Health, Department of

Medicaid

Chapter 29: Medicaid Case Management

Effective Date: 07/05/1994 to 08/13/2020

Rule Type: Superceded Rules & Regulations

Reference Number: 048.0037.29.07051994

WYOMING MEDICAID RULES

CHAPTER 29

MEDICAID CASE MANAGEMENT

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. Purpose and applicability.

(a) This Chapter shall apply to and govern case management. It is intended to be read in conjunction with and implement federal requirements for the review of the appropriateness and quality of services as set forth in 42 U.S.C. 1396a(a)(33)(A), 42 C.F.R. Part 456 and other applicable federal and State statutes and regulations. This Chapter authorizes the Department to educate recipients and coordinate and facilitate the provision of covered services to recipients in the most efficient manner and/or setting consistent with appropriate care.

(b) The Department may issue Provider Manuals, Provider Bulletins, or both, to providers and/or other affected parties 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. General provisions.

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

(b) General methodology. The Department uses case management to review the appropriateness and quality of services and to ensure the delivery of services in the most efficient manner and/or setting consistent with appropriate care

(c) Medical necessity. This Chapter is to be read in conjunction with Chapter 8 and the other rules and policies of the Department in determining whether services are medically necessary.

Section 4. Definitions.

(a) "Abuse." Abuse as defined in Chapter 16, Section 4(a), which is incorporated by this reference.

(b) "Administrator." The administrator of the division, the administrator's agent, designee or successor.

(c) "Admission" or "admitted." "Admission" or "admitted" as defined by Chapter 30, which is

incorporated by this reference.

(d) "Appropriate." Appropriate as defined by Chapter 8, which definition is incorporated by this reference.

(e) "Case management." Assistance to a recipient in gaining access to medically necessary care and services appropriate to the needs of the recipient through education, coordination of services, monitoring of services, or other appropriate means. Case management is provided by the Division.

(f) "Case management referral." A communication, written or oral, from the Department, a health care professional or any other source, to the Division, indicating the potential need for case management.

(g) "Case manager." A registered nurse or a health care professional designated by the Division to provide case management.

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

(i) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid rules.

(j) "Chapter 6." Chapter 6, Health Check Program, of the Wyoming Medicaid rules.

(k) "Chapter 8." Chapter 8, Inpatient Admission Certification, of the Wyoming Medicaid rules.

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

(m) "Chapter 28." Chapter 28, Swingbed Services, of the Wyoming Medicaid rules.

(n) "Chapter 30." Chapter 30, Level of Care Hospital Reimbursement, of the Wyoming Medicaid rules.

(i) "Covered services." Health care services, medical supplies and equipment which are Medicaid reimbursable pursuant to the rules of the Department.

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

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

(l) "Disabled adult." "Disabled adult" as defined in W.S. 35-20-102(a)(vi), which is incorporated by this reference.

(m) "Discharge." The act by which an individual that has been admitted to a hospital as an inpatient is released from the hospital. "Discharge" does not include an individual that is transferred from one unit of a hospital to another unit in the hospital, an individual that is transferred to a distinct part hospital unit, or an individual that is transferred to another hospital.

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

(o) "DSM." The most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, which is incorporated by this reference. The DSM is published by the American Psychiatric Association, Washington, D.C., and is available from the publisher.

(p) "EPSDT." EPSDT as defined in Chapter 6, which is incorporated by this reference.

(q) "Excess payments." Medicaid funds received by a provider which exceed the Medicaid allowable payment established by the Department. "Excess payments" includes a reduction in the Medicaid allowable payment pursuant to Section 5.

(r) "Expanded EPSDT services." Expanded EPSDT services as defined in Chapter 6, which is incorporated by this reference.

(s) "Extended psychiatric care." "Extended psychiatric care as defined in Chapter 30, which is incorporated by this reference.

(t) "Extended stay report." A report which contains information about recipients that have been inpatients for five days or more. A extended stay report shall be in writing, and shall contain the information and be in the form specified by the Department.

(u) "Extraordinary recipients." Extraordinary recipients as defined by Chapter 28, which definition is incorporated by this reference.

(v) "Facility." A hospital, nursing facility. psychiatric hospital or rehabilitation facility.

(w) "HCFA." The Health Care Financing Administration of HHS.

(x) "Health care professional." An individual licensed under the laws of Wyoming or another state to practice medicine, osteopathy, dentistry, nursing or any other professional health care, acting within the scope of his or her licensure.

(y) "Heavy care patient." Heavy care patient as defined by Chapter 28, which definition is incorporated by this reference.

(z) "HHS." The United States Department of Health and Human Services, including the Office of Inspector General.

(aa) "High cost services." Covered services furnished to or expected to be furnished to a recipient admitted to a facility with a severe medical problem, or a recipient that receives noninstitutional services for a severe medical problem. "High cost services" includes, but is not limited to:

(i) Expanded EPSDT services;

(ii) NICU Level III services;

(iii) Psychiatric services;

(iv) Rehabilitation services;

(v) Specialty services;

(vi) Services provided to extraordinary recipients and heavy care patients; and

(vii) Transplants.

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

(cc) "Inappropriate utilization of covered services." A recipient's receipt of covered services which are not medically necessary or appropriate, or which are furnished in a setting which is not appropriate.

(dd) "Inpatient." An "inpatient" as defined by 42 C.F.R. 440.2(a), which is incorporated by this reference.

(ee) "Inpatient Census Report (ICR)." A report which contains information about recipients admitted as inpatients to a hospital. An ICR shall be in writing, and shall contain the information and be in the form specified by the Division.

(ff) "Inpatient hospital services." "Inpatient hospital services" as defined in 42 C.F.R. 440.10, which is incorporated by this reference.

(gg) "Lock-in." Restricting a recipient's participation in Medicaid to receiving covered services from a provider or providers designated by the recipient and approved by the Division.

(hh) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and the Wyoming Medical Assistance and Services act of 1967, as amended.

(ii) "Medicaid allowable payment." Payment for covered services as permitted by the Medicaid rules and policies of the Department.

(jj) "Medical necessity criteria." The medical necessity criteria established pursuant to Chapter 8, which are incorporated by this reference.

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

(ll) "Medically necessary" or "medical necessity." A covered service that is:

(i) Consistent with the recipient's diagnosis and 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 or the provider of the services; and

(iv) Provided in the most efficient manner and/or setting consistent with appropriate care required by the recipient's condition.

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

(nn) "Monitor." To track a recipient's utilization of covered services by any or all of the following methods:

(i) Review of claims;

(ii) Review of ICRs;

(iii) Review of medical records;

(iv) Consultation with providers;

(v) Consultation with the recipient or the recipient's authorized representative; or

(vi) Any other reasonable method.

(oo) "Neglected child." "Neglected child" as defined by W.S. 14-6-201(a)(xvi), which is incorporated by this reference.

(pp) "NICU Level III." NICU Level III as defined by Chapter 8, which definition is incorporated by this reference.

(qq) "Nursing facility." Nursing facility as defined by 42 U.S.C. 1396d(f), which is incorporated by this reference.

(rr) "Nursing facility services." Nursing facility services as defined by 42 U.S.C. 1396d(f), which is incorporated by this reference.

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

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

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

(vv) “Psychiatric diagnosis.” A condition defined in the DSM, excluding a sole diagnosis of mental retardation or a specific developmental disorder.

(ww) “Psychiatric services.” Psychiatric services as defined by Chapter 30, which definition is incorporated by this reference.

(xx) “Recipient.” A person who has been determined eligible for Medicaid.

(yy) “Registered nurse.” A person licensed to practice professional nursing by the Wyoming Board of Nursing or a similar agency in another state.

(zz) “Rehabilitation services.” Rehabilitation services as defined by Chapter 30, which definition is incorporated by this reference.

(aaa) “Services.” Health care services or supplies furnished to a recipient.

(bbb) “Severe medical problem.” An injury or illness which results in cognitive or physical debilitation requiring intensive and/or expensive services, as determined by the Division. “Severe medical problem” includes, but is not limited to:

(i) Catastrophic illness or injuries;

(ii) Chronic illness;

(iii) High-risk pregnancies;

(iv) Illness or injury that requires rehabilitation services;

(v) Birth defects

(vi) Pre-term births;

(v) A psychiatric diagnosis or condition which requires inpatient hospital services;

(vi) Traumatic brain injury or spinal cord injuries; or

(vii) Ventilator dependent persons.

(ccc) “Specialty services.” “Specialty services” as defined by Chapter 30, which definition is incorporated by this reference.

(ddd) “Transplants.” Transplants as defined by Chapter 30, which definition is incorporated by this reference.

(eee) “Traumatic brain injury (TBI).” An acquired assault to the brain.

(fff) “Working day.” 8:00 a.m. through 5:00 p.m., Mountain Time, Monday through Friday, exclusive of State holidays.

Section 5. Facility reporting requirements.

(a) ICR reporting requirements. A facility must submit an ICR to the Division by 5:00 p.m. on Friday of each week. If Friday is not a working day, the ICR must be submitted by the close of business on the preceding working day.

(b) Extended stay reporting requirements.

(i) Time of submission. A facility must submit a extended stay report to the Division by 5:00 p.m. of the fifth working day after the recipient is admitted as an inpatient.

(ii) Supplemental reports. A facility must submit supplemental extended stay reports to the Division within one working day after the facility receives a request for such a report from the Division. Supplemental reports shall be in the form and contain the information specified by the Division.

(c) Method of submission. Unless otherwise agreed by the Division, reports required by this Section must be submitted by facsimile transmission.

(d) Exceptions. This Section shall not apply to individuals that are determined eligible for Medicaid after their discharge from the facility.

(e) Failure to timely report.

(i) If a recipient is not reported on an ICR or a extended stay report as required by this Section, but is reported before the recipient’s discharge, the Medicaid allowable payment to the facility for all covered services furnished to such recipient shall be reduced by twenty-five percent.

(ii) If a recipient is not listed on an ICR or a extended stay report until after the recipient’s discharge, the facility shall not receive Medicaid reimbursement for any services furnished to the recipient.

(iii) If Medicaid payment has already been made, payments which exceed the limitations established by this Section may be recouped as excess payments pursuant to Chapter 3.

Section 6. Case management.

(a) Applicability.

(i) Existing recipients.

(A) The Department and health care professionals are authorized to identify recipients that appear to require assistance in using covered services appropriately because of unfamiliarity with the Medicaid program or the delivery of services, or for any other reason; or

(B) If the Department learns that a recipient with a severe medical problem is receiving covered services, or that a recipient is receiving high cost services, the Department may monitor the services provided to that recipient.

(ii) New recipients. The Department may request that new recipients participate in case management for the reasons set forth in (i) or for any other reason.

(b) Procedure. After a recipient is identified pursuant to subsection (a), the Department shall:

(i) Notify the recipient pursuant to Section 10 that the recipient has been selected to participate in case management, and that the recipient has the option of participating. If the respondent does not respond to the notice within the time specified in the notice, the recipient shall be deemed to have agreed to case management services.

(ii) Refusal to participate. The refusal by a recipient to participate in case management shall not restrict the Medicaid services otherwise available to the recipient. A recipient's refusal to participate shall not restrict the Division's ability to perform case management provided there is no reduction in the services provided to the recipient.

(c) Methods of case management. After the Department identifies a recipient pursuant to (a), it may:

(i) Monitor the recipient's utilization of covered services to ensure that it is medically necessary;

(ii) Facilitate and coordinate placement in a more appropriate setting to ensure that the recipient receives appropriate services in the most efficient manner and/or setting consistent with appropriate care for the recipient's condition;

(iii) Conduct concurrent reviews pursuant to Chapter 8;

(iv) Conduct periodic utilization reviews to determine whether the recipient is engaged in a pattern of inappropriate utilization of covered services;

(v) Conduct on-site reviews to determine whether the services being furnished are medically necessary and appropriate; or

(vi) Take any other appropriate measures to coordinate and facilitate the provision of covered services in the most efficient manner and/or setting consistent with appropriate care for the recipient's condition.

Section 7. Case management of recipients receiving high cost services and/or recipients with severe medical problems.

(a) The division is authorized to monitor recipients receiving high cost services and/or recipients with severe medical problems.

(b) If the Department determines that a recipient receiving high cost services and/or a recipient with a severe medical problem could receive appropriate covered services at a lower cost to the Medicaid program, it shall:

(i) Determine if appropriate services may be furnished in a different setting at a lower cost to the Medicaid program;

(ii) Identify the provider or providers that can provide appropriate services;

(iii) Coordinate and facilitate placement of the recipient in the appropriate setting and for necessary transportation;

(iv) Notify the provider(s) from whom the recipient is receiving services of the date after which such services shall not be reimbursable unless furnished by a provider or providers specified by the Department; and

(v) Notify the recipient, and the recipient's legal guardian or other authorized individual, of the date after which such services shall not be reimbursable unless furnished by a provider or providers specified by the Department.

(b) Notice. All notices shall be pursuant to Section 10.

Section 8. Medicaid reimbursement of high cost services. High cost services provided to a recipient with a severe medical problem shall be Medicaid reimbursable only if:

(a) Medically necessary;

(b) Certified;

(c) Prior authorized, if required; and

(d) Otherwise reimbursable under the rules and policies of the Department.

Section 9. Recipient lock-in.

(a) The Department may require lock-in under the following circumstances;

(i) Pursuant to Chapter 16, Section 16; or

(ii) Pursuant to a referral from another state's Medicaid program which indicates that a recipient has engaged in a prior utilization pattern involving fraud or abuse of that state's Medicaid program.

(b) Procedures.

(i) The procedure for requiring lock-in pursuant to (a)(i) are set forth in Chapter 16, Section 16.

(ii) If the Department determines pursuant to (a)(ii) to lock-in a recipient, it shall notify the recipient that covered services provided after the date specified in the notice, and until further notice, shall not be Medicaid reimbursable unless furnished by the provider(s) specified in the notice.

(c) Freedom of choice waivers. This Chapter and the other rules of the Department may be superseded by freedom of choice waivers granted by HCFA pursuant to applicable provisions of the Social Security Act and HCFA regulations.

Section 10. Notice to recipients.

(a) Method of providing notice. All notices to recipients shall be in writing, sent by certified mail, return receipt requested, or hand-delivered. In addition, the Department may provide notice by telephone. The decision to provide telephone notice is discretionary, and the failure to provide telephonic notice shall not affect the validity of the notice.

(b) Contents of notices. Notice shall include:

(i) The proposed action;

(ii) The effective date of the proposed action;

(iii) The basis for the proposed action; and

(iv) The recipient's right to request a hearing pursuant to Chapter 1.

(c) Time of notice. Written notice shall be mailed to the recipient at least ten days before the effective date of the proposed action, unless the recipient's or newborn's physician has prescribed a change in the level of services, in which case the notice shall be mailed not later than the effective date of the proposed action.

(d) For purposes of this Section, "recipient" means an individual that has been determined eligible for Medicaid, the legal guardian of the recipient, or an individual authorized to act on behalf of the recipient.

Section 11. Notice to Providers.

(a) Method of providing notice. Notice to a provider shall be in writing, sent by certified mail or facsimile transmission. In addition, the Department may provide notice by telephone. The decision to provide telephone notice is discretionary, and the failure to provide telephonic notice shall not affect the validity of the notice.

(b) Contents of notice. Notice to a provider shall include:

(i) The proposed action;

(ii) The effective date of the proposed action; and

(iii) The basis for the proposed action.

Section 12. Appeal procedures.

(a) In general. A recipient, a recipient's guardian or an individual authorized to act on behalf of a recipient may request an administrative hearing pursuant to Chapter 1.

(b) Recipient lock-in. The request for an administrative hearing regarding a recipient lock-in shall not stay the effective date of the lock-in. The recipient may request a stay by filing a written request with the administrator. Such request must be submitted at the time the recipient requests a hearing. A stay shall be granted only if the administrator determines that the lock-in will cause the recipient irreparable harm. The administrator may issue a stay upon such conditions as the administrator finds are necessary to protect the health and welfare of the recipient and the interest of the Medicaid program. The administrator shall send written notice of his decision regarding a request for a stay to the recipient. Such notice shall include findings of fact in support of the decision.

(c) A provider may not appeal any action taken pursuant to this Chapter, except that a provider may request reconsideration and an administrative hearing regarding the decision to recover payments or impose a penalty pursuant to subsection 5(e). Such request must be pursuant to the reconsideration provisions of Chapter 3, which shall govern the reconsideration and/or administrative hearing. The reconsideration provisions of
Chapter 3 are incorporated by this reference.

Section 13. Referrals.

(a) The Division shall refer to DFS or other appropriate agencies all cases in which:

(i) There is reasonable cause to believe that a minor child is a neglected child;

(ii) A recipient is or appears to be a disabled adult and there is reasonable cause to believe that the recipient has been abused, neglected, exploited or abandoned; or

(iii) There is a perceived need for the recipient and/or the recipient's family to receive services offered by or through DFS or other appropriate agencies.

(b) Referrals pursuant to this section shall be in writing, and shall include the identity and address of the recipient and a brief description of the perceived problem.

Section 14. Access to medical records. The Division shall have access to medical records using the procedures set forth in Chapter 16, which are incorporated by this reference.

Section 15. Superseding effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including provider manuals and provider bulletins, which are inconsistent with this Chapter.

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