Health, Department of

Medicaid

Chapter 30: Level of Care Inpatient Hospital Reimbursement

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WYOMING MEDICAID RULES

CHAPTER 30

LEVEL OF CARE INPATIENT HOSPITAL REIMBURSEMENT

Section 1. Authority

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

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Medicaid reimbursement of inpatient hospital services, other than specialty services, for individuals admitted on or after its effective date. Inpatient hospital services are also subject to the provisions of Chapters 3, 8, 9, 24, 31, 32, 37 and 39 of these rules, except as otherwise specified in this Chapter.

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

Section 3. General Provisions.

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

(b) General methodology.

(i) Level of care. Except as otherwise specified in this Chapter, the Department pays for inpatient hospital services using a prospective per discharge payment system based on the level of care provided in response to the recipient's principal diagnosis.

(ii) Specialty services. The Department reimburses providers of specialty services pursuant to Chapter 31, not pursuant to this Chapter.

(iii) Per diem reimbursement. The Department reimburses certain inpatient hospital services, specified in this Chapter, using per diem rates.

(iv) Disproportionate share hospitals may receive an additional annual payment pursuant to Chapter 32.

Section 4. Definitions.

(a) "Active treatment." Active treatment as set forth in 42 C.F.R. § 441.154, which is incorporated by this reference.

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

(c) "Acute stabilization." The process of bringing to stability an acute medical or psychological condition within a relatively short time through the administration of inpatient hospital services.

(d) "Admission" or "admitted." The act that allows an individual to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the hospital's medical staff. "Admission" or "admitted" does not include an individual that is transferred from one unit of a hospital to another unit in the hospital or to a distinct part hospital unit.

(e) "Admission certification." "Admission certification" as defined by Chapter 8, which is incorporated by this reference.

(f) "Allowable costs." Medicare allowable costs as determined by 42 U.S.C. § 1395(f), except as otherwise specified by this Chapter.

(g) "Attending physician." The physician of record during a recipient's hospitalization for acute stabilization.

(h) "Ancillary services charges." Charges for furnishing inpatient ancillary services to a patient reported on a claim.

(i) "Average length of stay." The average length of stay is calculated by the Department and is equal to the average number of days a recipient remains in a hospital as an inpatient during the base period. The average length of stay is the sum of all lengths of stay divided by the number of claims. The length of stay is the number of inpatient days reported on a claim, excluding the date of discharge.

(j) "Base period." With respect to operating costs, a hospital's most recently audited twelve month cost reporting period which ends on or before August 31, 1994. With respect to claims and discharge data, the period from July 1, 1994 through December 31, 1996. With respect to capital costs, the most recently settled cost report year as of October 15, 1993.

(k) "CARF." The Commission on Accreditation of Rehabilitation Facilities.

(l) "Capital costs." Capital related costs as defined in 42 C.F.R. § 413.130, which is incorporated by this reference.

(m) "Certified." Approved by the survey agency as in compliance with applicable statutes and rules.

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

(o) “Chapter 3.” Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(p) “Chapter 4.” Chapter 4, Third Party Liability, of the Wyoming Medicaid Rules.

(q) “Chapter 8.” Chapter 8, Inpatient Admission Certification, of the Wyoming Medicaid Rules.

(r) “Chapter 9.” Chapter 9, Hospital Services, of the Wyoming Medicaid Rules.

(s) “Chapter 16.” Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid Rules.

(t) “Chapter 24.” Chapter 24, Wyoming Hospital Reimbursement System, of the Wyoming Medicaid Rules.

(u) “Chapter 28.” Chapter 28, Swingbed Services, of the Wyoming Medicaid Rules.

(v) “Chapter 31.” Chapter 31, Selective Contracting of Inpatient Hospital Services, of the Wyoming Medicaid Rules.

(w) “Chapter 32.” Chapter 32, Disproportionate Share Hospital Reimbursement, of the Wyoming Medicaid Rules.

(x) “Chapter 37.” Chapter 37, Fiscal Responsibility, of the Wyoming Medicaid Rules.

(y) “Chapter 39.” Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid Rules.

(z) “Children’s hospital.” An inpatient hospital which is:

(i) Designated by the Secretary of HHS as a children’s specialty hospital;

(ii) Exempt from the Medicare PPS; and

(iii) Is a participating provider.

(aa) “Claim.” A request by a provider for Medicaid payment for covered services provided to a recipient.

(bb) “Cost report.” A cost report prepared and submitted in conformance with Medicare requirements. “Cost report” includes any supplemental request by the Department for additional information relating to the hospital’s costs.

(cc) “Covered service.” A health service or supply eligible for Medicaid reimbursement pursuant to the rules of the Department. “Covered service” does not include nursing facility services provided in a swingbed.

(dd) “Department.” The Wyoming Department of Health, its agent, designee or successor.

(ee) “Desk review.” A review by the Department of a hospital’s cost report to determine: (i) if the cost report has been prepared and submitted in compliance with this Chapter; (ii) that costs have

been properly allocated; and (iii) that costs are allowable.

(ff) "Diagnosis codes." Diagnosis codes as contained in the International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM"), which is incorporated by this reference. The ICD-9-CM is authorized by HCFA and is available from the United States Government Printing Office, Washington, D.C. 20402.

(gg) "Direct medical education." Direct medical education as defined by 42 C.F.R. § 413.86(a)(2), which is incorporated by this reference.

(hh) "Director." The Director of the Department or the Director's designee.

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

(jj) "Discharge planning." To make arrangements during a recipient's hospitalization for the recipient to receive appropriate services at such time that inpatient hospital services will no longer be medically necessary.

(kk) "Disproportionate share hospital." A disproportionate share hospital as defined by Chapter 32, which is incorporated by this reference.

(ll) "Distinct part hospital unit." A distinct part hospital unit excluded from the Medicare prospective payment system pursuant to 42 C.F.R. § 412.20(b)(1), which is incorporated by this reference.

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

(nn) "Enrolled." Enrolled as defined in Chapter 3, Section 3(l), which is incorporated by this reference.

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

(pp) "Extended psychiatric care." Inpatient psychiatric services, other than level of care psychiatric services, provided to a recipient under age twenty-one if:

(i) Ambulatory care services in the recipient's community of residence do not meet the recipient's treatment needs and inpatient treatment is medically necessary;

(ii) Services are provided in a psychiatric hospital, a distinct part hospital unit or a residential treatment center;

(iii) The recipient is referred for extended psychiatric care by the attending physician;

(iv) Services are provided under the direction of a physician and involve active treatment that is reasonably expected to improve the recipient's condition or prevent further regression of the recipient's condition so that such services will no longer be necessary; and

(v) Services are medically necessary.

(vi) Maintenance psychiatric services are reimbursable only if:

(A) There is a downward change in the acuity level of patient treatment; or

(B) The recipient is ready for discharge and community care resources are not available to furnish appropriate follow-up care.

(vii) Services provided to a recipient that is not under age twenty-one are reimbursable only if the recipient was receiving services in the period immediately preceding the date on which the recipient attains age twenty-one. Such services are reimbursable until the earlier of:

(A) The date services are no longer medically necessary; or

(B) The month in which the recipient attains age twenty-two.

(viii) The service is not acute stabilization.

(qq) "Extraordinary circumstances." A catastrophic occurrence, beyond the control of a provider, which results in substantially higher costs and which meets the criteria of (i) through (v). "Extraordinary circumstances" include, but are not limited to, fire, earthquakes, floods or other natural disasters, and which:

(i) Is a one-time occurrence;

(ii) Could not have reasonably been predicted;

(iii) Is not insurable;

(iv) Is not covered by federal or state disaster relief; and

(v) Is not the result of intentional, reckless or negligent actions or inactions by any director, officer, employee or agent of the provider.

(rr) "Field audit." An examination, verification and review of a provider's financial records and any supporting or related documentation conducted by employees, agents or representatives of the Department or HHS. A field audit may be conducted at the hospital.

(ss) "Financial records." All records, in whatever form, used or maintained by a hospital in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the hospital's cost reports or a claim.

(tt) “Generally accepted auditing standards (GAAS).” Auditing standards, practices and procedures established by the American Institute of Certified Public Accountants.

(uu) “Geometric mean length of stay.” The exponential value of the average (mean logarathim) value of all natural logarathims of all lengths of stay.

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

(ww) “HCPCS.” The HCFA common procedures coding system.

(xx) “HHS.” The United States Department of Health and Human Services, its agent, designee or successor.

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

(zz) “Hospital specific payment rate.” A level of care payment rate based on a participating provider’s allowable costs and calculated pursuant to Section 10.

(aaa) “Incentive payment.” An additional payment to a hospital for a level of care capped by the statewide ceiling when the hospital’s mean cost per discharge for that level of care is less than the statewide mean cost per discharge for that level of care. An incentive payment is determined by subtracting the hospital’s mean cost per discharge for the level of care from the statewide mean cost per discharge for that level of care, and multiplying the difference by twenty-five percent.

(bbb) “Inflation factor.” The HCFA-PPS Hospital Market Basket index as published by DRI Data Resources Inc., in Health Care Costs, which is published quarterly by the DRI/McGraw division of McGraw-Hill, Inc. It is available from the publisher at 1200 G. Street, N.W., Washington, D.C. 20005. The inflation factors for historical data are from the Third Quarter 1996 historical tables for PPS type hospitals. The inflation factors for current data are from the Third Quarter 1996 historical tables for PPS type hospitals. The inflation factors for future years will be calculated using the Third Quarter National Forecasts for PPS Type Hospital Market Basket tables for the appropriate year.

(ccc) “Inpatient.” An “inpatient” as defined by 42 C.F.R. § 440.2(a), which is incorporated by this reference.

(ddd) “Inpatient hospital service.” “Inpatient hospital services” as defined by 42 C.F.R. § 440.10, which is incorporated by this reference.

(eee) “Intensive care unit (ICU)/critical care unit (CCU) services/Burn care. Inpatient hospital services which are:

(i) Provided to a patient who requires more intensive services than are furnished in a hospital’s general medical or surgical unit;

(ii) Expected to require significant time to complete; and

(iii) Accompanied by a high risk of complications.

(iv) The Division shall, from time to time, designate services as ICU/CCU/Burn care based on diagnosis codes, revenue codes, and clinical consultation with health care professionals. The Division shall disseminate a current list of procedures designated as ICU/ CCU/Burn care to providers through Provider Manuals or Provider Bulletins.

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

(ggg) "Less than one day stay." An admission and discharge which occur within twenty-four hours.

(hhh) "Level of care." A measure of the intensity of services provided to inpatients. Inpatient hospital services are separated into levels of care as specified in Section 8. Medicaid payment for inpatient hospital services is based on the level of care provided to each discharge.

(iii) "Levels of care capped by the statewide ceiling." The following levels of care:

(i) Maternity care - Surgical;

(ii) Maternity care - Medical;

(iii) Normal newborn;

(iv) Newborn readmission care; and

(v) Routine.

(jjj) "Level of care payment rate." The payment rate for each level of care as determined pursuant to this Chapter.

(kkk) "Level of care psychiatric services." Acute stabilization services furnished to an individual with a psychiatric diagnosis. The Division shall, from time to time, designate psychiatric services as acute stabilization services based on diagnosis codes, clinical consultation with mental health professionals and HCFA guidelines. The Division shall disseminate a current list of acute stabilization services which are Medicaid reimbursable to providers through Provider Manuals or Provider Bulletins. Except for extended psychiatric care, Medicaid reimbursement is limited to acute stabilization.

(lll) "Maintenance psychiatric services." Covered extended psychiatric services identified by revenue code 680.

(mmm) "Major surgery." Surgical procedures that are mainly performed in a hospital operating room, are expected to require significant time to complete, and which carry an increased risk of complications. The Division shall, from time to time, designate surgical procedures as major surgery based on

diagnosis codes, clinical consultation with health care professionals and HCFA guidelines. The Division shall disseminate a current list of major surgeries to providers through Provider Manuals or Provider Bulletins.

(nnn) "Maternity care - Medical." Routine prenatal services furnished to a pregnant mother, other than major surgery. The Division shall, from time to time, designate services as maternity care - medical based on diagnosis codes, clinical consultation with health care professionals and HCFA guidelines. The Division shall disseminate a current list of maternity care - medical services to providers through Provider Manuals or Provider Bulletins

(ooo) "Maternity care - Surgical." Prenatal services furnished to a pregnant mother which involve major surgery. The Division shall, from time to time, designate services as maternity care - surgical based on diagnosis codes, clinical consultation with health care professionals and HCFA guidelines. The Division shall disseminate a current list of maternity care - surgical services to providers through Provider Manuals or Provider Bulletins.

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

(qqq) "Medicaid allowable costs." Medicaid program costs as determined from Medicare cost reports that have been submitted to and audited by the Medicare Fiscal Intermediary. Medicaid allowable costs and calculations of payments shall not be adjusted because of changes that result from a Medicare appeal or reopening.

(rrr) "Medically necessary" or "medical necessity." "Medically necessary" as defined by Chapter 8, which definition is incorporated by this reference.

(sss) "Medical record." All documents, in whatever form, in the possession of or subject to the control of the hospital which describe the recipient's diagnosis, condition or treatment, including, but not limited to, the plan of care for the recipient.

(ttt) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.

(uuu) "Merged hospital." The surviving hospital in a merger or consolidation of two or more hospitals. A "merged hospital" includes the purchase of substantially all the assets of one or more hospitals by another hospital, in which each of the merged hospitals continues to operate as a hospital or part of a hospital.

(vvv) "Minor surgery." Surgical procedures that may be performed in a physician's office, which are expected to require minimal time for completion, or which carry a minimal risk of complications. The Division shall, from time to time, designate surgical procedures as minor surgery based on diagnosis codes, clinical consultation with health care professionals and HCFA guidelines. The Division shall disseminate a current list of minor surgeries to providers through Provider Manuals or Provider Bulletins.

(www) "Most recently settled cost report." A facility's most recent Medicare cost report which

has been: (i) submitted to Medicare in accordance with Medicare standards and procedures; and (ii) cost settled by the Medicare intermediary using Medicare principles of cost reimbursement.

(xxx) "Newborn readmission care." Services provided to a recipient who is less than twenty-nine (29) days old, and who has been discharged and readmitted to a hospital. The Division shall, from time to time, designate services as newborn readmission care based on diagnosis codes, clinical consultation with health care professionals and HCFA guidelines. The Division shall disseminate a current list of newborn readmission care to providers through Provider Manuals or Provider Bulletins

(yyy) "New hospital." A hospital which was not a participating provider, or a hospital which was not enrolled before July 1, 1996. "New hospital" does not include a merged hospital.

(zzz) "Nonallowable costs." Costs which are not related to covered services, including costs specified in this Chapter and the other rules of the Department.

(aaaa) "Normal newborn care." Services furnished to a newborn, other than newborn readmission care. The Division shall, from time to time, designate normal newborn care services based on diagnosis codes, clinical consultation with health care professionals and HCFA guidelines. The Division shall disseminate a current list of normal newborn care services to providers through Provider Manuals or Provider Bulletins.

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

(cccc) "Obligated capital." Obligated capital as defined by Medicare.

(dddd) "Old capital." Capital for assets that were placed in use for patient care on or before December 31, 1990.

(eeee) "Outlier." With respect to determining outlier payments pursuant to Section 16, a discharge with allowable costs that exceed the outlier threshold. With respect to calculating the mean cost per discharge for each level of care, claims with allowable costs greater than two standard deviations above the mean cost per discharge for any given level of care.

(ffff) "Outlier threshold."

(i) Participating providers other than children's hospitals. Three times the hospital's level of care payment rate for each level of care.

(ii) Children's hospitals. Two times the hospital's level of care payment rate for each hospital-specific level of care for children's hospitals during the appropriate rate period.

(iii) An outlier threshold shall be determined and applied separately for each level of care. To determine if a claim exceeds that threshold, allowable costs are calculated as the hospital specific cost-to-charge ratio for each level of care, multiplied by the allowable charges submitted on the claim for that level of care. Facilities with cost-to-charge ratios greater than 1.0 shall be capped at the statewide cost-to-charge ratio for each level of care.

(gggg) “Overpayments.” “Overpayments” as defined in Chapter 39, which definition is incorporated by this reference.

(hhhh) “Participating providers.” All hospitals within Wyoming that are providers, and all out-of-state hospitals that were paid $250,000.00 or more by the Wyoming Medicaid program during the period from July 1, 1994, through December 31, 1996. “Participating providers” include all rehabilitation facilities and psychiatric hospitals that received Wyoming Medicaid funds during the period from July 1, 1994, through December 31, 1996.

(iiii) “Patient.” An individual admitted to a hospital or other provider of inpatient hospital services.

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

(kkkk) “PPS.” The Medicare prospective payment system.

(llll) “Principal diagnosis.” Principal diagnosis as defined by 42 C.F.R. § 412.60(c)(1), which is incorporated by this reference.

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

(nnnn) “Provider.” A provider as defined by Chapter 3, Section 3(y), which is incorporated by this reference.

(oooo) “Psychiatric hospital.” An institution that is accredited as a psychiatric hospital by the JCAHO.

(pppp) “Rate year.” The State fiscal year (July 1 through the following June 30).

(qqqq) “Readmission.” The act by which an individual is:

(i) Admitted to a provider from which the individual had been discharged;

(ii) On or before the thirty-first day after the previous discharge; and

(iii) For treatment of any diagnosis.

(iv) Newborn readmissions which occur within twenty-eight days after the newborn’s initial discharge are not readmissions.

(rrrr) “Rebase.” To redetermine level of care payments using a base period which occurs after the base period as defined in this Chapter.

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

(tttt) “Recipient under age twenty-one.” A recipient before or during the month in which he or she turns twenty-one years of age.

(uuuu) “Rehabilitation services.” Covered services identified by diagnosis codes V5700-V5799, unless such services are reimbursed as specialty services. The Division may, from time to time, designate rehabilitation services to be reimbursed as specialty services. In such event, the Division shall disseminate to providers, through Provider Manuals or Provider Bulletins, a current list of which rehabilitation services are reimbursed as specialty services and which are reimbursed pursuant to this Chapter.

(vvvv) “Rehabilitation facility.” A free-standing rehabilitation treatment facility accredited by the JCAHO and operated primarily for the purposes of furnishing rehabilitative services.

(wwww) “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.

(xxxx) “Residential treatment center (RTC).” A facility or program accredited by the JCAHO, and operated for the primary purpose of providing residential psychiatric care to persons under age twenty-one, except as otherwise specified in this Chapter. The only services provided in an RTC that are covered services are extended psychiatric services.

(yyyy) “Revenue codes.” Revenue codes as used in the UB-92 Manual. The UB-92 Manual may be obtained from the Wyoming Hospital Association (WHA), 2005 Warren Ave., Cheyenne, WY 82001.

(zzzz) “Routine care.” Covered services other than ancillary care and those services included within any other level of care and other than specialty services.

(aaaaa) “Settled cost report.” A hospital’s cost report which has:

(i) Been submitted to Medicare in accordance with Medicare standards and procedures;

(ii) Cost settled by the Medicare intermediary using Medicare principles of cost reimbursement (a cost report is considered settled notwithstanding a request to reopen);

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

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

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

(bbbbb) “Services.” Inpatient hospital services.

(ccccc) “Specialty services.” “Specialty services” as defined by Chapter 31, which definition is incorporated by this reference.

(ddddd) “Statewide.” All participating providers.

(eeeee) “Survey agency.” The Office of Health Care Quality of the Department, its agent, designee or successor, or a comparable agency in another state.

(fffff) “Swingbed.” A bed in a hospital which is certified for either inpatient hospital services or nursing facility services.

(ggggg) “Swingbed services.” Nursing facility services provided to a recipient in a swing-bed that are reimbursed pursuant to Chapter 28.

(hhhhh) “Technical denial.” “Technical denial” as defined in Chapter 39, which definition is incorporated by this reference.

(iiiii) “Third party liability.” Third party liability as determined pursuant to Chapter 4, which is incorporated by this reference.

(jjjjj) “Transfer.” The act by which an individual that has been admitted to a hospital is released from that hospital to be admitted to another hospital. “Transfer” does not include movement of a patient to or from a distinct part hospital unit of the hospital or from one unit to another within a hospital.

Section 5. Provider Participation.

(a) Payments only to providers. No provider that furnishes inpatient hospital services to a recipient shall receive Medicaid funds unless the provider is certified, has signed a provider agreement and is enrolled.

(b) Compliance with Chapter 3. A provider that wishes to receive Medicaid reimbursement for inpatient hospital services furnished to a recipient must meet the requirements of Chapter 3, Sections 4 through 6, which are incorporated by this reference.

Section 6. Provider Records.

(a) A provider must comply with Chapter 3, Section 7, which is incorporated by this reference.

(b) Explanation of records. In the event of a field audit, the provider shall have available at the field audit location one or more knowledgeable persons who can explain to the auditors the provider’s financial records, the accounting and control system and cost report preparation, including attachments and allocations.

(c) Failure to maintain records. A provider unable to satisfy all of the requirements of this Section shall be given a written notice of deficiency and shall have sixty (60) days after the date of the written notice to correct such deficiency. If, at the end of the sixty (60) days, the Department determines that the deficiency has not been corrected, the Department shall reduce by twenty-five percent the Medicaid payment due for each of the provider’s claims received by the Department on or after the sixtieth

day. If at the end of one hundred and twenty days (120) after the mailing of the written notice of deficiency, the Department determines that the deficiency has not been corrected, the Department shall suspend all Medicaid payments to the provider for claims received by the Department on or after such date. The suspension of payments shall continue until the Department determines that adequate records are being maintained. After the deficiency is corrected, the Department shall release any withheld payments, without interest. This remedy shall not affect the Department's right to sanction the provider pursuant to applicable State or Federal rules or laws.

(d) Out-of-state records. If a provider maintains financial or medical records in a state other than the state where the provider is located, the provider shall either transfer the records to an in-state location that is suitable for the Department or reimburse the Department for reasonable costs, including travel, lodging and meals, incurred in performing the audit in an out-of-state location, unless otherwise agreed by the Department.

Section 7. Verification of recipient data. A provider must comply with Chapter 3, Section 8, which is incorporated by this reference.

Section 8. Medicaid allowable payment for inpatient hospital services.

(a) In General. Medicaid reimbursement for inpatient hospital services, other than specialty services and services paid a per diem as specified in this Chapter, is based on the level of care provided to each recipient. The payment rate is based on a hospital-specific rate or a level of care payment rate capped by the statewide ceiling as set forth in this Chapter, and payments shall not be cost settled based on actual costs.

(b) Levels of care. Inpatient hospital services are divided in the following levels of care:

(i) Maternity care - Surgical;

(ii) Maternity care - Medical;

(iii) Intensive care unit ("ICU")/Cardiac care unit ("CCU") services/Burn Care;

(iv) Major surgery;

(v) Level of care psychiatric services;

(vi) Rehabilitation services;

(vii) Normal newborn care;

(viii) Newborn readmission care; and

(ix) Routine care.

(c) Payment rates for each level of care are determined pursuant to Sections 9 through 11, except that services which are or become specialty services are reimbursed pursuant to Chapter 31.

(d) Hierarchy of levels of care. Inpatient hospital services are reimbursed pursuant to the following hierarchy, unless otherwise reimbursed as specialty services.

(i) Specialty services;

(ii) Maternity care - Surgical;

(iii) Maternity care - Medical;

(iv) Intensive care unit ("ICU")/Cardiac care unit ("CCU") services/Burn Care;

(v) Major surgery;

(vi) Level of care psychiatric services;

(vii) Rehabilitation services;

(viii) Normal newborn;

(ix) Newborn readmission care; and

(x) Routine care.

(e) Services that require prior authorization or admission certification. The Division may, from time to time, designate covered services that require prior authorization or admission certification. In designating such services, the Division shall consider the cost of the service, the potential for over-utilization of the service, and the availability of lower cost alternatives. The Division shall disseminate a current list of services that require prior authorization or admission certification to providers through Provider Manuals or Provider Bulletins.

Section 9. Determination of base period allowable costs.

(a) The Department shall determine base period Medicaid allowable costs for each level of care for each participating provider as specified in this Section. Base period allowable costs are the sum of routine per diem costs and ancillary service costs.

(b) Allowable Medicaid per diem costs for inpatient routine departments shall be extracted from the hospital's base period settled cost report.

(i) Medicaid per diem costs for inpatient routine departments extracted from the cost report shall exclude costs associated with capital and direct medical education.

(c) Medicaid per diem costs derived from (b)(i) shall be applied to Medicaid patient days on each base period claim to determine routine base period costs for each level of care.

(d) The Medicaid per diem costs for each level of care shall be inflated forward from the midpoint of the base period to December 31, 1997.

(e) Base period ancillary service costs.

(i) Costs for ancillary services shall be extracted from the base period cost report, grouped according to the type of service, and cost-to-charge ratios shall be established for each group of services for each provider.

(ii) The cost-to-charge ratios for each group of ancillary services for all providers shall be arrayed, from low to high, and the mean for each group shall be determined. Next, cost-to-charge ratios which are two standard deviations or more from the mean cost-to-charge ratio shall be eliminated from the array, and the mean shall be redetermined for each group.

(iii) The Medicaid allowable base period cost for ancillary services shall be determined using the lower of:

(A) The provider's cost-to-charge ratio for ancillary services as determined pursuant to paragraph (i); and

(B) The mean cost-to-charge ratio as determined pursuant to paragraph (ii) if the provider's cost-to-charge ratio exceeds the mean and if the mean is greater than 1.00.

(C) If the provider does not have a cost-to-charge ratio for a service, base period costs shall be the mean cost-to-charge ratio established pursuant to paragraph (ii).

(iv) Ancillary service charges for base period claims shall be inflated forward from the date of service to December 31, 1997, using the inflation factor.

(v) The Medicaid ancillary services cost-to-charge ratios determined in paragraph (iii) shall be applied to the ancillary services charges determined pursuant to paragraph (iv).

(f) Each claim's cost in the base period is derived from subsections (d) and (e).

(g) High and low cost Medicaid outlier costs shall be identified for each level of care. For purposes of this section, the high cost outlier threshold shall be discharges with allowable costs greater than two standard deviations from the mean. For purposes of this section, low cost outliers shall be discharges with allowable costs less than two standard deviations from the mean.

(h) Costs associated with less than one day stays shall be identified for each level of care.

(i) Claims with "zero dollars" in the payment field shall be identified.

(j) Transfers shall be identified.

(k) The base period allowable Medicaid cost for each level of care shall be determined by subtracting (g), (h), (i) and (j) from (f).

(l) The base period Medicaid discharges for each level of care shall be determined by subtracting the number of outliers, less than one day stays, transfer claims, and zero payment claims from

the total number of base period Medicaid discharges.

(m) The base period allowable Medicaid cost per discharge for each level of care shall be determined by dividing (k) by (l).

(n) Determination of mean.

(i) A hospital-specific mean base period cost per discharge for each level of care shall be determined by dividing the hospital's Medicaid allowable costs for each level of care by the number of discharges for that level of care.

(ii) The statewide mean base period cost per discharge for each level of care shall be determined by dividing the total Medicaid allowable costs for each level of care for all participating providers by the total number of discharges for each level of care for all participating providers.

(o) Determination of median. The median for each level of care shall be determined by taking the midpoint of the arrayed means determined pursuant to subsection (m).

(n) The level of care payment shall be:

(i) The amount determined pursuant to Sections 10 and 11;
(ii) The capital payment determined pursuant to Section 18; and

(iii) The direct medical education payment pursuant to Section 19.

Section 10. Hospital specific levels of care.

(a) The Department shall reimburse the following levels of care using hospital specific payment rates, unless reimbursed as specialty services:

(i) Major surgery;

(ii) Intensive care unit ("ICU")/Cardiac care unit ("CCU") services/Burn Care.

(iii) Level of care psychiatric services; and

(iv) Rehabilitation services.

(b) Determination of payment rates. The payment rates for hospital specific levels of care shall be:

(i) The hospital's base period allowable Medicaid per discharge costs, determined pursuant to Section 9;

(ii) The inflation adjustment established pursuant to Section 20;

(iii) The capital payment determined pursuant to Section 18; and

(iv) The direct medical education payment determined pursuant to Section 19.

(c) Caps for hospital specific payment rates.

(i) Payment rates for hospital specific levels of care shall not exceed one-hundred ten (110) percent of the median cost per discharge for all participating providers except children's hospitals.

(ii) Payment rates for children's hospitals shall not exceed one-hundred fifty (150) percent of the median cost per discharge for all participating providers.

(iii) For purposes of this subsection, providers with five or fewer discharges during the period from July 1, 1994, through December 31, 1996, were not considered.

Section 11. Levels of care capped by the statewide ceiling.

(a) The Department shall reimburse the following levels of care using level of care payment rates capped by a statewide ceiling, unless reimbursed as specialty services:

(i) Maternity care - Medical;

(ii) Maternity care - Surgical;

(iii) Normal newborn;

(iv) Newborn readmission care; and

(v) Routine.

(b) Determination of payment rates. The payment rates for each level of care capped by a statewide ceiling shall be the lesser of:

(i) The hospital-specific mean cost per discharge, as determined pursuant to Section 9 and inflated pursuant to Section 20; or

(ii) The statewide mean cost per discharge, determined pursuant to Section 9 and inflated pursuant to section 20.

(iii) If payment is pursuant to paragraph 11(b)(i), the level of care payment rate shall include an incentive payment.

(iv) A capital payment shall be determined pursuant to Section 18 and added to the level of care payment rate; and

(v) The direct medical education payment determined pursuant to Section 19 shall be added to the level of care payment rate.

Section 12. Reimbursement of non-participating hospitals.

(a) The Medicaid payment rate shall be the average level of care payment for all participating providers, including incentive payments.

(b) The Medicaid payment rate for non-participating hospitals shall not include reimbursement for capital costs or direct medical education costs.

(c) Medicaid payment to a non-participating hospital may not exceed the Medicaid level of care payment rate.

Section 13. Reimbursement of new hospitals.

(a) The Medicaid payment rate for new hospitals shall be the average level of care payment for all participating providers, including incentive payments.

(b) The Medicaid payment rates for new hospitals shall remain in effect until the level of care system is rebased.

(c) The Medicaid payment rate for new hospitals shall not include reimbursement for capital costs or direct medical education costs.

Section 14. Reimbursement of merged hospitals. The Medicaid allowable hospital-specific level of care payments for a merged hospital shall be:

(a) The level of care payment rates of the surviving hospital;

(b) The direct medical education payment determined pursuant to Section 19; and

(c) A capital payment. The capital payment shall be calculated by combining the surviving and former providers' capital payments and discharges. The blended rate will be effective as of the effective date of the merger. It shall be applied using the phase-in period and methodology of Section 18.

Section 15. Reimbursement for transfers.

(a) Transferring hospital. A hospital which transfers a patient after admission to another hospital shall receive a per diem payment, not to exceed the level of care payment, except as provided in subsection (d).

(b) Discharging hospital. The hospital which discharges a patient that has been transferred in shall receive a per diem payment, not to exceed the level of care payment, except as provided in subsection (d), unless the admission is a less than one day stay. Less than one day stays shall be reimbursed pursuant to Section 17.

(c) Receiving hospital that does not discharge. A hospital which receives a transfer, and then transfers the patient to another hospital, shall receive a per diem payment, not to exceed the level of care

payment, except as provided in subsection (d).

(d) Outlier payments. A hospital receiving reimbursement pursuant to this Section shall be eligible for an outlier payment pursuant to Section 16.

(e) The per diem rate to be paid pursuant to this Section shall be determined as follows:

(i) For hospital-specific levels of care. By dividing the applicable level of care payment rate by the provider's geometric mean length of stay for that level of care, except that for providers with five or fewer claims in the base period, the statewide geometric mean length of stay was used.

(ii) For levels of care capped by the statewide ceiling. By dividing the applicable level of care payment rate by the statewide geometric mean length of stay for that level of care.

(f) Capital payments. Payments made pursuant to this Section shall not include a capital payment unless the facility is entitled to a level of care payment.

Section 16. Reimbursement of outliers.

(a) The Medicaid allowable payment for outliers shall be the applicable level of care payment plus a payment equal to:

(i) The difference between the hospital's allowable costs for the outlier and the outlier threshold. For purposes of this Section, allowable costs are calculated as the hospital specific cost-to-charge ratio for each level of care, multiplied by the allowable charges submitted on the claim for that level of care. Facilities with cost-to-charge ratios greater than 1.0 shall be capped at the statewide cost-to-charge ratio for each level of care.

(ii) Multiplied by seventy-five (75) percent.

(iii) If a facility does not have a hospital-specific cost-to-charge ratio, the statewide cost-to-charge ratio shall be used.

(b) Submission of claims. Claims for outlier payments shall be submitted in the form specified by the Department in Provider Manuals or Provider Bulletins.

(c) Discharge planning. No hospital shall receive an outlier payment for a patient that is not discharged because of the hospital's failure to do appropriate discharge planning.

Section 17. Reimbursement of less than one day stays.

(a) Hospital specific levels of care.

(i) The Department shall determine a less than one day stay payment rate for each level of care for each participating provider.

(ii) The provider's level of care payment for each level of care, including incentive payments, shall be divided by the provider's geometric mean length of stay for that level of care. For providers with five or fewer claims during the base period, the statewide geometric mean length of stay shall be used. The quotient shall be the less than one day stay payment rate.

(iii) For new providers and non-participating providers, payment shall be the statewide level of care payment as described below.

(b) Levels of care capped by the statewide ceiling.

(i) The Department shall determine a per diem rate for each level of care.

(ii) Each hospital's payment rates for levels of care capped by the statewide ceiling, including any incentive payments, shall be divided by the provider's geometric mean length of stay for that level of care. The quotient shall be the per diem payment rate.

(c) The Medicaid allowable payment for stays of less than one day shall not include outlier reimbursement or reimbursement for capital costs or direct medical education costs.

Section 18. Reimbursement of capital costs.

(a) Capital costs. Capital costs shall be reimbursed using a three year phase-in of the statewide median per discharge prospective capital rate.

(i) Year one (July 1, 1994 through June 30, 1995). Capital costs shall be reimbursed using a blended rate equal to fifty percent of the hospital-specific capital prospective capital payment; and fifty percent of the state-wide average prospective capital rate.

(ii) Year two (July 1, 1995 through June 30, 1996). Capital costs shall be reimbursed using a blended rate equal to twenty-five percent of the hospital-specific capital prospective capital payment; and seventy-five percent of the state-wide average prospective capital rate.

(iii) Year three (July 1, 1996 through June 30, 1997) and thereafter. Capital costs shall be reimbursed at 100 percent of the statewide median prospective capital rate.

(b) To determine hospital-specific per discharge capital payment rates, the Department shall:

(i) Extract total capital costs and total inpatient discharges from each participating provider's most recently settled cost report received by the Department on or before October 15, 1993;

(ii) Determine total inpatient capital costs by applying the percent of the hospital's inpatient revenue as reported on the cost report specified in paragraph (i) to total capital costs.

(iii) Divide total inpatient capital costs determined pursuant to paragraph (ii) by the total discharges determined pursuant to paragraph (i).

(c) To determine the state-wide average prospective capital rate, the Department shall take

the midpoint of the arrayed hospital-specific capital payments determined pursuant to (b)(iii). An adjustment to a provider's capital rate pursuant to subsection (e) shall not result in the redetermination of the state-wide average prospective capital rate.

(d) No capital payment shall be made to non-participating providers.

(e) Adjustments to capital rates. A provider may request an adjustment of its hospital specific capital rate pursuant to Section 29 only to:

(i) Compensate for capital expenditures resulting from extraordinary circumstances; or

(ii) Reflect capital expenditures made after the base period and on or before June 30, 1994, if Medicare has approved a redetermination of the provider's 1990 base year capital costs.

(iii) The burden shall be on the provider to demonstrate that it is entitled to an adjustment to its capital rate pursuant to this subsection.

(f) If the request is made pursuant to (e)(ii), the following standards apply:

(i) Redetermination of hospital-specific capital rates for PPS hospitals. A PPS hospital may request the redetermination of the hospital-specific portion of the capital rate if the Medicare intermediary has approved a redetermination in the hospital's 1990 base period Medicare hospital-specific rate. If the intermediary approves a redetermination to reflect changes in obligated capital recognized as old capital and put into use subsequent to the hospital's 1990 base period, a request must be submitted to the Division within thirty days of the request for redetermination submitted to Medicare. The Department's final decision will be based on the final approval for redetermination by the Medicare intermediary. The Department will recalculate the hospital-specific capital rate within thirty days of Medicare's final determination. Requests for redetermination will not be recognized for any conditions not allowed under Medicare principles.

(ii) Redetermination of hospital-specific capital rates for non-PPS hospitals. Non-PPS hospitals may request the redetermination of the hospital-specific portion of the capital rate for obligated capital recognized as old capital. The determination of obligated capital will be made in accordance with the Medicare definition of obligated capital. The hospital must provide the appropriate support documentation consistent with Medicare principles. Such a request must be submitted to the Department within ninety days after the close of the cost reporting year that will serve as the new base period. No redetermination will be made for periods beginning after June 30, 1994. The Department's final decision will be based upon Medicare principles used to evaluate PPS hospital base year capital redetermination appeals. The Department will respond to such a request within sixty days after the receipt of the request for redetermination. Requests for redetermination will not be recognized for any conditions not allowed under Medicare principles.

(iii) Any request for adjustment made pursuant to this section must be made in writing and mailed to the Division by certified mail, return receipt requested.

(iv) A redetermination pursuant to this subsection will be effective thirty days after

the Department issues a notice of rate adjustment.

(v) The state-wide base year capital rate will not be adjusted to reflect adjustments to hospital-specific rates pursuant to this subsection.

(g) Capital rates shall not be inflated.

Section 19. Direct medical education costs.

(a) Direct medical education costs shall be reimbursed based on a hospital specific per discharge payment determined for each level of care pursuant to this section.

(b) Determination of direct medical education payment.

(i) Direct medical education costs shall be extracted from the facility's base year cost report;

(ii) The Department shall determine the percentage of the facility's total operating costs (excluding capital costs) that are direct medical education costs;

(iii) The direct medical education payment shall be the percentage determined pursuant to (ii) times the level of care payment or the transfer payment to which the facility is otherwise entitled pursuant to this Chapter.

(c) If a facility had direct medical education costs in the base year no longer incurs such costs, the facility must notify the Department, in writing, within thirty days of the termination of a medical education program. The Department shall adjust the hospital's level of care payment rates to eliminate reimbursement for direct medical education. Such an adjustment shall be effective beginning with the month after the termination of the medical education program.

(d) If a facility which had no direct medical education costs in the base year subsequently incurs such costs, the Department will determine a payment rate pursuant to this Section. The hospital must submit a written request for such payments to the Department within thirty days after the start of the hospital's medical education program. The payment will be determined based on the hospital's actual costs incurred for direct medical education during the hospital's first cost reporting period in which such expenses were incurred in the first month of the cost reporting period. Payments for direct medical education will be effective on the first month after the end of the cost reporting period used to determine the hospital's direct medical education rate.

Section 20. Inflation adjustment.

(a) Inflation of base period costs. To establish initial inpatient payment rates, the allowable base period Medicaid per diem costs, as determined for each level of care pursuant to Section 9, shall be inflated from the mid-point of the base to the midpoint of the rate year (December 31, 1997).

(b) Inflation of inpatient payment rates. Inpatient payment rates, except the payment for capital costs, shall be inflated from the mid-point of the rate year to the mid-point of the following rate

year.

(c) Effective date. New payment rates shall become effective on each July 1.

Section 21. Reimbursement of swingbed services. Reimbursement for swingbed services shall be pursuant to Chapter 28.

Section 22. Reimbursement of readmissions. Medicaid shall not reimburse for a readmission if the readmission is for the continuation of treatment begun in the initial admission and the Department determines that the treatment should have been provided during the initial admission.

Section 23. Third party liability.

(a) Submission of claims. Claims for which third party liability exists shall be submitted in accordance with Chapter 4, which is incorporated by this reference.

(b) Medicaid payment. The Medicaid payment for a claim for which third party liability exists shall be the difference between the Medicaid allowable payment and the third party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Chapter.

Section 24. Preparation and submission of cost reports.

(a) Time of submission. Each hospital must submit a complete cost report to the Medicare intermediary in accordance with Medicare requirements.

(b) Preparation of cost reports. Cost reports shall be prepared in conformance with Medicare requirements.

(c) Submission of additional information. The Department may request, in writing, that a hospital submit information to supplement its cost report. The hospital shall submit the requested information within thirty days after the date of the request.

(d) Failure to comply with this Section. The failure of a hospital to comply with the provisions of this Section shall result in the immediate suspension of all Medicaid payments to the hospital and all Medicaid payments under review shall be repaid to the Department within ten days after written request for such payment. The suspension of payments shall continue until the hospital complies with this Section. Upon the Department's receipt of all information required by this Section, payments will be reinstated, without interest. This remedy does not affect the Department's right to withhold payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules. If the hospital cannot comply with this section because of delay caused by the intermediary, the hospital must submit verification of the delay from the intermediary on or before the designated date. In such a case, the Department shall not withhold payments.

(e) Inpatient hospital services provided to individuals admitted before June 30, 1994, shall be paid and cost settled pursuant to Chapter 24.

(f) Providers may submit a cost report for a period of less than twelve months ending June

30, 1994, or submit a cost report for the fiscal year or years which includes that period. Any such cost reports shall be submitted using the procedures and standards set forth in Chapter 24. If a provider submits a full year's cost report that includes the period ending on June 30, 1994, the Department will allocate and inflate costs, pursuant to Chapter 24, for the appropriate period.

Section 25. Audits.

(a) Field audits. The Department or HCFA may perform a field audit of a provider at any time to determine the accuracy and reasonableness of cost reports, the accuracy of cost settlements or whether the hospital has received excess payments.

(b) Desk reviews. The Department or HCFA may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports, the accuracy of cost settlements or whether the hospital has received excess payments.

(c) The Department or HCFA may perform field audits or desk reviews through employees, agents, or through a third party. Audits shall be performed in accordance with GAAS.

(d) Disallowances. If a field audit or desk review discloses nonallowable costs, overpayments or excess payments, the Department shall recover any excess payments pursuant to Section 28.

(e) Notice of excess payments. After determining that a provider has received excess payments, the Department shall send written notice to the provider, by certified mail, return receipt requested, stating the amount of the excess payments, the basis for the determination of excess payments and the provider's right to request reconsideration of that determination pursuant to Section 29. The reconsideration shall be limited to whether the Department has complied with the provisions of this Chapter.

(f) Recovery of excess payments. A provider must reimburse the Department for excess payments within thirty days after the provider receives written notice from the Department pursuant to subsection (e), even if the provider has requested reconsideration or an administrative hearing regarding the determination of excess payments. If the provider fails to timely repay excess payments, the Department shall recover the excess payments pursuant to Section 28.

(g) Reporting audit results. If at anytime during a financial audit or a medical audit, HCF discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to HCF's final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit of the Wyoming Attorney General's Office.

Section 26. Rebasing. The Department shall rebase operating costs when the rates determined pursuant to this Chapter no longer meet the requirements of the Social Security Act.

Section 27. Payment of Claims.

(a) Payment of claims shall be pursuant to Chapter 3, Section 11, which is incorporated by this reference.

(b) The failure to obtain prior authorization or admission certification shall result in a technical denial.

Section 28. Recovery of excess payments or overpayments. The Department shall recover excess payments or overpayments pursuant to Chapter 39, which is incorporated by this reference.

Section 29. Reconsideration.

(a) Request for reconsideration. A provider may request reconsideration of the matters specified in subsection (d). Such a request must be mailed to the Department, by certified mail, return receipt requested, within twenty days after the date the provider receives notice of the action. 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 matter 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 the time specified in the request. Failure to provide the requested information shall result in the dismissal of the request with prejudice.

(d) Matters subject to reconsideration. A provider may request reconsideration of the following:

(i) A decision to recover excess payments;

(ii) The determination of capital costs, as specified in Section 18; or

(iii) The denial or calculation of disproportionate share payments.

(e) Reconsideration shall be limited to whether the Department has complied with the provisions of this Chapter.

(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 agency decision pursuant to Chapter 1 of these rules by mailing by certified mail, return receipt requested or personally delivering a request for hearing to the Department within twenty days after the date the provider receives notice of the final agency decision. At the hearing, the burden shall be on the provider to show that the agency's final decision does not comply with this Chapter.

(h) Failure to request reconsideration. A provider which fails to request reconsideration pursuant to this Section may not subsequently request an administrative hearing pursuant to Chapter 1.

(i) Matters not subject to reconsideration.

(i) The use or reasonableness of the reimbursement methodologies set forth in this Chapter;

(ii) A change in a payment rate caused by a change in the reimbursement methodology as the result of a change in state or federal law, including an amendment to this Chapter or other rules of the Department; or

(iii) A technical denial.

(j) 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.

(k) Effect of change in payment rate. A change to any payment as a result of a reconsideration, reopening, administrative hearing, or court review, shall not result in the redetermination of any arrays, medians, averages or other system wide computations, until the system is rebased pursuant to Section 26.

Section 30. Subject to Chapter 37. This Chapter shall be subject to Chapter 37.

Section 31. 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 32. Superseding effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including provider manuals and provider bulletins, which are inconsistent with this Chapter, except as otherwise specified in this Chapter.

Section 33. Severability. If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in effect.