Health, Department of

Medicaid

Chapter 16: Medicaid Program Integrity

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CHAPTER 16
Medicaid Program Integrity

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at Wyoming Statute § 42-4-101, 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, waste, or abuse of services, the recovery of overpayments, and the imposition adverse actions against both providers and clients.

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

Section 3. Definitions. Except as otherwise specified in Chapter 1 of the Wyoming Department of Health's Medicaid Rules, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare.

Section 4. Audits.

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

(b) The Department shall have the ability to conduct audits of providers or clients.

(c) The Department may audit a provider or client at any time, with or without prior notice.

(d) The Department may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with Generally Accepted Auditing Standards (GAAS).

(e) If at any time during an audit the Department discovers evidence of an overpayment, that evidence may be referred to the MFCU or the DFS Eligibility Integrity Unit.

(f) Provider self-audit.

(i) A provider may conduct 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 at any time.

(iii) The provider shall notify the Department within sixty (60) business days of the completion of the self-audit.

(g) The Department may require the development of corrective action plans to remediate identified deficiencies.

Section 5. Random Sample and Extrapolation.

(a) The Department shall notify the provider via certified mail 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.

(b) 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 6. Review of All Claims Submitted by the Provider. The Department may conduct a prepayment or post-payment review of all claims submitted by the provider for six (6) years from the paid date.

Section 7. Claim Adjustments and Denials.

(a) The Department shall make a claim adjustment after Medicaid payment has been made. If there is an adjusted amount, the Department may recover the adjustment amount.

(b) 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.

(c) A provider may not request reconsideration or an administrative hearing regarding a claims adjustment/denial.

Section 8. Repayment of Credit Balance.

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

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

(c) If an identified credit balance is not timely paid to the Department, the Department may recover the balance.

(d) A provider may not request reconsideration or an administrative hearing regarding a credit balance.

Section 9. Medicaid allowable payment.

(a) Any payment which exceeds the Medicaid allowable payment for the service shall be recovered.

(b) A provider may not request reconsideration or an administrative hearing regarding a recovery of payments which exceeds the Medicaid allowable payment.

Section 10. Investigation of Suspected Fraud, Waste, or Abuse of Services by Providers.

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

(b) The Department is authorized to investigate, or to refer to appropriate agencies the investigation of suspected fraud, waste, 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 in compliance with existing rules and regulations and state and federal laws;

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

(iii) Sufficient evidence can be developed to support the recovery of overpayments, the imposition of an adverse action 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 the 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; and

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

(d) For purposes of performing its duties under this Chapter, the Department may use any relevant information necessary to conduct an investigation.

(e) After the completion of an investigation, the Department shall take one or more of the following actions:

(i) Determine that no further action is warranted;

(ii) Take adverse action against the provider; or

(iii) Refer the matter to law enforcement, the Wyoming Attorney General, Health and Human Services (HHS), Department of Family Services (DFS) Eligibility Integrity Unit, the MFCU, or other appropriate authorities for possible civil or criminal action.

Section 11. Investigation of Suspected Fraud, Waste, 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, waste, or abuse of services by clients identified pursuant to this section. An investigation shall be for the purpose of determining if:

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

(ii) Sufficient evidence can be developed to support restricting client participation; or

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

(b) The Department may, at any time, refer suspected client fraud, waste, or abuse of services, to the DFS Eligibility Integrity Unit or any other appropriate law enforcement agency.

(c) For purposes of its duties under this Chapter, the Department may use any relevant information to conduct an investigation.

(d) 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) Impose adverse actions against the client.

Section 12. Adverse Actions for Providers.

(a) The Department may impose adverse actions against a provider for:

(i) Suspected or substantiated fraud, waste, 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) Civil Remedies imposed by Centers for Medicare and Medicaid Services (CMS);

(vi) Failure to render requested documentation;

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

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

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

(x) Provider's inability to repay overpayments;

(xi) Failure to maintain current contact information;

(xii) Exclusion by the Office of Inspector General;

(xiii) Termination/exclusion under Medicare, Children's Health Insurance Program (CHIP) or another State's Medicaid program;

(xiv) Failure to maintain records;

(xv) Refusal to grant access to records;

(xvi) Refusing to complete education;

(xvii) Pending the completion of an on-going investigation conducted by the MFCU or another law enforcement agency;

(xviii) Failure to notify the Department of the completion of a self-audit within sixty (60) days;

(xix) Prosecution by the MFCU or another law enforcement agency and found guilty of healthcare fraud;

(xx) Failure to submit any paid claims for over one (1) year;

(xxi) Failure to submit an acceptable corrective action/quality improvement plan, or has failed to implement the corrective action/quality improvement plan approved by the Department;

(xxii) The chronic failure to provide services pursuant to the individual plan of care;

(xxiii) Providing services that fail to meet the applicable standard of care for the profession/service involved;

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

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

(b) When making a decision to impose adverse actions, the State Medicaid Agent, or the Agent's 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) The Department may take any of the following adverse actions against a provider:

(i) Educational intervention;

(ii) Recovery of overpayments;

(iii) Suspension of payments;

(iv) Suspension of provider agreement;

(v) Termination of provider agreement;

(vi) Place conditions on the provider;

(vii) Impose a monitor;

(viii) Impose civil monetary penalties;

(ix) Impose an immediate suspension; or

(x) Impose an additional appropriate adverse action.

(d) The Department shall send written notice of the adverse action, to the provider, via certified mail, return receipt requested. The notice shall include:

(i) A statement of the intended action;

(ii) The effective date of the intended action;

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

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

(v) The provider's right to request reconsideration of the adverse action;

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

(vii) A statement that the failure to request reconsideration shall preclude any further appeal of the adverse actions.

(e) If a provider agreement has been terminated, and all appeal periods have been exhausted, the Department shall send written notice of the adverse action 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 adverse action, the findings of fact which led to the adverse action and the results of any appeals pursuant to 42 CFR 1001.2005 and 2006 and 42 CFR 1002.212.

(f) Effective date of adverse action.

(i) Adverse actions shall be effective on the date specified in the notice of adverse actions.

(ii) Suspension or termination of a provider shall be effective immediately in the following instances:

(A) When the Department determines there is an imminent threat to the health, safety, or welfare of clients the general public; or

(B) When the Department receives notice that a provider's state license, any certification required to provide services has been suspended or revoked, or when the provided has been terminated from another State Medicaid agency.

Section 13. Adverse Actions for Clients.

(a) The Department may impose or refer a client to the appropriate agency for adverse actions for instances including, but not limited to:

(i) Fraud, waste, 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;

(ix) Pending the completion of an on-going investigation conducted by the MFCU, Eligibility Integrity Unit or another law enforcement agency;

(x) Refusing to complete education; or

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

(b) The decision to take action pursuant to this Section shall be made by the State Medicaid Agent, or the Agent's 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) The Department may take any of the following adverse actions against a client:

(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.

(d) The Department shall send written notice of the adverse action, to the client, via certified mail, return receipt requested. The notice shall include:

(i) An explanation of:

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

(B) An explanation of circumstances where a hearing will be granted based on a change in the law.

(ii) The method for requesting a hearing;

(iii) The individual's right to be represented by a legally authorized representative, including a lawyer admitted to practice in Wyoming, a relative, friend or other spokesperson;

(iv) Notice that the individual shall notify the Department in writing that they will be represented;

(v) The intended action;

(vi) The effective date of the intended action;

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

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

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

(x) The client's right to request a reconsideration of the adverse action.

Section 14. Educational Intervention.

(a) If the adverse action includes educational intervention, the Department will inform the provider or client:

(i) The reason(s) for the educational intervention,

(ii) The education required,

(iii) The time and date of the education, and

(iv) That the continued participation as a provider or client in Medicaid is contingent on complete of the education by the specified date.

(b) If the education is refused, the provider or the client shall be suspended from participation in Medicaid until the education is completed.

Section 15. Recovery of Overpayments from Providers or Clients.

(a) The Department shall recover overpayments from providers. 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. The Department shall recover overpayments from a client that has engaged in abuse of services, fraud, or waste resulting in an overpayment.

(b) After determining that a provider or client has received overpayments, the Department shall send written notice, via certified mail, return receipt requested, to the provider or client. In addition to any additional notice requirements, the notice shall include:

(i) The amount of the overpayments; and

(ii) The basis for the determination of overpayments.

(c) A provider or client shall reimburse the Department for overpayments within thirty (30) business days after the provider or client 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.

(d) If a provider or client does not timely reimburse the Department, following final administrative action, the Department shall recover the overpayments by:

(i) Withholding all or part of future Medicaid payments:

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

(B) Payment arrangements may be entered into if the provider or client can demonstrate that one hundred percent (100%) withholding will result in an undue hardship, with the approval of the State Medicaid Agent or the Agent's designee;

(ii) Initiating a civil lawsuit against the provider or client; or

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

(e) If the provider is bankrupt or out of business, the Department shall notify the provider that an overpayment exists and take reasonable action to recover the overpayment during the three hundred and sixty-five (365) day recovery period in accordance with 42 CFR § 433.318. The Department shall take action to be listed as a creditor in the bankrupt proceedings.

Section 16. Suspension and Termination of Provider.

(a) A suspension or termination under this section shall be the same and shall run contemporaneously with the period of the provider's suspension from a licensing entity, Medicare, another State Medicaid Agency or any period of voluntary non-participation.

(b) A suspended or 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 suspension;

(c) 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 or termination; and

(d) The Department shall not pay any claims submitted by a provider for services provided to a client during any period of suspension or after a provider has been terminated.

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

(f) This section does not preclude the filing of claims prior to a termination. Any filed claims may be held in suspense until a final decision is rendered on the termination.

(g) The Department may reinstate or reenroll a suspended or terminated provider if:

(i) The Department has been reimbursed for all overpayments or a payment agreement is in effect;

(ii) The Department is satisfied that sufficient safeguards have been implemented to insure that fraud, waste, or abuse of services, or other factors which led the suspension or termination, will not recur; and

(iii) For terminated providers, an approved new provider agreement is signed by all parties.

Section 17. Conditions on Providers

(a) The Department may place the following condition(s) on the provider's certification or Medicaid enrollment:

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

(ii) Restricting the provider's certification or participation to a specific service;

(iii) Restricting the provider's certification or participation to a specific geographic area or location; and

(iv) Requiring the provider to deny new admissions.

(b) The provider shall be notified via certified mail that a condition is being place on their certification or participation and shall have fifteen (15) business days to abate all areas of noncompliance that warrant the condition(s), or to submit an acceptable corrective action/quality improvement plan.

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

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

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

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

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

(B) An acceptable corrective action/quality improvement plan and;

(C) Verification that the corrective action/quality improvement plan has been implemented for each area of non-compliance, within thirty (30) days of placement of the condition.

(c) Failure to comply with this section may result in revocation of the provider's certification or other applicable adverse action.

Section 18. Impose a Monitor.

(a) 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.

(b) The state monitor shall be removed when the provider has abated the areas of non-compliance and has submitted and implemented an acceptable corrective action / quality improvement plan.

(c) The state shall pay the costs and expenses of the state monitor if the provider fails to do so. The monitor shall continue to monitor the provider until payment in full is received from the provider.

(d) The Department shall make a reasonable effort to assure that there is not a potential conflict of interest between the state monitor and the provider.

Section 19. Civil Monetary Penalties.

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

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

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

(iii) 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;

(iv) Whether economic benefit resulted from the provider's failure to comply;

(v) The appropriateness of any action or inaction to mitigate a health, safety, or welfare risk to a participant;

(vi) The provider's history of previous substantiated violations; and

(vii) Any other relevant information submitted to the Department between the initial adverse action and the decision to impose civil monetary penalty.

(b) A finding that civil monetary penalty is warranted shall:

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

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

(iii) 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.

(c) For each day of continuing violation, the civil monetary 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.

(i) The provider may request that the Department reduce the penalty imposed.

(A) The Department may reduce the penalty upon a finding that the financial impact may negatively impact the provider's ability to provide services that meet participants' health and safety needs.

(B) Such a reduction shall be requested by the provider, in writing, and must be accompanied by relevant evidence to support the requested reduction within twenty (20) business days of receiving notice of the penalty

(C) 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.

(d) The civil monetary 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.

Section 20. Immediate suspensions.

(a) If a substantial and immediate threat to the health or safety of clients exists, the Department may immediately suspend the certification or enrollment of the provider and take action necessary to protect the health and safety of participants

(b) Notice of the immediate suspension shall be in writing provided to the provider at the time of the suspension.

(c) The provider shall be afforded an opportunity for a hearing within ten (10) business days after the effective date of the immediate suspension.

(i) A request for hearing shall be provided to the Department within two (2) business days after the receipt of notice.

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

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

(iv) All other procedures for immediate suspension hearings shall be as specified by Chapter 4 of the Wyoming Department of Health's Medicaid Rules.

(d) The immediate suspension of the provider shall remain in place until the conclusion of the Administrative Hearing process or the provider submits:

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

(ii) An approved corrective action or quality improvement plan for each area of non-compliance; and

(iii) Evidence that the corrective action or quality improvement plan for each area of non-compliance has been implemented.

(e) In addition to suspending the provider the Department make take action necessary to protect the health and safety of participants. The action may include:

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

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

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

Section 21. 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 via certified mail within twenty (20) business days after the mailing of the notice of the adverse action.

(A) The request must state with specificity the reasons for the request. Failure to provide such a statement shall result in the dismissal of the request with prejudice.

(B) A provider shall 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 submitted electronically via email to Department, made verbally to the Department, or mailed to the Department via certified mail, return receipt requested, within twenty (20) business days after the mailing of the notice of the adverse action.

(A) The request must state with specificity the reasons for the request. Failure to provide such a statement shall result in the dismissal of the request with prejudice.

(B) A client may submit any additional relevant information at the time of the request.

(b) 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.

(i) The party to whom the request is directed must provide the requested information within thirty (30) business days after the date of the request.

(ii) Failure to provide the requested information shall result in the dismissal of the request for reconsideration with prejudice.

(c) The Department shall review the decision and send written notice of its final decision via certified mail, return receipt requested, to the party requesting reconsideration.

(i) The Department shall send its final decision within forty-five (45) business days after the Department receives the request for reconsideration or after the receipt of any additional information requested, whichever is later.

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

(e) The party requesting reconsideration or the Department may request an informal meeting before the final decision is made to determine whether the matter may be resolved.

(i) 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 regarding the adverse action.

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

(A) Such a request for hearing shall be submitted electronically via email to Department, made verbally to the Department, mailed via certified mail, return receipt requested, or personally delivering a request for hearing to the Department within thirty (30) business days of the date of the notice of the adverse action.

(B) Failure to request reconsideration or an administrative hearing within the required time shall preclude the client's right to contest the adverse action.

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.

Section 23. Remedies Cumulative. The remedies provided by this Chapter are cumulative. The Department may seek multiple adverse actions simultaneously, and pursue any additional remedies permitted by law.

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

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

(b) 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 adverse actions, recover overpayments or take any other final action authorized by this Chapter.