Health, Department of

Medicaid

Chapter 3: Provider Enrollment and Participation, Pre-Authorization, Payment and Submission of Claims

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CHAPTER 3

Provider Enrollment and Participation, Pre-Authorization, Payment and Submission of Claims by Providers

Section 1. Authority. The Wyoming Department of Health (Department) promulgates this Chapter pursuant to the Wyoming Medical Assistance and Services Act at Wyoming Statute 42-4-101 through -124.

Section 2. Purpose and Applicability.

(a) The Department adopts this Chapter to govern the enrollment and participation in the Medicaid program by providers of covered services, including pre-authorization, and payment and submission of claims by providers, except as otherwise specified in the rules of the Department.

(b) This Chapter applies to all clients and providers for all furnished Medicaid services.

(c) The Department may issue manuals and bulletins to interpret this Chapter. Such manuals and bulletins shall be consistent with and reflect the rules contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to this Chapter.

Section 3. Definitions. Except as otherwise specified in Wyoming Medicaid Rules Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning as used in health care, Medicaid and Medicare.

Section 4. Provider Qualifications.

(a) The Department shall establish qualifications for individuals or entities to enroll as a provider of Medicaid covered services consistent with state and federal law.

(b) To qualify for enrollment as a provider of covered Medicaid services, an individual or entity shall, at a minimum, satisfy the following criteria:

(i) Meet applicable licensing and certification standards found in Wyoming statutes and rules, or in the statutes and regulations of the state in which the provider is located, or in the statutes and regulations of the state in which the services are provided. If applicable, a provider shall comply with Medicare certification standards;

(ii) Not be excluded from participation in federally funded health care programs by the U.S. Department of Health and Human Services, Office of Inspector General; and,

(iii) Be assigned a National Provider Identifier (NPI) number by the National Plan and Provider Enumeration System, as applicable.

Section 5. Provider Enrollment and Participation.

(a) The Department shall not pay Medicaid Funds to any individual or entity that provides services to a client unless the individual or entity is a party to a fully executed provider agreement and is enrolled by the Department.

(b) The following procedure governs the enrollment of providers in the Medicaid program:

(i) An individual or entity that wishes to participate in the Medicaid program shall apply to be a provider on the forms specified by the Department, and shall submit the qualifying documentation and information required by the Department to be enrolled as a provider.

(ii) The Department or its designated agent shall review and make a determination on the application within thirty (30) calendar days of the date it receives the application and all necessary qualification documentation, including any supplemental information requested by the Department.

(iii) If the application is approved, the provider and the Department shall execute a provider agreement as specified by the Department.

(iv) If the application is denied, the Department shall notify the applicant of its decision in writing in accordance with Wyoming Medicaid Rules Chapter 4.

(c) The provider's enrollment shall become effective when all requisite state and federal verifications have been completed and the provider agreement has been fully executed. It shall remain in effect for five (5) years from the effective date of the provider agreement or until terminated. Enrollment may be renewed upon application.

(d) The Department may retroactively enroll an individual or entity as a provider that previously furnished services to a client.

(i) The Department may provide Medicaid reimbursement for such services if the following requirements have been met:

(A) The individual or entity successfully applies to be a provider and states the requested effective date of enrollment;

(B) The services are otherwise reimbursable pursuant to Wyoming Medicaid Rules; and

(C) The individual or entity demonstrates it was qualified to provide the services for which it seeks reimbursement at the time services were delivered.

(ii) No Medicaid reimbursement shall be made before the provider seeking such reimbursement has been enrolled by the Department.

(e) Conditions of Provider's Participation.

(i) A provider shall not discriminate against any individual on the basis of race, color, religion, national origin, sex, disability, or age, except as allowed by law.

(ii) A provider shall not place restrictions or criteria on the services it will make available, the type of health conditions it will accept, or the persons it will accept for care or treatment, unless the provider applies those restrictions or criteria to all individuals seeking the provider's services.

(iii) A provider may not refuse to furnish services to a Medicaid client on account of a third party's potential liability for the service(s).

(iv) A provider shall comply with the Social Security Act, the Wyoming Medical Assistance and Services Act, and all rules and regulations promulgated under those Acts. A provider shall comply with other federal and state laws applicable to the services offered by the provider to clients.

(v) A provider shall comply with applicable licensing and certification standards found in Wyoming statutes and rules, or in the statutes and regulations of the state in which the provider is located, or in the statutes and regulations of the state in which the services are provided. If applicable, a provider shall comply with Medicare certification standards.

(vi) If acting as an employer or contractor of personnel a provider entity shall ensure:

(A) Its personnel operate within the limits and scope of practice allowed under the individual's professional licensure or certification and within the limits of the entity's licensure or certification; and

(B) It complies with the U.S. Department of Health and Human Services, Office of Inspector General's regulations and guidance on employment of individuals excluded from participation in federally funded health care programs.

(vii) A provider shall comply with all applicable state and federal laws in safeguarding information about applicants and clients.

(f) Termination of Provider Enrollment.

(i) The Department shall terminate a provider's enrollment if:

(A) The provider loses, or fails to provide documentation of, required licensure or certification. The termination shall be effective the same date the provider's license or certification status changes;

(B) The provider is excluded from participation in federally funded health care programs by the U.S. Department of Health and Human Services, Office of Inspector General. The termination shall be effective the same date the provider was excluded from the federal programs;

(C) The provider has been terminated from participation in Medicare when Medicare certification is a prerequisite to enrollment in Medicaid. The duration of the provider's termination for Medicaid shall be the same as and shall run contemporaneously with the provider's termination from participation in Medicare. The provider's remedies in regard to the termination under this subsection are limited to those provided by Medicare; or

(D) There was a finding of fraud, abuse, or other prohibited activities of the provider by a judicial or administrative process where that provider was afforded a notice and the right to a hearing.

(E) If a provider's enrollment is terminated under this subsection it is not an adverse action as defined, and the Department is not required to notify the provider in writing in accordance with Wyoming Medicaid Rules Chapter 4.

(ii) The Department may terminate a provider's enrollment pursuant to Wyoming Medicaid Rules Chapter 16. If a provider's enrollment is terminated under this subsection the Department shall notify the provider of the adverse action in writing in accordance with Wyoming Medicaid Rules Chapter 4.

(g) The Department may reenroll a terminated provider if:

(i) The Department has been reimbursed for all overpayments or a payment agreement is in effect;

(ii) The Department is satisfied that sufficient safeguards have been implemented to ensure that the factors which led to the termination will not recur; and

(iii) The provider successfully completes the Medicaid enrollment process.

Section 6. Provider Change in Ownership.

(a) A provider's Medicaid enrollment and any associated billing privileges are not transferrable and cannot be transferred at the time an individual provider's practice or a provider entity is sold or transferred.

(b) No party to a provider agreement shall assign or otherwise transfer any of its rights pursuant to that agreement.

(c) A provider shall not use its Medicaid enrollment or a provider agreement as collateral for any financial obligations.

(d) A provider which proposes a change in ownership, control, operation, management contract, or leasehold interest shall notify the Department in writing of the proposed change no later than sixty (60) days before the effective date of the proposed change.

(e) The prospective owner shall be required to enroll as a Medicaid provider in order to seek reimbursement for Medicaid covered services.

(f) A new owner shall not bill for claims until both the effective date of the sale or transfer has passed and the owner has been enrolled as a Medicaid provider.

(g) A provider entity that has changed ownership shall not be reimbursed for claims under the old provider agreement with dates of service on or after the effective date of the change in ownership.

(h) Wyoming Medicaid is not responsible for reimbursement of services provided during gaps in provider eligibility which arise as a result of a change in ownership.

(i) A change in the ownership of a provider entity as specified in this section shall not relieve the original provider of its obligations pursuant to the provider agreement or this Chapter.

Section 7. Out-of-State Providers.

(a) A service furnished by an enrolled provider located outside Wyoming is Medicaid reimbursable if:

(i) The services are needed because of a medical emergency;

(ii) The client is located outside of Wyoming and the client's health would be endangered if required to return to the state;

(iii) The Department determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

(iv) It is general practice for clients in a particular locality in Wyoming to use medical resources in another state;

(v) The client is referred to a provider outside Wyoming when prior authorized and comparable services are not available within the state;

(vi) The out-of-state provider is closer to the client's residence than a provider of comparable services within Wyoming; or

(vii) The client is less than 22 years of age; and

(A) Is a foster child and in the custody of the Wyoming Department of Family Services who resides with a foster family out of state and whose Medicaid coverage cannot otherwise be transferred to the receiving state; or

(B) Has been placed in an out-of-state institution.

Section 8. Provider Records.

(a) A provider shall collect and maintain medical and financial data, records, and information as necessary to provide services.

(b) A provider shall develop and maintain a record keeping system that includes a separate record for each client served.

(c) A provider shall maintain medical and financial records, including information regarding dates of service, diagnoses, services furnished, and claims, for at least six (6) years after the end of the state fiscal year in which payment for services was rendered.

(i) If any litigation, claim, audit or other action involving the records is initiated before the expiration of the six (6) year period, the records shall be maintained until the litigation, claim, audit or other action and any subsequent administrative or legal proceedings are resolved.

(ii) Such records shall be maintained for three (3) years in hard-copy, after which they may be maintained on micro-fiche, micro-film, or electronically.

(d) A provider shall make its financial records and the client's medical records available upon request to representatives of the Department, the United States Department of Health and Human Services, Health Care Finance Administration (HCFA), the Comptroller General of the United States, the Wyoming Attorney General, or the Medicaid Fraud Control Unit (MFCU).

(e) The Department may copy provider records as necessary to fulfill its authorized functions.

(f) The refusal of a provider to make financial or medical records available and accessible shall result in:

(i) The immediate suspension of all Medicaid payments to the provider including payments for services furnished after the date of the request. No payments shall be made to the providers until the Department determines that adequate records have been produced and maintained; and

(ii) All Medicaid payments made to the provider during the period for which records supporting such payments are not produced shall be repaid to the Department within ten (10) days after written request for such repayment.

Section 9. Verification of Client Data.

(a) The Department issues Medicaid identification numbers to clients. The provider is responsible for verifying the validity of each client's Medicaid identification.

(b) The provider will not be paid for any claims submitted for treatment of an individual who does not have a valid Medicaid identification number. If a provider receives payment from an individual that is later determined to be eligible for Medicaid, the provider shall refund any such payment to the individual before seeking Medicaid reimbursement.

(c) If a provider furnishes services to an individual who purposely fails to notify the provider that he is a Medicaid client, the provider may submit a claim to Medicaid or seek reimbursement or payment from the client. A provider that elects to seek Medicaid reimbursement shall accept such payment as payment in full.

(d) A provider that furnishes services to an individual who becomes a Medicaid client after the date services were provided may submit a claim to the Department seeking Medicaid reimbursement for services furnished during the period the individual was eligible for Medicaid.

Section 10. Prior Authorization.

(a) The Department may require prior authorization before provision of certain Medicaid covered services. The failure to obtain prior authorization before providing services precludes Medicaid reimbursement for such services. Prior authorization is not a guarantee of the client's eligibility or a guarantee of Medicaid payment.

(b) Before providing services that require prior authorization, the provider shall request such authorization using the forms specified by the Department.

(c) The Department shall grant a timely request for prior authorization if the proposed services are:

(i) Medically necessary;

(ii) Consistent with the diagnosis and treatment of the client's condition;

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

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

(v) Performed in the most cost effective and appropriate setting required by the client's condition; and,

(vi) Meet any additional criteria established by Wyoming Medicaid Rules or the coverage policies of the Department.

(d) Upon review, the Department or its designee may request additional information or documentation from the provider as necessary to determine that the above requirements have been met. The provider may request further review of the request for prior authorization following its submission of additional documentation.

(e) When the Department denies a request for prior authorization based upon the failure to meet the requirements set forth above, it shall inform the provider of the denial. The Department shall provide written notice to the client of the denial in accordance with Wyoming Medicaid Rules Chapter 4. Only the client has a right to a hearing pursuant to this section.

Section 11. Medicaid Allowable Payment.

(a) The Department shall establish and maintain payment rates for Medicaid services to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available, to the extent that such care and services are available to the general population in the geographic area.

(b) Except as otherwise specified in this Chapter or the Wyoming Medicaid Rules, the Medicaid Allowable Payment shall not exceed the lower of the provider's usual and customary charges or the Medicaid fee schedule in effect on the date services were provided. The Medicaid fee schedule may include specific fees for services and/or a methodology for establishing such fees. The fee schedule is available upon request from the Department.

Section 12. Payment of Claims.

(a) Medicaid is the payer of last resort. A provider may not seek Medicaid payment for services furnished to a client until payment from third parties has been sought pursuant to Wyoming Medicaid Rules Chapter 35.

(b) For Medicaid enrolled providers, if the service is a covered service, a provider may not request, receive or attempt to collect any payment from the client or the client's family for the service, with the exception of section 9(c) of this Chapter. The provider shall accept the Medicaid allowable payment as payment in full for the services.

(c) A provider that provides a noncovered service to a client may seek payment from the client if the provider informed the client in writing of the client's potential liability before providing the service, and the client agreed in writing to pay for such services before they were furnished.

(d) A provider that provides a covered service to a client that is in excess of service limits may seek payment from the client if the provider informed the client in writing of the client's potential liability before providing the service, and the client agreed in writing to pay for such services before they were furnished.

(e) A provider may seek copayment from clients as permitted by Department policy as reflected in the Department's manuals and bulletins. The amount of the permitted copayment shall be automatically deducted by the Department from the Medicaid Allowable Payment. Collection of a permitted copayment is at the discretion of the provider.

Section 13. Submission of Claims.

(a) The Department shall deny claims which are improperly submitted or which contain errors of any kind. Such claims may be resubmitted, subject to applicable federal and state requirements.

(b) A provider shall not bill the Department in excess of the provider's usual and customary charge for the service. The provider shall not bill the client or the Department for administrative fees such as standard processing or late fees.

(c) An individual provider shall not submit claims for reimbursement unless the services were rendered personally by that provider, or by an intern or resident while acting under the clinical supervision of that provider when allowed by applicable licensing or credentialing bodies. A provider entity shall not submit claims for reimbursement unless the services were rendered by qualified employed or contracted personnel acting under the supervision and control of the provider entity.

(d) A provider may seek Medicaid payment through a business agent for services furnished to a client by the provider if the business agent's compensation is related to the actual cost of processing the billing, is not related on a percentage or other basis to the amount of the claim, and is not dependent upon payment of the claim.

(e) A provider is responsible for all claims, whether submitted directly or through an agent, designee, employee or other intermediary.

(f) Any loss of Medicaid reimbursement caused by provider error is the responsibility of the provider and the provider may not bill the client for such services.

(g) A provider shall complete all required documentation, including required signatures, prior to claims submission to the Department. Documentation prepared or completed after the submission of the claim may be deemed by the Department or its designee as insufficient to substantiate the claim, in which case Medicaid funds shall be withheld or recovered.

(i) Claims shall be submitted to the Department in the manner and on the forms specified by the Department.

(ii) Claims shall include prior authorization number, if applicable, and

(iii) Claims shall include other documentation or records as the Department may request as outlined in the applicable Medicaid provider manual.

(iv) Claims submitted to the Department for standard processing, among other requirements shall include:

(A) Valid client identification (ID) number for the client of service;

(B) Valid provider NPI number and taxonomy for the service provided, including specification of the rendering provider as applicable;

(C) Valid billing and diagnosis codes as established by the Department;

(D) Appropriate billing code units as established by the Department; and,

(E) Other provider or specific claim fields as required for a "clean claim" by the Department.

(v) Any paid claim that does not meet the claims submission criteria established by the Department will be voided after appropriate provider notification. "Claim voids" conducted under this authority shall not be subject to reconsideration or the administrative hearing process described in Wyoming Medicaid Rules Chapter 4.

(vi) The Department shall deny claims not timely submitted. Claims shall be submitted and finalized on or before twelve (12) months after the date of service or the date of discharge, whichever is later, except for the following:

(A) Medicare cross-over claims shall be submitted within six (6) months after the date Medicare acts on the claim; or

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

Section 14. The Department shall recover overpayments pursuant to the Wyoming Medicaid Rules Chapter 16. In addition to using its own internal processes for recovery of overpayments, the Department may refer a matter involving suspected overpayments to the MFCU at any time.