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Prepared for: Wyoming Department of Health, Telligen

Prepared by: Telligen

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Contents

Program Overview

Corporate Background and Experience

As a Medicaid utilization management (UM) and Medicare Quality Improvement Organization (QIO) contractor for over 40 years, Telligen has developed contract specific UM plans for all elements of utilization review including admission, quality, invasive procedure, length of stay, outliers, coverage, discharge review and Diagnosis Related Group (DRG) validation. As a Utilization Review Accreditation Commission (URAC) accredited organization, we have corporate policies and procedures for utilization management that we will use as the foundation for the Wyoming Medicaid contract.

MISSION

Transforming lives and economies by improving health

VISION

To be one of the most sought-after companies to transform the health of populations

CORE VALUES

Ownership Integrity Ingenuity Community

Utilization Management Services

The purpose of Telligen's Utilization and Quality Management program is to ensure that appropriate medical services are provided with medical necessity and quality of care in accordance with state and federal regulations, statutes, and policies to members of Wyoming Medicaid.

Customer Service

Telligen Contact

Web Page: https://wymedicaid.telligen.com/contact-us/

The Telligen website is a central location to access information including prior authorization forms, admission criteria, and informational material.

Mail: Telligen Wyoming Medicaid Review

1776 West Lakes Parkway

West Des Moines, IA 50266

Toll Free Call Center: (833) 610-1057

Secure Fax: (877) 897-0111

Hours of Operation: Monday through Friday 7:00 am to 6:00 pm Mountain Time, except for recognized Federal and Wyoming State Holidays.

Utilization Management

The purpose of this document is to notify providers of the process that Telligen will follow for review of services provided to Wyoming Medicaid members. Wyoming Department of Health contracts with Telligen to:

- Review the medical necessity of an admission, continued stay and/or course of treatment or service ("medical necessity" as defined in Chapter 1, Definitions of the Wyoming Medicaid Rules and Regulations)
- Assess for the quality of care of those services so that they meet the professionally recognized standard of care
- Assess the setting the care was delivered in was appropriate for the type of service provided by the standards of practice
- Determine if the level of care was appropriate for the services rendered.
- Provide a monitoring system to determine that medical services are delivered at the appropriate level of care in a timely, effective, and cost-effective manner, to examine and improve the quality of medical care, and to evaluate practice patterns of healthcare delivery.

Federal regulations require Medicaid programs to review any service (admission or procedure) where it is anticipated or known that the service could either be over or underutilized, or otherwise abused, by providers or members, or easily result in excessive, uncontrolled Medicaid costs. This is accomplished through prior authorizations for certain procedures and inpatient admissions, and post payment claims reviews.

Providers are required to complete the prior authorization process in instances where the member has other insurance with another carrier or Medicare. If prior authorization is not obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.

Prior Authorization

Failure to Obtain a Timely Inpatient Prior Authorization

Failure to obtain prior authorization before providing services ***will result in a technical denial for late submission which precludes Medicaid reimbursement for such services and does not qualify for reconsideration (appeal) through Telligen.*** For inpatient stays, a technical denial will be issued for each day the request is received late.

Please Note: Per Chapter 1 of the Medicaid Rules and Regulations a late submission is considered a Technical Denial. For inpatient stays, per Chapter 30 of the Medicaid Rules and Regulations a Technical Denial does not qualify for reconsideration (appeal).

Submission Timelines

The Submission Timelines Table below summarizes the timeline requirements for submission of all utilization management requests.

Submission Timeline Table		
Type of Review	**Submission Timelines**	**Review Turnaround**
Acute Psychiatric / Detoxification Admission	Within 1 Business Day of admission	1 Business Day from Submission
Acute Psychiatric / Detoxification Continued Stay	On the last certified day	1 Business Day from Submission
Psychiatric Residential Treatment Facility Admission	At least 3 Business Days in advance of admission	1 Business Day from Submission
Psychiatric Residential Treatment Facility Continued Stay	No more than 3 Business Days from the last certified days	1 Business Day from Submission
Outpatient Surgical and Medical Procedure Codes	At least 3 Business Days in advance of procedure	1 Business Day from Submission
Vision Codes	At least 3 Business Days in advance of procedure	1 Business Day from Submission
Unlisted Procedure Codes	At least 3 Business Days in advance of procedure	1 Business Day from Submission
Skilled Nursing Facility Extraordinary Care Admission	Within 1 Business Day of admission	1 Business Day from Submission
Skilled Nursing Facility Extraordinary Care Continued Stay	On the last certified day	15 Business Days from Submission
Weight Loss Surgery	At least 3 Business Days in advance of procedure	1 Business Day from Submission
Vagal Nerve Stimulator (VNS) for Epilepsy	At least 3 Business Days in advance of procedure	1 Business Day from Submission
Transplants	If the date of the transplant is not yet determined, the facility may receive prior authorization. The authorization is good for 1	1 Business Day from Submission

	year from the date the authorization was issued. When the member is admitted for the transplant, the facility has 1 business day to notify Telligen of the actual admission date.	
Physical/Occupational/Speech Therapy over the threshold limits	Prior to meeting the Threshold is preferred. Services that are provided after the threshold limit has been reached but prior to receiving an authorization are provided at the provider's risk.	1 Business Day from Submission
Outpatient Behavioral Health services over the threshold limits **Residential Outpatient Behavioral Health services over the threshold**	Prior to meeting the Threshold is preferred. Services that are provided after the threshold limit has been reached but prior to receiving an authorization are provided at the provider's risk.	1 Business Day from Submission
Home Health Services	Services can be requested up to 10 days after the service has been rendered. Prior authorization is preferred.	1 Business Day from Submission
Durable Medical Equipment and Prosthetics and Orthotics (DMEPOS)	At least 3 Business Days in advance of purchase or rental	1 Business Day from Submission
Skilled Nursing Services for Waiver Plans	At least 3 Business Days in advance of service	1 Business Day from Submission
Retrospective Review	Within 30 Business Days of notification of: • Client's eligibility for Medicaid benefits • Provider's eligibility as Medicaid provider Facility/Provider must provide proof of notification of eligibility with submission of request	3 Business Days from Submission

Appeals of Medical Necessity Denials	Within 30 calendar days of date on denial notification letter	1 Business Day from Submission

Members with Other Insurance-Coordination of Benefits

Providers are required to complete the prior authorization process in instances where the member has other insurance with another carrier. If prior authorization is not obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.

Retrospective Reviews

A retrospective review is conducted after services are provided. There are two (2) circumstances that meet the criteria for a retrospective review:

1. An individual was admitted to a facility and received services that require a prior authorization and then, after the admission and services, became eligible for Medicaid.
2. A provider provided services requiring a prior authorization and then became a Medicaid provider and received its provider enrollment number.

Procedure for Obtaining a Retrospective Review

1. A provider or a facility cannot seek prior authorization for an individual whose application for Medicaid is pending at the time of admission.
2. The provider or facility should submit their request through Qualitrac within thirty (30) calendar days of receiving the notice of member eligibility or provider enrollment. The request must contain the following:
    - Completed Retrospective Review form
    - Complete medical record for date of services being requested
    - Proof of notification of eligibility
    - Date/Method of notice of initial ineligibility

Review Criteria

Medical Necessity Level of Care Guidelines

All medical necessity UM decisions are made using objective and evidence-based guidelines, which allows Telligen to standardize decisions, promote evidence-based practices, and support the member's wellbeing. The guidelines include the Wyoming Medicaid Service Criteria (located on ***https://wymedicaid.telligen.com*.** Additional guidelines that may be utilized include:

Medical

- MCG (formerly Milliman Clinical Care Guidelines)
- Wyoming Medicaid Services Criteria
- Durable Medical Equipment Covered Services Manual
- CMS 1500 Provider Manual
- Institutional Provider Manual
- Waiver Skilled Nursing PA Criteria

Behavioral

- Wyoming Medicaid Services Criteria is utilized for acute inpatient psychiatric and PRTF admissions and continued stays.
- ASAM PPC-2R* (American Society of Addiction Medicine- Patient Placement Criteria, 2nd Revision) criteria are currently utilized for all Substance Abuse services

Please Note: *ASAM criteria are proprietary and cannot be provided to providers or members unless a denial of service(s) is rendered, at which time a copy of the criteria in question can be obtained upon request. Providers wishing to access these criteria independently may purchase them using the following link: **https://www.asam.org/asam-criteria.**

Prior authorization (PA) shall be granted for both Medical and Behavioral reviews if all the following are met:

The stay/procedure/service is:

- Covered under Wyoming Medicaid
- Medically necessary and any medical necessary criteria/guidelines are met. Determination of medical necessity is based on criteria established by the rules of the Division of Healthcare Financing and a review of all submitted documentation.

Review Types Requiring Prior Authorization

Medical Necessity Prior Authorization

Prior authorization (PA) is utilization management that is conducted prior to a Medicaid member's procedure/service or admission.

PRIOR TO SUBMISSION, please verify all procedure codes within the request require a prior authorization. The Wyoming Medicaid Fee Schedule can be accessed via the following link: **https://www.wyomingmedicaid.com/portal/fee-schedules** Only codes listed and confirmed as requiring a PA should be submitted for review. Attach all required forms and documentation to your request.

Requests for prior authorizations (PAs) are required to be submitted before the initiation of the following services:

- Medical Necessity Reviews
- Transplants
- Weight Loss Surgery
- Vagal Nerve Stimulator for Epilepsy
- Skilled Nursing Extraordinary Care
- Acute Inpatient Psychiatric Hospitalization
- Psychiatric Residential Treatment Facility (PRTF)
- Outpatient Surgical and Medical Procedures
- Vision Procedures
- Genetic Testing
- Physical/Occupational/Speech Therapy services over the threshold limits
- Outpatient Behavioral Health services over the threshold limit
- Home Health Services (up to 10 days after initiation of services)
- Durable Medical Equipment and Prosthetics and Orthotics (DMEPOS)
- Skilled Nursing Services for Waiver Plans
- Severe Malocclusion Program

Submission for Prior Authorization

Qualitrac is the source for all prior authorization requests. In an effort to ensure timeliness of submission, faxes will only be accepted if there are access or technical issues with the Qualitrac system.

Please click here **https://wymedicaid.telligen.com/** to register and learn more about Qualitrac. If you are experiencing access or technical issues with Qualitrac please contact your local Provider Relations Advocate or email **wymedicaidum@telligen.com** for assistance.

Prior authorization forms and supporting documentation must be submitted within the time frames outlined in the **Submission Timelines Table**. Each submission must contain all required forms and necessary documentation. Telligen may request additional information in order to complete the review.

Continued Stay Reviews for Inpatient Stays

A Continued Stay Review (CSR) is required for member admissions to facilitate the most appropriate, cost-effective, and timely care for Medicaid member. The CSR takes place during the time in which a member is confined to the facility. The purpose is to determine if the continued confinement is medically necessary and appropriate.

A CSR will need to be submitted for stays until services are completed and the member is discharged, or a medical necessity denial has been issued. Failure to request prior authorization for admissions or to notify Telligen of a continued stay on the last certified day (defined below), will result in a technical denial for late submission.

The following admissions are reviewed for continued stays:

- Acute Psychiatric Care/Acute Detox
- Psychiatric Residential Treatment Facility (PRTF)
- Skilled Nursing Facility Extraordinary Care

Submitting a CSR

Facilities must submit the CSR form and supporting documentation to Telligen on the last certified day. Required items must be included in the CSR request are:

- Clinical rationale for continued stay
- Treatment provided
- Progress towards goals
- Current discharge plan

Last Certified Day

When utilizing Qualitrac, approved dates of service on the screen contain the discharge date or end date. The "**last certified day"** is the day PRIOR to the discharge date or end date. If the member is not discharging on the end date of the request, a continued stay must be submitted on the **last day approved**. For example, if the dates of service approve indicate 01/01/2022 – 01/07/2022, the continued stay review must be submitted on 01/07/2022.

Failure to submit the request on the last certified day will result in a denial for late submission.

Reminder: Granting of a prior authorization shall constitute approval for the provider to submit for Medicaid reimbursement for approved services to be furnished, subject to the requirements of post-payment review. Prior authorization is not a guarantee of the member's eligibility or a guarantee of Medicaid payment.

Review Determination Process

Medical Necessity Reviews

All requests must meet Wyoming Medicaid criteria before applying any other criteria. Each request is reviewed by a UM clinical review coordinator. If there is not enough supporting documentation to demonstrate medical necessity, the clinical reviewer will send the request to a physician to make a medical necessity determination. UM Clinic Review Coordinators may only approve cases based on application of criteria. Telligen ensures criteria are applied in a uniform manner through an internal Quality Assurance process.

Review Determinations

Medical Necessity Approvals

Telligen UM Clinical Review Coordinators complete a detailed review of the submitted documentation including the plan of care to ensure services have been ordered in compliance with all coverage regulations. Their review also includes the information submitted by the provider including pertinent portions of the medical record if available to determine whether the requested service is medically necessary by applying the appropriate criteria set.

If the information supplied by the provider is insufficient to complete the review, Telligen will suspend the case. Telligen will submit to the provider a request for information needed to complete the review. If the provider does not provide the requested information within three (3) business days following the initial contact, the system will generate a reminder email indicating records have been requested. If, after another three (3) business days, records still have not yet been received, Telligen will issue a technical denial for the requested procedure/service/stay and issue a Technical Denial Notice of Decision.

Upon receipt of the requested information, the UM Clinical Review Coordinator resumes the review process and completes the review within one (1) business day following receipt of the additional information. The review team has experience working collaboratively with providers offering education on the specific documentation needed to efficiently process authorization requests. Providers are encouraged to contact the Telligen review team with any questions regarding the requested information.

Medical Necessity Denials

If the information provided for the review does not meet the criteria for approval, the UM Clinical Review Coordinator refers the case to our Medical Director or Physician Peer Reviewer. Using clinical knowledge and medical judgment, the peer reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s). A Denial Notice of Decision letter indicating the requested

service, reason for denial, and appeal process will be mailed to the provider, facility, and the member via United States Postal Service.

Peer-to Peer Conversations

When the initial medical necessity denial is issued, a peer-to-peer conversation is optional for the treating provider. If a peer-to peer conversation did not take place prior to the denial determination one may be requested by the treating provider within **fourteen (14) calendar days** from the date of the initial denial determination. The goal of the conversation is to allow the treating provider a chance to discuss the determination before initiation of the appeal process. This process may provide additional information or clarification that would nullify the need for a formal appeal.

If the peer-to-peer conversation results in no change to the determination and the initial denial decision is upheld, the provider has the option to submit a formal appeal request to the Wyoming Department of Health

Reconsideration Process

The provider, facility, or member may request a reconsideration within thirty (30) calendar days from the date the medical necessity denial letter was issued. Telligen will review all information submitted with the request for reconsideration. The following documentation must be submitted with the reconsideration request:

- Original review documentation and physician review decision
- Letter from the requester including substantiation for medical necessity of the procedure/services/stay, and
- Documentation pertinent to the case including medical records, consultations, progress notes, case histories, therapy evaluations, care plans, etc.

The UM Clinical Review Coordinator will review all submitted information and prepare a case summary for Peer Review. The reconsideration is then referred to a Physician Peer Reviewer. Telligen will use a Peer Reviewer not involved in the original review decision to complete the reconsideration review. The Peer Reviewer will base the review decision on information used to make the initial determination, the decision and rationale of the original Peer Reviewer, and the additional supporting documentation supplied by the provider. Using medical judgement, the Peer Reviewer will render a determination and provide medical rationale for their decision.

After the review is completed, the original denial decision will either be upheld or overturned. The determination will be provided to the member, provider, and facility within the timelines noted above and a Notice of Decision letter will be mailed to the member via United States Postal Service.

If the denial was upheld, the member and provider will be notified of the appeal process with Wyoming Medicaid. The denial of a prior authorization precludes Medicaid reimbursement for the services in question.

Types of Medical Necessity Prior Authorization Reviews

Acute Psychiatric Stabilization \ Detoxification

A facility must complete and submit the admission form and any supporting documentation within one (1) business day of admission for the following inpatient hospital services:

- Acute psychiatric stabilization (including detoxification), adult
- Acute psychiatric stabilization, child/adolescent

A member's stay begins the day they are admitted to the facility. This includes those members that are admitted to the facility through the Emergency Department (ED). If a member is admitted through the ED prior to being transferred to a Behavioral Health unit, the request needs to be submitted within one (1) business day of their admission to the ED. The admit date listed on the request must be the date the member was admitted to the ED.

What is an IMD?

A Medicaid Institution for Mental Disease (IMD) exclusion is found in section 1905(a) (B) of the Social Security Act, which prohibits Medicaid "payments with respect to care or services for any individual who has not attained sixty-five (65) years of age and who is a patient in an institution for mental diseases" except for "inpatient psychiatric hospital services for individuals under age 21." The law goes on to define "institutions for mental diseases" as any "hospital, nursing facility, or other institution of more than 16 beds, which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services."

Acute Psychiatric Stabilization \ Detoxification Continued Stay Reviews (CSR) CSRs for psychiatric acute admissions are required for members who remain inpatient on the Last Certified Date (LCD). Continued stays are authorized in seven (7) day increments. The facility is required to submit a CSR request to Telligen for continued authorization until the date of discharge. Failure to submit a CSR request on the LCD will result in a technical denial for each day the request is submitted late.

The facility should submit a member discharge report within one (1) business day of discharge from the facility.

If a member is transferred to a medical unit after receiving a prior authorization for a behavioral health/detox primary diagnosis, there is no need to submit a CSR request while the member is receiving medical care. If that member is transferred back to a behavioral health unit, the facility then must submit a CSR request within one (1) business day of the member being transferred back to the behavioral health unit to have that continued stay reviewed for behavioral health/detox medical necessity. The facility is required to continue to submit a CSR request every 7 days until the member is either transferred out of the behavioral health unit or is discharged from the facility.

Acute CSR Timeframes

Continued stays are authorized in 7-day increments. Continued stay requests must be received on the last certified day in order to avoid denied days for late submission.

Psychiatric Residential Treatment Facility (PRTF)

Psychiatric Residential Treatment Facility (PRTF) is defined as twenty-four (24) hour, supervised, inpatient level of care provided to children and adolescents up to age twenty-one (21) who have long-term mental health or psychiatric illnesses and/or serious emotional disturbance(s) that are not likely to respond to short- term interventions and have failed to respond to community-based intervention(s).

PRTFs provide comprehensive mental health and substance abuse treatment services to children and adolescents. In addition, PRTFs will provide instruction and support toward attainment of developmentally appropriate basic living skills/daily living activities that will enable children and adolescents with the knowledge and training necessary to return and live within the community upon discharge.

The focus of a PRTF is on overall improvement of a member's symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; with the exception that evidence shows family therapy would be detrimental to the member.

Unless otherwise contraindicated, the program should facilitate family participation in the treatment planning process, implementation of treatment planning, and timely, appropriate discharge planning. This will include assistance for the family with varying levels of support and services to ensure a safe, stable, and nurturing home environment; often referred to as "*wrap-around services*," in effect, this means wrapping a child/family with support until the family reaches an adequate level of self-sufficiency. Wyoming Medicaid provides wrap around services within the Children's Mental Health Waiver.

Admission to a PRTF is appropriate if a member has a psychiatric condition that cannot be clinically addressed with treatment in an outpatient treatment setting and the condition is characterized by severely distressing, disruptive and/or immobilizing symptoms which are persistent and pervasive.

Please note: A member who is experiencing acute psychiatric behaviors is not appropriate to be admitted to a PRTF. PRTF services are not the entry point to accessing inpatient psychiatric services for members who are in need of an acute level of care.

The expected length of stay for Medicaid members is no longer than one hundred twenty (120) days*. Treatment plans, interventions, medication management, and discharge plans must reflect adherence to this timeline.

**Exception: There may be some instances where a member requires a longer length of stay. This circumstance will be addressed on a case-by-case basis.*

PRTF CSR Timeframes

The **first** CSR request **must** be submitted to Telligen within **fourteen (14) calendar days** of admission. After the initial fourteen (14) days, the number of days approved may vary from seven (7) to thirty (30) days depending on the clinical presentation of the child/adolescent.

PRTF Therapeutic Passes

A facility can request a therapeutic pass. Telligen should be notified of all therapeutic passes prior to the planned leave of absence. Medicaid reimbursement is available for reserving beds in a PRTF for therapeutic leaves of absence of Medicaid members less than twenty-one (21) years of age at the regular per diem rate when all the following conditions are present:

1. A therapeutic leave of absence **must** be for therapeutic reasons *only* as prescribed by the attending psychiatrist/physician and as indicated in the member's habilitation plan.
2. A physician's order for therapeutic leave **must** be maintained in the member's file at the facility.
3. The total length of time allotted for therapeutic leave of absence in any calendar year shall be 14 days. If the member is absent from the PRTF for more than 14 days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that member in that year.
4. In no instance will Medicaid reimburse a PRTF for reserving beds for Medicaid members when the facility has an occupancy rate of less than ninety percent (90%). (The occupancy rate is based on the total number of licensed beds. The PRTF is required to submit verification that the occupancy rate was at ninety percent (90%) or higher during any therapeutic leave of absence in order to obtain reimbursement for those days. If the bed rate is less than ninety percent (90%), the facility shall bill therapeutic leave days as non-covered days which are not eligible for reimbursement.)
5. Please reference Wyoming Medicaid Provider Manual for travel reimbursement questions.

PRTF Incident Reporting

The following list of incidents involving Wyoming Medicaid members require the use of the electronic PRTF form located at the State of Wyoming Department of Health website: **https://health.wyo.gov/healthcarefin/medicaid/** click on Healthcare Provider. The report must be made to the Wyoming Department of Health within one (1) business day of the incident. The incident report does not replace or change any other reporting requirements that apply.

- Physical or sexual assault

- Injury or illness that requires medical attention, including caused by restraint
- Medication error requiring medical attention
- Involvement of law enforcement, outside of WY DFS/probation
- Harm to self-requiring medical attention
- Fire or other disaster affecting member's living or treatment situation
- Elopement or abduction
- Illegal substance use while on facility grounds or on a facility supervised trip
- Pregnancy if not known at time of admission
- Discharge to the wrong facility
- Death

PRTF Court Ordered Care

Youth in the PRTF level of care in and outside of Wyoming may be under court order. The admission and continued stay review process is the same for these youth.

PRTF Discharge Planning

It is expected that the discharge plan has been discussed and reviewed by the treatment team at the facility, Telligen, the parent/or guardians/foster parents and any other care providers such as waiver case workers. The discharge plan should be viable and well thought out leading to a successful discharge. The parents/guardians should be actively involved in developing the discharge plan and follow-up services. A typical discharge plan should include the following:

1. An initial follow-up appointment that must be scheduled with an outpatient behavioral health provider to occur within seven (7) days of discharge
2. Availability of a provider for follow-up treatment who will continue treatment and management
3. Medication list of prescription refills to be obtained at a local pharmacy
4. A safety plan including instructions of who and when to call if behaviors escalate or become out of control
5. Names and phone numbers for resources available to the member/family
6. Referral to the Children's Mental Health Waiver or community mental health programs for additional support and services, as appropriate

Skilled Nursing Facility Extraordinary Care

Wyoming Medicaid provides extraordinary care benefits to members in a Skilled Nursing Facility with medical conditions defined by the Wyoming Division of Healthcare Financing, who require special care when they have a Minimum Data Set Activities of Daily Living Sum score of ten (10) or more, or clinically complex care as recognized under the Medicare RUG-III classification system. The extraordinary care benefit also extends to adult members presenting with a Severe and Persistent Mental Illness with long term psychiatric and behavioral health needs, which exhibit challenging and difficult behaviors and require care that exceeds the scope of traditional skilled nursing facility services.

Other medical and mental health conditions with special care needs are evaluated on a case- by-case basis. The services requested are individualized, specific and consistent with symptoms or confirmed diagnosis, and not in excess of the member's needs.

Continued stay reviews are due at fifteen (15) days, thirty (30) days, ninety (90) days, and then annually, as well as when medical or psychiatric evaluation demonstrates a change in status for the member.

Select Inpatient Medical Procedures

The following is a list of select medical procedures reviewed by Telligen:

- Transplants
- Weight Loss Surgery

- Vagal Nerve Stimulator for Epilepsy
- Hypoglossal Nerve stimulation

The procedures listed above, when approved, are approved for one (1) service day. If date modification is needed, the provider must notify Tellligen of the date change and review for ongoing medical necessity will be completed. Transplants will be approved for one (1) year. The provider is required to notify Telligen of the actual procedure date within one (1) working day of procedure.

Medical Outpatient Services

The following is a list of medical outpatient services reviewed by Telligen:

- Durable Medical Equipment
- Prosthetics and Orthotics
- Home Health Services
- Physical Therapy/Occupational Therapy/Speech Therapy services that have met the visit threshold
    - Post-operative physical and occupational therapy requests for members over the age of 21, may now be reviewed for treatment plan dates. After the initial treatment plan, cases will be reviewed 8 visits at a time thereafter.
- Behavioral Health services that have met the visit threshold
- Skilled Nursing Services for HCBS Waiver
- Outpatient Surgical and Medical Procedures
    - Hypoglossal Nerve stimulation
- Vision Procedures
- Genetic Testing
- Dental
    - As of January 1, 2024, selected mouth guards no longer require prior authorization

The services listed above are considered medical necessity reviews and follow the medical necessity denial and appeal process described on pages 15 and 16.

Please note the following crosswalk update effective 01/18/2023 for Home Health billing codes

Home Health Codes			
HCPCS Code	Revenue Code	Code Description	Unit
G0151	0421	Physical therapy	Per visit
G0152	0431	Occupational therapy	Per visit
G0153	0441	Speech therapy	Per visit
G0299 or G0154	0551	Skilled Nursing	Per visit
G0155	0561	Medical Social Services	Per visit
G0156	0571	Home Health Aide	Per Visit

Thresholds

Please note that if there are multiple treating providers, only one request is needed. The request needs to be submitted with the treating provider as the pay to-provider.

We will no longer accept multiple requests for one treatment plan date range. All codes and units must be submitted for the entire treatment plan once the threshold is met. The only exception will be if there was an additional visit needed, but documentation must report why the date of service was not included in the treatment plan or initial request

Waiver Skilled Nursing

The criteria for Waiver Skilled Nursing reviews are located at ***https://wymedicaid.telligen.com.***

Requests must be submitted by the skilled nursing provider. Requests submitted by the Case Manager will not be processed. The request will be voided. A new request will need to be submitted by the servicing provider. Please contact the waiver Benefits and Eligibility Specialist for questions.

Reviews for Waiver Skilled nursing may be submitted no earlier than 60 days prior to the start of the Plan of Care. The request must contain a signed MD order. The MD order needs to be signed no earlier than 60 days prior to the Start Date of the Plan of Care. Verbal orders are not sufficient. The MD order must be in writing and supported in the individual's Plan of Care.

The HCBS Request for Prior Authorization of Skilled Nursing form must be signed by the skilled nursing provider RN. This document must be completed and attached to the request for authorization.

Waiver services must fit within the member's existing budget and are subject to the availability of funds.

Please ensure your Plan of Care includes adequate information on any functional limitations that restrict the member's ability to care for him/herself and the availability and willingness of any natural supports.

Medication Assistance

Developmental Disabilities (DD) Comprehensive/Support Waivers: Medication Assistance should not be provided as part of Waiver Skilled Nursing services unless they are for IV or IM injections. Requests for medication assistance will be denied.

Community Choices Waiver (CCW): Home and community-based services should be delivered in the least restrictive manner and members of these programs should access the community as much as possible. Providers should ensure that they are not requesting skilled nursing services because it is easier to deliver it in this manner, but because there is some sort of barrier that is preventing the person from accessing services normally (i.e. monitoring or administration in the doctors' office). If there is a barrier then that must be specifically described, and the request should include why this is the only option. Simply saying a person is at risk of re-hospitalization does not mean that the member can't receive support in another way.

If you have questions, please contact the Waiver program at 800-510-0280.

Pre-Admission Screening and Resident Review (PASRR) Level II

Telligen completes PASRR Level II reviews when triggered by a PASRR Level I. PASRR refers to Pre-Admission Screening and Resident Review, a federally mandated program that requires all states to develop a comprehensive process to pre-screen all individuals applying for admission into Medicaid certified nursing facility care regardless of their payer source.

Everyone who applies for admission to a nursing facility (NF) must be screened for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities, or related conditions. Generally speaking, the intent of PASRR is to ensure that all NF applicants are thoroughly evaluated, placed in nursing facilities *only* when appropriate, and receive all necessary services while they are there. For those who are currently in a NF, the PASRR II is completed when a change in condition occurs. Information regarding the PASRR process is available on the Telligen website or by calling ***(833) 610-1057***. The PASRR Manual can be found at the WY Department of Health's Medicaid website: **https://wyomingmedicaid.com/portal/Provider-Manuals-and-Bulletins/Institutional- UBManual-and-Bulletins**

PASRR Level II reviews are required to be completed PRIOR to admission.

PASRR Categoricals are required to be submitted into the Telligen system but will not receive a full PASRR Level II.

Severe Malocclusion Program

Medicaid eligible Members under the age of 19 may receive treatment for severe malocclusion. Medicaid only reimburses codes D8000-D89999 to enrolled orthodontists who have obtained a Prior Authorization (PA) for treatment in the Wyoming Severe Malocclusion Program (SMP) prior to treatment.

Severe malocclusion is defined as malocclusion that is detrimental to the child's physical well-being, i.e., the ability to chew food in a compatible manner for digestion and/or breathing, or for corrections of speech pathology

Referral to the Severe Malocclusion Program

When a Member is provided services at their general dentist for a check-up appointment, and the Member appears to meet criteria of the Severe Malocclusion Program, the Member may be referred to an enrolled orthodontist. It is up to the Provider to know the criteria for the Severe Malocclusion Program and to only refer appropriate Members to the participating orthodontists.

Additional information regarding the Severe Malocclusion Program can be found in the WY BMS Dental Provide Manual located on the Wyoming Medicaid Website at the following link: Provider Dental Manuals | Serving Wyoming Medicaid Providers and Members

Forms for the Severe Malocclusion Program can be found at: Document Library | Wyoming Medicaid (telligen.com)

Other Telligen Reviews

Post Pay Reviews

Telligen is required to conduct post pay reviews monthly to evaluate medical necessity, appropriateness of level of care, quality of care and appropriate utilization of services. This requirement is defined in state and federal guidelines. The reviews are conducted after a member receives treatment in an inpatient or outpatient setting.

Facilities and providers are mailed certified letters requesting complete medical records for specific dates of service to complete the random post pay reviews. Facilities have twenty working days after the date on the certified request letter to submit the requested medical records to Telligen. It is the responsibility of the provider/facility to confirm that Telligen has received the required documentation. **Refusal to timely provide the requested information may result in suspension of provider payment** as stated in Wyoming Medicaid Rules, Chapter 3, Section 8(f), and Chapter 16, Sections 12(a) and (c). If you have any questions about the post pay medical necessity review, please call Telligen and follow the prompts for Prior Authorization: ***(833) 610-1057***. Prompts for prior authorizations for questions on post pay reviews will be an option on the phone line.

Focused Reviews

Focused reviews are performed at the direction of the Division of Healthcare Financing and may focus on:

- A single facility
- A single provider
- A member procedure
- A category of services

The focused review may be requested to review under and/or improper utilization of services and high-volume services. Telligen requests medical records to complete the review. For complicated or specialized reviews, Telligen has access to additional peer reviewers.

On-site Compliance Reviews (OSCR) of Psychiatric Residential Treatment Facilities

In coordination with the state of Wyoming, Telligen will conduct routine on-site reviews of Psychiatric Residential Treatment Facilities (PRTF) to monitor the facility's compliance with program requirements. On-site reviews may include, but are not limited to:

- Examination of records
- Interviews of providers, their associates, and employees
- Interviews of program members

- Verification of professional credentials of providers, their associates, and their employees
- Examination of any equipment, stock, materials, or other items used in or for the treatment of program members
- Examination of prescriptions written for program members
- Determination of whether the healthcare provided was medically necessary
- Random sampling of claims submitted by, and payments made to providers
- Audit of facility financial records for reimbursement

The facility must grant Telligen access during regular business hours to examine medical and financial records related to healthcare billed to the program.

Refusal to grant the State and its representatives (including Telligen) access to examine records or to provide copies of records when requested may result in:

- Immediate suspension of all Medicaid payments
- Suspension of all Medicaid payments furnished after the requested date of service.
- Reimbursement will not be reinstated until adequate records are produced or are being maintained.
- Repayment to the Division of Healthcare Financing of all Medicaid payments made to the provider during the six (6) year record retention period from the end of the State Fiscal Year (July through June) for which records supporting such payments are not produced.

1915c Waiver Reviews

Telligen conducts 1915c waiver mortality reviews for members receiving services in the six (6) HCBS waivers in Wyoming. The purpose of the review is to ensure members are receiving appropriate services and treatment.

Facilities and providers are mailed letters requesting medical records to complete the 1915c waiver reviews. Facilities/providers have twenty (20) working days to submit the requested medical records to Telligen when they receive the certified letter. If you have any questions about the 1915c review process or letters, please call Telligen at ***(833) 610-1057.***

Disability Determinations

Telligen is contracted by the Wyoming Department of Health to perform medical record reviews and make disability determinations according to Social Security guidelines. The Wyoming Department of Health forwards a referral to Telligen when a disability determination is needed. Referrals, along with medical records, are sent to Telligen. Each medical record review is completed by a Registered Nurse (RN); a

physician (MD) then reviews the recommendation and provides final approval. You may receive a request for medical records from us as we fulfill this service.

Medical Record Requests

Member medical records may be requested by Telligen for utilization management, medical management, disability determinations, Pre-Admission Screening and Resident Review (PASRR), 1915c reviews, post pay reviews, On-Site Compliance Reviews (OSCRs), and other types of reviews as needed. Pursuant to Wyoming and Federal Medicaid rules, providers may not charge, bill, or request payment from the State of Wyoming or Telligen, for submission of medical records, reports or other documents requested that substantiate the services rendered to the member.

Census Reporting

Acute Inpatient Facilities

All enrolled Wyoming Medicaid acute inpatient facilities are **required** to submit an Inpatient Census Report (ICR) as outlined below. This requirement complies with the specifications located in **Chapter 29, Section 3 of the Wyoming Medicaid Rule**. If a facility does not comply with this requirement, efforts will be made to reach out via phone, email, and/or postal mail reminding the facility of this requirement.

Continued failure to submit the required census reports may result in additional action, including payment reduction or claims recovery as outlined in Chapter 29, Section 3 of the Wyoming Medicaid Rules.

Census reports are to be submitted by all acute medical and psychiatric inpatient facilities no later than 5:00 pm on Friday of each week. If Friday is not a working day, the report must be submitted by 5:00 pm on the preceding working day.

Options to Fulfill this Requirement Include:

1. Entering your data into the designated Google Form here: **https://forms.gle/HvsYZkA4Sn2YBohC8**

2. Connecting your system to the Wyoming Frontier Information System (WYFI) to include ADT alerts. For more information about this option, please view their website: **https://health.wyo.gov/healthcarefin/wyoming_frontier_information_wyfi/**

You can use the WYFI Connection Request Form to request someone contact you about setting up the connection.

For questions regarding the Inpatient Census Report process or requirements, please contact **Amy.Buxton.wyo.gov**

Provider Relations

Provider Relations Activities

The Provider Relations team works closely with providers and community stakeholders to build strong working partnerships in care. Outreach activities include, but are not limited to:

Providers

- Serve as primary point of contact for any questions/concerns
- Conduct education and training as needed

Community

- Attendance at association conferences, meetings, and other events
- Participation in community events,
- Collaboration with the state of Wyoming

Training Topics

Provider Relations staff conducts education on a range of topics including, but not limited to:

- Overview of Telligen
- Utilization Management (UM) Processes
- Qualitrac (Portal for submitting Prior Authorization requests)
- Medical Necessity and Level of Care Guidelines
- Requirements Related to Daily Census Reports
- Other topics as needed/requested

Forms

Behavioral Health and Medical Review Forms

We maintain a library of the forms that are utilized to request prior authorizations for initial and concurrent reviews on our website, Medical and Behavioral Health Forms can be found at https://wymedicaid.telligen.com/document-library/

These forms may be completed and submitted to ensure a complete record for reviewers.

Other forms that may be required to be submitted as part of required documentation can be found **https://www.wyomingmedicaid.com/portal/Provider-Manuals-and-Bulletins**

Miscellaneous

Contact Us

The Telligen team can be reached in multiple ways:

Phone: ***(833) 610-1057***

Fax: ***(877) 897-0111***

Website: ***https://wymedicaid.telligen.com/***

E-mail**: *wymedicaidum@telligen.com***

Transportation

Wyoming Medicaid can assist with transportation to and from healthcare appointments. The phone number for requesting transportation is ***1-855-294-2127***. All transportation services are administered by the state of Wyoming.