The Wyoming Medical Assistance and Services Act (the Act) prohibits knowingly making false statements or misrepresentations or knowingly failing to disclose a material fact in providing or obtaining medical assistance under Wyoming’s Medicaid system. Wyo. Stat. 42-4-111. Violations of the Act can constitute a felony if the value of medical assistance is greater than $500, with penalties of imprisonment for not more than ten years, a fine of not more than $10,000, or both. If the value of the medical assistance is less than $500, a violation is punishable as a misdemeanor with a term of imprisonment of not more than six months and a fine of not more than $750, or both. Each violation by a provider is a separate offense under the Act.

To “knowingly” make a false statement or misrepresentation includes making statements, (A) with the intent to violate the law; (B) with actual knowledge of the truth or falsity of the information; or, (C) statements made in deliberate ignorance or reckless disregard of the truth or falsity of the information. Wyo. Stat. 42-4-102(a)(xii), (xiii)(A)-(C).

“Medical assistance” means partial or full payment of the reasonable charges assessed by any authorized provider of the services and supplies authorized by the Act, which are provided on behalf of a qualified recipient. The definition excludes services provided by a recipient’s relative, unless the relative is a family caregiver providing services through a separate corporate entity that the relative may own, through a home and community based waiver program, or for cosmetic purposes only. Wyo. Stat. § 42-4-102(a)(ii).
The Act also forbids a person to knowingly fail to maintain records required by Medicaid program rules as necessary to disclose fully the nature of the goods, services, items, facilities or accommodations for which a claim was submitted or payment received. Violations of this section of the Act are categorized based on the value of the medical assistance for which records were not properly maintained as a dollar amount and as a percentage of all Medicaid claims submitted by the provider in any consecutive three month period, and include a felony for intent to defraud:

- A misdemeanor punishable by imprisonment for not more than thirty days and a fine of not more than $750, or both, if the medical assistance for which records were not properly maintained is at least $5,000, and less than 25% of the Medicaid claims submitted by the provider in any consecutive three month period;
- A misdemeanor punishable by imprisonment for not more than six months and a fine of not more than $1,000, or both, if the medical assistance for which records were not properly maintained is at least $5,000, and 25% or more of the Medicaid claims submitted by the provider in any consecutive three month period;
- A felony punishable by imprisonment for not more than five years and a fine of not more than $10,000, or both, if the person intended to defraud, and the medical assistance for which records were not properly maintained is more than $5,000, and 25% or more of the Medicaid claims submitted by the provider in any consecutive three month period;

Wyo. Stat. 42-4-111(e)(i)-(iii).

The Wyoming Attorney General Medicaid Fraud Control Unit (MFCU) prosecutes criminal charges for Medicaid fraud. According to the MFCU’s webpage, nine providers have been convicted of Medicaid fraud in Wyoming since 2013. See Medicaid Fraud Control Unit.

Important Case:
In State v. Adekale, 344 P.3d 761, 2015 WY 30 (Wyo. 2015), a jury convicted Adekale of fifteen felony counts and one misdemeanor count of Medicaid fraud relating to claims submitted by Adekale’s company for residential habilitation and day habilitation services for developmentally disabled adults that the company never provided. In some cases, Adekale billed for services he claimed to have performed when the patients were out of town or otherwise unavailable, and in other instances, his company’s claims were partially valid but also included charges for services that were not provided. After the jury convicted Adekale, the district court sentenced him to concurrent terms of four to ten years for each count, but then suspended that sentence in favor of eight years of supervised probation. Adekale was also required to make restitution for the fraudulent claims.

Adekale appealed to the Wyoming Supreme Court, arguing that his conviction should be overturned because the Act was ambiguous. He argued that the definition of the crime in Wyo. Stat. 42-4-111(a), that “no person shall knowingly make a false statement or misrepresentation . . . in providing medical assistance . . .” was
ambiguous because medical assistance was defined in Wyo. Stat. 42-4-102(a)(ii) as “partial of full payment of the reasonable charges assessed by any authorized provider . . .” Adekale argued that he did not make payments for services received by his patients, as required by the definition of medical assistance, and therefore could not have made any false statements while providing medical assistance.

The Wyoming Supreme Court agreed that the definition of medical assistance caused the statute to be ambiguous because strict construction of the statute would render it meaningless. However, the Court reasoned that the clear intent of the legislature was to criminalize false representations by those obtaining payment for providing services to Medicaid recipients. The Court found that the trial court properly instructed the jury without included the Act’s definition of medical assistance, and that Adekale’s conviction was consistent with the intent of the Act.

The Court also encouraged the Wyoming Legislature to amend the Act to clarify the definitions and remove the unnecessary jargon, but to date the legislature has not done so.

2) FALSE CLAIMS

**Wyoming Medicaid False Claims Act, Wyo. Stat. 42-4-301 et seq.**

The Wyoming Medicaid False Claims Act, patterned after the federal False Claims Act, prohibits making or benefitting from false statements in a claim under the Medicaid program. The Act creates a civil cause of action, which may be pursued by the Wyoming Attorney General or any district attorney, against any person who:

- Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval;
- Knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim;
- Benefits from the inadvertent submission of a false claim, when, after discovery of the falsity of the claim, fails to disclose the false claim and make satisfactory arrangements for repayment within ninety (90) days after discovery; or,
- Conspires to commit any of the violations described above.

The state must prove all the elements of a violation, and the damages it claims, by clear and convincing evidence. Liability for violations is joint and several among two or more people who act together to violate the Act.

A “claim” is broadly defined by this Act to include any request or demand under the Medicaid program, under a contract or otherwise, for money, property or services that is presented to any employee, officer or agent of the state or any political subdivision of the state; or, is presented to any contractor, grantee or other recipient if the money or property is to be spent or used on the state’s behalf or to advance a state program or interest, or if the state has provided any portion of the money or property requested.
The Act provides substantial civil liability for damages and penalties, subject to a cap on the total amount of penalties, including the following:

- Damages up to three times the amount of damages which the state sustains as a result of the acts of the person;
- A civil penalty to the state of not less than $1,000 and not more than $10,000 for each violation;
- Costs of the litigation.

The damages may be capped at twice the amount sustained by the state, and the civil penalty eliminated, if the person committing the violation furnishes to state investigators all information known to that person within forty-five (45) days after the information is requested, and substantially cooperates with any state investigation. Damages are also capped for persons who receive Medicaid benefits at the amount of damage the state sustains as a result of the false claim and a civil penalty of not more than $1,000 for the first violation. Recipients can be liable for up to three times the amount of damages sustained by the state and a civil penalty of not more than $1,000 for all subsequent violations. Actions must be brought within the later of (i) six years after the date on which the violation was committed, or (ii) three years after the date when the state official who is responsible to act in the circumstance knows or reasonably should have known the facts material to the cause of action; however, in no event can a claim under this Act be brought more than seven years after the date on which the violation is committed.

The Act does not create a private cause of action for false claim violations. However, the Act does create a private cause of action for employees, contractors or agents who are retaliated against in the terms and conditions of employment because of their “lawful acts taken in good faith” in an action reported, filed or investigated under the Act. A lawsuit alleging retaliation in violation of this provision must be filed within three (3) years after the date of the retaliatory act, and the employee can recover only economic damages. State employees who are the subject of retaliation by their employer may have additional remedies under the State Government Fraud Reduction Act, Wyo. Stat. 9-11-101 through 103.

3) CRIMINAL PENALTIES

Wyoming Criminal Penalties for Violations of Wyoming Health Statutes and DOH Regulations
Two Wyoming statutes create criminal penalties for the violation of Wyoming health laws and regulations of the Department of Health:

Wyo. Stat. 35-1-106:
(a) No person, corporation or other organization nor representative thereof shall:
(i) Willfully violate, disobey or disregard the provisions of the public health laws of Wyoming or the terms of any lawful notice, order, rule or regulation issued pursuant thereto; . . . .

(iii) Being a person charged by law or rule of the department of health with the duty of reporting the existence of disease or other facts and statistics relating to the public health, fail to make or file such reports as required by law or requirement of the department;

(iv) Conduct a business or activity for which the department requires a certificate or permit without such a certificate or permit;

(v) Willfully and falsely make or alter any certificate or certified copy thereof issued pursuant to public health laws of Wyoming;

(b) Upon conviction of any of the offenses prohibited in subsection (a) of this section, the violator shall be fined not to exceed one hundred dollars ($100.00) or imprisonment not to exceed six (6) months, or both, and shall be liable for all expense incurred by health authorities in removing the nuisance, source of filth or cause of sickness. No conviction under the penalty provisions of this act or of any other public health laws shall relieve any person from an action in damages for injury resulting from violation of public health laws.

**Wyo. Stat. 35-1-106:**
Any person who shall violate any of the provisions of this act, or any lawful rule or regulation made by the state department of health pursuant to the authority herein granted, or who shall fail or refuse to obey any lawful order issued by any state, county or municipal health officer pursuant to the authority granted in this act shall be deemed guilty of misdemeanor, and shall be punished except as otherwise provided therein by a fine of not more than one thousand dollars ($1,000.00), or by imprisonment for not more than one (1) year or by both such fine and imprisonment.

4) MEDICAID REGULATIONS

**Wyoming Department of Health Medicaid Regulations**
The Wyoming Department of Health’s Medicaid Program Integrity (Chapter 16) regulations establish an administrative process for the investigation of fraud, theft or abuse of services, and the recovery of overpayments. The regulations authorize DOH to impose sanctions, and to refer matters to the Medicaid Fraud Control Unit (MFCU) of the Wyoming Attorney General’s Office.

The regulations adopt definitions of fraud, abuse and overpayment from the DOH’s general Medicaid definitions, as follows:

- Fraud is an intentional deception or misrepresentation made by an individual with the knowledge that the deception or misrepresentation may result in

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1Wyoming Department of Health regulations can be accessed through the Wyoming Secretary of State’s regulation database located here: [https://rules.wyo.gov/Search.aspx?mode=7](https://rules.wyo.gov/Search.aspx?mode=7). Select the pulldown menu for “Health, Department of” followed by the pulldown menu for “Medicaid.”
overpayments, as well as any actions or inactions that constitute fraud under federal or state law.

- **Overpayments** are Medicaid funds received by a provider or client to which the provider or client is not entitled for any reason including payments which exceed the Medicaid allowable payment. Overpayments include but are not limited to:
  - Payments made as a result of system errors;
  - Payments for services furnished to a non-client;
  - Payments for non-covered services furnished to a client;
  - Payments for services which are not documented and/or supported by records and/or financial records;
  - Payments for services for which admission certification has been denied or withdrawn;
  - Payments which exceed a provider’s usual and customary charge, unless otherwise permitted by the Department’s rules;
  - Payments resulting from fraud; or
  - Payments resulting from abuse.

- **Abuse** is broadly defined as a pattern of practice by a provider or a client that results in healthcare utilization which is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to Medicaid, or in payment for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse is characterized by, but not limited to, any one of the following:
  - The repeated submission of claims by a provider from which documentation of required material information is missing, incorrect or not provided for review when requested. Examples include, but are not limited to: incorrect or missing procedure or diagnosis codes, missing or invalid signatures, invalid prescription documentation, incorrect mathematical entries, incorrect third party liability information, or the incorrect use of procedure code modifiers;
  - The repeated submission of claims by a provider presenting procedure codes which overstate the level or amount of services provided (i.e., upcoding);
  - The repeated submission of claims by a provider for services which are not reimbursable under Medicaid, or the repeated submission of duplicate claims;
  - Failure by a provider to develop and maintain legible medical records which document the nature, extent and evidence of the medical necessity of services provided;
  - Failure of a provider to use generally accepted accounting principles or other accounting methods which relate entries on the medical record to entries on the claim;
  - Excessive or inappropriate patterns of referral;
  - The repeated submission of claims by a provider for services which were not medically necessary;
o The repeated submission of claims by a provider for services which exceed
that requested or agreed to by the client or the client's responsible relative
or guardian;
o The submission of claims for services not medically necessary under the
generally accepted practice of providers of such services;
o Overprescribing or misprescribing products or services;
o The repeated submission of claims by a provider without complying with the
provisions of these rules;
o A client permitting the use of the client's Medicaid identification by any
unauthorized individual for the purpose of obtaining services;
o A client obtaining services which are not medically necessary for the
purpose of resale or for the use of a non-client;
o A client obtaining duplicate services from more than one provider for the
same medical condition, other than confirmation of a diagnosis, evaluation
or assessment; or
o Misuse, which with respect to a client means the request for or utilization of
services that are inappropriate and with respect to a provider means the
furnishing of services that are inappropriate, or the submission of claims
that do not accurately reflect the services provided.

As part of any investigation under the regulations, the DOH is authorized to examine
medical, financial and patient records, including records relating to alternative
sources of payment; interview providers and their agents and employees; verify
providers’ professional credentials; interview clients; examine prescriptions,
equipment, supplies or other items used in a client’s treatment; and, conduct random
sampling and extrapolation of claims. The DOH is also authorized to perform audits
itself or through contractors, and to refer evidence of overpayment to MFCU.

Following an investigation, DOH is authorized to impose sanctions against a
provider upon findings of any of the following grounds:
• Suspected or substantiated fraud, theft or abuse of services in submitting claims;
• A pattern of presenting false or duplicate claims or claims for services not
medically necessary;
• A pattern of making false statements of material facts for the purpose of
obtaining overpayments;
• Failure to comply with the provisions of the provider agreement;
• Remedies imposed by CMS or the DOH;
• Lack of requested documentation;
• Situations that pose a threat to the health, safety, or welfare of the clients or
general public;
• Suspension or termination of state licensure or any certification required to
provide services;
• Lack of or repeated failure to provide documentation of Medicaid services;
• Inability to collect overpayments;
• Failure to maintain current contact information as required by DOH regulations;
• Exclusion by the Office of Inspector General;
- Lack of claims activity for one (1) year;
- Termination/exclusion under Medicare, CHIP or another State's Medicaid program;
- Refusal to grant access to records as required by DOH regulations; or,
- Violation of Medicaid, Department, or other State or Federal statute, rule, or law relating to provisions of services.

DOH is authorized to impose a wide range of sanctions against providers who are found to be in violation of the regulations. In selecting sanctions, DOH is directed to consider the nature and extent of the provider’s violations, the provider’s history of violations, actions or recommendations of other state regulatory or licensing agencies, and steps taken by the provider to lessen the possibility of future violations. Possible sanctions include:
- Educational intervention;
- Recovery of overpayments;
- Postpayment review of claims;
- Prepayment review of claims;
- Suspension of payments;
- Suspension of provider agreement;
- Termination of provider agreement;
- Conditional future provider agreement;
- Additional sanctions; or
- Referral to appropriate State regulatory agency, licensing agency; or MFCU.

DOH regulations provided a detailed process for providers and clients to request an administrative hearing when they dispute the DOH’s investigation findings, the amount of overpayments or penalties and any other sanctions.

**Important Cases:**

**Burke v. Wyoming Department of Health, 291 P.3d 122 (Wyo. 2009).**

Burke was a licensed pharmacist who operated three pharmacies in Wyoming. After DOH conducted an audit of Burke’s records for 1998-3003, DOH concluded that Burke had received excess payments in the amount of $172,337.36. The department also notified Burke that it had terminated his provider agreement, and that it had the right to seek recovery of the excess payments. DOH notified Burke that he could request reconsideration of the decision, and that he was entitled to an administrative hearing regarding the termination of the provider agreement. Over two years later, DOH sent Burke a letter seeking reimbursement of the excess payments within 30 days, and notifying Burke that he could seek reconsideration of the determination. Burke did request an administrative hearing, but withdrew the request before the hearing was scheduled. Later, DOH filed a civil complaint in state district court seeking a judgment for the excess payment amount. Burke attempted to challenge DOH’s complaint, but the district court decided that Burke had lost his opportunity to challenge DOH’s determinations when he withdrew his request for a hearing, thereby failing to exhaust the administrative hearing remedies available under DOH’s regulations.
Burke appealed to the Wyoming Supreme Court, arguing that DOH had compromised his rights because it had initially stated that it intended to pursue the amount due through the claims adjustment process under DOH’s overpayment regulations, which does not include an administrative hearing. However, the Court disagreed with Burke’s argument because later correspondence from the DOH clearly notified Burke that DOH intended to pursue its remedies under the excess payment regulations, and specifically notified Burke that he could request reconsideration or an administrative hearing, and the department could pursue a civil lawsuit against him. Even with this information, Burke decided to withdraw his request for an administrative hearing. As a result, when DOH filed a lawsuit to obtain a civil judgment, Burke could no longer challenge his liability to reimburse DOH or the amount of the reimbursement.

5) MEDICAL PRACTICE ACT


The Wyoming Medical Practice Act authorizes the Wyoming Board of Medicine to license, regulate and discipline physicians, physician’s assistants, and doctors of osteopathy. The Act gives the BOM authority to discipline licensees based on a variety of grounds encompassing circumstances which could constitute fraud or abuse:

(a) The board may refuse to renew, and may revoke, suspend or restrict a license or take other disciplinary action, including the imposition of conditions or restrictions upon a license on one (1) or more of the following grounds:

(i) Renewing, obtaining or attempting to obtain or renew a license by bribery, fraud or misrepresentation; . . . .

(iii) Making false or misleading statements regarding the licensee’s skill or the efficacy or value of his treatment or remedy for a human disease, injury, deformity, ailment, pregnancy or delivery of infants; . . . .

(v) Advertising the practice of medicine in a misleading, false or deceptive manner;

(vi) Obtaining any fee or claim for payment of a fee by fraud or misrepresentation;

(viii) Conviction of or pleading guilty or nolo contendere to a felony or any crime that is a felony under Wyoming law in any jurisdiction; . . . .

(x) Violating or attempting to violate or assist in the violation of any provision of this chapter or any other applicable provision of law; . . .

(xviii) Willful and consistent utilization of medical service or treatment which is inappropriate or unnecessary; . . .

(xxvii) Unprofessional or dishonorable conduct not otherwise specified in this subsection, including but not limited to: . . . .

(E) Engaging in conduct intended to or likely to deceive, defraud or harm the public;
(F) Using any false, fraudulent or deceptive statement in any document connected with the practice of medicine including the intentional falsification or fraudulent alteration of a patient or health care facility record; 
(G) Failing to prepare and maintain legible and complete written medical records that accurately describe the medical services rendered to the patient, including the patient's history, pertinent findings, examination, results, test results and all treatment provided; . . . . 
(T) Using or engaging in fraud or deceit to obtain third party reimbursement.

See also Grounds for suspension; revocation; restriction; imposition of conditions; refusal to renew or other disciplinary action, Wyo. Stat. § 33-26-402.

6) UNFAIR TRADE PRACTICES


Although the Wyoming Unfair Trade Practices Act is a general consumer protection statute, its definition of a covered “consumer transaction” includes the advertising, sale, offering for sale or distribution of any property or service to any individual for personal, family or household purposes. Wyo. Stat. 40-12-105(a)(ii), (vi). As a result, the Act could apply to transactions involving the provision of health care services, equipment, supplies or medication.

Although no reported cases in Wyoming have applied the Act in the health care context, the Act generally prohibits deceptive trade practices in consumer transactions, including when a person knowingly:

- Represents that he has a sponsorship, approval or affiliation he does not have;
- Represents that replacement or repair is needed, if it is not;
- Makes false or misleading statements of fact concerning the price of merchandise or the reason for, existence of, or amounts of a price reduction;
- Engages in unfair or deceptive acts or practices;

7) RETALIATION PROTECTIONS AND REMEDIES

**Health Care Facilities Retaliation Protections and Remedies, Wyo. Stat. 35-2-910(b)**

Wyoming law provides protection against retaliation for employees of health care facilities for reporting violations of law to the Department of Health.

**Wyo. Stat. 35-2-910(b)** states: Health care facilities subject to or licensed pursuant to this act shall not harass, threaten discipline or in any manner discriminate against any resident, patient or employee of any health care facility for reporting to the division a violation of any state or federal law or rule and regulation. Any employee
found to have knowingly made a false report to the division shall be subject to disciplinary action by the employing health care facility, including but not limited to, dismissal.

This prohibition applies to any ambulatory surgical center, assisted living facility, adult day care facility, adult foster care home, alternative eldercare home, birthing center, boarding home, freestanding diagnostic testing center, home health agency, hospice, hospital, freestanding emergency center, intermediate care facility for people with intellectual disability, medical assistance facility, nursing care facility, rehabilitation facility and renal dialysis center. Wyo. Stat. 35-2-901(a)(x).

The statute does not create a private cause of action or other remedy for employees subject to prohibited retaliation; however, Wyoming has adopted a common law claim for retaliatory discharge in violation of public policy, which may apply under the circumstances described in this statute.

8) HELPFUL LINKS
- Medicaid Regulations – Wyoming Secretary of State Regulatory Database
  (Select “Health, Department of” pulldown menu, followed by “Medicaid” pulldown menu)
- Wyoming Department of Health
- DOH Medicaid Program
- Wyoming Board of Medicine
- Wyoming Statutes
- Wyoming Legislature