# Health, Department of

## Medicaid

### Chapter 16: Program Integrity

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CHAPTER 16

Rules and Regulations for Medicaid

Medicaid Program Integrity

Section 1. Authority.

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

Section 2. Purpose and Applicability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Interviews with clients;

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

(vi) Examination of prescriptions;

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

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

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

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

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

(iii) Professional review organizations;

(iv) Clients;

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

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

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

(i) Determine that no further action is warranted;

(ii) Take action pursuant to this Chapter; or

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

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

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

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

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

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

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

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

specified in Section 4 of this Chapter.

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

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

(ii) Take action pursuant to this Chapter.

Section 6. Medical, Financial, and Patient Records.

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

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

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

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

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

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

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

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

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

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

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

(d) Provider self-audit.

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

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

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

Section 8. Random Sample and Extrapolation.

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

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

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

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

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

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

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

its intent to use extrapolation. The notice shall include:

(i) The nature of the claims;

(ii) The number of claims; and

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

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

Section 9. Sanctions for Providers.

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

(i) Educational intervention;

(ii) Recovery of overpayments;

(iii) Postpayment review of claims;

(iv) Prepayment review of claims;

(v) Suspension of payments;

(vi) Suspension of provider agreement;

(vii) Termination of provider agreement;

(viii) Conditional future provider agreement;

(ix) Additional sanctions; or

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

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

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

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

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

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

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

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

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

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

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

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

(v) Remedies imposed by CMS or the Department;

(vi) Lack of requested documentation;

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

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

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

(x) Inability to collect overpayments;

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

Chapter 3;

(xii) Exclusion by the Office of Inspector General;

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

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

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

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

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

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

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

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

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

(f) Effective date of sanction.

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

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

and

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

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

(A) Recovery of overpayments;

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

(C) Prepayment of claims submitted by the provider;

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

(E) Conditional future participation; and

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

Section 10. Sanctions for Clients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) Alteration or duplication of a prescription;

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

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

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

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

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

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

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

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

Section 11. Educational Intervention.

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

(i) The education available;

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

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

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

Section 12. Recovery of Overpayments from Providers.

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

(b) General Procedure.

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

(A) The amount of the overpayments; and

(B) The basis for the determination of overpayments.

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

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

(A) Withholding all or part of Medicaid payments:

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

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

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

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

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

(c) Department claim adjustments/denials.

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

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

resubmitted, subject to applicable federal and state requirements.

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

(d) Repayment of credit balance.

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

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

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

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

(e) Medicaid allowable payment.

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

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

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

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

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

(i) Complaints;

(ii) Investigations;

(iii) Medicaid program compliance; or

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

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

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

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

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

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

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

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

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

(c) Lack of requested documentation; or

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

Section 16. Suspension of Provider Agreement.

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

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

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

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

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

(v) Inability to collect overpayments;

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

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

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

(b) Effect of suspension.

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

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

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

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

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

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

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

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

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

Section 17. Termination of Provider Agreement.

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

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

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

(iii) Inability to collect overpayments;

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

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

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

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

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

(b) Effect of termination.

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

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

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

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

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

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

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

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

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

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

Section 18. Conditional Future Provider Agreement.

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

(i) Is for a limited duration; or

(ii) Establishes specific conditions of participation.

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

(i) Lack of documentation;

(ii) Inability to collect overpayments;

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

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

statute, rule, or law.

Section 19. Additional Sanctions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Denying new admissions.

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

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

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

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

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

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

(B) An acceptable quality improvement plan;

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

(I) For each area of non-compliance;

(II) Pursuant to Chapter 45; and

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

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

(c) Impose a Monitor.

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

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

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

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

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

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

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

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

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

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

(d) Civil Money Penalties.

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

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

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

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

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

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

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

(C) The good faith of the provider including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 20. Reconsideration.

(a) Request for reconsideration.

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

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

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

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

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

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

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

(f) Failure to Request Reconsideration.

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

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

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

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

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

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

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

(ii) There is a substantial likelihood the provider's pattern or practice which prompted the investigation will continue; or

(iii) There is reasonable cause to doubt the provider's financial ability to refund any overpayments.

(b) The decision to suspend or withhold payments pursuant to this section may be subject to an administrative hearing pursuant to Chapter 4.

Section 23. Remedies Cumulative. The remedies provided by this Chapter are cumulative. The Department may simultaneously seek to recover overpayments, impose sanctions, and refer the matter to the appropriate law enforcement agencies, PRICE, and/or MFCU for criminal action. Nothing in this Chapter shall preclude the Department from pursuing any remedies permitted by other provisions of state and federal statutes or rules.

Section 24. Effect of Fraud, Theft, or Abuse of Services of Medicare.

(a) Automatic suspension or termination. The Department shall suspend or terminate any provider who has been suspended or terminated from participation in Medicare, or any provider which voluntarily withdraws from Medicare when Medicare certification is a prerequisite to enrollment in Medicaid.

(b) Duration of suspension or termination. The duration of the provider's

suspension, termination, or withdrawal from participation in Medicaid shall be the same as and shall run contemporaneously with the provider's suspension, termination, or withdrawal from participation in Medicare.

(c) No separate appeal. A provider suspended or terminated from participation in Medicaid pursuant to this section shall not be entitled to reconsideration or an administrative hearing pursuant to this rule or any other rules of the Department. The provider's remedies are limited to those provided by Medicare.

Section 25. Disposition of Recovered Funds.

(a) Federal Medicaid funds. The Department shall, in accordance with the Social Security Act and applicable HHS regulations, repay all recovered federal Medicaid funds to CMS.

(b) State Medicaid funds. The Department shall retain the state Medicaid percentage of all recovered Medicaid funds as a state general fund reduction.

Section 26. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the Federal, State or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Chapter.

Section 27. Interpretation of Chapter.

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

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

Section 28. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and/or bulletins, which are inconsistent with this Chapter.

Section 29. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.