevailing charges, and average commercial rates. Charges were inflated to the SFY2007 rate year using the Medicare Economic Index. The reasonable charge was identified as the lower of the inflated charges or the newly computed rate under each of the three approaches. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for these services, for dates of service on or after July 1, 2015 are on the official website of the Department of Health, Medicaid at <http://wdh.state.wy.us> or <http://wyequalitycare.acs-inc.com>. Rates will be updated on July 1, 2016 and will be effective for the services provided on or after that date.

TN#__WY16-004_____Approval Date: June 7, 2016Effective Date: July 1, 2016

Supersedes:

TN#__95-005_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING A PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

18. REIMBURSEMENT METHODOLOGY FOR HOSPICE CARE

Payment for hospice care is in the same amounts as used under Part A of Title XVIII; except that a separate rate may be paid for hospice care which is furnished to an individual who is a resident of a nursing facility, and who would be eligible under the plan for nursing facility services if he had not elected to receive hospice care, to take into account the room and board furnished by such facility.

The state will pay no less than 95% of the usual per diem rate of the respective nursing facility to the hospice.

TN # 95-005
Supersedes
TN # 94-011

Approval Date 06/26/95

Effective Date 01/01/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

19. Payment is made at the lower of the actual charge or the Medicaid rate on file.

TN No. 95-008
Supersedes
TN No. NONE

Approval Date 07/24/95 Effective Date 07/01/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF WYOMING

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF SERVICES

Payment for Targeted Case Management (TCM) services provided to persons with a serious and persistent mental illness who are age twenty one (21) and older who have a behavioral health disorder that results in a long-term limitation of the person's capacity to function in activities of daily living and to remain in his/her home community without a range of treatment and other support services will be reimbursed on a fee-for-service basis per unit of service. For the purposes of this rule, a unit of service is a period of 15 minutes.

The Department will pay the lower of the following for TCM services for this target population:

- The provider's actual submitted charge for the services, or
- The Department's fee schedule

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both public and private providers of TCM services. Rates do not include the cost of room and board and include only Medicaid allowable costs.

The agency's fee schedule rates for targeted case management services for adults with severe and persistent mental illness were last updated September 22, 2007. The most recent agency fee schedule rates are effective for services provided on or after September 22, 2007. All rates are published at http://wyequalitycare.acs-inc.com/fee_schedule.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: WYOMING

CASE MANAGEMENT SERVICES

19. Targeted Case Management Service
(Non-Waiver Developmentally Disabled Individuals, All ages)

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

All public and private providers that are Medicaid providers and are billing the same codes are reimbursed with the same rates.

The rates are published on the following website: <http://wyequalitycare.acs-inc.com/pub.html>

- 1) A unit for Targeted Case Management is defined as a complete 15 minute unit. A maximum of 36 hours or 120 units will be paid per plan year per client. The service must be prior-authorized and the providers are monitored for appropriate billing accumulation of time.
- 2) The state agency will assure, through system monitoring, that billed time does not exceed 32 billable units per day by a practitioner to deliver the targeted case management services.
- 3) As required by regulations, these payments will be subject to utilization review and system editing for efficiency, economy and quality of care.
- 4) The ISC is required to document the following information for reimbursement of TCM services:
 - a. Date of Service
 - b. Start time of Service
 - c. End time of Service
 - d. Total billable units
 - e. Type of Service
 - f. Description of Service
- 5) The Medicaid fee schedule does reflect per unit of service, but not the fee, because this service is prior authorized. The rate is published in a provider bulletin that is then placed on the <http://wyequalitycare.acs-inc.com/pub.html>.

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM**

STATE OF WYOMING

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF SERVICES**

Payment for Targeted Case Management (TCM) services provided to individuals eligible for Medicaid who are being determined for eligibility for the Wyoming Adult Developmental Disabilities (DD) Waiver, the Child DD Waiver, Acquired Brain Injury Waiver, Comprehensive Waiver, or Supports Waiver; and to obtain coordination of services while on a wait list for Waiver services will be reimbursed on a fee-for-service basis. For the purposes of this rule, a unit of service is a period of 15 minutes.

Payment Limitations

1. Cap: Up to 120 units may be paid per plan year, per client, per provider.

The Department will pay the lower of the following for TCM services for this target population.

- The provider's actual submitted charge for the services, or
- The Department's fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of TCM services. Rates do not include the cost of room and board and include only Medicaid allowable costs.

The agency's fee schedule rates for targeted case management services for Medicaid eligible individuals who are being determined for eligibility for the Wyoming Adult Developmental Disabilities (DD) Waiver, the Child DD Waiver, Acquired Brain Injury Waiver, Comprehensive Waiver, or Supports Waiver; and to obtain coordination of services while on a wait list were last updated January 1, 2006. The most recent agency fee schedule rates are effective for services provided on or after January 1, 2006. All rates are published at http://wyequalitycare.acs-inc.com/fee_schedule.html.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM**

STATE OF WYOMING

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF SERVICES**

Payment for targeted case management (TCM) services provided to Medicaid eligible individuals (consumers) who are residing or waiting to be placed, in a Medicaid certified acute care facility or nursing facility and express an interest in returning to the community rather than reside in a facility and qualify based on the targeted case manager's assessment as a good candidate for community living will be reimbursed on a fee-for-service basis per unit of service. For the purposes of this rule, a unit of service is a period of 15 minutes.

Payment Limitations

- 1 A maximum of 80 hours or 320 units will be paid per nursing facility episode per client. The providers are monitored for appropriate billing accumulation of time.
- 2 The State agency will assure, through system monitoring, that billed time does not exceed a maximum of 80 hours or 320 units per nursing facility episode per client.
- 3 As required by regulations, these payments will be subject to utilization review and system editing for efficiency, economy and quality of care.
- 4 All providers are required to document the following information for reimbursement of TCM services:
 - a. Date of Service
 - b. Place of Services
 - c. Total billable units
 - d. Total charges
 - e. Type of service
 - f. Description of Service

TCM services for clients are reimbursed at the lower of the following:

- 1 Submitted charges, or
- 2 Fee schedule as determined by the Department of Health

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of TCM services for clients.

The agency's fee schedule rates for targeted case management services for Medicaid eligible individuals (consumers) who are residing, or waiting to be placed, in a Medicaid certified acute care facility or nursing facility and express an interest in returning to the community rather than reside in a facility were last updated on September 22, 2007. The most recent agency fee schedule rates are effective for services provided on or after September 22, 2007. All rates are published at http://wyequalitycare.acs-inc.com/fee_schedule.html

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- 5 The Medicaid fee schedule does reflect per unit of service, but not the fee. The rate is published in a provider bulletin that is then place on the <http://wyequalitycare.acs-inc.com/>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF WYOMING

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF SERVICES

Payment for Targeted Case Management (TCM) services provided to children and youth ages four (4) through twenty-one (21) who meet the definition of having a serious emotional disturbance (per Federal Register, volume 58, no. 96, published May 20, 1993, pgs. 29422 through 29425) will be reimbursed on a fee-for-service basis per unit of service. For the purpose of this rule, a unit of service is a period of 15 minutes.

The Department will pay the lower of the following for TCM services for this target population:

- The provider's actual submitted charge for the services; or
- The Department's fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of TCM services provided to children and youth ages four (4) through twenty-one (21) who meet the definition of having a serious emotional disturbance. The agency's fee schedule rate was set as of September 28th, 2018, and is effective for services provided on or after that date. All rates are published on the Medicaid fiscal agent's website at https://wymedicaid.portal.conduent.com/fee_schedule.html. Rates do not include the cost of room and board and include only Medicaid allowable costs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

23. CERTIFIED PEDIATRIC OR FAMILY NURSE PRACTITIONERS' SERVICES

Reimbursement will be the lesser of charges or a percentage of the physician fee schedule amount. All public and private providers are reimbursed according to the same fee schedule. A maximum allowable fee is established by procedure code regardless of provider location. Providers may access the fee schedule on the agency website or upon request by calling the fiscal agent.

Physician fees were determined by an RBRVS analysis of customary charges, prevailing charges, and average commercial rates. Charges were inflated to the SFY2007 rate year using the Medicare Economic Index. The reasonable charge was identified as the lower of the inflated charges or the newly computed rate under each of the three approaches. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for these services, for dates of service on or after July 1, 2015 are on the official website of the Department of Health, Medicaid at <http://wdh.state.wy.us> or <http://wyequalitycare.acs-inc.com>. Rates will be updated on July 1, 2016 and will be effective the services provided on or after that date.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wyoming

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

24a. Reimbursement for use of a private vehicle shall be at a rate established by the Medicaid agency utilizing a cost/benefit analysis. The rate is published and updated annually. The cost/benefit analysis compares the average cost per gallon of fuel and determines if the current fee is adequate to cover cost of mileage for vehicle traveling 15 miles on one gallon of fuel.

Reimbursement for public carrier and lodging is the lessor of charges or the Medicaid fee schedule amount.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of non-emergency transportation and lodging services. Reimbursement rates for dates of service on or after July 1, 2015 are on the official website of the Department, Medicaid <http://wymedicaid.acs-inc.com>.

Rates will be updated on 7/1/2016 and will be effective for services provided on or after that date. All rates are published on the Wyoming Medicaid web site (<http://wymedicaid.acs-inc.com>).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF
CARE PROVIDED

25. TRANSPLANT SERVICES

Reimbursement is the lesser of charges or the fee schedule amount.

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Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment specified in the chart on page 2 of this supplement. Codes appearing in the chart have the meanings defined below:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters **SP**, following the method described on pages 2, 3, 4 and 5, in items 1, 2, 4 of this attachment.

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses a special rate or method as set out on page 4 in item 3 of this attachment. (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters **MR**.
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in items A and B of this attachment, for those groups and payments listed below and designated with the letters **NR**.
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item of this attachment (see 3. above).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance
	Part B	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance
Other Medicaid Recipients	Part A	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance
	Part B	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance
Dual Eligible (QMB Plus)	Part A	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance
	Part B	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance
QT1 or SLMB	Part A	<u>Not Covered</u>	Deductibles		
	Part A	<u>Not Covered</u>	Coinsurance		
QT1 or SLMB	Part B	<u>Not Covered</u>	Deductibles		
	Part B	<u>Not Covered</u>	Coinsurance		

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING _____

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

1. Medicare Part A Deductible and Coinsurance - Services covered in the Medicaid State Plan.

Wyoming Medicaid covers the Medicare Part A deductible and coinsurance up to the Medicaid Fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the lesser of:

- The coinsurance and deductible up to the Medicare Part B deductible and coinsurance billed, OR
- The Medicaid Fee less any amounts paid by Medicare.

Exception to method above, if the method described above results in no payment for physician administered pharmaceuticals, then the state will pay at least \$0.01 for the physician administered pharmaceutical.

Medicare cross over claims do not count toward the service cap limits referenced in Section 4 of the Wyoming Medicaid State Plan.

Wyoming Medicaid covers the Part A deductible and coinsurance for QMB, QMB Plus, and Full Benefit Dual Eligibles who are not eligible as QMBs.

Medicaid does not cover Medicare Part A deductible and coinsurance for the QI1 or SLMB.

2. Medicare Part B Deductible and Coinsurance - Services covered in the Medicaid State Plan.

Wyoming Medicaid covers the Medicare Part B deductible and coinsurance up to the Medicaid Fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the lesser of:

- The coinsurance and deductible up to the Medicare Part B deductible and coinsurance billed, OR
- The Medicaid Fee less any amounts paid by Medicare.

Medicare cross over claims do not count toward the service cap limits referenced in Section 4 of the Wyoming Medicaid State Plan.

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Exception to method above, if the method described above results in a Medicaid payment of \$0 and the claim contains lines billed for physician administered pharmaceuticals, the state will authorize payment of \$0.01 on the pharmaceutical claim line.

Wyoming Medicaid covers the Part B deductible and coinsurance for QMB, QMB Plus, and Full Benefit Dual Eligibles who are not eligible as QMBs.

Medicaid does not cover Medicare Part B deductible and coinsurance for the QI1 or SLMB.

3. Medicare Part A & B deductible and coinsurance - Medicaid non-covered services.

For purposes of determining payment for Medicare Part A and Medicare Part B deductible and coinsurance, Wyoming Medicaid calculates the Medicaid Fee for Medicaid non-covered services using 50 percent of the Medicare allowed amount.

Wyoming Medicaid covers the Medicare Part A and Medicare Part B deductible and coinsurance for non-covered services up to the calculated Medicaid Fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the lesser of:

- The coinsurance and deductible up to the Medicare Part A or B deductible and coinsurance billed, OR
- The calculated Medicaid Fee less any amounts paid by Medicare.

Exception to method above, if the method described above results in a Medicaid payment of \$0 and the claim contains lines billed for physician administered pharmaceuticals, the state will authorize payment of \$0.01 on the pharmaceutical claim line.

Medicare cross over claims do not count toward the service cap limits referenced in Section 4 of the Wyoming Medicaid State Plan.

Wyoming Medicaid covers the Medicare Part A and Part B deductible and coinsurance for non-covered Medicaid services only for QMB and QMB plus.

For Full Benefit Dual Eligibles who are not eligible as QMBs, Wyoming Medicaid limits Medicare cost sharing to only those services covered in the Medicaid State Plan.

Wyoming Medicaid does not cover the Medicare Part A or Medicare Part B deductible and coinsurance for QI1 and SLMB.

4. Combined payments shall not exceed the amount Medicaid would have paid had it been the sole payer.

The financial obligations of Medicaid for services is based upon Medicare's allowable, not the provider's charge. Medicaid will not pay any portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid had it been the sole payer. Medicaid shall not pay on the claim if Medicare's payment is greater than what Medicaid would have paid had Medicaid been the sole payer.

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