WYOMING MEDICAID RULES

CHAPTER 1

DEFINITIONS

Section 1. Authority.

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

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to govern the definitions for all other chapters of the Wyoming Department of Health Medicaid Rules which come into effect on or after the effective date of this Chapter.

(b) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter.

Section 3. Definitions.

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

(b) For the purpose of these rules and regulations, the following definitions shall apply:

(i) "Abuse." A pattern of practice by a provider or a client that results in healthcare utilization which is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to Medicaid, or in payment for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse is characterized by, but not limited to, any one of the following:

(A) The repeated submission of claims by a provider from which documentation of required material information is missing, incorrect or not provided for review when requested. Examples include, but are not limited to: incorrect or missing procedure or diagnosis codes, missing or invalid signatures, invalid prescription documentation, incorrect mathematical entries, incorrect third party liability information, or the incorrect use of procedure code modifiers;

(B) The repeated submission of claims by a provider presenting procedure codes which overstate the level or amount of services provided (i.e., upcoding);

(C) The repeated submission of claims by a provider for services which are not reimbursable under Medicaid, or the repeated submission of duplicate claims;

(D) Failure by a provider to develop and maintain legible medical records which document the nature, extent and evidence of the medical necessity of services provided;

(E) Failure of a provider to use generally accepted accounting principles or other accounting methods which relate entries on the medical record to entries on the claim;

(F) Excessive or inappropriate patterns of referral;

(G) The repeated submission of claims by a provider for services which were not medically necessary;

(H) The repeated submission of claims by a provider for services which exceed that requested or agreed to by the client or the client's responsible relative or guardian;

(I) The submission of claims for services not medically necessary under the generally accepted practice of providers of such services;

(J) Overprescribing or misprescribing products or services;

(K) The repeated submission of claims by a provider without complying with the provisions of these rules;

(L) A client permitting the use of the client's Medicaid identification by any unauthorized individual for the purpose of obtaining services;

(M) A client obtaining services which are not medically necessary for the purpose of resale or for the use of a non-client;

(N) A client obtaining duplicate services from more than one (1) provider for the same medical condition, other than confirmation of a diagnosis, evaluation or assessment; or

(O) Misuse, which with respect to a client means the request for or utilization of services that are inappropriate and with respect to a provider means the furnishing of services that are inappropriate, or the submission of claims that do not accurately reflect the services provided.

(ii) "Acquired Brain Injury (ABI)." Any of the following:

(A) Any combination of focal and diffuse central nervous system dysfunction, both immediate and/or delayed, at the brain stem level and above;

(B) Acquired through the interaction of any external forces and the body, oxygen deprivation, infection, toxicity, surgery, and vascular disorders not associated with aging;

(C) Occurred by an injury to the brain since birth;

(D) Caused by an external physical force or by a metabolic disorder(s);

(E) Includes traumatic brain injuries, such as open or closed head injuries, and non-traumatic brain injuries, such as those caused by strokes, tumors, infectious disease, hypoxic injuries, metabolic disorders, and toxic products taken into the body through inhalation or ingestion;

(F) Does not include brain injuries that are congenital or brain injuries induced by birth trauma; and

(G) Are not developmental or degenerative.

(iii) "Acquired Brain Injury Home and Community Based Waiver." The "Acquired Brain Injury Home and Community Based Waiver" submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

(iv) "Active treatment." Active treatment as set forth in 42 C.F.R. § 441.154.

(v) "Acute." Having a short and relatively severe course.

(vi) "Acute stabilization." The process of bringing to stability an acute medical, psychiatric or psychological condition.

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

(viii) "Admission." The act that allows an individual to officially enter into a facility or program to receive covered services, which does not include an individual that is transferred from one unit of a hospital to another unit in the hospital or to a separate part of a hospital unit.

(ix) "Admission certification." The determination by the Department that all or part of a client's inpatient hospitalization meets or met the medical necessity criteria and that Medicaid funds may be used to pay the attending physician, hospital, and other providers of inpatient hospital services for providing medically necessary services,

subject to the Department's normal procedures and standards and subject to withdrawal of admission certification pursuant to Chapter 8. An admission certification may specify the number of days for which Medicaid payment for inpatient hospital services is approved.

(x) "Admitting diagnosis." The admitting practitioner's tentative or provisional diagnosis of the client's condition which provides the basis for examination and treatment when the practitioner requests admission certification.

(xi) "Adult." An individual who has reached the age of majority as provided by W.S. § 14-1-101. Emancipated minors may consent to services to the same extent as an adult as provided by W.S. § 14-1-101.

(xii) "Adult Developmental Disabilities Home and Community Based Waiver." The "Adult Developmental Disabilities Home and Community Based Waiver" submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

(xiii) "Advanced Practitioner of Nursing (APN)." A professional registered nurse who is licensed in a specialty area of advanced nursing practice by the Wyoming Board of Nursing or a similar agency in another state.

(xiv) "Adverse action." For an applicant, client, participant, or other person receiving covered services, an adverse action is a termination, reduction, or denial of services or eligibility, including a reduction in the level of care of a nursing facility resident. For a provider, an adverse action is the termination, suspension or other sanction of a provider (other than in those situations set forth below), the denial or withdrawal of admission certification, the determination of a per diem rate pursuant to Chapter 7, or the denial or reduction of a Medicaid payment to a provider (other than those set forth below).

(A) The following terminations, suspensions or other sanctions of a provider are not adverse actions:

(I) A termination, suspension, or other sanction based on the provider's loss of or failure to provide to Medicaid documentation of required licensure or certifications.

(II) A termination, suspension, or other sanction based on a provider's exclusion by OIG or termination by Medicare;

(III) A termination, suspension, or other sanction based on a finding of fraud, abuse, or other prohibited activities by a judicial or administrative process where the provider was afforded notice and the right to a hearing.

(B) The following reductions, denials, or recoveries of overpayments are not adverse actions:

(I) A reduction, denial, or recovery described in Section 12(c)(d) and (e) of Chapter 16 of these Rules;

(II) A reduction, denial, or recovery due solely by a change in Federal or State law; or

(III) An appeal of a rate setting methodology.

(xv) "Advocate." A person, chosen by the client or legal guardian, who supports and represents the rights and interests of the client in order to ensure the client's full legal rights and access to services. The advocate can be a friend, a relative, or any other interested person. An advocate has no legal authority to make decisions on behalf of a client.

(xvi) "Aged." A person sixty-five (65) years of age or older.

(xvii) "Alien." A person residing in, and who is not a citizen of, the United States of America.

(xviii) "Allowable cost." Medicare allowable costs as determined by 42 U.S.C. § 1395f, except as otherwise specified by the Medicaid Rules.

(xix) "Ancillary services." Those services listed as ancillary services on a hospital's most recently available cost report.

(xx) "Ancillary services charges." Charges for furnishing ancillary services to a client reported on a claim.

(xxi) "Annuity." A contract or agreement by which a beneficiary receives fixed, non-variable payments on an investment for a lifetime or a specified number of years. A commercial (non-employment related) annuity set up on or after February 8, 2006, is considered an available asset unless it meets the following criteria:

(A) The annuity is irrevocable and nonassignable;

(B) The annuity is actuarially sound, and pays out principal and interest in equal monthly installments (no balloon payments) to the individual in sufficient amounts that the principal is paid out within the actuarial life expectancy of the individual as published by the Office of the Chief Actuary of the United States Social Security Administration;

(C) The average number of years of expected life remaining for the individual must equal or exceed the stated life of the annuity.

(D) The Department is named as the residual beneficiary of the funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his/her lifetime, unless there is a community spouse and/or a minor or disabled child, in which case the Department must be named as the secondary beneficiary; and

(E) The annuity is issued by an insurance company licensed and approved to do business in the state of Wyoming.

(xxii) "Applicant." Any person applying for benefits under programs provided pursuant to W.S. § 42-1-101.

(xxiii) "Application." An applicant's request for a Medicaid funded program in a form specified by the Department.

(xxiv) "Application date." The date the signed application is received and date stamped by Wyoming Department of Health, Department of Family Services or an outstation facility.

(xxv) "Appropriate." Medical treatment or service that is medically necessary, suitable to a client's well-being based on current practices, and documented in the client's medical record.

(xxvi) "Appropriate bed." A certified bed in a nursing facility that is:

(A) Available; and

(B) In a room where the other bed, if any, is occupied by a member of the same sex or the spouse of the client.

(xxvii) "Appropriate placement." The placement of an individual in a treatment setting when the individual's needs meet the minimum standards for admission to that treatment setting and the individual's needs for treatment do not exceed the level of services which the treatment setting is capable of providing.

(xxviii) "Assets" as defined by W.S. § 42-2-401(a)(1), *et seq.*

(xxix) "Assignment of rights to benefits." As defined by 42 C.F.R. §§ 433.145 to 433.148. The transfer from an applicant or client to the Department of the applicant's or client's rights, or the rights of another, to medical support or payments for services from any third party payer.

(xxx) "Attending physician." The physician primarily responsible for a client's treatment in a hospital.

(xxxi) "Attorney General." The Attorney General of the State of Wyoming, its agent, designee or successor.

(xxxii) "Base rate." A rate in effect on a date chosen by the Department.

(xxxiii) "Billed charges." The charges billed by a provider to the Department for furnishing covered services to clients.

(xxxiv) "Capital costs." Capital related costs as defined in 42 C.F.R. § 413.130, including, but not limited to, costs incurred by a facility for construction, depreciation, interest, rent and leases.

(xxxv) "Case management." Services that assist clients in gaining access to needed medical, waiver, or Wyoming Medicaid state plan services, as well as social, educational, and other services, regardless of the funding source.

(xxxvi) "Case manager." A registered nurse, healthcare professional or individual designated by the Department to provide case management.

(xxxvii) "Centers for Medicare and Medicaid Services (CMS)." The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, its agent, designee, or successor.

(xxxviii) "Certified." Certified by the Department or survey agency as in compliance with applicable statutes and rules.

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

(xl) "Certified Registered Nurse Anesthetist (CRNA)." A professional registered nurse who is licensed in a specialty area of advanced nursing practice by the Wyoming Board of Nursing or a similar agency in another state.

(xli) "Change of ownership." A change in a provider's or facility's ownership, control, operation, management contract, or leasehold interest.

(xlii) "Child." Any person who does not meet the definition of adult.

(xliii) "Children's Developmental Disabilities Home and Community Based Waiver." The waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

(xliv) "Children's hospital." An inpatient hospital which is:

(A) Designated by the Secretary of Health and Human Services as a children's specialty hospital;

(B) Exempt from the Medicare prospective payment system (PPS); and

(C) Is a participating provider.

(xlv) "Claim." A request by a provider for Medicaid payment for covered services provided to a client.

(xlvi) "Classification in Mental Retardation." The most recent Classification in Mental Retardation of the American Association on Mental Deficiency.

(xlvii) "Client." A person who has been determined eligible for Medicaid.

(xlviii) "Client or applicant information." Any medical records, financial records, or other records, in whatever form, which contain any of the following information about an applicant or client:

(A) Names and addresses;

(B) Services provided;

(C) Social and economic conditions or circumstances;

(D) Evaluations by DFS of personal information;

(E) Medical data, including, but not limited to, diagnoses and history of disease or disability;

(F) Information received for the purpose of verifying income eligibility and the amount of Medicaid payments;

(G) Information received in connection with the identification of third party payers, including information contained in the Medicaid Management Information System (MMIS);

(H) Claims, claims histories, and Medicaid payments made to providers, including any information regarding the amount of payments made on behalf of a client;

(I) Any other information generated or maintained by the Department or in the possession of or subject to the control of any agent or contractor of the Department.

(xlix) "Commission for the Accreditation of Rehabilitation Facilities (CARF)." The Commission for the Accreditation of Rehabilitation Facilities, its agent, designee, or successor.

(l) "Comprehensive Outpatient Rehabilitation Facility (CORF)." CORF as described in 42 C.F.R. § 400.200.

(li) "Consultation." An opinion or advice rendered by one physician to another physician as part of the evaluation or treatment of a client.

(lii) "Consumer Price Index (CPI)." The consumer price index for all Urban Consumers (CPI-U) (United States city average), as determined by the United States Department of Labor and Statistics.

(liii) "Contestant." The person who requests a hearing.

(liv) "Contested case." A proceeding under these rules involving an adverse action.

(lv) "Continued stay review." A report that contains information about a client performed at specified intervals during a client's stay at a facility. A continued stay review shall contain the information and be in the form specified by the Department.

(lvi) "Copayment." A Department-established fee charged to a client by a provider.

(lvii) "Cost report." A cost report prepared and submitted in conformance with Medicaid requirements. "Cost report" includes any supplemental request by the Department for additional information relating to the facility's costs.

(lviii) "Cost reporting period." The fiscal period used by a facility to report its costs to Medicare.

(lix) "Cost that must be incurred." A cost that must be incurred by an efficiently and economically operated facility.

(lx) "Covered services." Services which are Medicaid reimbursable pursuant to the rules of the Department.

(lxi) "Credit balance." Medicaid funds received by a provider that are owed to the Department for any reason.

(lxii) "Current market value." The amount for which property can be expected to sell on the open market in the community at the time of the estimate or at the time of transfer or sale, also known as fair market value (FMV).

(lxiii) "Current Procedural Terminology (CPT®)." The most recent edition of the Current Procedural Terminology published by the American Medical Association.

(lxiv) "Dementia." An individual has dementia if the individual:

(A) Has a primary diagnosis of dementia, as defined in the DSM, including Alzheimer's disease; or

(B) Has a non-primary diagnosis of dementia, unless the individual's primary diagnosis is a major mental illness.

(lxv) "Denial of payment for new admissions." The denial of Medicaid payments for all clients admitted to a facility after a specified date. Payments that are denied shall not be retroactively paid to a facility.

(lxvi) "Dentist." A person licensed to practice dentistry by the Wyoming Board of Dental Examiners or a similar agency in another state.

(lxvii) "Department." *See* Wyoming Department of Health.

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

(lxix) "Department of Family Services Registry." Pursuant to W.S. § 35-20-115 *et seq.*, the Central Registry of the Department of Family Services that includes substantiated reports of abuse, neglect, exploitation, or abandonment of vulnerable adults and children.

(lxx) "Desk review." A review by the Department or a vendor contracted by the Department of a provider's financial records, cost reports, and/or other supporting documentation to determine if documentation and/or cost reports are in compliance with Medicaid program requirements.

(lxxi) "Developmental Disabilities Division (DDD)." The Developmental Disabilities Division of the Department, its agent, designee, or successor.

(lxxii) "Developmental disability." As defined in federal law (42 U.S.C. § 15002(8)), a severe, chronic disability of an individual that:

(A) Is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) Is manifested before the individual attains age twenty-two (22);

(C) Is likely to continue indefinitely; and

(D) Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

(I) Self-care;

(II) Receptive and expressive language;

(III) Learning;

(IV) Mobility;

(V) Self-direction;

(VI) Capacity for independent living;

(VII) Economic self-sufficiency; and

(E) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

(lxxiii) "Diagnosis codes." Codes contained in the latest version of the International Classification of Diseases, Clinical Modification (ICD-CM).

(lxxiv) "Diagnostic and Statistical Manual of the American Psychiatric Association (DSM)." The most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

(lxxv) "Dietician." A person who is registered as a dietician by the Commission on Dietetic Registration.

(lxxvi) "Dietician services." Services furnished by a registered dietician, including:

(A) Menu planning;

(B) Consultation with and training of caregivers; and

(C) Education of participants.

(lxxvii) "Direct supervision." Supervision in which the responsible practitioner is physically present in the building where the services are being provided.

(lxxviii) "Director." The Director of the Department of Health, the Director's agent, designee, or successor.

(lxxix) "Discharge." The act by which an individual who has been a patient in a facility or a client in a program ceases to be a patient and the facility or program ceases to be legally responsible for providing care for such individuals. "Discharge" does not include:

(A) A nursing home resident's temporary absence from the facility for treatment in a hospital, home visits or a trial community stay, provided such temporary absence is no longer than thirty (30) consecutive days;

(B) An LTC-HCBS client's temporary absence from the client's home for periods that do not exceed thirty (30) consecutive days;

(C) An individual that is transferred from one unit of a hospital to another unit in the hospital, an individual that is transferred to a distinct part of a hospital unit, or an individual that is transferred to another hospital; or

(D) An individual's temporary absence.

(lxxx) "Discharge planning." To make arrangements during a client's inpatient stay for the client to receive appropriate services upon discharge.

(lxxxi) "Dispensing fee." The amount of Medicaid reimbursement allowed by the Department as payment for the service of dispensing any prescribed drug or product.

(lxxxii) "Disposable medical supplies." Supplies prescribed by a practitioner which have a medical purpose, are specifically related to the active treatment or therapy of the client for a medical illness or physical condition, and which are consumable and/or expendable and non-durable. Supplies must meet the definition of medically necessary and shall be prescribed by an appropriate licensed practitioner.

(lxxxiii) "Disproportionate Share Hospital (DSH)." A hospital located in Wyoming that is entitled to a DSH disproportionate share payment pursuant to Chapter 32 of the Wyoming Medicaid Rules.

(lxxxiv) "Disproportionate share payments." Medicaid payments made by the Wyoming Department of Health to a disproportionate share hospital, including payments for inpatient and outpatient hospital services and Qualified Rate Adjustment payments.

(lxxxv) "Division of Criminal Investigation (DCI)." The Wyoming Division of Criminal Investigation within the Office of the Attorney General created at W.S. § 9-1-611, its agent, designee or successor.

(lxxxvi) "Division of Preventive Health and Safety." The Division of Preventive Health and Safety of the Department, its agent, designee or successor.

(lxxxvii) "Drug."

(A) Substances recognized as drugs in official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;

(B) Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in a person;

(C) Substances (other than food) intended to affect the structure or any function of a person's body; or

(D) Substances intended for use as a component of any article specified in (A) through (C) Substances (other than food) intended to affect the structure or any function of a person's body; or

(E) "Drug" includes over-the-counter (OTC) drugs.

(lxxxviii) "Drug used as a restraint." Any drug that:

(A) Is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others;

(B) Has the temporary effect of restricting the participant's freedom of movement; and

(C) Is not a standard treatment for the participant's medical or psychiatric condition.

(lxxxix) "Durable Medical Equipment (DME)." Equipment prescribed by a practitioner that has a medical purpose, is not considered to be experimental or investigational, is designed to withstand repeated use in the home, and primary purpose is not to enhance the personal comfort of the client or provide convenience for the client or caregiver. Equipment must be medically necessary and shall be prescribed by an appropriate licensed practitioner.

(xc) "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services." Services for clients under the age of twenty-one (21) through the HEALTH CHECK program pursuant to Chapter 6 of the Wyoming Medicaid Rules.

(xci) "Eligible." Entitled to receive Medicaid.

(xcii) "Emergency." The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(xciii) "Emergency detention." A person detained or involuntarily hospitalized pursuant to W.S. § 25-10-109, *et seq.*

(xciv) "Enrolled." A provider that has signed a provider agreement and has been certified as a provider with the Department.

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

(xcvi) "Extended Wyoming Medicaid state plan services." Services made available to a participant whose needs for that service exceed the Wyoming Medicaid state plan service limitations established for the general Medicaid population. Extended services include:

(A) Occupational therapy services;

(B) Physical therapy services;

(C) Speech, hearing, and language services; and

(D) Any other services covered by Medicaid.

(xcvii) "Extraordinary care clients." Clients who require skilled nursing facility and swing bed extraordinary care for those conditions which have received prior authorization from the Department because they have a Minimum Data Set (MDS) Activities of Daily Living Sum score of ten (10) or more, and require special care or clinically complex care as recognized under the Medicare RUG-III classification system.

(xcviii) "Facility rate." A facility's Medicaid allowable payment.

(xcix) "Federal fiscal year." The period beginning October 1st of each year and ending the following September 30th.

(c) "Federal Medicaid funds." Federal funds paid by HHS to the State pursuant to 42 U.S.C. § 1396b and subsequently paid to a provider.

(ci) "Federal Medicaid Assistance Percentage (FMAP)." Federal medical assistance percentage as defined in 42 U.S.C. § 1396d(b).

(cii) "Federally Qualified Health Center (FQHC)." Federally qualified health center (FQHC) as defined in 42 U.S.C. § 1396d(l)(2)(B).

(ciii) "Field audit." An onsite examination, verification and review conducted by employees, agents, or representatives of the Department or HHS of a provider's records and any supporting or related documentation.

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

(cv) "Fiscal agent." The Department's agent responsible for processing claims and supporting operational functions.

(cvi) "Foster care." The term used by DFS when a child is in the State's custody as a foster child.

(cvii) "Fraud." An intentional deception or misrepresentation made by an individual with the knowledge that the deception or misrepresentation may result in overpayments. "Fraud" includes any actions or inactions that constitute fraud under federal or state law.

(cviii) "Functionally necessary." A waiver service that is:

(A) Required due to the diagnosis or condition of the participant;

(B) One or both of the following:

(I) Recognized as a prevailing standard or current practice among the provider's peer group, or

(II) Intended to make a reasonable accommodation for functional limitations of a participant, to increase a participant's independence;

(C) Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition; and

(D) Not utilized experimentally or investigationally and is generally accepted by the medical community.

(cix) "Funding." The combination of federal and state funds available to pay for covered services. Funding does not include any other funds available to the Department that are not designated for covered services.

(cx) "Generally Accepted Accounting Principles (GAAP)." Accounting concepts, standards and procedures established by the American Institute of Certified Public Accountants.

(cxi) "Generally Accepted Auditing Standards (GAAS)." Auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.

(cxii) "Good cause." A specified reason based on accepted standards that supports an individual's action and thereby eliminates the penalty, which normally is imposed for failure to cooperate with child support or third party liability requirements as defined by 42 C.F.R. § 433.147(c)(1).

(cxiii) "Guardian." A person lawfully appointed as a guardian to act on the behalf of the client, participant, or applicant.

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

(cxv) "Healthcare Common Procedure Coding System (HCPCS)." Codes as contained in the latest version of the HCPCS Book.

(cxvi) "Home and Community Based Waiver Services (HCBS)." Services provided under a waiver from CMS that are not otherwise available under the Wyoming Medicaid state plan. Such services enable the elderly, disabled, and chronically mentally ill persons, who would otherwise be placed in an institution, to live in the community. Section 1915(c) of the Social Security Act specifies the services that may be included as HCBS waiver services.

(cxvii) "Home." A home is any property in which an individual (and spouse, if any) has an ownership interest and serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings as defined by 20 C.F.R. § 416.1212.

(cxviii) "Hospice." An optional benefit under the Medicaid program for individuals who are terminally ill and elect to receive hospice care.

(cxix) "Hospital." An institution that:

(A) Is approved to participate as a "hospital" under Medicare;

(B) Is maintained primarily for the treatment and care of patients with disorders other than mental diseases or tuberculosis;

(C) Is enrolled in the Medicaid program;

(D) Meets the requirements of 42 C.F.R. § 482.66; and

(E) Is licensed to operate as a "hospital" by the State of Wyoming or, if the institution is out-of-state, licensed by the state in which the institution is located.

(cxx) "Immediate jeopardy."

(A) A situation in which the provider's noncompliance with one (1) or more requirements of participation in Medicaid has caused or is likely to cause serious injury, harm, impairment, or death to a client or a substantial and immediate threat to the health or safety of clients; or

(B) As defined in 42 C.F.R. § 488.301.

(cxxi) "Inpatient." An inpatient as defined by 42 C.F.R. § 440.2(a).

(cxxii) "Inpatient hospital service." Inpatient hospital service as defined in 42 C.F.R. § 440.10.

(cxxiii) "Inpatient psychiatric services for individuals under age twenty-one (21)." Inpatient psychiatric services for individuals under age twenty-one (21) as defined in 42 C.F.R. § 441.

(cxxiv) "Institution for Mental Diseases (IMD)." An institution for mental diseases as defined by 42 C.F.R. § 435.1010.

(cxxv) "Institution for Mental Diseases (IMD) services." Services that meet the standards of 42 C.F.R., Ch. IV, Subch. C, Part 441.

(cxxvi) "Intellectual disability." Significantly sub-average general intellectual functioning with concurrent deficits in adaptive behavior manifested during the developmental period.

(cxxvii) "Intellectually disabled." A person with an intellectual disability.

(cxxviii) "Interdisciplinary team."

(A) A team that meets the requirements of 42 C.F.R. § 441.156; or

(B) A group consisting of representatives of the person, the person's family or legally authorized representative, or the professions, disciplines or service areas that are relevant to identifying the client's needs, as described in the comprehensive functional assessments and program design.

(cxxix) "Interim payments." Payments to a new facility during the time between the effective date of the new facility's or newly certified facility's provider agreement and the determination of a per diem rate.

(cxxx) "Intermediate Care Facility for People with Intellectual Disability (ICF/ID)." Intermediate Care Facility for People with Intellectual Disability (ICF/ID) means an intermediate care facility for the mentally retarded or intermediate care facility

for people with mental retardation (ICFMR or ICF/MR) as those phrases are used in 42 U.S.C. 1396d(d) or other applicable federal statutes, rules and regulations.

(cxxxi) "International Classification of Disease-Clinical Modification (ICD-CM)." The most recent version of the International Classification of Diseases.

(cxxxii) "Irrevocable trust." A trust which may not be revoked after its creation.

(cxxxiii) "Inventory for Client and Agency Planning (ICAP)." An instrument used by the Developmental Disabilities Division to help determine eligibility and to determine the needs of the participant, available from Riverside Publishing, its successor, or designee.

(cxxxiv) "JCAHO." The Joint Commission on Accreditation of Healthcare Organizations.

(cxxxv) "Laboratory services." Professional or technical laboratory services.

(cxxxvi) "Legally authorized representative." A minor child's parent or legal guardian, an individual's legal guardian, an attorney who presents written authorization that he or she represents an individual or entity, or any other person who is authorized in writing to act on behalf of an individual or entity. Any legally authorized representative, other than a parent or licensed attorney acting on behalf of a participant, must attach to the first document submitted to the Department a copy of a written authorization to act on behalf of the individual with respect to the matter in question. Formal authorizations must be legally enforceable and may include, but shall not be limited to, powers of attorney, court appointments or health care directives.

(cxxxvii) "LT101." A form, or its successor, used by Developmental Disabilities Division to document an individual's functional capacity and medical necessity for long term care services.

(cxxxviii) "LT-ABI-105." A document, or its successor, completed by the selected case manager and used by Developmental Disabilities Division to verify that the participant or applicant meets the ICF/ID level of care.

(cxxxix) "LT-MR-104." A document, or its successor, completed by the selected case manager and used by Developmental Disabilities Division to verify that the participant or applicant meets the ICF/ID level of care.

(cxl) "Local agency." The county offices of Department of Family Services, its agent, designee, or successor.

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

(cxlii) "Mechanical restraint." Any device attached or adjacent to a participant's body that he or she cannot easily move or remove that restricts freedom of movement or normal access to the body.

(cxliii) "Medicaid allowable costs." Medicaid program costs as determined from Medicare cost reports that have been submitted to the Medicare Fiscal Intermediary. Allowable costs are calculated using Medicare payment principles. Medicaid allowable costs and calculations of payments shall not be adjusted because of changes that result from a Medicare appeal or reopening.

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

(cxlv) "Medicaid fee schedule." The Medicaid fee schedule as established pursuant to Chapter 3.

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

(cxlvii) "Medicaid funds." The combination of federal Medicaid funds and state Medicaid funds that is available to the Department to make payments to providers. The federal portion shall be known as the FMAP. The state portion shall be known as the State Medicaid percentage.

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

(cxlix) "Medicaid Management Information System (MMIS)." The Medicaid Management Information System as certified by CMS and implemented by the Department.

(cl) "Medicaid payments." The payments made by the Department for covered services.

(cli) "Medical necessity" or "medically necessary." A determination that a health service is required to diagnose, treat, cure or prevent an illness, injury or disease which has been diagnosed or is reasonably suspected to relieve pain or to improve and preserve health and be essential to life. The service must be:

(A) Consistent with the diagnosis and treatment of the client's condition;

(B) In accordance with the standards of good medical practice among the provider's peer group;

(C) Required to meet the medical needs of the client and undertaken for reasons other than the convenience of the client and the provider; and

(D) Performed in the most cost effective and appropriate setting required by the client's condition.

(clii) "Medical necessity for long-term care services." The determination made using the LT101 assessment form or other tool designated by the Department, which documents the need of the applicant or client for long-term care services from a skilled nursing facility, swing bed facility or a Home and Community Based Waiver Services program.

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

(cliv) "Medical supplies." Disposable, semi-disposable or expendable medical supplies. "Medical supplies" does not include durable medical equipment, oxygen or oxygen supplies.

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

(clvi) "Medicare crossover claim." A claim for services provided to a client who is eligible for Medicare and Medicaid, paid by Medicare.

(clvii) "Medicare Economic Index (MEI)." Medicare economic index for primary care services, (MEI) as defined in 42 U.S.C. § 1396a(bb)(3)(A).

(clviii) "Mental disorder." A condition defined in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), excluding a sole diagnosis of mental retardation or a specific developmental disorder.

(clix) "Mental health center." A facility located in Wyoming which is certified by the Mental Health and Substance Abuse Services Division as a "mental health center."

(clx) "Mental Health and Substance Abuse Services Division." The Mental Health and Substance Abuse Services Division of the Department, its agent, designee, or successor.

(clxi) "Minimum Data Set (MDS)." A core set of standardized screening and assessment elements by which a resident's physical, mental, psychosocial and behavioral status is identified. This assessment forms the basis for a comprehensive assessment wherein the resident's strengths and weaknesses can be evaluated, and a plan of care developed to meet his individual needs.

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

(A) Review of claims;

(B) Review of Inpatient Census Reports (ICRs);

(C) Review of medical records;

(D) Consultation with providers;

(E) Consultation with the client or the client's authorized representative; or

(F) Any other reasonable method.

(clxiii) "Most recently available cost report." A facility's most recent Medicare cost report which has been submitted to Medicare in accordance with Medicare standards and procedures.

(clxiv) "Neglect." Neglect as defined by 42 C.F.R. § 488.301, W.S. § 35-20-102, *et seq.*, and W.S. § 14-3-202, *et seq*.

(clxv) "Negotiated rate." The rate agreed upon by the Department and a provider for services furnished to a client.

(clxvi) "New admission." The admission of a client who has never been in a facility or, if previously admitted, had been discharged or had voluntarily left the facility.

(clxvii) "Nonallowable cost." Costs which are not reasonably related to covered services.

(clxviii) "Nurse midwife." An "advanced practice registered nurse" as defined by W.S. § 33-21-120(a)(i), *et seq*, or licensed as a nurse practitioner by the Wyoming State Board of Nursing or a similar agency in another state and who is certified as a nurse midwife by the American College of Nurse-midwives.

(clxix) "Nurse practitioner." An "advanced practice registered nurse" as defined by W.S. § 33-21-120(a)(i), *et seq*, or licensed as a nurse practitioner by the Wyoming State Board of Nursing or a similar agency in another state.

(clxx) "Nursing facility." A nursing facility as defined by 42 U.S.C. § 1396r(a).

(clxxi) "Nursing facility services." Nursing facility services as defined by 42 U.S.C. § 1396d(f).

(clxxii) "Occupational therapist." A person licensed as an occupational therapist by the Wyoming State Board of Occupational Therapy or a similar agency in another state.

(clxxiii) "Occupational therapy services." Occupational therapy services, including both individual therapy and group therapy, that are:

(A) Prescribed by a physician;

(B) Provided by or under the scope of practice of an occupational therapist; and

(C) Necessary to keep a participant in his or her home or out of an institution.

(clxxiv) "The Omnibus Budget Reconciliation Act of 1993 (OBRA '93)." The Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66.

(clxxv) "Orthotics." Medical appliances or devices, other than routine foot appliances, used to strengthen weak or defective parts of the body, to aid mobility or to serve other medical purposes.

(clxxvi) "Outpatient." An outpatient as defined by 42 C.F.R. § 440.2(a).

(clxxvii) "Outpatient hospital services." Outpatient hospital services as defined in 42 C.F.R. § 440.20(a).

(clxxviii) "Over the counter (OTC) drugs." Drugs which are legally available without a prescription.

(clxxix) "Overpayments." Medicaid funds received by a provider or client to which the provider or client is not entitled for any reason including payments which exceed the Medicaid allowable payment. Overpayments include but are not limited to:

(A) Payments made as a result of system errors;

(B) Payments for services furnished to a non-client;

(C) Payments for non-covered services furnished to a client;

(D) Payments for services which are not documented and/or supported by records and/or financial records;

(E) Payments for services for which admission certification has been denied or withdrawn;

(F) Payments which exceed a provider's usual and customary charge, unless otherwise permitted by the Department's rules;

(G) Payments resulting from fraud; or

(H) Payments resulting from abuse.

(clxxx) "Participant." An individual who has been determined eligible for covered services on a Waiver.

(clxxxi) "Participant objectives." A set of meaningful and measurable goals for the participant and the methods used to train the participant on the goals.

(clxxxii) "Patient." An individual receiving healthcare services.

(clxxxiii) "Per diem rate." The total, daily allowable rate for covered services.

(clxxxiv) "Person with a related condition." An individual who has a severe, chronic disability, as specified in 42 C.F.R. § 435.101, which provides that the disability:

(A) is attributable to:

(I) Cerebral palsy or epilepsy; or

(II) Any other condition other than mental illness found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons; and

(B) Is manifested before the person reaches age twenty-two (22); and

(C) Is likely to continue indefinitely; and

(D) Results in substantial functional limitations in three (3) or more of the following areas of major life activity;

(I) Self-care;

(II) Understanding the use of language;

(III) Learning;

(IV) Mobility;

(V) Self-direction; or

(VI) Capacity for independent living.

(clxxxv) "Personal care services." Services to assist a participant with the activities of daily living, including eating, bathing, dressing, personal hygiene, and household activities.

(clxxxvi) "Personal restraint." The application of physical force or physical presence without the use of any device for the purposes of restraining the free movement of the body of the participant. The term personal restraint does not include briefly holding, without undue force, a participant in order to calm or comfort him or her, or holding a participant's hand to safely escort him or her from one area to another.

(clxxxvii) "Pharmacy." An entity licensed to operate a pharmacy by the Wyoming State Board of Pharmacy or a similar board or agency in another state.

(clxxxviii) "Physical therapist." A person licensed to practice as a physical therapist by the Wyoming State Board of Physical Therapy or a similar agency in another state.

(clxxxix) "Physical therapy services." Maintenance or restorative physical therapy services (including either individual therapy or group therapy) that are:

(A) Prescribed by a physician;

(B) Provided by or under the scope of practice of a licensed physical therapist; and

(C) Necessary to keep a participant in his or her home or out of an institution.

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

(cxci) "Plan of care." A written plan of care developed by qualified individuals approved by the Department.

(cxcii) "Power of Attorney." A written legal document created pursuant to W.S. §§ 3-5-101, *et seq.*, 34-1-103 *et seq.*, 35-22-402, *et seq.*, or other similar law of

another State, granting someone authority to act as agent or attorney-in-fact for the grantor.

(cxciii) "Practitioner." A health professional licensed by an agency or board of the State of Wyoming or a similar agency in another state who is acting within the scope of his or her licensure. "Practitioner" includes physicians and mid-level practitioners.

(cxciv) "Prepayment or post payment review." The prepayment or post payment review of a provider's or client's claims by the Department to determine whether such claims reflect generally accepted practices.

(cxcv) "Prescription." A written, faxed, electronic or oral order, as required by the Board of Pharmacy, from a practitioner that a certain drug, medical supply, device or service is medically necessary.

(cxcvi) "Prosecution, Recovery, Investigation, Collection and Enforcement" (PRICE). The Prosecution, Recovery, Investigation, Collection and Enforcement Unit of DFS, its agent, designee or successor.

(cxcvii) "Principal diagnosis." Principal diagnosis as defined by 42 C.F.R. § 412.60(c)(1).

(cxcviii) "Prior authorization." A written, faxed or electronic approval from the Department that permits payment or coverage of a service that is covered if such authorization is obtained. Prior authorization must be requested and received pursuant to Chapter 3. Services requiring a prior authorization may also be referred to as "prior authorized" in these rules.

(cxcix) "Private pay rate." The published semi-private routine daily rates a nursing facility charges to non-recipients, other than Medicare clients, after all discounts, allowances and subsidies are subtracted for the same or similar services in effect on the first day of each rate year. "Private pay rate" does not include the cost of Medicare Part A and/or Part B premiums or deductibles, or the cost of any other insurance premiums or deductibles.

(cc) "Procedure codes." Codes contained in the latest version of the CPT Book.

(cci) "Prosecution, Recovery, Investigation, Collection and Enforcement (PRICE)". The Prosecution, Recovery, Investigation, Collection and Enforcement Unit of DFS, its agent, designee or successor.

(ccii) "Prospective Payment System (PPS) Inflation factor." The CMS Prospective Payment System Hospital Market Basket index for the period in question, as

published by DRI Data Resources, Inc., in Healthcare Costs, which is published quarterly by the DRI/McGraw division of McGraw-Hill, Inc.

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

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

(ccv) "Psychiatric Residential Treatment Facility (PRTF)." Any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of twenty-one (21).

(ccvi) "Psychologist." A person licensed to practice psychology by the Wyoming State Board of Psychology or a comparable agency in another state.

(ccvii) "Public health nurse." A registered nurse who is either under contract to the County to perform public health nursing functions or is an employee of the Department that is assigned public health nursing functions.

(ccviii) "Qualified intellectual disabilities professional." A person who ensures the client receives those services and interventions identified in the individual program plan. Qualified intellectual disabilities professionals must have at least one (1) year of experience working directly with persons with intellectual or other developmental disabilities and be one of the following: a doctor of medicine, a doctor of osteopathy, a registered nurse, or an individual who holds at least a bachelor's degree in a professional category designated as a human services professional (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

(ccix) "Qualified mental health professional." A mental health practitioner whose qualifications meet standards set by the Mental Health and Substance Abuse Services Division.

(ccx) "Qualified Rate Adjustment (QRA) Payment." Annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's Medicaid allowable costs for the payment period and its pre-QRA Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. The Department will determine annual QRA payments prior to determining disproportionate share hospital payments.

(ccxi) "Readmission." The act by which an individual is admitted to a provider from which the individual had been discharged on or before the thirty-first (31st) day after the previous discharge for treatment of any diagnosis, excluding newborn

admissions which occur within twenty-eight (28) days after the newborn's initial discharge.

(ccxii) "Re-evaluation of medical necessity." The completion of an LT101 done in conjunction with the six (6) month renewal of the LTC HCBS plan of care or the twelve (12) month Assisted Living Facility Waiver renewal plan of care.

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

(ccxiv) "Reopen." A request by a hospital, pursuant to the procedures and standards established by Medicare, to re-examine or review the correctness of a cost settlement determination or decision made by or on behalf of Medicare.

(ccxv) "Representative payee." A person or organization appointed by the Social Security Administration to manage Social Security, Veterans' Administration, Railroad Retirement, Welfare Assistance, or other state or federal benefits or entitlement program payments on behalf of an individual who cannot manage or direct the management of his/her own money.

(ccxvi) "Reserved bed." A licensed bed in a facility reserved for a client who is temporarily absent.

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

(ccxviii) "Respite care." Services provided:

(A) On a short-term basis pursuant to the individual plan of care;

(B) To a participant who is unable, unassisted, to care for himself or herself; and

(C) Because the participant's primary caregiver is absent or in need of relief from furnishing such services.

(ccxix) "Restraint." A ''personal restraint,'' ''mechanical restraint,'' or ''drug used as a restraint," as those terms are defined in this Chapter.

(ccxx) "Revenue codes." Revenue codes as contained in the latest version of the UB Editor.

(ccxxi) "Rural Health Clinic (RHC)." Rural health clinic (RHC) as defined in 42 U.S.C. § 1396d(l)(1).

(ccxxii) "Seclusion." The involuntary confinement of a participant or client alone in a room or an area from which the participant is physically prevented from leaving.

(ccxxiii) "Service care plan." A written plan prepared for a Waiver applicant by the LT101 assessor or their designee that describes the type and frequency of provider of services for all funding sources that will meet or move the applicant toward meeting the needs identified in the LT101 assessment.

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

(ccxxv) "Services." Programs authorized by W.S. § 42-4-103 and offered pursuant to these rules.

(ccxxvi) "Settled cost report." A facility's cost report:

(A) Which has been submitted to Medicare in accordance with Medicare standards and procedures;

(B) Which has been cost settled by the Medicare intermediary using Medicare principles of cost reimbursement;

(C) For which a notice of program reimbursement has been issued; and

(D) For which a notice of Medicaid program reimbursement has been issued.

(E) A cost report is settled notwithstanding a request to reopen.

(ccxxvii) "Skilled nursing service." Professional nursing services provided which are included within the definition of "practice of professional nursing" as set forth in the Wyoming Nurse Practice Act.

(ccxxviii) "Social Security Administration (SSA)." A division of the United States Department of Health and Human Services, its agent, designee, or successor that administers federal Social Security programs.

(ccxxix) "Social Security Number (SSN)." Nine-digit number issued to U.S. Citizens, permanent residents and temporary working residents, by the Social Security Administration.

(ccxxx) "Social worker." A person licensed as a licensed clinical social worker by the Wyoming Board of Mental Health Professionals or a similar agency in another state.

(ccxxxi) "Specialized services." Specialized services as defined in 42 C.F.R. § 483.120.

(ccxxxii) "Specialty services." Services identified by the Department and approved by CMS.

(ccxxxiii) "Speech, hearing and language services." The following services, if furnished either as individual therapy or group therapy, provided by a speech pathologist or audiologist or under the scope of practice of a speech pathologist or audiologist, and prescribed by a physician:

(A) Speech pathology and audiology services, including articulation, pragmatic language training, and devices used by the participant;

(B) Assessment of participant's use of visual cues;

(C) Assessment of the need for and use of amplification;

(D) Assessment of a person's need for alternative speech output devices; or

(E) Speech, hearing and language services may be provided as individual therapy and group therapy.

(ccxxxiv) "Speech pathologist." A person licensed to practice speech pathology by the Wyoming Board of Speech Pathology and Audiology or a similar agency in another state.

(ccxxxv) "State fiscal year." The twelve-(12) month period beginning each July 1st and ending the following June 30th.

(ccxxxvi) "State Medicaid funds." The dollar amount of the state general funds appropriated by the Wyoming Legislature for the Medicaid program which constitutes the State Medicaid percentage.

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

(ccxxxviii) "State monitor." An individual who is an employee or contractor of the provider's certifying division of the Department and that is appointed by the Director to do any one or more of the following:

(A) Assure that participants receiving services from the provider are receiving appropriate levels of services and are free from abuse, neglect, and exploitation;

(B) Oversee the abatement of the areas of non-compliance by the provider;

(C) Oversee development and implementation of the provider's quality improvement plan; or

(D) Report to the Department on whether the provider is operating in compliance with the Medicaid Rules, properly implementing a quality improvement plan or both.

(ccxxxix) "State survey agency." The Office of Healthcare Licensing and Surveys of the Department, its agent, designee or successor.

(ccxl) "Supervision." The ready availability of the supervisor for consultation and direction of the individual providing services. Contact with the supervisor by telecommunications is sufficient to show ready availability if such contact is sufficient to provide quality care.

(ccxli) "Supervisor." An individual licensed to provide services who take professional responsibility for such services, even when provided by another individual or individuals.

(ccxlii) "Supplemental Security Income (SSI)." The program enacted as Title XVI of the Social Security Act.

(ccxliii) "Survey." Any survey as defined in 42 C.F.R. § 488.301.

(ccxliv) "Swing bed." A bed in a hospital which is certified for either inpatient hospital service or nursing facility services.

(ccxlv) "Swing bed services." Nursing facility services provided to a client in a hospital bed which is certified for either inpatient hospital services or nursing facility services.

(ccxlvi) "Technical denial." A determination by the Department to deny payment or recoup payments previously made because of a provider's failure to comply with the timeliness or other procedural requirements of any of the Wyoming Medicaid Rules. A technical denial is a final agency action, not an adverse action. Technical denial includes, but is not limited to, the denial of payment or recoupment of payments because of a provider's:

(A) Failure to timely and properly obtain admission certification;

(B) Failure to timely and properly obtain prior authorization;

(C) Furnishing covered services to a non-client;

(D) Furnishing non-covered services to a client; or

(E) Furnishing covered services in excess of the service limitations.

(ccxlvii) "Temporary absence" or "temporarily absent." When a client is out of a facility for hospitalization, therapeutic home visits, or for any other reason, and is expected to return to the facility.

(ccxlviii) "Third Party Liability (TPL)." The right of the Department to recover, on behalf of a client, from a third party payer the costs of Medicaid services furnished to the client.

(ccxlix) "Third Party Payer." A person, entity, agency, insurer, or government program that may be liable to pay, or that pays pursuant to a client's right of recovery arising from an illness, injury, or disability for which Medicaid funds were paid or are obligated to be paid on behalf of the client. Third party payer includes, but is not limited to:

(A) Medicare;

(B) Insurance companies;

(C) Workers' compensation;

(D) Persons or entities or others alleged to be legally liable for injury to a client for which Medicaid provides services to the client;

(E) A spouse or parent who is obligated by law or court order to pay all or part of such costs; or

(F) A client's estate.

(ccl) "Time out." The restriction of a participant for a reasonable period of time to a designated area from which the participant is not physically prevented from leaving, for the purpose of providing the participant an opportunity to regain self-control.

(ccli) "Treatment plan." A written description of expected services outcome developed approved and signed by a clinical professional. The treatment plan must:

(A) Contain a description of the methods and activities and their frequency that will be employed by specific persons to implement the treatment; and

(B) Specify the changes in the client's symptoms and behavior that are expected during the course of the treatment plan.

(cclii) "Usual and customary." The provider's charge to the general public for the same or similar services.

(ccliii) "Utilization review." A review of the costeffectiveness of the utilization of covered services. The review shall be undertaken in accordance with the standards and procedures specified by the Department and disseminated to providers by manuals and bulletins.

(ccliv) "Waiting list." A list of applicants who are eligible for but are not receiving covered services because of limits imposed by funding or program scope.

(cclv) "Waiver." An exception of Medicaid standards granted by CMS to the Wyoming Medicaid Program pursuant to Section 1915(c) or 1115 of the Social Security Act.

(cclvi) "Working days." 8:00 a.m. through 5:00 p.m., Mountain Time, Monday through Friday, exclusive of State holidays.

(cclvii) "Wyoming Department of Health (WDH or the Department)." The Wyoming Department of Health, its agent, designee or successor.

(cclviii) "Wyoming Life Resource Center." The Wyoming Life Resource Center as established pursuant to W.S. § 25-5-101, *et seq*.

(cclix) "Wyoming Medical Service Area (WMSA)." The geographic area surrounding the client's residence within Wyoming commonly used by other persons in the same area to obtain similar services, including the following cities or towns outside Wyoming: Craig, Colorado; Idaho Falls, Montpelier and Pocatello, Idaho; Billings and Bozeman, Montana; Kimball and Scottsbluff, Nebraska; Belle Fourche, Custer, Deadwood, Rapid City and Spearfish, South Dakota; and Ogden and Salt Lake City, Utah.

WYOMING MEDICAID RULES

CHAPTER 4

MEDICAID ADMINISTRATIVE HEARINGS

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-101, *et seq*., and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq*.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to all contested cases involving Medicaid in accordance with Medicaid rules, except as otherwise specified in the Department's Medicaid rules.

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

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter.

Section 3. Definitions. Except as otherwise specified in Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare.

Section 4. Right to Hearing.

(a) Applicants. An applicant has a right to a hearing if the application is denied or not acted upon within the time frames as specified by the Department rules.

(b) Clients. A client has a right to a hearing if eligibility is denied, reduced, terminated or suspended.

(c) Providers. A provider has a right to a hearing regarding an adverse action following the request for reconsideration as specified in Chapter 16.

(d) Pharmaceutical manufacturers. Pharmaceutical manufacturers shall have the same rights to a hearing as providers pursuant to this Chapter.

Section 5. Notice of Right to Hearing and Adverse Action.

(a) Applicants and clients. Where the right to a hearing is provided by this Chapter, the Department shall provide notice at the time of any adverse action. The notice shall include a statement:

(i) Of the right to a hearing;

(ii) Of an explanation of:

(A) The individual's right to request a hearing; or

(B) That in cases of action based on a change in law, the circumstances under which a hearing will be granted;

(iii) Of the method for requesting a hearing;

(iv) That the applicant or client has the right to be represented by a legally authorized representative, including a lawyer admitted to practice in Wyoming, or a relative, friend or other spokesman;

(v) That the applicant or client must notify the Department in writing that they will be represented by any of the representatives listed in Section 5(a)(iv);

(vi) Of the intended action;

(vii) Of the effective date of the intended action;

(viii) Of the reason(s) for the intended action;

(ix) Of the specific regulations that support, or the change in federal or state law that requires the action;

(x) Where applicable, an explanation of the circumstances under which benefits may be continued if a hearing is requested pursuant to 42 C.F.R. § 431.231.

(b) Providers. The Department shall notify a provider of the right to a hearing following the request for reconsideration as specified in Chapter 16 at the time of the notice of adverse action, except when issuing a notice of claims payment or denial. A provider shall be notified of the right to request reconsideration and a hearing involving claims at the time the provider executes a provider agreement. Except as otherwise specified in this Chapter, notice shall be in writing and shall include:

(i) A statement of the intended action;

(ii) The effective date of the intended action;

(iii) The reason(s) for the intended action;

(iv) The specific regulations that support, or the change in federal or state law that requires the action;

(v) The provider's right to request reconsideration and subsequently a hearing; and

(vi) The right to representation by a lawyer admitted to practice in Wyoming.

Section 6. Time of Notice.

(a) Applicants. The Department shall mail notice of adverse actions within the timeframe specified in Department rules.

(b) Clients. The Department shall mail notice of adverse action at least ten (10) days before the effective date, except:

(i) The Department may shorten the period of advance notice to five (5) days before the effective date if the Department has facts indicating that action should be taken because of probable fraud by the client, and the facts have been verified, if possible, through secondary sources.

(ii) The Department may mail notice not later than the effective date if:

(A) The Department has factual information confirming the death of a client;

(B) The Department receives a clear written statement signed by a client that:

(I) The client no longer wishes services; or

(II) Gives information that requires termination or reduction of services and indicates that the client understands that this will be the result of supplying that information;

(C) The client has been admitted to an institution where he or she is ineligible under the plan for further services.

(D) The client's whereabouts are unknown and the post office returns agency mail indicating no forwarding address;

(E) The Department establishes that the client has been accepted for benefits by another local jurisdiction, state, territory or commonwealth;

(F) A change in the level of medical care is prescribed by the client's physician; or

(G) The notice involves an adverse determination made with regard to preadmission screening requirements for persons with mental illness or intellectual disability.

(c) Providers.

(i) Notice of denial or reduction of payments. The Department shall notify a provider of the denial or reduction of payments as soon as practicable after such denial or reduction.

(ii) Notice of termination, suspension or sanction. The Department shall notify a provider of the termination, suspension or other sanction on or before the effective date, except as otherwise specified in the Department's Medicaid rules.

Section 7. Request for Hearing.

(a) Clients. A request for a hearing shall be mailed or personally delivered by a client, or the client's representative authorized by Section 5(a)(iv), to the Department within thirty (30) days after the receipt of the notice of adverse action.

(b) Providers.

(i) A request for a hearing shall be mailed by a provider or the provider's lawyer admitted to practice in Wyoming, by certified mail, return receipt requested, or personally delivered to the Department within twenty (20) days after the receipt of the notice of adverse action.

(ii) A provider's request for hearing shall:

(A) State with specificity the reasons for the request. The failure to provide such a statement shall result in the dismissal of the request with

prejudice; and

(B) Identify the issues to be raised at the hearing. Issues not identified in the request for hearing may not be subsequently raised at the hearing.

Section 8. Procedure after Request for Hearing.

(a) The Department shall evaluate the request and, within ten (10) working days of receipt of the request:

(i) Notify the requesting party in writing that a determination in his or her favor has been made and specify the action to be taken by the Department;

(ii) Notify the requesting party in writing that a request for hearing has been accepted; or

(iii) Notify the requesting party in writing that the request for hearing has been denied and the reasons for the denial.

(b) Denial of hearing.

(i) The Department may deny a request for hearing if the action complained of is not an adverse action or the request does not meet the requirements of Section 4 of this Chapter.

(ii) A denial of a request for hearing is a final decision of the Department, which may be appealed to district court pursuant to the Wyoming Administrative Procedure Act.

Section 9. Clients Maintaining Services Pending Appeal.

(a) If the Department mails the notice as required pursuant to subsection 6(a) of this Chapter, and the client requests a hearing before the effective date of the action, the Department may not terminate or reduce services until the final decision is rendered after the hearing unless:

(i) It is determined at the hearing that the sole issue is one of federal or state law or policy; and

(ii) The Department promptly informs the client in writing that services are to be terminated or reduced pending the final decision.

(b) If the adverse action is affirmed, the Department may institute recovery procedures against the client to recoup the cost of any services furnished to the client, to the extent they were furnished solely by reason of this section, and may recover any overpayments made to a provider.

(c) The Department shall reinstate and continue services until a decision is rendered if the action resulted from other than the application of federal or state law or policy pursuant to 42 C.F.R. § 431.231(c)(3).

Section 10. Notice of Hearing.

(a) In any contested case, the Department shall afford reasonable notice of the hearing to all parties.

(i) Reasonable notice, as used in this section, shall be not less than twenty (20) days prior to the hearing date. The time period may be waived by the contestant upon written or oral notification to the Department. Where notification of waiver of the time period is made orally, it shall be reduced to writing by the Department and entered in the contestant's record.

(ii) Notice shall be served personally or by certified mail, return receipt requested, to the last known address of the party, the party's lawyer admitted to practice in Wyoming, or the party's other legally authorized representative.

(iii) Where the necessary and indispensable parties are composed of a large class, notice shall be:

(A) Served upon a reasonable number of representatives of the class; or

(B) Published in newspaper(s) of the state in reasonable numbers and times, and at a minimum in a paper of general circulation in the county in which the contestant resides, and in at least one newspaper with state-wide circulation. In any county in which more than one newspaper is published, notice shall be published in the official paper of the county designated pursuant to W.S. § 18-3-517.

(b) A notice of hearing shall contain the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing is being held; the particular sections of the statutes or rules involved; a short and plain statement of the matters asserted; the docket number assigned to the case; the right to be represented by an attorney admitted to practice in Wyoming; and the availability of legal aid.

(i) If the Department is unable to state the matters in detail at the time

notice is served, the initial notice may be limited to a statement of the issues involved, and thereafter, upon request of any party, a more definite and detailed statement shall be furnished within ten (10) days of receipt of that request by the Department.

(ii) Upon written request by one of the parties, or upon his own motion, the hearing officer may reschedule the hearing to a time convenient for the parties. A party must submit such request within ten (10) days of receipt of the notice of hearing. When such request is granted, the hearing officer shall reissue the notice in accordance with these rules except that reasonable notice as used in this subsection shall be five (5) days prior to the hearing date. Only one request for rescheduling of a hearing shall be honored unless, in the Hearing Officer's judgment, additional changes must be allowed to avoid manifest injustice.

(c) A hearing shall be held within:

(i) Applicants and Clients. Forty (40) days of the applicant or client's request for a hearing, unless otherwise provided by law or by agreement of the parties.

(ii) Providers. One hundred twenty (120) days of the effective date of the adverse action, unless otherwise provided by law or by agreement of the parties.

Section 11. Location of Hearing.

(a) Hearings involving applicants or clients may be held in the county of the applicant or client's residence, or in Cheyenne, Wyoming. Regardless of the location, the parties shall be given the opportunity to appear by telephone or video conferencing, rather than in person.

(b) Hearings involving providers shall be held in Cheyenne, Wyoming, unless otherwise agreed to by the parties. Regardless of the location, the parties may be given the opportunity to appear by telephone or video conferencing, rather than in person.

Section 12. Consolidation of Hearings. Upon motion of one of the parties, the hearing officer may consolidate two or more hearings if the hearings involve the same parties or related parties with similar or related issues.

Section 13. Procedural Rights of Contestant. The contestant, or the contestant's representative authorized by Section 5(a)(iv), shall be given the opportunity to:

(a) Examine, at a reasonable time before the date of the hearing and during the hearing:

(i) The content of the contestant's case file; and

(ii) All documents and records to be used by the Department at the hearing.

(b) Bring witnesses, establish all pertinent facts and circumstances, present an argument, and question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

Section 14. Failure to Appear. If a contestant fails to appear at the place, date, and time specified in a notice, the hearing officer may:

(a) Continue the hearing to a later date and provide proper notice as prescribed in these rules; or

(b) Proceed to conduct the hearing without the contestant and dispose of the contested case, unless prohibited by federal or state statute; or

(c) Dismiss a hearing if:

(i) The contestant withdraws the request in writing; or

(ii) The contestant fails to appear at a scheduled hearing without good cause. Good cause shall be determined by considering circumstances which are beyond the contestant's control, such as illness, illness of another household member requiring the presence of the contestant, a household emergency, unavailability of transportation, lack of adequate child care or other such circumstances which the hearing officer determines were beyond the contestant's control.

Section 15. Discovery. All discovery in a contested case hearing shall be governed by the Wyoming Rules of Civil Procedure, as described in W.S. § 16-3-107(g) and (h).

Section 16. Prehearing Conference.

(a) At a time on or before the day of the hearing, the hearing officer, on his own or either party's motion, may meet with the parties for a conference to consider simplification of the issues, stipulations and admissions of fact, clarification or limitation of evidence, and any other matters that may expedite the proceeding and assure a just conclusion of the case. The meeting may be held by telephone conference.

(b) Any stipulations, limitations or agreements made at a prehearing

conference shall be recited in the record and shall control the course of the proceedings, unless modified during the hearing to prevent manifest injustice.

Section 17. Informal Disposition.

(a) Settlement of a contested case by any informal means (i.e., stipulation, agreed settlement or consent order) shall be allowed at any time, unless precluded by law.

(b) Settlement conference. Any party may request that the matter be set for a settlement conference. Upon such request, the hearing officer shall schedule a conference and direct that a representative of each party attend, and such representative shall have authority to settle the matter. The hearing officer shall neither attend the conference nor be advised of the proposals of either party. The hearing officer may designate another individual, not previously involved in the matter, to attend the conference and assist the parties in attempting to reach a settlement.

Section 18. Hearing Officer.

(a) The Director shall appoint a hearing officer to preside over contested case hearings on a case-by-case basis, or for a scheduled period of time, as the Director sees fit or may refer the case to the Office of Administrative Hearings (OAH) for a recommended decision under its rules. If the case is referred to OAH, then notwithstanding anything to the contrary in this Chapter, the OAH Rules for contested cases shall apply.

(b) The hearing officer shall be an employee of the Department, or other individual determined by the Director to be qualified to serve in such a capacity, who has not taken part in the investigation, preparation, or earlier disposition of the case to be heard.

(i) The hearing officer shall withdraw from consideration of a case at any time he or she deems himself or herself disqualified, providing there are other qualified presiding officers available to act. Withdrawal shall be made in writing to the Director.

(ii) Any party may request in writing that the Director remove and replace the hearing officer in a contested case hearing. This request must be accompanied by a statement and affidavits setting forth the alleged grounds for disqualification. The Director may deny a party's request for removal and shall issue a written statement explaining the grounds for his denial which shall be made a part of the record. If the request is granted, the Director shall appoint a new hearing officer as soon as is practicable.

(iii) The contestant may object to the appointment of the hearing officer in the record at the hearing. The objection shall set forth the alleged grounds for disqualification.

(c) The hearing officer shall have all powers necessary to conduct a fair and impartial hearing, including, but not limited to, the following authority:

(i) To administer oaths and affirmations;

(ii) To subpoena witnesses and require the production of any books, papers or other documents relevant or material to the inquiry;

(iii) To rule upon offers of proof and relevant evidence;

(iv) To provide for discovery and determine its scope;

(v) To regulate the course of the hearing;

(vi) To hold conferences for the settlement or simplification of the issues;

(vii) To dispose of procedural requests or similar matters;

(viii) To dismiss cases as specified by this rule or on agreement of the parties; and

(ix) To take any other action authorized by the Department's rules.

(d) Failure or refusal to appear or obey orders of the hearing officer may result in the sanctions provided in W.S. § 16-3-107(c) and (f).

(e) Except to the extent required for the disposition of ex parte matters authorized by law, the hearing officer shall not consult with any individual or party on any fact at issue except as allowed in W.S. § 16-3-111.

Section 19. Evidence and Testimony.

(a) Burden of proof. The Department shall have the burden of proof.

(b) Admissibility of evidence.

(i) The parties shall be entitled to present any oral or documentary evidence, submit rebuttal evidence and conduct cross-examinations, as may be required for a full disclosure of the facts. All documentary or physical evidence submitted for

consideration shall be marked as exhibits. The Department's exhibits shall be marked by letters of the alphabet beginning with "A." Contestant's exhibits will be marked by numbers beginning with "1."

(ii) The hearing officer shall allow any oral or documentary evidence, except irrelevant, immaterial or unduly repetitious evidence.

(c) Objections.

(i) The grounds for objection to any evidentiary ruling by the hearing officer shall be briefly stated. Rulings on all objections shall appear in the record. Only those objections made before the hearing officer, or specifically stipulated to by both parties, may be relied on in a subsequent proceeding.

(ii) Formal exception to an adverse ruling is not required.

(d) Privileged and confidential information.

(i) Any privilege at law shall be recognized by the hearing officer in considering evidence.

(ii) No employee of the Department shall be compelled to testify or to divulge information which is confidential or privileged at law and which is contained within the records of the Department or acquired within the scope of his or her employment except as provided in W.S. § 16-3-107, *et seq*.

(e) The hearing officer may take official notice of any material fact not appearing in evidence in the record that is of the nature of traditional matters of judicial notice or within the special technical or scientific knowledge or files of the Department. Parties shall be given an opportunity to contest matters officially noticed prior to a final decision by the Department in accordance with W.S. § 16-3-108, *et seq*.

(f) Each witness who is present to give testimony must identify himself or herself by stating his or her name and address, indicate on whose behalf he or she will testify, and be administered the following oath by the hearing officer: "Do you swear or affirm to tell the truth, the whole truth, and nothing but the truth?"

(g) A party or his or her representative authorized by Section 5(a)(iv) may examine or cross-examine witnesses.

(h) The hearing officer may examine witnesses.

Section 20. Representation.

(a) Any applicant, client, or individual provider has the right to represent themselves, to be represented by a lawyer admitted to practice in Wyoming, or, if the contestant is an applicant or client, by a representative authorized by Section 5(a)(iv).

(i) If an applicant or client chooses a representative who is not legally authorized to speak for that applicant or client, the applicant shall provide written notice of appointment of the spokesman to the Department.

(ii) A non-lawyer authorized to represent an applicant or client under this provision may advocate for the applicant or client in a representative capacity, draft pleadings or other documents. However, this provision does not authorize a person who is not a lawyer admitted to practice in Wyoming to provide legal advice or services, or represent any person before the courts of the State of Wyoming.

(b) A provider which is a corporation, professional corporation, limited liability company, partnership, governmental entity, or any other legal entity, may appear and be represented by a lawyer admitted to practice in Wyoming.

(c) The Department may request the Attorney General to assist in contested case hearings to the extent required by W.S. § 16-3-112(c).

(d) If the contestant is represented by an attorney, payment of attorney's fees and costs are the responsibility of the contestant.

Section 21. Order of Procedure.

(a) As nearly as practicable, the following order of procedure shall be followed:

(i) The hearing officer shall announce the hearing is open and call by docket number and title of the case to be heard. The hearing officer shall ask if parties are ready to proceed and will allow parties an opportunity to dispose of any preliminary matters.

(ii) The hearing officer shall administer the oath to all witnesses who will present testimony.

(iii) The hearing officer may, in his or her discretion, allow evidence to be heard in an order other than that prescribed here.

(iv) Opening statements may be made.

(v) The party with the burden of proof shall offer evidence first, followed by the other party. The party which proceeded first may then offer rebuttal

evidence. Parties may cross-examine.

(vi) No testimony shall be received by the hearing officer unless given under oath/affirmation administered by the hearing officer.

(vii) Closing statements may be made.

(viii) The hearing officer may limit the time for opening and closing statements.

(ix) After all parties have had an opportunity to be heard, the hearing officer shall excuse all witnesses and close the evidence.

(x) Evidence may be reopened only upon a motion by a party to the proceeding on a showing of good cause.

(b) Upon their own motion, all parties or other interested persons may submit legal briefs after the close of the hearing. The hearing officer shall allow a reasonable time, not less than ten (10) working days from the date of hearing, for preparation of the briefs. The time may be extended upon agreement between the parties with the approval of the hearing officer.

Section 22. Decisions.

(a) The hearing officer shall make proposed findings of fact and conclusions of law within twenty (20) working days of the close of the hearing and forward them to the Director for final determination. This time may be extended if the parties or other interested persons are to submit briefs; but may not be extended by more than ten (10) working days, unless the parties stipulate, in writing or on the record at the hearing, to a later date.

(i) Within ten (10) working days of the close of the hearing, or such additional time as the hearing officer may allow, each party shall be allowed to file with the hearing officer any proposed findings of fact and conclusions of law, together with a supporting brief. Such proposals and briefs shall be served on all other parties.

(ii) Within ten (10) working days after the issuance of the hearing officer's proposed findings of fact and conclusions of law, any of the parties may submit exceptions. Such exceptions shall be filed with the Director and served on all other parties.

(b) Within ten (10) working days after the period for submitting exceptions pursuant to subsection (a)(ii), the Director shall make and enter into the record the final decision. The final decision shall be served on all parties to the proceedings. The final

decision shall include:

(i) A statement of the findings of fact and conclusions of law; and

(ii) The appropriate rule, order, relief or denial thereof. The decision shall be based upon the contested case record or any portion stipulated to by the parties. The decision shall include facts officially noticed as provided by W.S. § 16-3-108(d). It shall be made on the basis of a preponderance of evidence contained in the record.

(c) Final decisions of the Department shall be effective immediately after being entered in the record and served upon all parties. Service shall be in-person or by mailing a copy of any decision or order to each party or the party's attorney of record within a reasonable time after the entry of the decision into the record.

Section 23. Appeals. Appeals from a final decision of the Department shall be in accordance with W.S. § 16-3-114 through 16-3-115, and Rule 12 of the Wyoming Rules of Appellate Procedure.

Section 24. Transcripts and Record.

(a) When a contested case is set for hearing, the Department shall assign a docket number to the case and enter the case with its number and date of filing on a docket. The Department shall maintain a separate file for each docketed case in which all pleadings, transcriptions, correspondence, papers, and exhibits for that case shall be maintained. All such items shall have noted thereon the assigned docket number and the date of filing.

(b) The Department shall record all contested case hearing proceedings electronically, through the use of a qualified court reporter, or any other appropriate means determined by the agency or the hearing officer. Transcriptions of oral proceedings or written transcripts of a witness's testimony may be obtained by contestant from the Department upon payment of the cost.

(i) In a nonpublic investigatory proceeding, requests for copies or transcripts may be limited to testimony of the requesting party.

(ii) Where contestant can demonstrate that he or she is indigent and cannot effectively perfect his or her appeal without such transcription, the Department may waive the payment of the fee.

(c) The record of the hearing shall contain:

(i) All formal or informal notices, pleadings, motions and

intermediate rulings;

(ii) Evidence received or considered, including matters officially noticed;

(iii) Questions and offers of proof, objections and rulings;

(iv) Any proposed findings and conclusions of law;

(v) The proposed findings of fact and conclusions of law of the hearing officer;

(vi) Any exceptions to the hearing officer's proposed findings of fact and conclusions of law; and

(vii) The agency's final decision.

(d) A stipulation resolving the matter shall not be part of the record unless otherwise agreed by the parties.

Section 25. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, Health and Human Services, any other agency of the federal, state or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments, or take any other final action authorized by this Chapter.

Section 26. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of various provisions.

Section 27. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals or bulletins, which are inconsistent with this Chapter.

Section 28. Severability. If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in effect.

WYOMING MEDICAID RULES

CHAPTER 16

MEDICAID PROGRAM INTEGRITY

Section 1. Authority.

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

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to govern the process and procedures pertaining to Medicaid Program Integrity including, but not limited to, the identification and investigation of suspected fraud, theft, or abuse of services, the recovery of overpayments, and the imposition of sanctions against both providers and clients.

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

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter.

Section 3. Definitions. Except as otherwise specified in Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare.

Section 4. Investigation of Suspected Fraud, Theft, or Abuse of Services by Providers.

(a) The Department shall be responsible for the detection of suspected fraud, theft, or abuse of services.

(b) The Department is authorized to investigate, or to refer to appropriate agencies for investigation, suspected fraud, theft, or abuse of services identified pursuant to this section. An investigation shall be for the purpose of determining if:

(i) The identified practice is lawful and/or in compliance with existing rules and regulations and state and federal laws;

(ii) Fraud, theft, or abuse of services exists and can be documented;

(iii) Sufficient evidence can be developed to support the recovery of overpayments, the imposition of sanctions or any other civil or criminal action permitted by law; or

(iv) The matter should be referred for additional investigation or other action by a law enforcement agency or Medicaid Fraud Control Unit (MFCU).

(c) The Department's investigation may include, but is not limited to:

(i) Examination of medical, financial, or patient records;

(ii) Interviews of providers, their associates, agents or employees, or contractors;

(iii) Verification of a provider's professional credentials, the credentials of the provider's associates, agents, employees, or contractors;

(iv) Interviews with clients;

(v) Examination of equipment, supplies or other items used in a client's treatment;

(vi) Examination of prescriptions;

(vii) Random sampling and extrapolation pursuant to Section 8 of this Chapter; and

(viii) Examination of financial records, including, but not limited to, insurance claims or records, or records of any other source of payment.

(d) Sources of information. For purposes of performing its duties under this Chapter, the Department may use information from sources including, but not limited to:

(i) Units of state, local or the federal government;

(ii) Other third-party payers of health services, including health insurance carriers;

(iii) Professional review organizations;

(iv) Clients;

(v) Computer reports based on Medicaid claims data generated by the Department, Medicaid Management Information System, or the fiscal agent; or

(vi) Contractors hired by the Department to assist in the administration of the Medicaid program.

(e) Post-investigation actions. After the completion of an investigation, the Department shall either:

(i) Determine that no further action is warranted;

(ii) Take action pursuant to this Chapter; or

(iii) Refer the matter to law enforcement, the Wyoming Attorney General, Health and Human Services (HHS), Prosecution Recovery Investigation Collection and Enforcement (Price), the MFCU, or other appropriate authorities for possible civil or criminal action.

Section 5. Investigation of Suspected Fraud, Theft, or Abuse of Services by Clients.

(a) The Department is authorized to identify and investigate, or to refer to appropriate agencies for investigation, suspected fraud, theft, or abuse of services by clients identified pursuant to this section. An investigation shall be for the purpose of determining if:

(i) Fraud, theft, or abuse of services occurred or is occurring and can be documented;

(ii) Sufficient evidence can be developed to support restricting client participation pursuant to Section 10 of this Chapter; or

(iii) Sufficient evidence can be developed to support recovery of overpayments.

(b) The Department may, at any time, refer suspected client fraud, theft, or abuse of services, to PRICE or any other appropriate law enforcement agency.

(c) Sources of information. For purposes of its duties under this Chapter, the Department may use information from sources including, but not limited to, those

specified in Section 4 of this Chapter.

(d) Post-investigation actions. After the completion of or during an investigation, the Department shall take one or more of the following actions:

(i) Determine that no further action is warranted; or

(ii) Take action pursuant to this Chapter.

Section 6. Medical, Financial, and Patient Records.

(a) Record keeping requirements. Providers shall maintain medical and financial records pursuant to Chapter 3.

(b) Access to records. The Department shall have access to records pursuant to Chapter 3.

(c) Refusal to provide access. The refusal or inability of a provider to make financial or medical records available and accessible shall result in:

(i) The immediate suspension of all Medicaid payments to the provider;

(ii) All Medicaid payments made to the provider during the record retention period for which records supporting such payments are not produced shall be repaid to the Department after written request for such repayment; and

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

(d) A provider may request a reconsideration of a decision to recover the payments pursuant to this Chapter.

Section 7. Audits. Nothing in this rule shall prohibit the Department from conducting audits of providers as required or permitted by federal or state laws or policies.

(a) The Department or CMS may audit a provider at any time to determine whether the provider has received overpayments.

(b) The Department or CMS may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.

(c) Reporting audit results. If at any time during an audit the Department discovers evidence of an overpayment, that evidence may be referred to the MFCU.

(d) Provider self-audit.

(i) A provider may do a self-audit at any time. The Department may review or audit the provider's self-audit.

(ii) The Department may require a provider to conduct a self-audit if there is a reasonable belief that the provider has received overpayments.

(iii) If the provider should have notified the Department of any overpayments and did not provide notification within thirty (30) days of the completion of the self-audit, the Department has the option of imposing additional sanctions pursuant to Section 9 of this Chapter.

Section 8. Random Sample and Extrapolation.

(a) Determination to use sampling. The determination to use sampling shall be within the Department's discretion.

(b) Sampling methods. The Department shall adhere to the following standards in using sampling:

(i) Samples shall be selected using a method which ensures that each claim in the universe to be sampled has an equal and independent chance of being chosen for the sample;

(ii) Samples shall be selected only from claims within a time period which coincides with the period under investigation and from which recovery may be made;

(iii) The sampling method, including the size of the sample, the selection of the samples and any extrapolation from the results of the sample, shall be in accordance with Department approved statistical procedures in accordance with Generally Accepted Auditing Standards (GAAS) and Statement on Accounting Standards (SAS); and

(iv) Samples shall be selected at the ninety-five percent (95%) confidence level.

(c) Notice of intent to extrapolate. The Department shall notify the provider of

its intent to use extrapolation. The notice shall include:

(i) The nature of the claims;

(ii) The number of claims; and

(iii) The method to be used in extrapolating from the sample.

(d) Effect of extrapolation results. The amount of overpayments determined pursuant to extrapolation shall be refutably presumed to be correct. The provider may rebut the presumption by providing, at the provider's expense, an audit using GAAS or SAS, or by demonstrating that the method used by the Department failed to comply with the requirements of this Section.

Section 9. Sanctions for Providers.

(a) Available sanctions. The Department is authorized to take any of the following actions after determination that a provider has engaged in conduct described by this Chapter:

(i) Educational intervention;

(ii) Recovery of overpayments;

(iii) Postpayment review of claims;

(iv) Prepayment review of claims;

(v) Suspension of payments;

(vi) Suspension of provider agreement;

(vii) Termination of provider agreement;

(viii) Conditional future provider agreement;

(ix) Additional sanctions; or

(x) Referral to appropriate State regulatory agency, licensing agency; or MFCU.

(b) Decision to impose sanctions. When making a decision to impose

sanctions, the State Medicaid Agent, or other designee shall consider:

(i) The nature and extent of the provider's violations;

(ii) The provider's history of previous violations;

(iii) Actions taken or recommended by other State regulatory or licensing agencies; and

(iv) The steps taken by the provider to reduce the possibility of future violations.

(c) Grounds. The Department is authorized to impose sanctions against a provider for:

(i) Suspected or substantiated fraud, theft or abuse of services in submitting claims;

(ii) A pattern of presenting false or duplicate claims or claims for services not medically necessary;

(iii) A pattern of making false statements of material facts for the purpose of obtaining overpayments;

(iv) Failure to comply with the provisions of the provider agreement;

(v) Remedies imposed by CMS or the Department;

(vi) Lack of requested documentation;

(vii) Situations that pose a threat to the health, safety, or welfare of the clients or general public;

(viii) Suspension or termination of state licensure or any certification required to provide services;

(ix) Lack of or repeated failure to provide documentation of Medicaid services;

(x) Inability to collect overpayments;

(xi) Failure to maintain current contact information as described in

Chapter 3;

(xii) Exclusion by the Office of Inspector General;

(xiii) Lack of claims activity for one (1) year;

(xiv) Termination/exclusion under Medicare, CHIP or another State's Medicaid program;

(xv) Refusal to grant access to records as required by Chapter 3; or

(xvi) Violation of Medicaid, Department, or other State or Federal statute, rule, or law relating to provisions of services.

(d) Notice of sanctions. After determining to impose sanctions against a provider, the Department shall send written notice to the provider by certified mail, return receipt requested. The notice shall include:

(i) The notice requirements set forth in Chapter 4 as applicable;

(ii) The provider's right to request reconsideration of that determination pursuant to Section 20 of this Chapter; and

(iii) That the failure to request reconsideration shall preclude any further appeal of the decision to impose sanctions.

(e) If the sanction specified in Section 17 of this Chapter has been imposed, and after all administrative and judicial appeals and any applicable appeal periods have been exhausted, the Department shall send written notice to the public, known beneficiaries, known entities where the Provider was receiving payment for services, MFCU, Utilization and Quality Control Quality Improvement Organizations, the appropriate professional society, the appropriate state licensing agency, CMS, Office of Inspector General (OIG), and any other appropriate authority. Such notice shall include the sanction, the findings of fact which led to the sanction and the results of any appeals pursuant to 42 CFR 1001.2005 and 2006 and 42 CFR 1002.212.

(f) Effective date of sanction.

(i) The following sanctions shall be effective upon the receipt of notice:

(A) Suspension or termination for issues involving situations that pose a threat to the health, safety, and welfare of clients and/or the general public;

and

(B) Suspension or termination of state license or any certification required to provide services pursuant to these rules.

(ii) The following sanctions shall be effective on the date specified in the notice of sanction sent pursuant to subsection (c):

(A) Recovery of overpayments;

(B) Postpayment review of all claims submitted by the provider;

(C) Prepayment of claims submitted by the provider;

(D) Referral to the appropriate State regulatory agency, licensing agency, or MFCU;

(E) Conditional future participation; and

(F) Withholding of future payments and suspension of the provider's certification.

Section 10. Sanctions for Clients.

(a) Available actions. The Department is authorized to take any of the following actions after a determination that a client has engaged in conduct described by this Chapter:

(i) Refer the client to educational intervention to correct inappropriate or dangerous utilization of services;

(ii) Recover overpayments from the client, to the extent permitted by law;

(iii) Restrict the client's future participation in Medicaid to receiving services from the provider or providers designated by the Department. Medicaid payments shall be limited to the designated provider, except for payments for emergency care; or

(iv) Any other action allowed by state or federal law.

(b) Decision to impose sanctions. The decision to take action pursuant to this

Section shall be made by the State Medicaid Agent, or other designee, who shall consider, among other things:

(i) The nature and extent of the client's violations; and

(ii) The client's history of previous violations.

(c) Grounds for referral. The Department may refer a client pursuant to Section 5(b) of this Chapter for actions including, but not limited to:

(i) Fraud, theft or abuse in obtaining services;

(ii) Alteration or duplication of the client's Medicaid identification card;

(iii) Permitting, authorizing or assisting a non-client to use the client's Medicaid identification card to obtain services;

(iv) Using another client's Medicaid identification card to obtain services;

(v) Alteration or duplication of a prescription;

(vi) Knowingly misrepresenting material facts regarding the client's physical or mental condition for the purpose of obtaining services;

(vii) Knowingly furnishing incorrect information regarding eligibility to a provider;

(viii) Knowingly furnishing incorrect information to a provider to obtain services which are not medically necessary; or

(ix) Obtaining services by any false or incorrect pretenses.

(d) Notice of sanctions. After determining to impose sanctions against a client, the Department shall send written notice to the client by certified mail, return receipt requested. The notice shall include:

(i) The notice requirements set forth in Chapter 4 as applicable; and

(ii) The client's rights to request reconsideration of that determination pursuant to Section 20 of this Chapter.

(e) Effective date of action. The effective date of the action shall be specified in the notice.

Section 11. Educational Intervention.

(a) If the Department determines that a provider's claims are not being submitted properly or a client has engaged in abuse of services, fraud, or theft, the Department may educate the provider or client or require the provider or client to participate in and complete an educational program. The Department will send a notice to the provider or client, which shall state the reason(s) for the educational intervention. The notice may also include:

(i) The education available;

(ii) The time and date of such education, if applicable; and

(iii) That continued participation as a provider or client in Medicaid is contingent upon completion of the specified education by a date indicated in the notice.

(b) An educational program may be presented by the Department and shall provide instruction in the correct submission of claims, the appropriate utilization of services, or other such problems as are identified by the Department. A provider or client that is asked to participate in an educational program and refuses shall be suspended from participation in Medicaid until such time as the provider or client completes the required program.

Section 12. Recovery of Overpayments from Providers.

(a) Authorization. The Department shall recover claim overpayments submitted by a provider and paid by Medicaid. The Department may recover overpayments from a clinic, group, corporation, professional association, or other organization of any current or former member of that practice. The Department may also recover overpayments from an individual provider that was formerly part of a clinic, group, corporation, professional association or other organization.

(b) General Procedure.

(i) Notice of overpayments. After determining that a provider has received overpayments, the Department shall send written notice, by certified mail, return receipt requested, to the provider. In addition to the requirements for notice of adverse action contained in Chapter 4, the notice shall include:

(A) The amount of the overpayments; and

(B) The basis for the determination of overpayments.

(ii) Reimbursement of overpayments. A provider must reimburse the Department for overpayments within thirty (30) days after the provider receives written notice from the Department of the overpayments. Neither the filing of a request for reconsideration nor a request for an administrative hearing shall stay the effective date of the adverse action.

(iii) Methods of recovery of overpayments. If a provider does not timely reimburse the Department, following final administrative action, the Department shall recover the overpayments by:

(A) Withholding all or part of Medicaid payments:

(I) Payments shall be withheld at one hundred percent (100%);

(II) Payment arrangements can be made if the provider can demonstrate that one hundred percent (100%) withholding will result in an undue hardship, with the approval of the State Medicaid Agent or his or her designee;

(B) Initiating a civil lawsuit against the provider; or

(C) Any other method of collecting a debt or obligation permitted by law.

(iv) Overpayments involving providers who are bankrupt or out of business. The Department must notify the provider that an overpayment exists in any case involving a bankrupt or out-of-business provider and take reasonable actions to recover the overpayment during the sixty (60) day recovery period in accordance with 42 CFR § 433.318. The Department shall also take action to be listed as a creditor in bankruptcy proceedings.

(c) Department claim adjustments/denials.

(i) Time of claims adjustment. The Department shall make a claim adjustment after Medicaid payment has been made, in which case recovery of the adjusted amount may be made pursuant to this Section.

(ii) Denial of improper claims. The Department shall deny claims which are improperly submitted or which contain errors of any kind. Such claims may be

resubmitted, subject to applicable federal and state requirements.

(iii) No reconsideration or administrative hearing. A provider may not request reconsideration or an administrative hearing regarding a claims adjustment/denial.

(d) Repayment of credit balance.

(i) A provider shall repay any credit balance within thirty (30) days after the date such credit balance is identified by the Department or the provider.

(ii) A provider credit balance can be collected from the same provider under another provider number if that provider number is listed with the same tax identification number.

(iii) Lump sum adjustment. If an identified credit balance is not timely paid to the Department, the Department may recover the balance pursuant to this section or as otherwise allowed by the Department's Medicaid Rules.

(iv) No reconsideration or administrative hearing. A provider may not request reconsideration or an administrative hearing regarding a credit balance.

(e) Medicaid allowable payment.

(i) Compliance with Wyoming Medicaid rules. A provider must comply with the Medicaid allowable payment provisions of the Wyoming Medicaid Rules.

(ii) Payments which exceed Medicaid allowable payment. Any payment which exceeds the Medicaid allowable payment for the service shall be recovered pursuant to this section.

(iii) No reconsideration or administrative hearing. A provider may not request reconsideration or an administrative hearing regarding a recovery of payments which exceeds the Medicaid allowable payment.

Section 13. Postpayment Review of All Claims Submitted by the Provider.

(a) The Department may conduct a postpayment review of all claims submitted by the provider for six (6) years from the paid date under the following conditions:

(i) Complaints;

(ii) Investigations;

(iii) Medicaid program compliance; or

(iv) Violation of Medicaid, Department, or other state or federal statute, rule, or law relating to provisions of services.

Section 14. Prepayment Review of All Claims Submitted by the Provider. The Department may conduct a prepayment review of any claims submitted by the provider under the following conditions:

(a) Suspected fraud, theft, or abuse of services;

(b) Failure to comply with the provisions of the provider agreement;

(c) Remedies imposed by CMS or the Department; or

(d) Violation of Medicaid, Department, or other state or federal statute, rule, or law relating to provisions of services.

Section 15. Suspension of Payments. The Department may suspend payments to the provider under the following conditions:

(a) Suspected fraud, theft, or abuse of services;

(b) Failure to comply with the provisions of the provider agreement;

(c) Lack of requested documentation; or

(d) Violation of Medicaid, Department, or other state or federal statute, rule, or law relating to provisions of services.

Section 16. Suspension of Provider Agreement.

(a) The Department may suspend providers under the following conditions:

(i) Suspected fraud, theft or abuse of services;

(ii) Situations that pose a threat to the health, safety, or welfare of clients and/or the general public;

(iii) Suspension or termination of state licensure or any certification required to provide services;

(iv) Lack of, or repeated failure to provide documentation of Medicaid services;

(v) Inability to collect overpayments;

(vi) Failure to comply with the provisions of the provider agreement;

(vii) Failure to maintain current contact information as described in Chapter 3; or

(viii) Violation of Medicaid, Department, or other state or federal statute, rule, or law relating to provisions of services.

(b) Effect of suspension.

(i) A suspension under this section shall be the same and shall run contemporaneously with the period of the provider's suspension from a licensing entity, Medicare, or the period of voluntary non-participation from either, if these are a requirement of Medicaid enrollment.

(ii) A suspended provider shall not submit any claims, either personally or through a third party payer, clinic, group or other association, for any services provided after the effective date of the suspension;

(iii) No clinic, group, corporation, professional association or other organization shall submit any claim for services provided by an individual provider within such organization after the effective date of the individual provider's suspension; and

(iv) The Department shall not pay any claims submitted by a provider for services provided to a client during any period of suspension.

(c) The Department may suspend any and all provider numbers that have the same tax identification number as the provider number that has been suspended.

(d) Reinstatement. No provider that has been suspended shall be reinstated as a Medicaid provider until:

(i) The Department has been reimbursed for all overpayments; and

(ii) The Department is satisfied that sufficient safeguards have been installed to insure that the fraud, theft, or abuse of services, or other factors which led to the suspension, will not recur.

(e) No obligation to reinstate. The Department shall not be obligated to reinstate a suspended provider prior to the end of the period of suspension even if the requirements of subsection 16(d) of this Chapter are satisfied.

Section 17. Termination of Provider Agreement.

(a) The Department may terminate providers under the following conditions:

(i) Fraud, theft, or abuse of services;

(ii) Lack of, or repeated failure to provide documentation of Medicaid services;

(iii) Inability to collect overpayments;

(iv) Failure to comply with the provisions of the provider agreement;

(v) Violation of Medicaid, Department, or other state or federal statute, rule, or law requiring termination of the provider;

(vi) If a provider is excluded by Office of Inspector General (OIG);

(vii) If a provider has not submitted any paid claims for over one (1) year; or

(viii) If a provider has been terminated under Medicare, CHIP or another state's Medicaid program.

(b) Effect of termination.

(i) The termination under this section shall be the same as termination from the licensing agency, Medicare or the voluntary non-participation from either, if these are a requirement of Medicaid enrollment;

(ii) A terminated provider shall not submit any claims, either personally or through a third party payer, clinic, group or other association, for any services provided after the effective date of the termination;

(iii) No clinic, group, corporation, professional association or other

organization shall submit any claim for services provided by an individual provider within such organization after the effective date of the individual provider's termination; and

(iv) The Department shall not pay any claims submitted by a provider for services provided to a client after the effective date of termination.

(c) The Department may terminate any and all provider numbers that have the same tax identification number as the provider number that has been terminated.

(d) Reapplication. Once terminated, a provider must reapply in order to provide services. Previously terminated providers shall not provide services for Medicaid until:

(i) The Department has been reimbursed for all overpayments; and

(ii) The Department is satisfied that sufficient safeguards have been installed to insure that the fraud, theft, or abuse of services, or other factors which led to the termination, will not recur.

(e) No obligation to reinstate. The Department shall not be obligated to reinstate a terminated provider even if the requirements of subsection 17(c) above are satisfied.

Section 18. Conditional Future Provider Agreement.

(a) The Department may condition future participation upon the provider's agreement to a conditional provider agreement which:

(i) Is for a limited duration; or

(ii) Establishes specific conditions of participation.

(b) The Department may condition future participation for the following reasons:

(i) Lack of documentation;

(ii) Inability to collect overpayments;

(iii) Failure to comply with the provisions of the provider agreement; or

(iv) Violation of Medicaid, Department, or other state or federal

statute, rule, or law.

Section 19. Additional Sanctions.

(a) The sanctions listed in this section shall be available with respect to providers of home and community-based waiver services independent of or in addition to the sanctions listed in Section 9 of this Chapter.

(b) Conditions for the Continued Provision of Services: The Department may place a condition(s) upon a home or community-based waiver service provider.

(i) The Department shall place a condition(s) on a provider if:

(A) A provider has failed to submit an acceptable quality improvement plan pursuant to Chapter 45, or has failed to implement the quality improvement plan approved by the Department;

(B) There has been a chronic failure to provide services pursuant to the individual plan of care;

(C) A provider is providing services that fail to meet the applicable standard of care for the profession/service involved; or

(D) There is a continuing condition creating serious detriment to the health, safety, or welfare of recipients of home and community-based waiver services.

(ii) The Department may place the following condition(s) on the provider's certification:

(A) Requiring completion of education, including evidence of competency in the area of the education:

(I) Education may occur concurrent with continued services; or

(II) Services may be suspended until education is completed and evidence of competency is received by the Department.

(B) Requiring a physician's or appropriate medical specialist's statement verifying the ability to perform service duties as required;

(C) Restricting the provider's provision of a specific service;

(D) Restricting the provider's provision of services in a specific geographic area or location; and

(E) Denying new admissions.

(iii) The provider shall be notified by certified mail that a condition is being placed on their certification and shall have fifteen (15) working days to abate all areas of noncompliance that warrant the condition(s), or to submit an acceptable quality improvement plan pursuant to Chapter 45.

(A) If the provider fails to abate all areas of noncompliance or submit an acceptable quality improvement plan within fifteen (15) days of this notice, then the condition(s) shall go into effect and continue until removed.

(B) If all areas of noncompliance are successfully abated or an acceptable quality improvement plan is received by the Department, within fifteen (15) days of receipt of the notice then the condition(s) shall not be imposed.

(C) If the provider does not implement the quality improvement plan accepted by the Department, than the provider shall be notified by certified mail that condition(s) shall be effective immediately.

(iv) Once in place, a condition(s) shall not be removed or lifted until the provider submits the following:

(A) Evidence that the areas of non-compliance have been abated;

(B) An acceptable quality improvement plan;

(C) Verification that the quality improvement plan has been implemented:

(I) For each area of non-compliance;

(II) Pursuant to Chapter 45; and

(III) Within thirty (30) calendar days of placement of the condition; and

(D) Failure to comply with provision (C) above may result in revocation of the provider's certification.

(c) Impose a Monitor.

(i) The Department may impose a state Monitor, at the provider's expense, when:

(A) There has been chronic failure to provide services that has not been abated within fifteen (15) working days of placement of a condition;

(B) A provider is providing services that fail to meet the applicable standard of care for the profession involved and the non-compliance has not been abated within fifteen (15) working days of placing a condition; or

(C) There is a continuing condition creating serious detriment to the health, safety, or welfare of participants of home and community-based waiver services.

(ii) The state Monitor shall have access to all of the provider's financial and health records, service delivery settings, staff and participant information that is otherwise available to the Department.

(iii) The state Monitor shall be removed when the provider has abated the areas of non-compliance and has submitted and implemented an acceptable quality improvement plan.

(iv) All state Monitor costs and expenses shall be paid by the provider, including a per diem rate based on wages and benefits established by contract. If the provider fails to pay the costs and expenses of the state Monitor, the state shall pay, but the state Monitor shall not be removed until payment in full is received from the provider. Payment for the state Monitor shall include:

(A) When the state Monitor is working at a location requiring an overnight stay, the state Monitor shall be paid a per diem allowance not to exceed the allowances specified in W. S. § 9-3-102; and

(B) When required to travel on behalf of the state, the state Monitor shall be reimbursed at a rate not to exceed the rates specified in W. S. § 9-3-103.

(v) The Department has final authority to name the state Monitor, and shall make a reasonable effort to assure that there is not a potential conflict of interest between the state Monitor and the provider.

(d) Civil Money Penalties.

(i) The Department may impose civil money penalties when:

(A) There is a chronic failure to provide services, and the same has not been abated within fifteen (15) working days of placement of a condition;

(B) The services fail to meet the applicable standard of care for the profession involved, and the non-compliance has not been abated within fifteen (15) working days of placement of a condition; or

(C) There is a continuing condition creating serious detriment to the health, safety, or welfare of participants of home and community-based waiver services.

(ii) When determining the amount of any proposed penalty, the Department shall consider the following factors:

(A) The size of the provider's operation, including number of clients served;

(B) The gravity and extent of any potential or actual health, safety, or welfare risk to a participant;

(C) The good faith of the provider including:

(I) The degree of fault of the provider in causing or failing to correct the violation either through act or omission, ranging from inadvertent action causing an event which was unavoidable by the exercise of reasonable care to reckless, knowing, or intentional conduct; and

(II) Whether economic benefit resulted from the provider's failure to comply.

(D) The appropriateness of any acts taken, or which should have been taken, to mitigate a health, safety, or welfare risk to a participant;

(E) The provider's history of previous substantiated violations, regardless of whether any previously substantiated violation resulted in a civil penalty assessment; and

(F) Any other relevant information submitted to the Department between the initial sanction and the decision to impose civil money penalties.

(iii) A finding that civil money penalties are warranted shall:

(A) Be submitted to the provider, in writing, via certified mail;

(B) Include reference to specific factors relevant to the determination of the penalties as supported by substantial evidence; and

(C) Begin upon the provider's receipt of the notice of penalties, except that a provider's bad faith attempts to avoid notice shall cause the penalties to begin to run immediately.

(iv) For each day of continuing violation, the civil money penalty shall not exceed one thousand dollars ($1,000.00) or one percent (1%) of the amount paid to the provider during the previous twelve (12) months, whichever is greater. The provider may request, in writing, that the Department reduce the penalties imposed upon a finding that the financial impact may negatively impact the provider's ability to provide services that meet participants' health and safety needs.

(A) Such a reduction must be requested by the provider, in writing, and must be accompanied by relevant evidence to support the requested reduction within twenty (20) days of receiving notice of the penalties.

(B) The Department's findings with regard to the reduction must be supported by substantial evidence and shall be sent to the provider via certified mail.

(v) The civil money penalty shall continue until the provider submits evidence that the areas of non-compliance are abated, or the provider submits and implements an acceptable quality improvement plan.

(e) Suspensions. If at any time the Department finds that the provider is non-compliant with the rules to the extent that there exists a substantial and immediate threat to the health or safety of clients, the Department may summarily suspend the certification of that provider and take action necessary to protect the health and safety of participants.

(i) Action necessary to protect the health and safety of participants may include:

(A) Removing the person or persons deemed to be at significant risk;

(B) Making a report of abuse or neglect to the appropriate investigative agency as may be required by law; or

(C) Other actions deemed necessary to protect the health or safety of participants.

(ii) The suspension shall remain in place until the provider submits:

(A) Evidence that the substantial and immediate threat to the health or safety of participants has been abated;

(B) An acceptable quality improvement plan for each area of non-compliance; and

(C) Evidence that the quality improvement plan for each area of non-compliance has been implemented.

(iii) If after thirty (30) calendar days the provider has not complied with subsection (ii)(B) above, then the provider's certification shall be terminated.

(iv) Notice of suspension under this section shall be in writing and shall be provided to the provider at the time of any action taken pursuant to this section.

(v) In cases of suspension under this section, the provider shall be afforded an opportunity for a hearing within ten (10) days after the effective date of the suspension pursuant to W.S. § 42-4-120(e) and W.S. § 35-2-905(e).

(A) A request for hearing for a suspension under this section shall be provided to the Department within two (2) days after the receipt of notice sent by the Department pursuant to Chapter 4.

(B) The Department shall notify the provider that the hearing has been accepted or denied within one (1) business day of receipt of the request.

(C) Providers shall not be afforded the opportunity to request reconsideration for suspensions under this section.

(D) All other procedures for suspension hearings under this section shall be as specified by Chapter 4.

Section 20. Reconsideration.

(a) Request for reconsideration.

(i) A provider may request that the Department reconsider an adverse

action. Such request shall be mailed to the Department by certified mail within twenty (20) days after the date the provider receives notice pursuant to subsection 9(d) of this Chapter. The request must state with specificity the reasons for the request. Failure to provide such a statement shall result in the dismissal of the request with prejudice. A provider may submit any additional relevant information at the time of the request.

(ii) A client may request that the Department reconsider a decision to recover overpayments. Such request must be mailed to the Department by certified mail, return receipt requested, within twenty (20) days of the date the individual receives notice pursuant to Section 10 of this Chapter. A client may submit any additional relevant information at the time of the request.

(b) Reconsideration. The Department shall review the decision and send written notice of its final decision by certified mail, return receipt requested, to the party requesting reconsideration within forty-five (45) days after receipt of the request for reconsideration or the receipt of any additional information requested pursuant to subsection (c) below, whichever is later.

(c) Request for additional information. The Department may request additional information from the party requesting reconsideration as part of the reconsideration process. Such a request shall be made in writing by certified mail, return receipt requested. The party to whom the request is directed must provide the requested information within thirty (30) days after the date of the request. Failure to provide the requested information shall result in the dismissal of the request for reconsideration with prejudice.

(d) Matters subject to reconsideration. Reconsideration shall be limited to whether the Department has complied with the provisions of this Chapter or other applicable rules of the Department.

(e) Informal resolution. The party requesting reconsideration or the Department may request an informal meeting before the final decision on reconsideration to determine whether the matter may be resolved. The substance of the discussions and/or settlement offers made pursuant to an attempt at informal resolution shall not be admissible as part of a subsequent administrative hearing or judicial proceeding.

(f) Failure to Request Reconsideration.

(i) A provider that fails to request reconsideration pursuant to this section may not subsequently request an administrative hearing pursuant to Chapter 4 regarding the adverse action.

(ii) A client may elect not to request reconsideration and may request an administrative hearing pursuant to Chapter 4 regarding the adverse action. Such a

request for hearing shall be made by mailing by certified mail, return receipt requested, or personally delivering a request for hearing to the Department within thirty (30) days of the date of the notice of the adverse action.

Section 21. Administrative Hearing. A provider or client may request an administrative hearing regarding the final decision pursuant to Chapter 4 subject to the requirements of this Chapter.

Section 22. Suspending or Withholding Payments Pending Reconsideration or Administrative Hearing.

(a) The Department may suspend a provider or withhold all payments for services furnished by a provider pending reconsideration or administrative hearing if the State Medicaid Agent or his or her designee determines in writing and notifies the provider that:

(i) There is a substantial likelihood the Department will prevail in an action to recover overpayments;

(ii) There is a substantial likelihood the provider's pattern or practice which prompted the investigation will continue; or

(iii) There is reasonable cause to doubt the provider's financial ability to refund any overpayments.

(b) The decision to suspend or withhold payments pursuant to this section may be subject to an administrative hearing pursuant to Chapter 4.

Section 23. Remedies Cumulative. The remedies provided by this Chapter are cumulative. The Department may simultaneously seek to recover overpayments, impose sanctions, and refer the matter to the appropriate law enforcement agencies, PRICE, and/or MFCU for criminal action. Nothing in this Chapter shall preclude the Department from pursuing any remedies permitted by other provisions of state and federal statutes or rules.

Section 24. Effect of Fraud, Theft, or Abuse of Services of Medicare.

(a) Automatic suspension or termination. The Department shall suspend or terminate any provider who has been suspended or terminated from participation in Medicare, or any provider which voluntarily withdraws from Medicare when Medicare certification is a prerequisite to enrollment in Medicaid.

(b) Duration of suspension or termination. The duration of the provider's

suspension, termination, or withdrawal from participation in Medicaid shall be the same as and shall run contemporaneously with the provider's suspension, termination, or withdrawal from participation in Medicare.

(c) No separate appeal. A provider suspended or terminated from participation in Medicaid pursuant to this section shall not be entitled to reconsideration or an administrative hearing pursuant to this rule or any other rules of the Department. The provider's remedies are limited to those provided by Medicare.

Section 25. Disposition of Recovered Funds.

(a) Federal Medicaid funds. The Department shall, in accordance with the Social Security Act and applicable HHS regulations, repay all recovered federal Medicaid funds to CMS.

(b) State Medicaid funds. The Department shall retain the state Medicaid percentage of all recovered Medicaid funds as a state general fund reduction.

Section 26. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the Federal, State or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Chapter.

Section 27. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 28. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and/or bulletins, which are inconsistent with this Chapter.

Section 29. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.

WYOMING MEDICAID RULES

CHAPTER 38

SAFEGUARDING INFORMATION ON APPLICANTS

AND RECIPIENTS

This rule is being Repealed due to the current HIPAA laws that have been put in place.

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-101 et seq., and the Wyoming Administrative Procedure Act at W.S. §16-3-101 et seq.

Section 2. Purpose and Applicability. This Chapter shall apply to and

(a) This Chapter has been adopted to govern the collection, dissemination and disposal of information regarding applicants or recipients for Medicaid. It is intended to be read in conjunction with 42 U.S.C. §1396a(a)(7), 42 C.F.R. § 431 Subpart F, and W.S. § 42-4-112 et seq.

Section 3. General provisions.

(a) Except as otherwise provided by this Chapter and/or applicable Federal and State law, all information concerning applicants or recipients is confidential, and may be disclosed only in accordance with this Chapter.

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

Section 4. Definitions. Except as otherwise specified in this section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare.

(a) "Agency." An agency of the State of Wyoming or any of its political subdivisions, an agency of the United States of America, or the agency's agent or designee.

(b) "Applicant." A person whose written application for Medicaid has been submitted to the Department of Family Services or the Social Security Administration, but has not received final action.

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

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

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

(f) "Chapter 16." Chapter 16, "Medicaid Program Integrity," of the Wyoming Medicaid Rules.

(g) "Chapter 35." Chapter 35, Medicaid Benefit Recovery, of the Wyoming Medicaid Rules.

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

(i) "Court order." A certified copy of an order signed by a federal or state judge and entered by the clerk of that court. "Court order" does not include a subpoena or request for discovery pursuant to the Federal Rules of Civil or Criminal Procedure, the Wyoming Rules of Civil or Criminal Procedure, or any similar rules.

(j) "Covered services." Services which are Medicaid reimbursable pursuant to the Wyoming Medicaid Rules.

(k) "Data exchange agreement." A written agreement between the Department and another agency that specifies:

(i) The information to be exchanged;

(ii) The titles of all agency and Department officials with the authority to request information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The limitations on the use and disclosure of the information by the Department and the agency;

(v) The method, if any, the Department and the agency will use to reimburse the other for the reasonable costs of furnishing the information; and

(vi) Any other provisions required by applicable federal or State

statutes or regulations.

(vii) A data exchange agreement may be part of a more comprehensive memorandum of understanding between the agency and the Department.

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

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

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

(o) "Emergency." A situation where the failure to disclose information is likely to result in:

(i) A condition that could cause an individual serious physical or mental disability, continuation of severe pain or death if not immediately diagnosed and treated; or

(ii) The legal rights of the Department or the person or entity requesting the release of information will be irreparably harmed if such information is not disclosed.

(p) "Financial records." "Financial records" as defined in Chapter 3, which definition is incorporated by this reference.

(q) "HCFA." The Health Care Financing Administration of HHS, its agent, designee, or successor.

(r) "HHS." The United States Department of Health and Human Services, including the Office of Inspector General, its agent, designee, or successor.

(s) "Information." Any medical records, financial records, or other records, in whatever form, which contain any of the following information about an applicant or recipient:

(i) Names and addresses;

(ii) Services provided;

(iii) Social and economic conditions or circumstances;

(iv) Evaluations by DFS of personal information;

(v) Medical data, including, but not limited to, diagnoses and history of disease or disability;

(vi) Information received for the purpose of verifying income eligibility and the amount of Medicaid payments;

(vii) Information received in connection with the identification of third party payers, including information contained in the MMIS;

(viii) Claims, claims histories, and Medicaid payments made to providers, including any information regarding the amount of payments made on behalf of a recipient;

(ix) Any other information generated or maintained by the Department, or in the possession of or subject to the control of any agent or contractor of the Department.

(t) "Local agency." The county office of DFS.

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

(v) "Medical records." "Medical records" as defined in Chapter 3, which definition is incorporated by this reference.

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

(x) "MMIS." The Medicaid Management Information System, as certified by HHS and implemented by the Department.

(y) "Outside source." Any person or entity that is not part of the Department. "Outside source" includes, but is not limited to, any other governmental body, a court, a corporation or partnership, a private association, a health plan, or a law enforcement agency.

(a) "Provider." "Provider" as defined in Chapter 3, which definition is incorporated by this
reference.

(aa) "Provider agreement." "Provider agreement" as defined in Chapter 3, which definition is incorporated by this reference.

(bb) "Purposes directly related to the administration of Medicaid." Any action to:

(i) Establish eligibility for Medicaid;

(ii) Determine the amount of Medicaid payments;

(iii) Provide services for recipients; or

(iv) Conduct or assist in an investigation, prosecution, or civil or criminal proceeding related to Medicaid.

(cc) "Recipient." A person who has been determined eligible for Medicaid, or who has received services for which Medicaid reimbursement has been sought or received..

(dd) "Services." Health care services, medical supplies, or equipment provided to a recipient.

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

(ff) "Written authorization." A document signed and dated by an applicant or recipient, or the applicant's or recipient's legal guardian or conservator, authorizing the Department to release information. The document must be in a form acceptable to the Department and shall specify the party to whom the information is to be released and the information to be released.

Section 5. Record keeping and release of information by providers.

(a) Record keeping requirements. Providers shall maintain medical records and financial records as required by Chapter 3 and other applicable provisions of the Department's rules.

(b) Access to records. In addition to the requirements of the Department's rules, federal regulations, and the provider agreement, providers shall grant access to medical records and financial records during regular business hours to the Department, the Division, DFS, HCFA, HHS and the Wyoming Attorney General, or any of their lawful agents or representatives, for purposes directly related to Medicaid, including, but not limited to, audit, identification, investigation and prosecution of fraud and/or abuse pursuant to the laws of the United States or the State of Wyoming, or the rules of the Department or HHS. Individuals seeking access to records shall furnish proper identification. Unless otherwise specified by the entity seeking access, the provider may provide access by permitting the review of the original records or by making legible copies available.

(c) Release of records. Except as provided in this Section or as otherwise required by law, a provider shall not release medical records, financial records, or other information to any individual or entity without first obtaining written authorization or being presented with a certified copy of a court order. If the records are released in response to a court order, the provider shall promptly forward copies of the court order to the Department and any and all applicant(s) or recipient(s) who are identified or are identifiable in the records.

Section 6. Release of information by the Department.

(a) Generally. Except as otherwise required by law, the Department shall not release information to an outside source except for purposes directly related to the administration of Medicaid and shall release information only as specified in this Section.

(b) Release of information to applicants or recipient s. The Department shall not release information to a recipient or an applicant, except:

(i) After receiving written authorization;

(ii) Pursuant to a court order; or

(iii) In an emergency.

(iv) Any information released pursuant to this subsection shall be limited to that pertaining to the applicant or recipient who signed the authorization, is named in the court order, or is the subject of the emergency.

(c) Release of information to another agency. The Department shall not release information to another agency, except as specified in this subsection:

(i) Verification of applicant or recipient eligibility. Before requesting information from or releasing information to any other agency to verify income, eligibility, or the amount of assistance, the Department shall execute a data exchange agreement with that agency. Any request for or release of information shall be pursuant to such a data exchange agreement;

(ii) Information regarding third party payers. Before requesting information from or releasing information to another agency to identify third party payers, the Department shall execute a data exchange agreement with that agency. Any request for or release of information shall be pursuant to such a data exchange agreement; or

(iii) The Department may release information pursuant to Chapter 16 to the extent necessary to fulfill its responsibilities under that rule.

(iv) The Department shall grant access to all records in its possession to the United States Attorney, the Wyoming Attorney General, or any of their authorized agents or representatives, for purposes directly related to the administration of the Medicaid program, including, but not limited to, audit and identification, investigation and prosecution of fraud or abuse pursuant to the laws of the United States or the State of Wyoming, or the rules of the Department or HHS. Individuals seeking access shall provide proper identification before being afforded access. Unless otherwise required by the entity requesting access, the Division may provide access by permitting the inspection of original documents or making available legible copies.

(d) Release of information regarding potential third party liability. The Department may release information to a third party payer pursuant to Chapters 4 or 35 to the extent necessary to protect and exercise its rights under those Chapters.

(e) Release of information to any other outside source. Information shall not be released to any outside source other than as specified above unless:

(i) The Department obtains written authorization;

(ii) The party requesting the information provides the Department with a certified copy of a court order directing release;

(iii) In an emergency; or

(iv) Pursuant to applicable federal or state laws.

(f) Subpoena of information. If the Department or any person acting as an employee or agent of the Department is served with a subpoena to testify about an applicant or recipient or to produce information, the Department shall inform the court issuing the subpoena of applicable federal and state statutes and rules restricting disclosure, including this Chapter. No information shall be produced nor shall any person testify except pursuant to court order issued after the court is informed pursuant to this subsection.

(g) Release of information in an emergency. If information is disclosed to any individual or entity, the disclosing individual or entity shall inform the applicant or recipient in writing of the disclosure and the reasons for the disclosure. Such notice shall be mailed to the last known address of the applicant or recipient as soon as practicable after the disclosure.

(h) Reimbursement for copying expenses. The Department may charge a reasonable fee for the costs of reproducing records requested pursuant to this section.

Section 7. Violations. A violation of this rule may be a violation of and

punishable under W.S. § 42-4-112 *et seq*.

Section 8. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 9. Superseding effect. When promulgated, this Chapter supersedes the provisions of all prior rules or policy statements issued by the Department, including Manuals or Bulletins, which are inconsistent with this Chapter.

Section 10. Severability. If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in effect.

WYOMING MEDICAID RULES

CHAPTER 39

RECOVERY OF EXCESS PAYMENTS

THIS RULE IS BEING COMBINED INTO CHAPTER 16. CHAPTER 39 IS BEING REPEALED

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

Section 2. Purposed and Applicability

(a) This Chapter shall apply to and govern the recovery of excess payments made to providers, except as otherwise specified in the Department's Medicaid rules.

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

Section 3. General Provisions

(a) The Department is required by the Social Security Act and State law to limit Medicaid payments to providers to the Medicaid allowable payment. Any payment which exceeds that amount for any reason, including, but not limited to, payments made because of a system error, claims adjustment, fraud or abuse, is an excess payment and must be recovered.

(b) A provider may not bill a recipient if the Division has recovered Medicaid payments for a service furnished to the recipient.

Section 4. Definitions. Except as otherwise specified in this section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

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

(b) "Admission certification." "Admission certification" as defined in Chapter 8, which definition is incorporated by this reference.

(c) “Adverse action.” “Adverse action” as defined in Chapter 1, which definition is incorporated by this reference. “Adverse action” does not include a technical denial.

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

(e) “Chapter 1.” Chapter 1, Medicaid Fair Hearings, of the Wyoming Medicaid rules.

(f) “Chapter 3.” Chapter 3, Provider Participation, of the Wyoming Medicaid rules.

(g) “Chapter 4.” Chapter 4, Third Party Liability, of the Wyoming Medicaid rules.

(h) “Chapter 7.” Chapter 7, Wyoming Nursing Home Reimbursement System, of the Wyoming Medicaid rules.

(i) “Chapter 8.” Chapter 8, Inpatient Hospital Certification, of the Wyoming Medicaid rules.”

(j) “Chapter 16.” Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid rules.

(k) “Chapter 30.” Chapter 30, Level of Care Inpatient Hospital Reimbursement, of the Wyoming Medicaid rules.

(l) “Chapter 35.” Chapter 35, Medicaid Benefit Recovery, of the Wyoming Medicaid rules.

(m) “Claim.” A request by a provider for Medicaid payment for services provided to a recipient.

(n) “Claims adjustment.” An adjustment to a payment by the Division to correct a system error. A claims adjustment is a final agency action, not an adverse action. A claims adjustment does not preclude further action pursuant to this Chapter, Chapter 16, or a referral to the MFCU.

(o) “Cost report.” “Cost report” as defined in Chapter 7, Chapter 30, or any of the Wyoming Medicaid rules, as appropriate, which definitions are incorporated by this reference.

(p) “Covered service.” Services which are reimbursable pursuant to the rules of the Department.

(q) “Credit balance.” Any amount of funds owed to the Division as a result of excess payments, regardless of the reason.

(r) “Department.” The Wyoming Department of Health, its, agent, designee, or successor.

(s) “Department of Family Services (DFS).” The Wyoming Department of Family Services, its agent, designee, or successor.

(t) “Division.” The Division of Health Care Financing of the Department, its agent, designee, or successor.

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

(v) “Excess payments.” Medicaid funds received by a provider, to which the provider is not entitled for any reason, including payments which exceed the Medicaid allowable payment. “Excess payments” includes, but is not limited to:

(i) Overpayments;

(ii) Payments made as a result of system errors;

(iii) Payments for services furnished to a non-recipient;

(iv) Payments for non-covered services furnished to a recipient;

(v) Payments for services which are not documented and/or supported by medical records and/or financial records;

(vi) Payments for services for which admission certification has been denied or withdrawn;

(vii) Payments which exceed a provider’s usual and customary charge, unless otherwise permitted by the Department’s rules.

(w) “Federal Medicaid funds.” Federal funds paid by HHS to the State pursuant to 42 U.S.C. §1396b(d) and subsequently paid to a provider.

(x) “Federal medical assistance percentage (FMAP).” “Federal medical assistance percentage” as defined in 42 U.S.C. § 1396d(b), which definition is incorporated by this reference.

(y) “Financial records.” “Financial records” as defined in Chapter 3, which definition is incorporated by this reference.

(z) “Fraud.” “Fraud” as defined in Chapter 16, which definition is incorporated by this reference.

(aa) “Generally accepted accounting principles (GAAP).” Accounting concepts, standards, and procedures established by the American Institute of Certified Public Accountants.

(bb) “Generally accepted auditing standards (GAAS).” Auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.

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

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

(ee) “Medicaid allowable payment.” The maximum Medicaid reimbursement as determined pursuant to the rules of the Department.

(ff) “Medicaid funds.” That combination of Federal Medicaid funds and State Medicaid funds that is available to the Division to make payments to providers. The Federal portion of Medicaid funds shall be the FMAP. The State portion shall be the State Medicaid percentage.

(gg) “Medicaid Fraud Control Unit (MFCU).” The Medicaid Fraud Control Unit of the Wyoming Attorney General’s Office, its agent, designee, or successor.

(hh) “Medically necessary” or “medical necessity.” “Medically necessary” or “medical necessity” as defined in Chapter 3, which definition is incorporated by this reference.

(ii) “Medical records.” “Medical records” as defined in Chapter 3, which definition is incorporated by this reference.

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

(kk) “Overpayments.” Medicaid payments received by a provider as the result of fraud or abuse.

(ll) “Prior authorized.” “Prior authorized” as defined in Chapter 3, which definition is incorporated by this reference.

(mm) “Provider.” “Provider” as defined in Chapter 3, which definition is incorporated by this reference.

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

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

(pp) “Service limitations.” “Service limitations” as defined in Chapter 3, which definition is incorporated by this reference.

(qq) “State Medicaid funds.” The funds appropriated by the Wyoming Legislature for the Wyoming Medicaid program, which funds shall be used to constitute the State Medicaid percentage.

(rr) “State Medicaid percentage.” The state percentage of Medicaid payments determined pursuant to 42 U.S.C. § 1396d(b).

(ss) “System error.” An unintentional mistake on a claim, including, but not limited to:

(i) A clerical error;

(ii) A coding error;

(iii) A cost reporting error;

(iv) A claim for services in excess of the service limitations;

(v) Claims which are not submitted in accordance with the applicable provisions of the Wyoming Medicaid Rules; or

(vi) An erroneous payment, including an incorrect per diem payment or level of care payment.

(tt) "Technical denial." A determination by the Division to deny payment or recoup payments previously made because of a provider's failure to comply with the timeliness or other procedural requirements of any of the Wyoming Medicaid Rules. A technical denial is a final agency action, not an adverse action. "Technical denial" includes, but is not limited to, the denial of payment or recoupment of payments because of a provider's:

(i) Failure to timely and properly obtain admission certification;

(ii) Failure to timely and properly obtain prior authorization;

(iii) Furnishing covered services to a non-recipient;

(iv) Furnishing non-covered services to a recipient; or

(v) Furnishing covered services in excess of the service limitations.

(uu) "Third party payer." "Third party payer" as defined in Chapter 4, which definition is incorporatedby this reference.

(vv) "Usual and customary charge." The provider's charge to the general public for the same or similar services.

Section 5. Providers.

(a) Payments only to providers. No person or entity that provides services to a recipient shall receive Medicaid funds unless the person or entity has signed a provider agreement and is enrolled. Any payment to a non-provider for furnishing covered services is an excess payment.

(b) Compliance with Chapter 3. A provider that wishes to receive Medicaid reimbursement for covered services furnished to a recipient must meet the requirements of Chapter 3, which requirements are incorporated by this reference. Any payment made to an individual or entity that has failed to comply with Chapter 3 is an excess payment and shall be recovered pursuant to Section 13.

Section 6. Provider Records.

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

(b) Failure to comply with Chapter 3. Any payment made to a provider that has failed to maintain required records is an excess payment and shall be recovered pursuant to Section 13.

Section 7. Verification of recipient data.

(a) Compliance with Chapter 3. A provider must comply with the verification of recipient data requirements of Chapter 3, which requirements are incorporated by this reference

(b) Failure to comply with Chapter 3. Any payment made to a provider for furnishing services to a non-recipient is an excess payment and shall be recovered pursuant to Section 13.

Section 8. Third party liability.

(a) Compliance with Chapters 4 and 35. A provider must comply with the third party liability and benefit recovery provisions of Chapters 4 and 35, which are incorporated by this reference.

(b) Any payment made for services which are the responsibility of a third party payer is an excess payment and shall be recovered pursuant to Section 13.

Section 9. Prior authorization.

(a) Compliance with prior authorization requirements. A provider must comply with the prior authorization requirements of the Wyoming Medicaid rules.

(b) Failure to obtain required prior authorization. Any payment made for services which require prior authorization and for which such authorization has not been timely received is an excess payment and shall be recovered pursuant to Section 13.

Section 10. Medicaid allowable payment.

(a) Compliance with Wyoming Medicaid rules. A provider must comply with the Medicaid allowable payment provisions of the Wyoming Medicaid rules.

(b) Payments which exceed Medicaid allowable payment. Any payment which exceeds the Medicaid allowable payment for the service is an excess payment and shall be recovered pursuant to Section 13.

Section 11. Payment and submission of claims.

(a) Compliance with Wyoming Medicaid rules. Claims shall be paid pursuant to the payment and submission of claims provisions of Chapter 3 and/or other

applicable provisions of the Wyoming Medicaid rules, which provisions are incorporated by this reference.

(b) Failure to comply with Wyoming Medicaid rules. Any payment made to a provider in response to a claim that is not submitted in accordance with Chapter 3 and/or other applicable provisions of the Wyoming Medicaid rules is an excess payment and shall be recovered pursuant to Section 13.

Section 12. Audits.

(a) The Department or HCFA may audit a provider at any time to determine whether the provider has received excess payments.

(b) The Department or HCFA may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.

(c) Excess payments. If an audit discloses excess payments, the Department shall recover any excess payments pursuant to Section 13.

(d) Reporting audit results. If at anytime during a financial audit or a medical audit, the Division discovers evidence of an overpayment, that evidence, in addition to the Division's final audit report regarding that provider, shall be referred to the MFCU.

Section 13. Recovery of excess payments.

(a) Excess payments shall be recovered pursuant to subsections (b) through (e) of this Section, Chapter 3, Chapter 16, any other applicable provisions of the Wyoming Medicaid rules, or the matter may be referred to the MFCU.

(b) Claims adjustments.

(i) Time of claims adjustment. The Division may make a claims adjustment after Medicaid payment has been made, in which case recovery of the adjusted amount may be made pursuant to subsection 13(c).

(ii) No reconsideration or administrative hearing. A provider may not request reconsideration or an administrative hearing regarding a claims adjustment.

(iii) Denial of improper claims. The Division may deny claims which are improperly submitted or which contain errors of any kind. Such claims may be resubmitted, subject to applicable Federal and state requirements.

(c) Recovery of overpayments.

(i) Recovery pursuant to Chapter 16. The Division may recover overpayments pursuant to Chapter 16;

(ii) Recovery pursuant to other Wyoming Medicaid rules. The Division may recover overpayments pursuant to any other applicable provisions of the Wyoming Medicaid rules; or

(iii) Referral to MFCU. The Division may refer cases involving suspected fraud and abuse to the MFCU. A referral to MFCU is not a final determination of the existence of an overpayment.

(d) Recovery of excess payments. If the Division determines to recover excess payments pursuant to this Chapter, it shall follow the procedures specified in this subsection.

(i) Notice of excess payments. After determining that a provider has received excess payments, the Department shall send written notice to the provider stating the amount of the excess payments, the basis for the determination of excess payments, and, except in the case of a claims adjustment or a technical denial, the provider's rights to request reconsideration of that determination pursuant to Section 14.

(ii) Reimbursement of excess payments. Except as otherwise specified by the Wyoming Medicaid rules, a provider must reimburse the Department for excess payments within 30 days after the provider receives written notice from the Department of the excess payments, even if the provider has requested reconsideration or an administrative hearing regarding the determination of
excess payments.

(iii) Methods of recovery of excess payments. If a provider does not timely reimburse the Department, the Department may recover the excess payments, even if the provider has requested reconsideration, an administrative hearing, or sought judicial relief regarding the determination of excess payments, by:

(A) Withholding all or part of Medicaid payments until the excess payments are recovered;

(B) Initiating a civil lawsuit against the provider; or

(C) Any other method of collecting a debt or obligation permitted by law.

(e) Repayment of credit balance.

(i) A provider shall repay any credit balance within sixty days after the date such credit balance is identified by the Department or the provider.

(ii) Lump sum adjustment. If a credit balance identified pursuant to paragraph 13(e)(i) is not timely paid to the Department, the Department may recover the balance pursuant to subsection 13(d) or as otherwise allowed by the Department's Medicaid rules.

Section 14. Reconsideration.

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

(b) Reconsideration. The Department shall review the decision and send written notice by certified mail, return receipt requested, to the provider of its final decision within forty-five days after receipt of the request for reconsideration or the receipt of any additional information requested pursuant to (c), whichever is later.

(c) Request for additional information. The Department may request additional information from the provider as part of the reconsideration process. Such a request shall be made in writing by certified mail, return receipt requested. The provider must provide the requested information within thirty days after the date of the request. Failure to provide the requested information shall result in the dismissal of the request with prejudice.

(d) Matters subject to reconsideration. Reconsiderationshall be limited to whether the Department has complied with the provisions of this Chapter and/or other applicable rules of the Department.

(e) Matters not subject to reconsideration. A provider may not request reconsideration of:

(i) A claims adjustment; or
(ii) A technical denial.

(f) Informal resolution. The provider or the Department may request an informal meeting before the final decision on reconsideration to determine whether the matter may be resolved. The substance of the discussions and/or settlement offers made pursuant to an attempt at informal resolution shall not be admissible as part of a

subsequent administrative hearing or judicial proceeding.

(g) Administrative hearing. A provider may request an administrative hearing regarding the final decision pursuant to Chapter I of these rules by mailing by certified mail, return receipt requested or personally delivering a request for hearing to the Department within twenty days of the date the provider receives notice of the final decision.

(h) Confidentiality of settlement agreements. If the Division and a provider enter into a settlement agreement as part of a reconsideration or an administrative hearing, such agreement shall be confidential, except as otherwise required by law. A breach of confidentiality by the provider shall, at the Division's option, result in the settlement agreement becoming null and void.

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

Section 15. Disposition of recovered Medicaid funds.

(a) Federal Medicaid funds. The Division shall, in accordance with the Social Security Act and applicable HHS regulations, repay all recovered Federal Medicaid funds to HCFA.

(b) State Medicaid funds. The Division shall retain the State Medicaid percentage of all recovered Medicaid funds, which funds shall be used to reimburse providers for furnishing covered services to recipients.

Section 16. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

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

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