Health, Department of

Medicaid

Chapter 1: Definitions

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CHAPTER 1

Rules and Regulations for Medicaid

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 cost effectiveness 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.