

WYOMING MEDICAID RULES

CHAPTER 7

WYOMING NURSING HOME REIMBURSEMENT SYSTEM

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 establish methods and standards for Medicaid reimbursement rates for nursing facilities which provide services to clients. It shall apply to and govern all payments of Medicaid funds to facilities for services furnished on or after October 1, 2009.

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

(d) Effective with rates beginning on October 1, 2010, nursing facilities shall remain at the finalized rate paid beginning October 1, 2009.

Section 3. Definitions. Except as otherwise specified in the Rules and Regulations for Wyoming Medicaid, Chapter 1, Definitions, the terminology used in this Chapter is the standard terminology and has the standard meaning used in healthcare, Medicaid and Medicare.

Section 4. General Provisions.

(a) Cost terms and hierarchy. This rule includes the following cost terms, even though such cost may not be reimbursable because of other provisions of this rule, in the following hierarchy:

(i) General ledger cost. A cost properly recorded on a nursing facility's general ledger in accordance with GAAP. This includes cost incurred at an individual nursing facility as well as central office or pooled cost reasonably allocated to

an individual nursing facility;

(ii) Reported cost. General ledger cost properly reported on the cost report. It is composed of allowable cost and nonallowable cost;

(iii) Non-allowable cost. Cost which is not reasonably related to covered services; and

(iv) Allowable cost, as defined in the Rules and Regulations for Wyoming Medicaid, Chapter 1, Definitions.

(b) General methodology.

(i) Costs related to direct patient care are more likely to benefit quality of patient care than indirect costs.

(ii) Costs incurred in the actual delivery of patient care are more likely to contribute to the quality of care offered by a nursing facility than costs incurred at a distance from the delivery of services.

(iii) To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. Providers shall incur costs in such a manner that economical and efficient delivery of quality health care to participants will result.

(iv) Except as otherwise specified in this Chapter, the Department shall determine per diem rates using the methodology set forth in the Medicare Provider Reimbursement Manual ("PRM") and CMS instructions for administering the PRM. The PRM and the CMS instructions are published by CMS and are available from that agency.

Section 5. Submission and Preparation of Cost Reports.

(a) Time of submission. Complete cost reports shall be submitted by the end of the fifth (5th) month following the provider's fiscal period end.

(i) Complete cost report. A cost report shall be deemed complete upon receipt of the completed and certified cost report and the information specified in subsections (c)(iii)(A-J). The per diem rate shall not be computed, however, until the receipt of the information specified in subsections (c)(iii)(A-J). The Department may request additional information, in writing, by certified mail, return receipt requested. Any such information must be submitted, by certified mail, return receipt requested, within thirty (30) days after the date of the request. A cost report may not be amended after submission.

(ii) Extension. A thirty (30) day extension of the submission date shall

be granted by the Department for good cause if requested by a provider, in writing, prior to the due date. A cost report shall not be deemed past due while an extension term is in effect. Only one (1) request for an extension may be granted for each cost reporting period.

(b) Failure to timely submit cost report. If a cost report, including the information specified in subparagraphs (c)(iii)(A-J) and any information requested pursuant to paragraph (a)(i), is more than ten (10) days past due, the Department shall reduce the per diem rate by twenty-five (25) percent until all missing information is received in writing in the form specified by the Department. If the cost report, including the information specified in subparagraphs (c)(iii)(A-J) is more than sixty (60) days past due, the Department shall suspend all Medicaid payments until all missing information is received in writing in the form specified by the Department. Upon receipt of a complete cost report that has been prepared in accordance with these rules, the penalty will be refunded, without interest. This remedy does not affect the Department's right to withhold per diem payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules.

(c) Preparation of cost reports.

(i) Cost reporting must be reasonable and consistent within a nursing facility, between Medicaid certified and noncertified parts where such distinction is utilized for cost finding, among multiple facilities under the same ownership or control, and over time.

(ii) Allocation of costs. Costs must be allocated pursuant to the cost report.

(iii) Required information. Authenticated copies of significant agreements and other documentation must be attached to the cost report. This material includes:

(A) Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years, unless previously submitted;

(B) Contracts or agreements with owners or parties related to the provider, unless previously submitted;

(C) Leases regarding real or personal property, unless previously submitted;

(D) Management contracts, unless previously submitted;

(E) Mortgages and loan agreements, unless previously submitted;

(F) Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications;

(G) Audit, review or compilation statements prepared by an independent accountant that includes nursing facility costs or allocation of costs to the nursing facility, including disclosure statements and management letters or SEC Forms 10-K;

(H) Home office cost statement;

(I) Medicare cost report; and

(J) Any other document, requested, in writing, by the Department, relating to the provision of services, the submission of claims for reimbursement or a nursing facility's cost reports.

(iv) If any document is not submitted with the cost report, an explanation must be attached to the cost report and subsection (b) shall apply.

(v) Changes in a nursing facility's reporting methods are permissible only when written application is received by the Department prior to the end of the cost report period. The Department shall approve the change if it can reasonably be expected to result in more accurate reporting.

(vi) Fiscal period. A provider shall adopt the same fiscal period for completing the cost report as the nursing facility uses for reporting Medicare costs.

(A) If a provider is not certified by Medicare, the nursing facility's Medicaid cost reporting period shall be the same period the nursing facility uses for federal income tax reporting.

(B) Normally, a fiscal period will be twelve (12) months in length. It may be less than twelve (12) months because of changes in the nursing facility's Medicare cost reporting period. For purposes of nursing facility rate-setting, cost report periods of less than six (6) months will not be used.

(vii) Determination of allowable costs. The Department shall determine a nursing facility's allowable cost within ninety (90) days of the Department's receipt of the nursing facility's cost report and all information required by section 5(c)(iii)(A-J) of this Chapter. These costs will be utilized to set the rate pursuant to Section 17 of this Chapter.

(d) Certification of cost reports.

(i) General requirement. The provider must certify the accuracy and validity of the cost report.

(ii) Who may certify. Certification must be made by a person authorized by the governing body of the nursing facility to make such certification. Proof of such authorization shall be furnished upon request by the Department.

(A) If the provider is a corporation, an officer of the corporation must certify;

(B) If the provider is a general or limited partnership, a general partner must certify;

(C) If the provider is a sole proprietorship or sole owner, the owner must certify;

(D) If the provider is a public nursing facility, the chief administrative officer of the nursing facility must certify; or

(E) If the provider is any other entity, the person certifying must be approved in writing by the Department before the certification.

(iii) Certification statement. The cost report must contain the following certification statement:

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and I have examined the accompanying cost report and supporting schedules prepared by (Provider name and number) _____ for the cost report beginning _____, 20____, and ending _____, 20____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature Title Date

(e) Substitute cost report forms. If a nursing facility desires to submit its cost report on forms other than those specified by the Department, the nursing facility must submit such substitute forms to the Department for approval in advance of their use. To be approved, such forms must be accompanied by a letter which represents that each page of the substitute form is the same size and has the same general appearance as the

Department's cost report, and that all form and data elements are present and appear in the same location and sequence on each page as on the Department's cost report. If approved, the Department shall issue an approval letter. Each use of substitute forms shall require a reference to the date of the Department's approval letter and indicate the substitute form's sponsor.

Section 6. Joint Use of Resources.

(a) Multiple business enterprises. If a provider owns, controls or manages multiple business enterprises, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable. If a field audit or desk review establishes that the provider's records do not clearly identify the information required by this rule, none of the commingled cost shall be an allowable cost for purposes of the nursing facility's per diem rate.

(b) Control, ownership or management by third party.

(i) Separate records. When the nursing facility is owned, controlled or managed by a person or entity that owns, controls or manages one (1) or more other nursing facilities, records of central office and other costs incurred outside the nursing facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities.

(ii) Allocation of pooled costs shall be reasonable and conform to GAAP, the provisions of this rule, and the instructions of the Department. Pooled cost is allowable only to the extent that the pooled cost is incurred in providing patient-related services and the provider can demonstrate that pooled cost improves efficiency, economy, or quality of care. All patient-related pooled costs allocated to a nursing facility that meet these requirements shall be reported in the operating cost component.

(iii) Direct patient service costs. Direct patient service costs incurred by multiple nursing facility organizations may be reported in the health care component if the service was rendered to the client at the nursing facility and is separately identified, rather than allocated, in the provider's accounting records. Patient service costs which do not meet these criteria must be reported in the operating cost component.

Section 7. Per Diem Rate Determination.

(a) New nursing facilities. A newly constructed facility, a newly designated portion of a hospital which has not previously been designated as a facility, or an existing facility which has not previously been certified. An addition to a certified facility is not a "new facility."

(i) A new nursing facility shall receive an initial rate determined pursuant to subsection 17(c).

(ii) A new nursing facility's initial rate will be effective until the end of the first fiscal year ending six (6) or more months after the certification date, at which time the Department shall establish a per diem rate pursuant to this rule. This per diem rate will also be utilized as the facility's base rate.

(b) Change of ownership.

(i) A nursing facility which has a change of ownership shall receive the per diem rate in effect for that nursing facility on the date of the change of ownership. This per diem rate shall remain in effect until the end of the first fiscal year ending six (6) or more months after the date of the change of ownership, at which time the Department shall establish a per diem rate pursuant to this rule.

(ii) Record keeping requirements. The former owner shall be responsible for maintaining all medical and financial records for one (1) year after the date of the change of ownership. If the nursing facility is involved in an audit or administrative or judicial proceedings which require access to such records, the records must be maintained for one (1) year after completion of all proceedings, including any applicable appeal periods.

(c) Other facilities. The per diem rate for facilities other than a new facility or those without a change of ownership shall be established pursuant to the provisions of this Chapter.

(d) Effective dates of per diem rates. Per diem rates are established prospectively and shall remain in effect from the rate effective date until redetermined pursuant to this rule.

Section 8. Medicaid Reimbursement for Reserve Bed Days.

(a) Reserved bed days.

(i) Facilities may receive the per diem rate for reserved bed days during temporary absences if an appropriate bed is not available during the time for which reimbursement is sought.

(ii) Reimbursement for temporary absences is limited to fourteen (14) days per calendar year.

(iii) If a nursing facility maintains an average occupancy of ninety (90) percent or more within the month of the leave, the nursing facility may receive the per diem rate for reserved bed days during temporary absences. Occupancy is calculated as total patient days (period of service rendered to a patient, not including any day that a patient was temporarily absent), divided by licensed beds, multiplied by the number of

calendar days in the period being measured.

(iv) A provider may not bill a client or the client's family for reserved bed days that are not reimbursed pursuant to this section unless the nursing facility has informed the client, in writing, before the period for which reimbursement is sought of the client's option to make payments to hold the bed if the temporary absence exceeds the period for which Medicaid reimbursement is available.

Section 9. Cost Components.

(a) General requirements. Costs shall be allocated among the following cost components as specified in this section: (1) health care costs; (2) capital costs; and (3) operating costs. For purposes of this section, "labor costs" includes the cost of employee benefits and taxes. Services and supplies used in providing patient-related services include, but are not limited to, those specified in Attachment A.

(b) Health care cost component. The health care cost component consists of the following costs provided such costs are direct costs of patient-related services actually rendered within the nursing facility (or direct patient-related services provided outside the nursing facility, if medically necessary) and the cost of related supplies actually used in the nursing facility:

- (i) Activities, including direct labor cost;
- (ii) Dietary, including direct labor cost;
- (iii) Direct health care labor costs for the following:
 - (A) Health care education, including OBRA '87 nurse aide training requirements;
 - (B) Licensed practical nurses;
 - (C) Medical director;
 - (D) Nurse assistants;
 - (E) Nursing administrators;
 - (F) Nursing consultants;
 - (G) Registered nurses; and
 - (H) Rehabilitation personnel.

(iv) Services and supplies included in the per diem rate (reduced by the cost of services paid from other sources);

(v) Social services, including direct labor cost; and

(vi) Travel costs related to the above.

(c) Capital cost component. The capital cost component consists of the following costs:

(i) Leasehold amortization;

(ii) Rent/lease expense;

(iii) Depreciation; and

(iv) Interest on real estate and personal property.

(d) Operating cost component. The operating cost component consists of:

(i) Housekeeping, including direct labor cost;

(ii) Laundry, including direct labor cost;

(iii) Medical records;

(iv) Patient-related administrative costs (including home office and management fees which are not health care costs under subsection (b));

(v) Plant operations and equipment costs; and

(vi) Travel costs related to the above.

Section 10. Determination of Capital Cost.

(a) Depreciation.

(i) The depreciation of a tangible asset used to deliver patient-related services is an allowable cost if the asset is:

(A) In use;

(B) Identifiable to patient care;

(C) Available for physical inspection; and

(D) Recorded in the provider's records.

(ii) Basis. The basis used in calculating depreciation shall be the historical cost of the asset, which is the cost incurred by the present owner in acquiring the asset and preparing it for its use. Generally such cost includes costs that are capitalized under GAAP. For example, in addition to the purchase price, historical cost includes architectural fees, consulting fees, and related legal fees.

(iii) Method. Depreciation must be reported on the straight-line method.

(iv) Useful life. Useful life shall be determined in accordance with the most recent edition of Estimated Useful Lives of Depreciable Assets, as published by the American Hospital Association.

(v) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least two (2) years and historical cost of at least five hundred dollars (\$500.00), the cost shall be depreciated over the useful life of the asset.

(vi) Patient-related items that do not qualify for the above definition shall be expenses in the year acquired.

(vii) Donated assets.

(A) Definition. An asset is donated to the extent the provider acquired the asset without paying fair market value in cash, property or services.

(B) Basis. The basis of donated assets, except for donations between providers or from a party related to the provider, is the asset's fair market value, minus the value the provider gave for the asset. If the fair market value of the asset is over two thousand dollars (\$2,000.00), the basis shall be the lesser of the appraised value and the fair market value. If the donor is related to the provider, the basis shall be the lesser of the net book value of the donor and fair market value.

(C) Cash donations. Cash donations shall be treated as revenue, and not as an offset to expense accounts.

(b) Permanent Financing Interest. Permanent Financing Interest is financing attendant to the acquisition of patient-related tangible assets.

(i) Allowable cost. Permanent financing interest incurred on patient-related real property, improvements to real property, buildings, building components and equipment is an allowable cost subject to the limitations of this subsection.

(ii) Maximum allowable interest rate. The allowable interest rate on permanent financing from a party related to the provider shall not exceed the Federal Home Loan Mortgage Corporation, Whole Loan Purchase, Multi-Family rate in effect on the date the loan commitment was signed by the lender and borrower.

(iii) Maximum allowable interest expense. The principal amount of permanent financing shall not exceed the allowable historical cost of the facilities and equipment.

(iv) Investment income offset. Interest allowable pursuant to this section must be reduced by investment income pursuant to the PRM.

(v) Reporting requirements. Interest expense must be supported by a written loan agreement, showing that funds were borrowed, payment of interest and repayment of principal is required, and funds were used to purchase patient-related real property, buildings, building components and equipment. The lender, purpose, principal amount, terms and interest rate must be identifiable in the provider's financial records.

(c) Lease and rental expense.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components and equipment are an allowable cost subject to the limitations of this subsection.

(ii) Maximum allowable. Leases, rental agreements, and contracts involving the use of real or personal property shall be subject to the same maximum capital component limit as owners of property.

(iii) Related parties. If a provider rents, leases or purchases patient-related real property, buildings, building components and equipment from a party related to the provider, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the allowable capital cost.

(d) Amortization of leasehold improvements.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components and equipment are an allowable cost subject to the limitations of this subsection.

(ii) Amortization of leasehold improvements shall be calculated and reported in accordance with GAAP and are a capital cost.

(iii) Amortization of organizational cost shall be reported in the operating cost component.

Section 11. Determination of Operating Cost Component.

(a) Working capital interest. Working capital interest is patient-related financing other than permanent financing.

(i) Generally. Interest on working capital loans is an allowable cost only if the loans were costs that must be incurred to provide patient-related services.

(ii) Limitation. Interest on working capital loans may not exceed the actual reported interest less any investment income revenue.

(iii) Reporting. Interest on working capital loans shall be reported as an operating cost.

(b) Compensation for services from owners or parties related to the provider.

(i) Compensation for services from an owner or a party related to the provider is an allowable cost if such services were:

(A) Actually performed;

(B) Necessary to the delivery of patient-related services; and

(C) The compensation paid was reasonable.

(ii) Documentation. A provider must maintain written documentation of the time and work performed, the relationship of the work to patient care, whether such work was performed at the nursing facility or outside the nursing facility, and the compensation paid for such work.

(iii) Maximum allowable. Compensation of an owner or party related to the provider is not an allowable cost to the extent it exceeds the median range for comparable services as contained in the most recent survey of administrative salaries paid to persons other than owners of proprietary and nonproprietary providers conducted by the Bureau of Health Insurance and published in the Medicare Provider Reimbursement Manual PRM Part 1, Section 905.2.

(A) Part-time employees. For individuals who work less than a forty (40) hour work week, the maximum allowable amount shall be reduced by the ratio of actual number of hours worked per week to forty (40).

(B) Full-time employees. Individuals who work more than a forty (40) hour work week may have their total salary expenses reviewed for reasonableness. The total salary for that job classification will be compared to industry

averages for that position. Any amounts that appear to be excessive as compared to industry averages will be adjusted to a reasonable amount.

Section 12. Cost of Services and Supplies not Included in the Per Diem Rate.

(a) Services and supplies which are not included in the per diem rate include, but are not limited to:

- (i) Ambulance services;
- (ii) Audiology services;
- (iii) Barber and beauty shop services other than routine personal hygiene items and services;
- (iv) Cigarettes, cigars, pipes and tobacco;
- (v) Clothing;
- (vi) Cosmetics;
- (vii) Dental services (unless under purchase for service contract);
- (viii) Dry cleaning;
- (ix) Eye examinations and other optical supplies and services;
- (x) Hearing aids;
- (xi) Hospital services;
- (xii) Laboratory services;
- (xiii) Orthotic services;
- (xiv) Physician services;
- (xv) Podiatry services;
- (xvi) Prosthetic devices;
- (xvii) Ventilators; and
- (xviii) Customized wheelchairs that are fitted or fabricated to a specific individual and cannot be used by any other person, and electric wheelchairs, including

batteries.

(b) The cost of services and supplies not included in the per diem rate shall be removed from patient-related cost.

(c) Costs not related to patient care are costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary may include, but are not limited to, costs that are not usual, common, and accepted occurrences in the field of the provider's activity.

(d) The method of removal depends on a provider's accounting and other records. If a provider has adequate segregation in accounting records, such adjustment shall be based on the cost of services or supplies not included in the per diem rate. If a provider does not maintain adequate cost segregation or if such accounts cannot reasonably be subjected to normal audit procedures, then the related revenue shall be used as an adjustment to patient expense, provided the related revenue amount is reasonably equal to or greater than cost. If these conditions are not met, the entire group of aggregated ancillary or other revenue accounts, or aggregated ancillary or other cost accounts, if greater, shall be used as an offset to patient expenses.

Section 13. Rate Period.

(a) Effective date. For nursing facility services effective on or after October 1, 2009, a provider's per diem rate shall become effective on the rate effective date, which is October 1 of each year. Per diem rates are established prospectively and shall remain in effect from the rate effective date until redetermined pursuant to this rule.

(b) Effective period of rate. A facility shall be bound by the per diem rate until a new rate is computed pursuant to this rule, unless the rate is changed as the result of a desk review or field audit.

(c) Applicable cost report data. The cost data used in establishing the rate calculation effective each October 1 is from the cost reports which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 2008 to December 31, 2008, will be used in setting rates effective October 1, 2009).

(d) Notice of rate. The Department shall notify providers of the per diem rate by certified mail, return receipt requested.

(e) If the desk review or audit of the cost report used to set the rate effective October 1 of each year is not complete when the rate is due to be issued, an interim rate will be issued based on the reported cost. When the review is complete, the rate will be revised and issued as final. Any amounts paid pursuant to the interim rate which exceed the final rate shall be overpayments and shall be recovered pursuant to Section 31 of this

Chapter. If the interim rate is less than the final rate, the Department shall pay the difference to the provider within sixty (60) days.

Section 14. Creation of Database.

(a) Creation of database. Each year the Department shall create a database using the latest complete desk reviewed cost reports for each provider. "Latest complete" means the cost report used to compute the provider's most recent per diem for the applicable year.

(b) Adjustment of cost reports. Cost reports included in the database shall be adjusted so that transactions with owners or parties related to providers are limited pursuant to this rule. Per diem cost report information for the capital cost component shall be subject to a minimum occupancy of ninety (90) percent.

(c) Each year the Department shall create a database which reflects the quality of care and the average level of care provided in facilities.

Section 15. Determination of Medians.

(a) Median health care cost. Using the database created pursuant to Section 14 of this Chapter, the median health care cost shall be determined by arraying the inflation-adjusted allowable per-diem health care cost for each provider, from low to high, and selecting the cost associated with the median licensed bed.

(b) Median operating cost. Using the database created pursuant to Section 14 of this Chapter, the median operating cost shall be determined by arraying the inflation-adjusted allowable per-diem operating cost for each provider, from low to high, and selecting the cost associated with the median licensed bed.

(c) Median capital cost. Using the database created pursuant to Section 14 of this Chapter, the median capital cost shall be determined by arraying the inflation-adjusted allowable per-diem capital cost for each provider, from low to high, and selecting the cost associated with the median licensed bed.

Section 16. Cost Component Limitations.

(a) The Department shall, on or before September 1 of every year, determine limitations for each cost component in accordance with this rule using the database created pursuant to Section 14 of this Chapter, and the medians determined pursuant to Section 15 of this Chapter.

(b) Capital costs. Capital costs shall not exceed the maximum allowable as determined pursuant to Section 18 of this Chapter.

(c) Health care costs. Health care costs shall not exceed one hundred twenty-five (125) percent of the median health care cost.

(d) Operating costs. Operating costs shall not exceed one hundred five (105) percent of median operating costs.

(e) Effective period of limitations. The cost component limitation shall be effective for rate effective dates from October 1 through September 30 of each subsequent year. Cost component limitations shall not be redetermined to reflect changes in facilities allowable costs that result from reconsideration, administrative appeals or judicial decisions.

Section 17. Determination of Per Diem Rate.

(a) Except as otherwise provided in this Chapter, the Department shall determine per diem rates to be effective for services furnished on or after October 1, 2009, as follows:

(i) Per diem rate. The Department reimburses facilities providing nursing facility services, as defined by 42 U.S.C. 1396d(f), to clients using the per diem rates established pursuant to this Chapter.

(ii) Calculated rate. The Department shall establish a calculated per diem rate for each nursing facility pursuant to this Chapter, using that nursing facility's most recent Medicaid cost report for the period ending in the previous calendar year.

(iii) Minimum per diem rate. The Department shall establish a minimum per diem rate for each nursing facility. The minimum per diem rate shall be the nursing facility's base rate, minus the capital component of that rate, plus the capital component of the nursing facility's calculated rate. The minimum rate shall be the rate paid if it is greater than the calculated rate.

(A) The base rate is the per diem rate in effect for a nursing facility on June 30, 2005.

(B) The base rate for a new facility as defined in Section 7(a) will be the first per diem rate established pursuant to this Chapter.

(iv) Maximum per diem rate. The Department shall establish a maximum per diem rate for each nursing facility. The maximum per diem rate shall be:

(A) The base rate, minus the capital component of that rate, multiplied by one hundred ten percent (110%) of the inflation factor, as published quarterly by DRI/McGraw-Hill as the Market Basket and as measured from the mid-point of the base rate to the mid-point of the current rate period; plus

(B) The capital component of the calculated rate.

(C) The maximum rate shall be the rate paid if it is less than the calculated rate.

(b) New facilities. A new nursing facility shall receive a per diem rate equal to one hundred ten (110) percent of the median per diem rate in effect as of the most recent October 1st, except that the capital component of the rate shall be the median allowable capital cost currently in effect in Wyoming.

(c) Application of cost component limitations. The provider's reimbursable rate is the lesser of the provider's inflated allowable cost or the cost component limitations established pursuant to Section 16 of this Chapter.

(d) Maximum per diem rate. A provider's per diem rate shall be the lesser of the rate determined pursuant to this Chapter or the nursing facility's private pay rate.

(e) Except as otherwise specified in (a), a provider shall receive one (1) rate change per year on the rate effective date, unless:

(i) The rate is changed as the result of a desk review or field audit; or

(ii) Changes in federal or state statutes or regulations cause increases in health care costs, as defined in subsection 9(b) of this Chapter, or operating costs, as defined in subsection 9(d) of this Chapter, in which case the Department shall determine whether and how to reimburse for such costs. Any changes pursuant to this paragraph shall be subject to the minimum and maximum rates established pursuant to subsection (a).

Section 18. Determination of Maximum Allowable Capital Costs.

(a) The maximum capital basis per licensed bed shall be twenty-eight thousand five hundred dollars (\$28,500.00) as of January 1, 1989.

(b) Increase in maximum capital basis. The maximum capital basis shall be increased effective July 1 of each year by the lesser of one-half (½) of the percentage increase in the Dodge Construction Index, an independently published index used to calculate construction costs, or one-half (½) of the increase in the consumer price index, the consumer price index for all Urban Consumer (CPI-U (United States city average)), as determined by the United States Department of Labor and Statistics. (If either the Dodge Construction Index or the consumer price index is discontinued, the Department shall use whichever index is available.) The increase shall be rounded to the nearest one hundred dollars (\$100.00).

(c) Allowable maximum capital basis shall be limited to the maximum capital basis per licensed bed at the time of construction of each bed or January 1, 1989, whichever is later, plus one-half ($\frac{1}{2}$) of the difference between that amount and the maximum capital basis per bed at the rate effective date.

(d) For facilities constructed, acquired or leased prior to January 1, 1989, and facilities constructed after January 1, 1989, the capital component limitation shall be limited to the allowable maximum capital basis for each licensed bed times the average annual Federal Home Loan Mortgage Corporation, Whole Loan Purchase, Multi-Family rate rounded to the nearest half percent (.5%), divided by ninety (90) percent of a nursing facility's total available licensed beds, times three hundred and sixty-five (365) days. The average annual Federal Home Loan Mortgage Corporation Whole Loan Purchase, multi-family rate, shall be calculated as of January 1, 1989. This limit shall apply to all depreciation, interest, lease, rent, or other consideration paid for the use of property.

(e) For facilities acquired through purchase or a capital lease as defined by GAAP on or after January 1, 1989, the buyer/lessee's allowable historical cost of property shall be limited to the seller/lessor's acquisition cost increased by the lesser of one-half ($\frac{1}{2}$) of the percentage increase in the Dodge Construction Index, or one-half ($\frac{1}{2}$) of the increase in the consumer price index. (If either the Dodge Construction Index or the consumer price index is discontinued, the Department shall use whichever index is available.) The maximum capital basis buyer/lessee shall be limited to the seller/lessor's maximum capital basis at the date of transaction. Any additional allowable capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had acquired the additional capital expenditure. For facilities leased through a lease determined not to be a capital lease in accordance with GAAP on or after January 1, 1989, the lessee's allowable capital component shall be limited to the lessor's capital component at the date of transaction. The maximum capital basis of the lessee shall be limited to the lessor's maximum capital basis at the date of transaction.

Section 19. Inflation Adjustment.

(a) A nursing facility's allowable operating and allowable health care costs shall be inflated from the midpoint of the cost reporting period to the midpoint of the rate period as defined in Section 13 of this Chapter.

(b) "Inflation factor." The inflation factor is the Skilled Nursing Facility (SNF) Market Basket as published quarterly by DRI/Global Resources or its successor.

Section 20. Incentive Adjustment.

(a) Eligibility for incentive adjustment. A nursing facility with allowable operating cost below the operating cost component limitations established pursuant to this Chapter shall be eligible for an incentive adjustment.

(b) Computation of incentive adjustment. The incentive adjustment shall be twenty-five (25) percent of the difference between the nursing facility's allowable operating cost and the operating cost component limitations. That amount shall be calculated on a per diem basis and added to the nursing facility's inflation adjusted operating costs. The adjustment may not exceed two dollars (\$2.00) per day.

Section 21. Legislative Appropriations.

(a) If the Wyoming Legislature passes a special appropriation to be used to increase nursing facility reimbursement for any specific purpose defined by the Legislature in such appropriation, this section shall control the allocation of such appropriation among nursing facilities in Wyoming.

(b) The Department shall develop a methodology to allocate the appropriation among nursing facilities in Wyoming.

(i) The Department may consult with representatives of nursing homes, such as representatives of associations which represent nursing homes in Wyoming, about how to allocate the appropriation.

(ii) The Department shall collect the information it deems necessary to allocate the appropriation. The Department shall request information in writing, by certified mail, return receipt requested. Providers shall furnish the requested information in the format and according to the schedule established by the Department. All such information shall be submitted to the Department by certified mail, return receipt requested. Any information provided to the Department shall contain a certification statement substantially in the form specified in subsection 5(d) of this Chapter.

(iii) After collecting information pursuant to subsection (b)(i), the Department shall develop a methodology to distribute the appropriation among nursing facilities in Wyoming. The methodology shall:

(A) Effectuate the legislative purpose of the appropriation in a timely and cost-effective manner;

(B) Benefit Wyoming nursing facilities equitably, such that no nursing facility benefits disproportionately, based on the intent of the appropriation;

(C) Include safeguards to ensure that appropriated funds are spent for the purposes specified in the appropriation. Such safeguards shall include reporting and documentation requirements for facilities; and

(D) Specify how such funds shall be reported on facilities' future cost reports, and whether and how such funds shall be considered in determining facilities' future base rates and per diem rates.

(E) The Department shall disseminate the methodology to facilities through a manual or bulletin.

(c) Funds which are not spent for the purposes specified in the appropriation or pursuant to the methodology developed by the Department, and funds for which a nursing facility cannot provide documentation as required by the Department, are overpayments and shall be recovered pursuant to Section 31 of this Chapter.

(d) Any increase in a nursing facility's per diem rate or other payment pursuant to this Section shall be subject to the cost component limitations of Section 16 of this Chapter, and the maximum per diem rate established pursuant to Section 17 of this Chapter, except as otherwise specified in the methodology developed pursuant to subsection (b) of this Section.

Section 22. Reimbursement Rate for Extraordinary Care Clients.

(a) Medicaid reimbursement for services provided to an extraordinary care client may be negotiated for clients who require skilled nursing facility care and require special care or clinically complex care as recognized with prior authorization by the Department. Services for these clients shall be the per diem rate calculated in accordance with other sections of this Chapter, plus a negotiated rate to cover the cost of medically necessary services and supplies that are not included in the per diem rate.

(i) The Department will negotiate with providers on a case-by-case basis to determine the negotiated rate and the billing procedures for extraordinary care clients.

(ii) Prior to such negotiations, the provider shall submit to the Department:

(A) A treatment plan; and

(B) A proposed reimbursement rate, including all relevant financial records and all medical records which document the medical necessity for services provided to an extraordinary care client.

(iii) The Department may request, and the provider shall furnish before a negotiated rate is established, additional information to document the medical necessity for services provided to an extraordinary care client.

(iv) The negotiated rate shall be the rate determined by the Department based on the negotiations with the provider for medically necessary services.

(v) The Department shall reevaluate the condition of an extraordinary

care client after the first fifteen (15) days after admission, again at (30) days, ninety (90) days thereafter, and then every six (6) months thereafter. The State shall review records on a yearly basis to determine if a renegotiation of the negotiated rate is necessary to reflect changes in the client's condition. Exceptions to the frequency of reporting are at the discretion of the reviewer. It is the provider's responsibility to report any significant changes in care requirements, condition changes, and/or changes in client physical location at any time prior to the established review.

(b) All inclusive. The per diem rate plus the negotiated rate shall be an all inclusive reimbursement rate for all services and supplies furnished by the nursing facility, except as specified in Section 24 of this Chapter, and/or as otherwise agreed by the Department.

(c) Maximum rate. The negotiated rate shall not exceed the actual cost of the services provided to the extraordinary care client.

(d) Until the Department agrees, in writing, to a negotiated rate, reimbursement for services provided to an extraordinary care client shall be limited to the nursing facility's per diem rate.

(e) The nursing facility shall maintain records of the costs it incurs in furnishing services to each extraordinary care client. Costs related to services furnished to extraordinary care clients, other than nursing facility services, are not allowable costs for purposes of determining the nursing facility's per diem rate.

Section 23. Contracted Rate.

(a) The Department may pay a contracted rate to a nursing facility that furnishes added value. The contracted rate may exceed the nursing facility's per diem rate as determined pursuant to Section 17 of this Chapter.

(b) The Department shall negotiate and enter into contracts for added value using the following procedures:

(i) Determine what constitutes added value, taking into consideration for each nursing facility, the factors specified in (A) and the objectives specified in (B):

(A) Factors:

(I) The standard level of care, reasonably expected to be furnished in the nursing facility;

(II) The quality of care furnished in the nursing facility;

(B) Objectives:

(I) Reduction in the number and frequency of institutionally acquired infections;

(II) Reduction in the number and frequency of adverse resident incidents, such as falls, skin tears, and wandering from the facility.

(III) Reduction in official and unofficial complaints;

(IV) Maintenance of residents' ideal body weight;

(V) Maintenance or improvement of nursing facility survey results;

(VI) Maintenance of ambulatory levels of residents from admission to discharge;

(VII) Increases in the number of discharges to lesser acute settings; and

(VIII) Decreases in the incidence of residents' incontinence.

(ii) Solicit proposals for added value contracts; and

(iii) Negotiate with providers.

(c) The Department will negotiate with providers on an individual basis to determine whether a contracted rate is appropriate for that nursing facility, using value added criteria developed for that nursing facility.

(i) Prior to such negotiations, the provider shall submit to the Department, in the format prescribed by the Department:

(A) A proposed contracted rate; and

(B) Supporting documentation, including:

(I) All relevant financial records and medical records which demonstrate the added value the provider is or will be furnishing to clients;

(II) A proposed method of collecting and evaluating clinical data to demonstrate that added value is being furnished, such method to be subject to review and approval by the Department; and

(III) The additional cost the nursing facility will reasonably and necessarily be incurring to provide that added value.

(ii) The Department may request, and the provider shall furnish before a contracted rate is established, additional information to document the added value and/or added costs.

(iii) The contracted rate shall be the rate agreed upon by the provider and the Department for the value-added performance. The rate shall apply to all clients in the nursing facility, unless otherwise agreed by the Department.

(iv) The Department may establish monitoring criteria and procedures to determine whether the added value is being furnished.

(v) If the Department determines that the value added criteria are not being satisfied, the Department shall reduce the nursing facility's Medicaid reimbursement rate to the per diem rate established pursuant to Section 17 of this Chapter.

(d) All inclusive. The contracted rate shall be an all inclusive per diem rate for all services and supplies furnished by the nursing facility, except as specified in Section 24 of this Chapter, and/or as otherwise agreed by the Department.

(e) Maximum rate. The negotiated rate shall not exceed the nursing facility's actual costs.

(f) Until the Department agrees, in writing, to a contracted rate, reimbursement for services provided to clients shall be limited to the nursing facility's per diem rate as determined in Section 17 of this Chapter.

(g) The Department's refusal to agree to a contracted rate requested by a provider is not an adverse action for purposes of the Rules and Regulations of Wyoming Medicaid, Chapter 2, State Licensed Shelter Care Eligibility Services.

Section 24. Nursing Care Facility Assessment Act.

(a) Nursing facility adjustment payments to providers based on the upper payment limit calculation.

(i) The Department will make adjustment payments to nursing facilities under the provisions of the Nursing Care Facility Assessment Act, W.S. §§ 42-8-101 through 109.

(A) Adjustment payments will be calculated prospectively on an annual basis to be effective from October 1 through September 30 of each year. The

adjustments will be paid quarterly. New providers opening during that assessment year will not be included in the program until the next assessment year.

(B) The quarterly adjustment payments will be due to the providers not later than thirty (30) days after the end of each calendar quarter.

(C) Change of ownership. If a facility changes ownership, beginning at the start of the calendar quarter following the date of the change of ownership, the new owner will collect the adjustment payment that was calculated using the prior owner's data.

(D) Adjustment payments will be calculated based on Medicaid days paid by the Wyoming medical assistance program.

(I) Wyoming Medicaid days will be collected for the dates of service represented in cost reports ended in the calendar year that precedes the assessment effective each October 1. The Medicaid days will be generated by the Department from their MMIS payment system.

(II) New facilities without a qualifying cost report. For new facilities that opened prior to the October 1 annual calculation that do not have either a full year cost report or a qualifying cost report, as described in Section 5(c) of this Chapter, resident days will be determined using more current information and will be annualized.

(b) Nursing facility assessment payable to the Department.

(i) The Department will collect an assessment from nursing facilities under the provisions of the Nursing Care Facility Assessment Act, W.S. §§ 42-8-101 through 109.

(A) Assessments will be calculated prospectively on an annual basis to be effective from October 1 through September 30 of each year. The annual assessments will be paid quarterly. New providers opening during that assessment year will not be included in the program until the next assessment year.

(B) The quarterly assessments will be due to the Department no later than forty-five (45) days after the end of each calendar quarter.

(C) Change of ownership. If a facility changes ownership, beginning with the quarter following the date of the change of ownership, the new owner will assume the payment schedule calculated using prior owner's data. If it is not clear to the Department which owner is responsible for the assessment, the owner who received the quarterly adjustment payment will be responsible to pay the Department for the assessment related to that same quarter.

(D) Assessments will be calculated based on a per-resident day basis, exclusive of Medicare resident days.

(I) Resident days will be collected from the Wyoming Nursing Home Reimbursement System, Financial Report for Nursing Homes (cost report) that ended in the calendar year that precedes the assessment effective each October 1. The Department will revise its cost report form to collect the appropriate patient day data. Until the revised cost report forms are in use and have been filed with the Department, the Department will utilize a provider survey to gather the necessary data.

(II) New facilities without a qualifying cost report. If a new facility opened prior to the October 1 annual calculation that does not have either a full year cost report or a qualifying cost report, as described in Section 5(c) of this Chapter, resident days will be determined using more current information and will be annualized.

(E) Assessment expenses shall be reported on the State of Wyoming Financial Report for Nursing Homes annual cost report. Expenses should be reported in the administrative and general section of the operating cost section.

Section 25. Medicaid Allowable Payment for Medicaid Program Services. Any Medicaid program service other than nursing facility services reimbursable within this Chapter shall be reimbursed according to the rules and policies of the Department for that specific program.

Section 26. Billing Requirements.

(a) Submission of claims. A provider seeking Medicaid reimbursement for services provided to a client must submit claims on the forms and in the manner specified by the Department.

(b) Medicaid payment as payment in full. A provider which receives or requests Medicaid payment for services and supplies included in the per diem rate must accept Medicaid payment as payment in full for such services and supplies. A provider may not attempt to collect or retain payment in addition to the per diem rate, except as permitted by 42 C.F.R. § 483.10(c) or other applicable federal law.

Section 27. Change in Provider Status.

(a) Termination of participation. If a provider's participation in the Medicaid program is terminated or suspended for any reason, the provider must submit a cost report for the period ending with the effective date of the termination or suspension. The cost report is due within forty-five (45) days after the date of termination or suspension,

even though the provider's tax period does not end on the date of termination or suspension. The final month's payment due a provider shall be withheld until its cost report is filed and the Department has a reasonable time to perform a desk review and field audit of the cost report and patient funds account.

(b) Change of ownership.

(i) Notice of change of ownership. The parties to a transaction involving a change of ownership must notify the Department, in writing, of the proposed transaction no later than thirty (30) days before the effective date of the change.

(ii) Representation agreement. Upon a change of ownership, all parties to the transaction shall have thirty (30) days after the change to complete and sign a representation statement, in written form specified by the Department, which details the persons or entities which have assumed the assets and liabilities of a nursing facility. If a representation statement is not timely submitted, both the original provider and any subsequent provider shall be jointly and severally responsible for all Medicaid liabilities which exist either before or after the change of ownership.

Section 28. Reimbursement of Out-of-State Providers.

(a) The reimbursement rate for out-of-state facilities providing services to Wyoming clients shall be the lesser of:

(i) The Medicaid reimbursement rate the nursing facility receives for the same or similar services from the Medicaid program in the state where the nursing facility is located;

(ii) The average bed-weighted Medicaid rate in effect in Wyoming as of the previous July 1; or

(iii) The nursing facility's usual and customary rate.

(b) The average bed-weighted Medicaid rate in effect shall be determined by:

(i) Multiplying the number of licensed beds in each nursing facility by the Medicaid per diem rate in effect for that nursing facility;

(ii) Adding the products determined pursuant to (A); and

(iii) Dividing the sum determined pursuant to (B) by the total number of licensed beds in the state.

(c) No cost reports. An out-of-state provider need not submit cost reports to the Department.

(d) Billing requirements. An out-of-state provider must submit with each claim a certification of the provider's reimbursement rate under the Medicaid program in the state where the provider is located and the nursing facility's usual and customary charge.

Section 29. Record Retention.

(a) Providers shall comply with the Provider Records requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 3, Provider Participation.

(b) Explanation of records. In the event of a field audit, the provider shall have available at the field audit location one (1) or more knowledgeable persons who can explain the provider's financial records, the accounting and control system and cost report preparation, including attachments and allocations, to the auditors.

(c) Failure to maintain records. A provider unable to satisfy any of the requirements of this Section shall be given a written notice of deficiency and shall have sixty (60) days after the date of the written notice to correct such deficiency. If, at the end of the sixty (60) days, the Department determines that the deficiency has not been corrected, the Department shall withhold twenty-five (25) percent of the provider's per diem rate for services provided on or after the sixtieth (60th) day. If, at the end of one hundred and twenty (120) days after the mailing of the written notice of deficiency, the Department determines that the deficiency has not been corrected, the Department shall suspend all Medicaid payments for services provided after such date. Reimbursement shall not be reinstated until the Department determines that adequate records are being maintained. After the deficiency is corrected, the Department shall release any withheld payments.

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

Section 30. Repayment of Credit Balance.

(a) Report on cost report. A provider shall report a credit balance on the provider's cost report. A credit balance shall be repaid pursuant to subsection (c).

(b) Annual request. The Department may request the repayment of any credit balance annually. Such request shall be made in writing and mailed by certified mail, return receipt requested. The provider shall repay the credit balance within sixty (60) days after the date of receipt of the request for repayment.

(c) A provider shall repay any credit balance within sixty (60) days after the date such credit balance is identified by the Department or the provider.

(d) Lump sum adjustment. If a credit balance identified pursuant to subsections (a) or (b) is not timely paid to the Department, the Department may recover the credit balance pursuant to Section 31 of this Chapter.

Section 31. Audits.

(a) Field audits. The Department or CMS may perform a field audit of a provider at any time to determine the accuracy and reasonableness of cost reports submitted by the provider and/or the validity of rate adjustments made pursuant to a desk review.

(b) Desk review. The Department or CMS may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports submitted by the provider.

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

(d) Disallowances.

(i) Nonallowable costs. If a field audit or desk review discloses nonallowable costs or costs for services and supplies not included in the per diem rate, the Department shall adjust the per diem rate retroactively to the beginning of the rate period in question, recover any overpayments pursuant to Section 31 of this Chapter, and adjust the per diem rate for the remainder of the rate period.

(A) Costs which are not reasonably related to services included in the Medicaid per diem rate, or which are against public policy, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are adjustments to revenue and, therefore, are not included in allowable cost. Nonallowable costs also include, but are not limited to:

(I) Advertising expense (other than help wanted ads and telephone directory expense);

(II) Attorney fees and other costs associated with negotiations, administrative proceedings or litigation involving the Department, except as specified in settlement;

(III) Bad debts;

(IV) Cost arising from joint use of resources (including central office and pooled cost) not reasonably related to patient care;

(V) Capital costs due solely to changes in ownership;

(VI) Costs incurred in transactions with organizations related to the provider by common ownership or control, to the extent that such costs exceed the limits established under 42 C.F.R. § 413.17;

(VII) Costs incurred as a result of enforcement actions taken by the Department pursuant to the Rules and Regulations for Wyoming Medicaid, Chapter 5, Long Term Care Facility Remedies, Terminations, and/or CMS in response to nursing facility deficiencies, including costs of directed in-service training, suspended or denied per diem payments, reimbursement expenses, transfer costs, and costs relating to state monitoring and/or the appointment of a temporary manager;

(VIII) Costs not reasonably related to patient care;

(IX) The costs associated with ancillary and other services attributable to Medicare Part A or Medicare Part B, including direct and indirect costs;

(1.) Ninety (90) percent of the costs identified pursuant to this paragraph shall be nonallowable costs, and one hundred (100) percent of Medicare bed days shall be removed.

(2.) When determining the capital component for nursing facilities with occupancy below ninety (90) percent Medicare days will be computed to reflect Medicare occupancy.

(X) Costs related to the acquisition, establishment or operation of an in-house pharmacy, other than the reasonable costs of a pharmacy consultant;

(XI) Costs related to extraordinary clients that exceed the per diem rate;

(XII) Costs related to hospice services;

(XIII) Costs (such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies) which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any Medicaid payment has been previously made;

(XIV) Federal income and excess profit taxes;

(XV) Fees paid to directors and salaries, wages or fees paid to non-working officers, employees or consultants;

(XVI) Fund-raising expenses;

(XVII) Interest or penalties on federal or state taxes;

(XVIII) Judgments entered against a nursing facility or settlements entered into by a nursing facility arising out of actions or inactions of the nursing facility's agents or employees, including judgments entered against a nursing facility's agent or employee that a nursing facility pays, or settlements involving the nursing facility's agent or employee that the nursing facility pays;

(XIX) Life insurance premiums for officers and owners and related parties, except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(XX) Meals and lodging provided to guests and employees. If the cost cannot be ascertained, the revenue from meals and lodging furnished to guests and employees shall be offset against the appropriate cost;

(XXI) Prescription drugs;

(XXII) Public relations expenses;

(XXIII) Resident personal purchases;

(XXIV) Return on equity;

(XXV) Self-employment taxes;

(XXVI) Stockholder relations or stock proxy expenses;

(XXVII) Taxes or assessments for which exemptions are available;

(XXVIII) Telephone, television and radio which are located in patient accommodations and which are furnished solely for the personal comfort of patients;

(XXIX) Value of services (imputed or actual) rendered by non-paid workers or volunteers; and

(XXX) Vending machines and related supplies.

(ii) Unsubstantiated cost.

(A) Upon written request by the Department, a provider must substantiate cost or other information reported on the provider's cost report. Substantiation must be provided, in writing, within thirty (30) days after the date of the request.

(B) Any cost which a provider cannot substantiate shall be disallowed.

(C) Substantiation may include, but is not limited to, home office cost statement, resident census, statistical and related information, cost allocations, account analyses, invoices, stock ownership information, related parties' financial information, or subcontractor's financial information.

(e) Financial or medical records which are not made available at the time of an audit shall not be admissible at an administrative hearing held pursuant to Section 32 of this Chapter unless the nursing facility shows good cause for not making the records available at the time of the audit.

Section 32. Recovery of Overpayments. The Department may recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 33. Reconsideration.

(a) A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

(b) A provider may request reconsideration of the determination of the provider's per diem rate following the procedures outlined in the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 34. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 35. 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 36. 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 37. Superseding Effect. When promulgated, this Chapter supersedes all prior rules or policy statements issued by the Department, including manuals or bulletins, which are inconsistent with this Chapter.

Section 38. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.

CHAPTER 7

ATTACHMENT A

ABD Pads
Adhesive Tape
Aerosol, other types
Air Mattresses, Air P.R. Mattresses
Airway-Oral
Alcohol Plaster
Alcohol Sponges
Alternating Pressure Pads
Applicators, Cotton-tipped
Applicators, Swab-eez
Aquamatic K Pads (Water-heated Pad)
Arm slings
Asepto Syringes
Baby Powder
Bandages
Bandages, Elastic or Cohesive
Band-Aids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpans, all types
Beds: Manual, Electric and Clinitron
Bedside Tissues
Bibs
Blood Infusion Sets
Bottle, Specimen
Canes, all types
Cannula, Nasal
Catheter Indwelling
Catheter Plugs
Catheter Tray
Catheter (any size)
Colostomy Bags
Combs
Commodes, all types
Composite Pads
Cotton Balls
Crutches, all types
Decubitus Ulcer Pads/Dressings
Denture Cleaner/Soak
Denture Cups
Deodorants
Diapers
Disposal Under pads

Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressing, all types
Enema Soap
Enema Supplies
Enema Unit
Equipment and Supplies for Diabetic Blood and Urine Testing
Eye Pads
Feeding Tubes
Fingernail Clipping and Cleaning
Flotation Mattress or Biowave Mattress
Flotation Pads and/or Turning Frames
Foot Cradle, all types
Gastric Feeding Unit, including bags
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hair Brushes
Hair Care, Basic
Hand Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Hydraulic Patient Lifts
Hypothermia Blanket
Ice Bags
Incontinency Care
Incontinency Pads and Pants
Influenza Vaccine
Infusion Arm Boards
Infusion Pumps, Enteral and Parenteral
Inhalation Therapy Supplies
Irrigation Bulbs
Irrigation Trays
I.V. Needles
I.V. Trays
Jelly, Lubricating
Lines, Extra
Lotion, Soap and Oil

Massages (by nursing facility personnel)
Mattresses, all types
Medical Social Services
Medicine Dropper
Medicine Cups
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding and Feeding Bags
Nebulizer and Replacement Kit
Needles (various sizes)
Needles: Hypodermic, Scalp and Vein
Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care
Nursing Supplies and Dressing
Ostomy Supplies: Adhesive, Applicance, Belts, Face Plates, Flanges, Gaskets, Irrigation Sets, Night Drains, Protective Dressings, Skin Barriers, Tail Closures
Overhead Trapeze Equipment
Over the counter (OTC) drugs, as designated by the Food and Drug Administration
Oxygen, Gaseous and Liquid
Oxygen Concentrators
Oxygen Delivery Systems, Portable or Stationary
Oxygen Mask
Pads
Pitcher
Plastic Bib
Pump, Aspiration and Suction
Pumps for Alternating Pressure Pads
Respiratory Equipment: Ambu Bags, Cannulas, Compressors, Humidifiers, IPPS Machines and Circuits, Mouthpieces, Nebulizers, Suction Catheters, Suction Pumps, Tubing, etc.
Restraints
Room and Board (semi-private or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Shampoo
Shaves
Shaving Cream
Shaving Razors
Sheepskin
Side Rails
Soap
Special Diets
Specimen Cups
Sponges
Steam Vaporizers

Sterile Pads
Sterile Saline for Irrigation
Sterile Water for Irrigation
Stomach Tubes
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including sterile sponges)
Surgical Pads
Surgical Tapes
Suture Removal Kit
Suture Trays
Syringes, all sizes
Syringes, Disposable
Tape, (for laboratory tests)
Tape, Non-allergic or Butterfly
Testing Sets and Refills (S & A)
Therapy Services, including specialized rehabilitative services as set forth in 42 C.F.R.
§483.45
Toenail Clipping and Cleaning
Tongue Depressors
Toothbrushes
Toothpaste
Tracheostomy Sponges
Trapeze Bars
Tray Service
Under pads
Urinals, male and female
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Walkers, all types
Water Circulating Pads
Water Pitchers
Wheelchairs: Amputee, Geriatric, Heavy Duty, Hemi, Lightweight, One Arm Drive,
Reclining, Rollabout, Semi-Reclining, Standard