Certification Page
Regular and Emergency Rules
Revised June 2020

☐ **Emergency Rules** *(Complete Sections 1-3 and 5-6)* ☒ **Regular Rules**

1. General Information			
a. Agency/Board Name* Workforce Services, Department of			
b. Agency/Board Address 5221 Yellowstone Road		c. City Cheyenne	d. Zip Code 82002
e. Name of Agency Liaison Marcia J. Price		f. Agency Liaison Telephone Number 307-777-6746	
g. Agency Liaison Email Address marcia.price@wyo.gov	h. Adoption Date 12/7/2021		
i. Program Workers' Compensation			
Amended Program Name (*if applicable*):			

*☐ *By checking this box, the agency is indicating it is exempt from certain sections of the Administrative Procedure Act including public comment period requirements. Please contact the agency for details regarding these rules.*

2. Legislative Enactment For purposes of this Section 2, "new" only applies to regular (non-emergency) rules promulgated in response to a Wyoming legislative enactment not previously addressed in whole or in part by prior rulemaking and does not include rules adopted in response to a federal mandate.

a. Are these non-emergency or regular rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

☒ **No.** ☐ **Yes.** If the rules are new, please provide the Legislative Chapter Numbers and Years Enacted (e.g. 2015 Session Laws Chapter 154):

3. Rule Type and Information For purposes of this Section 3, "New" means an emergency or regular rule that has never been previously created.

a. Provide the Chapter Number, Title* and Proposed Action for Each Chapter. *Please use the "Additional Rule Information" form to identify additional rule chapters.*

Chapter Number:	Chapter Name:	Action
9	Fee Schedules	☐ New ☒ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
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	Amended Chapter Name (*if applicable*):	

4. Public Notice of Intended Rulemaking

a. Notice was mailed 45 days in advance to all persons who made a timely request for advance notice. ☐ No. ☑ Yes. ☐ N/A

b. A public hearing was held on the proposed rules. ■ No. ☐ Yes. Please complete the boxes below.

Date:	Time:	City:	Location:

5. Checklist

a. ☑ For regular rules, the Statement of Principal Reasons is attached to this Certification and, in compliance with Tri-State Generation and Transmission Association, Inc. v. Environmental Quality Council, 590 P.2d 1324 (Wyo. 1979), includes a brief statement of the substance or terms of the rule and the basis and purpose of the rule

b. ☐ For emergency rules, the Memorandum to the Governor documenting the emergency, which requires promulgation of these rules without providing notice or an opportunity for a public hearing, is attached to this Certification.

6. Agency/Board Certification

The undersigned certifies that the foregoing information is correct. By electronically submitting the emergency or regular rules into the Wyoming Administrative Rules System, the undersigned acknowledges that the Registrar of Rules will review the rules as to form and, if approved, the electronic filing system will electronically notify the Governor's Office, Attorney General's Office, and Legislative Service Office of the approval and electronically provide them with a copy of the complete rule packet on the date approved by the Registrar of Rules. The complete rules packet includes this signed certification page; the Statement of Principal Reasons or, if emergency rules, the Memorandum to the Governor documenting the emergency; and a strike and underscore copy and clean copy of each chapter of rules.

Signature of Authorized Individual	Elizabeth Gagen
Printed Name of Signatory	Elizabeth Gagen
Signatory Title	Deputy Director, DWS
Date of Signature	12-7-21

7. Governor's Certification

I have reviewed these rules and determined that they:

1. Are within the scope of the statutory authority delegated to the adopting agency;
2. Appear to be within the scope of the legislative purpose of the statutory authority; and, if emergency rules,
3. Are necessary and that I concur in the finding that they are an emergency.

Therefore, I approve the same.

Governor's Signature	
Date of Signature	

Statement of Reason
Workers' Compensation Chapter 9 – Fee Schedules

Wyoming Workers' Compensation Chapter 9 – Fee Schedules rules were last updated on 9/3/2021. The Division usually updates the fee schedules and the rules each year to adopt the most recent codes published by the American Medical Association (AMA) and Optum 360. Fee schedules are a cost containment strategy as well as ensuring our injured workers can obtain quality health care and our health care providers are reimbursed at a fair rate.

The Division proposes to adopt the 2022 fee schedule, effective 1/1/22, and with the following changes (including minor formatting, grammatical and weblink updates):

1. Section 1 – General Guidelines, Section 2 – Fee Schedules, and Section 4 – Fees for Supplies, Implants, Durable Medical Equipment (DME), Orthotics and Prosthetics, changes include using a fee based on the date of service submitted. Section 1 and Section 2 also includes incorporation by reference language to adopt the most recent editions of the Relative Values for Physicians and the Relative Values for Dentists fee schedules.

2. Added new Section 10 – Fees for Home Infusion Therapy. This section defines how home infusion therapy, fees and drugs used will be reimbursed. Here is the actual proposed rule:

Section 10. Fees for Home Infusion Therapy

(a) Home Infusion Therapy will be paid in accordance with the Wyoming Medicare Home Infusion Therapy Fees, for the year of service submitted, plus a thirty percent (30%) increase.

(b) The Division shall pay only one of the G-codes per line item date of service when one of the drugs from the applicable category is billed with the same line item date of service or a date of service within thirty (30) days prior to the G-code visit.

(i) The fees associated with the G-codes on the MPFSD fee file will be "a per day rate"; therefore, the units on the line should not be multiplied by the rate.

(ii) The drug remains separately payable from the G-code line item home infusion therapy suppliers will report the following HCPCS G-codes associated with the payment categories for the professional services furnished in the individual's home and on an infusion drug administration calendar day.

(iii) For additional information regarding the Medicare rates and coding for these services, please visit: https://www.cms.gov/files/document/se19029.pdf and https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/home-infusion-therapy-fees

Mark Gordon
Governor

State of Wyoming
Department of Workforce Services

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Robin Sessions Cooley, J.D.
Director

Elizabeth Gagen, J.D.
Deputy Director

November 23, 2021

Public Comments
For Workers' Compensation Chapter 9 – Fee Schedules

The Secretary of State's office accepted and posted the proposed rule for public viewing on October 4, 2021. On October 5, 2021, an email was sent out to all interested parties and was posted on the DWS website as a public notice.

On October 10, 2021, a public notice was published in the Casper newspaper for statewide notice.

The 45 day public comment period for this rule expired on November 19, 2021.

No public comments were received.

CHAPTER 9
FEE SCHEDULES

Section 1. General Guidelines. Pursuant to Wyoming Statutes § 27-14-401(b), (e), and (g) medical and or hospital care shall be reviewed for appropriateness and reasonableness and shall be reimbursed according to the adopted schedule(s). The following guidelines are applicable to each section within this chapter.

(a) All claims shall be paid in accordance with the fee schedule in effect at the time of service.

(b) Certain services may be subject to preauthorization pursuant to Chapter 10 of these rules. These guidelines can be found at: http://www.wyomingworkforce.org/providers/preauth/

(c) The Division shall use accepted medical resources and publications to aid in adjudicating bills. This shall include, but not be limited to, the most recent edition of the following sources at the time services are rendered the American Medical Association (AMA), Current Procedural Terminology codebook (CPT), the AMA Knowledge Base System and The American Academy of Orthopaedic Surgeons, Complete Global Values Service Data for Orthopaedic Surgery Guidelines, Centers for Medicare and Medicaid Services (CMS), and the Division's medical advisors.

(d) The Division may change billed codes to achieve compliance with the current rules and regulations. The provider payment statement shall advise of code changes and the right to appeal.

(e) Codes designated as Relativity Not Establish (RNE), or By Report (BR) shall be assigned the unit value of a comparable procedure or procedures.

(f) In no case shall any provider bill for charges greater than those charged the general public for like services.

(g) The Division shall not pay more than the total billed amount.

Section 2. Fee Schedules.

(a) The Division adopts the most recent version published prior to the date of service for the following references *Relative Values for Physicians (RVP),* as published by Optum360, LLC, as authored by Relative Value Studies, Inc., insofar as it addresses medical matters under the Act unless otherwise defined in this chapter and, the *Relative Values for Dentists (RVD),* as published and authored by Relative Value Studies, Inc., Thornton, Colorado, insofar as it addresses dental matters under the Act.

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

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (a) of this section,

(iii) The incorporated code, standard, rule or regulation is maintained at 5221 Yellowstone Road, Cheyenne, WY 82002 and is available for public inspection and copying at cost at the same location.

(b) Each code incorporated by reference in these rules is further identified as follows:

(i) *Relative Values for Physicians (RVP)* and *Relative Values for Dentists (RVD)*, as they were in effect on the date of service submitted, and adopted by the Department of Workforce Services, Wyoming Workers' Compensation Division.

(ii) National Correct Coding Initiative/Medicare Unlikely Edits, NCCI and MUE as they were in effect on January 1, of the year for the date of service submitted, and adopted by the Department of Workforce Services, Wyoming Workers' Compensation Division found at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

(A) MUE edits under CMS that have a value of 0 (zero) will be overridden and reviewed for medical necessity and relatedness to the injury and treatment.

(c) Conversion Factors for Professional Fees. The Division adopts the following conversion factors.

SPECIALTY GROUP	CONVERSION FACTOR
Anesthesia	$ 51.06
Surgeon	$ 120.21
Radiology/Nuclear Medicine	$ 21.97
Pathology/Laboratory	$ 15.23
Medicine	$ 7.91
Physical Medicine	$ 6.39
Evaluation and Management	$ 8.34
Dental	$ 55.73

(d) Modifiers for Anesthesia and Surgical Assistants.

(i) Surgical Assistants.

(A) MD assistants shall be paid 20% of the surgical allowance.

(B) Non-MD assistants shall be paid 15% of the surgical allowance.

(ii) Anesthesia.

(A) All services are paid in accordance with the Wyoming Fee Schedules in effect at the time that services are rendered.

(B) At least one of the following anesthesia modifiers must be submitted with each bill.

(C) Modifiers P1-P6 are suggested but not required.

(D) AA-anesthesia services performed by the Anesthesiologist, are paid at one hundred percent (100%) of the allowable fees.

(E) AD-medical supervision by a Physician with more than four (4) concurrent anesthesia procedures are paid at fifty percent (50%) of the allowable fees.

(F) QK-medical direction of two (2), three (3) or four (4) concurrent anesthesia procedures involving qualified individuals are paid at fifty percent (50%) of the allowable fees.

(G) QX-qualified non-physician Anesthetist with medical direction by a Physician are paid at fifty percent (50%) of the allowable fees.

(H) QY-medical direction of one qualified non-physician Anesthetist by an Anesthesiologist are paid at fifty percent (50%) of the allowable fees.

(I) QZ-CRNA (Certified Registered Nurse Anesthetist) without medical direction by a Physician are paid at one hundred percent (100%) of the allowable fees.

(e) Fees for Independent Medical Evaluations (IME), Permanent Partial Impairment Ratings (PPI), Medical Testimony and Deposition(s). See Chapter 10, and Chapter 9, Section 1 for additional guidelines. Medical bills must indicate total time spent on review of records, actual examination and writing of the report on the written report and the CMS-1500 claim form. The medical report must include a breakdown of the total time spent. Medical bills must also include time spent on travel, if applicable.

(i) Independent Medical Evaluations (IME) or Impairment Ratings. The Division shall pay according to the following fee schedule:

(A) If the IME or Impairment Rating is completed by the treating physician, use Code 99455. If the IME or Impairment Rating is completed by a physician, other than the treating healthcare provider, use Code 99456.

Code	**Time**	**Payment**
99455-99456	1st hour	$750.00
	Each additional 15 minutes	$93.75

(ii) Medical Testimony and Deposition Charges. The Division shall pay according to the following fee schedule:

Code	**Time**	**Payment**
99075	1st hour	$750.00
	Each additional 15 minutes	$65.00

Section 3. Fees for Home Health Nursing.

(a) The Division adopts the following fee-based schedule guidelines for home health nursing services being provided by independent Medicare/Medicaid certified agencies. This is a straight fee, no overtime, holiday rate, or shift differential shall be paid and Fair Labor Standards Act (FSLA) exempt. A visit equals a range of fifteen (15) minutes to a maximum of four (4) hours per day. See Chapter 10, Section 17 and Chapter 9, Section 1 for additional guidelines.

Type of Nursing	Per Visit Rate
RN	$146.50
LPN	$146.50
CNA	$66.34

(b) The Division adopts the following fee-based schedule guidelines for Private duty services/attendant care. This fee schedule is for long term daily care at home and is Fair Labor Standards Act (FSLA) exempt. This is a straight hourly fee, no overtime, holiday rate or shift differential shall be paid. See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

Type of Nursing	Hourly Rate
RN	$35.00
LPN	$35.00
CNA	$16.00
*Attendant	*Federal minimum wage

*Attendant care includes personal care for activities of daily living. A physician prescription and time limit is required. Attendant care shall be provided by individuals approved by the primary treating health care provider.

Section 4. Fees for Supplies, Implants, Durable Medical Equipment (DME), Orthotics and Prosthetics.

(a) The Division adopts the Wyoming Medicare rate plus thirty percent (+30%) of the Healthcare Common Procedure Coding System (HCPCS) as the rates were published as of January 1, of the year for the date of service submitted, for the payment of supplies, DME, orthotics and prosthetic devices prescribed by a health care provider. See Chapter 9, Section 1 for additional guidelines. The Division shall not pay for any supplies, DME, orthotics, or prosthetics unless prescribed by the primary health care provider. The Division will not include quarterly updates for these payments, the payments will remain consistent with the January 1, of the year for the date of service submitted published rates.

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

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection a of this section;

(iii) The incorporated code, standard, rule or regulation is maintained at 5221 Yellowstone Road, Cheyenne, WY 82002 and is available for public inspection and copying at cost at the same location.

(b) Each code incorporated by reference in these rules is further identified as follows:

(i) Reference to the Rural Wyoming Medicare rate of the Healthcare Common Procedure Coding System (HCPCS) is adopted by the Division and effective on January 1, of the year for the date of service submitted found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS- Fee-Schedule.html

(c) Any related charges for supplies, DME, orthotics and prosthetics not listed in the Medicare HCPCS fee schedule shall be paid at eighty percent (80%) of billed charges. Charges deemed excessive shall require additional documentation for justification.

(i) Any single supply/implant charged at $1,000.00 or more, shall require a suppliers' invoice. Reimbursement shall be at 130% of invoice cost. Shipping and handling charges shall not be reimbursed.

(ii) The Division shall not provide direct payment to suppliers or manufacturers for implantable items.

(d) The preceding fees are not intended to address newly developed items or technologies.

Section 5. **Fees for Hearing Aids/Prescription Lenses.** See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

(a) The Division shall pay 130% of the supplier's/manufacturer's invoice price for hearing aids when the provider submits the invoice to the Division.

(b) The Division shall reimburse for frames and lenses as prescribed for compensable vision loss, or replacement due to a work-related accident, not to exceed 80% HCPCS usual and customary benchmarks as determined annually by the Division. The Division may demand additional documentation and justification for any charges deemed excessive by the Division.

(c) The Division shall reimburse an injured worker for the repair or comparable replacement of a hearing aid device or prescription lens damaged or destroyed in a work- related accident.

Section 6. Fees for Pharmacy Items. Pharmaceuticals must be billed with a National Drug Code (NDC). See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

(a) Pharmaceuticals shall be reimbursed at the lower of:

(i) Average Wholesale Price (AWP) minus 10% plus a $5.00 dispensing fee; or

(ii) The provider's usual and customary charge. In no case shall any provider bill for charges greater than those charged to the general public for like services. The Division reserves the right to review such charges and reimburse at the usual and customary rate if a discrepancy is found.

(b) Reimbursement shall be decreased by $2.50 per prescription if a paper claim is submitted unless:

(i) The provider has received prior approval from the Division to submit a claim on paper.

(ii) Electronic billing is unavailable at the time of service making it is unreasonable to submit the claim through the online process.

(c) Over the counter items that do not have a valid NDC number shall be considered supplies and shall not be paid with an added dispensing fee. See Chapter 9, Section 4 for additional guidelines.

(i) Please see the nutritional supplements section in Chapter 10, Section 18 for additional information.

(d) If the pharmaceutical is a repackaged drug, as determined by the NDC for the product dispensed, reimbursement shall be calculated per Section 6(a) using the AWP of the lowest cost therapeutic equivalent product.

(e) If a pharmaceutical intended for outpatient use is dispensed through the office of a medical care provider, reimbursement will be calculated per Section 6(a) – (d), equivalent to the reimbursement provided to a retail pharmacy.

Section 7. **Fees for Compounded Medications. –** See Chapter 10, Section 7, and Chapter 9, Section 1 for additional guidelines.

(a) Physicians billing for compounded drugs must provide the pharmacy invoice. The Division shall pay 130% of the supplier's/manufacturer's invoice price.

(b) Compounding pharmacies that bill directly, shall be compensated for the drugs prescribed and related materials in accordance with Chapter 9, Section 6. The Division shall allow a fee for compounding services. Compounding medications shall be reimbursed per line item if each ingredient is determined to be coverable per Chapter 10, Section 7, Compound Prescription Medications.

Section 8. Fees for Ambulance Services.

(a) Ambulance services shall be paid the lesser of the billed charge or the maximum allowable rate for the code appropriate for the documented service. The maximum allowable rates are all-inclusive. Mileage shall be reimbursed per documented loaded statute mile. See Chapter 9, Section 1 for additional guidelines. Contact the Division for additional information regarding Air Ambulance codes and reimbursement.

(b) The Division adopts CMS Medicare rates plus 10%, these rates can found at: https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/ambulance-fees

(c) The following codes shall be recognized by the Division:

Code	Short Descriptor	Maximum Allowable – Medicare plus 10%
A0425	Mileage, Ground	$8.45 per statute mile
A0426	Advance Life Support – 1, Non-Emergent	$387.60
A0427	Advance Life Support - 1, Emergent	$613.69
A0428	Basic Life Support, Non-Emergent	$322.99
A0429	Basic Life Support, Emergent	$516.79
A0433	Advance Life Support – 2	$888.24
A0434	Specialty Care Transport	$1,049.74

(d) Please contact the Division's Provider Service Unit for information regarding Air Ambulance reimbursement at: (307) 777-7441.

Section 9. Facility Fees.

(a) Fees for Inpatient Hospital Services.

(i) Inpatient hospital services shall be reimbursed in accordance with the CMS IPPS (Inpatient Prospective Payment System) payment methodology. With the Wyoming Base Rate ($5,961.31 + 30%): $7,749.70 and the MS-DRG (Medicare Severity-Diagnosis Related Group) weight according to the CMS Table 5 (for the corresponding year of service) found at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

(ii) Required documentation to support billed charges are as follows:

(A) Detailed itemization;

(B) Anesthesia graphic;

(C) Operative report;

(D) History and physical;

(E) Discharge summary;

(F) Implant Log/itemization; and,

(G) Supplier's invoice for any single supply/implant charged at one thousand dollars ($1,000.00) or more. Such items shall be reimbursed at one hundred thirty percent (130%) of invoice amount. Shipping and handling charges shall not be reimbursed.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(v) Critical Access Hospitals (CAH) will be paid in accordance with the Tricare Cost-to-Charge Ratio's plus a twenty percent (20%) increase for the year of service submitted. More information can be found at: https://www.tricare-west.com/content/hnfs/home/tw/prov/claims/billing_tips/CAH_Reimbursement.html

(b) Fees for Skilled Nursing Services.

(i) Inpatient Skilled Nursing Services shall be reimbursed in accordance with the Annual Skilled Nursing Facility Per Diem Room Rate Survey conducted by the Division.

(ii) The per diem room rates for a semi-private bed shall be the usual and customary rates charged to the general public. Such rates shall be effective automatically on the first day of each calendar year.

(A) The per diem room rates will be all inclusive of the care for the claimant for the day. This includes but is not limited to:

(I) Administration of oxygen and related medication;

(II) Hand feedings;

(III) Incontinence Care;

(IV) Tray Service;

(V) Therapy Services, including physical therapy, occupational therapy, speech and language therapy;

(VI) Over the counter medications.

(B) Certain items are permitted to be billed outside of the per diem rate, such as:

(I) Ambulance services when medically necessary;

(II) Some durable medical equipment (DME) items;

(III) Wheelchairs;

(IV) Braces;

(V) Medical services including laboratory, radiology and surgical procedures;

(VI) Physician and other practitioner services, excluding physical therapy, occupational therapy and speech and language therapy;

(VII) Prosthetics.

(c) Fees for Inpatient Rehabilitation Services.

(i) Inpatient Rehabilitation Services shall be reimbursed at eighty percent (80%) of billed charges.

(ii) Required documents to support billed charges are as follows:

(A) History and physical;

(B) Daily Notes including physician visits, therapy notes, nursing notes, etc.; and,

(C) Discharge summary, if applicable.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(d) Fees for Ambulatory Surgery Services.

(i) Ambulatory Surgery Services shall be reimbursed in accordance with Wyoming Medicare ASC (Ambulatory Surgery Center) rates at one hundred thirty percent (130%) of the allowed amount, found at: https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf

(ii) Required documentation to support billed charges are as follows:

(A) Operative report.

(B) Implant Log/itemization – if applicable (device allowance will be calculated into the ASC total allowance).

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(e) Fees for Outpatient Facility Services.

(i) Outpatient Services shall be reimbursed in accordance with Wyoming Medicare APC (Ambulatory Payment Classifications) rates at one hundred thirty percent (130%) of the allowed amount, found at: https://public-inspection.federalregister.gov/2020-26819.pdf

(ii) Required documentation to support billed charges are as follows:

(A) Treatment notes to support the billed services.

(B) Physicians Order/Prescription.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

Section 10. Fees for Home Infusion Therapy

(a) Home Infusion Therapy will be paid in accordance with the Wyoming Medicare Home Infusion Therapy Fees, for the year of service submitted, plus a thirty percent (30%) increase.

(b) The Division shall pay only one of the G-codes per line item date of service when one of the drugs from the applicable category is billed with the same line item date of service or a date of service within thirty (30) days prior to the G-code visit.

(i) The fees associated with the G-codes on the MPFSD fee file will be "a per day rate"; therefore, the units on the line should not be multiplied by the rate.

(ii) The drug remains separately payable from the G-code line item home infusion therapy suppliers will report the following HCPCS G-codes associated with the payment categories for the professional services furnished in the individual's home and on an infusion drug administration calendar day.

(iii) For additional information regarding the Medicare rates and coding for these services, please visit: https://www.cms.gov/files/document/se19029.pdf and https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/home-infusion-therapy-fees

CHAPTER 9
FEE SCHEDULES

Section 1. General Guidelines. Pursuant to Wyoming Statutes § 27-14-401(b), (e), and (g) medical and or hospital care shall be reviewed for appropriateness and reasonableness and shall be reimbursed according to the adopted schedule(s). The following guidelines are applicable to each section within this chapter.

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(c) The Division shall use accepted medical resources and publications to aid in adjudicating bills. This shall include, but not be limited to, the most recent edition of the following sources at the time services are rendered the American Medical Association (AMA) ~~(2021),~~ Current Procedural Terminology codebook (CPT) ~~(2021)~~, the AMA Knowledge Base System ~~(2021),~~ and The American Academy of Orthopaedic Surgeons ~~(2021),~~ Complete Global Values Service Data for Orthopaedic Surgery Guidelines ~~(2021),~~ Centers for Medicare and Medicaid Services (CMS), and the Division's medical advisors.

(d) The Division may change billed codes to achieve compliance with the current rules and regulations. The provider payment statement shall advise of code changes and the right to appeal.

(e) Codes designated as Relativity Not Establish (RNE), or By Report (BR) shall be assigned the unit value of a comparable procedure or procedures.

(f) In no case shall any provider bill for charges greater than those charged the general public for like services.

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Section 2. Fee Schedules.

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

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(ii) National Correct Coding Initiative/Medicare Unlikely Edits, NCCI and MUE as they were in effect on January 1, ~~2021~~, of the year for the date of service submitted, and adopted by the Department of Workforce Services, Wyoming Workers' Compensation Division found at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

(A) MUE edits under CMS that have a value of 0 (zero) will be overridden and reviewed for medical necessity and relatedness to the injury and treatment.

(c) Conversion Factors for Professional Fees. The Division adopts the following conversion factors.

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(d) Modifiers for Anesthesia and Surgical Assistants.

(i) Surgical Assistants.

(A) MD assistants shall be paid 20% of the surgical allowance.

(B) Non-MD assistants shall be paid 15% of the surgical allowance.

(ii) Anesthesia.

(A) All services are paid in accordance with the Wyoming Fee Schedules in effect at the time that services are rendered.

(B) At least one of the following anesthesia modifiers must be submitted with each bill.

(C) Modifiers P1-P6 are suggested but not required.

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(E) AD-medical supervision by a Physician with more than four (4) concurrent anesthesia procedures are paid at fifty percent (50%) of the allowable fees.

(F) QK-medical direction of two (2), three (3) or four (4) concurrent anesthesia procedures involving qualified individuals are paid at fifty percent (50%) of the allowable fees.

(G) QX-qualified non-physician Anesthetist with medical direction by a Physician are paid at fifty percent (50%) of the allowable fees.

(H) QY-medical direction of one qualified non-physician Anesthetist by an Anesthesiologist are paid at fifty percent (50%) of the allowable fees.

(I) QZ-CRNA (Certified Registered Nurse Anesthetist) without medical direction by a Physician are paid at one hundred percent (100%) of the allowable fees.

(e) Fees for Independent Medical Evaluations (IME), Permanent Partial Impairment Ratings (PPI), Medical Testimony and Deposition(s). See Chapter 10, and Chapter 9, Section 1 for additional guidelines. Medical bills must indicate total time spent on review of records, actual examination and writing of the report on the written report and the CMS-1500 claim form. The medical report must include a breakdown of the total time spent. Medical bills must also include time spent on travel, if applicable.

(i) Independent Medical Evaluations (IME) or Impairment Ratings. The Division shall pay according to the following fee schedule:

(A) If the IME or Impairment Rating is completed by the treating physician, use Code 99455. If the IME or Impairment Rating is completed by a physician, other than the treating healthcare provider, use Code 99456.

Code	**Time**	**Payment**
99455-99456	1st hour	$750.00
	Each additional 15 minutes	$93.75

(ii) Medical Testimony and Deposition Charges. The Division shall pay according to the following fee schedule:

Code	**Time**	**Payment**
99075	1st hour	$750.00
	Each additional 15 minutes	$65.00

Section 3. Fees for Home Health Nursing.

(a) The Division adopts the following fee-based schedule guidelines for home health nursing services being provided by independent Medicare/Medicaid certified agencies. This is a straight fee, no overtime, holiday rate, or shift differential shall be paid and Fair Labor Standards Act (FSLA) exempt. A visit equals a range of fifteen (15) minutes to a maximum of four (4) hours per day. See Chapter 10, Section 17 and Chapter 9, Section 1 for additional guidelines.

Type of Nursing	Per Visit Rate
RN	$146.50
LPN	$146.50
CNA	$66.34

(b) The Division adopts the following fee-based schedule guidelines for Private duty services/attendant care. This fee schedule is for long term daily care at home and is Fair Labor Standards Act (FSLA) exempt. This is a straight hourly fee, no overtime, holiday rate or shift differential shall be paid. See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

Type of Nursing	Hourly Rate
RN	$35.00
LPN	$35.00
CNA	$16.00
*Attendant	*Federal minimum wage

*Attendant care includes personal care for activities of daily living. A physician prescription and time limit is required. Attendant care shall be provided by individuals approved by the primary treating health care provider.

Section 4. Fees for Supplies, Implants, Durable Medical Equipment (DME), Orthotics and Prosthetics.

(a) The Division adopts the Wyoming Medicare rate plus thirty percent (+30%) of the Healthcare Common Procedure Coding System (HCPCS) as the rates were published as of January 1, ~~2021~~ of the year for the date of service submitted, for the payment of supplies, DME, orthotics and prosthetic devices prescribed by a health care provider. See Chapter 9, Section 1 for additional guidelines. The Division shall not pay for any supplies, DME, orthotics, or prosthetics unless prescribed by the primary health care provider. The Division will not include quarterly updates for these payments, the payments will remain consistent with the January 1, ~~2021~~ of the year for the date of service submitted published rates.

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

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection a of this section;

(iii) The incorporated code, standard, rule or regulation is maintained at 5221

Yellowstone Road, Cheyenne, WY 82002 and is available for public inspection and copying at cost at the same location.

(b) Each code incorporated by reference in these rules is further identified as follows:

(i) Reference to the Rural Wyoming Medicare rate of the Healthcare Common Procedure Coding System (HCPCS) is adopted by the Division and effective on January 1, ~~2021~~, of the year for the date of service submitted found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS- Fee-Schedule.html

(c) Any related charges for supplies, DME, orthotics and prosthetics not listed in the Medicare HCPCS fee schedule shall be paid at eighty percent (80%) of billed charges. Charges deemed excessive shall require additional documentation for justification.

(i) Any single supply/implant charged at $1,000.00 or more, shall require a suppliers' invoice. Reimbursement shall be at 130% of invoice cost. Shipping and handling charges shall not be reimbursed.

(ii) The Division shall not provide direct payment to suppliers or manufacturers for implantable items.

(d) The preceding fees are not intended to address newly developed items or technologies.

Section 5. **Fees for Hearing Aids/Prescription Lenses.** See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

(a) The Division shall pay 130% of the supplier's/manufacturer's invoice price for hearing aids when the provider submits the invoice to the Division.

(b) The Division shall reimburse for frames and lenses as prescribed for compensable vision loss, or replacement due to a work-related accident, not to exceed 80% HCPCS usual and customary benchmarks as determined annually by the Division. The Division may demand additional documentation and justification for any charges deemed excessive by the Division.

(c) The Division shall reimburse an injured worker for the repair or comparable replacement of a hearing aid device or prescription lens damaged or destroyed in a work- related accident.

Section 6. Fees for Pharmacy Items. Pharmaceuticals must be billed with a National Drug Code (NDC). See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

(a) Pharmaceuticals shall be reimbursed at the lower of:

(i) Average Wholesale Price (AWP) minus 10% plus a $5.00 dispensing fee; or

(ii) The provider's usual and customary charge. In no case shall any provider bill for charges greater than those charged to the general public for like services. The Division reserves the right to review such charges and reimburse at the usual and customary rate if a discrepancy is found.

(b) Reimbursement shall be decreased by $2.50 per prescription if a paper claim is submitted unless:

(i) The provider has received prior approval from the Division to submit a claim on paper.

(ii) Electronic billing is unavailable at the time of service making ~~and~~ it unreasonable to submit the claim through the online process.

(c) Over the counter items that do not have a valid NDC number shall be considered supplies and shall not be paid with an added dispensing fee. See Chapter 9, Section 4 for additional guidelines.

(i) Please see the nutritional supplements section in Chapter 10, Section 18 for additional information.

(d) If the pharmaceutical is a repackaged drug, as determined by the NDC for the product dispensed, reimbursement shall be calculated per Section 6(a) using the AWP of the lowest cost therapeutic equivalent product.

(e) If a pharmaceutical intended for outpatient use is dispensed through the office of a medical care provider, reimbursement will be calculated per Section 6(a) – (d), equivalent to the reimbursement provided to a retail pharmacy.

Section 7. **Fees for Compounded Medications. –** See Chapter 10, Section 7, and Chapter 9, Section 1 for additional guidelines.

(a) Physicians billing for compounded drugs must provide the pharmacy invoice. The Division shall pay 130% of the supplier's/manufacturer's invoice price.

(b) Compounding pharmacies that bill directly, shall be compensated for the drugs prescribed and related materials in accordance with Chapter 9, Section 6. The Division shall allow a fee for compounding services. Compounding medications shall be reimbursed per line item if each ingredient is determined to be coverable per Chapter 10, Section 7, Compound Prescription Medications.

Section 8. Fees for Ambulance Services.

(a) Ambulance services shall be paid the lesser of the billed charge or the maximum allowable rate for the code appropriate for the documented service. The maximum allowable rates are all-inclusive. Mileage shall be reimbursed per documented loaded statute mile. See Chapter 9, Section 1

for additional guidelines. Contact the Division for additional information regarding Air Ambulance codes and reimbursement.

(b) The Division adopts CMS Medicare rates plus 10%, these rates can found at: https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/ambulance-fees

(c) The following codes shall be recognized by the Division:

Code	Short Descriptor	Maximum Allowable – Medicare plus 10%
A0425	Mileage, Ground	$8.45 per statute mile
A0426	Advance Life Support – 1, Non-Emergent	$387.60
A0427	Advance Life Support - 1, Emergent	$613.69
A0428	Basic Life Support, Non-Emergent	$322.99
A0429	Basic Life Support, Emergent	$516.79
A0433	Advance Life Support – 2	$888.24
A0434	Specialty Care Transport	$1,049.74

(d) Please contact the Division's Provider Service Unit for information regarding Air Ambulance reimbursement at: (307) 777-7441.

Section 9. Facility Fees.

(a) Fees for Inpatient Hospital Services.

(i) Inpatient hospital services shall be reimbursed in accordance with the CMS IPPS (Inpatient Prospective Payment System) payment methodology. With the Wyoming Base Rate ($5,961.31 + 30%): $7,749.70 and the MS-DRG (Medicare Severity-Diagnosis Related Group) weight according to the CMS Table 5 (for the corresponding year of service) found at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

(ii) Required documentation to support billed charges are as follows:

(A) Detailed itemization;

(B) Anesthesia graphic;

(C) Operative report;

(D) History and physical;

(E) Discharge summary;

(F) Implant Log/itemization; and,

(G) Supplier's invoice for any single supply/implant charged at one thousand dollars ($1,000.00) or more. Such items shall be reimbursed at one hundred thirty percent

(130%) of invoice amount. Shipping and handling charges shall not be reimbursed.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(v) Critical Access Hospitals (CAH) will be paid in accordance with the Tricare Cost-to-Charge Ratio's plus a twenty percent (20%) increase for the year of service submitted. More information can be found at: https://www.tricare-west.com/content/hnfs/home/tw/prov/claims/billing_tips/CAH_Reimbursement.html

(b) Fees for Skilled Nursing Services.

(i) Inpatient Skilled Nursing Services shall be reimbursed in accordance with the Annual Skilled Nursing Facility Per Diem Room Rate Survey conducted by the Division.

(ii) The per diem room rates for a semi-private bed shall be the usual and customary rates charged to the general public. Such rates shall be effective automatically on the first day of each calendar year.

(A) The per diem room rates will be all inclusive of the care for the claimant for the day. This includes but is not limited to:

(I) Administration of oxygen and related medication;

(II) Hand feedings;

(III) Incontinence Care;

(IV) Tray Service;

(V) Therapy Services, including physical therapy, occupational therapy, speech and language therapy;

(VI) Over the counter medications.

(B) Certain items are permitted to be billed outside of the per diem rate, such as:

(I) Ambulance services when medically necessary;

(II) Some durable medical equipment (DME) items;

(III) Wheelchairs;

(IV) Braces;

(V) Medical services including laboratory, radiology and surgical procedures;

(VI) Physician and other practitioner services, excluding physical therapy, occupational therapy and speech and language therapy;

(VII) Prosthetics.

(c) Fees for Inpatient Rehabilitation Services.

(i) Inpatient Rehabilitation Services shall be reimbursed at eighty percent (80%) of billed charges.

(ii) Required documents to support billed charges are as follows:

(A) History and physical;

(B) Daily Notes including physician visits, therapy notes, nursing notes, etc.; and,

(C) Discharge summary, if applicable.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(d) Fees for Ambulatory Surgery Services.

(i) Ambulatory Surgery Services shall be reimbursed in accordance with Wyoming Medicare ASC (Ambulatory Surgery Center) rates at one hundred thirty percent (130%) of the allowed amount, found at: https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf

(ii) Required documentation to support billed charges are as follows:

(A) Operative report.

(B) Implant Log/itemization – if applicable (device allowance will be calculated into the ASC total allowance).

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(e) Fees for Outpatient Facility Services.

(i) Outpatient Services shall be reimbursed in accordance with Wyoming Medicare APC (Ambulatory Payment Classifications) rates at one hundred thirty percent (130%) of the allowed amount, found at: https://public-inspection.federalregister.gov/2020-26819.pdf

(ii) Required documentation to support billed charges are as follows:

(A) Treatment notes to support the billed services.

(B) Physicians Order/Prescription.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

Section 10. Fees for Home Infusion Therapy

(a) Home Infusion Therapy will be paid in accordance with the Wyoming Medicare Home Infusion Therapy Fees, for the year of service submitted, plus a thirty percent (30%) increase.

(b) The Division shall pay only one of the G-codes per line item date of service when one of the drugs from the applicable category is billed with the same line item date of service or a date of service within thirty (30) days prior to the G-code visit.

(i) The fees associated with the G-codes on the MPFSD fee file will be "a per day rate"; therefore, the units on the line should not be multiplied by the rate.

(ii) The drug remains separately payable from the G-code line item home infusion therapy suppliers will report the following HCPCS G-codes associated with the payment categories for the professional services furnished in the individual's home and on an infusion drug administration calendar day.

(iii) For additional information regarding the Medicare rates and coding for these services, please visit: https://www.cms.gov/files/document/se19029.pdf and https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/home-infusion-therapy-fees