Health, Department of

Medicaid

Chapter 6: Health Check

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HEALTH CHECK (formerly EPSDT) PROGRAM

CHAPTER 6

Section 1. Authority. This rule is promulgated by the Department of Health pursuant to W.S. § 42-4-101 et seq. and the Wyoming Administrative Procedures Act at W. S. § 16-3-101 et seq.

Section 2. Applicability.

(a) This rule shall apply to and govern the provision of and reimbursement of HEALTH CHECK program services, formerly known as EPSDT services, provided to recipients under age twenty-one. It shall apply to all recipients and HEALTH CHECK providers.

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

Section 3. General Provisions.

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

(b) This Chapter is intended to be read consistently with applicable federal statutes, including OBRA '89, and HHS regulations.

Section 4. Definitions.

(a) "ACIP." The Advisory Committee for Immunization Practices of the Centers for Disease Control, United States Public Health Service, HHS.

(b) "Administrative transportation." Transportation by means other than an ambulance to obtain covered services.

(c) "Ambulance." An ambulance as defined by Chapter 15, which definition is incorporated by this reference.

(d) "Appropriate immunizations." Those immunizations recommended by the Division of Preventive Medicine, and the ACIP recommended schedule of vaccinations.

(e) "Appropriate laboratory tests." Those tests which a HEALTH CHECK provider determines to be appropriate for a recipient under age twenty-one. Appropriate laboratory tests may include a blood lead level test, anemia tests, sickle cell test, and tuberculin test.

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

(g) "Chapter 15." Chapter 15, Ambulance Services, of the Wyoming Medicaid rules.

(h) "Chapter 26." Chapter 26, Covered Services, of the Wyoming Medicaid rules.

(i) "Claim." A request by a HEALTH CHECK provider for payment of Medicaid funds for services provided to a recipient.

(j) "Covered service." Services provided to a recipient that may be reimbursed as provided in this Chapter.

(k) "Dental screening." An oral assessment of a recipient by a HEALTH CHECK provider.

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

(m) "Department of Family Services (DFS)." The Wyoming Department of Family Services, its designee, agent or successor.

(n) "Developmental screening." An examination of a recipient and an evaluation of a recipient's activities to determine whether he or she is within the normal range of achievement for the recipient's age group and cultural background.

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

(p) "Division of Preventive Medicine." The Division of Preventive Medicine of the Department, its successor, agent or designee.

(q) "Early and periodic screening, diagnosis and treatment services ("EPSDT)." Early and periodic screening, diagnosis and treatment services as defined in 42 U.S.C. § 1396d(r), which is incorporated by this reference.

(r) "Excess payments." Medicaid funds received by a HEALTH CHECK provider which exceed the Medicaid allowable payment.

(s) "Expanded services." Medically necessary health care, including diagnostic services and treatment, which are reimbursable pursuant to 42 U.S.C. § 1396d, and which are not otherwise reimbursable under the Wyoming Medicaid State Plan.

(t) "Eyecare practitioner." An optometrist or an ophthalmologist.

(u) "HEALTH CHECK." A comprehensive EPSDT screening examination of a well-child or young adult up to age twenty-one which includes all of the following:

(i) A comprehensive health and developmental history, including a developmental screening, a nutritional screening, and a mental health screening;

(ii) An unclothed physical examination;

(iii) Appropriate immunizations;

(iv) Appropriate laboratory tests;

(v) Age appropriate health education and counseling;

(vi) Vision screening;

(vii) Hearing screening;

(viii) Dental screening; and

(ix) Treatment or referral services for any diagnosed abnormalities.

(v) "HEALTH CHECK periodicity schedule." The periodicity schedule established pursuant to Section 9.

(w) "HEALTH CHECK program." The Wyoming EPSDT program.

(x) "HEALTH CHECK provider." A provider that meets the requirements of Section 5.

(y) "Health education and counseling." Education of and counseling to recipients and their parents or guardians to assist them in understanding the benefits of healthy lifestyle practices; accident and disease prevention; the services available under the HEALTH CHECK program and where and how to obtain them; and that medically necessary HEALTH CHECK services are available without cost to recipients under age twenty-one.

(z) "Hearing screening." Age-appropriate hearing screening.

(aa) "Lead screening verbal assessment." An evaluation of a recipient's exposure to dangerous levels of lead using the guidelines set forth by the Department from time to time in Manuals or HEALTH CHECK provider bulletins.

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

(cc) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and the Wyoming Medical Assistance and Services Act.

(dd) "Medicaid allowable payment." The maximum Medicaid reimbursement for covered services as specified by this Chapter.

(ee) "Medicaid fee schedule." The Medicaid fee schedule established pursuant to Chapter 3, which is incorporated by this reference.

(ff) “Medically necessary.” 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 services must be:

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

(ii) Recognized as the prevailing standard or current 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) Provided in the most efficient manner and/or setting consistent with appropriate care required by the recipient’s condition.

(gg) “Medicare.” The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

(hh) “Mental health screening.” A consideration by a HEALTH CHECK provider of a recipient’s social interaction, behavior, thinking patterns, feelings and physical problems.

(ii) “Non-medical services.” Services, supplies, items or equipment that are not medical in nature, as determined by the Division, even if medically necessary. “Non-medical services” includes, but is not limited to, communication assisted technology boards.

(jj) “Nurse midwife.” A registered nurse who is certified as a nurse midwife by the American College of Nurse-midwives.

(kk) “Nurse practitioner.” An “advanced practitioner of nursing” as defined by W.S. § 33-21-120(a)(i), which is incorporated by this reference, or a registered nurse that is certified or licensed as a nurse practitioner pursuant to the laws of another state.

(ll) “Nutritional screening.” A consideration by a HEALTH CHECK provider of a recipient’s nutritional status, eating habits, use of alcohol/drugs and tobacco.

(mm) “OBRA ’89.” The Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239.

(nn) “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.

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

(pp) “Physician.” A person licensed to practice medicine or osteopathy by the Wyoming State Board of Medical Examiners or a comparable agency in another state.

(qq) “Prior authorized.” Prior authorized pursuant to the procedures of Chapter 3, which are incorporated by this reference.

(rr) “Provider.” A provider as defined by Chapter 3, which definition is incorporated by this reference.

(ss) “Public health nurses.” A registered nurse who is either under contract to the county to perform public health nursing functions or is an employee of the Department that is assigned public health nursing functions.

(tt) “Recipient” or “recipient under age twenty-one.” An individual under age twenty-one that has been determined eligible for Medicaid. A recipient is under age twenty-one before or during the month in which he or she turns twenty-one years of age.

(uu) “Screening.” An evaluation of a recipient under age twenty-one by a HEALTH CHECK provider to determine the need for a full assessment by a qualified specialist. A screening includes a direct referral to an appropriate specialist when medically necessary.

(vv) “Services.” Health services, medical supplies or equipment.

(ww) “Treatment and referral services.” Medically necessary services that are reimbursable pursuant to the Wyoming State Medicaid Plan that are furnished to a recipient under age twenty-one by a provider after a referral from a HEALTH CHECK provider.

(xx) “Unclothed physical examination.” A physical examination pursuant to the guidelines set forth by the Department in Manuals or HEALTH CHECK provider bulletins.

(yy) “Usual and customary charge.” The provider’s charge to the general public for the same or similar services.

(zz) “Vision screening.” Administration by a HEALTH CHECK provider of age-appropriate vision screening which includes the following:

(i) General external examination and evaluation of ocular motility;

(ii) Visual acuity examination;

(iii) Pupillary light reflex test; and

(iv) Intraocular examination with an ophthalmoscope.

Section 5. Provider participation.

(a) Compliance with Chapter 3. An individual or entity which wishes to receive Medicaid funds for HEALTH CHECK program services furnished to a recipient must meet the requirements of Chapter 3, which requirements are incorporated by this reference.

(b) Eligible HEALTH CHECK providers. Physicians, nurse practitioners, nurse midwives and public health nurses that are:

(i) In public practice, including employees of federally qualified-health centers (FQHCs), rural health clinics (RTCs) and Indian Health Services Clinics, or private practice; and

(ii) Deliver primary care services.

Section 6. Provider Records.

(a) Compliance with Chapter 3. A HEALTH CHECK provider must comply with the record keeping requirements of Chapter 3, which are incorporated by this reference.

(b) HEALTH CHECK requirements. The medical record for each recipient that receives HEALTH CHECK services must include documentation that all required components of such services have been furnished.

Section 7. Verification of Recipient Data.

A HEALTH CHECK provider must comply with Chapter 3, Section 8, which is incorporated by this reference.

Section 8. Covered services.

(a) HEALTH CHECKs.

(b) Treatment and referral services. Treatment and referral services are covered pursuant to the other rules of the Department.

(c) Expanded services. Expanded services are covered services if:

(i) There is a physician referral;

(ii) Prior authorized, if required; and

(iii) Furnished in the most cost effective setting, as determined by the Division.

(d) Transportation services.

(i) Ambulance transportation. Ambulance transportation is covered pursuant to Chapter 15.

(ii) Administrative transportation. Necessary transportation to obtain covered services is available through the local office of DFS.

(e) Excluded services. HEALTH CHECK treatment and referral services or expanded services do not include:

(i) Services or treatments not approved by the FDA;

(ii) Experimental procedures;

(iii) Procedures that are not medically necessary;

(iv) Procedures that are not generally recognized as an accepted modality of medical practice or treatment;

(v) Educational services.

(f) Limits on services. HEALTH CHECK services otherwise reimbursable if furnished in a particular setting must be furnished in that setting and are subject to the reimbursement rules of the Department.

Section 9. Periodicity schedule.

(a) Frequency of HEALTH CHECKs. Recipients under age twenty-one should be screened pursuant to the Recommendations for Preventive Pediatric Health Care, which is incorporated by this reference. It is prepared and published by the American Academy of Pediatrics, and is available from the Academy.

(b) Dental examinations. Recipients under age twenty-one should be referred by a HEALTH CHECK provider to a dentist for an initial examination at approximately age three, assuming the recipient is able to cooperate during the examination. Thereafter, subsequent dental examinations are recommended every six months, or as frequently as recommended by a dentist or other appropriate provider.

(c) Hearing screens. All neonates should be screened before departing the hospital. HEALTH CHECK providers should perform pure tone testing at ages 4-10, 12 and 18 years. Subjective testing, by history, is recommended through 3 years, ages 11, 13-17 and 20+.

(d) Vision screens. Recipients under age twenty-one should be referred by a HEALTH CHECK provider for a vision examination by an eyecare practitioner at approximately age three, assuming the recipient is able to cooperate during the examination. Thereafter, subsequent vision examinations are recommended every twelve months, or as frequently as recommended by an eyecare practitioner.

(e) Interperiodic HEALTH CHECKs. HEALTH CHECKs, vision hearing and dental examinations may be provided whenever medically necessary to evaluate a suspected physical, developmental or mental problem. An interperiodic HEALTH CHECK must meet the standards of a regular HEALTH CHECK.

(f) School and sports physical. A HEALTH CHECK provider requested to do a school or sports physical should first determine when the most recent periodic HEALTH CHECK was completed.

(i) If the recipient is current according to the HEALTH CHECK periodicity sched-

ule, a complete HEALTH CHECK should be conducted.

(ii) If the recipient is not current according to the HEALTH CHECK periodicity schedule, the provider may bill only for a limited routine physical examination.

Section 10. Medicaid allowable payment.

(a) The Medicaid allowable payment for HEALTH CHECK services is the lower of the provider's usual and customary charge and the Medicaid fee schedule. Laboratory tests and immunizations are separately reimbursed at the lower of the provider's usual and customary charge and Medicaid fee schedule.

(b) Treatment and referral services. The Medicaid allowable payment for the referral and treatment of conditions detected during a HEALTH CHECK examination shall be determined pursuant to the rules of the Department.

(c) Expanded services. Expanded services are reimbursed:

(i) Pursuant to the other rules of the Department, if the expanded service is a covered services under any such rule; or

(ii) At the lower of the provider's usual and customary charge and the Medicaid fee schedule, if the expanded service is not a covered service under any of the Department's rules.

Section 11. Payment of Claims.

Payment of claims shall be pursuant to the procedures specified in Chapter 3, which are incorporated by this reference.

Section 12. Recovery of excess payments.

The Department may recover excess payments using the procedures specified in Chapter 3, which are incorporated by this reference.

Section 13. Reconsideration.

(a) Request for reconsideration. A provider may request that the Department reconsider a decision to recover excess payments. Such request must be mailed to the Department by certified mail, return receipt requested within twenty days of the date the facility receives notice pursuant to Section 12. 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 decision 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 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 thirty days after the date of the request. Failure to provide the requested information shall result in the dismissal of the request with prejudice.

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

(e) 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 a subsequent administrative hearing or judicial proceeding.

(f) 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, return receipt requested or personally delivering a request for hearing to the Department within twenty days of the date the provider receives notice of the final decision.

(g) Failure to request reconsideration. A provider which fails to request reconsideration pursuant to this section may not subsequently request an administrative hearing regarding the recovery of excess payments pursuant to Chapter I.

Section 14. Administrative hearing.

(a) Recipients. A recipient may request an administrative hearing pursuant to Chapter I regarding the denial or reduction of services.

(b) Procedures. A request for an administrative hearing must be made in conformance with Chapter I, and the hearing shall be held pursuant to Chapter I.

Section 15. Superseding effect. When promulgated, this Chapter supersedes all prior rules or policy statements issued by the Department regarding the EPSDT/HEALTH CHECK program, including provider manuals and provider bulletins, which are inconsistent with this Chapter.

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