Health, Department of

Medicaid

Chapter 3: Provider Participation

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WYOMING DEPARTMENT OF HEALTH

WYOMING MEDICAID RULES

CHAPTER 3

PROVIDER PARTICIPATION

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W. S. § 42-4-101 et seq and the Wyoming Administrative Procedures Act at W. S. §16-3-101 et seq.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern the participation in the Medicaid program of providers of covered services, except as otherwise specified in the rules of the Department.

(b) The Division may issue Provider Manuals, Provider Bulletins, or both, to interpret the provisions of this Chapter. Such Provider Manuals and Provider Bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in Provider Manuals or Provider Bulletins shall be subordinate to the provisions of this Chapter.

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

(a) "Business agent." A person or entity that submits a claim for or receives Medicaid funds on behalf of a provider.

(b) "Certified mail, return receipt requested." Certified mail, return receipt requested as provided by the United States Postal Service, or delivery via a commercial delivery service which provides tracking of the communication and written documentation of its delivery. "Certified mail, return receipt requested" does not include communication by facsimile transmission, telephone, or electronic mail.

(c) "Chapter 1." Chapter 1, Rules for Medicaid Administrative Fair Hearings, of the Wyoming Medicaid rules.

(d) "Chapter 2." Chapter 2, State Licensed Shelter Care Eligibility and Services, of the Wyoming Medicaid Rules.

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

(f) "Chapter 8." Chapter 8, Inpatient Hospital Certification, of the Wyoming Medicaid rules.

(g) "Chapter 16." Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid rules.

(h) "Chapter 35." Chapter 35, Medicaid Benefit Recovery, of the Wyoming Medicaid rules.

(i) "Chapter 38. Chapter 38, Safeguarding Information on Applicants and Recipients, of the Wyoming Medicaid rules.

(j) "Chapter 39." Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid rules.

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

(l) "Covered service." Services which are reimbursable pursuant to the rules of the Division.

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

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

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

(p) "Emergency." The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe 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.

(q) "Enrolled." A provider that has signed a provider agreement and has been enrolled as a provider with the Division.

(r) "Equipment." Items, including durable medical equipment, that are designed for repeated use, have a medical purpose and are intended for home use.

(s) "Excess payments." "Excess payments" as defined in Chapter 39, which definition is incorporated by this reference.

(t) "Federal Medicaid Percentage (FMAP)." "Federal medical assistance percentage as defined in 42 U.S.C. § 1396d(b), which definition is incorporated by this reference.

(u) "Financial records." All records, in whatever form, used or maintained by a provider in the conduct of its business affairs and which are necessary to substantiate or understand claims submitted to the Department.

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

(w) "Legally authorized representative." A minor child's parent or legal guardian; an individual's legal guardian; an attorney who asserts, in writing, that he or she represents an individual or entity; or any other person who is authorized in writing to act on behalf of an individual or entity. Any person, other than a parent acting on behalf of a minor child or an attorney who represents an individual or entity, must attach to the first document submitted to the Division a copy of a written authorization to act on behalf of the specified individual or entity with respect to the particular matter in question.

(x) "Local agency." The County office of DFS, its agent, designee, or successor.

(y) "Local trade area." The geographic area surrounding the recipient's residence, including portions of states other than Wyoming commonly used by other persons in the same area to obtain similar services.

(z) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act of 1967, as amended. "Medicaid" includes any successor or replacement program enacted by Congress or the Wyoming Legislature.

(aa) "Medicaid allowable payment." The maximum Medicaid reimbursement as determined pursuant to the rules of the Department.

(bb) "Medicaid funds." That combination of Federal Medicaid funds and State Medicaid funds which is available to the Division to make payments to providers. The federal portion shall be the FMAP. The state portion shall be the State Medicaid percentage.

(cc) "Medicaid Fraud Control Unit (MFCU)." The Medicaid Fraud Control Unit of the Wyoming Attorney General's Office, its agent, designee, or successor.

(dd) "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 most cost effective and appropriate setting required by the recipient's condition.

(ee) "Medical records." All records, in whatever form, in the possession of or subject to the control of a provider which describe the recipient's diagnosis, treatment or condition.

(ff) "Medicare." The health insurance program for the aged and disabled under Title XVIII of

the Social Security Act.

(gg) "Minimum Medical Program (MMP)." The Minimum Medical Program as established by the MMP rule.

(hh) MMP rule." Chapter 1, Minimum Medical Program, of the Department's rules.

(ii) "Overpayment." "Overpayment" as defined in Chapter 39, which definition is incorporated by this reference.

(jj) "Prior authorized." Approval by the Division pursuant to Section 9. "Prior authorized" does not include admission certification pursuant to Chapter 8.

(kk) "Provider." Any individual or entity that has a current provider agreement, is licensed and/or certified to provide services, and is enrolled with the Division.

(ll) "Provider agreement." A written contract between a provider and the Division in which the provider agrees to comply with the provisions of the provider agreement as a condition of receiving Medicaid payment for services provided to recipients.

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

(nn) "Residence." The place a recipient uses as his or her primary dwelling place and intends to continue to use indefinitely for that purpose.

(oo) "Service." Health services, medical supplies or equipment provided to a recipient.

(pp) "Service area." The State of Wyoming and the following cities or towns: Craig, Colorado; Idaho Falls, Montpelier and Pocatello, Idaho; Billings and Bozeman, Montana; Kimball and Scottsbluff, Nebraska; Belle Fourche, Custer, Deadwood, Rapid City and Spearfish, South Dakota; and Ogden and Salt Lake City, Utah.

(qq) "Service limitations." Limits on the quantity of covered services which are Medicaid reimbursable as set forth in the rules of the Department.

(rr) "State licensed shelter care." The state licensed shelter care program as established by Chapter 2.

(ss) "State Medicaid percentage." The state percentage as determined pursuant to 42 U.S.C. § 1396d(b).

(tt) "Third party payer." "Third party payer" as defined in Chapter 4, which definition is incorporated by this reference.

(uu) "Usual and customary charge." The provider's charge for comparable services provided to non-recipients.

Section 4. Provider Participation.

(a) Payments only to providers. No person or entity that provides services to a recipient shall receive Medicaid funds unless the person or entity is a party to a fully executed provider agreement and is enrolled.

(b) Enrollment as provider. An individual or entity which wishes to participate in the Medicaid program shall apply to be a provider on the forms specified by the Division. The Division shall review the application within ten working days after the date it receives the application and all necessary information, including supplemental information requested by the Division. If the application is not approved, the Division shall, in writing, specify the reasons for the decision and advise the applicant of its right to reapply.

(c) Duration of provider agreement. A provider agreement shall become effective when fully executed and shall remain in effect until terminated pursuant to subsection 4(d).

(d) Termination of provider agreement.

(i) A provider which loses its state licensure or Medicare certification, or which voluntarily withdraws from Medicare when Medicare certification is a prerequisite to Medicaid enrollment, shall be terminated as a provider effective the same date the provider loses Medicare certification or state licensure. The suspension or termination shall be the same as and shall run contemporaneously with the period of the provider's suspension or termination from Medicare or the period of voluntary non-participation, or the period for which it is not licensed; or

(ii) A provider agreement may be terminated pursuant to the provider agreement, Chapter 16 or as otherwise provided by law.

(e) Administrative remedies.

(i) A provider who is terminated as a Medicaid provider or otherwise sanctioned pursuant to Chapter 16 is entitled to reconsideration and an administrative hearing as set forth in that Chapter.

(ii) A provider whose provider agreement is terminated for cause pursuant to the provider agreement shall be entitled to reconsideration and an administrative hearing as set forth in this Chapter.

(f) Sale of provider.

(i) A provider agreement cannot be transferred at the time a provider is sold except in accordance with applicable law.

(ii) A provider which sells or otherwise transfers ownership or control of his or its practice, or which sells or otherwise transfers ownership or control of an entity which has a provider agreement, shall notify the Division, in writing, of the proposed sale or transfer no later than sixty days before the effective date of the sale or transfer. The failure to give such notice shall result in the termination of the provider agreement.

(iii) A change in the ownership or control of a provider as specified in paragraph 4(f)(ii) shall not relieve the provider of its obligations pursuant to the provider agreement and/or this Chapter.

(g) No assignment. No party to a provider agreement shall assign or otherwise transfer any of its rights pursuant to that agreement without the prior written consent of the other party.

(h) Not collateral. A provider shall not use a provider agreement as collateral for any of the provider's financial obligations.

Section 5. Conditions of Participation.

(a) Nondiscrimination. A provider shall not discriminate against any individual on the grounds of sex, race, color, religion, national origin or disability as required by Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. The provider shall not discriminate on the basis of age under the Age Discrimination Act of 1975, except as allowed by law.

(b) A provider must not restrict the services it will make available or the persons to whom it will provide services unless such restrictions apply to all persons.

(c) Compliance with Federal and State laws. A provider must comply with the Social Security Act, the Wyoming Medical Assistance and Services Act, and all rules promulgated under those Acts.

(d) Compliance with licensing and certification laws. A provider must comply with applicable licensing and certification standards as contained in Wyoming statutes and regulations or the statutes and regulations of the state in which the provider is located and/or the services are provided, and, where specified, Medicare certification standards.

(e) Safeguarding information. A provider shall comply with Chapter 38 and other applicable law in safeguarding information about applicants and recipients.

Section 6. Out-of-State Providers.

(a) Services furnished within service area. A service furnished by a provider located outside Wyoming, but within the service area, is Medicaid reimbursable if:

(i) The services are furnished in response to an emergency; or

(ii) The provider has entered a provider agreement;

and

(A) The service is not available in the recipient's local trade area; and

(B) The out-of-state provider is closer to the recipient's residence than a provider of comparable services within Wyoming.

(b) Services furnished outside the service area. Services furnished by a provider located outside

the service area are not Medicaid reimbursable unless:

(i) The service is furnished in response to an emergency;

(ii) The recipient is outside the service area and the recipient's health would be endangered if he were required to return to the service area;

(iii) The recipient is referred to a provider outside the service area when prior authorized and comparable services are not available within the service area; or

(iv) The recipient is less than 19 years of age; and

(A) Is a foster child not covered by Title IV-E of the Social Security Act and resides with a foster family out of state; or

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

(c) Retroactive enrollment. An individual or entity which furnishes services to a recipient prior to enrolling as a provider may enroll as a provider and receive Medicaid reimbursement for such services if the services are otherwise reimbursable pursuant to the rules of the Department. No Medicaid reimbursement shall be made before the provider seeking such reimbursement has enrolled.

Section 7. Provider Records.

(a) Retention. A provider shall maintain medical and financial records, including information regarding dates of services, diagnoses, services furnished, and claims, for at least six years after the end of the state fiscal year in which payment for services was rendered. If any litigation, claim, audit or other action involving the records is initiated before the expiration of the six years, the records must be maintained until the litigation, claim, audit or other action and any subsequent administrative or legal proceedings are resolved. Such records must be maintained for three years in hard-copy, after which they may be maintained on micro-fiche or micro-film.

(b) Documentation requirements. A provider must have completed all required documentation, including required signatures, before or at the time the provider submits a claim to the Division. Documentation prepared or completed after the submission of a claim will be deemed to be insufficient to substantiate the claim and Medicaid funds shall be withheld or recovered.

(c) Availability of records. A provider shall make financial or medical records available upon request to representatives of the Division, the United States Department of Health and Human Services, HCFA, the Comptroller General of the United States, the Wyoming Attorney General or the MFCU . Such visits may be made pursuant to Chapter 16, and may be announced or unannounced.

(d) Refusal to produce or maintain records. 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;

(ii) All Medicaid payments made to the provider during the record retention period

for which records supporting such payments are not produced shall be repaid to the Division within ten days after written request for such repayment; and

(iii) The suspension of all Medicaid payments for services furnished after such date.

(iv) Reimbursement shall not be reinstated until the Division determines that adequate records have been produced or are being maintained.

(e) Copying records. The Division may copy records pursuant to the record copying provisions of Chapter 16, which are incorporated by this reference.

Section 8. Verification of recipient data.

(a) Identification Coupons. The Division issues Medicaid identification coupons to recipients. Such coupons are valid only for the month and year shown on the coupons.

(b) An individual who seeks services and does not have a valid Medicaid identification coupon is responsible for all charges for such services unless the provider receives written verification of eligibility from the Division or local agency before providing services. If a provider receives payment from an individual that is later determined to be eligible for Medicaid, the provider must refund any such payment to the individual before seeking Medicaid reimbursement.

(c) Failure to notify provider of eligibility. If a provider furnishes services to an individual who fails to notify the provider that he or she is a recipient, the provider may submit a claim to Medicaid or seek reimbursement or payment from the recipient. A provider which elects to seek Medicaid reimbursement must accept such payment as payment in full.

(d) Retroactive eligibility. A provider that furnishes services to an individual that becomes a recipient after the date of services may submit a claim to the Division seeking Medicaid reimbursement for services furnished during the period the individual was eligible for Medicaid. The provider may receive reimbursement as provided by the rules of the Department.

Section 9. Prior authorization.

(a) Procedures. A provider seeking reimbursement for services that require prior authorization as specified in the rules of the Department must:

(i) Submission of information. The provider shall submit a written request to the Division, on the forms specified by the Division, requesting prior authorization before providing services. The Division may request additional information as necessary to review the request.

(ii) Criteria for review. Prior authorization shall be granted if the proposed services:

(A) Are covered services;

(B) Are consistent with the recipient's diagnosis;

(C) Are medically necessary;

(D) Meet the criteria established by the rules of the Department; and

(E) Are not reimbursable by any third party payer.

(iii) Denial of prior authorization.

(A) If a request for prior authorization is denied, the provider may submit a revised request for prior authorization or additional documentation as necessary for the Division to reconsider the matter; or

(B) The recipient may request reconsideration of the denial of prior authorization pursuant to Chapter 1.

(C) The denial of prior authorization precludes Medicaid reimbursement for the services in question.

(iv) Failure to timely request prior authorization. The failure to obtain prior authorization before providing services precludes Medicaid reimbursement for such services.

(v) Effect of prior authorization. Granting prior authorization shall constitute approval for the provider to receive Medicaid reimbursement for the approved services to be furnished, subject to the other requirements of this rule and post payment review. Prior authorization is not a guarantee of the recipient's eligibility or a guarantee of Medicaid payment.

(b) Relationship to Chapter 8. The prior authorization provision of this section are separate and apart from the admission certification requirements of Chapter 8.

Section 10. Medicaid allowable payment.

(a) Except as otherwise specified in this Chapter or the other rules of the Department, the Medicaid allowable payment shall not exceed the lower of the provider's usual and customary charges and 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 Division.

(b) Adjustment to Medicaid fee schedule. The Division shall review the Medicaid fee schedule periodically. The Medicaid fee schedule may be adjusted when necessary to:

(i) Enlist enough providers so that services are available to recipients to the extent that those services are available to the general population; and

(ii) Ensure that payments are consistent with efficiency, economy and quality of care.

(c) Laboratory fees. The Division shall review laboratory fees periodically and adjust the fees

as necessary to ensure that the Medicaid payment does not exceed Medicare allowable payment for clinical laboratory procedures. If the Medicaid allowable payment exceeds the Medicare allowable payment, the Medicaid allowable payment shall be automatically adjusted to equal the Medicare allowable payment. Such adjustment shall be retroactive to the effective date of the Medicare allowable payment. Any Medicaid payments made in excess of the Medicare allowable payment shall be considered excess payments.

Section 11. Payment and submission of claims.

(a) Payer of last resort. Medicaid is the payer of last resort. A provider may not seek Medicaid payment for services furnished to a recipient until payment from third parties has been sought pursuant to Chapter 4 and/or Chapter 35.

(b) Payment in full of covered services. If the service is a covered service, a provider may not request, receive or attempt to collect any payment from the recipient or the recipient's family for the service. The provider must accept the Medicaid allowable payment as payment in full for the services. This subsection does not apply to services provided in excess of service limitations.

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

(d) Payment for services that exceed service limits. A provider that provides a covered service to a recipient that is in excess of service limits may seek payment from the recipient without complying with subsection (c).

(e) Copayment. A provider may seek copayment from recipients as permitted by the rules of the Department. The amount of the authorized copayment shall be automatically deducted by the Division from the Medicaid allowable payment. Collection of copayment is the sole responsibility of the provider.

(f) Submission of claims.

(i) Claims must be submitted to the Division in the manner and on the forms specified by the Division, must include documentation of prior authorization, if necessary, and such other documentation or records as the Division may request.

(ii) Except as specified below, claims must be submitted to and finalized on or before twelve months after the date of service or the date of discharge, whichever is later.

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

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

(C) The date of submission is the date the claim is received by the Division.

(D) Claims not timely submitted shall be rejected.

(iii) A provider shall not bill the Division in excess of the provider's usual and customary charge for the service.

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

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

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

Section 12. Recovery of excess payments. The Division may recover excess payments pursuant to Chapter 39 or, at any time, refer a matter involving suspected excess payments to MFCU.

Section 13. Recovery of overpayments. The Division may recover overpayments pursuant to Chapter 16 or, at any time, refer a matter involving suspected overpayments to MFCU.

Section 14. Reconsideration.

(a) Request for reconsideration. A provider or the provider's legally authorized representative may request that the Division reconsider a decision to recover excess payments. Such request must be mailed to the Division by certified mail, return receipt requested within twenty days of the date the facility receives notice pursuant to Section 12 or 13. 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 Division shall review the decision to recover 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 Division 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 Division has complied with the provisions of this Chapter and/or other applicable rules of the Department.

(e) Informal resolution. The provider or the provider's legally authorized representative or the Division 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 or the provider's legally authorized representative may request an administrative hearing regarding the final decision pursuant to Chapter 1 by mailing by certified mail, return receipt requested or personally delivering a request for hearing to the Division within twenty days of the date the provider receives notice of the final decision. The request must state with specificity the reasons for the request and the issues the provider intends to raise. Failure to state the reasons with specificity shall result in the dismissal of the request with prejudice. The failure to identify issues shall preclude them from being raised at the administrative hearing or on judicial review.

(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 regarding the decision to recover excess payments.

(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 provided 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 15. Disposition of recovered funds. The Division shall dispose of recovered funds pursuant to the provisions of Chapter 16, which provisions are incorporated by this reference.

Section 16. 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 its various provisions.

Section 17. Superseding effect. When promulgated, this Chapter supersedes all prior rules or policy statements issued by the Department, including Manuals or Bulletins, which are inconsistent with this Chapter.

Section 18. Severability. If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in full force and effect.