Chapter 45, Wyoming Medicaid Rules, Provider Certification and Sanctions, covers restraint usage and positive behavior support plans. The rules specifically prohibit seclusion. The pertinent sections are:

Section 28: Restraint Standards
Section 29: Positive Behavior Support Plan Standards

Effective 12/29/06 WYOMING MEDICAID RULES
CHAPTER 45
WAIVER PROVIDER CERTIFICATION AND SANCTIONS

Section 1. Authority.
This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-101 et seq. and the Wyoming Administrative Procedures Act at W.S. § 16-3-101 et seq.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern certification of providers under the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver, the Wyoming Children’s Developmental Disabilities Home and Community Based Waiver, and the Wyoming Acquired Brain Injury Home and Community Based Waiver on or after June 1, 2006.

(b) The provisions contained in this Chapter shall be subordinate to the provisions in the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver, the Wyoming Medicaid Children’s Developmental Disabilities Home and Community Based Waiver, and the Wyoming Medicaid Acquired Brain Injury Home and Community Based Waiver submitted to the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act, codified as 42 U.S.C. § 1396n.

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


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

(b) Methodology. This Chapter establishes standards and qualifications for providers under the Developmental Disabilities Division’s Home and Community Based Waivers.
(c) This Chapter is intended to be read in conjunction with the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver, the Children’s Developmental Disabilities Home and Community Based Waiver, and the Acquired Brain Injury Home and Community Based Waiver; Chapter 41, Chapter 42, Chapter 43, and Chapter 44 of the Medicaid Rules; and Chapter 1, Rules for

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(d) Unless otherwise specified, 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, including any applicable amendments, corrections, or revisions, but excluding any subsequent amendments or changes.

Section 4. Definitions.
The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indicates that such is the intent, words in the singular number shall include the plural and vice versa. Throughout these rules gender pronouns are used interchangeably. The drafters have attempted to utilize each gender pronoun in equal numbers, in random distribution. Words in each gender include individuals of the other gender.


(b) “Abuse.” Abuse as defined by W.S. § 35-20-102 and W.S. § 14-3-202.

(c) “Acquired brain injury.” Acquired Brain Injury as defined in Chapter 43.

(d) “Acquired Brain Injury Home and Community Based Waiver.” The Acquired Brain Injury Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

(e) “Adult.” A person twenty-one years of age or older for purposes of the Adult Developmental Disabilities Home and Community Based Waiver. Participants between the ages of 18 and 21 receive services on the Children’s Developmental Disabilities Home and Community Based Waiver but are considered an adult in the State of Wyoming.

(f) “Adult Developmental Disabilities Home and Community Based Waiver.” The Adult Developmental Disabilities Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

(g) “Advocate.” A person, chosen by the participant or legal guardian, who supports and represents the rights and interests of the participant in order to ensure the participant’s full legal rights and access to services. The advocate can be a friend, a relative, or any other interested person. An advocate has no legal authority to make decisions on behalf of a participant.
(h) “Behavior support plan.” A written plan that is developed based on a functional assessment of behaviors that negatively impact a person’s ability to acquire, retain, and/or improve the self-help, socialization, and adaptive skills necessary to reside

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successfully in home and community-based settings, and that contains multiple intervention strategies designed to modify the environment and teach new skills.

(i) “Caregiver.” A person who provides services to a participant.

(j) “Case management.” Case management as defined in Chapter 41.

(k) “Centers for Medicare and Medicaid Services (CMS).” The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, its agent, designee, or successor.

(l) “Chapter 1.” Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid Rules.

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

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

(o) “Chapter 26.” Chapter 26, Medicaid Covered Services, of the Wyoming Medicaid Rules.


(r) “Chapter 41.” Chapter 41, DD Adult Waiver Services, of the Wyoming Medicaid Rules.

(s) “Chapter 42.” Chapter 42, DD Child Waiver Services, of the Wyoming Medicaid Rules.

(t) “Chapter 43.” Chapter 43, Acquired Brain Injury Waiver Services, of the Wyoming Medicaid Rules.
(u) “Chapter 44.” Chapter 44, Environmental Modifications and Specialized Equipment, of the Wyoming Medicaid Rules.

(v) “Child.” A person under 21 years of age for participants receiving services on the Children’s Developmental Disabilities Home and Community Based Waiver. Participants between the ages of 18 and 21 receive services on the Children’s Developmental Disabilities Home and Community Based Waiver but are considered an adult in the State of Wyoming and shall sign their own documents unless they have a legal guardian.

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(w) “Children’s Developmental Disabilities Home and Community Based Waiver.” The Children’s Developmental Disabilities Home and Community Based Waiver submitted to and approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act.

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

(y) “Clinically eligible.” Determination that a person has met the requirements set forth in Chapter 41, Chapter 42, or Chapter 43.

(z) “Cognitive retraining services.” Cognitive retraining services as defined in Chapter 43.

(aa) “Commission for the Accreditation of Rehabilitation Facilities (CARF).” The Commission for the Accreditation of Rehabilitation Facilities, its agent, designee, or successor.

(bb) “Conservator.” A person appointed by the court to manage the estate for an individual incapable of managing his or her financial affairs.

(cc) “Covered services.” Those services that are Medicaid reimbursable pursuant to Chapter 41, Chapter 42, and/or Chapter 43.

(dd) “DCI.” Department of Criminal Investigation.

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

(ff) “Department of Family Services (DFS).” The Wyoming Department of Family Services, its agent, designee, or successor.

(gg) “Department of Family Services Registry.” Pursuant to W.S. § 35-20-115, The Central Registry of the Department of Family Services that includes substantiated reports of abuse, neglect, exploitation, or abandonment of vulnerable adults and children.

(hh) “Developmental disability.” Developmental disability as defined in Chapter 41 and Chapter 42.
(ii) “Dietician.” A person who is registered as a dietician by the Commission on Dietetic Registration.

(jj) “Dietician services.” Dietician services as defined in Chapter 41, Chapter 42, and Chapter 43.

(kk) “Direct supervision.” Direct supervision means the supervisor shall be working the same shift, schedule, and proximity of the volunteer, individual under the

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age of 18, or new employee pending the results of the Department of Family Services Registry screening.

(ll) “Director.” The Director of the Department or the Director’s agent, designee, or successor.

(mm) “Division.” The Developmental Disabilities Division of the Department, its agent, designee, or successor.

(nn) “Drug used as a restraint.” Any drug that:

(i) Is administered to manage a participant’s behavior in a way that reduces the safety risk to the participant or others, and

(ii) Has the temporary effect of restricting the participant’s freedom of movement, and

(iii) Is not a standard treatment for the participant’s medical or psychiatric condition.

(oo) “Elopement.” The unexpected or unauthorized absence of an individual for more than four hours when that person is receiving waiver services or the unexpected or unauthorized absence of any duration for a participant whose absence constitutes an immediate danger to himself or others.

(pp) “Employment records.” Records maintained by a provider that relate to the provider’s employees’ participation in furnishing covered services and that are required by the Division, which may include but is not limited to staff qualifications, results of background checks, documentation of trainings, CPR/First Aid certification, copies of current drivers license, and proof of current automobile insurance, if applicable.

(qq) “Enrolled.” Enrolled as defined in Chapter 3.

(rr) "Environmental modification." The physical modification of a residence of a participant pursuant to Chapter 44.

(ss) “Excess payments.” Excess payments as defined in Chapter 19 and Chapter 39.

(uu) “Extended Wyoming Medicaid state plan services.” Extended state plan services as defined in Chapter 41, Chapter 42, and Chapter 43.

(vv) “Extraordinary Care Committee (ECC).” A committee that has the authority to approve or deny individual plans of care, emergency funding, and funding due to a material change in circumstance or other condition justifying an increase in funding as defined in Chapter 41, Chapter 42, and Chapter 43.

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(ww) “FBI.” Federal Bureau of Investigation.

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

(yy) “Functional Behavioral Assessment Analysis.” A process that seeks to identify the behavior a participant may exhibit to determine the function or purpose of the behavior, and to develop interventions to teach acceptable alternatives to the behavior. The process shall include:

(i) Identifying the behavior(s) that needs to change.

(ii) Collecting data on the behavior(s).

(iii) Developing a hypothesis about the reason for the behavior.

(iv) Developing an intervention to help change the behavior.

(v) Evaluating the effectiveness of the intervention.

(zz) “Functionally necessary.” A waiver service that is:

(i) Required due to the diagnosis or condition of the participant, and

(ii) Recognized as a prevailing standard or current practice among the provider's peer group, or

(iii) Intended to make a reasonable accommodation for functional limitations of a participant, to increase a participant's independence, or both.

(iv) Provided in the most efficient manner and/or setting consistent with appropriate care required by the participant's condition.

(v) For the purposes stated, utilization is not experimental or investigational and is generally accepted by the medical community.
(aaa) “Funding.” That combination of federal and state funds available to pay for covered services. Funding does not include any other funds available to the Department that are not designated for covered services.

(bbb) “Generally Accepted Auditing Standards (GAAS).” Current auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.

(ccc) “Guardian.” A person lawfully appointed as a guardian to act on the behalf of the participant or applicant.

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(ddd) “Habilitation.” Services designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation services for each Waiver are defined in Chapter 41, Chapter 42, and Chapter 43.

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

(ff) “Homemaker.” Homemaker services as defined in Chapter 42.

(ggg) “ICF/MR.” An intermediate care facility for people with mental retardation as defined in 42 U.S.C. § 1396d(d), which is incorporated by this reference.

(hhh) “Individualized Budget Amount (IBA).” The Division's allocation of Medicaid waiver funds that may be available to a participant to meet his or her needs pursuant to Chapter 41, Chapter 42, and Chapter 43.

(iii) “Individual Plan of Care (IPC).” Individual plan of care as defined in Chapter 41, Chapter 42, and Chapter 43.

(jjj) “Individual Plan of Care (IPC) team.” Individual Plan of Care team as defined in Chapter 41, Chapter 42, and Chapter 43.

(kkk) “Individually-selected Service Coordinator (ISC).” Individually-selected service coordinator as defined in Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.

(III) “Informed choice.” A decision made by a participant or guardian if applicable that is made voluntarily, without coercion or undue influence and that is based on sufficient experience and knowledge, including exposure, awareness, interactions, and/or instructional opportunities, to ensure that the choice is made with adequate awareness of all the available alternatives to and consequences of options available.

(mmm) “Institution.” An Intermediate Care Facility for people with Mental Retardation (ICF/MR), nursing facility, hospital, prison, or jail.

(nnn) “Inventory for Client and Agency Planning (ICAP).” An instrument used by the Division to help determine eligibility and to determine the needs of the participant, available from Riverside Publishing, its successor, or designee.
(ooo) “Mechanical restraint.” Any device attached or adjacent to a participant’s body that he or she cannot easily move or remove that restricts freedom of movement or normal access to the body.

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

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(qqq) “Medicaid allowable payment.” Medicaid reimbursement for covered services as
determined pursuant to Chapter 41, Chapter 42, and/or Chapter 43.

(rrr) “Medicaid Fraud Control Unit (MFCU).” The Medicaid Fraud Control Unit of the
Wyoming Attorney General’s Office, its agent, designee, or successor.

(sss) “Medical records.” All documents, in whatever form, in the possession of or subject
to the control of a provider, which describe the participant’s diagnosis, condition or treatment,
including, but not limited to, the individual plan of care.

(ttt) “Medically necessary.” A health service that is required to diagnose, treat, cure, or
prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected, to
relieve pain or to improve and preserve health and be essential to life. The services must be:

(i) Consistent with the diagnosis and treatment of the participant’s condition.

(ii) Recognized as the prevailing standard or current practice among the
provider’s peer group.

(iii) Required to meet the medical needs of the participant and undertaken for
reasons other than the convenience of the participant and the provider, and

(iv) Provided in the most efficient manner and/or setting consistent with
appropriate care required by the participant’s condition.

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

(vvv) “Medication administration.” Medication physically given by someone other than a
participant because the participant cannot take his or her own medications or administer
treatments. Parents of a child on the Children’s Developmental Disabilities Home and
Community Based Waiver may give written authorization to a provider to administer medications
to the child.

(www) “Medication management training.” Medication management training completed
by a nurse, including instructing and assisting the participant in setting up medications.

(xxx) “Medication monitoring.” Observation and documentation of participant’s self-
administration of medication by provider or provider staff for participants who do not require
medication administration or medication management by a nurse.
(yyy) “Mental retardation.” A diagnosis as determined by a psychologist per the American Association on Mental Deficiency, Classification in Mental Retardation (Herbert J. Grossman ed., 8th ed. 1983).

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(zzz) “Modification to individual plan of care.” A change to an individual plan of care pursuant to Chapter 41, Chapter 42, and Chapter 43. A modification may include the addition, substitution, or deletion of providers, covered services, or both. Modifications may increase or decrease the Medicaid waiver allowable payment.


(bbbb) “Objectives.” Set of meaningful and measurable goals for the participant and the methods used to train the person on the goals.

(cccc) “Occupational therapist.” A person licensed to practice occupational therapy pursuant to W. S. § 33-40-102(a)(iii).

(dddd) “Occupational therapy services.” Occupational therapy services as defined in Chapter 41 and Chapter 43.

(eeee) “Overpayments.” Overpayments as defined in Chapter 16 and Chapter 39.

(ffff) “Participant.” An individual who has been determined eligible for covered services under a Home and Community Based Services Waiver.

(gggg) “Participant specific training.” Training on specific health, safety, and support needs of a participant that are described in the person’s individual plan of care.

(hhhh) “Personal care services.” Personal care services as defined in Chapter 41, Chapter 42, and Chapter 43.

(iii) “Personal restraint.” The application of physical force or physical presence without the use of any device, for the purposes of restraining the free movement of the body of the participant. The term personal restraint does not include briefly holding, without undue force, a participant in order to calm or comfort him or her, or holding a participant’s hand to safely escort him or her from one area to another.

(iiij) “Person-centered planning.” A process, directed by a participant, that identifies the participant’s strengths, capacities, preferences, needs, the services needed to meet the needs, and providers available to provide services. Person centered planning allows a participant to exercise choice and control over the process of developing and implementing the individual plan of care.
(kkkk) “Physical therapist.” A person licensed to practice physical therapy pursuant to W. S. § 33-25-101(a)(ii).

(llll) “Physical therapy services.” Physical therapy services as defined in Chapter 41 and Chapter 43.

(mmmm) “Physician.” A person licensed to practice medicine or osteopathy by the Wyoming Board of Medical Examiners or a similar agency in a different state.

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“Police involvement.” For the purpose of this Chapter, defined as any incident that results in police involvement with participants, including but not limited to arrests of participants, questioning of participants by law enforcement, or police calls to participant’s home or service delivery site.

“Power of Attorney.” An instrument in writing whereby one person, as principal, appoints another as his agent and confers authority to perform certain specified acts or kinds of acts on behalf of principal (Black's Law Dictionary, Sixth Edition, 1990).

“Prior authorization.” Prior authorization as defined in Chapter 3.

“Provider.” A person or entity that is certified by the Division to furnish covered services and is currently enrolled as a Medicaid Waiver provider.

“Psychologist.” A person licensed to practice psychology pursuant to W.S. § 33-27-113(a)(v).

“Qualified behavioral health practitioner.” A person certified, licensed, registered or credentialed by a government entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide mental health or alcohol and other drug services. Persons other than a physician designated by a program to order restraints must be permitted to do so by federal, state, provincial, or other regulations.

“Related condition.” Related condition as defined in Chapter 41 and Chapter 42.

“Representative payee.” Representative payee as defined in Chapter 41, Chapter 42, and Chapter 43.

“Respiratory therapist.” A person licensed as a respiratory care practitioner by the Wyoming Board for Respiratory Care, or a person certified or registered with the American Respiratory Therapy Association.

“Respiratory therapy services.” Respiratory therapy services as defined in Chapter 41 and Chapter 42.

“Respite” or “Respite services.” Respite as defined in Chapter 41, Chapter 42, and Chapter 43.

“Restraint.” A personal restraint, mechanical restraint, or drug used as a restraint as defined in this section.

“Schedule.” A personalized list of tasks or activities that describe a typical week for a participant. The schedule shall reflect the desires of the participant and shall include the
service being provided, details on training on specific goals for habilitation services, level of supervision needed if specified in the individual plan of

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care, health and safety needs, activities, date, time in and time out for provision of services, provider signatures, and approximate number of hours in service.

(aaaaa) “Seclusion.” The involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving. Providers seeking reimbursement for waiver services shall not use seclusion.


(ccccc) “Serious Injury.” An injury, such as suspected fractures, wounds requiring stitches, or injuries due to falls, which requires an emergency room visit, hospital visit, or non-routine visit to a doctor or clinic.

(ddddd) “Services.” Medical, habilitation, or other services, equipment, or supplies, appropriate to meet the needs of a participant.

(eeeeee) “Skilled nursing services.” Skilled nursing services as defined in Chapter 41, Chapter 42, and Chapter 43.

(fffff) “Specialized equipment.” New or used devices, controls, or appliances that enable a participant to increase his or her ability to perform the activities of daily living or to perceive, control, or communicate with the environment in which the participant lives, pursuant to Chapter 44.

(ggggg) “Speech, hearing and language services.” Speech, language and hearing services as defined in Chapter 41 and Chapter 43.

(hhhhh) “Speech pathologist.” A person licensed to practice speech pathology pursuant to W. S. 33-33-102(a)(iii).

(iiiii) “Third-party liability.” Third-party liability pursuant to Chapter 35.

(jjjjj) “Time out.” The redirection of a participant for a period of time to a designated area from which the person is not physically prevented from leaving, for the purpose of providing the person an opportunity to regain self-control.

(kkkkk) “Transition process.” The process of changing from one provider of services to another, from one home and community based service to another, or from one residential location to another.
Section 5. Philosophy.

(a) All persons possess inalienable rights under the Constitutions of the United States and the State of Wyoming, including persons with acquired brain injuries. Persons with developmental disabilities also possess the rights outlined in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. § 15001, and which are included as Appendix A to this Chapter.

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(b) It is the philosophy of the Division to develop reasonable and enforceable rules for
the provision of services to individuals with developmental disabilities in community settings in
lieu of unnecessary institutionalization. This philosophy is mandated in the Supreme Court ruling

(c) This Chapter is designed not only to support the philosophy of community-based
services but to also protect the health, welfare, and safety of participants.

Section 6. Covered Services. The services listed in Section 7 through Section 22 are covered
services if they are functionally necessary and part of an individual plan of care approved by the
Division pursuant to Chapter 41, Chapter 42, or Chapter 43.

Section 7. Case Management Services. A provider of case management services, otherwise
known as an individually-selected service coordinator, shall:

(a) Meet the qualifications pursuant to Chapter 1, Rules for Individually-selected Service

(b) Maintain current CPR/First Aid certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete training pursuant to Section 26 of this Chapter.

(e) Comply with the documentation requirements in section 27 of this Chapter.

(f) Monitor the implementation of the individual plan of care, in accordance with Chapter
1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental
Disabilities Division. The monitoring shall include:

(i) Reviewing objectives monthly for trends and working with the individual plan of
care team to make changes to the objectives when progress is not made.

(ii) Reviewing documentation of the units billed by each provider on the individual
plan of care monthly to assure services are being provided in the quantity and quality specified
in the plan and to monitor implementation of the plan.

(g) Providers shall provide the individually-selected service coordinator with the billing
information and documentation of services, including progress on objectives, on a monthly basis
by the 10th business day of the calendar month following the month in which services were
provided.
(h) The individually-selected service coordinator shall report to the Division significant concerns with implementation of the individual plan of care or significant concerns with the health and safety of a participant.

(i) Individually-selected service coordinators shall meet the standards and requirements of Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Division of Developmental Disabilities, and Chapter 41, Chapter 42, Chapter 43, and Chapter 44.

Section 8. **Cognitive Retraining Services.** A provider of Cognitive Retraining Services shall:

(a) Be certified in Cognitive Retraining from an accredited institution of higher learning, or

(b) Be a certified Brain Injury Specialist through the Brain Injury Association of America, or

(c) Be a licensed professional with one year of acquired brain injury training or Bachelors degree in related field and three years experience in acquired brain injuries.

(d) Maintain current CPR/First Aid Certification.

(e) Complete a background check pursuant to Section 25 of this Chapter.

(f) Complete training pursuant to Section 26 of this Chapter.

(g) Comply with the documentation requirements in Section 27 of this Chapter.

(h) Meet the standards and requirements of Chapter 43.

Section 9. **Dietician Services.** A provider of dietician services shall:

(a) Have a current license to practice as a dietician by the Commission on Dietetic Registration.

(b) Maintain current CPR/First Aid Certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete training pursuant to Section 26 of this Chapter.
(e) Comply with the documentation requirements in Section 27 of this Chapter.

(f) Meet the standards and requirements of Chapter 41, Chapter 42, and Chapter 43.

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Section 10. Environmental Modifications. A provider of environmental modification services shall:

(a) Have the applicable building, electrical, plumbing contractor’s license as required by local or state regulations.

(b) Complete training pursuant to Section 26 of this Chapter.

(c) Provide environmental modification services pursuant to Chapter 44.

Section 11. Habilitation Services. A provider of habilitation services, except special family habilitation home services and residential habilitation training services, shall:

(a) Be 18 years of age or older or, if under the age of 18, be subject to direct supervision as identified in Section 4 of these rules.

(b) Maintain current CPR/First aid certification.

(c) Have current CPR/First Aid certification for all individuals 18 years of age or older living in the home who shall have, at any time, unsupervised access to the participant.

(d) Complete a background check pursuant to Section 25 of this Chapter.

(e) Complete a background check pursuant to Section 25 of this Chapter for all persons living in the home who are 18 years of age or older.

(f) Complete training pursuant to Section 26 of this Chapter.

(g) Comply with the documentation requirements in Section 27 of this Chapter.

(h) Document progress on objectives on at least a monthly basis.

(i) Maintain CARF accreditation pursuant to Section 23 of this Chapter if organization is serving three or more people in day habilitation services or residential habilitation services.

(j) Maintain standards for non-CARF providers pursuant to Section 24 of this Chapter if provider is serving fewer than three people in day habilitation services or residential habilitation services.
(k) Residential habilitation trainer service providers shall meet the requirements of Section 16 of this Chapter.

(l) Special family habilitation home service providers shall meet the requirements of Section 20 of this Chapter.

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(m) Habilitation providers shall meet all service requirements of Chapter 41, Chapter 42, and Chapter 43.

Section 12. **Homemaker Services.** A provider of homemaker services shall:

(a) Be 18 years of age or older.

(b) Complete a background check pursuant to Section 25 of this Chapter.

(c) Complete training pursuant to Section 26 of this Chapter.

(d) Comply with the documentation requirements in Section 27 of this Chapter.

(e) Meet the standards and requirements of Chapter 42.

Section 13. **Occupational Therapy Services.** A provider of occupational therapy services shall:

(a) Have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy.

(b) Maintain current CPR/First Aid Certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete training pursuant to Section 26 of this Chapter.

(e) Comply with the documentation requirements in Section 27 of this Chapter.

(f) Meet the standards and requirements of Chapter 41 and Chapter 43.

Section 14. **Personal Care Services.** A provider of personal care services shall:

(a) Be 18 years of age or older or, if under the age of 18, be subject to direct supervision as identified in Section 4 of these rules.

(b) Maintain current CPR/First Aid Certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.
(d) Complete training pursuant to Section 26 of this Chapter.

(e) Comply with the documentation requirements in Section 27 of this Chapter.

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(f) Maintain standards for non-CARF providers per Section 24 of this Chapter.

(g) Meet the standards and requirements of Chapter 41, Chapter 42, and Chapter 43.

(h) Providers of personal care services who are family members of the participant shall meet the same standards as providers certified to provide personal care services who are unrelated to the participant.

Section 15. Physical Therapy Services. A provider of physical therapy services shall:

(a) Have a current license to practice physical therapy by the Wyoming Board of Physical Therapy.

(b) Maintain current CPR/First Aid Certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete training pursuant to Section 26 of this Chapter.

(e) Comply with the documentation requirements in Section 27 of this Chapter.

(f) Meet the standards and requirements of Chapter 41 and Chapter 43.

Section 16. Residential Habilitation Training Services. A provider of residential habilitation training services shall:

(a) Be 18 years of age or older.

(b) Maintain current CPR/First Aid Certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete training pursuant to Section 26 of this Chapter.

(e) Comply with the documentation requirements in Section 27 of this Chapter.

(f) Document that a portion of each session includes training of family on how to work with participant on objectives, when participant is living with family.
(g) Document progress on objectives on at least a monthly basis.

(h) Meet the standards and requirements of Chapter 42.

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(i) Maintain standards for non-CARF providers per Section 24 of this Chapter if providing services in the provider home.

Section 17. **Respiratory Therapy Services**. A provider of respiratory therapy services shall:

(a) Have a current license as a respiratory care practitioner by the Wyoming Board for Respiratory Care.

(b) Maintain current CPR/First Aid Certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete training pursuant to Section 26 of this Chapter.

(e) Comply with the documentation requirements in Section 27 of this Chapter.

(f) Meet the standards and requirements of Chapter 41 and Chapter 42.

Section 18. **Respite Services**. A provider of respite services shall:

(a) Be 18 years of age or older or, if under the age of 18, be subject to direct supervision as identified in Section 4 of these rules.

(b) Maintain current CPR/First Aid Certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete a background check pursuant to Section 25 of this Chapter for individuals 18 years of age or older living in the home.

(e) Complete training pursuant to Section 26 of this Chapter.

(f) Comply with the documentation requirements in Section 27 of this Chapter.

(g) Maintain standards for non-CARF providers pursuant to Section 24 of this Chapter.

(h) Meet the standards and requirements of Chapter 41, Chapter 42, and Chapter 43.
Section 19. Skilled Nursing Services. A provider of skilled nursing services shall:

(a) Have a current license to practice nursing by the Wyoming State Board of Nursing.

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(b) Maintain current CPR certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete training pursuant to Section 26 of this Chapter.

(e) Comply with the documentation requirements in Section 27 of this Chapter.

(i) A billable skilled nursing service unit is considered to be a service that is provided up to 15 minutes and that involves direct patient care; the provider shall not seek reimbursement for transportation, time spent charting, time spent in waiting room with participant, or time spent completing paperwork.

(f) Meet the standards and requirements of Chapter 41, Chapter 42, and Chapter 43.

Section 20. Special Family Habilitation Home Services. A provider of special family habilitation home services shall:

(a) Be 21 years of age or older.

(b) Maintain current CPR/First Aid Certification.

(c) Maintain current CPR/First aid certification for all individuals 18 years of age or older living in the home who shall have, at any time, unsupervised access to the participant.

(d) Complete a background check pursuant to Section 25 of this Chapter.

(e) Complete a background check pursuant to Section 25 of this Chapter for individuals 18 years of age or older living in the home.

(f) Complete training pursuant to Section 26 of this Chapter.

(g) Comply with the documentation requirements in Section 27 of this Chapter.

(h) Maintain standards for non-CARF providers pursuant to Section 24 of this Chapter.

(i) Meet the standards and requirements for Chapter 42.
Section 21. Specialized Equipment Services. A provider of specialized equipment services shall:

(a) Be 18 years of age or older.

(b) Provide specialized equipment services pursuant to Chapter 44.

45 - 18 Effective 12/29/06
Section 22. Speech, Hearing and Language Services. A provider of speech hearing and language services shall:

(a) Have a current license to practice speech hearing and language services by the Wyoming Board of Speech Therapy.

(b) Maintain current CPR/First Aid Certification.

(c) Complete a background check pursuant to Section 25 of this Chapter.

(d) Complete training pursuant to Section 26 of this Chapter.

(e) Comply with the documentation requirements in Section 27 of this Chapter.

(f) Meet the standards and requirements for Chapter 41 and Chapter 43.

Section 23. Standards for CARF Accredited Organizations.

(a) Providers providing residential habilitation or day habilitation services to three or more participants, regardless of the funding stream, shall obtain CARF accreditation within 24 months of the date that they begin to provide services to the third participant.

(b) Providers shall maintain CARF accreditation as long as they are providing residential habilitation or day habilitation services to three or more participants in any one service.

(i) The Division shall suspend the certification of providers who fail to obtain or maintain CARF accreditation pending the outcome of the provider’s appeal to CARF, if applicable.

(A) Within 30 days of the suspension, the provider shall submit a transition plan to the Division that details the transition of each participant to other providers and service settings.

(B) The plan shall be approved by the Division prior to implementation of the plan.

(C) If the CARF appeal process confirms the original survey results and CARF does not accredit the provider, the transition plans shall be implemented and participants shall move to different providers within 90 days of the date the Division receives confirmation from CARF that the provider is not accredited.
(D) The provider’s decertification date shall be 90 days from the written notice from CARF that the provider has not been accredited.

45 - 19 Effective 12/29/06
(E) If a provider fails to obtain or maintain CARF accreditation, the Division shall complete an immediate site survey.

(c) In addition to obtaining and maintaining CARF accreditation, providers certified to provide employment services, including prevocational services and supported employment services, shall assure that:

(i) Participants are involved in making informed employment related decisions.

(ii) Participants are linked to services and community resources that enable them to achieve their employment objectives.

(iii) Participants are given information on local job opportunities, and

(iv) Participants’ satisfaction with employment services is assessed on a regular basis.

(d) In addition to obtaining and maintaining CARF accreditation, providers shall meet the following standards for homes or facilities that they own or lease:

(i) Providers shall provide nutritious meals and snacks.

(ii) Food, whether raw or prepared, if removed from the container or package in which it was originally packaged, shall be stored in clean, covered, labeled, and dated containers.

(iii) All foods shall be served and displayed in a clean and sanitary manner.

(iv) Homes or facilities shall have smoke detectors installed on every level of the home and shall be tested quarterly to assure they are functional; the provider shall maintain documentation of the testing.

(v) Homes or facilities shall have an appropriate fire extinguisher on each level which is accessible and visible.

(A) Fire extinguishers shall be properly charged and recharged after use or replaced per manufacturer’s instruction.
(vi) Homes or facilities shall be equipped with carbon monoxide detectors if there are any natural gas appliances.

(vii) Homes or facilities shall have appropriate egress on all levels.

(viii) Floors and floor coverings shall be maintained in good repair and shall not be visibly soiled or malodorous.

45 - 20 Effective 12/29/06
(ix) The walls, wall coverings, and ceilings shall be maintained in good repair and shall not be visibly soiled.

(x) All doors, windows, and other exits to the outside shall be effectively protected against the entrance of insects and rodents and shall be maintained in good repair.

(xi) All windows shall have no cracks or breaks.

(xii) All restrooms shall be provided with trash receptacles, towels, hand cleansers, and toilet tissue at all times.

(xiii) Toilet facilities shall be kept clean and sanitary and maintained in good repair.

(xiv) The overall condition of the home or facility shall be maintained in a clean, uncluttered, sanitary, and healthful manner that does not impede mobility or jeopardize a participant’s health or safety.

(xv) Providers with private water supplies shall have a bacterial test every three years. If participants under one year of age are in the home, the water supply shall be tested for nitrates every three years.

(xvi) There shall be no more than two people to a bedroom.

(xvii) Children over two years of age shall not sleep in the same room as adults unless noted in the plan of care that this is medically necessary.

(xviii) Unrelated people shall each have an individual bed.

(xix) Unrelated people of the opposite sex over four years of age shall not reside in the same bedroom.

(xx) Participants shall have a sleeping area that allows for privacy, appropriate egress, and a secure place for personal belongings.

(e) External inspections shall be required on all new locations before the services are provided in the new location.
(i) The provider shall notify the Division of the new location at least 30 calendar days before the location is to be used to provide services.

(ii) The provider shall not provide services in the new location until the Division has reviewed the external inspection report and has verified that all recommendations have been addressed. The Division shall complete an on-site visit of the new location within 6 months.

(f) Providers shall be responsible for assuring that subcontractors meet all applicable requirements and standards for the services they are providing.

45 - 21 Effective 12/29/06
(i) Failure of providers to assure that subcontractors meet all applicable requirements and standards may result in revocation of their certification pursuant to Section 36 and Section 37 of this Chapter.

(g) All providers shall identify, in writing, potential conflicts of interest and shall share this information with participants before the provider is chosen to provide services.

(i) If a provider permits the hiring of guardians of participants receiving services from the provider, or if a provider permits the hiring of relatives of staff working for the organization, the provider shall have a written policy on how it addresses potential conflicts that arise from these relationships and shall share this policy with participants.

(ii) The written policy shall include a description of how the provider shall assure that guardians are not providing or overseeing services to their wards as part of their employment with the provider.

(h) In addition to obtaining and maintaining CARF accreditation, providers providing day habilitation or residential habilitation services to three or more participants shall also meet or follow the following standards:

(i) Section 25 – Background check requirements

(ii) Section 26 – Training requirements

(iii) Section 27 – Documentation Standards

(iv) Section 28 – Restraint Standards

(v) Section 29 – Positive Behavior Support Plan Standards

(vi) Section 30 – Division’s Notification of Incident Process

(vii) Section 31 – Complaint Process

(viii) Section 32 – Transition Process

(ix) Section 33 – Funds of Participants
(x) Section 34 – Mortality Review Committee

(xi) Section 36 – Recertification of Providers

(xii) Section 37 – Sanctions

Section 24. Standards for Non-CARF Accredited Providers. The following requirements are for providers who are not required to obtain and maintain CARF accreditation as specified in Section 23 of this Chapter, including providers who are certified by the Division to provide habilitation services, respite services, and personal

45 - 22 Effective 12/29/06
care services, and providers certified to provide any services in a home or facility they own or lease.

(a) Emergency plans.

(i) Providers shall have written emergency plans and procedures for:

(A) Fires.

(B) Bomb threats.

(C) Natural disasters, including but not limited to earthquakes, blizzards, floods, tornadoes, fires.

(D) Power failures.

(E) Medical/behavioral emergencies/missing person.

(F) Safety during violent or other threatening situations.

(G) Vehicle emergency; and

(H) How the provider is able to care for or provide supervision to both participants and any children under the age of 12 or other individuals requiring support and supervision.

(I) Providers shall notify the Division in writing within 7 calendar days if additional individuals move into the home or have the intent of staying in the home for a period longer than one month pursuant to (H) in this section.

(ii) The emergency plans shall include a contingency plan that assures that there is a continuation of essential services when emergencies occur.

(iii) If the provider is providing 24 hour services, the provider shall document testing of all applicable emergency plans at least once a year on each shift. The documentation shall include:

(A) Written identification of concerns noted during testing of plans.
(B) Written documentation of follow-up to concerns noted during the testing of plans.

(C) Testing shall not necessarily require actual evacuation, but one actual evacuation shall be required once a year.

(iv) If provider is not providing 24 hour services, the provider shall document testing of all applicable emergency plans during normal working hours at least once a year on each shift. The documentation shall include:

45 - 23 Effective 12/29/06
(A) Written identification of concerns noted during testing of plans.

(B) Written documentation of follow-up to concerns noted during the testing of plans.

(C) Testing does not necessarily require actual evacuation, but one actual evacuation shall be required at least once a year.

(v) If a provider has signed a form designated by the Division stating that the provider shall not be providing services in a home or facility owned or leased by the provider, the provider shall develop emergency plans and procedures that are applicable to the service they are providing and the settings in which the services are provided.

(A) Provider shall document testing of all applicable emergency plans during normal working hours at least once a year. The documentation shall include:

   (I) Written verification of concerns noted during testing of plans.

   (II) Written documentation of follow-up on concerns noted during the testing of plans.

   (III) Testing does not necessarily require actual evacuation, but one actual evacuation shall be required at least once a year.

(b) External inspections.

   (i) Providers shall have an external inspection of the home or facility where services are provided every three years.

   (ii) Providers shall notify the Division if they have attempted to schedule an external inspection with three of the entities listed in (iii) of this section who have refused to complete the inspections.

   (iii) The external inspections shall be completed by the local fire department, fire marshal, OSHA inspector, insurance company, licensing authorities, industrial health specialist, health department official, safety engineer, home inspector, or other appropriate authority.

   (iv) The external inspection shall include verification that:
(A) All areas are free of fire and safety hazards, including but not limited to the garage, attic, basement areas.

45 - 24 Effective 12/29/06
(B) Home or facility is free of any other significant health or safety concerns, including structural concerns, wiring problems, plumbing problems.

(v) The external inspection shall include a written report that includes recommendations to address areas of deficiencies.

(vi) The provider shall complete follow-up on the recommendations and document how deficiencies from the external inspection have been adequately addressed.

(vii) External inspections shall be required on all new locations before the services are provided in the new location.

(A) The provider shall notify the Division of the new location at least 30 calendar days before location is to be used to provide services.

(B) The provider shall not provide services in the new location until the Division has reviewed the external inspection report and has verified that all recommendations have been addressed. The Division shall complete an on-site visit of the new location within 6 months.

(viii) External inspections shall be required when additions or significant remodeling has occurred in the home.

(ix) Providers who choose not to provide services in a home or facility they own or lease shall sign a form designated by the Division verifying that they are not providing services in these locations. The provider shall not be required to obtain external inspections.

(A) If a provider is subsequently found to be providing services in a facility owned or leased by the provider, the provider shall be subject to immediate decertification pursuant to Section 36 and Section 37 of this Chapter.

(c) Self-Inspections. Providers providing services in a home or facility they own or lease shall annually complete an internal inspection of the home or facility where services are provided.

(i) The self inspection shall include verification that:

(A) There is a fire insurance carrier on the property.
(B) Address is visible from the street.

(C) All dangerous chemicals, poisons, cleaning supplies, and medications are in a locked cabinet and/or out of reach of participants if they pose a health or safety risk.

(D) The chimney or vent pipe has been inspected/cleaned within the past year if appropriate for coal, wood, pellet burning appliances.

45 - 25 Effective 12/29/06
(E) Heating appliances and filters are clean.

(F) Smoke detectors are installed on every level of the home or facility and there is written documentation that they have been checked once a quarter to assure they are functional.

(G) Home or facility has appropriate fire extinguisher on each level which is accessible and visible.

(H) Fire extinguisher is properly charged and is recharged after use, or replaced per manufacturer’s instructions.

(I) Home or facility is equipped with carbon monoxide detectors if there are any natural gas appliances.

(J) Home or facility shall have appropriate egress on all levels.

(K) Home or facility has a written fire escape plan.

(L) Emergency numbers and address/directions to home or facility are posted by phone.

(M) The yard is secure from environmental hazards.

(N) The home or facility has appropriate egress in basement and upper levels.

(O) All areas are free of fire and safety hazards, including but not limited to the garage, attic, basement areas.

(P) Home or facility is free of any other significant health or safety concerns, including structural concerns, wiring problems, plumbing problems.

(Q) Vehicles are maintained in good repair if provider is transporting participants.
(ii) The self-inspection shall include a written report that includes recommendations to address areas of deficiencies.

(iii) The provider shall complete follow-up on the recommendations and document how deficiencies from the internal inspection have been adequately addressed.

(iv) Providers who choose not to provide services in a home or facility they own or lease shall sign a form designated by the Division verifying that they are not providing services in these locations. The provider shall not be required to complete internal inspections.

45 - 26 Effective 12/29/06
(d) Written policies on smoking, pets, and weapons. Providers shall complete written policies to address health, safety, and rights when:

(i) Any occupants or visitors of the home smoke, a policy on smoking that assures protection of health of participant.

(ii) Any occupants or visitors have pets, a plan to protect participant, including verification that the pets are current with vaccinations.

(iii) Any occupants or visitors have weapons in the home, a policy on weapons that shall include the requirements that weapons are stored in a locked cabinet and/or in an inaccessible location and that, for firearms, ammunition is stored in a separate location from the firearm.

(iv) Providers shall share policies with participants before the participant formally chooses the provider.

(e) Other standards.

(i) Providers shall provide nutritious meals and snacks.

(ii) Food, whether raw or prepared, if removed from the container or package in which it was originally packaged, shall be stored in clean, covered, dated, and labeled container.

(iii) All foods shall be served and displayed in a clean and sanitary manner.

(iv) Floors and floor coverings shall be maintained in good repair and shall not be visibly soiled or malodorous.

(v) The walls, wall coverings, and ceilings shall be maintained in good repair and should not be visibly soiled.

(vi) All doors, windows, and other exits to the outside shall be effectively protected against the entrance of insects and rodents and shall be maintained in good repair.

(vii) All windows shall be free of cracks or breaks.
(viii) All restrooms shall be provided with trash receptacles, towels, hand cleansers, and toilet tissue at all times.

(ix) Toilet facilities shall be kept clean and sanitary and maintained in good repair.

(x) The overall condition of the home or facility shall be maintained in a clean, uncluttered, sanitary, and healthful manner that does not impede mobility or jeopardize a participant's health or safety.

45 - 27 Effective 12/29/06
(xi) Providers with private water supplies shall have a bacterial test every three years. If infants under one year of age are in the home, the water supply shall be tested for nitrates every three years.

(xii) There shall be no more than two people to a bedroom.

(xiii) Children over two years of age shall not sleep in the same room as adult providers unless noted in the plan of care that this is medically necessary.

(xiv) Unrelated people shall each have an individual bed.

(xv) Unrelated people of the opposite sex over four years of age shall not reside in the same bedroom.

(xvi) Participants shall have a sleeping area that allows for privacy, appropriate egress, and a secure place for personal belongings.

(xvii) Providers who subcontract for services shall be responsible for assuring that the subcontractors meet all applicable requirements and standards for the services they are providing.

(A) Failure of providers who subcontract to assure that subcontractors meet all applicable requirements and standards may result in revocation of their certification pursuant to Section 36 and Section 37 of this Chapter.

(xviii) All providers shall identify, in writing, potential conflicts of interest and share this information with potential clients before they are chosen to provide services.

(A) If a provider permits the hiring of guardians of participants receiving services from the provider, or if a provider permits the hiring of relatives of staff working for the organization, the provider shall have a written policy on how it addresses potential conflicts that arise from these relationships and share this policy with participants.

(I) The written policy shall include a description of how the provider shall assure that guardians are not providing or overseeing services to their wards as part of their employment with the provider.

(xix) All providers transporting participants shall comply with all applicable federal, state, county, and city requirements, including but not limited to assuring that all drivers are appropriately licensed to drive the vehicle and current car insurance is maintained, and shall assure that:
(A) Vehicles are maintained in good repair.

(B) Current emergency information on each participant is maintained in the vehicle.

45 - 28 Effective 12/29/06
(C) First aid supplies are maintained in the vehicle, and

(D) Documentation of self-inspections of vehicles is completed pursuant to (c) of this Section.

(xx) Non-CARF providers certified to provide employment services, including prevocational services and supported employment services, shall assure that:

(A) Participants are involved in making informed employment related decisions.

(B) Participants are linked to services and community resources that enable them to achieve their employment objectives.

(C) Participants are given information on local job opportunities, and

(D) Participants’ satisfaction with employment services is assessed on a regular basis.

(xxi) Non-CARF providers shall meet the following standards for all services they are certified to provide by the Division:

(A) Section 24 – Standards for non-CARF accredited providers.

(B) Section 25 – Background check requirements

(C) Section 26 – Training requirements

(D) Section 27 – Documentation Standards

(E) Section 28 – Restraint Standards

(F) Section 29 – Positive Behavior Support Plan Standards

(G) Section 30 – Division’s Notification of Incident Process
(H) Section 31 – Complaint Process

(I) Section 32 – Transition Process

(J) Section 33 – Funds of Participants

(K) Section 34 – Mortality Review Committee

(L) Section 36 – Recertification of Providers

45 - 29 Effective 12/29/06
(M) Section 37 – Sanctions

Section 25. Background Check Requirements.

(a) All self-employed providers and employees of providers who provide services to participants pursuant to Sections 7 through 22 of this Chapter shall successfully complete a Federal Bureau of Investigation (FBI) fingerprint background check and State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check.

(i) A successful background check shall verify the person has not been convicted of an Offense Against the Person including:

(A) Homicide (W.S. § 6-2-101 et seq.)

(B) Kidnapping (W.S. § 6-2-201 et seq.)

(C) Sexual assault (W.S. § 6-2-301 et seq.)

(D) Robbery and blackmail (W.S. § 6-2-401 et seq.), and

(E) Assault and battery (W.S. § 6-2-501 et seq.), or

(F) Similar laws of any other state or the United States relating to these crimes.

(ii) A successful background check shall verify the person has not been convicted of an Offense Against Morals, Decency and Family including:

(A) Bigamy (W.S. § 6-4-401)

(B) Incest (W.S. § 6-4-402)

(C) Abandoning or endangering children (W.S. § 6-4-403)

(D) Violation of order of protection (W.S. § 6-4-404), and

(E) Endangering children; controlled substances (W.S. § 6-4-405), or
(F) Similar laws of any other state or the United States relating to these

(b) All self-employed providers and employees of providers providing services to
participants pursuant to Sections 7 through 22 of this Chapter shall complete a Wyoming
Department of Family Services (DFS) Central Registry Screening (W.S. § 7-19-201). The
screening shall verify that the person does not appear on a substantiated Wyoming Department
of Family Services Central Registry.

45 - 30 Effective 12/29/06
(c) All respite and personal care providers shall successfully complete a Wyoming Department of Family Services Central Registry Screening pursuant to (b) of this Section for each individual 18 years of age or older who is living in the home or staying in the home for a period longer than one month unless the provider has signed a form designated by the Division stating that services shall not be provided in a home or facility owned or leased by the provider.

(i) Individuals 18 years of age or older living with respite or personal care providers who have signed a form designated by the Division stating that services shall not be provided in a home or facility owned or leased by the provider, shall successfully complete a Wyoming Department of Family Services Central Registry Screening pursuant to (b) of this Section if those individuals are taking part in activities with the provider and participant while services are being delivered.

(A) If the Wyoming Department of Family Services Central Registry Screening results indicate further background checks should be sought, that individual shall also obtain a Federal Bureau of Investigation (FBI) fingerprint background check and State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check at the provider’s expense. These checks shall show that the individual meets the requirements pursuant to (a) of this Section.

(B) Providers shall notify the Division in writing within 7 calendar days if someone 18 years of age or older moves into the home or has the intent of staying in the home for a period longer than one month pursuant to (c) of this Section.

(d) All habilitation providers shall successfully complete a background check pursuant to (a) of this section and a Wyoming Department of Family Services Central Registry Screening pursuant to (b) of this section for each individual living in the home or staying in the home for a period longer than one month who are 18 years of age or older unless they have signed a form designated by the Division stating that services shall not be provided in a home or facility owned or leased by the provider.

(i) Individuals 18 years of age or older living with habilitation providers who have signed a form designated by the Division stating that services shall not be provided in a home or facility owned or leased by the provider, shall successfully complete a Wyoming Department of Family Services Central Registry Screening pursuant to (b) of this Section if those individuals are taking part in activities with the provider and participant while services are being delivered.

(A) If the Wyoming Department of Family Services Central Registry Screening results indicate further background checks should be sought, that individual shall also obtain an Federal Bureau of Investigation (FBI) fingerprint background check and State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check at the provider’s expense. These checks shall show that the individual meets the requirements pursuant to (a) of this Section.
(B) Providers shall notify the Division in writing within 7 calendar days if someone 18 years of age or older moves into the home or has the intent of staying in the home for a period longer than one month pursuant to (d) of this Section.

45 - 31 Effective 12/29/06
(e) For self-employed providers or employees of a provider, if a Federal Bureau of Investigation (FBI) fingerprint background check or State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check report does not include a disposition of a charge or if the Division receives notification that charges have been filed, the self-employed provider or employee of a provider shall not have any unsupervised access or provide billable services to participants until a successful background check is obtained pursuant to (a) of this Section at the provider’s expense.

(i) The self-employed provider or provider organization shall submit a successful background check within 90 days of written notification from the Division. Failure to submit a successful background check within the 90 day period shall result in:

(A) The self-employed provider’s certification being revoked pursuant to Section 36 and Section 37 of this Chapter; or the employee of the provider being terminated as direct support staff.

(I) If the self-employed provider’s certification is revoked, he or she may reapply to become a provider when a successful background check can be obtained.

(II) If an employee of a provider is terminated as direct support staff, he or she can be rehired as direct support staff for a provider when a successful background check can be obtained.

(ii) All providers shall notify the Division in writing if it comes to their attention that a self-employed provider or an employee of a provider has been convicted of any offense listed in (a) of this Section or has been charged with any offense listed in (a) of this Section.

(f) For self-employed providers or employees of providers, if the Division receives notification that a provider or employee of a provider appears on a substantiated Wyoming Department of Family Services Central Registry, the self-employed provider or employee of provider shall not have any unsupervised access or provide billable services to participants until the results of a Wyoming Department of Family Services (DFS) Central Registry Screening verify that the person does not appear on a substantiated Wyoming Department of Family Services Central Registry.

(i) The self-employed provider or provider organization shall submit a screening within 90 days of written notification from the Division pursuant to (b) of this Section. Failure to submit a successful screening within the 90 day period shall result in:

(A) The self-employed provider’s certification being revoked pursuant to Section 36 and Section 37 of this Chapter; or the employee of the provider being terminated as direct support staff.
(l) If the self-employed provider's certification is revoked, he or she may reapply to become a provider when a successful screening can be obtained.

45 - 32 Effective 12/29/06
(II) If an employee of a provider is terminated as direct support staff, he or she can be rehired as direct support staff for a provider when a successful screening can be obtained.

(B) All providers shall notify the Division in writing if it comes to their attention that a self-employed provider or an employee of a provider has been placed on the Department of Family Services Central Registry.

(g) The Division shall immediately deny the certification of an applicant if the applicant's Federal Bureau of Investigation (FBI) fingerprint background check or State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check does not include a disposition of a charge or if, during the application process, the applicant is charged with any offense listed in (a) of this section.

(i) The applicant may reapply to become a provider when a successful background check can be obtained.

(h) Volunteers and individuals under the age of 18 shall be under the direct supervision of an adult who has had a successful Federal Bureau of Investigation (FBI) fingerprint background check, State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check, and DFS Central Registry Screening.

(i) Organizations employing one or more people shall submit a Federal Bureau of Investigation (FBI) fingerprint background check, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check, and a Department of Family Services Central Registry Screening for the employee before the employee begins employment and/or simultaneously starting employment. The employee shall be under direct supervision of another employee who has a successfully completed background check pursuant to (a) of this Section until:

(i) The results of the Wyoming Department of Family Services Central Registry screening are received verifying that the person does not appear on a substantiated Wyoming Department of Family Services Central Registry, or

(ii) A successfully completed background check is received if the results of the Wyoming Department of Family Services Central Registry screening have determined that a complete criminal history background check shall be obtained.

(j) The Division shall not transfer background checks from one provider entity to another.
(k) The Division may request a Federal Bureau of Investigation (FBI) background check, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check, and/or a Department of Family Services Central Registry Screening at the Division's expense with probable cause or as part of an investigation.

(l) A self-employed provider or employee of a provider who does one or more of the following, shall be suspended immediately until resolution of the charges:

45 - 33 Effective 12/29/06
(i) Is charged with any offense listed in (a) of this section.

(ii) Appears on a substantiated Wyoming DFS Central Registry.

(iii) Is charged with a violation of the Wyoming Controlled Substance Act including driving under the influence, driving while intoxicated, or contributing to the delinquency of a minor, that allegedly occurs while they were providing services to participants, or

(iv) Is charged with any offense that is directly related to the well-being of a participant.

(m) The self-employed provider or employee of a provider shall not have any unsupervised access or provide billable services to participants until a successful background check, obtained at the provider’s expense, has been obtained pursuant to (a) of this Section and/or a Wyoming DFS Central Registry verifies that the person does not appear on a substantiated Wyoming Department of Family Services Central Registry pursuant to (b) of this Section. If a self-employed provider or an employee of a provider organization fails to obtain a successful background check pursuant to (a) and (b) of this Section within sixty (60) days of the suspension:

(i) The self-employed provider’s certification shall be revoked pursuant to Section 36 and Section 37 of this Chapter, or the employee of the provider shall be terminated as direct support staff.

(A) If the self-employed provider’s certification is revoked, he or she may reapply to become a provider when a successful background check has been obtained pursuant to (a) of this Section and a Wyoming Department of Family Services (DFS) Central Registry verifies that the person does not appear on a substantiated Wyoming Department of Family Services Central Registry pursuant to (b) of this Section.

(B) If an employee of a provider is terminated as direct support staff, he or she can be rehired as direct support staff for a provider when a successful background check has been obtained pursuant to (a) of this Section and a Wyoming Department of Family Services (DFS) Central Registry verifies that the person does not appear on a substantiated Wyoming Department of Family Services Central Registry pursuant to (b) of this Section.

(n) A provider or an employee of the provider organization may be given an extension of the sixty (60) days deadline in pursuant to (m) of this Section if good cause can be shown for an extension. This extension is not mandatory and is at the discretion of the Department.

Section 26. Provider and Provider Staff Training Requirements.

(a) General training.

45 - 34 Effective 12/29/06
(i) The following general training modules shall be provided by the Division and shall be completed by providers and provider staff within one month of their hire or certification date. Providers may choose to develop their own training modules as long as the modules cover the key elements covered in the Division’s training modules for each topic.

(A) Training on rights of participants and rights restrictions shall be required of all providers and provider staff except providers certified to complete environmental modification services, specialized equipment, and homemaker services.

(B) Recognizing and reporting abuse, neglect, and exploitation shall be required of all providers and provider staff.

(C) Division’s Notification of Incident process shall be required of all providers and provider staff.

(D) Billing and documentation shall be required of all providers and provider staff responsible for documenting and/or billing services.

(E) Releases of information/confidentiality shall be required of all providers and provider staff providing services.

(F) Grievance/complaint procedure shall be required of all providers and provider staff.

(G) Recertification process shall be required by at least one representative from each provider.

(H) Objectives, including monthly documentation on progress on objectives, shall be required of all providers and provider staff who are responsible for writing objectives.

(I) Implementing objectives shall be required of all providers and provider staff who are responsible for implementing objectives.

(ii) Training for newly hired/certified individually-selected service coordinators shall be completed within 90 days of the provider’s certification date or the provider staff’s hire date, and shall include:

(A) How to write an individual plan of care.
(B) How to do modifications to the individual plan of care.

(C) Individually-selected service coordinator rules & regulations.

(iii) All providers shall complete mandatory general training as determined by the Division when updates or new training topics occur. This training shall be made available through compressed video and viewing training tapes.

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(iv) The Division may require additional mandatory general training or participant specific training if concerns are found with a provider’s provision of services.

(b) Participant specific training.

(i) All providers providing habilitation, respite, cognitive retraining, and personal care services and all individually-selected service coordinators who have not written the plan of care for the person they are providing case management services to shall receive training on the specific needs of the participant before working with that person.

(ii) Participant specific training categories include:

(A) General overview of individual plan of care for participant.

(B) Mealtime plans or guidelines.

(C) Positioning needs, including skin integrity needs.

(D) Use and maintenance of adaptive equipment.

(E) Behavioral needs, including training on behavior plan if applicable.

(F) Rights and rights restrictions specific to the participant.

(G) Medications, including side effects.

(H) Seizures.

(I) Habilitation training.

(J) Supervision levels.

(K) Changes to the individual plan of care.

(c) Documentation of participant specific training and general training.
(i) All training must be documented and include:

(A) The date of the training.

(B) The name, signature, and title of the trainer.

(C) The name and signature of the person receiving the training.

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(D) An agenda of the training topic, including the type of training (hands-on, review of individual plan of care, shadowing etc.).

(ii) Provider/staff training records shall be maintained in an appropriate location and made available upon request to the Division and other monitoring agencies.

Section 27. Documentation Standards. All providers certified by the Division to provide services on Medicaid Home and Community Based Services Waiver shall:

(a) Adhere to the documentation standards in Chapter 3 of the Wyoming Medicaid rules and the standards set forth in this Chapter.

(b) Include the following when documenting services on each page of documentation:

(i) Name of participant on each page of documentation.

(ii) Individual plan of care date for participant.

(iii) Location of services.

(iv) Date of service, including year, month, and day.

(v) Name of service provided on each page of documentation.

(vi) Time services begin and time services end consistently using either AM and PM or military time.

(vii) Document time services begin and time services end for each calendar day, even when services are provided over a period of longer than a calendar day.

(viii) Signature of person performing service.

(A) If initials are used a full signature shall be on each page of documentation.

(ix) Detailed description of services provided.
(A) These descriptions may be done on a schedule, task analysis, therapy notes, or the individually-selected service coordinator monthly form.

(c) Document each service on separate forms or schedules.

(d) Bill for only one service for a specific period of time except:

(i) When the participant’s approved individual plan of care identifies the need for more than one service to be provided at the same time.

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(ii) When providers’ reimbursement is a daily rate or monthly rate, other services may be billed on the same day as the service with the daily rate or monthly rate, but documentation of services must include a beginning time for services and an ending time for services.

(e) Provide direct services to participants, except homemaker services, environmental modification services, and specialized equipment services.

(f) Not round up total service time to the next unit except for skilled nursing services.

(g) Assure that the documentation of services is legible.

(h) Assure that services being provided meet the definition of the service and are provided pursuant to the participant’s individual plan of care.

(i) Submit service documentation and billing information for each month to the individually-selected service coordinator by the 10th business day of the following month.

(j) Failure to adhere to the documentation standards set forth in this Section shall result in recovery of funds pursuant to Chapter 3, Chapter 16, or Chapter 39 of the Wyoming Medicaid rules.

(k) Failure to adhere to the documentation standards set forth in this Section, including the submission of claims for services that have not been delivered, may result in a referral to the Medicaid Fraud Control Unit for potentially fraudulent activity pursuant to Chapter 16.

Section 28. Restraint Standards.

(a) Providers providing direct services to participants shall have a policy that identifies whether or not:

(i) The provider shall use emergency intervention procedures in response to assault, physical aggression, or self-injury.

(ii) Restraint, including physical restraint, mechanical restraint, and chemical restraint, is used within the programs it provides.
(b) In the event that a physical hold is used only as a time-limited emergency measure until the appropriate law enforcement, safety, or other emergency service providers arrive on site, the provider shall implement policies and procedures that:

   (i) Identify the emergency circumstances under which a physical hold will be used.

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(ii) Provide staff training on de-escalation and safe physical management.

(iii) Direct that the emergency intervention procedure is restricted to time-limited, approved physical holds by designated, trained, and competent personnel.

(iv) Identify the process by which law enforcement, safety, or other emergency service providers will be summoned when necessary.

(c) If a provider uses restraint, including physical restraint, chemical restraint, or mechanical restraint, they shall have policies and procedures governing its use that specify that:

(i) Restraint is used only for intervention in an individual’s emergency situation and to prevent harm to him/herself or others.

(ii) Appropriate interaction with staff occurs as an effort to de-escalate the crisis.

(iii) The use of restraint is ordered by a physician or designated, trained, and competent qualified behavioral health practitioner.

(iv) Restraint is administered by personnel who are trained and competent in the proper techniques of applying and monitoring the form of restraint ordered.

(d) Removal from restraint, including physical restraint, mechanical restraint, and chemical restraint shall occur as soon as the threat of harm has been safety minimized.

(e) Restraint, including physical restraint, mechanical restraint, and chemical restraint shall not be used as coercion, discipline, convenience, or retaliation by personnel.

(f) The provider shall document that the participant has been consulted regarding alternatives he or she prefers prior to the development of the behavior support plan that includes the use of restraint, when possible.

(g) The procedures for the use of restraint, including physical restraint, mechanical restraint, and chemical restraint shall adhere to the following:

(i) Documentation demonstrates that less restrictive intervention techniques were used prior to the use of restraint.
(ii) Designated staff provides face-to-face evaluation of the participant within one hour of the use of restraint.

(iii) Appropriately trained personnel continually assess, monitor, and re-evaluate the participant to determine if restraint is still needed.

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(iv) The guardian and provider shall establish written guidelines for when the guardian is notified when the use of restraint occurs.

(h) The use of restraint, including physical restraint, mechanical restraint, and chemical restraint shall always:

(i) Be documented as an incident following the provider’s internal incident reporting policy.

(ii) Be reported to the Division when an injury results from the use of restraints pursuant to Section 30 of this Chapter.

(iii) Result in a review and, as appropriate, revision of the treatment plan or program model for the participant.

(i) Following the use of the restraint, the participant, the guardian when appropriate, and staff shall discuss the reasons for the use of restraint. The discussion shall be documented and address:

(i) The incident.

(ii) Its antecedents.

(iii) The reasons for the use of restraint.

(iv) The person’s reaction to the intervention.

(v) Actions that could make future use of restraint unnecessary.

(vi) When applicable, modifications are made to the treatment plan to address issues or behaviors that impact the need to use restraint.

(j) The chief executive or designated management staff member shall review and sign off on all uses of restraint after every occurrence. The review shall include:

(i) Verification that the provider’s policies and procedures regarding restraints were followed.
(ii) Verification that the behavior support plan for the participant was followed.

(iii) Determination if modifications to the treatment plan are needed.

(iv) Determination if staff involved in the restraint had received appropriate training and utilized this training appropriately when using a restraint.

(v) Verification that recommendations identified during the review of the restraint usage are appropriate and are being implemented.

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(vi) The chief executive or designated management staff member shall document the results of this review.

(k) The use of restraint shall be recorded in the provider’s information system and reviewed for:

(i) Analysis of patterns of use.

(ii) History of use by personnel.

(iii) Environmental contributing factors.

(iv) Assessment of program design contributing factors.

(l) If the frequency of use of restraint, including physical restraint, mechanical restraint, and chemical restraint changes, the chief executive or a designee shall investigate the pattern of use and take action to continuously reduce or eliminate the use of restraint.

(m) All personnel involved in the direct administration of restraint shall receive initial and annual competency-based training in the following:

(i) The contributing factors or causes of threatening behavior.

(ii) The use of alternative interventions, such as mediation, de-escalation, self-protection, and time out, which still permits the participant the freedom to leave the time-out area.

(iii) Recognizing signs of physical distress in the person who is being restrained.

(iv) The re-establishment of communication after a person has been restrained.

(v) The prevention of threatening behaviors.

(vi) When and how to restrain safely.
(vii) Provider and provider staff shall receive training on use of restraint from entities that are certified to conduct such training.

(viii) Providers and provider staff shall adhere to the requirements established by the certifying entity and shall not modify those requirements.


(a) A positive behavior support plan shall:

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(i) Maintain the dignity, respect, and values of the participant.

(ii) Be person centered with the participant involved in the development of the plan on a level appropriate for that person.

(iii) Define the targeted behavior or behaviors; behaviors identified as targeted behaviors shall be those that the participant, with the participant’s team, identifies as behaviors that need to be replaced or reduced.

(iv) Be based on a functional analysis of targeted behaviors that includes:

   (A) Pertinent history of participant.

   (B) Direct observation of and interview with participant, including observation of targeted behaviors and antecedents.

   (C) Identification of replacement behaviors or approaches that assist the participant in getting needs met in an appropriate way.

(v) Describe positive behavioral supports that assist the participant in replacing targeted behaviors with replacement behaviors.

(vi) Provide protocols for staff to recognize emerging targeted behaviors and interventions to implement positive behavioral supports.

(vii) Provide protocols for staff response when targeted behaviors take place; protocols shall focus on positive interventions that are the least restrictive and the most effective.

(viii) Be reviewed at least quarterly to assess the effectiveness of the plan.

(ix) Include specific documentation guidelines for tracking the occurrence of targeted behaviors and the results of positive behavioral interventions. Documentation shall include:

   (A) Dates and times of the occurrence of the targeted behavior.
(B) Description of the antecedents to the targeted behavior.

(C) Description of what helped alleviate the targeted behavior, including the positive interventions used by the provider or provider staff.

(D) Signature of staff implementing the positive behavioral interventions.

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(b) Staff implementing behavior support plans shall receive competency-based training on the plan and on positive behavior supports before they begin working with the participant.

(c) When restrictive measures such as restraint are part of a person’s behavior support plan, providers shall adhere to the standards in Section 28 of this Chapter.

(d) When behavior support plans include rights restrictions.

(i) The plan shall include:

(A) The reasons for the restrictions.

(B) How the restriction is imposed.

(C) How the right shall be restored.

(D) Include information on temporarily lifting the restriction during times of personal crisis, when appropriate.

(ii) Restrictions from community activities shall:

(A) Not exceed 36 hours unless the plan includes information from a psychologist on the health, safety, or therapeutic reasons for a longer restriction.

(B) Include opportunities for the person to reduce the length of time of restriction.

(C) Not include restrictions from employment unless the restrictions are due to health and safety concerns.

Section 30. Notification of Incident Process.

(a) All providers are required to report on the Division’s Notification of Incident Form the following categories of incidents to the Division, the Department of Family Services, Protection & Advocacy Systems, Inc., the individually-selected service coordinator, and the guardian as required by law; providers shall also report the following to law enforcement if a crime may have been committed:
(i) Suspected abuse

(ii) Suspected neglect

(iii) Suspected self-neglect

(iv) Suspected self-abuse

(v) Suspected abandonment

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(vi) Suspected exploitation

(vii) Police involvement

(viii) Injuries caused by restraints, including drugs used as restraints, physical restraints, and mechanical restraints

(ix) Serious injury to the participant

(x) Death

(xi) Elopement

(b) Reports shall be made immediately after assuring the health and safety of the participant and other individuals.

(c) Providers shall have incident reporting policies and procedures that include the requirements of the Division’s Notification of Incident process.

(d) Providers shall comply with requests for additional information from the Division.


(a) CARF Accredited Providers. All CARF accredited providers shall adhere to the current CARF requirements for complaints or grievances.

(i) If, after following the CARF process, a complainant is not satisfied with the resolution of the complaint, a complaint may be filed with the Division.

(ii) When a provider files a complaint with the Division, the complaint shall be submitted in writing unless the complaint involves a participant whose health or safety is in jeopardy.

(A) If a provider believes a participant’s health or safety is in jeopardy, the provider shall immediately contact the Division and, when appropriate, other governmental agencies such as law enforcement and/or the Department of Family Services.
(b) Non-CARF accredited providers. All non-CARF accredited providers shall adhere to the following complaint process:

(i) After receiving a complaint, provider shall attempt to resolve complaint through discussion and mediation between the parties.

(ii) If the complaint has not been resolved through discussion and mediation, the provider shall document the complaint, including action steps the provider

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has taken to resolve the complaint. Upon completion of investigation or follow-up actions on a complaint, the provider shall document the final resolution of the complaint.

(A) This information shall be shared with the complainant and the individually selected service coordinator of the participant in written form, unless doing so would violate confidentiality and HIPAA rules and regulations.

(B) If the complainant is not satisfied with the resolution of the complaint, a complaint may be filed with the Division.

(c) Complaints may be filed with the Division in writing or verbally. When a provider files a complaint, the complaint shall be submitted in writing unless the complaint involves a participant whose health or safety is in jeopardy. Upon receipt of a complaint, the Division shall:

(i) First encourage complainant to work with the provider or party that they have concerns with;

(A) If the complainant refuses, the Division shall treat the concerns as a formal complaint.

(ii) Notify the complainant within 10 calendar days in writing that the complaint has been received. Included in the notification shall be:

(A) Anticipated timeframe for completing complaint investigation.

(B) The authority for taking actions.

(iii) Notify the provider(s) in writing when a complaint has been received involving that provider, unless the complaint involves significant health, safety, or rights concerns which require an unannounced on-site visit. In these cases, the provider shall be provided written documentation hand delivered at the time of the on-site investigation, outlining that a complaint has been received and is being investigated.

(iv) Notify the complainant if the complainant is the participant or guardian, when the complaint has been investigated and has been closed.

(v) Submit a written report to the provider(s) involved in the complaint summarizing the results of complaint investigation. The report shall include findings, corrective actions, timeframes for completion of corrective actions, and applicable standards.
(vi) Providers not completing corrective actions as required in the report may be subject to decertification as stipulated in Section 36 and Section 37 of this Chapter.

Section 32. Transition process.
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(a) Participants and/or guardians have the right to informed choice in providers and services.

(b) Participants and/or guardians can choose to change individually-selected service coordinators pursuant to Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division.

(c) Participants can choose to change any providers, other than individually-selected service coordinators, at any time during the plan year.

(d) When a participant and/or guardian chooses to change providers, they shall inform the participant’s individually-selected service coordinator of the decision. The individually-selected service coordinator shall then complete the following steps:

(i) Notify the Division of the request for change within 5 business days of request.

(A) If the participant and/or guardian is requesting a change of individually-selected service coordinator, the Division shall review choice and provider lists with the participant and/or guardian.

(B) If the participant and/or guardian is requesting a change of providers other than individually-selected service coordinator, the individually-selected service coordinator shall review choice and provider lists with the participant and/or guardian.

(ii) Complete the Transition Checklist as dictated by the Division, and shall:

(A) Gather and share appropriate information as outlined in the checklist.

(B) Schedule individual plan of care team meetings and notify all providers (current and new), participant, guardian, and the Division at least two weeks prior to the meeting.

(I) Individual plan of care meetings may be scheduled sooner than two weeks with Division approval due to an emergency situation.

(C) Complete new individual plan of care (if required) and submit to the Division at least 20 days before the new provider(s) is scheduled to begin to provide services.
(e) All providers shall share pertinent information with the individually-selected service coordinator and the individual plan of care team in a timely manner as outlined in the Transition Checklist.

(f) If a provider providing residential services to a participant requires a participant to move to another residential location, the provider shall:

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(i) Notify the participant, family, and guardian (if applicable) of the move at least 30 days in advance so that the participant can exercise the choice to find a new residence and/or provider if the move is not acceptable.

(ii) Notify the participant's individually-selected service coordinator of the move in advance so the individually-selected service coordinator can review choices with the participant.

(A) The participant’s individually-selected service coordinator shall schedule a team meeting to discuss the move, including discussing other service and living options for the participant, specific health and safety measures that need to be in place if the person agrees with the move, and outlining timeframes for the move.

(B) The participant's individually selected service coordinator shall follow the applicable sections of the Division's Transition Checklist.

(g) Providers who are terminating services with a participant shall notify that participant in writing at least 30 days prior to ending services unless a shorter transition period is approved in advance by the Division. Failure to provide services during this 30 day period shall be considered abandonment of services and may result in decertification of the provider.

Section 33. Funds of Participants.

(a) These standards apply to providers who take responsibility for the funds of participants which may include:

(i) Serving as representative payee.

(ii) Involvement in managing the funds of the participant.

(iii) Receiving benefits on behalf of the participants.

(iv) Temporarily safeguarding funds or personal property for the participants.

(b) The provider shall have written policies that are communicated to participant/guardian/family:

(i) How the participants will give informed consent for the expenditure of funds.

(ii) How the participants will access the records of their funds.
(iii) How funds will be segregated for accounting purposes.

(iv) Safeguards shall be in place to ensure that funds are used for the designated and appropriate purposes.

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(v) If interest is accrued, how interest will be credited to the accounts of participants.

(vi) If services fees are charged for managing funds.

Section 34. Mortality Review Committee.

(a) The Division shall have a Mortality Review Committee that reviews information on deaths of participants receiving waiver services.

(b) Providers shall provide information requested by the Mortality Review Committee, including but not limited to:

(i) Copies of documentation of services.

(ii) Copies of incident reports.

(iii) Copies of any health related records, including assessments, and results of physicians’ office visits and hospital visits.

(c) The Committee may make provider specific recommendations and/or systemic recommendations.

(i) The Division and the Office of Health Care Financing shall have final authority over the implementation of recommendations.

(ii) Provider specific recommendations shall relate to current Medicaid and/or Division rules, policies or provider bulletins.

Section 35. Initial Provider Certification.

(a) To receive initial certification as a provider, an applicant shall submit the following:

(i) A provider application on a form prescribed by the Division.

(ii) Evidence that the applicant meets the qualifications for each service that the applicant is seeking certification to provide pursuant to Sections 7 through 22 of this Chapter.

(iii) Completed Confidentiality Statement.

(iv) Completed Remember/disclosure Form.
(v) Completed Wyoming EqualityCare Provider Enrollment form or its successor, including the Wyoming EqualityCare Provider Agreement.

(vi) Completed EDI form or its successor.

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(vii) Signed statement stating that the applicant has reviewed the current standards and rules for the services the applicant is seeking certification to provide and that the applicant will comply with these standards and rules.

(viii) Applicable written policies and procedures as required within this rule for the services the applicant is seeking certification to provide.

(ix) Copy of valid current driver’s license if applicant is transporting participants.

(x) Evidence of current automobile insurance if applicant is transporting participants.

(xi) Funds for background checks pursuant to Section 25 of this Chapter.

(xii) Completed external inspection pursuant to Section 24 of this Chapter or a completed No Services in My Home Form or its successor.

(xiii) Current CPR/First Aid certification pursuant to Sections 7 through 22 of this Chapter.

(xiv) Verification that the applicant has access to a computer and a current e-mail address.

(b) Applications shall be held by the Division for 45 calendar days after the Division receives the results of the successful background checks pursuant to Section 25 of this Chapter.

(i) If the applicant fails to submit the required forms and information within this 45 calendar day period, the applicant will receive a letter from the Division stating that their application has been denied and the applicant will need to reapply to become a provider.

(c) Once the Division has received all required forms and a successful background check from the applicant, the Division shall provide the applicant with the appropriate provider manual and/or provider information by mail. The applicant shall have 20 calendar days to review the manual and/or information and to contact the Division to schedule a telephone consultation to review the material.
(i) If the applicant does not contact the Division within 20 calendar days, the applicant shall receive a final notification from the Division that the application will be denied unless the applicant schedules a consultation within 10 calendar days.

(ii) For applicants being certified in case management services, habilitation services, respite services, personal care services, and residential habitation training services, in addition to the telephone consultation, the Division shall complete an on-site visit within 6 months of the certification of the applicant.

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(A) If the applicant is not providing services in a home or facility they own or lease, an on-site visit shall not be required.

(d) Upon approval from the Division, the applicant shall become a certified provider and shall be reimbursed for services provided once:

(i) The applicant has been assigned a provider number by the Office of Health Care Financing or its designee, and

(ii) The applicant has been chosen to provide services and appears on a pre-approval form signed by the Division.

(e) The Division shall certify a new provider for a period of up to one year.

(f) Applicants who have previously been certified by the Division as a provider and who are reapplying to become a provider shall not have any open or pending quality improvement plans with the Division.

(i) If there is an open quality improvement plan, then the applicant shall be required to address the deficiencies outlined in the plan to the Division’s satisfaction before the applicant shall be recertified.

(g) Self-employed providers and/or provider organizations previously certified by the Division as a provider who are reapplying to become a provider who have been convicted of Medicaid fraud shall not be certified.

(h) If an applicant fails to disclose any convictions in a court of law on the Division's provider application or organization’s application, this may constitute a bar to certification and/or employment.

(i) Any falsifications of statements, documents, or any concealment of material fact may be subject to criminal prosecution.

Section 36. Recertification of Providers.

(a) The Division shall notify providers in writing that their certification is expiring at least 90 calendar days prior to the certification expiration date. The letter shall detail the requirements the provider must meet to be recertified.
(b) Providers who require an on-site visit shall request recertification from the Division at least 60 calendar days prior to their certification expiration date. Providers who do not require an on-site visit shall submit verification that they have met all applicable requirements to the Division at least 45 calendar days prior to their certification expiration date.

(i) If a provider fails to notify the Division requesting recertification or fails to submit requirements to the Division at least 45 calendar days prior to the certification expiration date, the Division shall notify the provider in writing of the

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expiration of the certification and grant the provider 15 business days to meet the recertification requirements.

(A) If the provider does not meet the recertification requirements within the 15 business days of the date of the letter from the Division, the provider’s certification shall expire and the provider shall need to reapply to the Division to become a certified provider.

(B) Providers shall be notified in writing that their certification has expired by certified letter.

(c) The Division shall review providers’ certification requirements and shall complete a written report, including a statement of recommendations, within 30 calendar days. The Division may:

(i) Approve the certification for a period of up to two years.

(ii) Approve the certification for a period of one year with recommendations that identify deficiencies that affect the health, safety, welfare, rights or habilitation of participants.

(iii) Approve the certification for a period of less than a year with recommendations that identify deficiencies that seriously affect the health, safety, welfare, rights, or habilitation of participants or for providers who have failed to comply with the rules and standards applicable to the services they are providing.

(d) The provider shall submit a quality improvement plan for each recommendation made in the written report.

(i) The quality improvement plan shall include action steps, responsible parties, and dates of completion for each recommendation.

(A) For recommendations that identify deficiencies that relate to health, safety, welfare, or rights of participants, the provider shall submit the quality improvement plan to the Division within 15 business days of date of the report.

(B) For all other recommendations, the provider shall submit the quality improvement plan to the Division within 30 calendar days of receipt of the written report from the Division.
(ii) If the quality improvement plan is not received by the Division within the required timeframe, the Division shall notify the provider in writing that the Division may impose probation, a monitor, or revoke the provider’s certification pursuant to Section 36 and Section 37 of this Chapter unless the Division receives the quality improvement plan.

(e) The Division shall notify the provider in writing within 30 calendar days after receipt of the provider’s quality improvement plan regarding the approval of the plan.

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(i) If the quality improvement plan is not approved, the provider shall receive notification in writing of the reasons for the disapproval and will be required to submit a revised plan within 10 business days of receipt of the written disapproval from the Division.

(ii) If the second quality improvement plan is not approved, the provider shall have 15 calendar days from notification of the disapproval to submit an acceptable plan or the Division may impose probation, a monitor, or revoke the provider’s certification pursuant to Section 36 and Section 37 of this Chapter.

(f) The Division shall complete appropriate follow-up monitoring to assure that the actions identified in the provider’s quality improvement plan have been completed within the specified time frame.

Section 37. Sanctions.

(a) In the event of a chronic failure to provide services, or services that fail to meet the applicable standard of care for the profession involved, or a continuing condition creating serious detriment to the health, safety, or welfare of participants of home and community based services, the Department may impose a civil monetary penalty, impose a monitor, suspend, or revoke the provider’s certification pursuant to W.S. § 42-4-120.

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

(ii) The Division shall have the same authority to place conditions upon a provider, to impose a monitor, to revoke a certification issued under this section, or suspend a provider in the manner described in W.S. § 35-2-905.

(b) When the Division determines that there is sufficient evidence to take one or more of the actions listed in (a) of this Section, the Division shall notify the provider within 5 calendar days of the actions taken.

(c) If the Division obtains evidence of abuse, neglect, or exploitation of a participant by a provider, the Division may remove the person(s) deemed to be at significant risk.

(d) When the Division revokes a provider’s certification, the Division shall notify the provider in writing of the revocation.

(i) The provider shall submit transition plans to the Division detailing the transition of each participant to other settings within 30 calendar days of the notification that the certification is being revoked.
(ii) The plans shall need to be approved by the Division.

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(iii) The transition plans shall be implemented and participants shall move to different providers within 90 calendar days of the date the Division informed the provider of the revocation of certification.

(iv) Providers shall be required to adhere to the transition process requirements in Section 32 of this Chapter.

Section 38. Provider Participation.

(a) Payments only to providers. No person or entity that furnishes covered services to a participant shall receive Medicaid funds unless the person or entity has signed a provider agreement, is enrolled, and is certified by the Division as a provider at the time of service delivery.

(b) Compliance with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules. A provider that wishes to receive Medicaid reimbursement for services furnished to a participant shall meet the provider participation requirements of Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Sections 4 through 6, which are incorporated by this reference.

(c) Compliance with Chapter 45, Provider Certification and Sanctions, of the Wyoming Medicaid Rules. A provider that wishes to provide Waiver services shall also meet the applicable criteria for Division certification set forth in Chapter 45, which is incorporated by this reference.

(d) A caregiver that is not a parent, guardian, or spouse of a participant and who wishes to receive Medicaid reimbursement for furnishing covered services to a participant shall enroll with the Division as a provider, except for personal care services pursuant to Chapter 43.

Section 39. Provider Records.

(a) A provider shall comply with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, Section 7, which is incorporated by this reference.

(b) Individually-selected service coordinators shall maintain copies of documentation from other providers for a twelve month period.

(c) Providers shall provide the individually-selected service coordinator with copies of required documentation at no charge, including but not limited to monthly billing information, documentation of services, information on incident reports, results of medical visits or tests, copies of assessments, and other information needed for the individually-selected service coordinator to develop and monitor the participant’s individual plan of care.

Section 40. Verification of Participant Data. A provider shall comply with Chapter 3, Section 8, which is incorporated by this reference.
Section 41. Medicaid Waiver Allowable Payment. Medicaid payment under this Chapter shall not exceed the provider’s usual and customary charge for like or similar services to non-waiver clients.

Section 42. Third-party Liability.

(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with Chapter 35.

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

Section 43. Submission and Payment of Claims. The submission and payment of claims shall be pursuant to the provisions of Chapter 3.

Section 44. Recovery of Excess Payments or Overpayments.

(a) The Department may recover excess payments pursuant to Chapter 39.

(b) The Department may recover overpayments pursuant to Chapter 16.

Section 45. Audits.

(a) The Division or the Centers for Medicare and Medicaid Services may audit a provider’s financial records, medical records, or employment records at any time to determine whether the provider has received excess payments or overpayments.

(b) The Division or the Centers for Medicare and Medicaid Services may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.

(c) Disallowance. The Division shall recover excess payments or overpayments pursuant to Section 16 of this Chapter.

(d) Reporting audit results. If at anytime during a financial audit or a medical audit, the Division discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Division’s final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit.

(e) The Division shall share the results of the audit with the provider before excess payments or overpayments are recovered. However, nothing in this Section shall abrogate the rights of the State to recover excess payments or overpayments in accordance with Chapter 16 or Chapter 39.
Section 46. Reconsideration. A provider may request that the Department reconsider a decision to recover excess payments or overpayments. The request for
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reconsideration, the reconsideration, and any administrative hearing shall be pursuant to the reconsideration provisions of Chapter 3, Chapter 16 or Chapter 39 as applicable.

Section 47. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of Chapter 16.

Section 48. 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 49. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Division, including Provider Manuals and Provider Bulletins, which are inconsistent with this Chapter, except Chapter 1, Rules for Individually-selected Service Coordinators of the Rules of the Developmental Disabilities Division, which remains in effect.

Section 50. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

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