Health, Department of

Medicaid

Chapter 26: Covered Services

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CHAPTER 26

Rules and Regulations for Medicaid

Covered Services

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W. S. § 42-4-104 and the Wyoming Administrative Procedures~~s~~ Act at W. S. § 16-3-102.

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to establish the scope of covered services, except as otherwise specified in the rules of the Department, and shall apply to all clients and providers for all services furnished on or after the Chapter's effective date.

(b) The requirements of Title XIX of the Social Security Act; Code of Federal Regulations Title 42, Sections 136 Subpart C, 435.1009, 440.165, 441 Subparts E and F, 482 Subpart D; Indian HealthCare Improvement Act, Section 4, 25 U.S.C. 1603; National Council on Interpreting in Healthcare; Wyoming State Plan Amendment Attachment 4.18-A, Supplement 1 to Attachment 3.1A; Wyoming Statute Section 33-21-119; also apply to Medicaid and shall be incorporated by this reference as of the effective date of this Chapter, and may be cross-referenced throughout this Chapter where applicable. This incorporation by reference does not include any later amendments or editions of the incorporated matter. The incorporated matter may be viewed at http://www.socialsecurity.gov/OP_Home/ssact/title19/1900.htm; http://www.ecfr.gov/cgi-bin/ECFR; http://www.ihs.gov/ihcia/; http://www.ncihc.org/; www.health.wyo.gov; http://legisweb.state.wy.us/statutes/dlstatutes.htm; or may be obtained at cost from the Department.

Section 3. Incorporation by Reference.

(a) For any rule incorporated by reference in these rules:

(i) The Department of Health has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does to include any later amendments or editions of the incorporated matter beyond adoption of this Rule; and

(iii) The incorporated rule is maintained at the WDH and is available

for public inspection and copying at cost at the same location.

(b) Each rule incorporated by reference, in addition to those cited in (b) of Section 2 is further identified as follows:

(i) Abortions - 42 C.F.R. § 441 Subpart E;

(ii) Case Management Services Targeted Groups - Supplement 1 to Attachment 3.1A of the Wyoming State Plan

(iii) Co-payments - State Plan Amendment 4.18-A

(iv) Emergency Hospital Services – 42 C.F.R. § 440.170(e) and 42 C.F.R. § 482.55;

(v) Nurse Midwife Services - 42 C.F.R. § 440.165;

(vi) Public Institution - 42 C.F.R. § 435.1009;

(vii) Sterilizations - 42 C.F.R. § 441 Subpart F.

Section 4. Definitions.

Except as otherwise specified in Chapter 1, or as specified herein, the terminology used in this Chapter is the standard terminology and has the standard meaning as used in health care, Medicaid and Medicare.

(a) "Ambulatory Surgical Center (ASC) Services." ASC services are surgical procedures or other services offered by an ASC facility that do not require overnight inpatient hospital care.

(b) "Audiologist." A person licensed to practice audiology by the Wyoming Board of Examiners of Speech Pathology and Audiologists or a similar agency in another state.

(c) "Audiology Services." Audiology services are services necessary to test hearing function with evaluation of medical problems and evaluate for hearing aid use.

(d) "Certified Registered Nurse Anesthetist (CRNA) Services." CRNA services are anesthesia services provided by a CRNA at a hospital or ASC.

(e) "Chiropractic Services" Chiropractic services are manual manipulation

services provided by a licensed chiropractor.

(f) "Chiropractor" A chiropractor is an individual licensed by the Wyoming Board of Chiropractic Examiners or by a similar agency in another state as a chiropractor.

(g) "Dental Services." Dental services are professional services and dental appliances furnished by a dentist within the scope of his/her practice.

(h) "Developmental center." An agency which:

(i) Provides developmental services to developmentally disabled children under the age of six; and

(ii) Is certified to provide services to clients under age twenty-one by the Division of Developmental Disabilities.

(i) "Developmental Center Services." Services provided to developmentally disabled clients under age twenty-one as part of an individualized education plan or as part of an individualized family services plan.

(j) "Diagnostic evaluation/assessment." A comprehensive, multi-disciplinary evaluation of a child five years of age or under, that:

(i) Is performed after a written referral from a physician licensed in Wyoming;

(ii) Is performed using standardized assessment tools or, if no standardized assessment tools are available based on the child's chronological age or suspected developmental age, using criterion based assessments; and

(iii) Includes an assessment of the following:

(A) Physical development, including fine and gross motor skills;

(B) Cognitive development;

(C) Speech development; and

(D) Social and emotional development.

(k) "Emergency hospital services." Emergency hospital services as defined in 42 C.F.R. § 440.170(e)

(l) "End Stage Renal Dialysis (ESRD) Services." ESRD services are services

for outpatient dialysis and other treatment for persons with end-stage renal disease.

(m) "Family Planning Clinic Services." Family Planning Clinic Services are services for medically approved diagnosis, treatment, counseling, contraceptive supplies or devices, which are prescribed or furnished to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.

(n) "Hospice Services." Hospice services are a program of care delivered in a person's home or health care facility that provides reasonable and necessary medical and support services for the management of a terminal illness.

(o) "Independent occupational therapist." An independent occupational therapist is licensed by the Wyoming State Board of Occupational Therapy or a similar agency in another state. An independent occupational therapist is neither employed by, directly affiliated with, nor working under the supervision of a hospital, nursing facility, physician or other provider of health.

(p) "Independent physical therapist." An independent physical therapist is licensed by the Wyoming State Board of Physical Therapy or a similar agency in another state as an independent physical therapist. An "independent physical therapist" is neither employed by, directly affiliated with, nor working under the supervision of a hospital, nursing facility, physician or other provider of health services.

(q) "Interpretation Services." Interpretation Services are those services that assist clients with oral or sign language interpretation.

(r) "Nurse midwife services" as defined in 42 C.F.R. § 440.165

(s) "Ophthalmologist." A physician who has successfully completed a postgraduate ophthalmology program of at least three years duration that is accredited by the American Board of Ophthalmology.

(t) "Optometrist." A person licensed to practice optometry by the Wyoming State Board of Examiners of Optometry or a similar agency in another state.

(u) "Physician assistant." A person certified as a physician assistant by the Wyoming State Board of Medical Examiners or a similar agency in another state.

(v) "Physician Services." Physician services are professional services furnished by or under the supervision of a licensed physician.

(w) "Preventive services." Any routine service or examination which is performed in the absence of a diagnosed illness, injury or complaint.

(x) "Public institution." Public institution as defined in 42 C.F.R. § 435.1009.

(y) "Radiology Services." Professional or technical services in which X-rays or scans are used for diagnostic or therapeutic purposes.

(z) "Speech Therapy Services." Outpatient services provided by or under the direct supervision of a licensed speech therapist pursuant to written orders of a physician.

(aa) "Vision Services." Professional services and corrective lenses furnished by a licensed optometrist, optician, or licensed ophthalmologist within the scope of his/her practice.

Section 5. Covered Services.

(a) The services and supplies specified in subsection (b) are covered services if medically necessary, subject to any exclusions or limitations contained in this Chapter and the rules of the Department.

(b) Covered services:

(i) Administrative transportation;

(ii) Advanced Practitioner of Nursing (APN) services in accordance with Section 7;

(iii) Ambulance services;

(iv) Ambulatory Surgical Center (ASC) services in accordance with Section 8;

(v) Audiology services and hearing aids in accordance with Section 9;

(vi) Certified Registered Nurse Anesthetist (CRNA) services in accordance with Section 10;

(vii) Certified Community Mental Health Center services (CMHC);

(viii) Chiropractic Services in accordance with section 11;

(ix) Comprehensive Outpatient Rehabilitation Facility (CORF) services in accordance with Section 12;

(x) Dental services in accordance with Section 13;

(xi) Developmental center services in accordance with Section 14;

(xii) Emergency hospital services in accordance with 42 C.F.R. § 482.55 and Section 15;

(xiii) Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

(xiv) End-Stage Renal Dialysis center services (ESRD) in accordance with Section 16;

(xv) Family planning clinic services in accordance with Section 17;

(xvi) Federally Qualified Health Center (FQHC) services;

(xvii) Certified Substance Abuse Treatment Center (SATC) services;

(xviii) Home and Community Based Services (HCBS);

(xix) Home health services;

(xx) Hospice services in accordance with Section 18;

(xxi) Hospital services (inpatient and outpatient) in accordance with Section 19;

(xxii) Intermediate Care Facility for the Intellectually Disabled (ICF/ID) services;

(xxiii) Institution for mental disease (IMD) services furnished to individuals sixty-five years of age and older;

(xxiv) Interpretation services in accordance with Section 20;

(xxv) Laboratory services in accordance with Section 21;

(xxvi) Medical supplies and equipment;

(xxvii) Nurse midwife services in accordance with Section 22;

(xxviii) Nursing facility services;

(xxix) Occupational therapy services in accordance with Section 23;

(xxx) Pharmaceutical services;

(xxxi) Physical therapy services in accordance with Section 24;

(xxxii) Physician services in accordance with Section 25;

(xxxiii) Psychiatric Residential Treatment Facility (PRTF) services;

(xxxiv) Psychological services;

(xxxv) Radiology services in accordance with Section 26;

(xxxvi) Rural Health Clinic (RHC) services;

(xxxvii) Solid organ transplants and bone marrow transplants

(a) For clients over the age of 21, transplants limited to bone marrow, kidney, and liver;

(xxxviii) Speech therapy services in accordance with Section 27;

(xxxix) Swing-bed services;

(xl) Targeted case management in accordance with Section 28;

(xli) Vision services in accordance with Section 29; and

(xlii) Weight reduction treatment, including intestinal bypass surgery, gastric bypass surgery, and gastric stapling.

Section 6. Services Not Covered.

(a) Services furnished without the consent of the client or the client's legal guardian, except in an emergency;

(b) Experimental procedures which are not generally accepted or used by a provider's peer group as current or standard practice;

(c) Examinations or reports required for legal purposes or other purposes not specifically related to medical care;

(d) Services furnished outside the United States;

(e) Services furnished to an individual who is an inmate of a public institution,

or an individual that is in the custody of a state, local, or federal law enforcement agency;

(f) Services provided to an individual during the first seventy-two (72) hours of emergency detention;

(g) Services which exceed the service limitations(cap limits) established by the rules of the Department, unless pre-approved;

(h) Services provided pursuant to a court order if such services:

(i) Are not covered services;

(ii) Exceed service limitations;

(iii) Are furnished by a health care practitioner or facility that is not a provider on the date(s) of services;

(iv) Have not received prior authorization, if applicable; or

(v) Have not received admission certification, if applicable.

(i) The following medical services:

(i) Abortions, except to the extent required by federal law, 42 C.F.R. § 441 Subpart E;

(ii) Acupuncture;

(iii) Alcohol and chemical rehabilitation furnished to an inpatient, except for purposes of detoxification and/or stabilization of acute conditions;

(iv) Autopsies;

(v) Biofeedback therapies and equipment;

(vi) Chronic pain rehabilitation;

(vii) Community mental health services furnished outside Wyoming;

(viii) Cosmetic procedures, except as specified in Section 23 of this Chapter;

(ix) Custodial care such as non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or

chair, moving around, and using the bathroom.;

(x) Infertility services, including counseling, reverse sterilization and artificial insemination;

(xi) Missed or canceled appointments;

(xii) Personal comfort items;

(xiii) Private-duty nursing services;

(xiv) Residential Treatment Centers (RTCs)

(xv) Sterilizations, unless the requirements of 42 C.F.R. § 441 Subpart F are satisfied; and

(xvi) Gender reassignment surgery

Section 7. Advanced Nurse Practitioner Services.

(a) Eligible providers. Advanced Nurse Practitioners, independently or in collaboration with a physician.

(b) Covered services.

a. Professional services furnished by an advanced nurse practitioner, which are within the scope of the nurse practitioner's practice as permitted by the Wyoming Nurse Practice Act.

Section 8. Ambulatory Surgical Center (ASC) Services.

(a) Eligible providers. A facility or distinct portion of a facility certified under Medicare to provide ASC services.

(b) Covered services.

(i) All surgical procedures covered by Medicare; and

(ii) Additional surgical procedures approved by Medicaid and which may be provided as outpatient hospital services.

Section 9. Audiology Services and Hearing Aids.

(a) Eligible providers. Physicians, independently practicing licensed

audiologists or hearing aid equipment providers.

(b) Covered services.

(i) Audiologic function tests;

(ii) Hearing aid examinations; and

(iii) Hearing aid equipment.

Section 10. Certified Registered Nurse Anesthetist (CRNA) Services.

(a) Eligible providers. Hospitals and physicians that employ a CRNA or independently practicing CRNAs.

(b) Covered services. Anesthesia services, except as otherwise specified by the rules of the Department.

(c) Excluded services. Anesthesia services when performed in conjunction with a surgical procedure:

(i) That is not a covered service;

(ii) For which prior authorization is required, but has not been obtained; or

(iii) For which the client has not given informed consent.

Section 11. Chiropractic Services

(a) Eligible providers. Licensed chiropractors

(b) Covered services.

(i) Restorative services furnished in response to physical debilitation caused by acute physical trauma or physical illness;

(ii) Medically necessary professional services furnished by a chiropractor

(c) Service limitations.

(i) Medicaid reimbursement for Chiropractic treatment(s) shall be limited to a total of twenty (20) visits per calendar year, unless pre-approved.

(ii) Medicaid reimbursement for Evaluation and Management shall be limited to a total of twelve (12) visits per calendar year and is inclusive of all outpatient medical services provided by a chiropractor, physician, nurse practitioner, ophthalmologist, physician assistant, and optometrist and to the outpatient department of a hospital. The limitations of this subsection shall not apply to:

(i) A client who is under age twenty-one (21);

(ii) Pregnant woman

Section 12. Comprehensive Outpatient Rehabilitation Facility (CORF) Services.

(a) Eligible providers. Facilities certified by Medicare as a CORF.

(b) CORF services are limited to:

(i) Drugs and biologicals that cannot be self-administered;

(ii) Medical supplies and equipment;

(iii) Nursing services;

(iv) Occupational therapy;

(v) Orthotics and prosthetics;

(vi) Physician services;

(vii) Physical therapy;

(viii) Respiratory therapy;

(ix) Social or psychological services; and

(x) Speech therapy.

(c) Excluded services.

(i) Services directed at general conditioning and/or maintenance; and

(ii) Services that exceed the limitations imposed by this and the other rules of the Department.

Section 13. Dental Services.

(a) Covered services for clients under the age of twenty-one (21):

(i) Preventive visits;

(ii) Restorative fillings, crowns, and tooth replacement;

(iii) Extractions;

(iv) Partial or complete dentures;

(v) Root canal therapy;

(vi) Periodontal treatment;

(vii) Oral and maxillofacial surgery;

(viii) Orthodontic treatment for severe malocclusions; and

(ix) Palliative treatment.

(b) Covered services for clients age twenty-one (21) and older:

(i) Preventive visits;

(ii) Restorative fillings;

(iii) Extractions;

(iv) Partial or complete dentures;

(v) Palliative treatment; and

(vi) Oral and maxillofacial surgery.

Section 14. Developmental Center Services.

(a) Eligible providers. Developmental centers certified by the Developmental Disabilities Division and under contract with that Division to provide such services.

(b) Covered services. Diagnostic assessment and evaluation, behavioral health, speech, physical and occupational therapy services and case management services.

Section 15. Emergency Hospital Services. Emergency hospital services are covered at the most accessible enrolled hospital available that is equipped to furnish

appropriate emergency hospital services.

Section 16. End Stage Renal Dialysis (ESRD) Services.

(a) Covered services must be provided by free-standing or hospital-based facilities certified by Medicare to provide ESRD services.

(b) Covered services. ESRD services as defined by Medicare, which is incorporated by this reference.

Section 17. Family Planning Clinic Services.

(a) Eligible Providers. A clinic, which is neither located on the premises of a hospital nor owned by a hospital, which meets the minimum requirements for routine contraceptive management as specified by the state Public Health Division. A laboratory in a clinic shall be licensed by the State of Wyoming.

(b) Covered Services. The following services when furnished under the supervision of a physician who is directly affiliated with the clinic. A physician is directly affiliated with the clinic if there is a contract between the physician and the clinic under which the physician is obligated to supervise the care furnished to the clinic's patients:

(i) Office visits;

(ii) Contraceptive supplies and devices;

(iii) Laboratory tests; and

(iv) Counseling.

Section 18. Hospice Services.

(a) Eligible providers. Hospice providers certified by Medicare and located within the State of Wyoming. Services provided by a hospice provider located outside the State of Wyoming shall not be eligible for Medicaid reimbursement unless the services are pre-approved.

(b) Covered services. The following services shall be covered if provided pursuant to a written plan of care established by the hospice provider and approved by the client’s attending physician:

(i) Routine home care;

(ii) Continuous home care;

(iii) Inpatient respite care;

(iv) General inpatient care;

(v) Hospice, nursing facility room and board; and

(vi) Hospice, inpatient hospice facility room and board.

(c) Limitations. During the time a client elects to receive hospice services, the client shall waive all rights to Medicaid payments for the following services:

(i) Hospice services provided by a provider other than the hospice provider designated by the client (unless provided under arrangements by the designated hospice); and

(ii) Any Medicaid services that are related to the treatment of the terminal illness (or a related condition) for which hospice services were elected, or services that are equivalent to hospice services, except for services:

(A) Provided by the designated hospice, either directly or by arrangement with another provider;

(B) Provided by the client's attending physician if that physician is neither an employee of the designated hospice nor receiving compensation from the hospice for furnishing such services;

(C) Provided as room and board by a nursing facility if the client is a resident of a nursing facility;

(D) Provided by a Home and Community Based Waiver; or

(E) Delivered to a client under the age of twenty-one (21) years. Clients under the age of twenty-one (21) shall be eligible for curative services as well as terminal illness hospice care.

(d) Medicaid allowable payment. The Medicaid allowable payment shall be determined as follows:

(i) The Medicaid allowable payment to the hospice provider for room and board furnished in a nursing facility shall be ninety-five percent (95%) of the nursing facility's per diem rate as determined pursuant to Chapter 7. The hospice provider shall be responsible for paying the nursing facility for the room and board services furnished to a client of hospice services.

(ii) Clients receiving hospice services in an inpatient hospice facility

that do not meet eligibility criteria for inpatient hospice care billing may receive room and board payments to the approved inpatient hospice facility. Payments for room and board shall not exceed fifty percent (50%) of the average Wyoming Medicaid nursing home room and board rate.

(iii) Total Medicaid payments to a hospice provider for inpatient care furnished to clients of hospice services shall not exceed twenty percent (20%) of the aggregate number of days of hospice care provided by the hospice provider to all Medicaid clients during the applicable twelve-month period. The limit shall be applied as follows:

(A) For each twelve-month period beginning on each November 1, the Department shall determine the aggregate number of days of inpatient care furnished by each hospice provider to clients of hospice services (the number of days of inpatient care shall include general inpatient care and inpatient respite care); and

(B) If payments for inpatient services exceed twenty percent (20%) of the total days of Medicaid services, the Medicaid payments for such services shall be considered overpayments, and shall be recovered pursuant to Chapter 16.

Section 19. Hospital Services.

(a) Hospital Services (including ancillary services provided in a hospital) shall be covered services if provided:

(i) Pursuant to the written orders of a licensed physician; and

(ii) By or under the supervision of a licensed physician.

(iii) Inpatient Hospital Limited Services. Psychiatric Services. Psychiatric services are limited to stabilization of acute conditions. Such services shall only be covered services when:

(A) The client is evaluated by a multidisciplinary team within forty-eight (48) hours after admission;

(B) The multidisciplinary team prepares an individualized treatment plan; and

(C) The medical record documents a plan of active treatment and individual, group, or family therapy directed to achieve the goals specified in the individualized treatment plan.

(a) Outpatient Hospital Limited and Non-covered Services.

(i) Medicaid reimbursement for outpatient hospital services shall be limited to a total of twelve (12) visits per calendar year to a hospital clinic, a hospital emergency room (for non-emergency services), and/or a physician's office, unless additional visits are pre-approved.

(ii) Exceptions. The limitations of subsection (b)(i) shall not apply to:

(A) An individual seeking emergency services who is diagnosed with an emergent condition;

(B) An individual seeking family planning services;

(C) A client who is under age twenty-one (21);

(D) A pregnant woman;

(E) Items and services furnished directly by the Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through a referral under a purchase order contract health services (as described in 42 C.F.R. § Part 136 Subpart C) to an American Indian or Alaskan Native who is enrolled as a member of a Federally-Recognized Tribe or otherwise meets the definition of "Indian" at Section 4 of the Indian Healthcare Improvement Act (25 U.S.C. §1608);

(F) A resident of a nursing facility; or

(G) A client who is also eligible for Medicare and where Medicare has reimbursed the provider for the claim.

Section 20. Interpretation Services.

(a) Interpreters shall adhere to national standards developed by the National Council on Interpreting in Healthcare (NCIHC), to include accuracy, confidentiality, impartiality, role boundaries, professionalism, professional development, and advocacy.

(b) Covered Services. The interpretation provider shall only bill for time spent with the client.

(i) Excluded services. Interpreter services in conjunction with the following services:

(A) Inpatient and outpatient services;

(B) Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID);

(C) Nursing Facilities;

(D) Ambulance Services by public providers;

(E) Psychiatric Residential Treatment Facility (PRTF) services;

(F) Comprehensive Inpatient and Outpatient Rehabilitation Facilities; and

(G) Services provided by other agencies/organizations receiving federal funding.

(H) Interpreter services provided by a family member, volunteer, associate, or friend; and

(I) Reimbursement for interpreter travel to and from the appointment.

Section 21. Laboratory Services.

(a) Eligible providers. Independent laboratories certified by Medicare, hospitals, and physicians with a laboratory licensed by the state in which the laboratory is located.

(b) Covered services. Professional or technical laboratory services ordered by a licensed provider under their scope of practice which are directly related to the diagnosis and treatment of the patient as specified in the treatment plan developed by the ordering provider.

(c) Excluded services:

(i) Handling charges where a specimen is referred by one (1) laboratory to another;

(ii) Post-mortem examinations;

(iii) Fees charged to obtain immediate results;

(iv) Technician callback fees.

(b) Limited services:

(i) Specimen collection fees shall be paid only to the provider that

collects the specimen from the client;

(ii) Only one collection fee shall be allowed for each type of specimen for each client encounter, regardless of the number of specimens extracted; and

(iii) Clinical laboratory services routinely performed by non-physicians shall not be entitled to a professional component.

Section 22. Nurse Midwife Services.

(a) Covered services. Professional services furnished by a licensed nurse midwife, in collaboration with a physician, throughout the maternity period, which are within the scope of the nurse midwife's practice as permitted by the Wyoming Nursing Practice Act (W.S. § 33-21-119, et seq.).

(b) Excluded and limited services. Services furnished in a hospital or a clinic shall be covered only to the extent the facility permits such services.

Section 23. Occupational therapy services.

(a) Eligible providers. Licensed independent occupational therapists, hospitals, physicians, PRTFs, and developmental centers that employ licensed occupational therapists.

(b) Covered services.

(i) Restorative occupational therapy services furnished in response to physical debilitation caused by acute physical trauma or physical illness as prescribed by a physician;

(ii) Occupational therapy services prescribed while the client was an inpatient and continuing on an outpatient basis;

(iii) Occupational therapy services furnished in a developmental center or PRTF to a client pursuant to:

(A) Individualized education plan (IEP) developed by the school system or a~~n~~ PRTF; or

(B) Individualized family services plan developed by a developmental center.

(c) Service limitations.

(i) Medicaid reimbursement for client occupational therapy visits shall be limited to twenty (20) visits per calendar year, unless pre-approved.

(ii) Except as otherwise specified in this Chapter, physical, occupational, or speech therapy services shall be covered if prescribed by the attending physician and re-certified by the attending physician every thirty (30) days.

Section 24. Physical Therapy Services.

(a) Eligible providers. Licensed independent physical therapists, physicians, hospitals, PRTFs, and developmental centers that employ licensed physical therapists.

(b) Covered services.

(i) Restorative physical therapy services furnished in response to physical debilitation caused by acute physical trauma or physical illness as prescribed by a physician;

(ii) Physical therapy services prescribed while the client was an inpatient and continuing on an outpatient basis;

(iii) Physical therapy services prescribed as a direct result of outpatient surgery required as a result of an injury; and

(iv) Physical therapy services provided to a client under age twenty-one (21) with chronic disabilities when furnished by a developmental center or PRTF pursuant to an:

(A) Individualized education plan developed by the school system or PRTF; or

(B) Individualized family services plan developed by a developmental center.

(c) Service limitations.

(i) Medicaid reimbursement for client physical therapy visits shall be limited to a total of twenty (20) visits per calendar year, unless pre-approved.

(ii) Except as otherwise specified in this Chapter, physical, occupational, or speech therapy services shall be covered if prescribed by the attending physician and re-certified by the attending physician every thirty (30) days.

Section 25. Physician Services.

(a) Covered services. Medically necessary professional services furnished by or under the supervision of a licensed physician, except as otherwise specified by this

Chapter.

(b) Excluded or limited services:

(i) Anesthesia services shall be limited as follows:

(A) An anesthesiologist shall not receive Medicaid reimbursement for a consultation in addition to any other anesthesia services for the same surgery.

(B) Anesthesia services shall not be covered when performed in conjunction with a:

(I) Non-covered surgical procedure; or

(II) Procedure requiring client consent if proper consent was not obtained.

(ii) The following allergy and clinical immunotherapy services are excluded:

(A) Sublingual, intracutaneous and subcutaneous provocative and neutralization testing; and

(C) Neutralization therapy for food allergies.

(iii) Cosmetic surgery:

(A) Services intended solely to improve an individual's physical appearance and which do not restore bodily function or correct a physical deformity are excluded.

(B) Reconstructive surgery procedures which are intended to improve bodily functions and the appearance of a body area which has been altered by disease, trauma, congenital or developmental anomalies or previous surgical procedures shall be covered only if prior authorized.

(iv) Dermatology. The following shall be excluded:

(A) Removal of lesions not suspected to be precancerous, unless medically necessary to restore a bodily function; and

(B) Services performed primarily for cosmetic reasons.

(v) Medical supplies. Expendable medical supplies normally used in a physician's office shall be included in the Medicaid payment for the office visit or test performed. The actual cost of special expendable supplies prescribed for home use by a client may be separately billed to Medicaid;

(vi) Prolonged care shall be limited to a total of three (3) hours per day unless there is documentation in the medical records that additional prolonged care was medically necessary;

(vii) Sterilizations shall not be covered unless the requirements of 42 C.F.R. § 441 Subpart F are satisfied, which is incorporated by this reference;

(viii) Therapeutic injections shall not be covered unless:

(A) The drug cannot be administered orally;

(B) The drug cannot be self-administered; and

(C) The drug is reasonable and necessary for treatment of the client's diagnosed condition.

(c) Service Limitations. Medicaid reimbursement for client visits to a physician, ophthalmologist, physician assistant, nurse practitioner, or optometrist and to the outpatient department of a hospital shall be limited to a total of twelve (12) visits per calendar year, unless pre-approved. The limitations of this subsection shall not apply to:

(i) A client seeking emergency services who is diagnosed with an emergent condition;

(i) A client seeking family planning services;

(ii) A client who is under age twenty-one (21);

(iii) A pregnant woman;

(iv) Items and services furnished directly by the Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through a referral under a purchase order contract health services (as described in 42 C.F.R. § Part 136 Subpart C) to an American Indian or Alaskan Native who is enrolled as a member of a Federally-Recognized Tribe or otherwise meets the definition of a "Indian" as Section 4 of the Indian Healthcare Improvement Act (25 U.S.C. §1608);

(v) A resident of a nursing facility; or

(vi) A client who is also eligible for Medicare and where Medicare has reimbursed the provider for the claim.

Section 26. Radiology Services.

(a) Eligible providers. Licensed independent radiology practices, hospitals, chiropractors and physician practices.

(b) Excluded services:

(i) Unordered X-rays;

(ii) Separate consultations procedures unless ordered by the attending physician;

(c) Limited services:

(i) Routine mammography is limited as follows:

(A) One mammography between the ages of thirty-five (35) and thirty-nine (39); and

(B) One mammography per year at age forty (40) and after.

(ii) Services performed in a physician's office shall be covered only if performed by or under the direct supervision of the physician.

(iii) Services performed in a hospital using equipment owned by the physician. The physician may bill for the total procedure if the technical component is not billed by the hospital.

Section 27. Speech Therapy Services.

(a) Eligible Providers. Independent licensed speech therapists, physicians, hospitals, PRTFs, and developmental centers that employ licensed speech therapists.

(b) Covered Services.

(i) Restorative speech therapy services furnished in response to physical debilitation caused by acute physical trauma or physical illness as prescribed by a physician;

(ii) Speech therapy services prescribed while the client was an inpatient and continuing on an outpatient basis;

(iii) Speech therapy prescribed as a direct result of outpatient surgery required as a result of an injury; and

(iv) Speech therapy services provided to a client under age twenty-one (21) with chronic disabilities when furnished by a developmental center or a PRTF pursuant to an:

(A) Individualized Education Plan (IEP) developed by the school system or PRTF; or

(B) Individualized family services plan developed by a developmental center.

(c) Service limitations. Medicaid reimbursement for client speech therapy visits shall be limited to twenty (20) visits per calendar year, unless pre-approved.

(d) Except as otherwise specified in this Chapter, physical, occupational, or speech therapy services shall be covered if prescribed by the attending physician and re-certified by the attending physician every thirty (30) days.

Section 28. Targeted Case Management Services.

(a) Eligible providers. Case managers.

(b) Covered services. Case management services provided only to the target groups defined in Supplement 1 to Attachment 3.1A of the Wyoming State Plan.

Section 29. Vision Services.

(a) Eligible providers. Licensed optometrist, opticians and licensed ophthalmologists.

(b) Covered services. Medical treatment for clients:

(i) At risk of eye diseases, including eye disease secondary to chronic illness; or

(ii) With eye injuries.

(c) Additional covered services for clients under twenty-one (21) years of age:

(i) Contact lenses if medically necessary;

(ii) Eyeglasses;

(iii) Photosensitive lenses if medically necessary;

(iv) Routine eye examinations; and

(v) Vision therapy.

Section 30. Client Co-Payments.

(a) Except as specified in subsection (c), clients who receive the following services shall make a co-payment:

(i) Chiropractor evaluation and management services;

(ii) Eye examinations;

(iii) FQHC services;

(iv) Physician services:

(A) Physician office visit;

(B) Physician home visit; and

(C) Psychiatric services.

(v) RHC services.

(vi) Hospital emergency room (non-emergent).

(vii) Pharmaceutical products.

(b) Co-payment amounts. Co-payment amounts shall be made as specified in State Plan Amendment 4.18-A.

(c) Exceptions. Co-payment requirements of this Section shall not apply to:

(i) Emergency services;

(ii) Family planning services;

(iii) Clients under the age of twenty-one (21);

(iv) Pregnant women;

(v) Residents of a nursing facility;

(vi) A client who is also eligible for Medicare and where Medicare has reimbursed the provider for the claim;

(vii) Items and services furnished directly to an American Indian or Alaska Native who is enrolled as a member of a Federally-Recognized Tribe or otherwise meets the definition of an "Indian" at Section 4 of the Indian HealthCare Improvement Act (25 U.S.C. § 1608);

(viii) Hospice services; and

(ix) Inpatient hospital stays.

(d) Collection of co-payment. Providers shall be responsible for collecting the co-payment. The amount of the co-payment shall be automatically deducted by the Department from the Medicaid allowable payment, regardless of whether the co-payment is actually paid. For purposes of this section, a provider shall not deny service to a client due to a client's inability to make the co-payment, unless a client "regularly" refuses to make co-payments.

Section 31. Recovery of Overpayments. The Department shall recover overpayments pursuant to the provisions of Chapter 16. A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of Chapter 16.

Section 32. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the federal, state or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments, or take any other final action authorized by this Chapter.

Section 33. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter 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 Chapter shall control the titles of various provisions.

Section 34. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in effect.