Wyoming Department of Health
Division of Healthcare Financing

Long Term Care Medicaid Waiver

Assisted Living Facility Medicaid Waiver

Provider Instructions

Electronic Medicaid Waiver System (EMWS)

Wyoming Department of Health

Commit to your health.

Created 12/13/2011

Last Updated 4/26/2012

Table of Contents

INTRODUCTION **4**

LOGGING INTO THE ELECTRONIC MEDICAID WAIVER SYSTEM (EMWS) **5**

LOG-IN SCREEN 5
CONFIDENTIALITY AGREEMENT 6
CHANGE PASSWORD 7
TOP SCREEN TABS 8
LOGOUT 9
REASON FOR ACCESSING FILE 9

TASK LIST SCREEN **11**

FILTER THE TASK LIST SCREEN 12
VIEW INFORMATION FROM THE TASK LIST SCREEN 15

SEARCH CASES SCREEN **17**

REPORTS SCREEN **20**

ADMIN SCREEN **21**

WAITLIST PROCESS **22**

TO PUT A PARTICIPANT ON THE WAITLIST 22
RECEIVING A FUNDING OPPORTUNITY FOR A PARTICIPANT 38

ENTERING A PARTICIPANT ON EMWS **55**

NOTIFICATION 55
PLAN STATUS SCREEN 55
UPDATING/VERIFYING INFORMATION 56
ASSESSMENTS 63
MEDICAL 64
GOALS 68
SERVICES 75
DOCUMENTS 81
NOTES 86
FINAL SUBMISSION 88

RENEWAL PLANS **91**

NOTIFICATION OF RENEWAL 91
PLAN STATUS SCREEN 91
UPDATING/VERIFYING INFORMATION 92
ASSESSMENTS 99
MEDICAL 100
GOALS 104
SERVICES 111
DOCUMENTS 117
NOTES 122
FINAL SUBMISSION 125

MODIFYING A CURRENT PLAN **127**

UPDATING A CURRENT SERVICE 129
ADDING A NEW SERVICE 130
CHANGING PROVIDERS 131
CORRECTING ERRORS TO PLANS 134
FINAL SUBMISSION 136

DISCHARGING A PARTICIPANT **139**

DISCHARGING A PARTICIPANT THROUGH THE TASK LIST SCREEN 139
DISCHARGING A PARTICIPANT THROUGH THE SEARCH CASES SCREEN 142

NAMING CONVENTIONS FOR UPLOADING DOCUMENTS **145**

SERVICE RATES **145**

Introduction

This document is to assist Case Managers and Care Coordinators to navigate through the new web-based Electronic Medicaid Waiver System (EMWS). This document will be used for the following Home & Community Based Waivers (HCBS):

- Long Term Care (LTC)
- Assisted Living Facility (ALF)

For those Case Managers and Care Coordinators that provide services to multiple (HCBS) waivers in multiple divisions, each division will have their own guides and documentation.

Each user accessing the EMWS has a specific role and access. As each task is completed, the system automatically sends the case to the next user in the working queue to perform the assigned task. This role-based processing is referred to as workflow.

As this is a new system, this document is a working document that will change as changes to the system are made. It is important to make sure you are using the most current version of this document. This document can be located on the Home Care Services website in the Resources section to download or print.

The Home Care Services website is:

http://health.wyo.gov/healthcarefin/medicaid/homecareservices.html

Logging into the Electronic Medicaid Waiver System (EMWS)

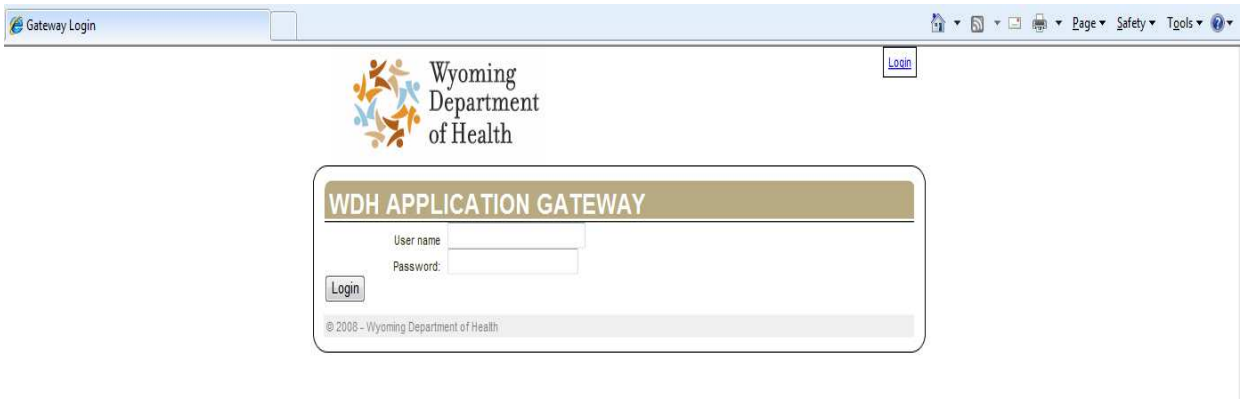
The website address to log into the EMWS is:

https://waivers.health.wyo.gov

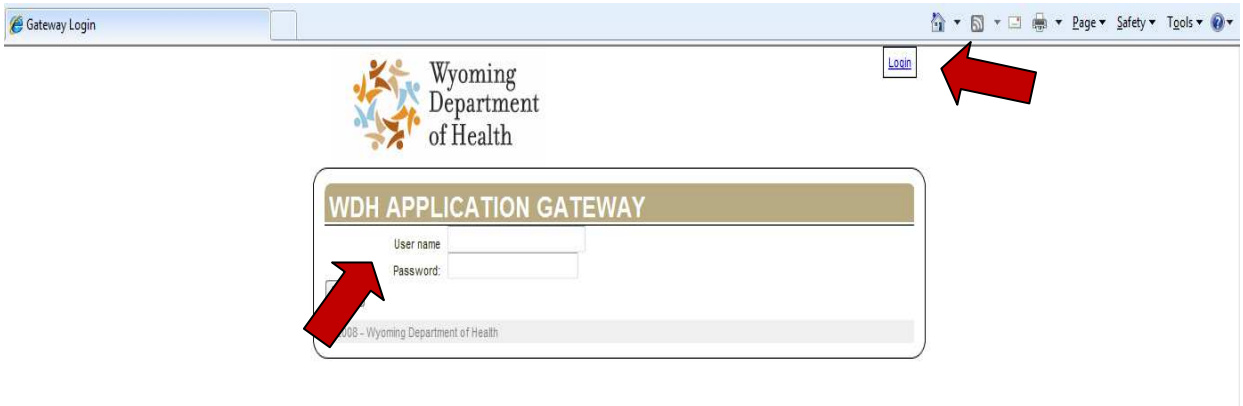
Use Microsoft Internet Explorer to access this website. Please refer to the "Computer Instructional Guide" for further requirements.

Log-In Screen

When you access this site, you will see the following screen:



Each user accessing this site will have a user ID and password. The ID and password is unique to each user and should not be shared within offices. A user will only be able to log into this website after receiving their unique user ID and password. *See note below*.



To log into the site:

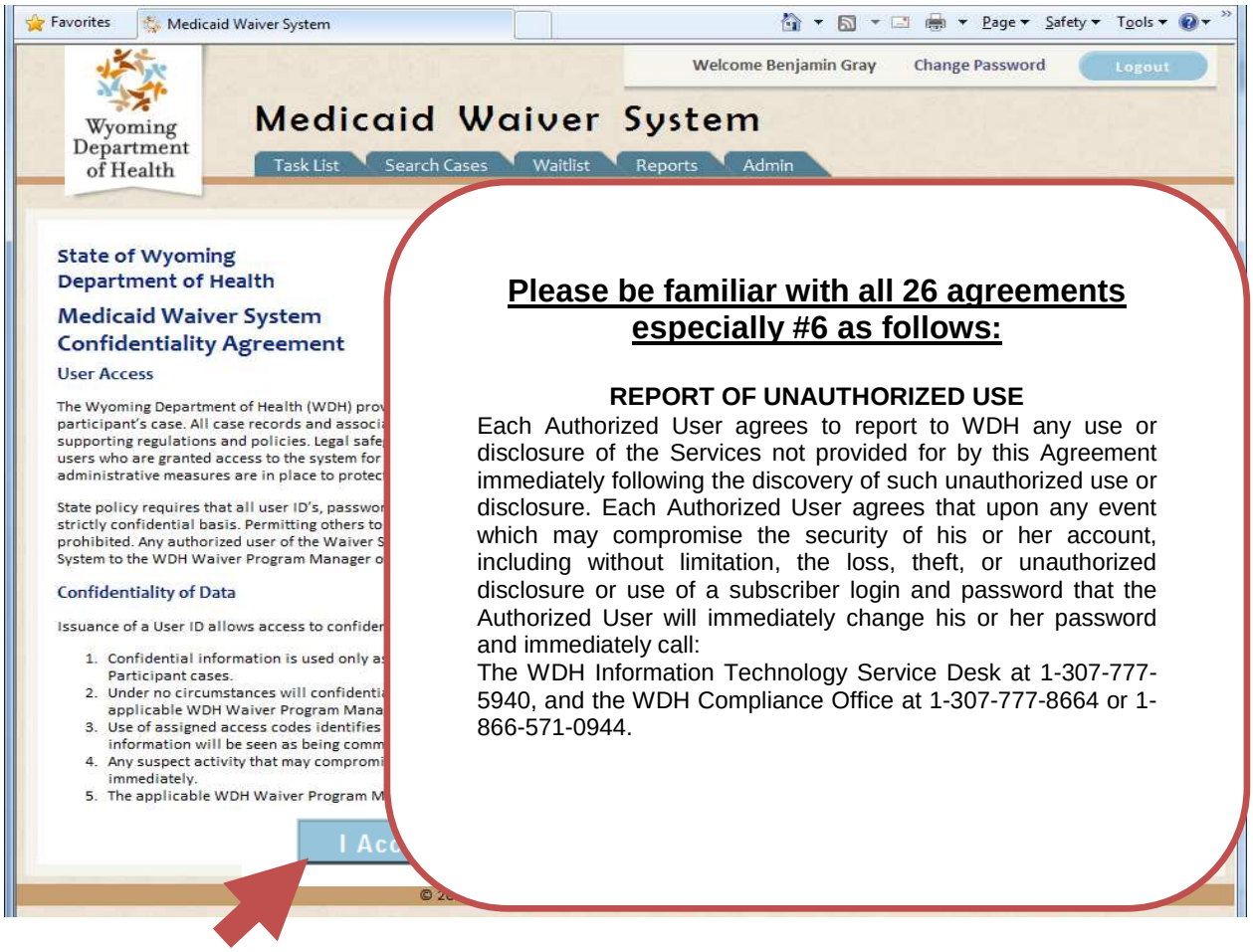
- Enter User Name
- Enter Password
- Click Login or press Enter

NOTE: Users are encouraged to store their user name and password in a secure place. In the event a user has forgotten user name or password, please ***contact (307) 777-7861.***

Confidentiality Agreement

When ***logging into the EMWS for the first time and every 45 days thereafter***, the user is presented with the ***Medicaid Waiver System Confidentiality Agreement*** known as an End License User Agreement (EULA).

Each user is responsible for reviewing and adhering to the terms and conditions of the EULA.

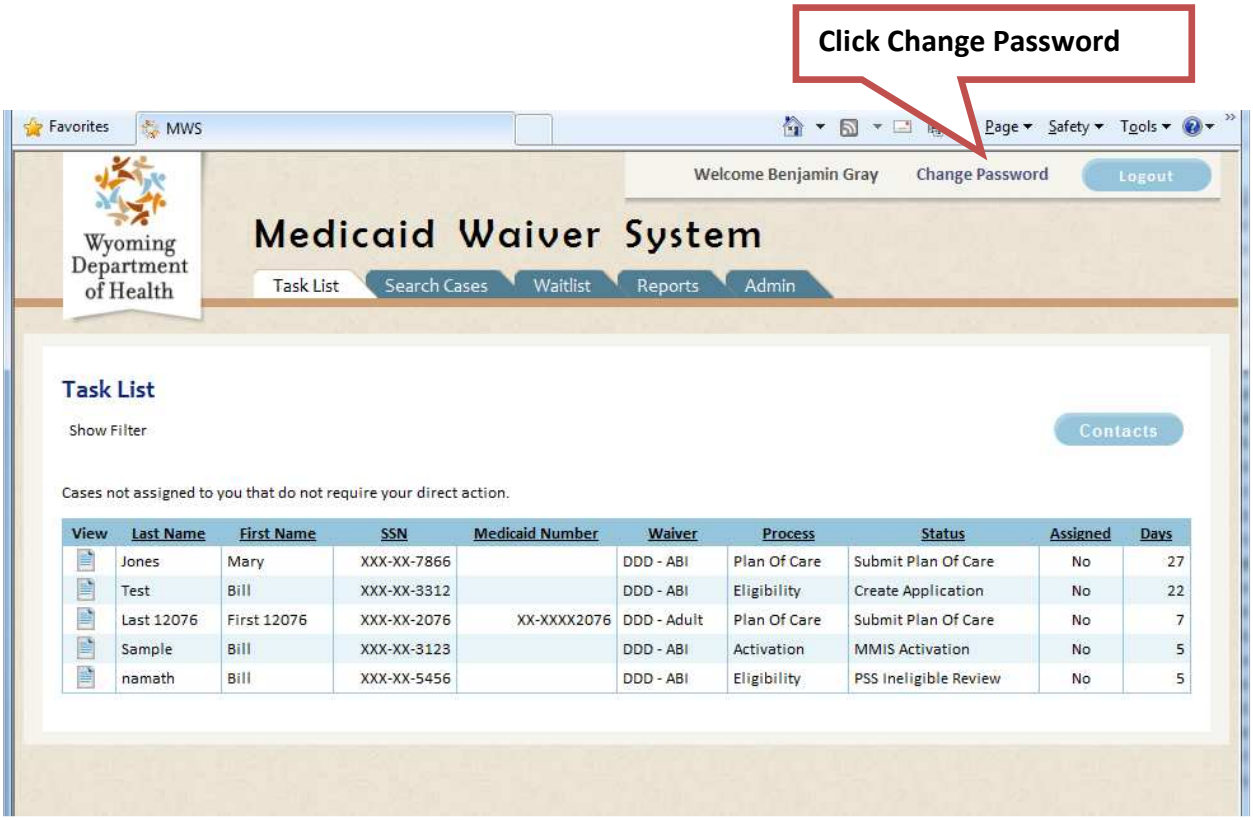


Upon Agreement, User clicks the "I Accept" box to continue

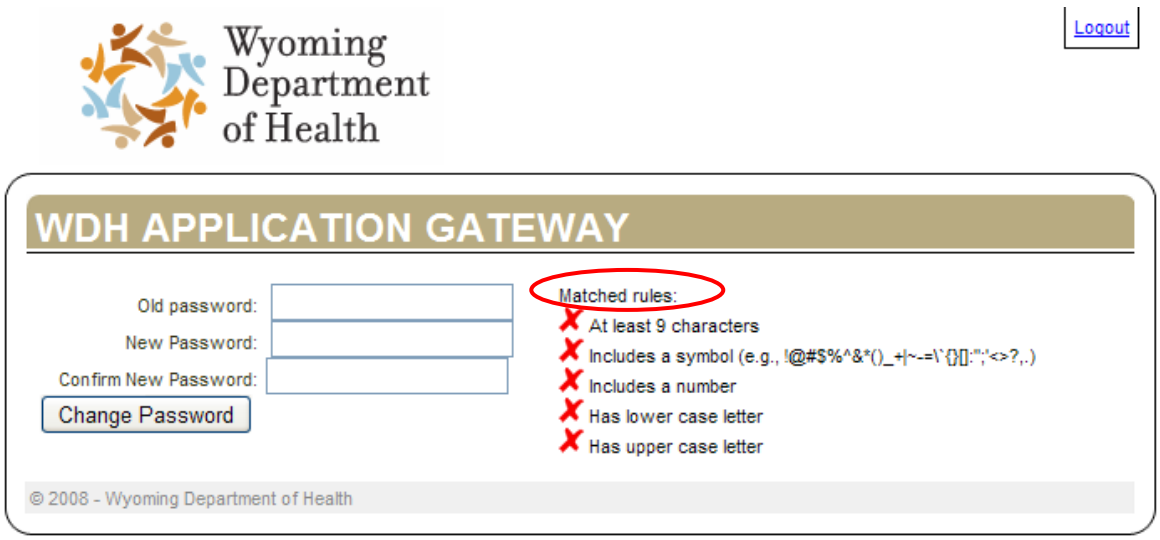
NOTE: For security purposes, the ***system times out after 20 minutes of idle time*** and the user is then required to log in again. In most cases, User is returned to the last screen they were on when logged out.

Change Password

Once a user logs into the system, they can change their password.



Case Managers will initially receive their password from the Home Care Services Unit and they are encouraged to change it after logging in the first time.



Review password requirements indicated at the right of the screen. You will not be able to have similar passwords from previous passwords when changing your password. For example: a user's old password is !Dog2cat2011. It cannot be changed to!Dog**3**cat2011

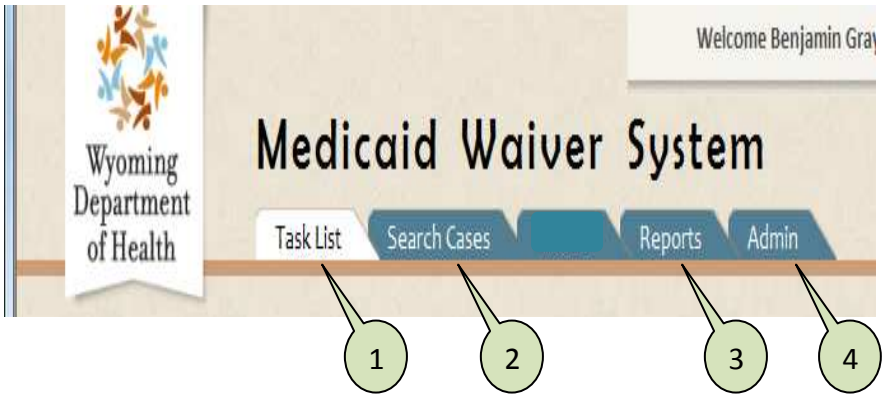
To change your password:

- Enter Old Password
- Enter New Password twice – be sure to match rules
- Click Change Password

NOTE: Users will be prompted to change their password every 45 days.

Top Screen Tabs

At the top of the EMWS screen are 4 tabs:

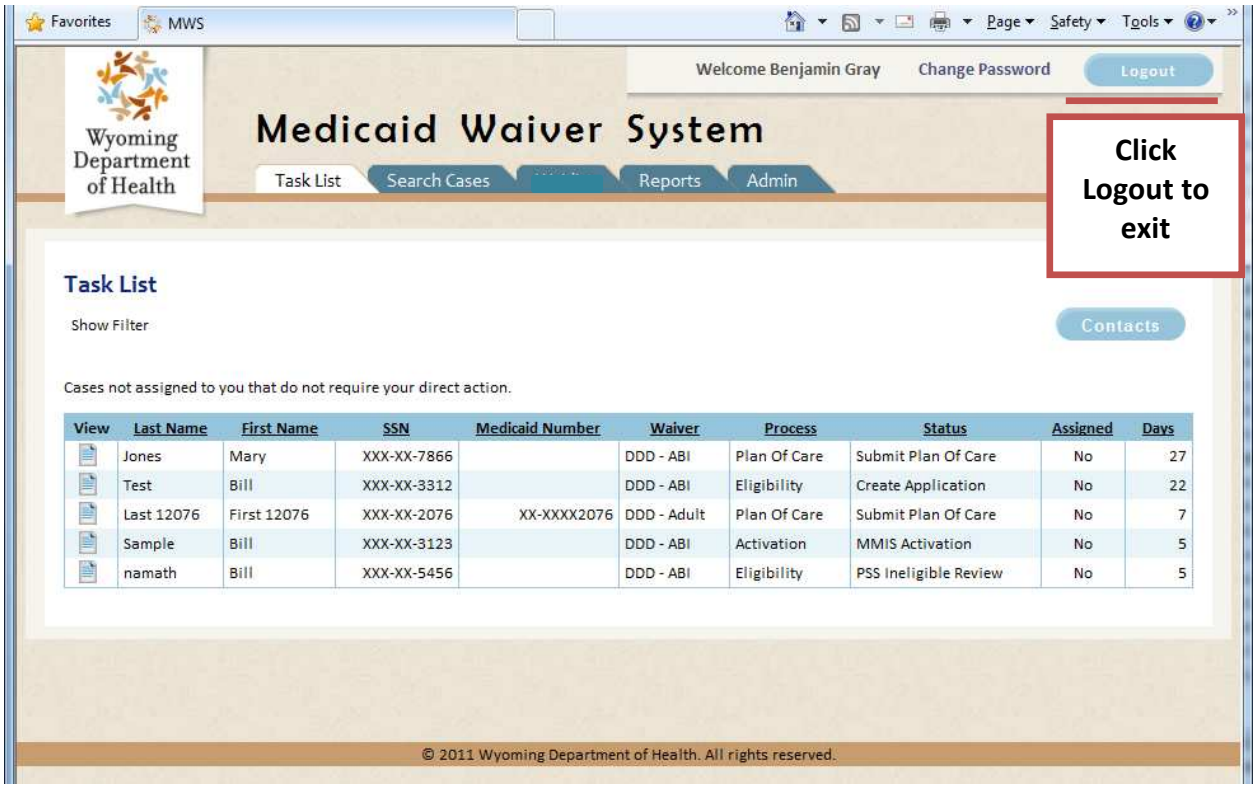


1. Task List – Your default first screen. Lists all tasks related to your participants. This includes tasks for immediate attention and tasks allowing the Case Manager/Care Coordinator to follow the process of the participant's plan.
2. Search Cases – Locate participants already in the system or create new participants. In this system a "case" is a participant and all information relating to a participant.
3. Reports – A listing of reports available to Case Managers.
4. Admin – A limited view of administrative documents.

A detailed account of each screen is on subsequent pages.

Logout

To logout of the EMWS, click on the logout button in the top left-hand corner.



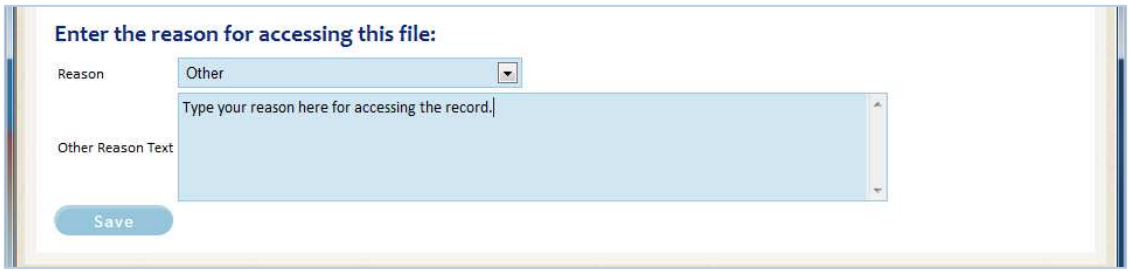
Please use the logout button when exiting the website rather than just exiting Windows Explorer. Using the logout button will validate the end of a user's secure session.

Reason for Accessing File

In certain instances to meet HIPAA compliance, a user may be asked to provide a reason why they are accessing a particular record.

- Click the drop down menu next to Reason and click the reason for access.

- Click the reason that applies or
- Click "Other" then enter the reason for accessing the file



- Click Save

NOTE: The system automatically tracks all user activity.

Task List Screen

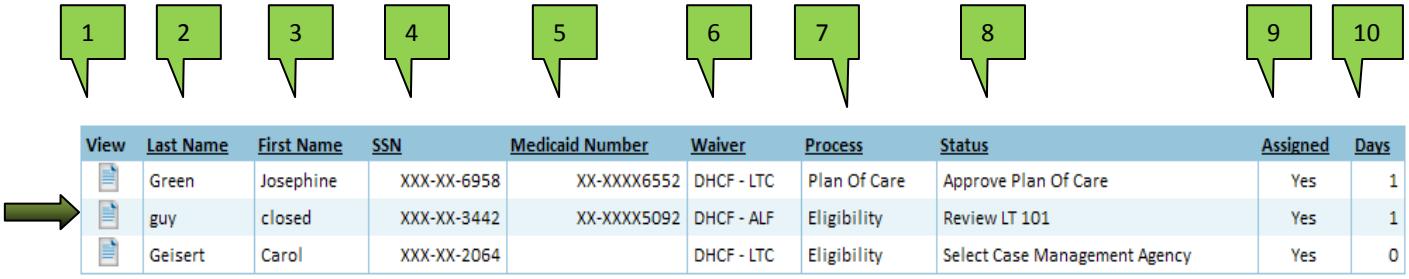
As mentioned in the previous section, the Task List screen will be the default screen after logging into the system. This screen shows all tasks that are attached to a participant where the user is listed as Case Manager/Care Coordinator. The role a user is given will dictate what information is seen.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Green	Josephine	XXX-XX-6958	XX-XXXX6552	DHCF - LTC	Plan Of Care	Approve Plan Of Care	Yes	1
	guy	closed	XXX-XX-3442	XX-XXXX5092	DHCF - ALF	Eligibility	Review LT 101	Yes	1
	Geisert	Carol	XXX-XX-2064		DHCF - LTC	Eligibility	Select Case Management Agency	Yes	0

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Green	Josephine	XXX-XX-6958	XX-XXXX6552	DHCF - LTC	Funding Opportunity	Confirm Financial Eligibility	Yes	1
	Dubry	Donald	XXX-XX-8610	XX-XXXX5002	DHCF - LTC	Plan Of Care	Pending MMIS Approval	Yes	1

After logging in, the task list will show 2 sections:

- **Cases assigned to you that require your direct action.** The participants listed in this section have tasks the Case Manager/Care Coordinator must finish before the participant can move to the next task.
- **Cases assigned to you that DO NOT require your direct action.** The participants listed here still have tasks that need completion, but **NOT** by the Case Manager/Care Coordinator. This task list is to let Case Managers and Care Coordinators know where a participant is in the workflow process.



View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Green	Josephine	XXX-XX-6958	XX-XXXX6552	DHCF - LTC	Plan Of Care	Approve Plan Of Care	Yes	1
	guy	closed	XXX-XX-3442	XX-XXXX5092	DHCF - ALF	Eligibility	Review LT 101	Yes	1
	Geisert	Carol	XXX-XX-2064		DHCF - LTC	Eligibility	Select Case Management Agency	Yes	0

The task list view shows the following information:

1 **View** – allows the user to open the participant's information. To open a participant to view the task, click on the document icon.

2 **Last Name** – participant last name

3 **First Name** – participant first name

4 **SSN** – participant's Social Security Number. In the task list view, the user will only see the last four digits of the SSN.

6 **Medicaid Number** – participant's Client ID Number. In the task list view, the user will only see the last four digits of the Client ID.

6 **Waiver** – which waiver the task is referencing

7 **Process** – which process the task is in

8 **Status** – where the participant is in the workflow

9 **Assigned** – the provider and Case Manager/Care Coordinator the participant is assigned to. Roll the mouse over the "Yes" to view the information.

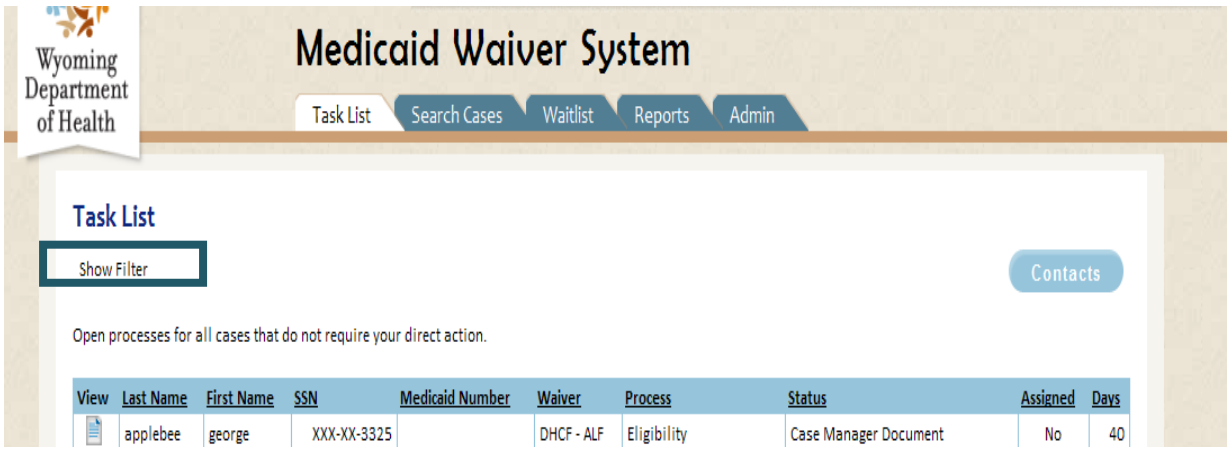
10 **Days** – the number of days the participant has been at the particular task

If a participant has a task for more than one waiver, process or status there will be multiple listings for the participant.

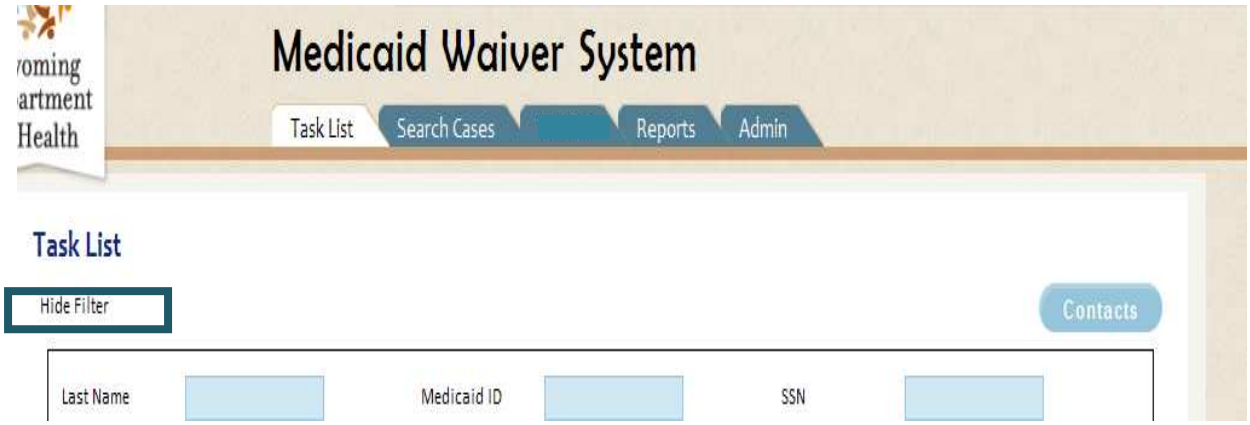
Filter the Task List Screen

The task list screen also has the ability to filter which participants are viewed on the screen. By default the filter section does not show on the screen. It must be selected to show the fields available for filtering.

To open the filter section, click on the words “Show Filter” underneath the words “Task List”.



Once clicked, it will open another section to the window. *Notice that “Show Filter” has now changed to “Hide Filter”.*



Currently the system has the following options in which a user can filter the task list:

- Last Name – Last name of a participant
- Division
  - DDD - Developmental Disabilities

- DHCF – Division of HealthCare Financing. *Unless user is a provider for a waiver other than LTC or ALF this will be the only choice.*
- MHSAD – Mental Health and Substance Abuse

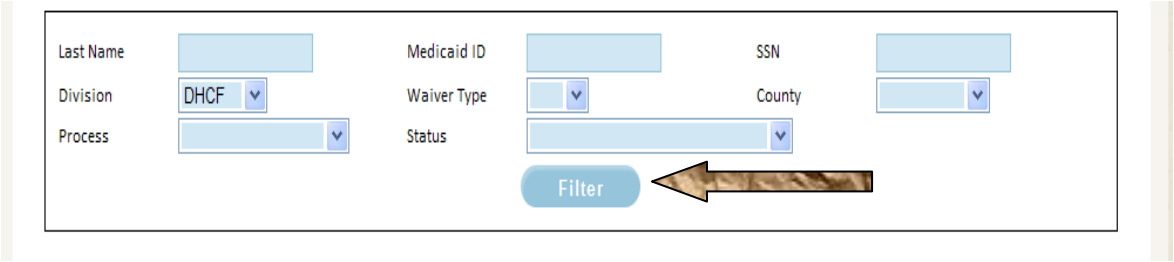
- Process
  - Closure
  - Eligibility
  - Funding Opportunity
  - Plan of Care
- Medicaid ID – the "06…" of the participant. ***REMINDER – ID's that start with "00…" are NOT Client ID's and cannot be used as such.***
- Waiver Type – *Unless user is a provider for a waiver other than LTC or ALF these will be the only options*
  - LTC
  - ALF
- Status – This would be where the participant is in the workflow process
- SSN – The Social Security Number of the participant
- County – The county of the participant's residence as listed in the demographics

A user may utilize one or all criteria to filter the Task List screen. Determine what information is necessary to filter the list. With the exception of "SSN" and "Medicaid ID" *(which if entered correctly, should return the desired participant in the result set)* the more criteria entered, the smaller the result set will be.

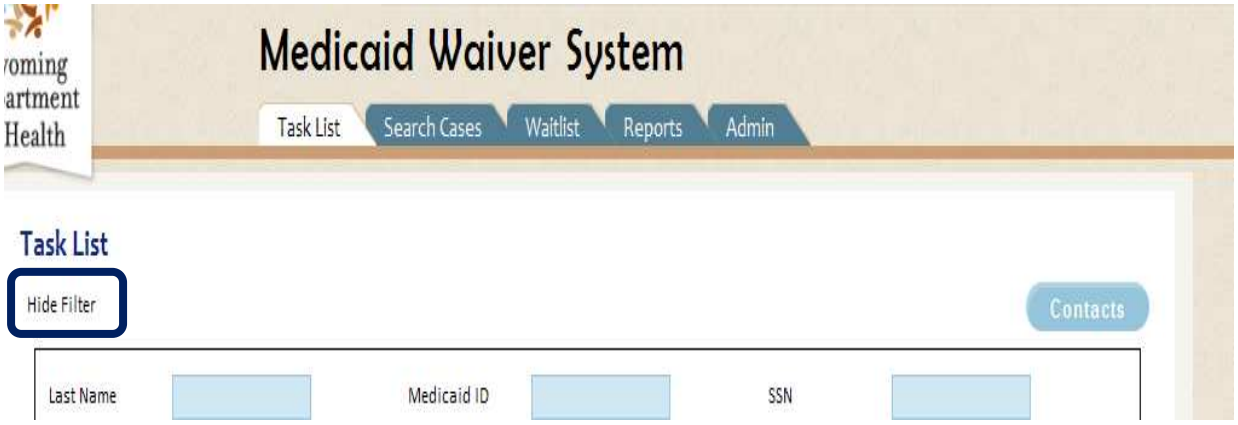
- If a user only enters county "Fremont", all participants with the county "Fremont" will appear in the result set.

- If a user enters both county "Fremont" and the last name "Smith", the result set will return all participants with the county "Fremont" and the last name "Smith".

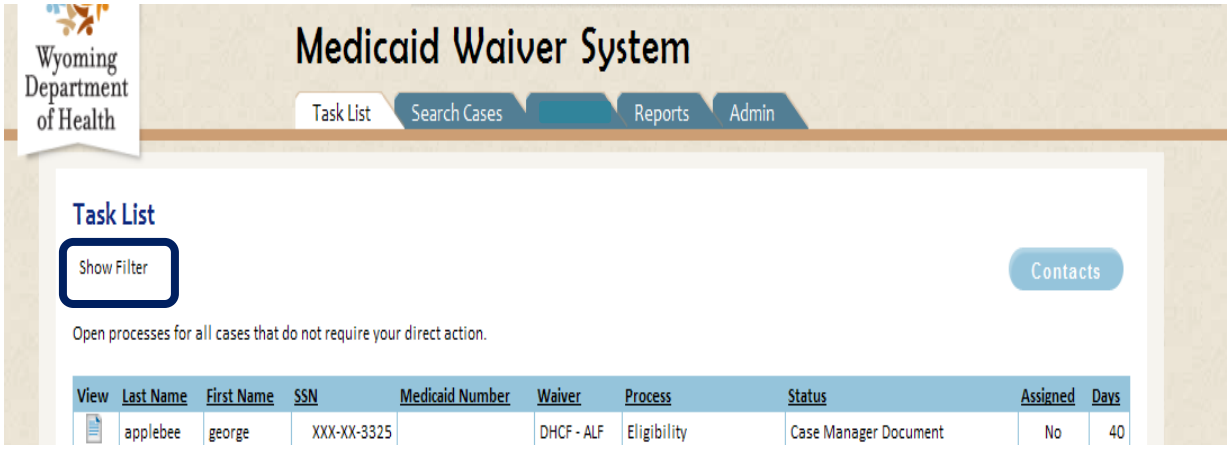
Once a user has chosen the desired filter criteria, click on the "Filter" button to return the result set. If no results show, take out one or more filter criteria and try again.



A user can collapse or hide the filter section of the Task List screen. To hide the filter section, click on the words “Hide Filter” underneath the words “Task List”.

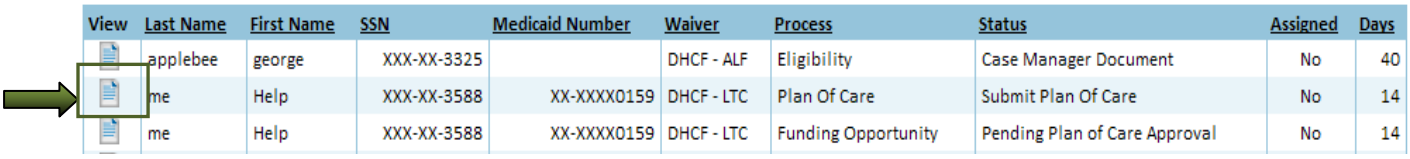


Once clicked, it will close the filter section of the window. *Notice that “Hide Filter” has now changed to “Show Filter”.*



View Information from the Task List Screen

To process the needed task, or to view a task at any point in the workflow process, click on the document icon in the “View” column of the task. This will take you directly to the task associated with that icon.

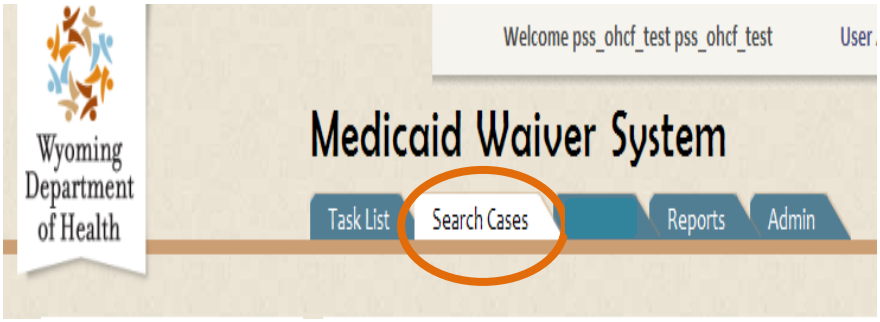


View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	applebee	george	XXX-XX-3325		DHCF - ALF	Eligibility	Case Manager Document	No	40
	me	Help	XXX-XX-3588	XX-XXXX0159	DHCF - LTC	Plan Of Care	Submit Plan Of Care	No	14
	me	Help	XXX-XX-3588	XX-XXXX0159	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	No	14

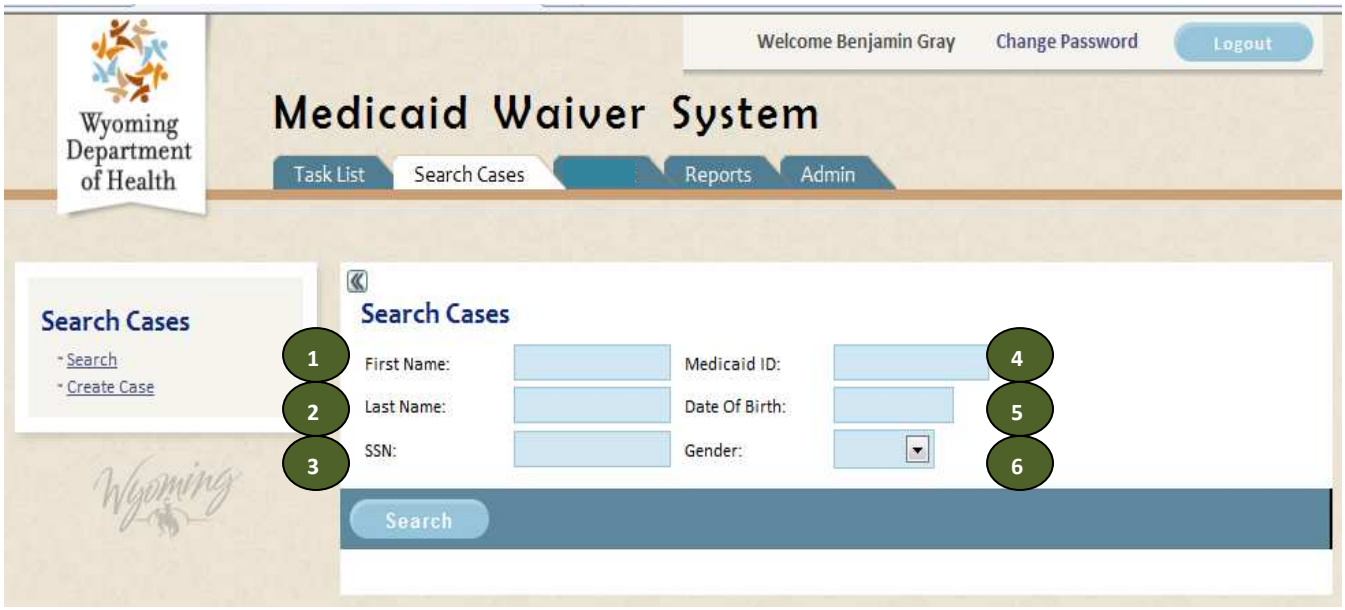
In the example above, choosing to view the task "Submit Plan of Care" for Help Me, opens the "Submit Plan of Care" screen.

From this point a user may access other sections of a participant's information by using the links to the left of the screen.

Search Cases Screen



When looking for a participant in the database, the user will click on the "Search Cases" tab. After clicking on the tab the following screen will open.



To the left of the screen are two options:

- Search
- Create Case

The screen will default to the option "Search Cases". *A Case Manager/Care Coordinator should not need to create a case.*

To search for a participant, currently there are six potential search criteria:

1. First Name
2. Last Name
3. SSN

4 Medicaid ID

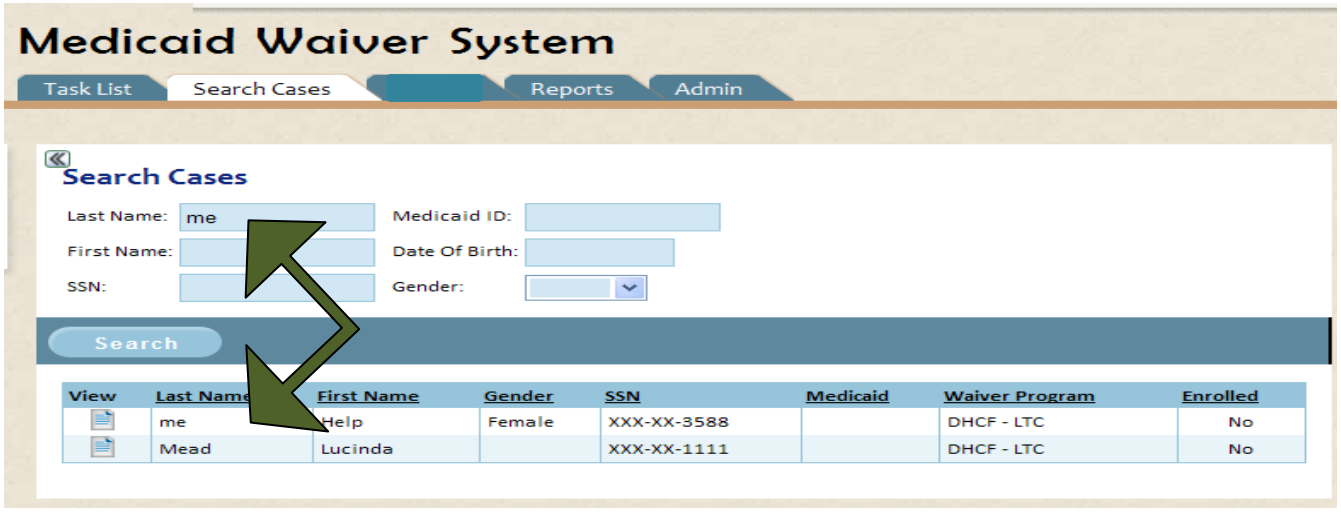
5 Date of Birth

6 Gender

A user may utilize one or all six criteria to search for a participant. Determine what information you will be using. With the exception of "SSN" and "Medicaid ID" *(which if entered correctly, should return the desired participant in the result set)*, the more criteria entered, the smaller the result set will be.

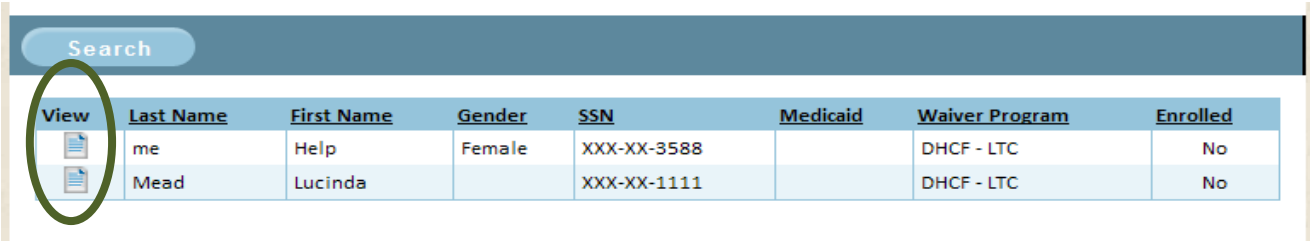
- If a user only enters female, all females will appear in the result set.
- If a user enters both female and the last name "Smith", the result set will return all females with the last name "Smith".

In the example below just the letters "m" and "e" were entered in the last name field. Notice both the last names "Me" and "Mead" appeared.



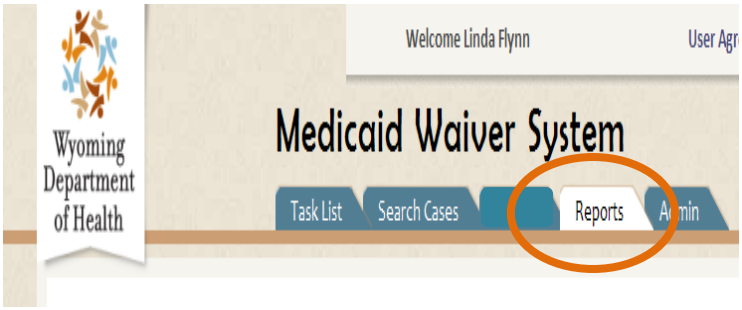
Case Managers and Care Coordinators will only see the participants associated with their provider number.

Once the participant desired is located, the user will click on the document icon in the "View" column to access the participant's information.



From this point a user may access other sections of a participant's information by using the links to the left of the screen.

Reports Screen



The Reports Screen will have all reports available to Case Manager/Care Coordinator Agencies.

There are NO reports available.

Admin Screen

The Admin Screen will have all documents and administrative items available to Case Manager/Care Coordinator Agencies.

There are NO items available.

Waitlist Process

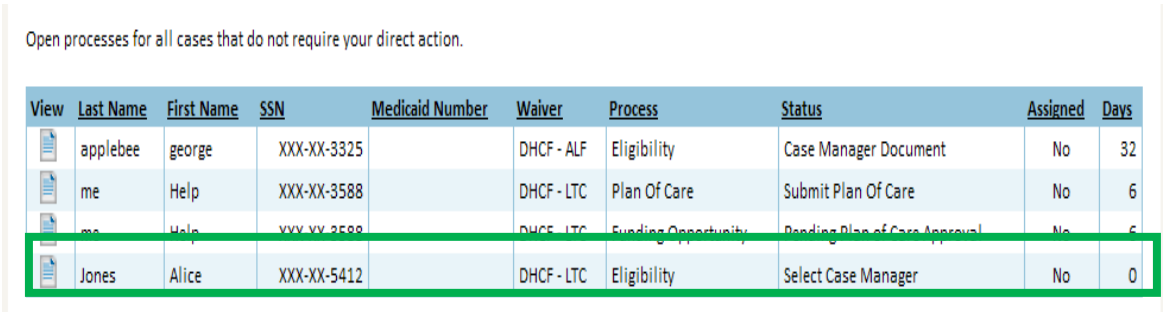
To Put a Participant on the Waitlist

Steps to put a participant on the waiting list:

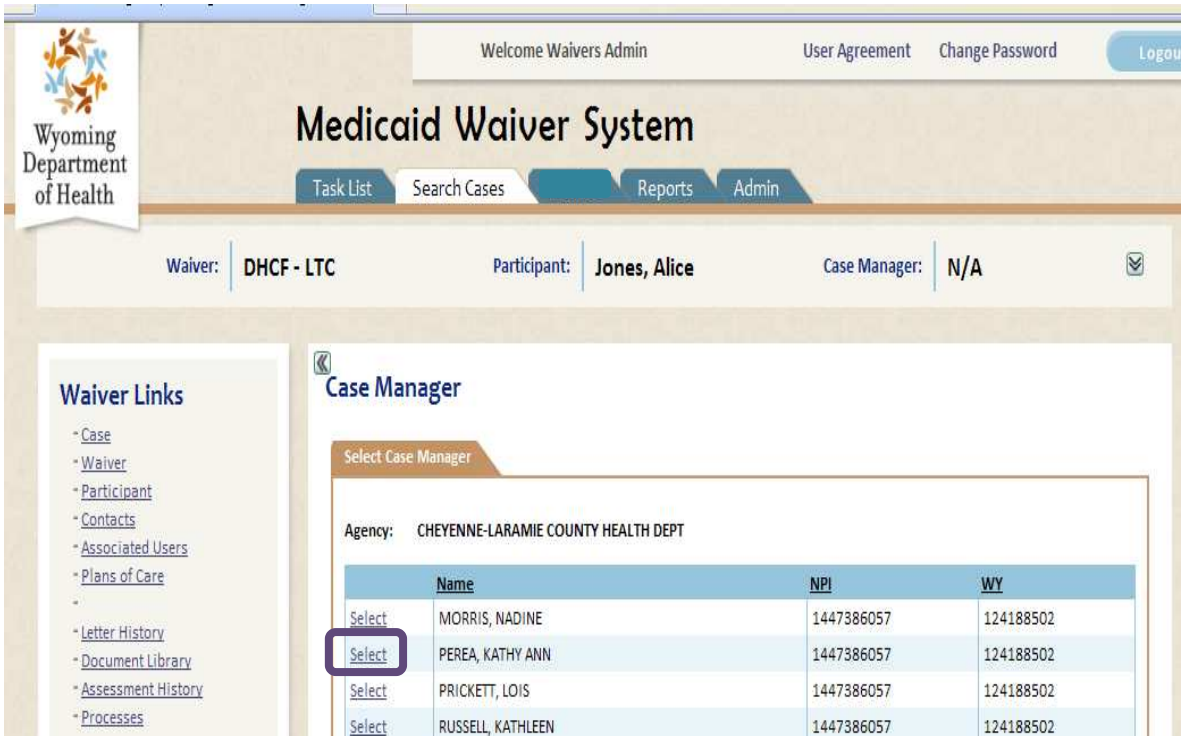
1. Participant contacts Home Care Services Unit for information.
2. Information is sent to participant.
3. Follow-up by Home Care Services Unit if application is not received timely.
4. Once application has been completed, Home Care Services unit will enter application information into EMWS. This will trigger a notification to:
    a. Department of Family Services (DFS) to initiate financial evaluation.
    b. Clinical Manager for Long Term Care to contact Public Health Nursing (PHN) to initiate evaluation of medical necessity.
    c. Chosen Case Management/Care Coordinator Agency to assign a Case Manager/Care Coordinator to the participant.
5. After BOTH the financial evaluation and the evaluation of medical necessity are complete, and participant is deemed financially and functionally eligible, the Case Manager/Care Coordinator is notified to proceed.
6. Case Manager/Care Coordinator will visit participant in their home (if this hasn't been already been done).
    a. Review with participant needed services.
    b. Have participant sign "Client Choice of Service" form.
    c. Review with participant the "Rights and Responsibilities" form and have participant sign to indicate understanding.
7. Case Manager/Care Coordinator reviews/validates/updates participant information.
    a. Case Manager/Care Coordinator uses the task list to view required information for participant.
    b. Case Manager/Care Coordinator locates the participant through the "Search Case" screen.
8. Case Manager/Care Coordinator uploads "Client Choice of Service" and "Rights and Responsibilities" forms.
9. Home Care Services Unit reviews and validates information and documentation.
10. If information and documentation is valid, participant goes onto waiting list.

4.c. Case Manager/Care Coordinator assignment by agency

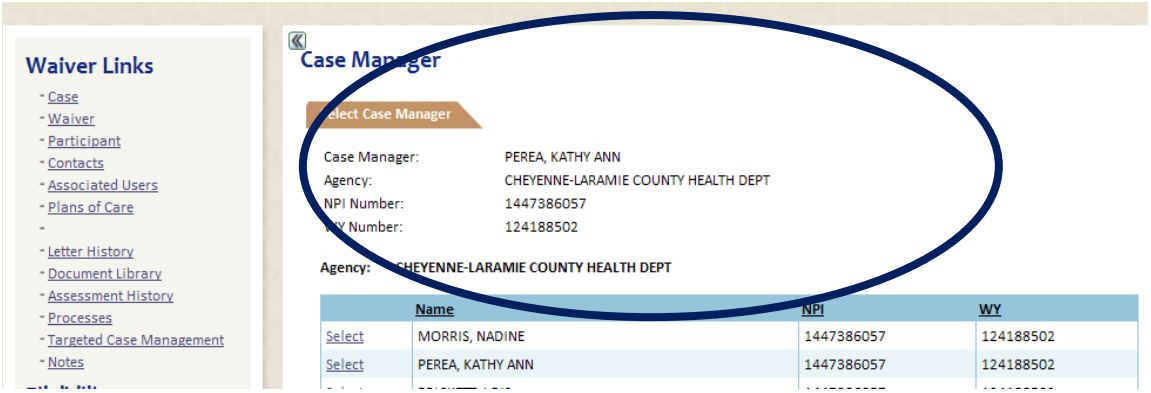
After a participant's application has been entered into the EMWS, notification will be sent to the chosen agency for Case Manager/Care Coordinator assignment.



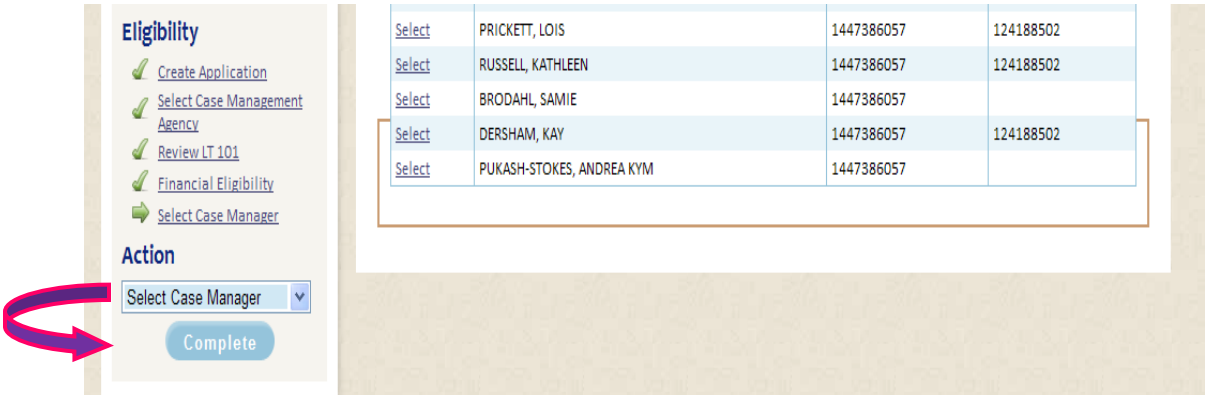
The Case Manager/Care Coordinator will click on the document icon in the "View" column to access this task. When this screen opens, a choice of providers for the agency will appear.



Click on "Select" next to the Case Manager/Care Coordinator chosen. Once the Case Manager/Care Coordinator is chosen, their information will appear above the selection options.



When the choice has been made, to the left is an action drop down box. Choose “Select Case Manager” then click on the “Complete” button

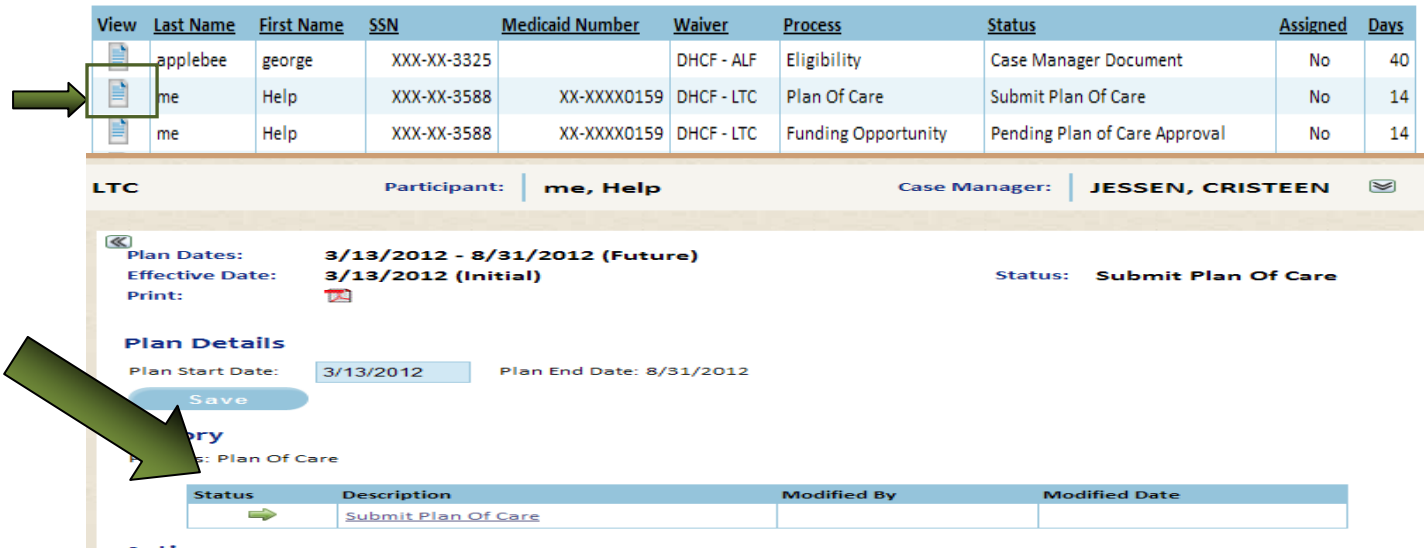


6. Obtaining required documentation (from page 22)

After the participant has been determined BOTH financially and functionally eligible, the Case Manager/Care Coordinator visits the participant (if not done already). The Case Manager/Care Coordinator will review the participant’s needs and review the document “Client Choice of Service”. If client continues to be interested in one of the LTC/ALF waiver programs, the Case Manager/Care Coordinator will obtain the participant’s signature on the “Client Choice of Service” document.

7.a. Locating participant in the waiver system through the Task List Screen (from page 22)

To process the needed task, or to view a task at any point in the workflow process, click on the document icon in the “View” column of the task. This will take you directly to the task associated with that icon.

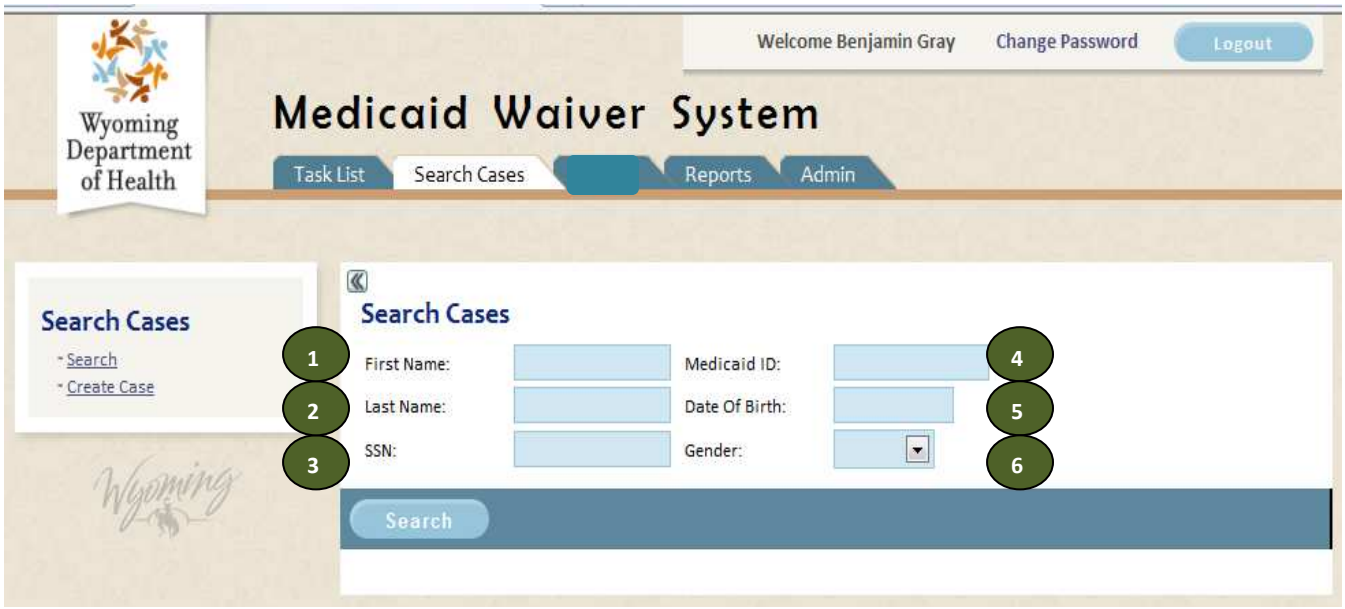


In the example above, choosing to view the task “Submit Plan of Care” for Help Me, opens the “Submit Plan of Care” screen.

From this point a user may access other sections of a participant's information by using the links to the left of the screen.

7.b. Locating participant in the waiver system through the Search Cases Screen (from page 22)

When looking for a participant in the database, the user will click on the "Search Cases" tab. After clicking on the tab the following screen will open.



To the left of the screen are two options:

- Search
- Create Case

The screen will default to the option “Search Cases”. *A Case Manager/Care Coordinator should not need to create a case.*

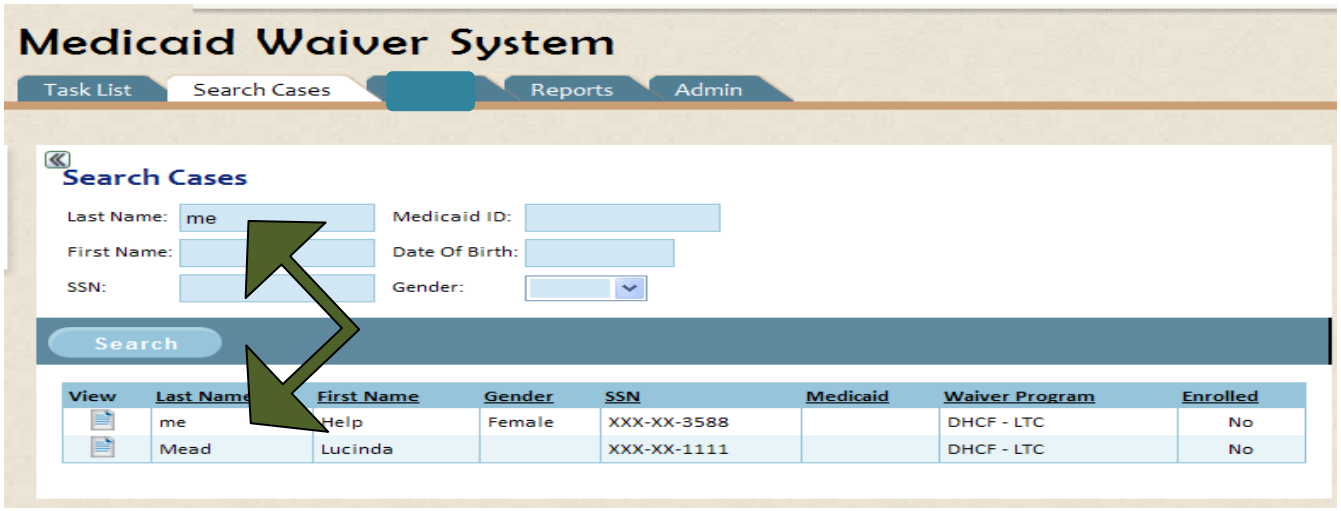
To search for a participant, currently there are six potential search criteria:

1. First Name
2. Last Name
3. SSN
4. Medicaid ID
5. Date of Birth
6. Gender

A user may utilize one or all six criteria to search for a participant. Determine what information you will be using. With the exception of “SSN” and “Medicaid ID” *(which if entered correctly, should return the desired participant in the result set)*, the more criteria entered, the smaller the result set will be.

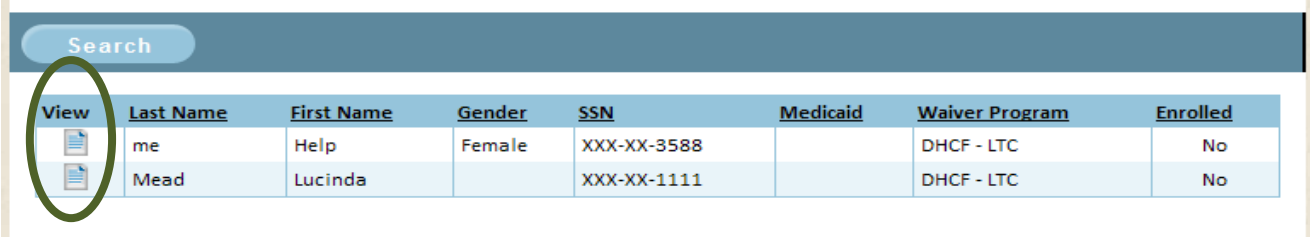
- If a user only enters female, all females will appear in the result set.
- If a user enters both female and the last name “Smith”, the result set will return all females with the last name “Smith”.

In the example below just the letters “m” and “e” were entered in the last name field. Notice both the last names “Me” and “Mead” appeared.



Case Managers and Care Coordinators will only see the participants associated with their provider number.

Once the participant desired is located, the user will click on the document icon in the "View" column to access the participant's information.

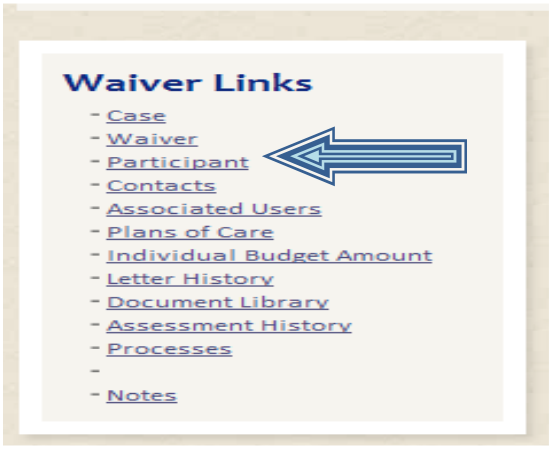


From this point a user may access other sections of a participant's information by using the links to the left of the screen.

7. Updating participant information (from page 22)

To update a participant's information, a Case Manager/Care Coordinator must be in the "Participant" screen. The "Participant" screen should look like the screen below at the top of a user's screen.

If the screen does not look like above, click on the link "Participant" under the title "Waiver Links" to the left of the screen.



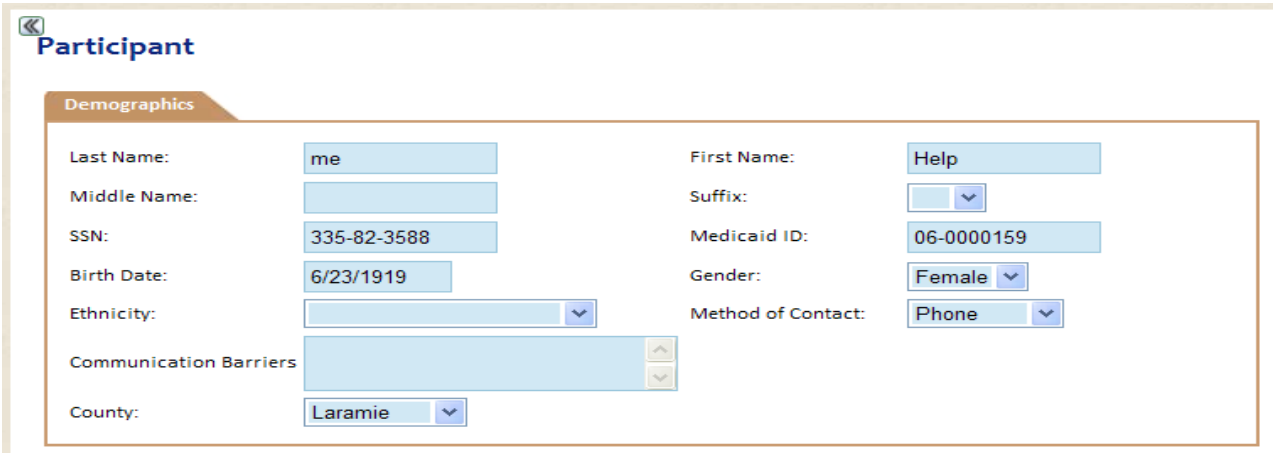
If a user is not at a participant's screen, please refer to sections *"Review Information through Task List Screen" on page 11 or "Search Cases Screen" on page 17 for instructions to access a screen with "Waiver Links".*

On the Participant's demographic screen are four sections:

- Demographics
- Addresses
- Phone Numbers
- Email Addresses

Each section must be verified for correctness.

Demographics



The demographics section has the following fields:

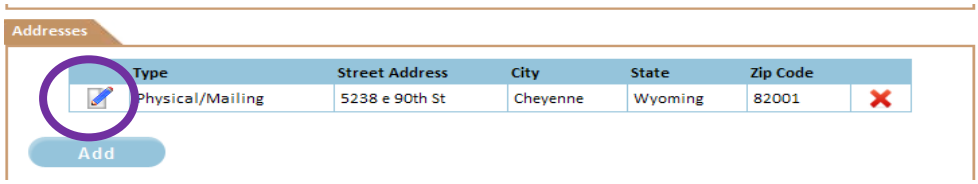
- Last Name – The last name of the participant
- First Name – The first name of the participant
- Middle Name – The middle name of the participant (if available)
- Suffix – Jr., III, etc
- SSN – the social security number of the participant. This **MUST** be the participant's SSN; not the spouse's.

- Medicaid ID - the "06…" of the participant. ***REMINDER – ID's that start with "00…" are NOT Client ID's and cannot be used as such.***
- Birth Date – The participant's date of birth
- Gender – Male/Female
- Ethnicity – Race of participant
- Method of Contact – the Participant's desired form of contact.
- Communication Barriers – A note section to indicate any limitations the participant may have to communicate. This can include a physical disability or language barrier.
- County – the participant's county of residence. (This is dictated by the participant's physical address).

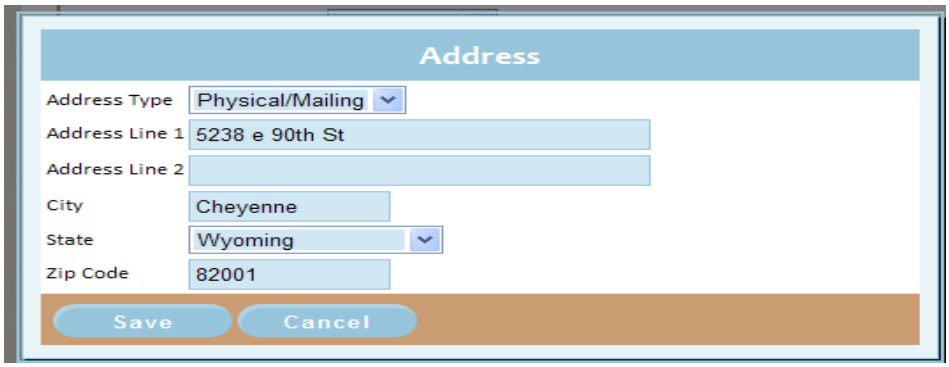
Verify the information is correct and current.

Addresses

The next section has the participant's address information. A participant may have one or multiple addresses.

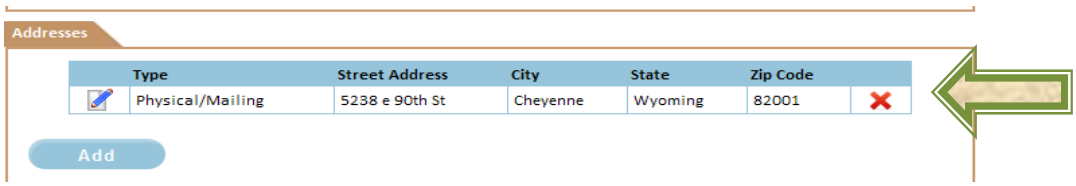


To update an address currently in the system, click on the "pencil" icon next to the address to update. This will open the address window.



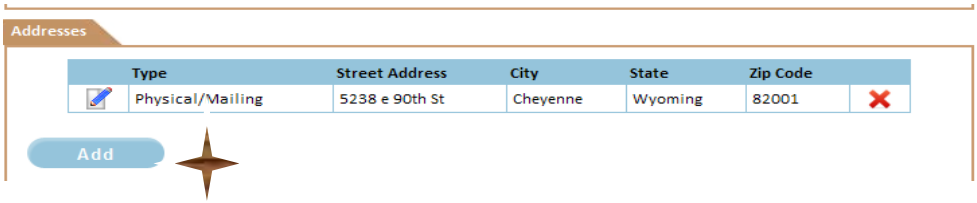
Update any information to be changed. When finished, click on the "Save" button.

To disregard any changes made, click on the "Cancel" button.



To delete an address, click on the Red "X" button . This will delete the address from the system.

To add a new address, click on the "Add" button.

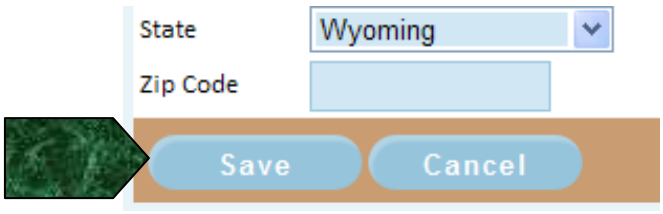


This will open the window to add a new address.

Enter the following information:

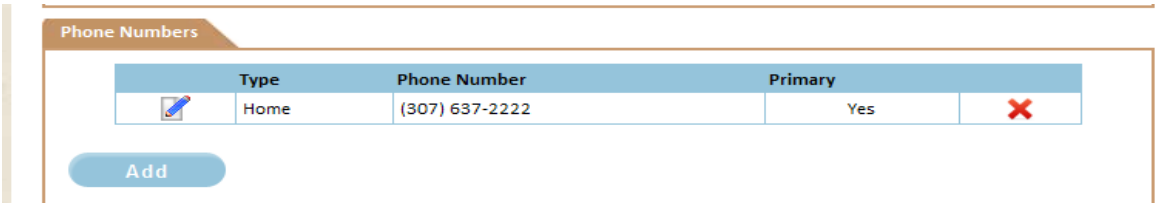
- Address Type – this will be one of three options
  - Physical – The address the participant resides
  - Mailing – The address all correspondence is mailed to, if different from the physical address.
  - Physical/Mailing – If both the physical and mailing addresses are the same, use this option.
- Address Line 1 – Street address or PO Box
- Address Line 2 – Apt. number, or additional street address information if there is not enough room on the first line.
- City – City the address is associated with. *Mailing and Physical addresses may be different.*
- State – the State will default to Wyoming. Can be changed for mailing address information. ***THE PARTICIPANT MUST RESIDE IN THE STATE TO BE AN ELIGIBILE PARTICIPANT ON THE WAIVER.***
- Zip Code – the zip code associated with the city and address.

When the address has been added, click on the "Save" Button.

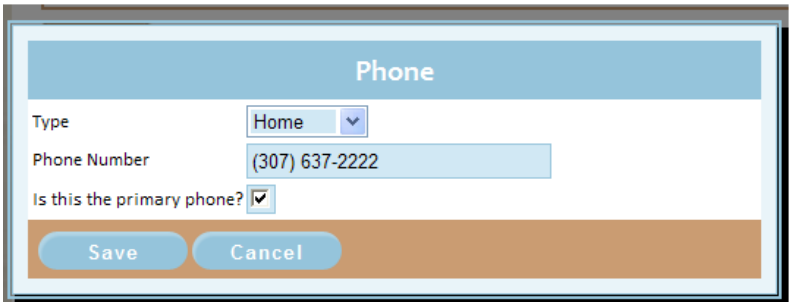


Phone Numbers

In the phone number section of the screen, all phone numbers associated with the participant are listed here. A participant may have one or many phone numbers.

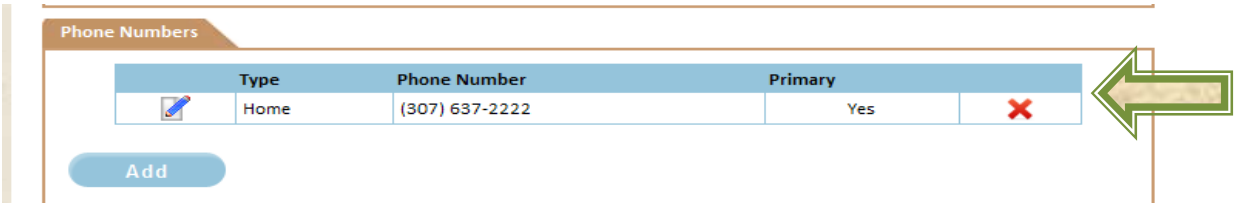


To update a phone number currently in the system, click on the "pencil" icon next to the phone number to update. This will open the phone window.



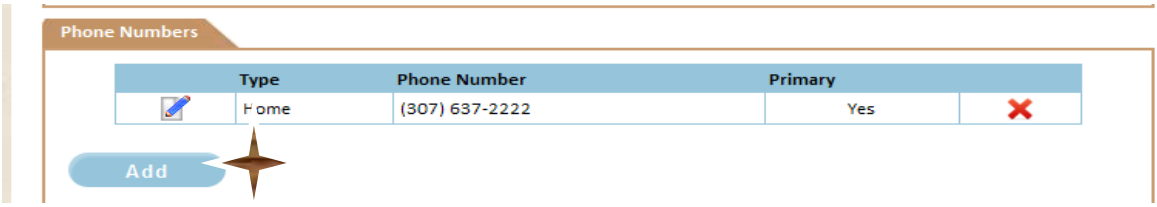
Update any information to be changed. When finished, click on the "Save" button.

To disregard any changes made, click on the "Cancel" button.



To delete a phone number, click on the Red "X" button . This will delete the phone number from the system.

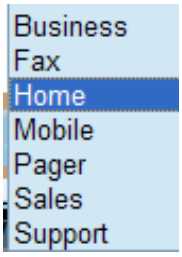
To add a new phone number, click on the "Add" button.



This will open the window to add a new phone number.

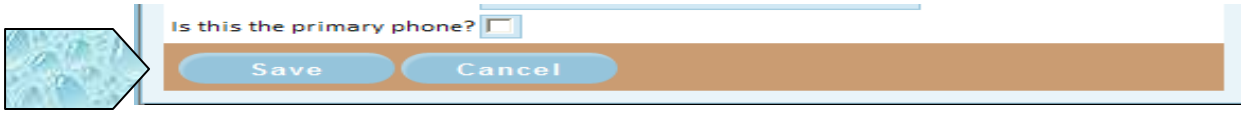
Enter the following information:

- Type – the phone type. Current phone types are listed below:



- Phone number – the full phone number for the participant. This includes area code.
- Is this the primary phone? – A check box to indicate the primary phone for the participant.

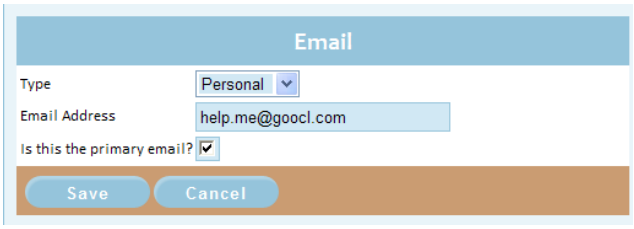
When the phone number has been added, click on the "Save" Button.



Email Addresses

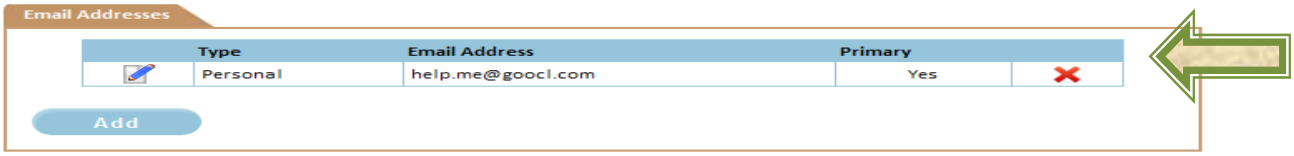
The email section is an optional section to the participant's demographics. If a participant wishes to give their email, it is to be entered here. A participant may have one or multiple email addresses.

To update an email address currently in the system, click on the "pencil" icon next to the address to update. This will open the email window.



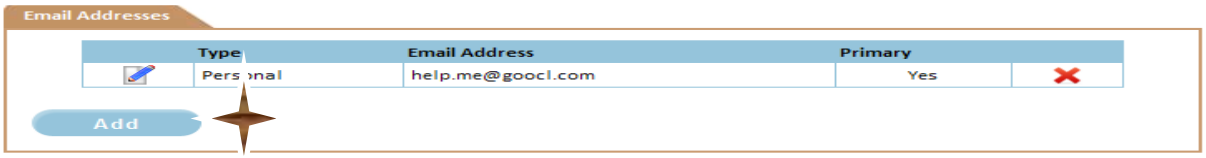
Update any information to be changed. When finished, click on the "Save" button.

To disregard any changes made, click on the "Cancel" button.

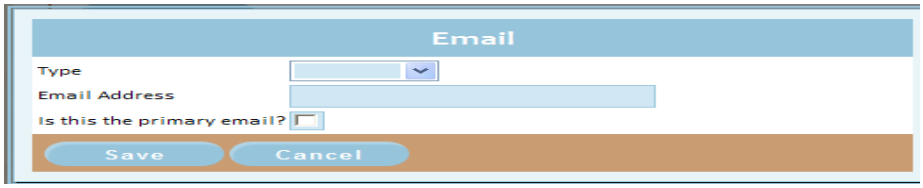


To delete an email address, click on the Red "X" button . This will delete the address from the system.

To add a new email address, click on the "Add" button.

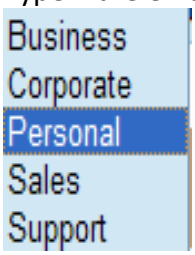


This will open the window to add a new email address.



Enter the following information:

- Type – the email type. Current email types are listed below



- Email Address – the full email address for the participant. This includes the @ symbol and a valid ".com" site.
- Is this the primary email? – A check box to indicate the primary email address for the participant.

When the email address has been added, click on the "Save" Button.

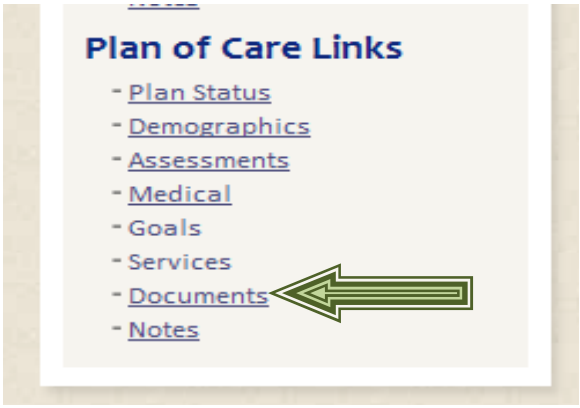
There is no "Action" button for this task.

8. Uploading documents (from page 22)

There are two documents that are required for a Plan of Care:

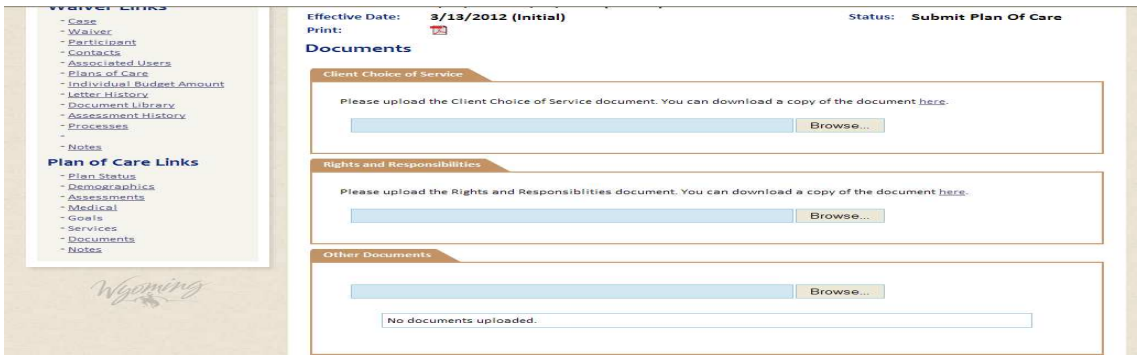
- ✓ Client Choice of Service (HCBS-1)
  - o Due when putting a participant on the waiting list
  - o Due when a participant has received a funding opportunity
  - o Due at each renewal plan period
- ✓ Client Rights and Responsibilities
  - o Due when a participant has received a funding opportunity
  - o Due at each renewal plan period

To upload the documents into the system, click on the "Documents" link under the section "Plan of Care Links" to open the document window.



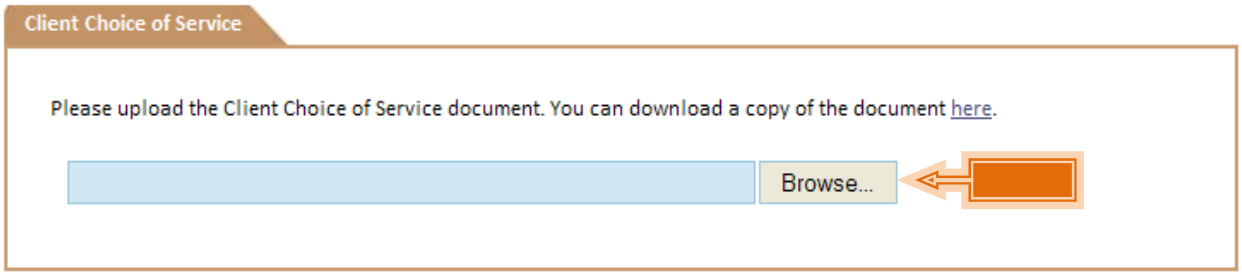
If a user is not at a participant's Plan of Care screen, please refer to sections *"Review Information through Task List Screen" on page 15 or "Search Cases Screen*" on page 17 for instructions to access a participant's information.

When open, the document window should look like this.

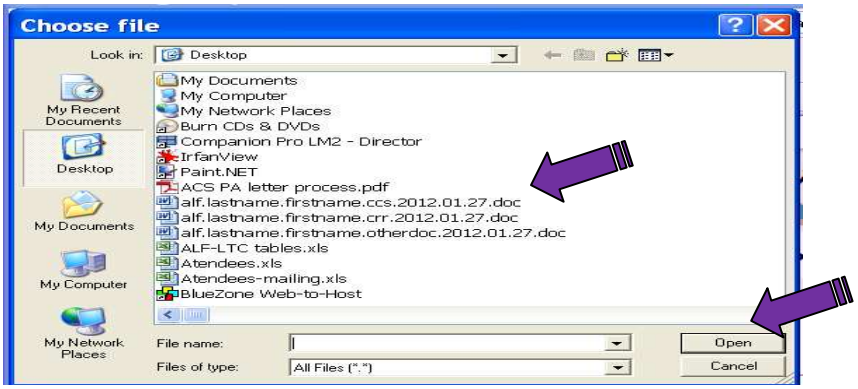


Client Choice of Service

To upload a scanned Client Choice of Service, click on the Browse button.



This will open the "choose file" window. Locate the file, highlight the file and click on the "Open" button.

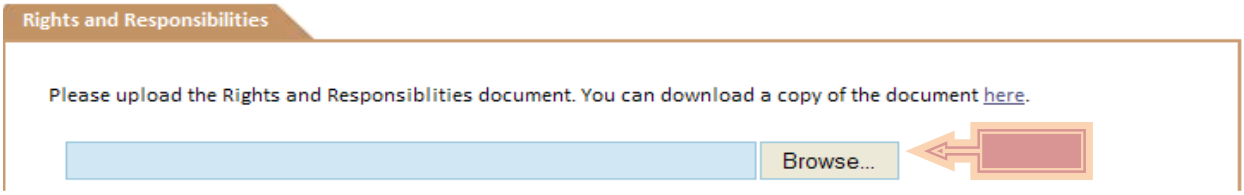


Once uploaded, a link to the document will be available.

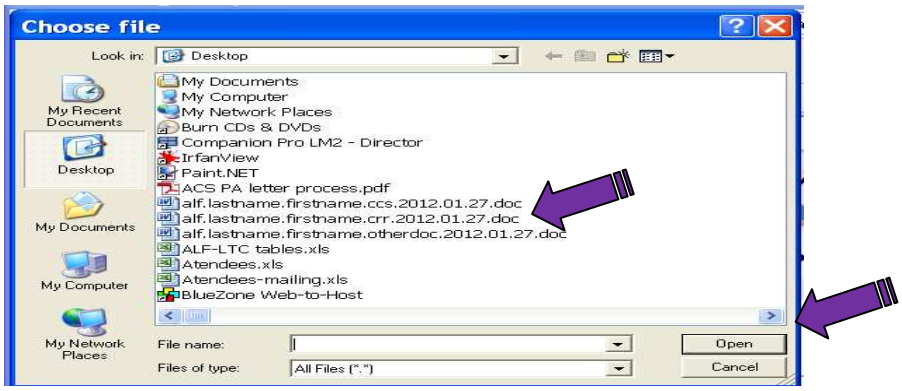
If an error is made and the wrong document is uploaded, just re-upload the correct document. It will override the incorrect document.

Client Rights and Responsibilities

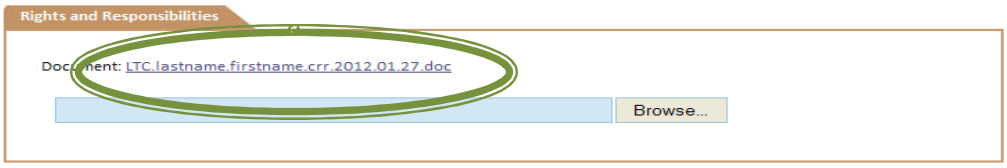
To upload a scanned Client Rights and Responsibilities, click on the "Browse" button under "Rights and Responsibilities" section.



This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



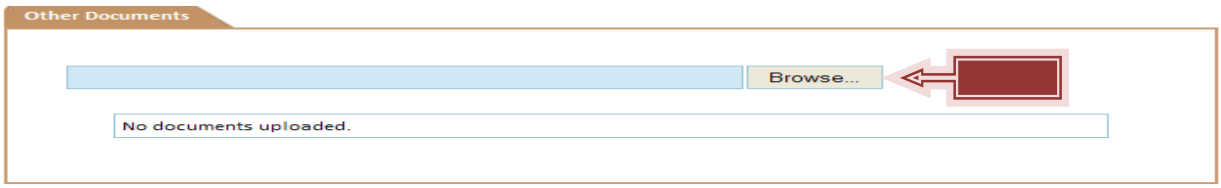
Once uploaded, a link to the document will be available.



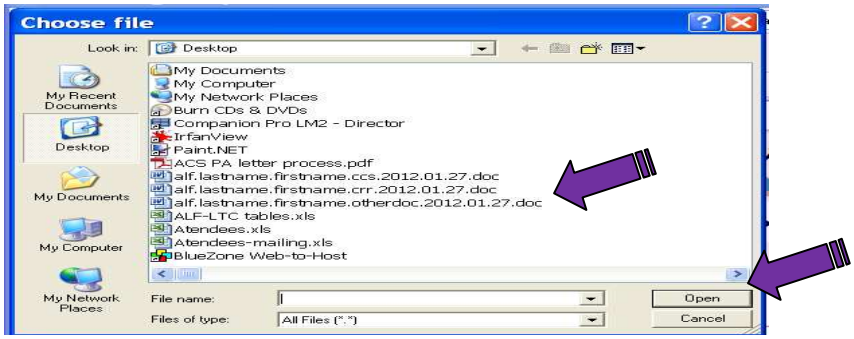
If an error is made and the wrong document is uploaded, just re-upload the correct document. It will override the incorrect document.

Other Documents

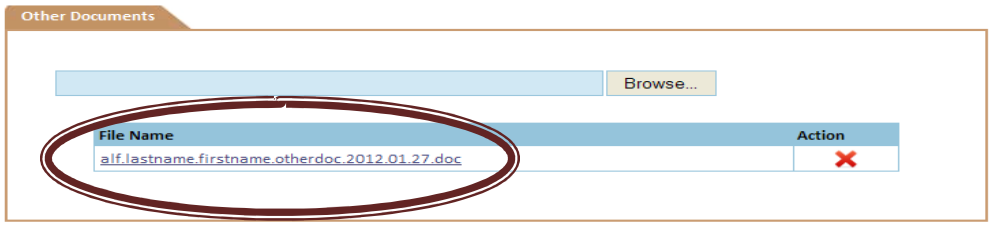
There may be times when additional documentation is required. To upload additional documents, click on the “Browse” button under “Other Documents” section.



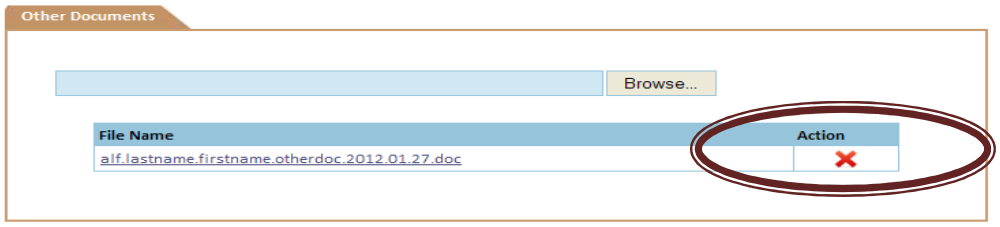
This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



Once uploaded, a link to the document will be available.



These documents may be deleted if necessary. To delete the scanned and uploaded document, click on the red "X" under "Action" to the left of the file name.



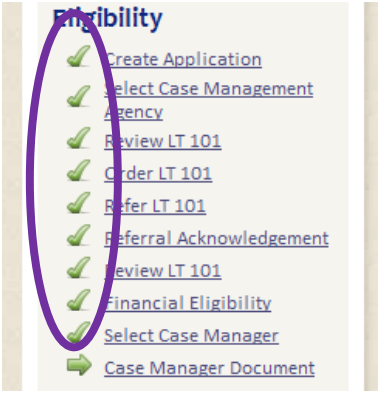
This will remove the document from the system.

Receiving a Funding Opportunity for a Participant

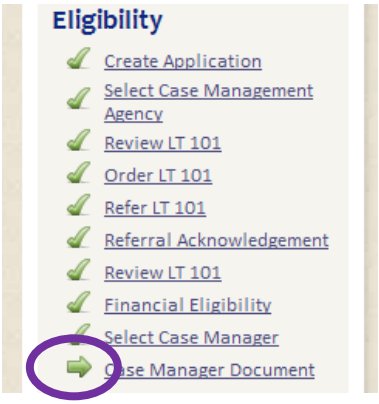
Steps when a participant receives a funding opportunity:

1. Participant reaches the top of the waiting list and receives a funding opportunity.
2. This will trigger a notification to:
    a. Department of Family Services (DFS) to re-verify financial eligibility.
    b. Clinical Manager for Long Term Care to contact Public Health Nursing (PHN) to initiate the evaluation of medical necessity, if current LT101 is more than 60 days old.
    c. The chosen Case Management/Care Coordinator to inform of participant status.
3. After the evaluation of medical necessity is complete, and participant is deemed functionally eligible, the Case Manager/Care Coordinator is notified of ability to complete the Plan of Care.
4. Case Manager/Care Coordinator will visit participant (if this hasn't been already been done).
    a. Review needed services with participant.
    b. Have participant sign "Client Choice of Service" form.
    c. Review with participant the "Rights and Responsibilities" form and have participant sign to indicate understanding.
5. Case Manager/Care Coordinator reviews/validates/updates participant information.
    a. Case Manager/Care Coordinator uses the task list to view required information for participant.
    b. Case Manager/Care Coordinator locates the participant through the "Search Case" screen.
6. Case Manager/Care Coordinator reviews/validates/updates participant demographic information.
7. Case Manager/Care Coordinator enters information to create a Plan of Care:
    a. Medical information
    b. Goals
    c. Services
8. Case Manager/Care Coordinator uploads Client Choice of Service and Rights and Responsibilities forms.
9. Home Care Services Unit reviews and validates information and documentation.
10. DFS re-validates participant eligibility for LTC/ALF waiver.
11. If information and documentation is valid and eligibility is confirmed, participant receives funding opportunity.
12. Participant's Plan of Care is sent to Fiscal Agent (ACS, a Xerox Company) for Prior Authorization.

As a user goes through each step in the system, there will be a green check mark next to each finished task. The task list for each process is located below the "Waiver Links" to the left of the participant's screen.



If there is a green arrow next to the task, this is the next task to be worked on.



2.c. Notification of participant status (from page 38)

When a participant reaches the top of the waiting list, either through a special funding opportunity or through the normal progression, notification will be sent to the Case Manager/Care Coordinator to inform of the participant's status. The Case Manager/Care Coordinator may inform the participant of their status and to be aware of the PHN visit and DFS re-verification. The Case Manager/Care Coordinator may commence the Plan of Care process.

4. Obtaining required documentation (from page 38)

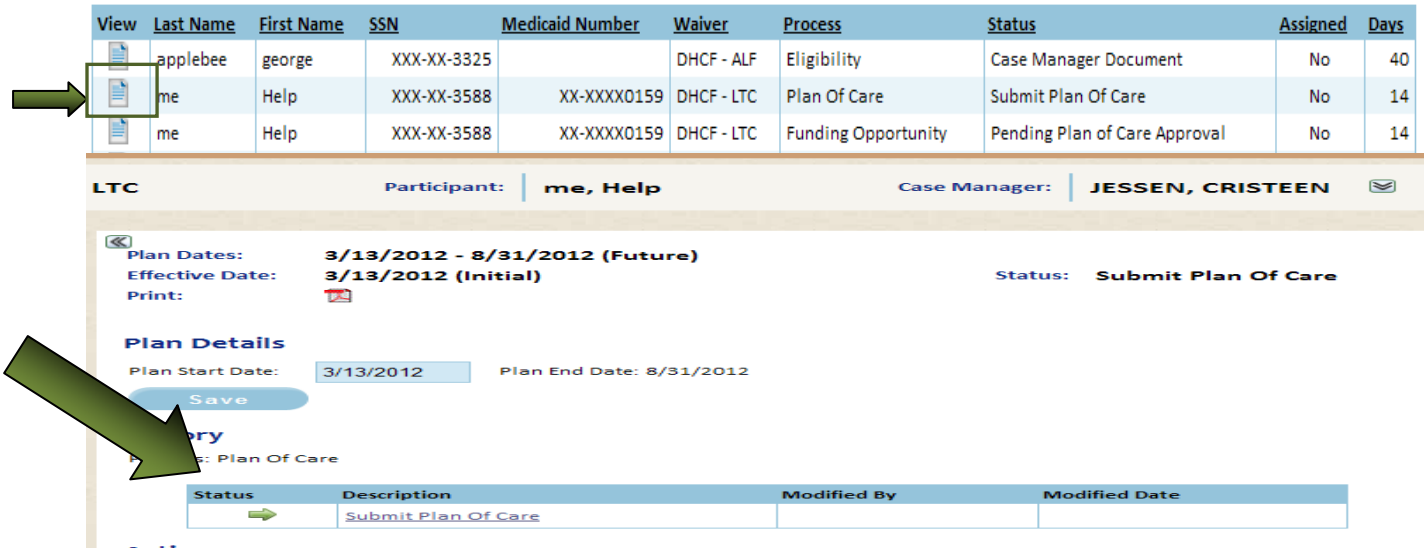
After the participant has been determined BOTH financially and functionally eligible, the Case Manager/Care Coordinator visits the participant (if not done already).

1. The Case Manager/Care Coordinator will review the participant's needs.
2. Reviews the document "Client Choice of Service".
3. If client continues to be interested in one of the LTC/ALF waiver programs, the Case Manager/Care Coordinator will obtain the participant's signature on the "Client Choice of Service" document.
4. The Case Manager/Care Coordinator will review the "Client Rights and Responsibilities" document with the participant. After reviewing the document, making sure the

participant understands their rights and responsibilities, the Case Manager/ Care Coordinator will have the client sign the document.

5.a. Locating participant in the waiver system through the Task List Screen (from page 38)

To process the needed task, or to view a task at any point in the workflow process, click on the document icon in the "View" column of the task. This will take you directly to the task associated with that icon.

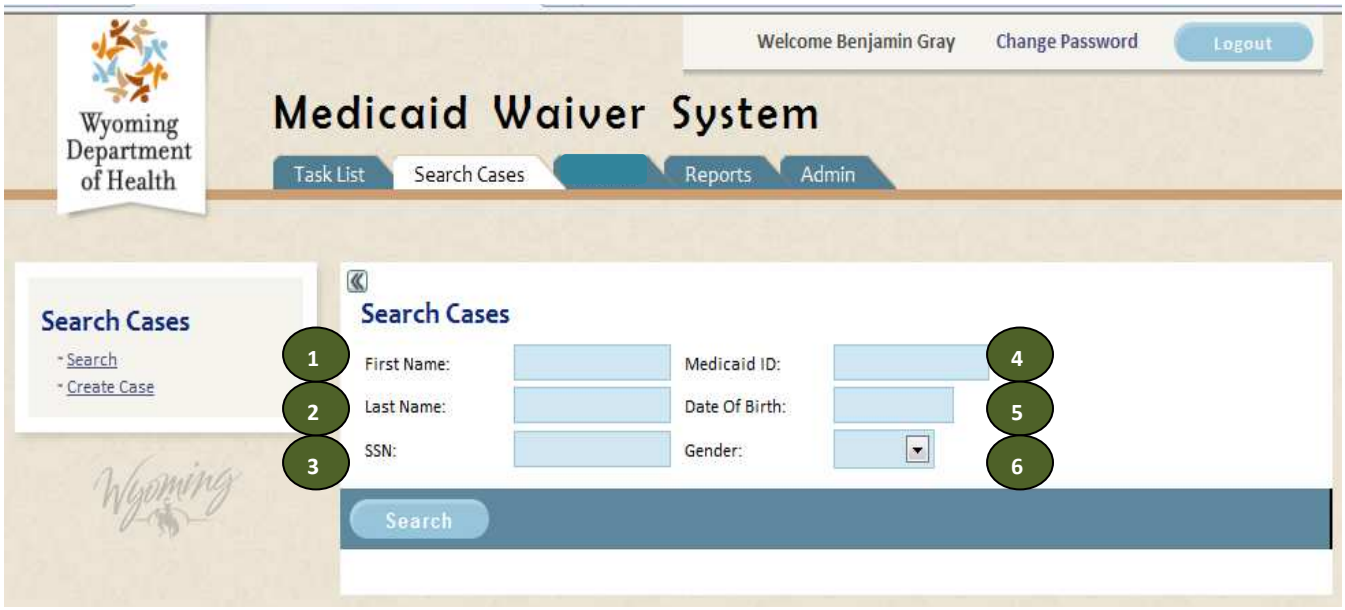


In the example above, choosing to view the task "Submit Plan of Care" for Help Me, opens the "Submit Plan of Care" screen.

From this point a user may access other sections of a participant's information by using the links to the left of the screen.

5.b. Locating participant in the waiver system through the Search Cases Screen (from page 38)

When looking for a participant in the database, the user will click on the "Search Cases" tab. After clicking on the tab, the following screen will open.



To the left of the screen are two options:

- Search
- Create Case

The screen will default to the option "Search Cases". *A Case Manager/Care Coordinator should not need to create a case.*

To search for a participant, currently there are six potential search criteria:

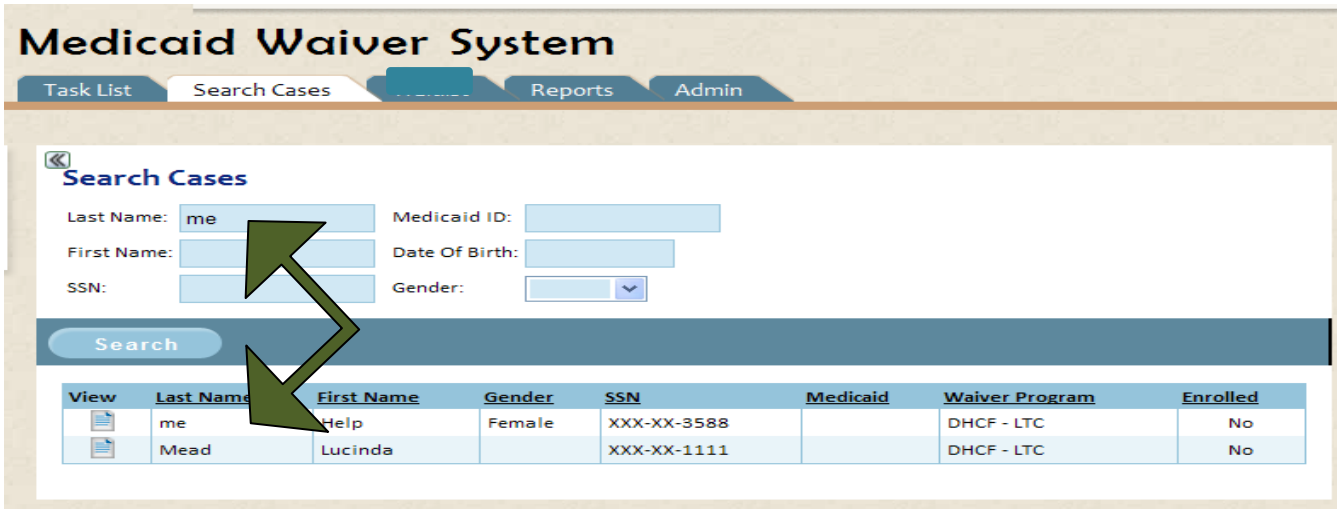
1. First Name
2. Last Name
3. SSN
4. Medicaid ID
5. Date of Birth
6. Gender

A user may utilize one or all six criteria to search for a participant. Determine what information you will be using. With the exception of "SSN" and "Medicaid ID" *(which if entered correctly, should return the desired participant in the result set)*, the more criteria entered, the smaller the result set will be.

- If a user only enters female, all females will appear in the result set.

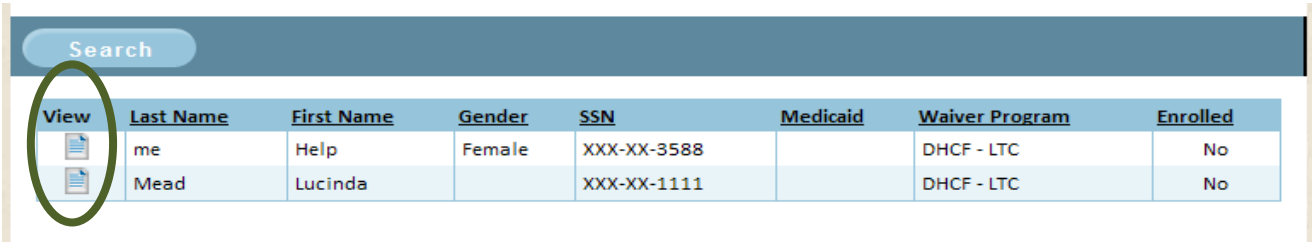
- If a user enters both female and the last name “Smith”, the result set will return all females with the last name “Smith”.

In the example below just the letters “m” and “e” were entered in the last name field. Notice both the last names “Me” and “Mead” appeared.

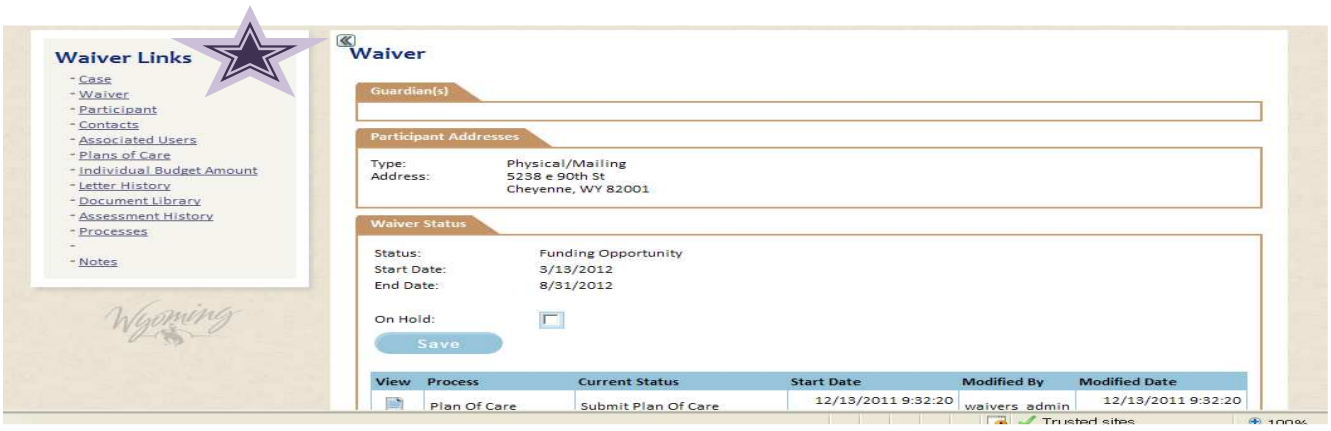


Case Managers and Care Coordinators will only see the participants associated with their provider number.

Once the participant desired is located, the user will click on the document icon in the “View” column to access the participant’s information.



From this point a user may access other sections of a participant’s information by using the links to the left of the screen.



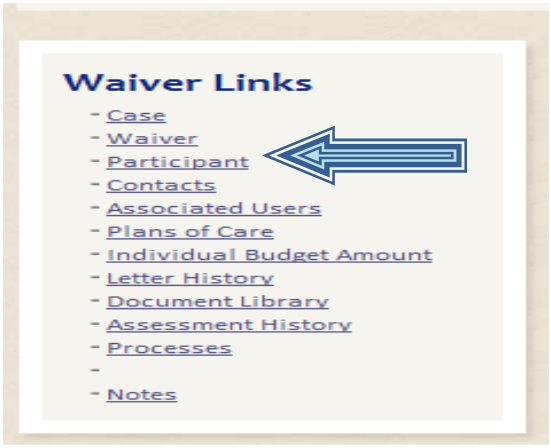
6. Updating participant information (from page 38)

It is important to keep a participant's demographic information current and up-to-date. At a minimum, a Case Manager/Care Coordinator **must** validate and update demographic information at these times:

- When placing a participant on the wait list
- When a participant has received a funding opportunity
- At each renewal period for a participant
- Anytime a participant's information changes

To update a participant's information, a Case Manager/Care Coordinator must be in the "Participant" screen. The "Participant" screen should look like the screen below at the top of a user's screen.

If the screen does not look like above, click on the link "Participant" under the title "Waiver Links" to the left of the screen.



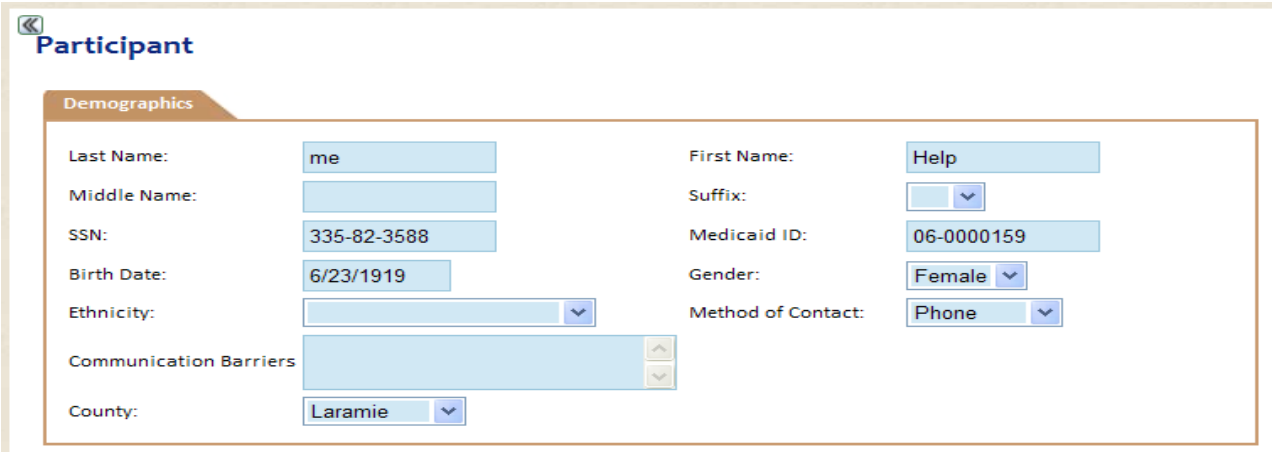
If a user is not at a participant's screen, please refer to sections *"Review Information through Task List Screen" on page 11 or "Search Cases Screen" on page 17* for instructions to access a screen with "Waiver Links".

On the Participant's demographic screen are four sections:

- Demographics
- Addresses
- Phone Numbers
- Email Addresses

Each section must be verified for correctness.

Demographics



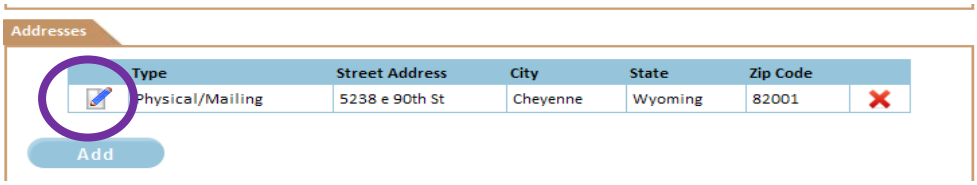
The demographics section has the following fields:

- Last Name – The last name of the participant
- First Name – The first name of the participant
- Middle Name – The middle name of the participant (if available)
- Suffix – Jr., III, etc
- SSN – the social security number of the participant. This **MUST** be the participant's SSN; not the spouse's.
- Medicaid ID - the "06…" of the participant. ***REMINDER – ID's that start with "00…" are NOT Client ID's and cannot be used as such.***
- Birth Date – The participant's date of birth
- Gender – Male/Female
- Ethnicity – Race of participant
- Method of Contact – the Participant's desired form of contact.
- Communication Barriers – A note section to indicate any limitations the participant may have to communicate. This can include a physical disability or language barrier.
- County – the participant's county of residence. (This is dictated by the participant's physical address).

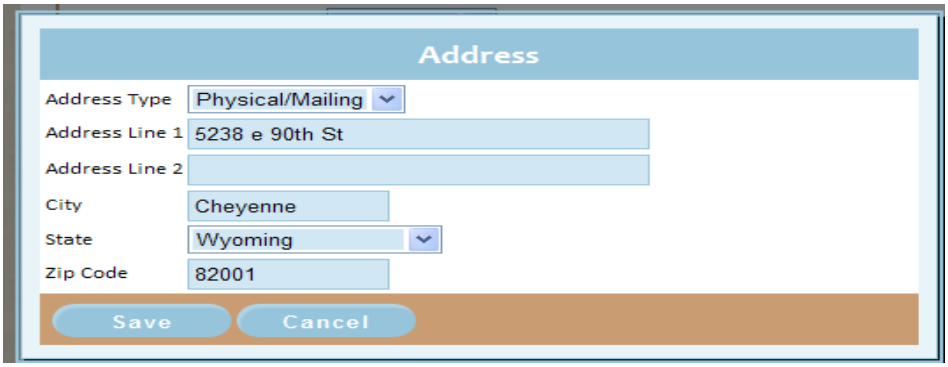
Verify the information is correct and current.

Addresses

The next section has the participant's address information. A participant may have one or multiple addresses.

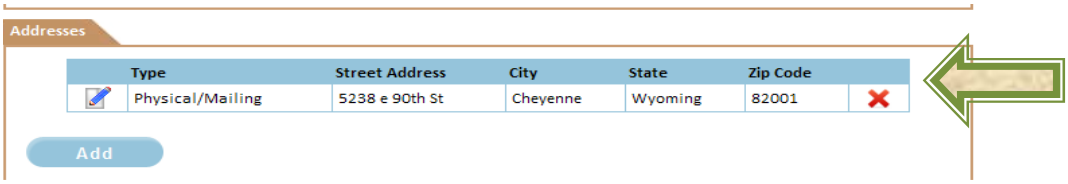


To update an address currently in the system, click on the "pencil" icon next to the address to update. This will open the address window.



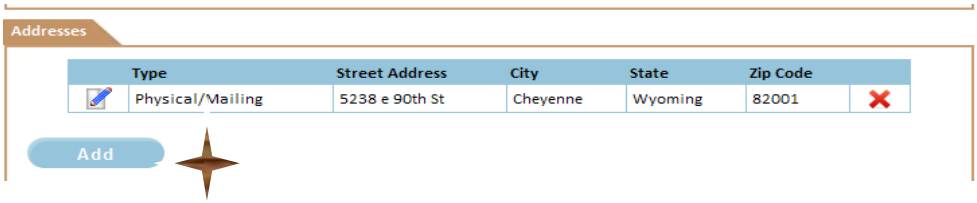
Update any information to be changed. When finished, click on the "Save" button.

To disregard any changes made, click on the "Cancel" button.

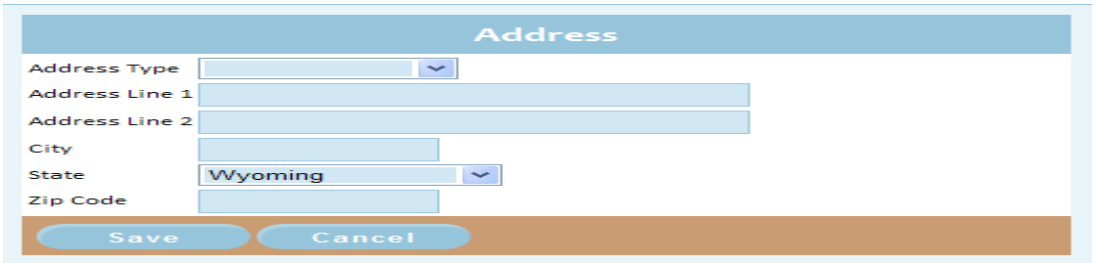


To delete an address, click on the Red "X" button . This will delete the address from the system.

To add a new address, click on the "Add" button.



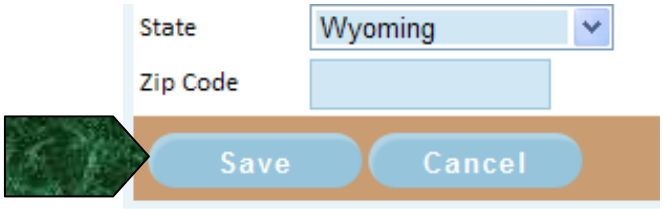
This will open the window to add a new address.



Enter the following information:

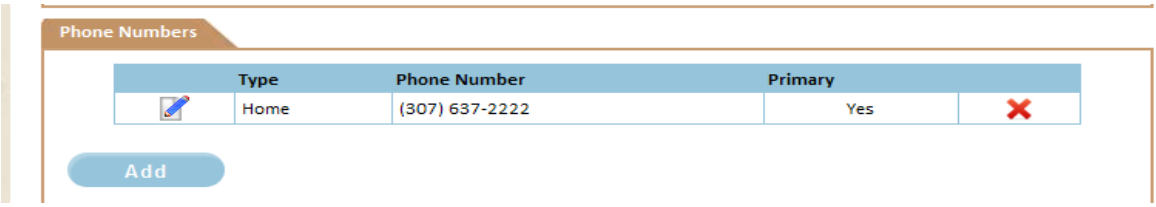
- Address Type – this will be one of three options:
  - Physical – The address the participant resides
  - Mailing – The address all correspondence is mailed to, if different from the physical address.
  - Physical/Mailing – If both the physical and mailing addresses are the same, use this option.
- Address Line 1 – Street address or PO Box
- Address Line 2 – Apt. number, or additional street address information if there is not enough room on the first line.
- City – City the address is associated with. *Mailing and Physical addresses may be different.*
- State – the State will default to Wyoming. Can be changed for mailing address information. ***THE PARTICIPANT MUST RESIDE IN THE STATE TO BE AN ELIGIBILE PARTICIPANT ON THE WAIVER.***
- Zip Code – the zip code associated with the city and address.

When the address has been added, click on the "Save" Button.

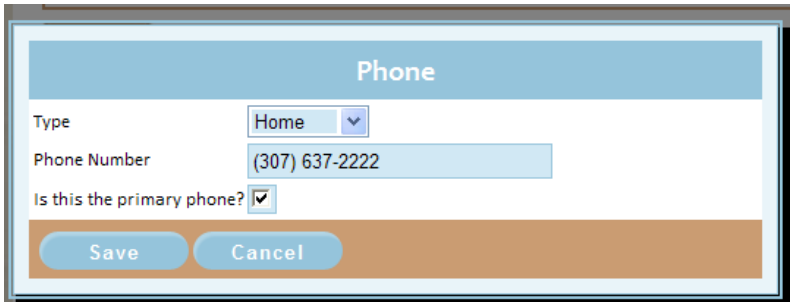


Phone Numbers

In the phone number section of the screen, all phone numbers associated with the participant are listed here. A participant may have one or many phone numbers.

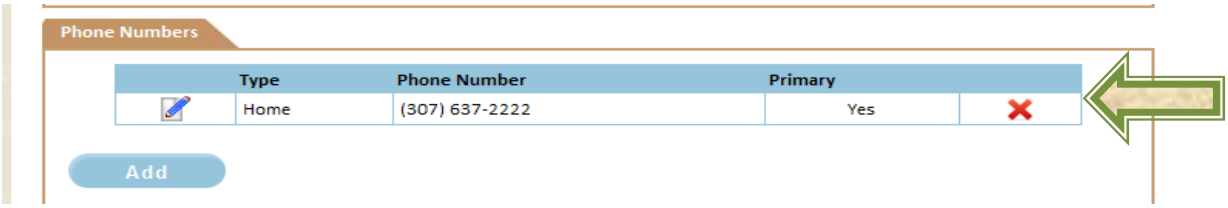


To update a phone number currently in the system, click on the “pencil” icon next to the phone number to update. This will open the phone window.



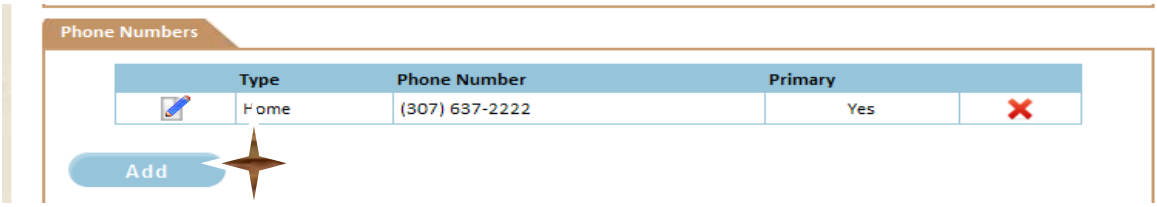
Update any information to be changed. When finished, click on the “Save” button.

To disregard any changes made, click on the “Cancel” button.

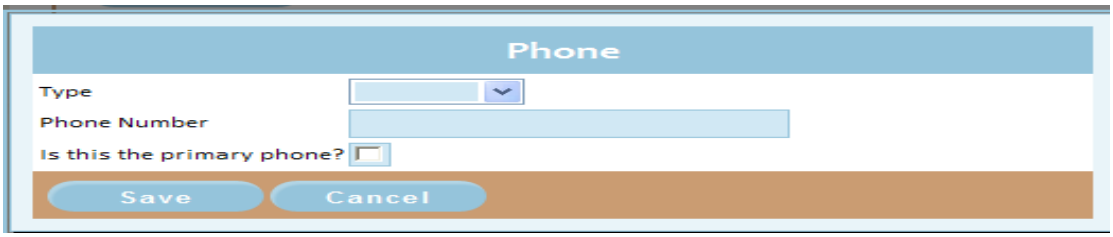


To delete a phone number, click on the Red “X” button . This will delete the phone number from the system.

To add a new phone number, click on the “Add” button.

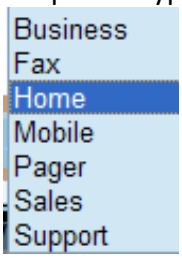


This will open the window to add a new phone number.



Enter the following information:

- Type – the phone type. Current phone types are listed below



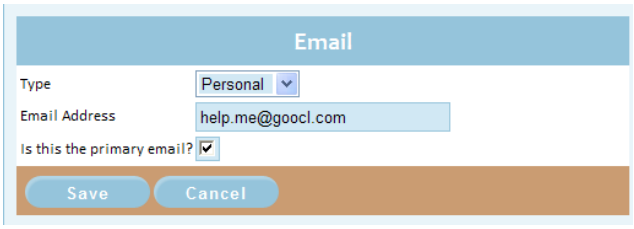
- Phone number – the full phone number for the participant. This includes area code.
- Is this the primary phone? – A check box to indicate the primary phone for the participant.

When the phone number has been added, click on the "Save" Button.

Email Addresses

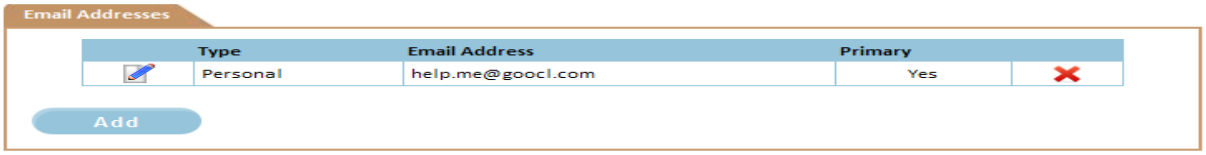
The email section is an optional section to the participant's demographics. If a participant wishes to give their email, it is to be entered here. A participant may have one or multiple email addresses.

To update an email address currently in the system, click on the "pencil" icon next to the address to update. This will open the email window.



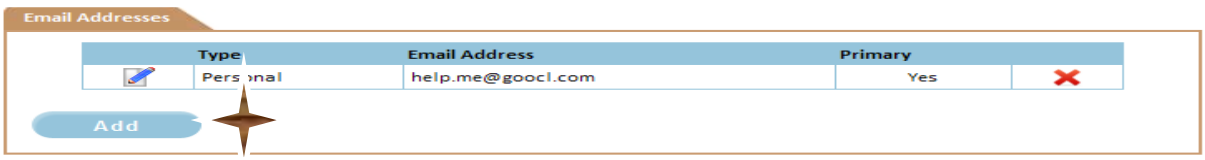
Update any information to be changed. When finished, click on the "Save" button.

To disregard any changes made, click on the "Cancel" button.

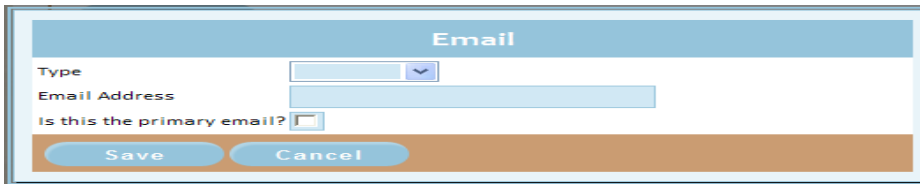


To delete an email address, click on the Red "X" button . This will delete the address from the system.

To add a new email address, click on the "Add" button.

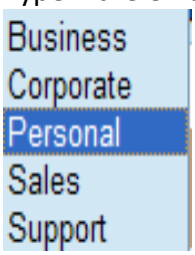


This will open the window to add a new email address.



Enter the following information:

- Type – the email type. Current email types are listed below



- Email Address – the full email address for the participant. This includes the @ symbol and a valid ".com" site.
- Is this the primary email? – A check box to indicate the primary email address for the participant.

When the email address has been added, click on the "Save" Button.

There is no "Action" button for this task.

7. Creating the participant Plan of Care (from page 38)

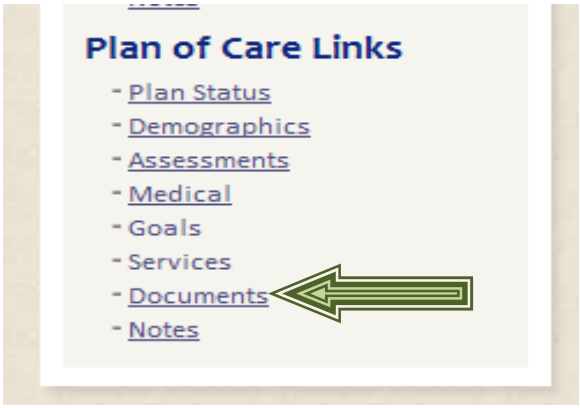
Refer to section "Entering a participant on EMWS" on page 55 for instructions.

8. Uploading documents (from page 38)

There are two documents that are required for a Plan of Care:

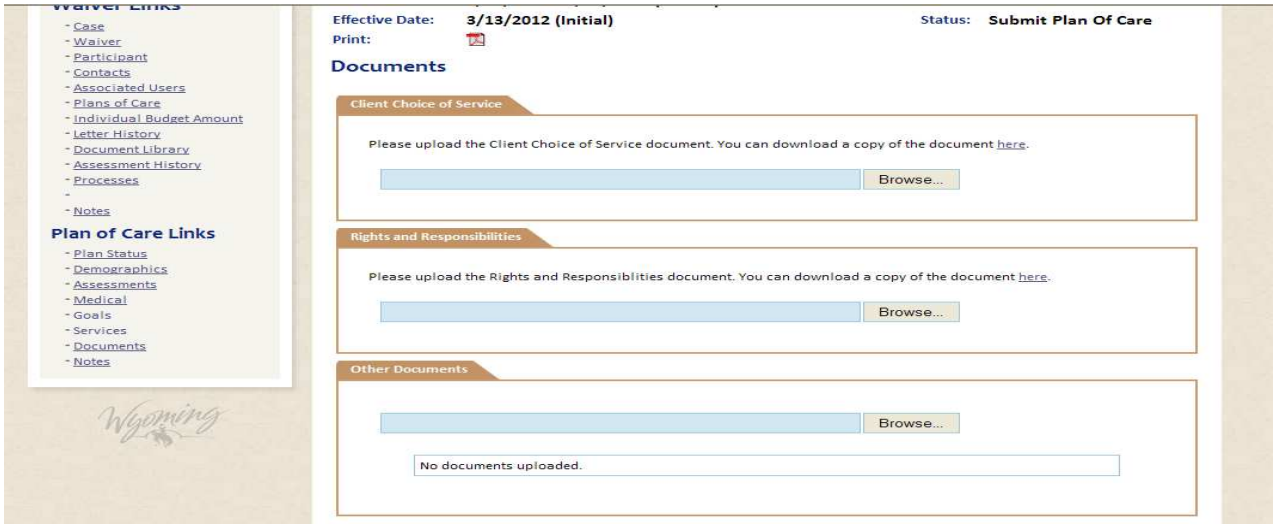
- ✓ Client Choice of Service (HCBS-1)
  - o Due when putting a participant on the waiting list
  - o Due when a participant has received a funding opportunity
  - o Due at each renewal plan period
- ✓ Client Rights and Responsibilities
  - o Due when a participant has received a funding opportunity
  - o Due at each renewal plan period

To upload the documents into the system, click on the "Documents" link under the section "Plan of Care Links" to open the document window.



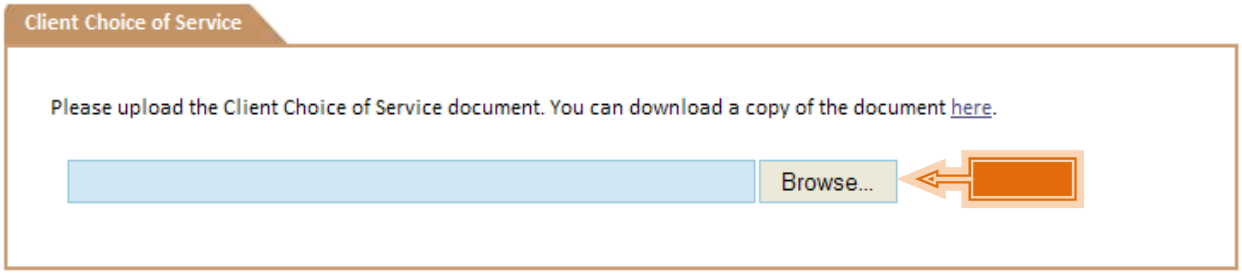
If a user is not at a participant's Plan of Care screen, please refer to sections *"Review Information through Task List Screen" on page 11 or "Search Cases Screen*" on page 17 for instructions to access a participant's information.

When open the document window should look like this.

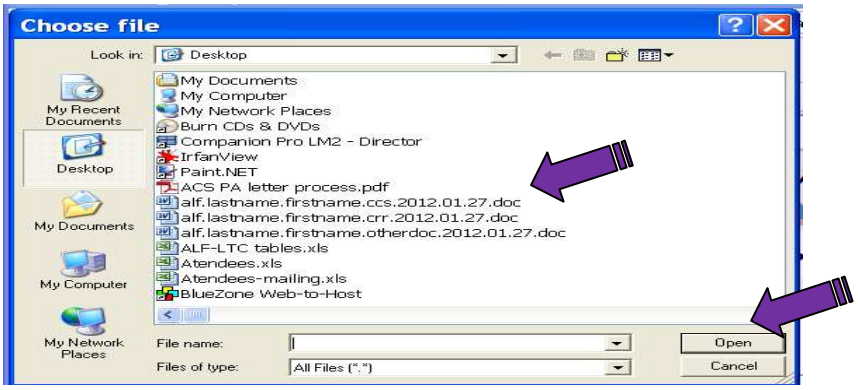


Client Choice of Service

To upload a scanned Client Choice of Service, click on the Browse button.



This will open the "choose file" window. Locate the file, highlight the file and click on the "Open" button.

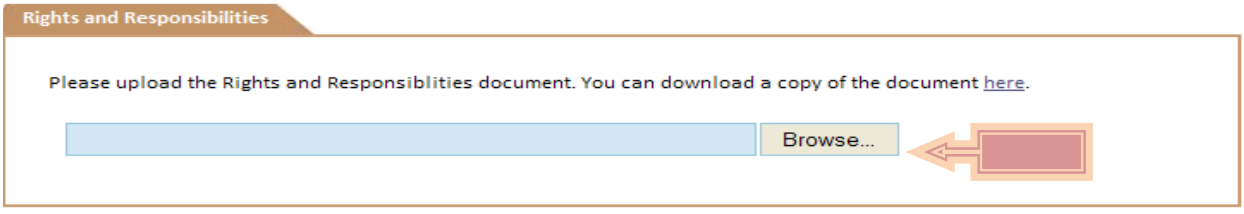


Once uploaded, a link to the document will be available.

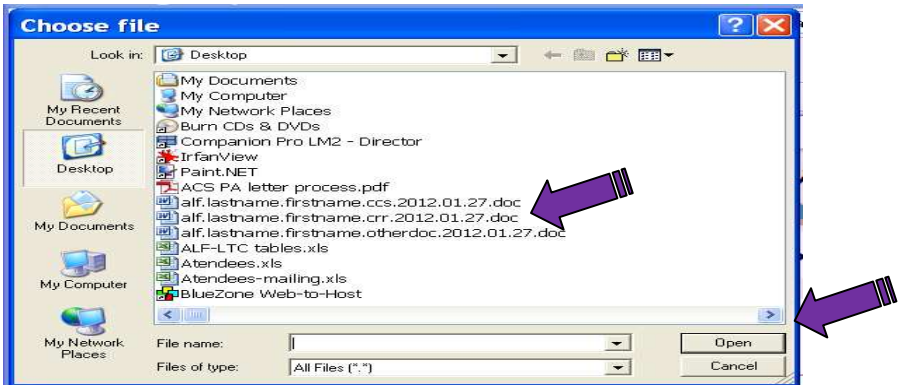
If an error is made and the wrong document is uploaded, just re-upload the correct document. It will override the incorrect document.

Client Rights and Responsibilities

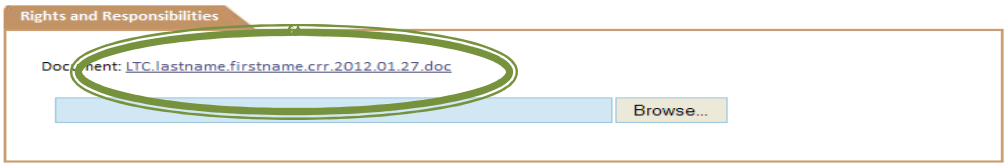
To upload a scanned Client Rights and Responsibilities, click on the "Browse" button under "Rights and Responsibilities" section.



This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



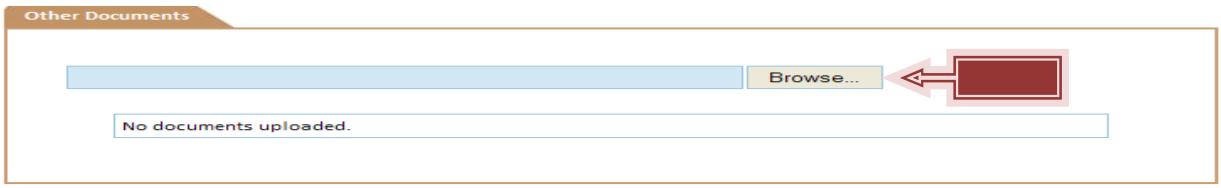
Once uploaded, a link to the document will be available.



If an error is made and the wrong document is uploaded, just re-upload the correct document. It will override the incorrect document.

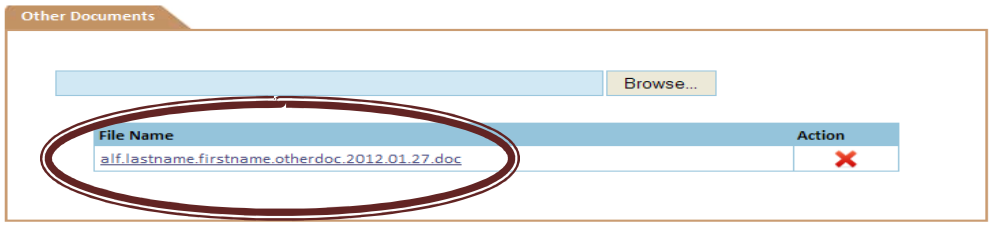
Other Documents

There may be times when additional documentation is required. To upload additional documents, click on the “Browse” button under “Other Documents” section.

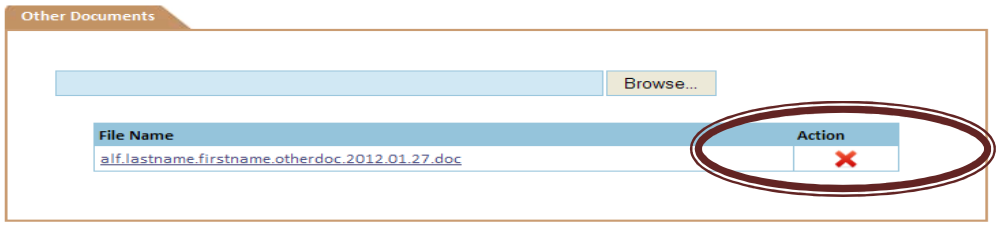


This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.

Once uploaded, a link to the document will be available.

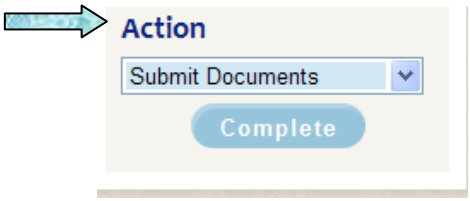


These documents may be deleted if necessary. To delete the scanned and uploaded document, click on the red "X" under "Action" to the left of the file name.

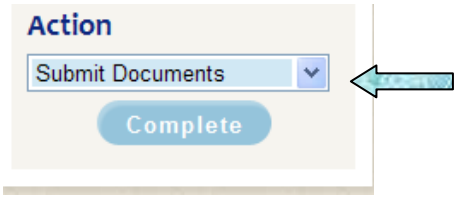


This will remove the document from the system.

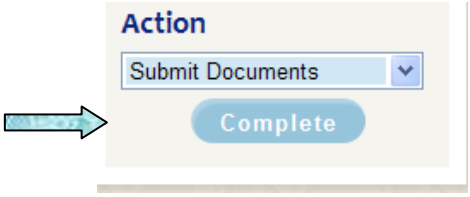
After all required documents have been scanned and uploaded in the appropriate sections, go to the "Action" drop down box to the left of the screen.



Choose "Submit Documents" and



click on the "Complete" button to finish the process.

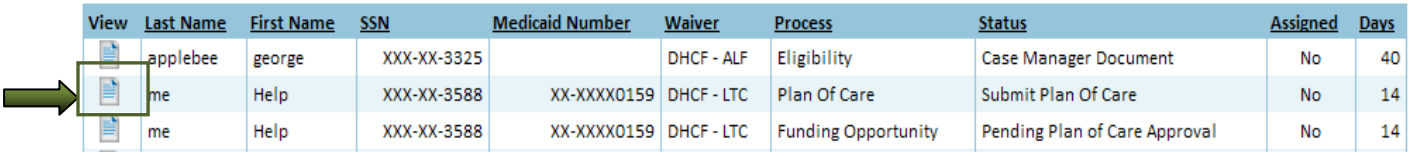


At this point the Program Manager reviews the documents. If the documents are correct, the participant will go on the waitlist. If the documents are NOT correct, the Case Manager/Care Coordinator will receive a notification to make corrections and re-submit.

Entering a participant on EMWS

Notification

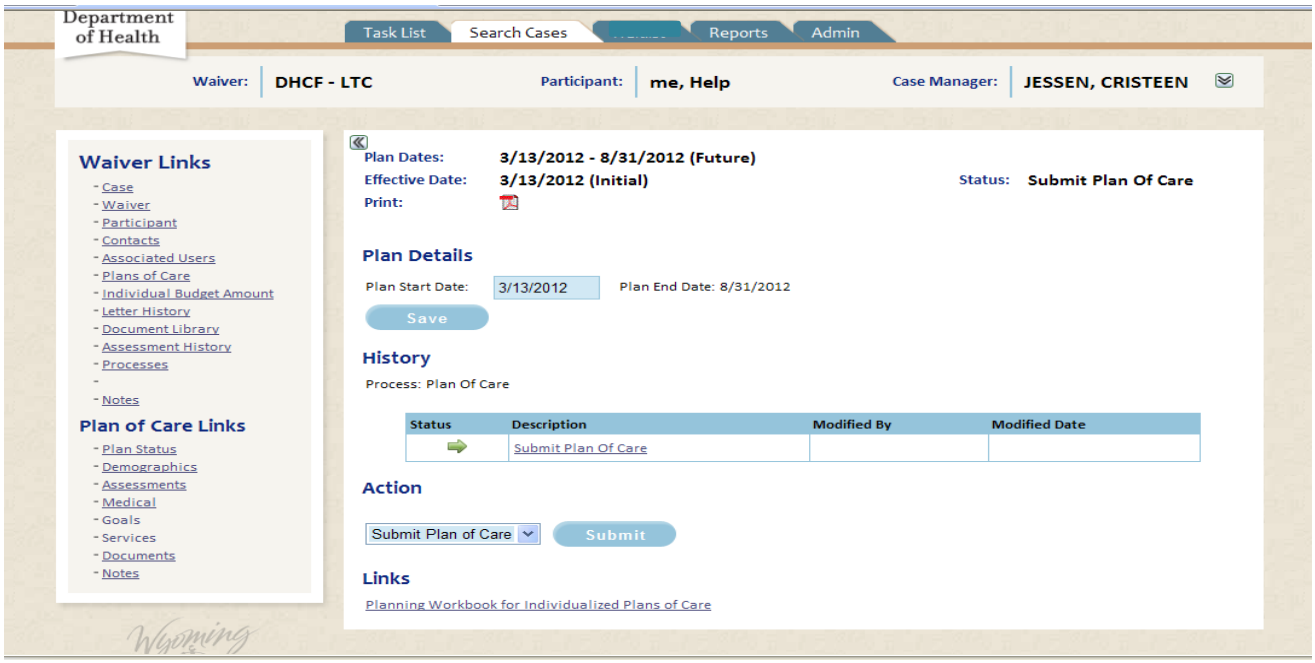
When a participant is ready to have their Plan of Care entered into the system and submitted, notification is sent to the Case Manager/Care Coordinator. When a Case Manager/Care Coordinator logs into the system, a task will be in the top section of the Task List screen. Click on the document icon in the "View" column of the associated task. This will open the "Plan Status" screen.



View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	applebee	george	XXX-XX-3325		DHCF - ALF	Eligibility	Case Manager Document	No	40
	me	Help	XXX-XX-3588	XX-XXXX0159	DHCF - LTC	Plan Of Care	Submit Plan Of Care	No	14
	me	Help	XXX-XX-3588	XX-XXXX0159	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	No	14

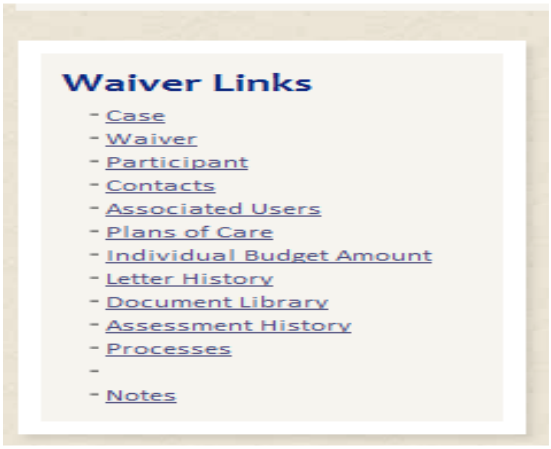
Plan Status Screen

When the Plan Status screen is open, it should look like this.



To the left are several links to allow the user to access other areas of the participants information.

- Waiver Links – This section gives links to participant specific information that may or may not be related to a specific Plan of Care.



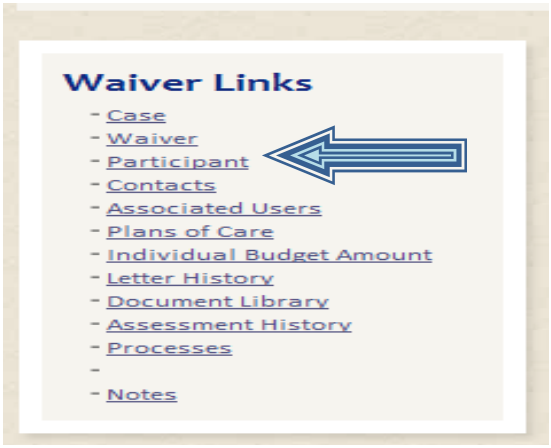
- Plan of Care Links – This section gives links to participant information related to a specific Plan of Care.

If a section is not available to view or edit, there will not be a link to the section. In the example above, "Goals" and "Services are not underlined. This indicates these sections are not available.

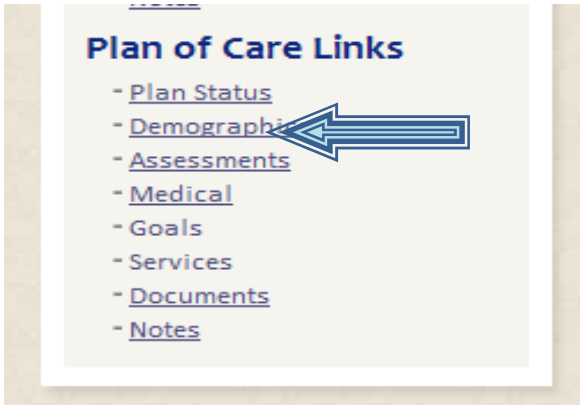
Updating/Verifying Information

To update a participant's information, a Case Manager/Care Coordinator must be in the "Participant" or "Demographics" screens. The "Participant" and "Demographics" screens should look like the screen below at the top of a user's screen.

If the screen does not look like above, click on the link “Participant” under the title “Waiver Links” to the left of the screen.



OR



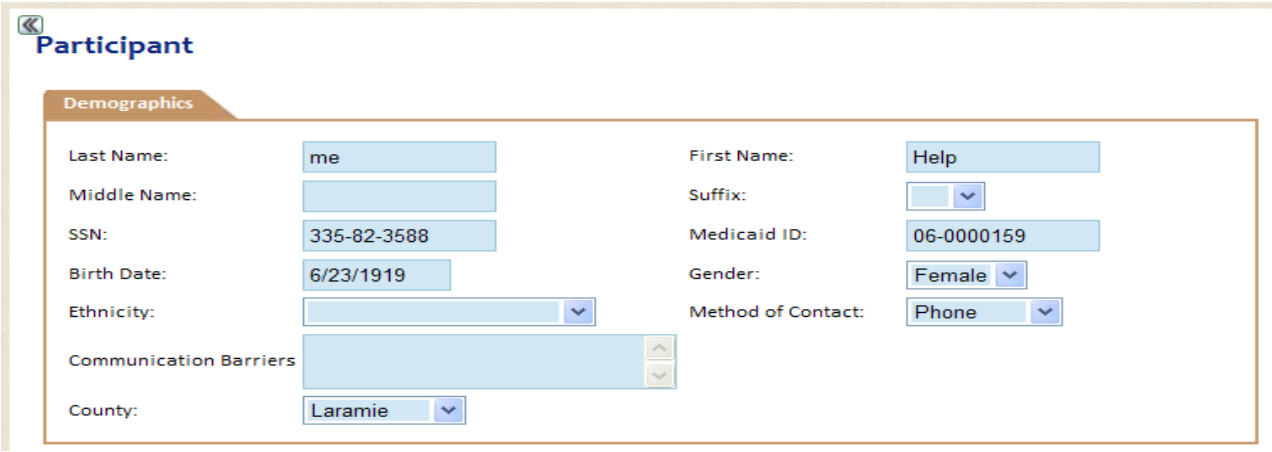
If a user is not at a participant’s screen, please refer to sections *“Review Information through Task List Screen” on page 11 or “Search Cases Screen” on page 17 for instructions to access a screen with “Waiver Links”.*

On the Participant’s demographic screen are four sections:

- Demographics
- Addresses
- Phone Numbers
- Email Addresses

Each section must be verified for correctness.

Demographics



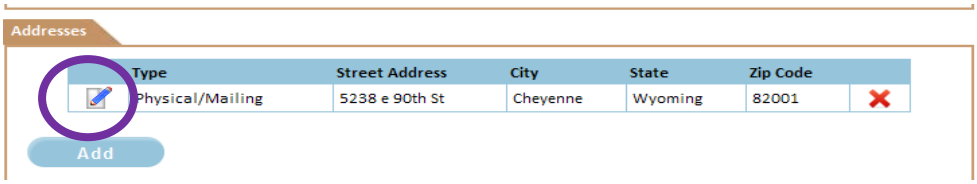
The demographics section has the following fields:

- Last Name – The last name of the participant
- First Name – The first name of the participant
- Middle Name – The middle name of the participant (if available)
- Suffix – Jr., III, etc
- SSN – the social security number of the participant. This **MUST** be the participant's SSN; not the spouse's.
- Medicaid ID - the "06…" of the participant. ***REMINDER – ID's that start with "00…" are NOT Client ID's and cannot be used as such.***
- Birth Date – The participant's date of birth
- Gender – Male/Female
- Ethnicity – Race of participant
- Method of Contact – the Participant's desired form of contact.
- Communication Barriers – A note section to indicate any limitations the participant may have to communicate. This can include a physical disability or language barrier.
- County – the participant's county of residence. (This is dictated by the participant's physical address).

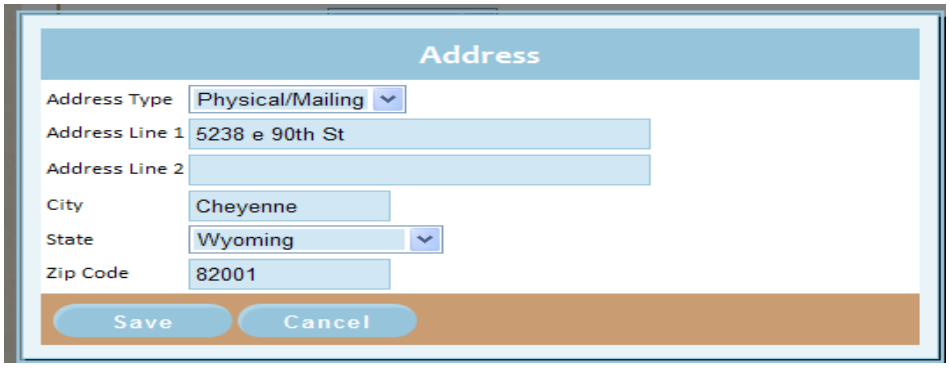
Verify the information is correct and current.

Addresses

The next section has the participant's address information. A participant may have one or multiple addresses.

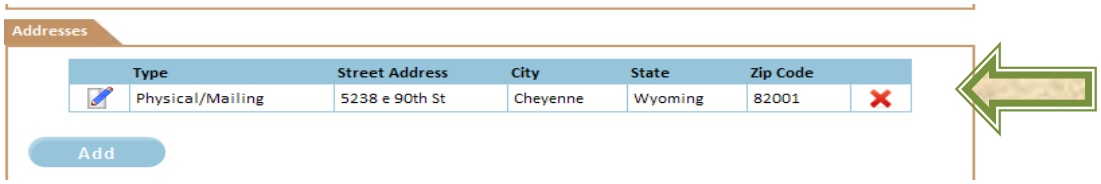


To update an address currently in the system, click on the “pencil” icon next to the address to update. This will open the address window.



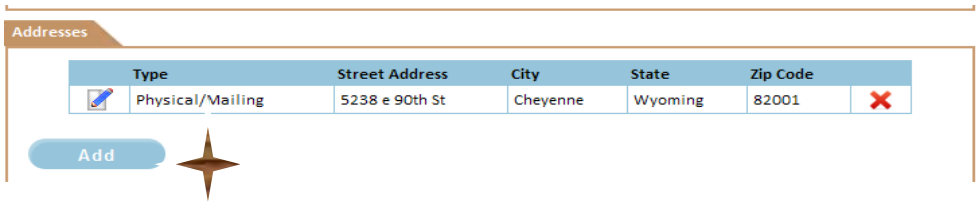
Update any information to be changed. When finished, click on the “Save” button.

To disregard any changes made, click on the “Cancel” button.



To delete an address, click on the Red “X” button . This will delete the address from the system.

To add a new address, click on the “Add” button.

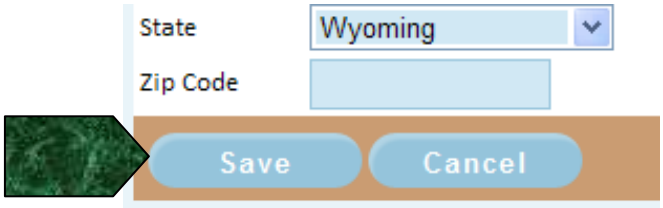


This will open the window to add a new address.

Enter the following information:

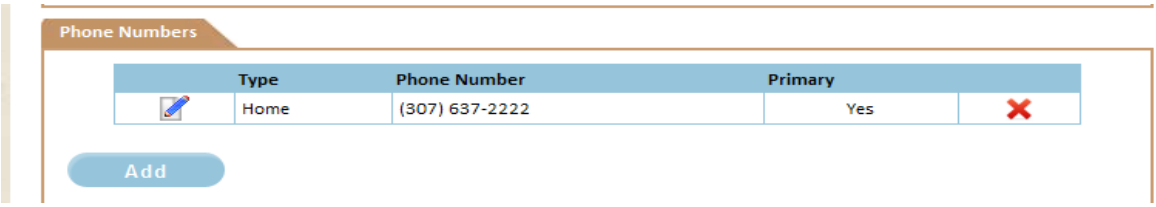
- Address Type – this will be one of three options:
  - Physical – The address the participant resides
  - Mailing – The address all correspondence is mailed to, if different from the physical address.
  - Physical/Mailing – If both the physical and mailing addresses are the same, use this option.
- Address Line 1 – Street address or PO Box
- Address Line 2 – Apt. number, or additional street address information if there is not enough room on the first line.
- City – City the address is associated with. *Mailing and Physical addresses may be different.*
- State – the State will default to Wyoming. Can be changed for mailing address information. ***THE PARTICIPANT MUST RESIDE IN THE STATE TO BE AN ELIGIBILE PARTICIPANT ON THE WAIVER.***
- Zip Code – the zip code associated with the city and address.

When the address has been added, click on the "Save" Button.

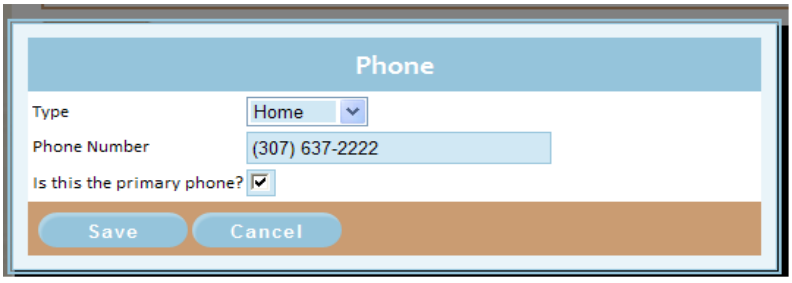


Phone Numbers

In the phone number section of the screen, all phone numbers associated with the participant are listed here. A participant may one or many phone numbers.

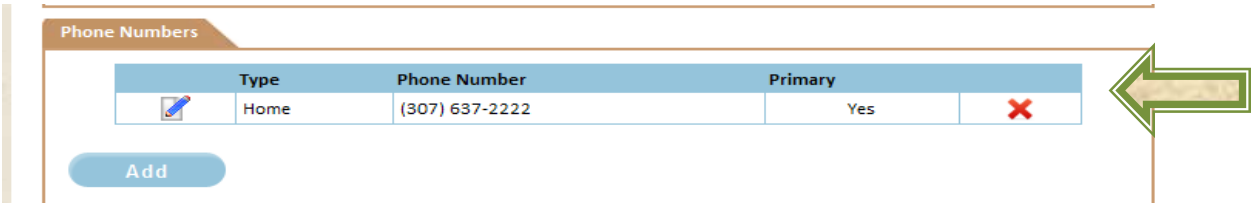


To update a phone number currently in the system, click on the "pencil" icon next to the phone number to update. This will open the phone window.



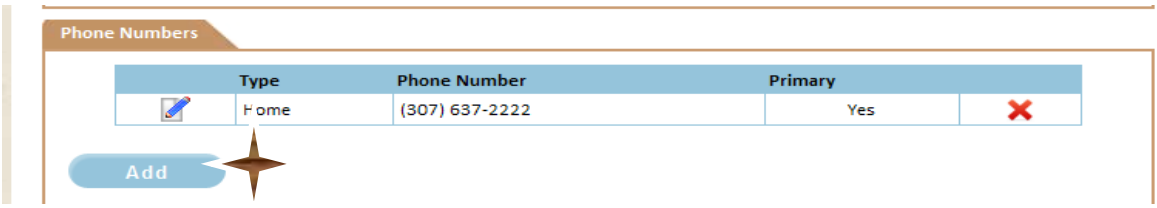
Update any information to be changed. When finished, click on the “Save” button.

To disregard any changes made, click on the “Cancel” button.

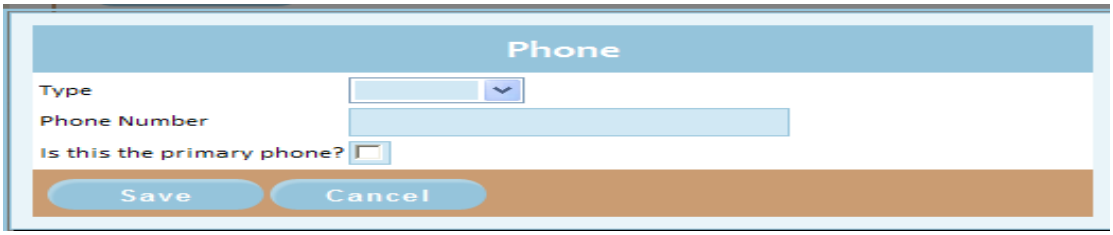


To delete a phone number, click on the Red “X” button . This will delete the phone number from the system.

To add a new phone number, click on the “Add” button.

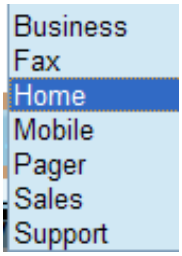


This will open the window to add a new phone number.



Enter the following information:

- Type – the phone type. Current phone types are listed below:

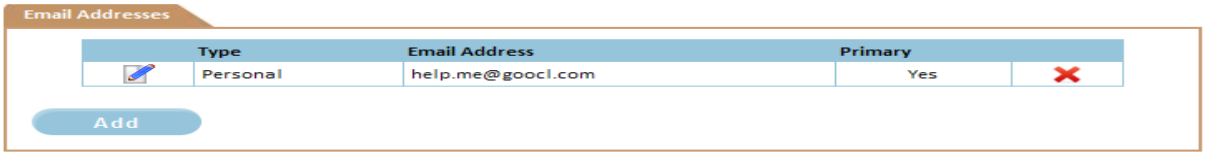


- Phone number – the full phone number for the participant. This includes area code.
- Is this the primary phone? – A check box to indicate the primary phone for the participant.

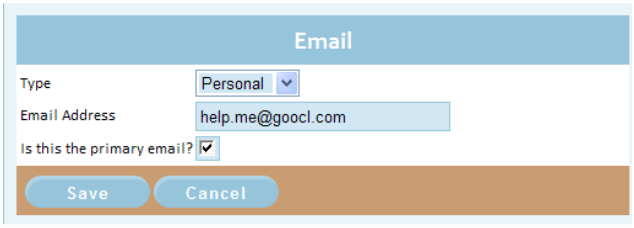
When the phone number has been added, click on the “Save” Button.

Email Addresses

The email section is an optional section to the participant’s demographics. If a participant wishes to give their email, it is to be entered here. A participant may have one or multiple email addresses.

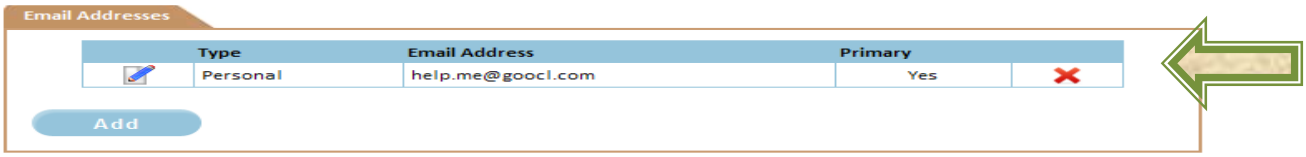


To update an email address currently in the system, click on the “pencil” icon next to the address to update. This will open the email window.



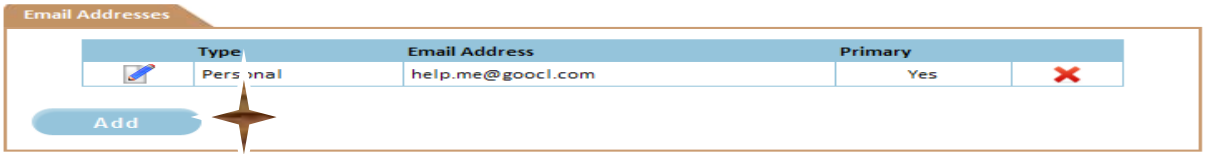
Update any information to be changed. When finished, click on the “Save” button.

To disregard any changes made, click on the “Cancel” button.



To delete an email address, click on the Red “X” button . This will delete the address from the system.

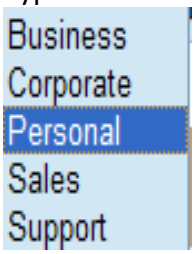
To add a new email address, click on the “Add” button.



This will open the window to add a new email address.

Enter the following information:

- Type – the email type. Current email types are listed below



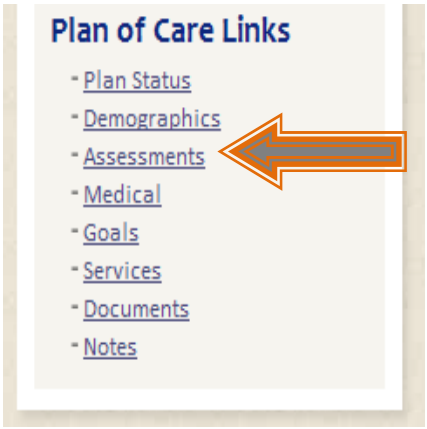
- Email Address – the full email address for the participant. This includes the @ symbol and a valid ".com" site.
- Is this the primary email? – A check box to indicate the primary email address for the participant.

When the email address has been added, click on the "Save" Button.

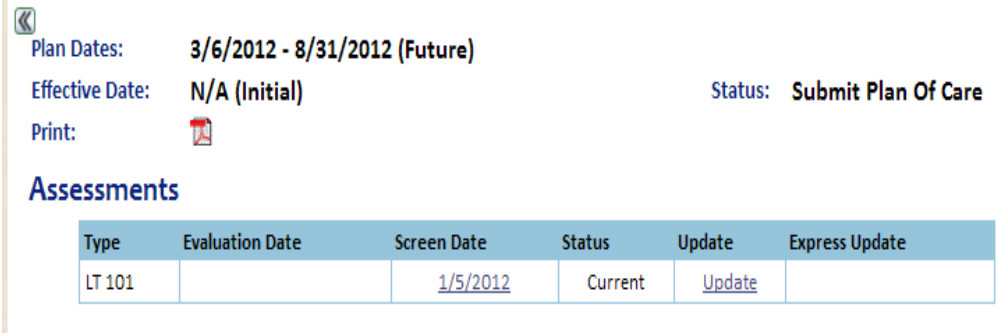
There is no "Action" button for this task.

Assessments

After client information has been verified, the Case Manager chooses the most appropriate LT101 for the Plan of Care. In the "Plan of Care Links" section to the left of the screen, choose the "Assessment" link.



Once the “Assessment” screen is open it will show a list of all LT101’s for the participant. It will only allow the user to choose a valid LT101. To choose the desired LT101, click on the LT101 with the evaluation date that has “Current” in the Status column AND a “Screen Date” with an underline (indicating a link).

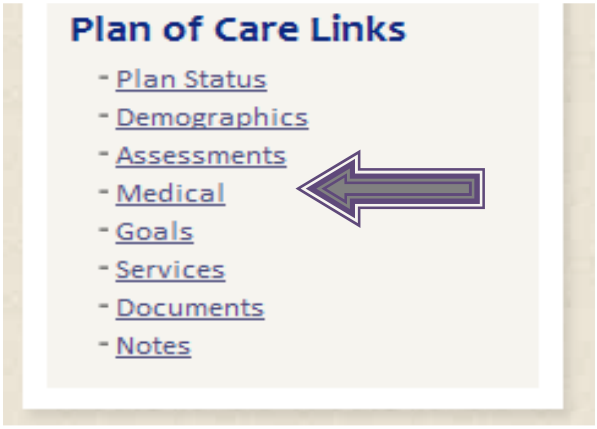


There is no need to do anything on this screen, as long as there is a current LT101 in place.

Medical

(Optional screen – Information on this screen is not required.)

The “Medical” screen has all diagnosis and medication information stored. To access the “Medical” screen, choose the “Medical” link in the “Plan of Care Links” section to the left of the screen.

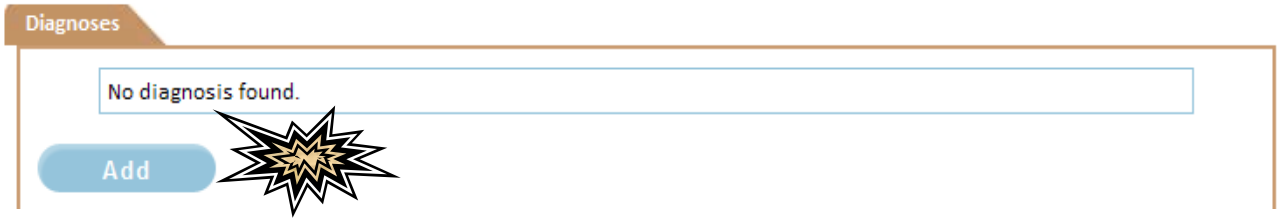


Once the “Medical screen is open, it will show 2 sections:

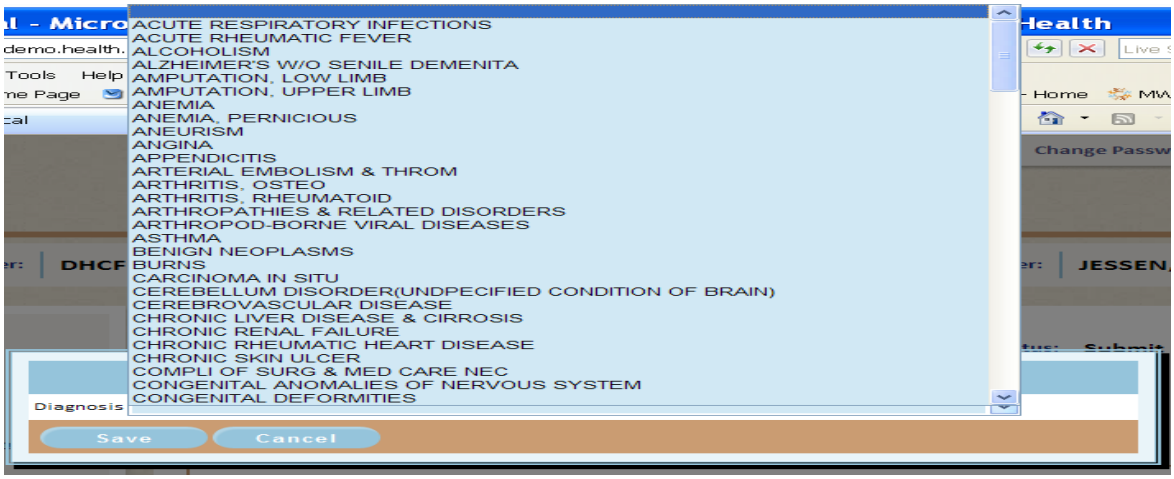
- Diagnosis
- Medications

Diagnosis

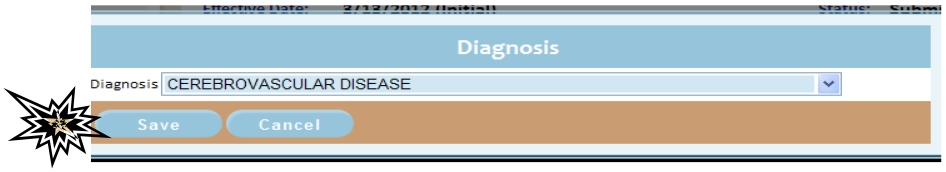
To add a diagnosis, click on the “Add” button



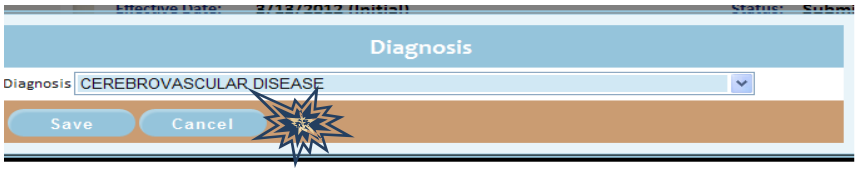
This will open a new window. Click on the drop down button to view diagnosis choices. The choices no longer have the diagnosis code just the words.



Choose the desired diagnosis and click on the “Save” button.



To cancel the choice, click on the “Cancel” button.

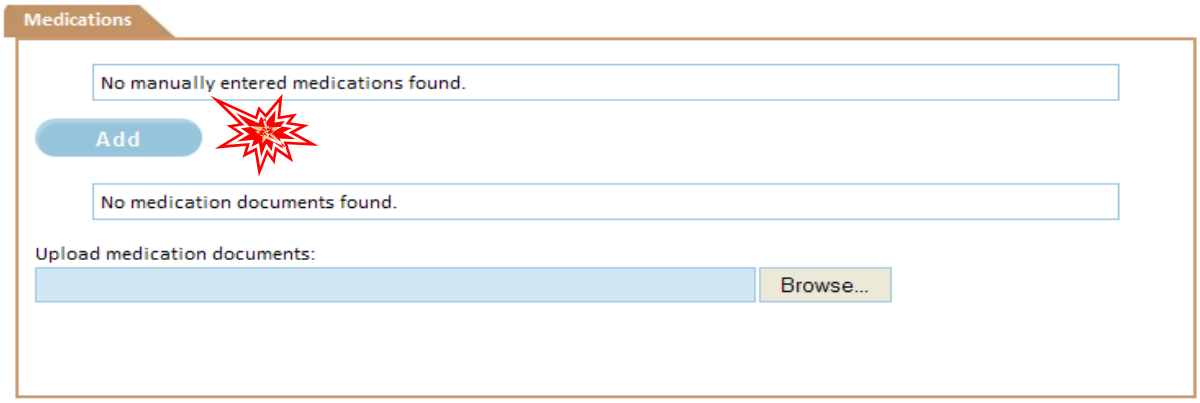


Medications

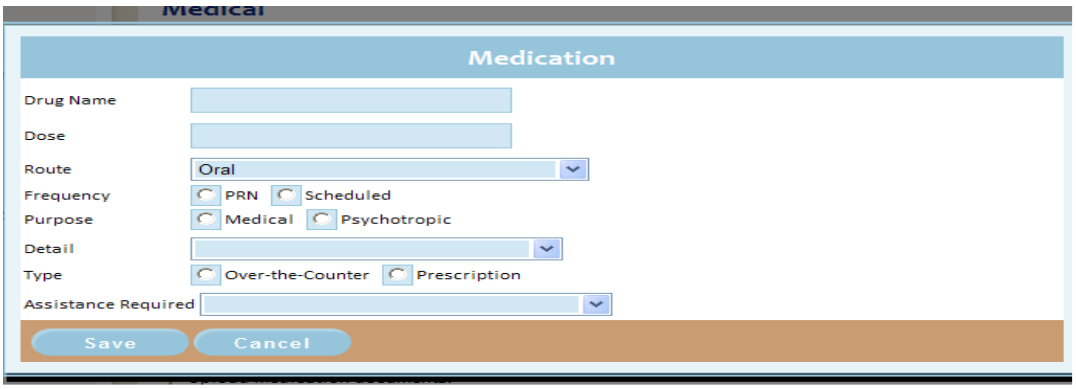
To upload a participant’s current medication list, there are 3 options:

- Enter each medication separately
- Upload a medication list
- A combination of both

To enter each medication separately, click on the “Add” button.



This will open the "Medication" window. Enter all available information.

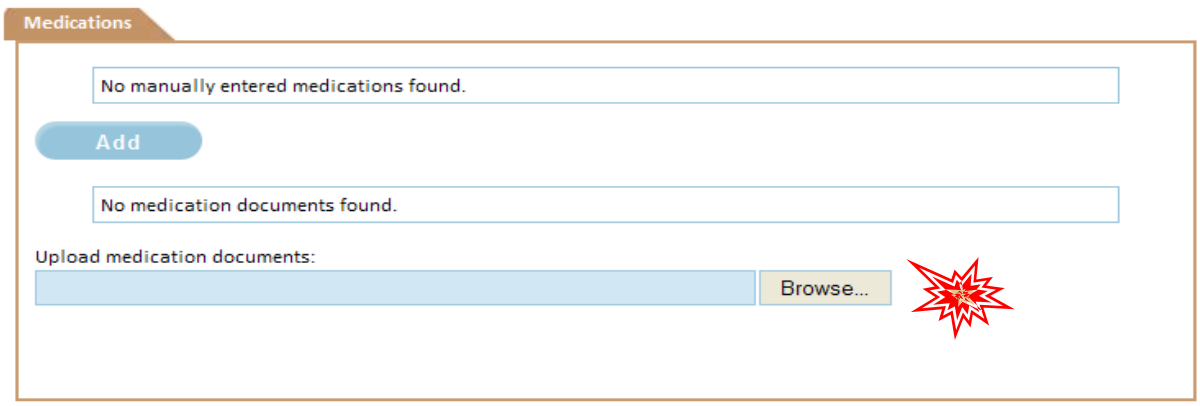


When finished click on the "Save" button.

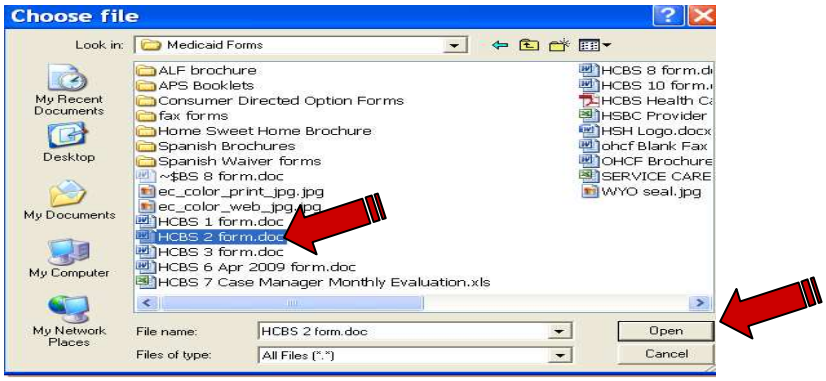
To cancel the information, click on the "Cancel" Button.

If a Case Manager/Care Coordinator already has a participant's current list of medications and does not want to enter each one manually, the list may be uploaded into the system.

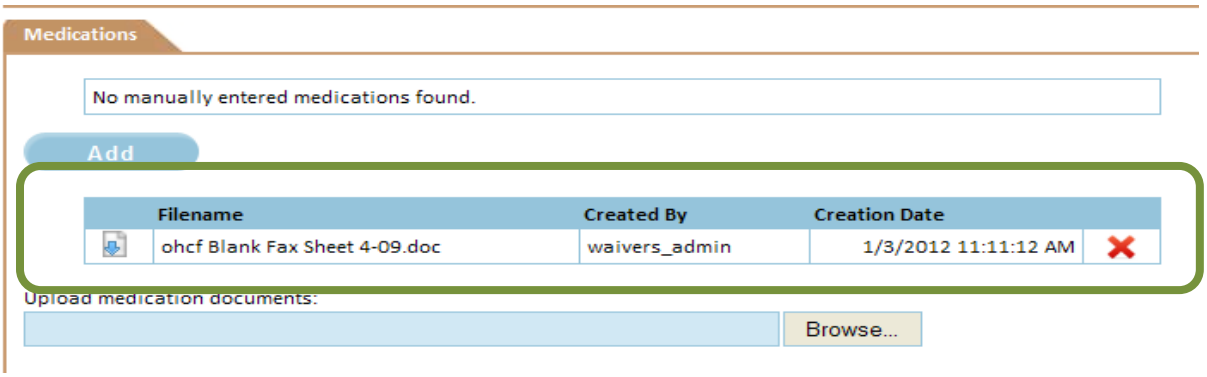
To upload the scanned document, click on the "Browse" button next to the "Upload medication documents:" window.



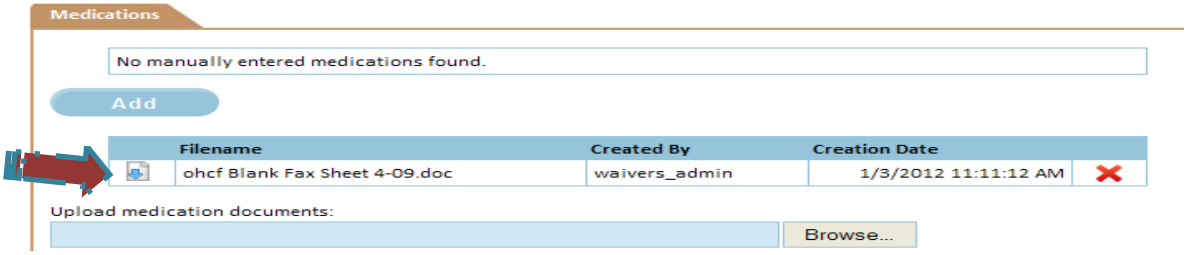
This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



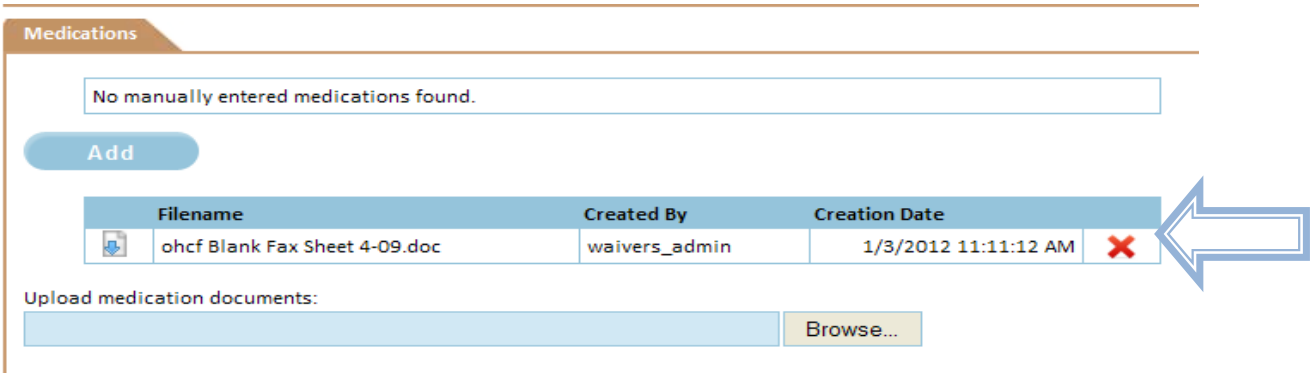
Once uploaded, the document will be available to view.



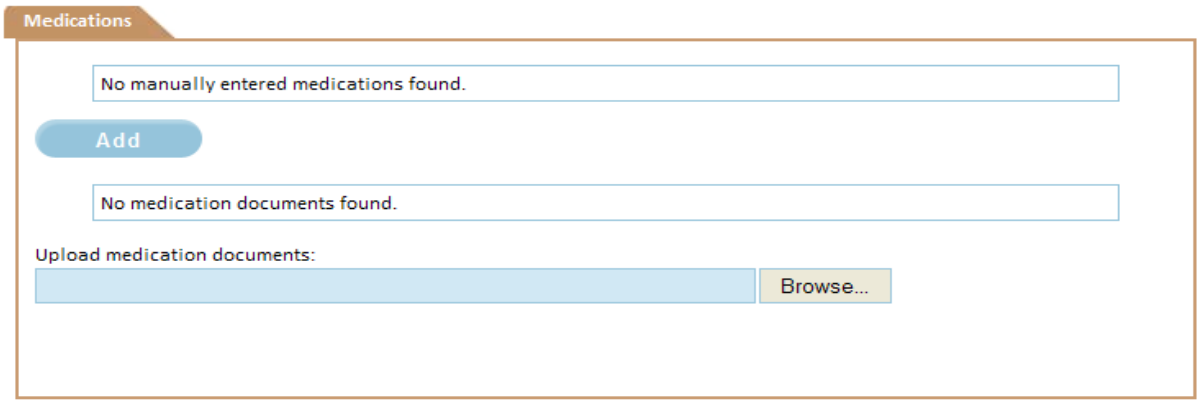
To open the document, click on the document icon located left of the “Filename”.



To delete the document, click on the red”X” located to the right of the “Creation Date”.

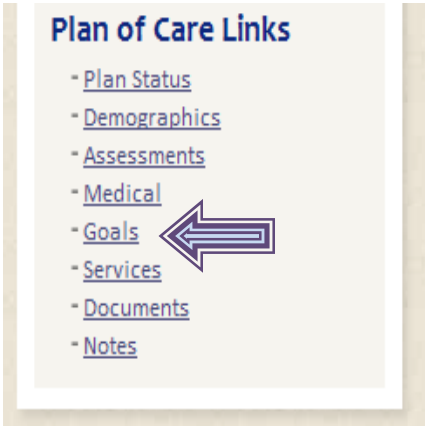


Once deleted, the document will no longer be accessible.



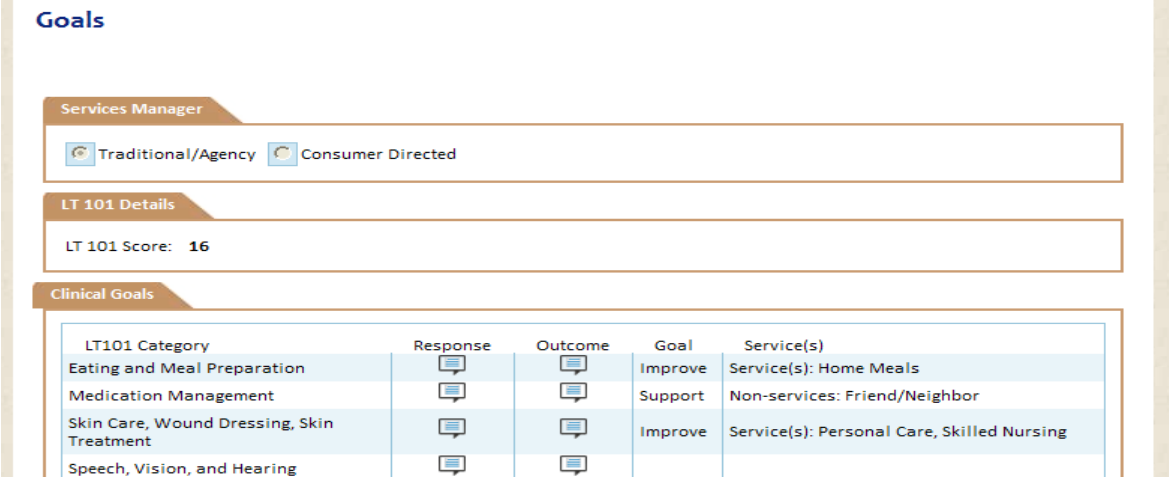
Goals

After the LT101 has been uploaded, reviewed and approved by the Home Care Unit, goals can be entered. To access the "Goals" screen, choose the "Goals" link in the "Plan of Care Links" section to the left of the screen.



This will open the "Goals" screen. There will be 3 sections on this screen:

- Services Manager
- LT101 Details
- Clinical Goals



Services Manager

The "Services Manager" section allows the Case Manager/Care Coordinator to indicate whether the participant has chosen the traditional services or consumer directed for personal care. A user can **ONLY** choose one.

When choosing "Traditional/Agency", the Case Manager/Care Coordinator **WILL NOT** be able to choose the following services:

- Care Coordination
- Self Help Assistant
- Fiscal Management

When choosing "Consumer Directed", the Case Manager/Care Coordinator **WILL NOT** be able to choose the following services:

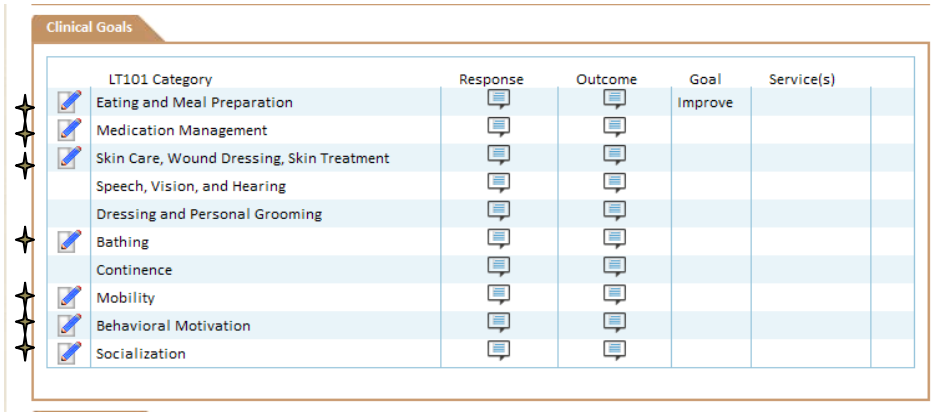
- Case Management
- Personal Care

LT101 Details

In the Case Manager/Care Coordinator view, the only item to show in the "LT101 Details" section is the points the participant received on the chosen LT101.

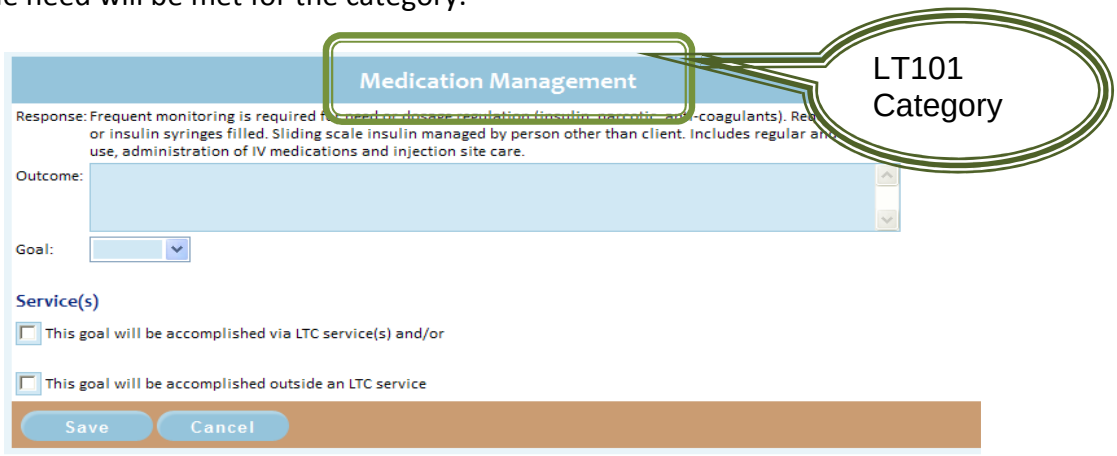
Clinical Goals

After the "Services Manager" selection has been made, goals, outcomes, and services must be chosen for each appropriate LT101 Category. Only those categories that received points may be chosen. If an LT101 Category can be edited, there will be a "Pencil" icon next to it. Click on the "Pencil" icon to update the information.

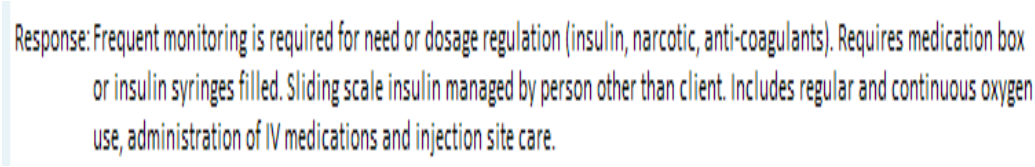


Choose the first available category. It will open a new window.

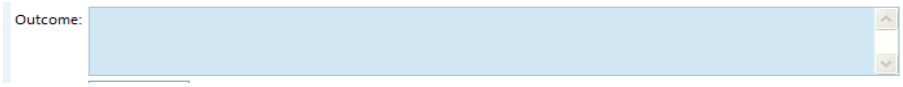
- At the top is the LT101 Category. In the example below the LT101 Category is "Medication Management";
- The next portion is the text response;
- Then is a window to enter the outcome;
- A drop down of the goal for the category; and finally
- How the need will be met for the category.



The response cannot be updated. It is for Case Manager/Care Coordinator information only.



The Case Manager/Care Coordinator enters the outcome in the "Outcome" box. This is a free form text box. Enter the desired outcome of the need.



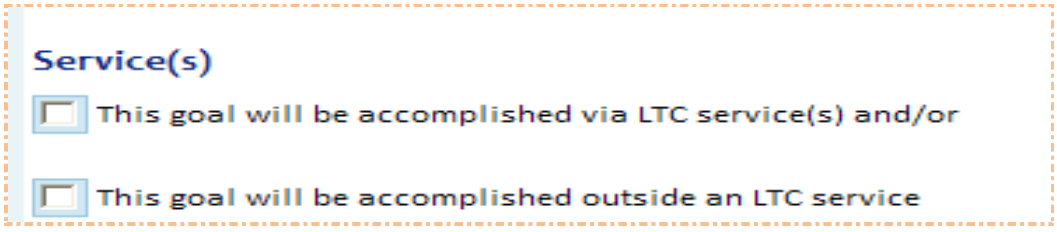
Next the goal is chosen from the drop down box. Currently, the choices are:

- Improve
- Maintain
- Support

Finally, services will be chosen. Every LT101 Category that can be edited has a need that **must be** met. A Case Manager/Care Coordinator has several options to meet the need.

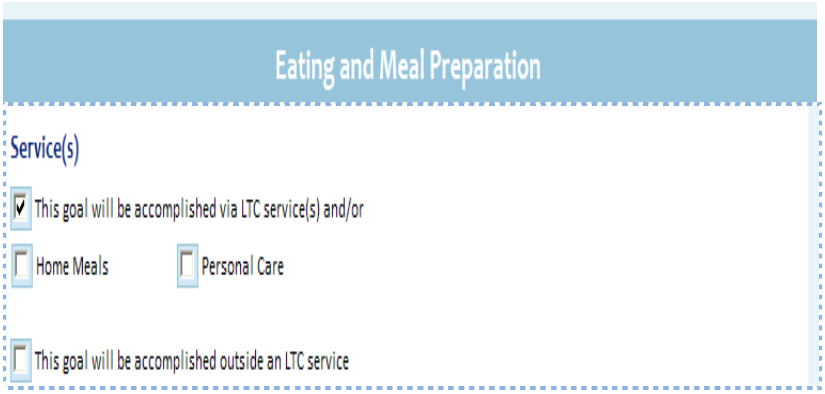
- One or more services may be provided through LTC/ALF waiver services
- One or more services may be provided through another source
- One or more services may be provided through a combination of LTC/ALF waiver services or through other sources.

On each screen is a section named "Service(s)". There are check boxes that are marked when determining how a need will be met.



If LTC/ALF services will be used to meet the need of the category, click on the option "This goal will be accomplished via LTC (ALF) service(s) and/or". When checked, services that are appropriate for the LT101 Category will appear. In the example being used "Medication Management", there is only one service.

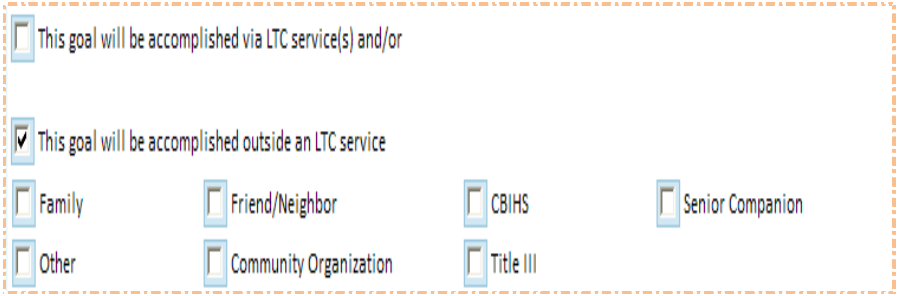
For the LT101 Category "Eating and Meal Preparation" there is a different set of services.



Choose the services that will be provided through the LTC/ALF waiver. One or multiple services may be chosen to meet the specific need.

NOTE: Services chosen in this section will be the only services initially available in the Plan of Care

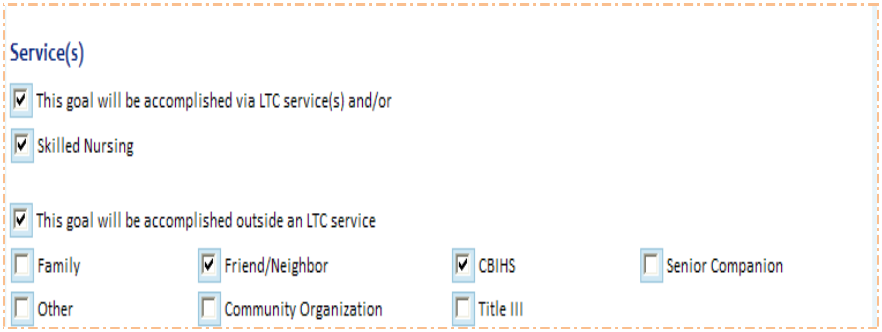
If services will be provided by a Non-waiver source, click on the option "This goal will be accomplished outside an LTC (ALF) service". When checked, outside services will appear.



This list of options is the same for all LT101 Categories.

Choose the source that will provide the need for the LT101 Category. One or multiple options may be chosen to meet the specific need.

There may be times when both an outside source and a LTC/ALF waiver provider will meet the need for a category. A provider may have staffing issues or not provide services during a specific time of day. A family member may be available to provide care at only certain times. In instances such as these (instances are NOT limited to these reasons), it may be necessary to choose from both lists.

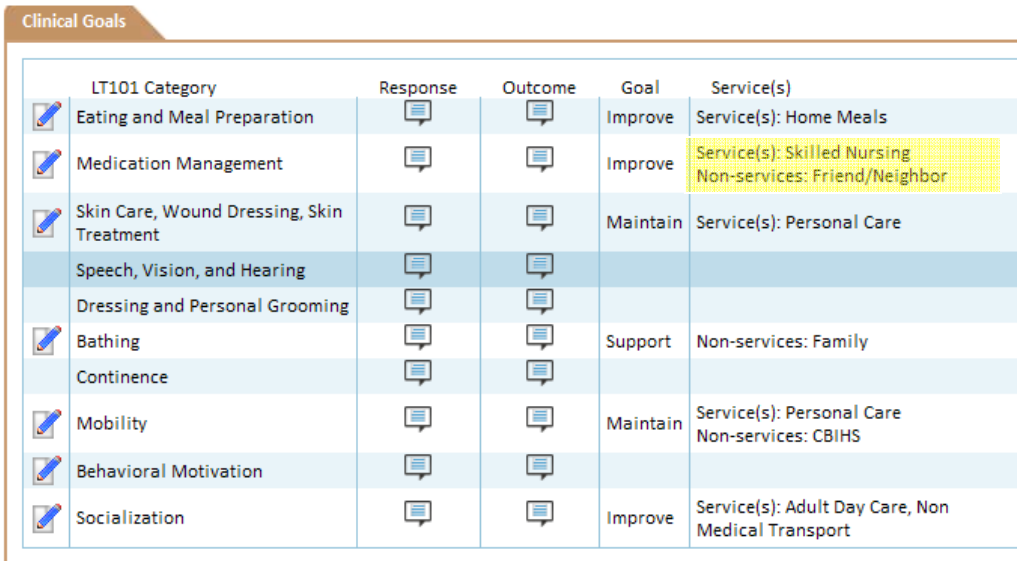


If there is someone who will meet the need, but is not listed, click the "Other" option and enter who will meet the need. This may be a specific name or a general type.

When finished click on the "Save" button.

To cancel what has been entered, click on the "Cancel" Button.

After the LT101 Category has been completed, choose the next available category. Continue until all available categories are complete. Once complete, the user will be able to view choices in the "Clinical Goals" section.



Notice in the LT101 Category "Medication Management", there are both "Service(s)" **AND** "Non-services".

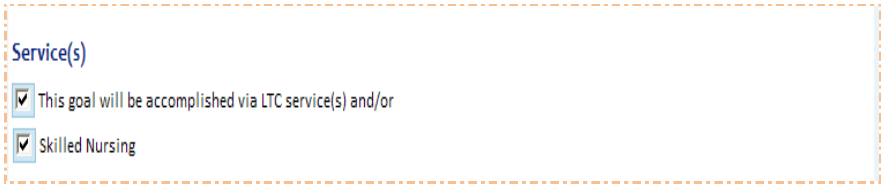
To **change or update a category**, click on the "Pencil" icon to update the information. This will open the category window to allow for any changes. Update any changes needed.

When finished click on the "Save" button.

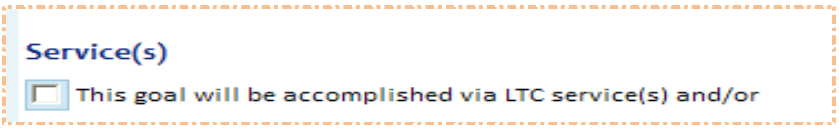
To cancel what has been entered, click on the "Cancel" Button.

To **remove a service from a category**, click on the "Pencil" icon to update the information. This will open the category window. Click in the appropriate check boxes to remove the service. After un-checking the service, if there are no other services checked, uncheck the section.

The service will go from:



To:



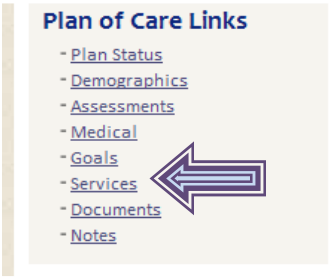
When finished click on the “Save” button.

To cancel what has been entered, click on the “Cancel” Button.

There is no “Action” button for this task.

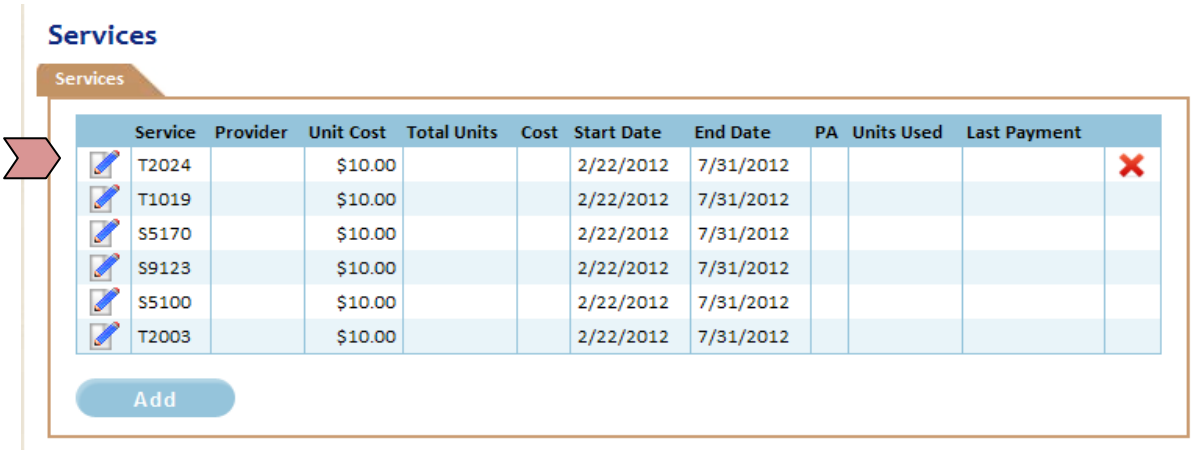
Services

After the “Goals” section is completed, services are completed. To access the “Services” screen, choose the “Services” link in the “Plan of Care Links” section to the left of the screen.



This will open the “Services” screen. The services screen will default to the services listed from the “Goals” screen, plus the mandatory services. Mandatory services are:

- Traditional/Agency
  - Case Management
- Consumer Directed
  - Care Coordination
  - Self-help Assistant
  - Fiscal Management



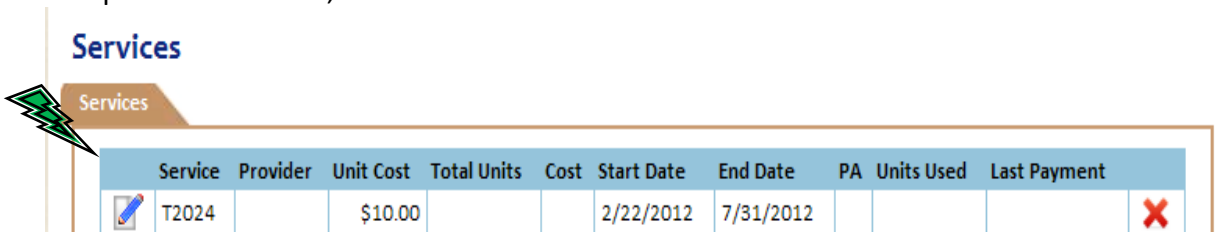
Each service added in the "Goals" section will be listed on the "Services" screen. Each service must be updated to indicate the provider providing the service, and the number of units to be provided monthly.

Before updating the services, the screen will list:

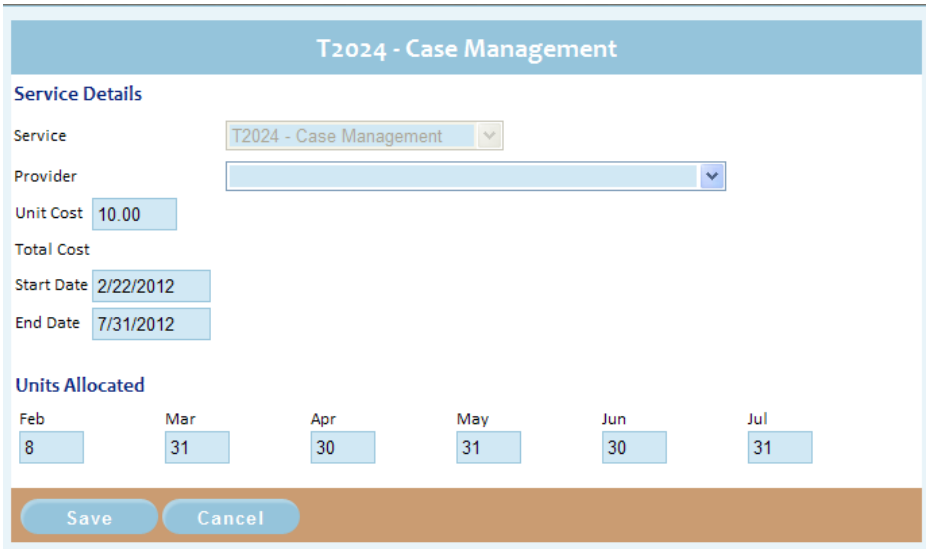
- The service
- The unit cost for the service - this will default to the maximum allowable unit cost, but can be edited in the "Service Details" screen.
- The start date – this will default to the plan start date but can be edited in the "Service Details" screen.
- The end date - this will default to the plan end date but may be edited in the "Service Details" screen.

If a service cannot be provided through the LTC/ALF waiver, the "Goals" section MUST be updated to indicate how the need associated with the service will be met and the service deleted from the "Services" screen.

To update the service, click on the "Pencil" icon next to the service.

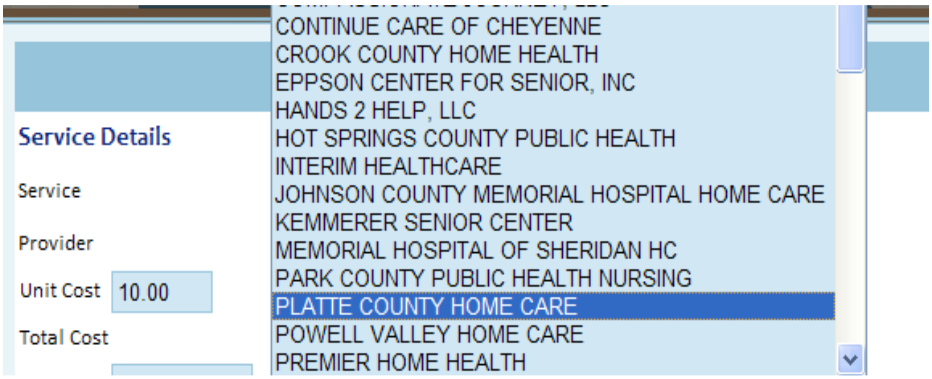


This will open the "Services Details" window.



The service cannot be edited in this window and is grayed out.

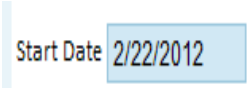
The provider is chosen from a drop down menu.



The unit cost may be changed at this point. The cost **CANNOT** be higher than the maximum allowable. Change the cost if the service provider's unit cost is lower than the maximum unit cost.

The total cost will remain blank until the service has been entered and saved.

If the service starts later than the plan start date, change the "Start Date" to the date the service will be starting.



The end date should not change.

Enter the number of total number of units in a month for each month. Zero fill the months with no units provided.

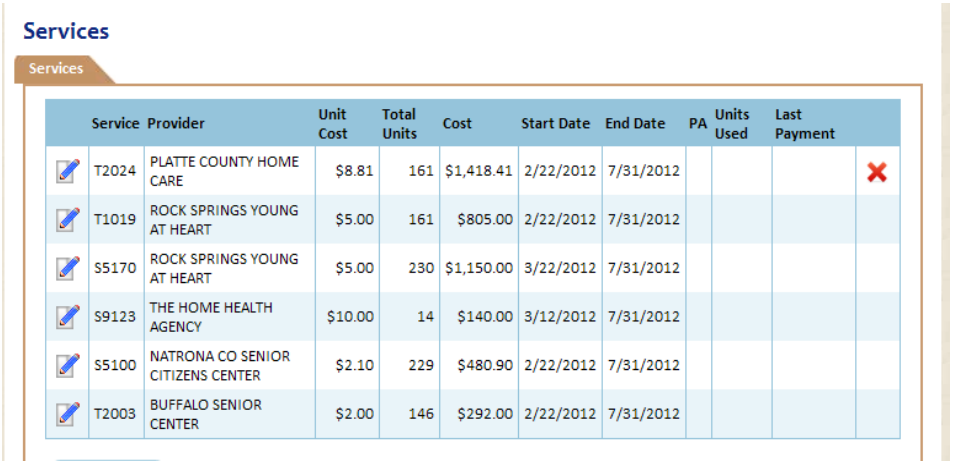
As a user enters the monthly units, remember that each service has its own service designation. Verify the service unit designation if unsure.

> ***A unit for Non-Medical Transportation is a one way trip, while a unit of Personal Care Attendant is 15 minutes.***

When finished click on the "Save" button.

To cancel what has been entered, click on the "Cancel" Button.

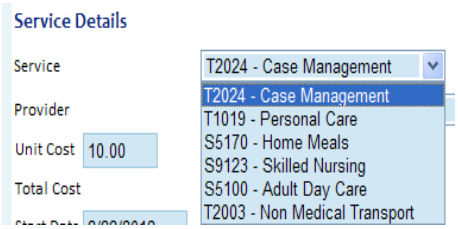
Continue with each service on the "Services" screen until complete. As each service is updated, the information will appear on the "Services" screen.



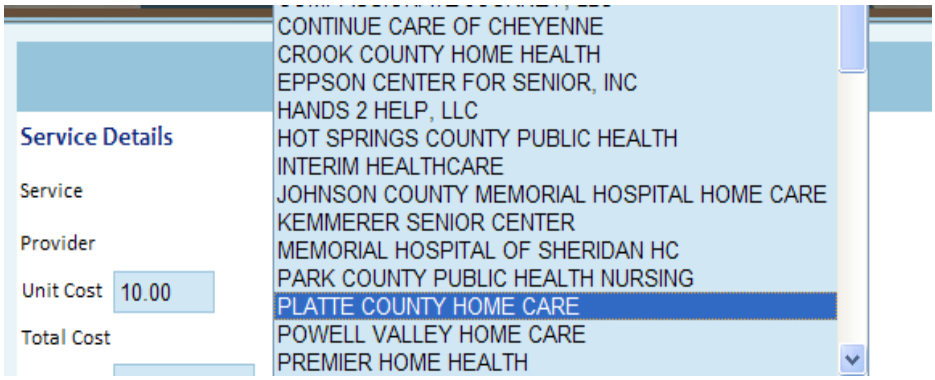
	Service	Provider	Unit Cost	Total Units	Cost	Start Date	End Date	PA	Units Used	Last Payment	
	T2024	PLATTE COUNTY HOME CARE	$8.81	161	$1,418.41	2/22/2012	7/31/2012				
	T1019	ROCK SPRINGS YOUNG AT HEART	$5.00	161	$805.00	2/22/2012	7/31/2012				
	S5170	ROCK SPRINGS YOUNG AT HEART	$5.00	230	$1,150.00	3/22/2012	7/31/2012				
	S9123	THE HOME HEALTH AGENCY	$10.00	14	$140.00	3/12/2012	7/31/2012				
	S5100	NATRONA CO SENIOR CITIZENS CENTER	$2.10	229	$480.90	2/22/2012	7/31/2012				
	T2003	BUFFALO SENIOR CENTER	$2.00	146	$292.00	2/22/2012	7/31/2012				

To add a service not listed by default. There may be the occasion where a user must add a service to the plan that was not added by default – for example you have two separate meal providers providing Home Delivered Meals. Click on the "Add" button under the list of plan services.

This will open the "Service Details" window. This is the same window as the window to update services, except the service may be updated. Choose the appropriate service from the "Service" drop down menu.



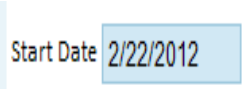
The provider is chosen from a drop down menu.



The unit cost may be changed at this point. The cost CANNOT be higher than the maximum allowable. Change the cost if the provider's unit cost is lower than the maximum unit cost.

The total cost will remain blank until the service has been entered and saved.

If the service starts later than the plan start date, change the "Start Date" to the date the service will be starting.



The end date should not change.

Enter the number of total number of units in a month for each month. Zero fill the months with no units provided.

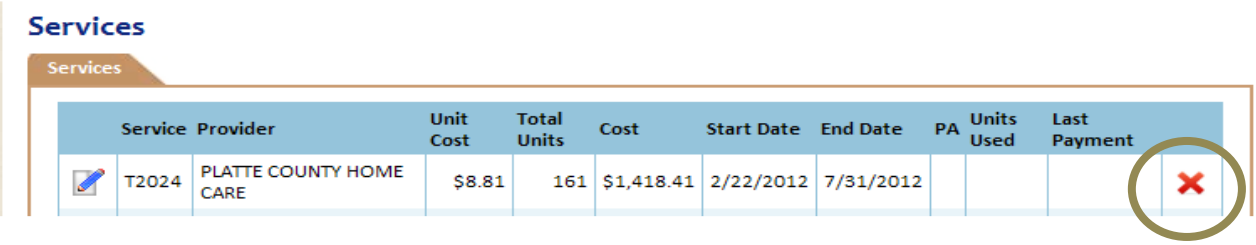
As a user enters the monthly units, remember that each service has its own service designation. Verify the service unit designation if unsure.

> ***A unit for Non-Medical Transportation is a one way trip, while a unit of Personal Care Attendant is 15 minutes.***

When finished click on the "Save" button.

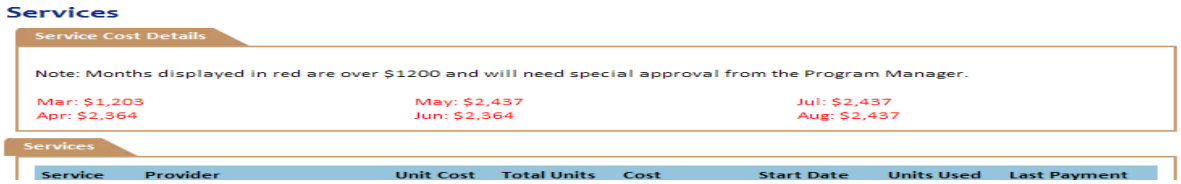
To cancel what has been entered, click on the "Cancel" Button.

To delete a service from the "Services" screen, click on the red "X" to the right of the service. If there is no red "X", the service cannot be deleted.



Plans over $1200

Above the list of services is the "Services Cost Details" section.



This section shows by month the total plan costs. **IF THERE IS AT LEAST ONE MONTH THAT IS OVER $1200, IT MUST BE APPROVED BY THE PROGRAM MANAGER.** To request approval by the program manager, the case manager must enter the following information into a note:

- Previous plan high (not necessary for new plans)
- New plan high (if this is a renewal or modification, note if there is a plan change or not)
- Reason for new plan high (services are based upon need, not necessarily want)
- History of participant (examples: quadriplegic, has broken arm, decline in health, LT101 has increased, etc)
- Any further information that will assist the Program Manager in making the determination

For instructions on how to enter plan notes, refer to "Notes" section on pages 86 or 122.

FAILURE TO GET APPROVAL FOR PLANS OVER $1200 WILL CAUSE DELAYS IN PLAN SUBMISSION

Documents

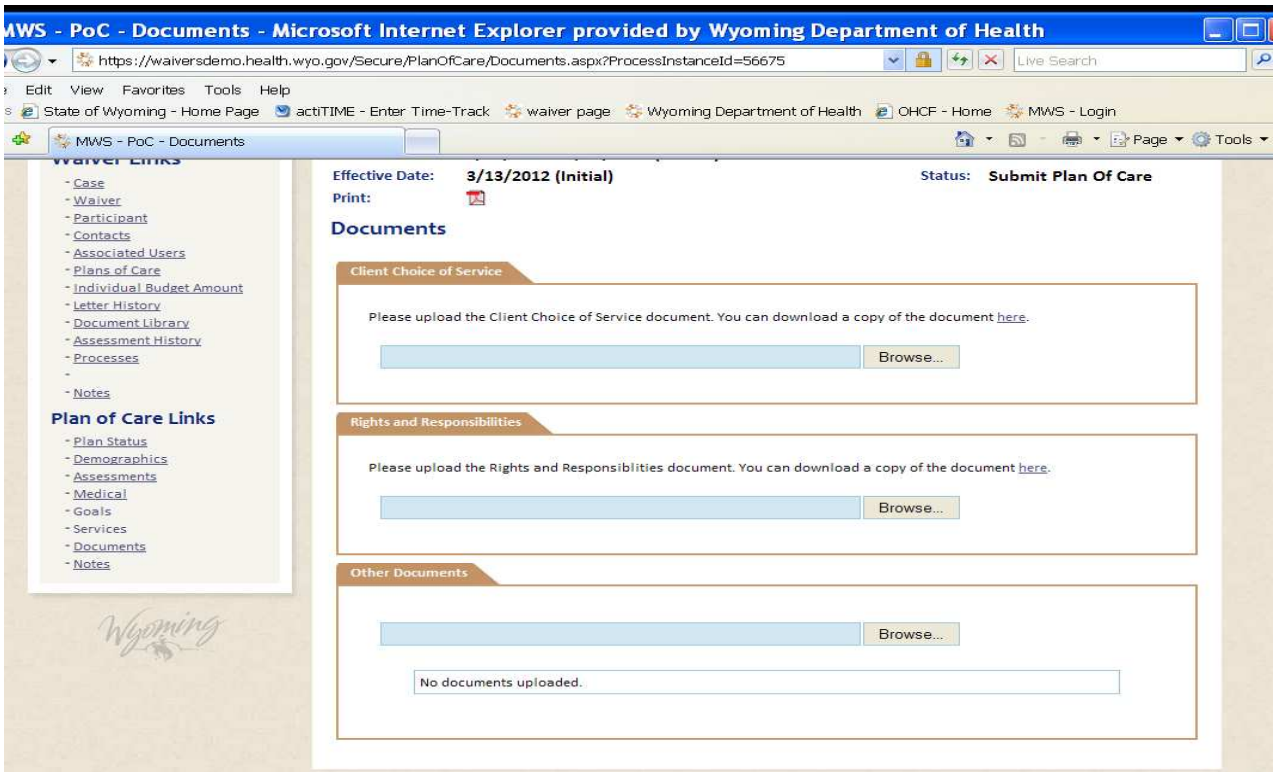
There are two documents that are required for a Plan of Care:

- ✓ Client Choice of Service (HCBS-1)
  - o Due when putting a participant on the waiting list
  - o Due when a participant has received a funding opportunity
  - o Due at each renewal plan period
- ✓ Client Rights and Responsibilities
  - o Due when a participant has received a funding opportunity
  - o Due at each renewal plan period

To upload the documents into the system, click on the "Documents" link under the section "Plan of Care Links" to open the document window.

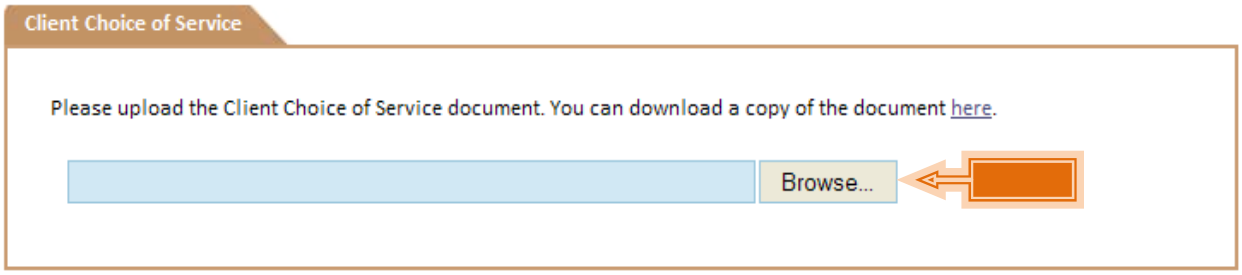
If a user is not at a participant's Plan of Care screen, please refer to sections *"Review Information through Task List Screen" on page 15 or "Search Cases Screen" on page 17 for instructions to access a participant's information.*

When open the document window should look like this.

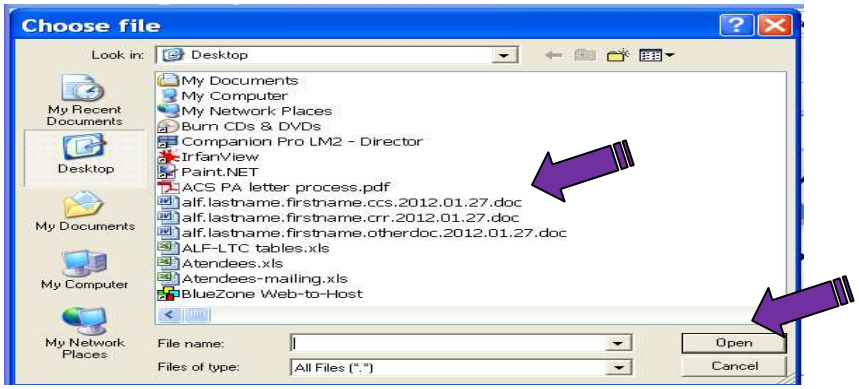


Client Choice of Service

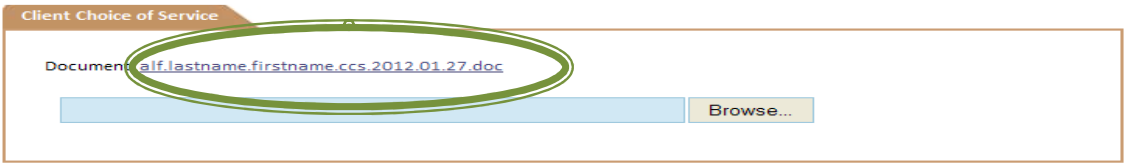
To upload a scanned Client Choice of Service, click on the Browse button.



This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



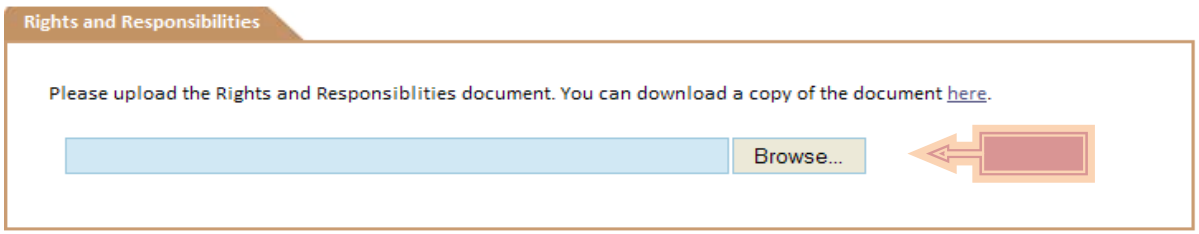
Once uploaded, a link to the document will be available.



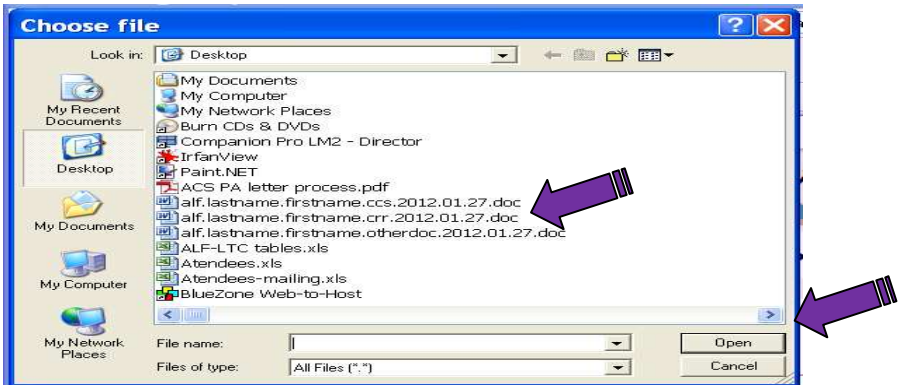
If an error is made and the wrong document is uploaded, just re-upload the correct document. It will override the incorrect document.

Client Rights and Responsibilities

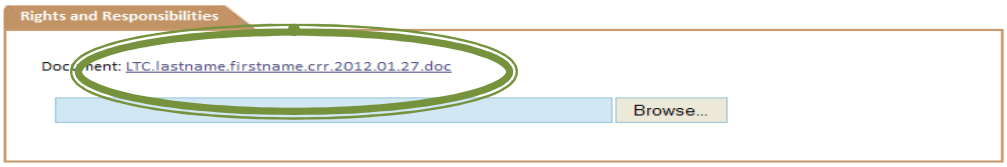
To upload a scanned Client Rights and Responsibilities, click on the “Browse” button under “Rights and Responsibilities” section.



This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



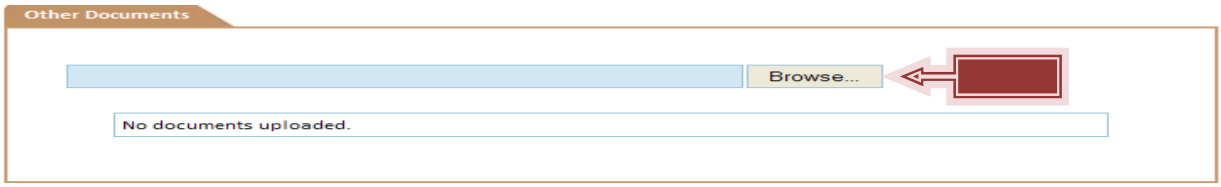
Once uploaded, a link to the document will be available.



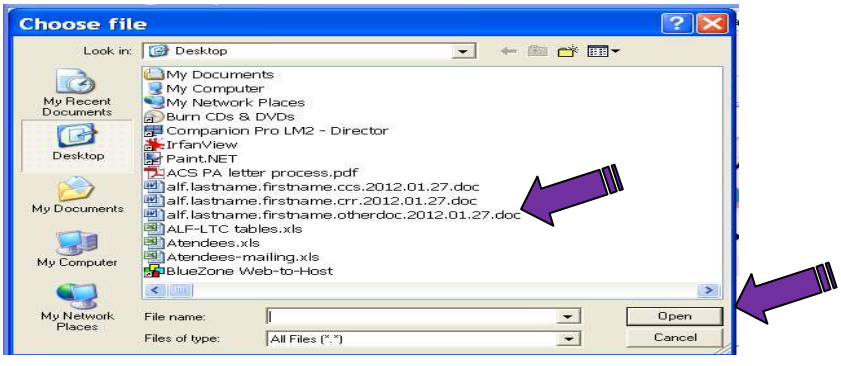
If an error is made and the wrong document is uploaded, just re-upload the correct document. It will override the incorrect document.

Other Documents

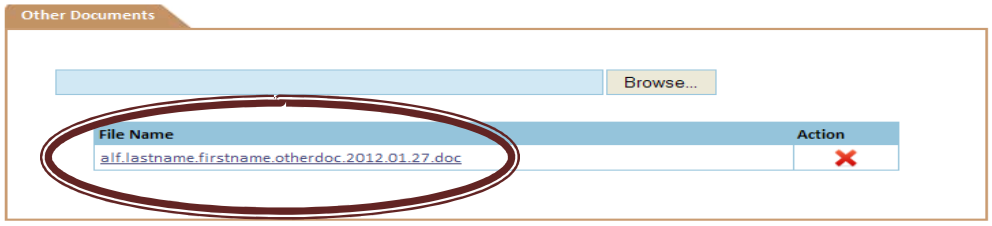
There may be times when additional documentation is required. To upload additional documents, click on the "Browse" button under "Other Documents" section.



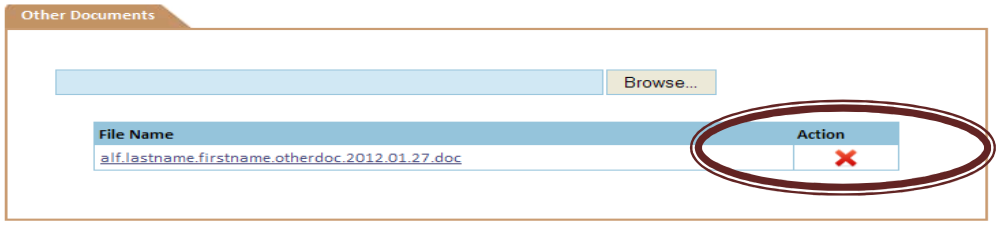
This will open the "choose file" window. Locate the file, highlight the file and click on the "Open" button.



Once uploaded, a link to the document will be available.

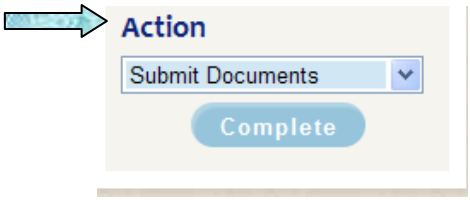


These documents may be deleted if necessary. To delete the scanned and uploaded document, click on the red "X" under "Action" to the left of the file name.

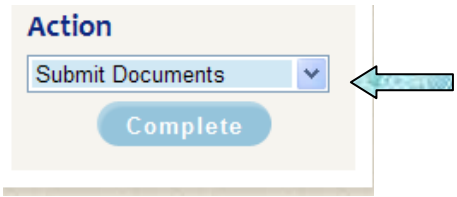


This will remove the document from the system.

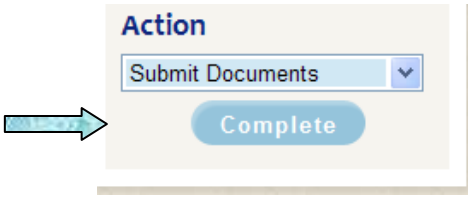
After all required documents have been scanned and uploaded in the appropriate sections, go to the "Action" drop down box to the left of the screen.



Choose "Submit Documents" and



click on the "Complete" button to finish the process.



At this point the Program Manager reviews the documents. If the documents are correct, the participant's plan is ready for final submission. If the documents are NOT correct, the Case Manager/Care Coordinator will receive a notification to make corrects and re-submit.

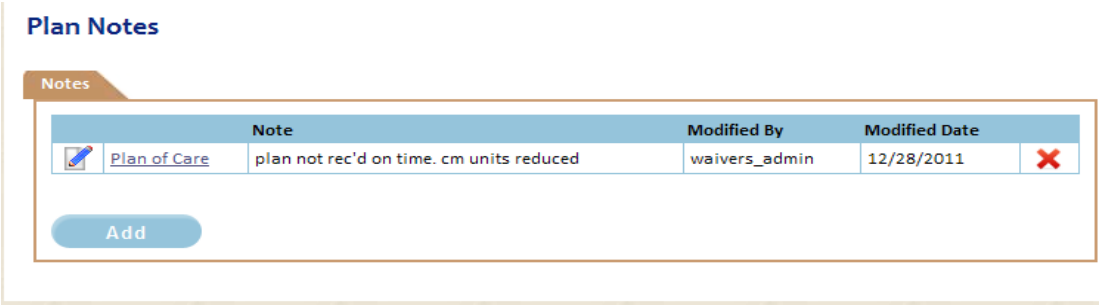
The Case Manager/Care Coordinator is finished until the participant comes to the top of the waitlist and receives a notification that the participant has a funding opportunity.

Notes

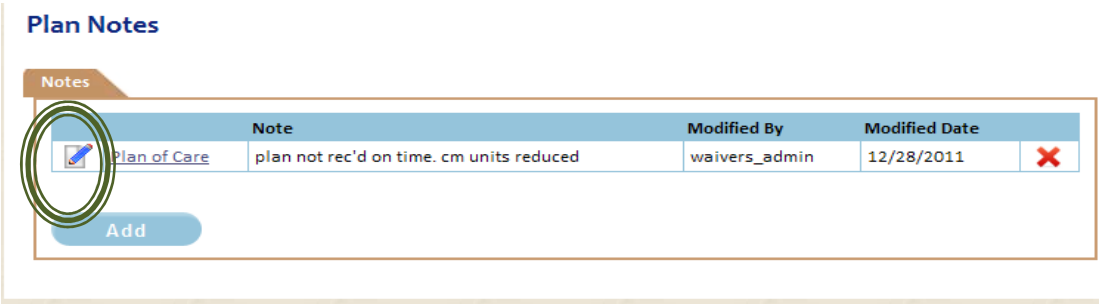
The "Notes" section allows for notes to be added to a participant's plan. ***These notes are specific to a plan, but will also show up in the "Notes" section of the "Waiver Links".***

To access the "Notes" screen, choose the "Notes" link in the "Plan of Care Links" section to the left of the screen.

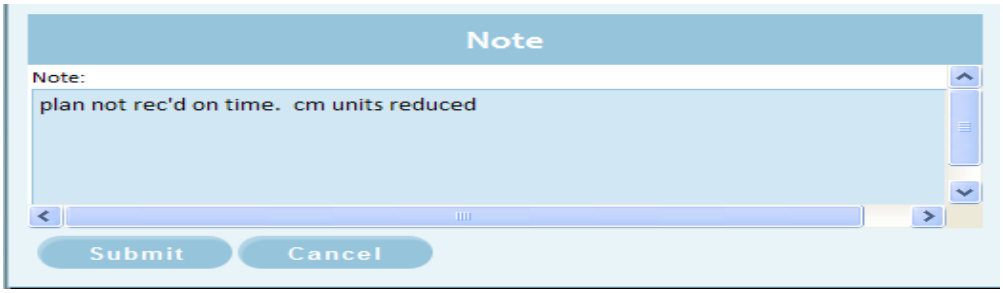
Once the screen is open, it will list all notes related to the Plan of Care.



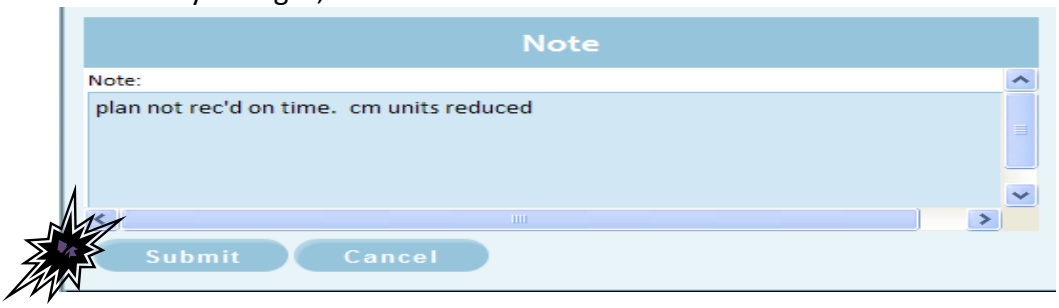
To view a note already in the system, click on the "Pencil" icon to the left.



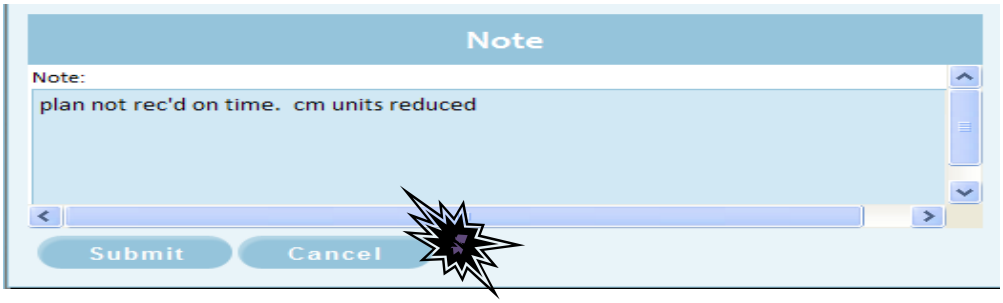
This will open the window of the note chosen.



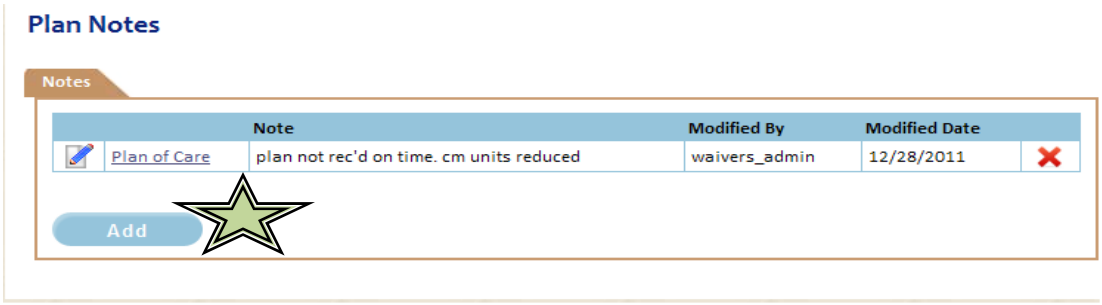
At this time, the details of the note may be viewed and/or any changes may be made. To submit any changes, click on the "Submit" button.



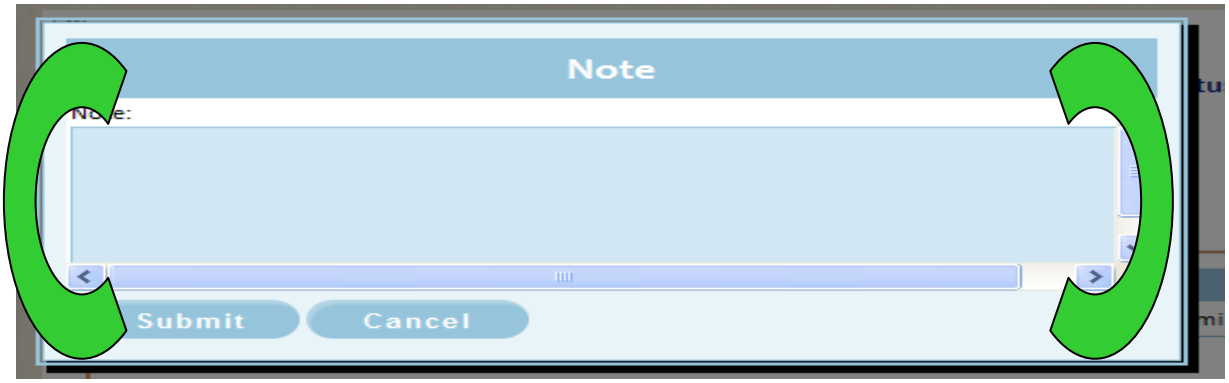
To return back to the "Notes" screen without making changes, click on the "Cancel" button.



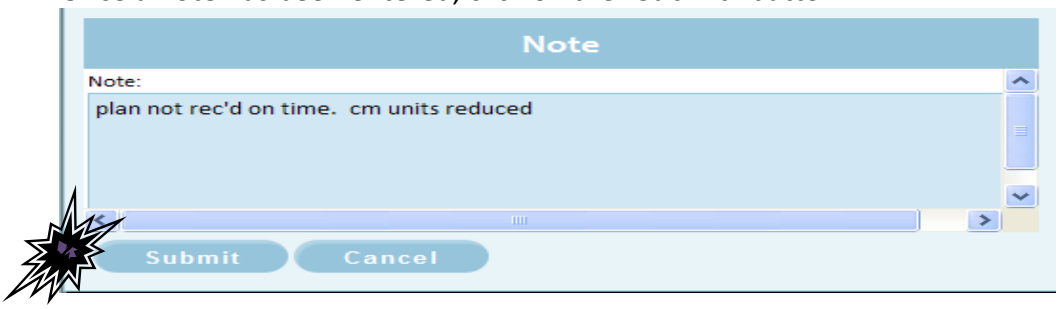
To add a new note, click on the "Add" button.



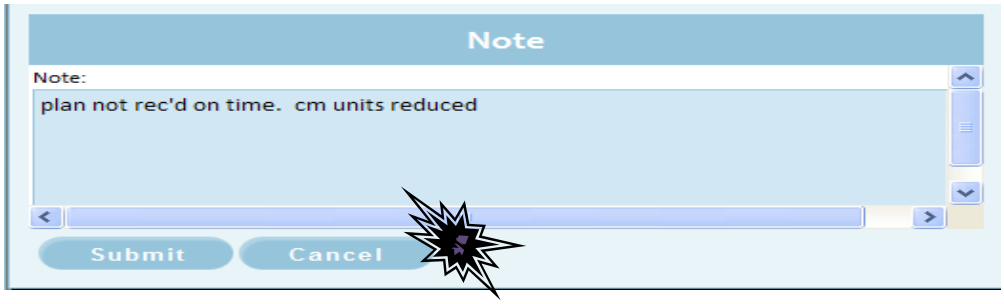
This will open a new window. Add any information pertinent to the plan in the "Note" section.



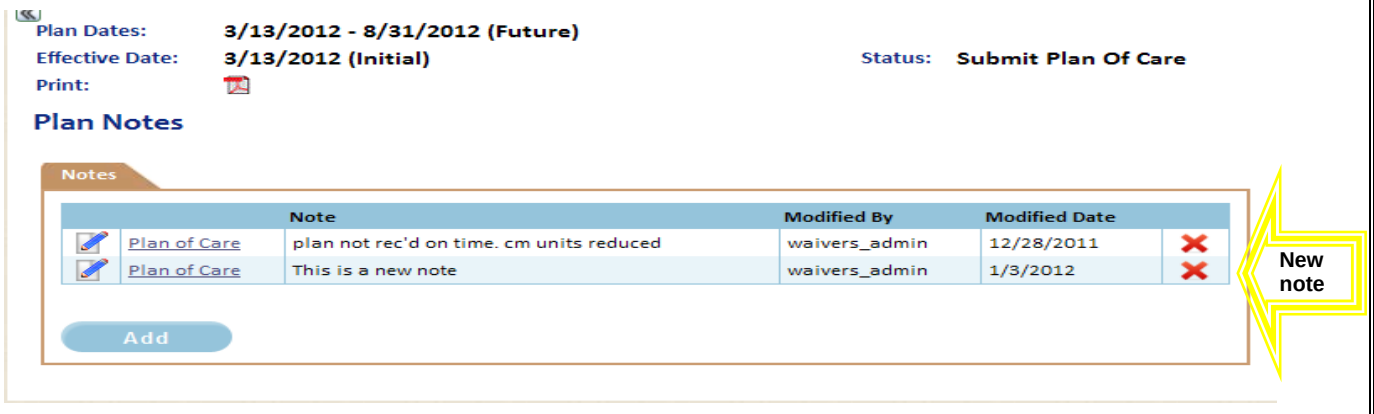
Once a note has been entered, click on the "Submit" button.



To return back to the "Notes" screen without adding a note, click on the "Cancel" button.

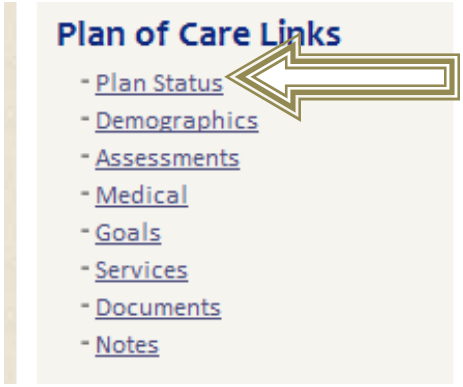


As each new note is added, it will appear on the "Plan Notes" screen.



Final Submission

Once all tasks are completed and the plan is ready for submission, click on the "Plan Status" link under "Plan of Care Links' to the left of the screen.



This will open the "Plan Details" screen.

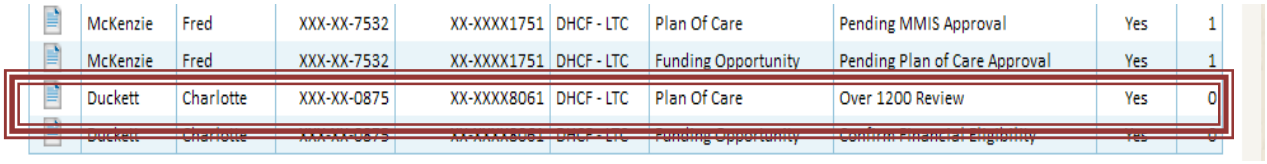
The action in the "Action" drop down box should be "Submit Plan of Care" (this is the ONLY option.

Click on the "Submit" button to finish the process.

At this point the Case Manager/Care Coordinator is finished with their tasks and is waiting for a prior authorization from the fiscal agent.

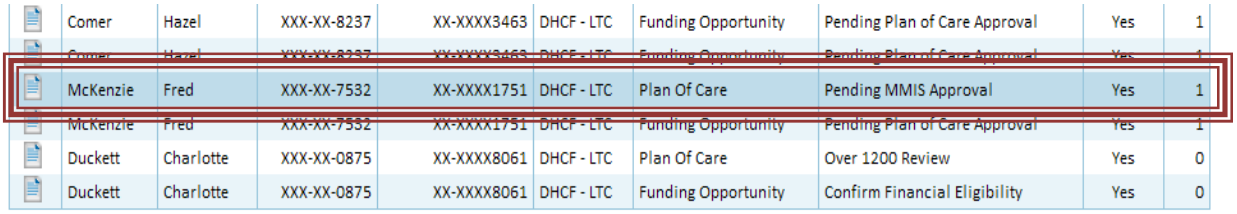
UNLESS

If the plan is over $1200 for any month, there is further review by the Program Manager. The Case Manager/Care Coordinator must monitor for the "over $1200 approval". If the approval does not happen timely, the Case Manager/Care Coordinator needs to call the Program Manager. Note the example below – the participant has a status of "Over 1200 Review".



	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Plan Of Care	Pending MMIS Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Plan Of Care	Over 1200 Review	Yes	0
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Funding Opportunity	Confirm Financial Eligibility	Yes	0

A participant that is waiting for a prior authorization number will have notation in the bottom section of the task list. Note the example below – the participant has a status of "Pending MMIS Approval".



	Comer	Hazel	XXX-XX-8237	XX-XXXX3463	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Plan Of Care	Pending MMIS Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Plan Of Care	Over 1200 Review	Yes	0
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Funding Opportunity	Confirm Financial Eligibility	Yes	0

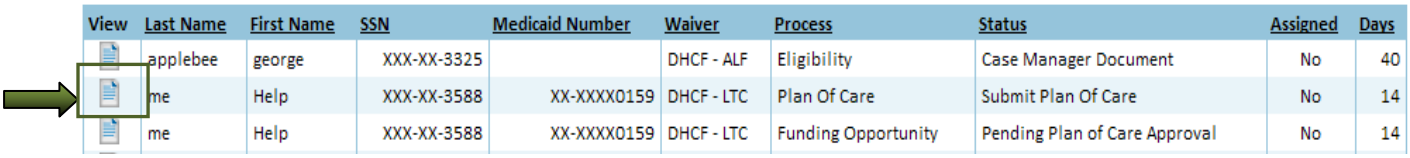
When a participant disappears from both tasks lists, there are no further workflow tasks to be done. The participant at this point is either:

- on the waitlist waiting for a funding opportunity
- has received the funding opportunity, the plan has been submitted AND service prior authorizations have been received OR
- the renewal plan has been submitted AND service prior authorizations have been received

Renewal Plans

Notification of Renewal

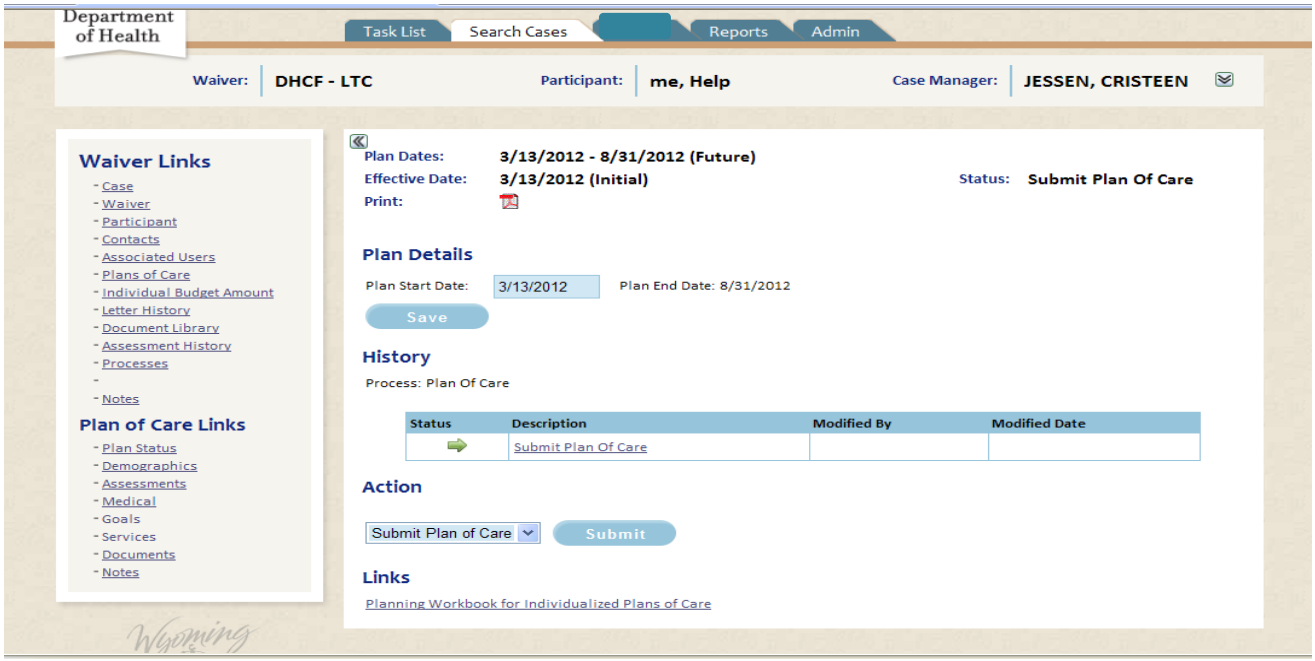
When a participant is due to renew their Plan of Care, notification is sent to the Case Manager/Care Coordinator. When a Case Manager/Care Coordinator logs into the system, a task will be in the top section of the Task List screen. Click on the document icon in the "View" column of the associated task.



View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	applebee	george	XXX-XX-3325		DHCF - ALF	Eligibility	Case Manager Document	No	40
	me	Help	XXX-XX-3588	XX-XXXX0159	DHCF - LTC	Plan Of Care	Submit Plan Of Care	No	14
	me	Help	XXX-XX-3588	XX-XXXX0159	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	No	14

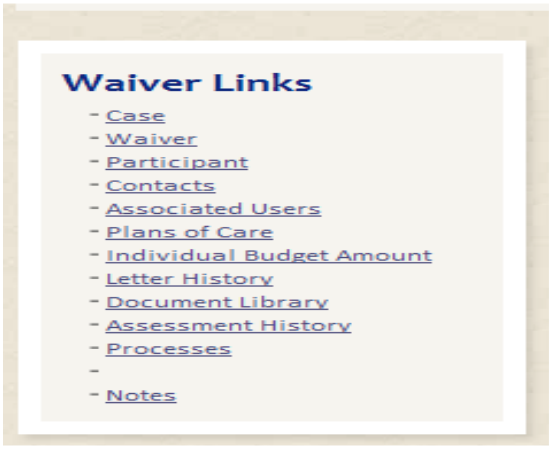
Plan Status Screen

When the Plan Status screen is open, it should look like this.



To the left are several links to allow the user to access other areas of the participants information.

- Waiver Links – This section gives links to participant specific information that may or may not be related to a specific Plan of Care.

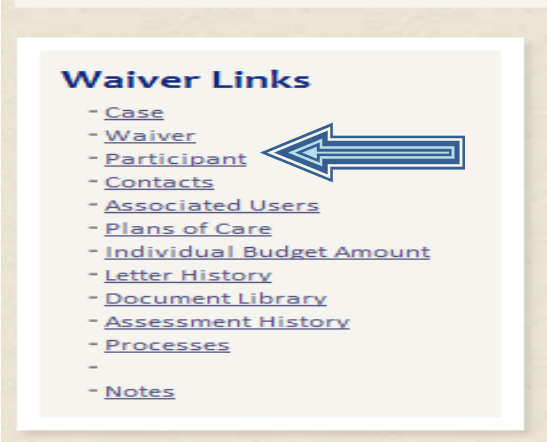


- Plan of Care Links – This section gives links to participant information related to a specific Plan of Care.

Updating/Verifying Information

To update a participant's information, a Case Manager/Care Coordinator must be in the "Participant" screen. The "Participant" screen should look like the screen below at the top of a user's screen.

If the screen does not look like above, click on the link "Participant" under the title "Waiver Links" to the left of the screen.



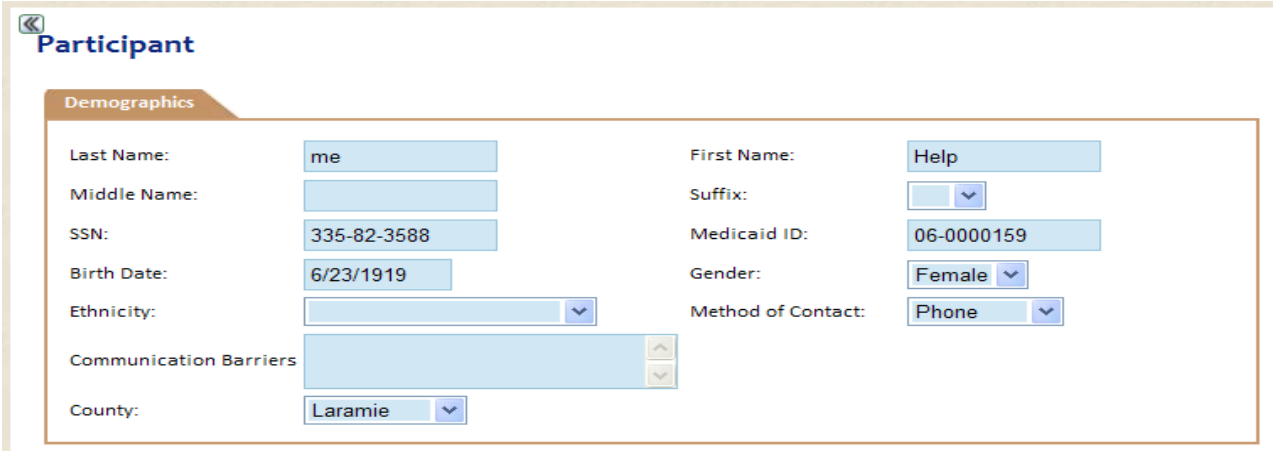
If a user is not at a participant's screen, please refer to sections *"Review Information through Task List Screen" on 15 or "Search Cases Screen" on page 17 for instructions to access a screen with "Waiver Links".*

On the Participant's demographic screen are four sections:

- Demographics
- Addresses
- Phone Numbers
- Email Addresses

Each section must be verified for correctness.

Demographics



The demographics section has the following fields:

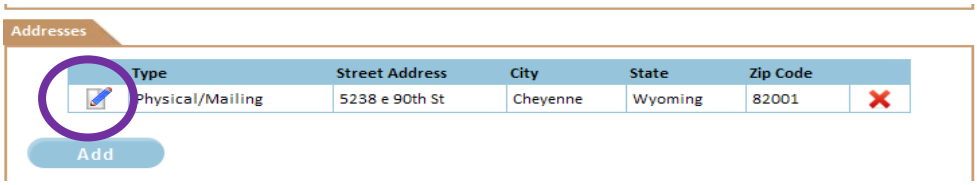
- Last Name – The last name of the participant
- First Name – The first name of the participant
- Middle Name – The middle name of the participant (if available)
- Suffix – Jr., III, etc

- SSN – the social security number of the participant. This **MUST** be the participant's SSN; not the spouse's.
- Medicaid ID - the "06…" of the participant. ***REMINDER – ID's that start with "00…" are NOT Client ID's and cannot be used as such.***
- Birth Date – The participant's date of birth
- Gender – Male/Female
- Ethnicity – Race of participant
- Method of Contact – the Participant's desired form of contact.
- Communication Barriers – A note section to indicate any limitations the participant may have to communicate. This can include a physical disability or language barrier.
- County – the participant's county of residence. (This is dictated by the participant's physical address).

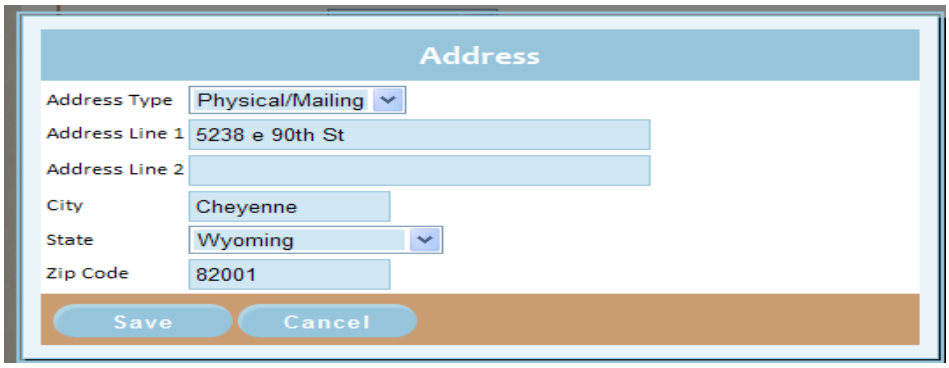
Verify the information is correct and current.

Addresses

The next section has the participant's address information. A participant may have one or multiple addresses.

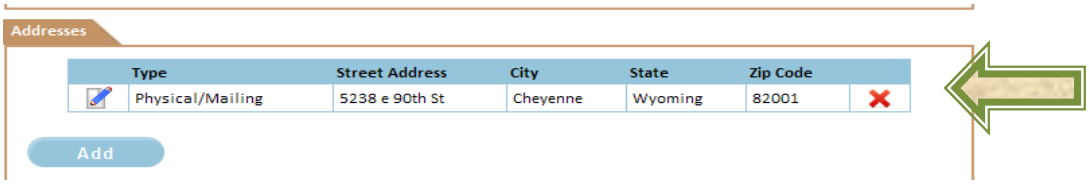


To update an address currently in the system, click on the "pencil" icon next to the address to update. This will open the address window.



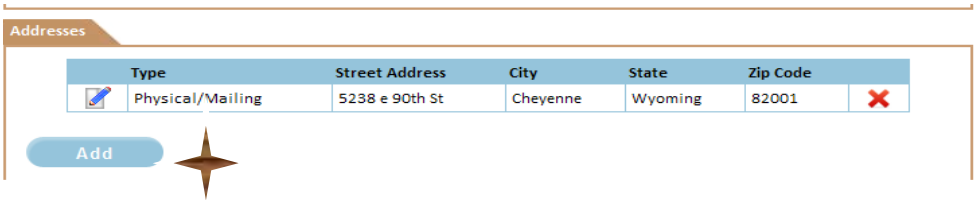
Update any information to be changed. When finished, click on the "Save" button.

To disregard any changes made, click on the "Cancel" button.



To delete an address, click on the Red "X" button . This will delete the address from the system.

To add a new address, click on the "Add" button.

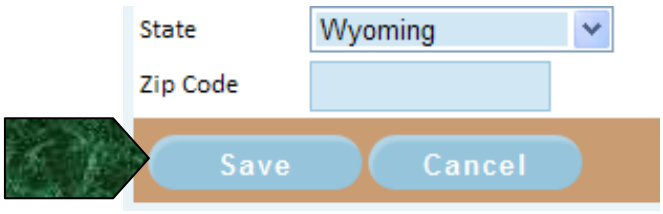


This will open the window to add a new address.

Enter the following information:

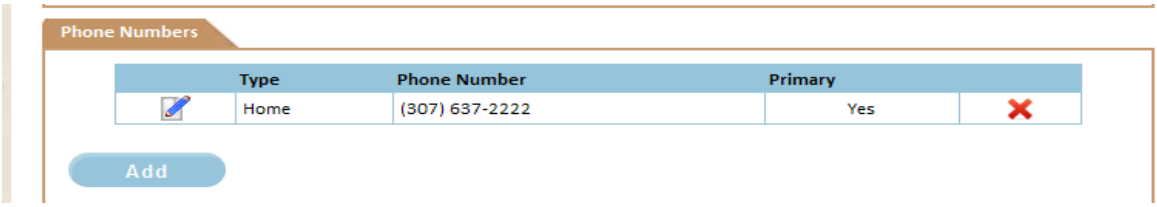
- Address Type – this will be one of three options
  - Physical – The address the participant resides
  - Mailing – The address all correspondence is mailed to, if different from the physical address.
  - Physical/Mailing – If both the physical and mailing addresses are the same, use this option.
- Address Line 1 – Street address or PO Box
- Address Line 2 – Apt. number, or additional street address information if there is not enough room on the first line.
- City – City the address is associated with. *Mailing and Physical addresses may be different.*
- State – the State will default to Wyoming. Can be changed for mailing address information. ***THE PARTICIPANT MUST RESIDE IN THE STATE TO BE AN ELIGIBILE PARTICIPANT ON THE WAIVER.***
- Zip Code – the zip code associated with the city and address.

When the address has been added, click on the “Save” Button.

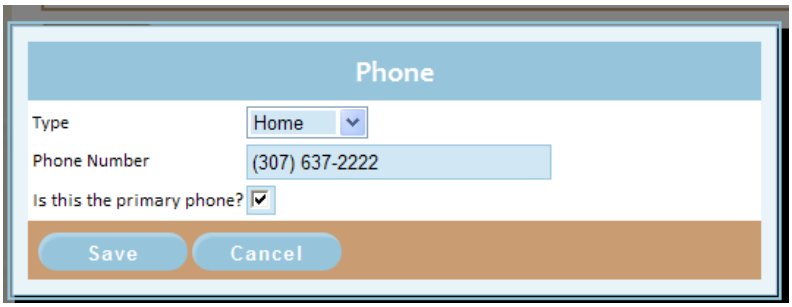


Phone Numbers

In the phone number section of the screen, all phone numbers associated with the participant are listed here. A participant may one or many phone numbers.

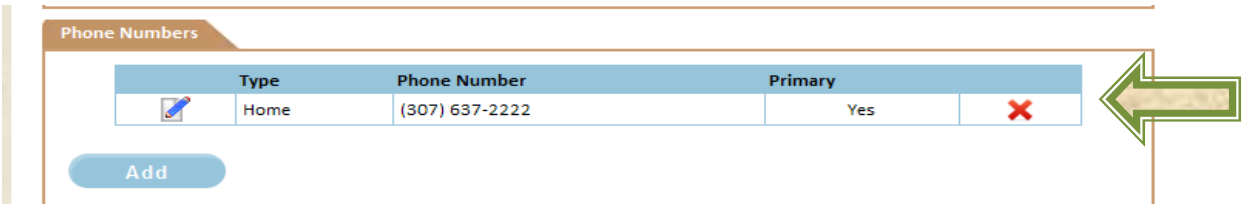


To update a phone number currently in the system, click on the “pencil” icon next to the phone number to update. This will open the phone window.



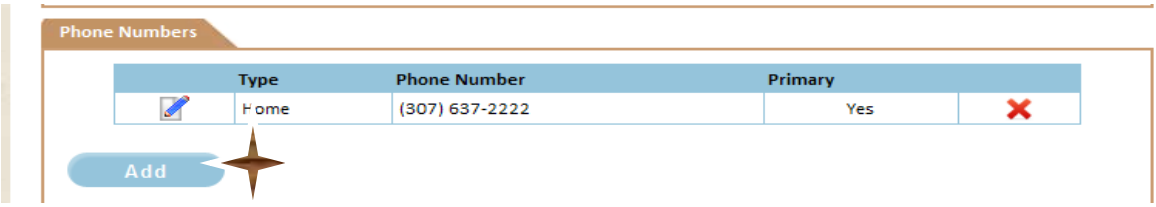
Update any information to be changed. When finished, click on the “Save” button.

To disregard any changes made, click on the “Cancel” button.

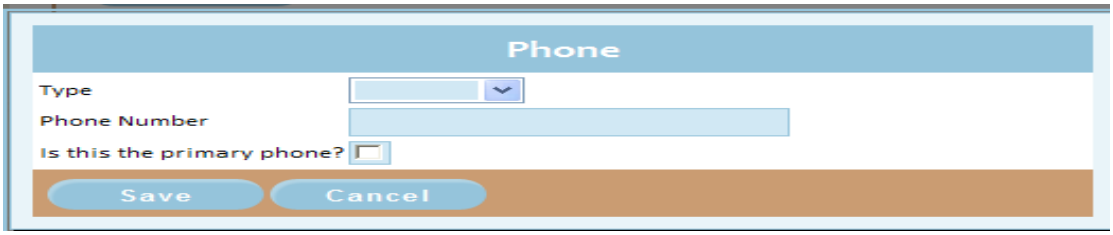


To delete a phone number, click on the Red “X” button . This will delete the phone number from the system.

To add a new phone number, click on the “Add” button.

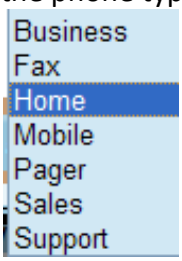


This will open the window to add a new phone number.



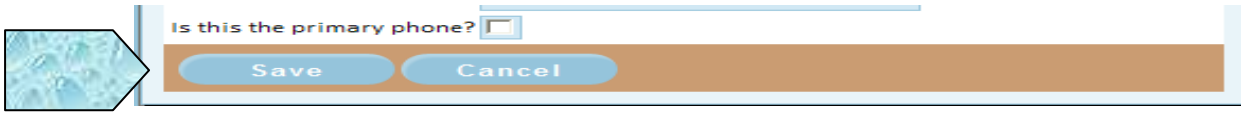
Enter the following information:

- Type – the phone type. Current phone types are listed below:



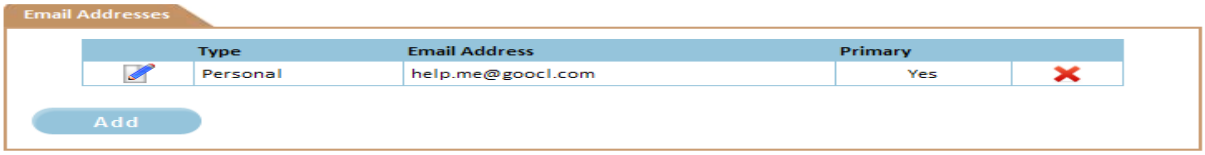
- Phone number – the full phone number for the participant. This includes area code.
- Is this the primary phone? – A check box to indicate the primary phone for the participant.

When the phone number has been added, click on the “Save” Button.

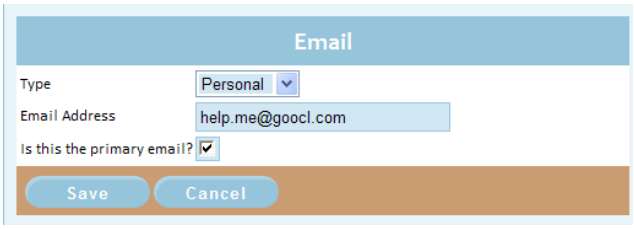


Email Addresses

The email section is an optional section to the participant’s demographics. If a participant wishes to give their email, it is to be entered here. A participant may have one or multiple email addresses.



To update an email address currently in the system, click on the "pencil" icon next to the address to update. This will open the email window.

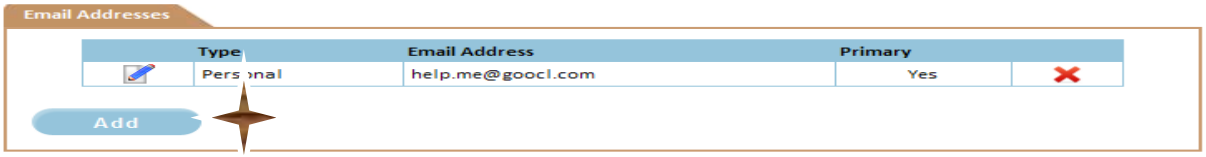


Update any information to be changed. When finished, click on the "Save" button.

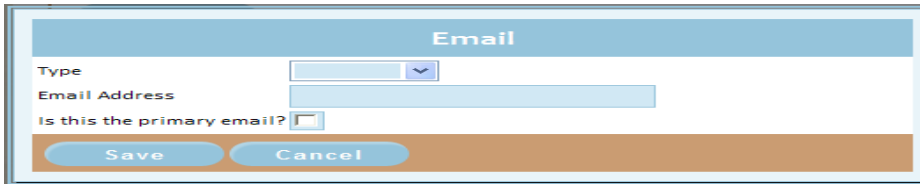
To disregard any changes made, click on the "Cancel" button.

To delete an email address, click on the Red "X" button . This will delete the address from the system.

To add a new email address, click on the "Add" button.

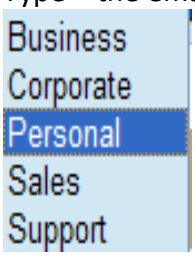


This will open the window to add a new email address.



Enter the following information:

- Type – the email type. Current email types are listed below



- Email Address – the full email address for the participant. This includes the @ symbol and a valid ".com" site.

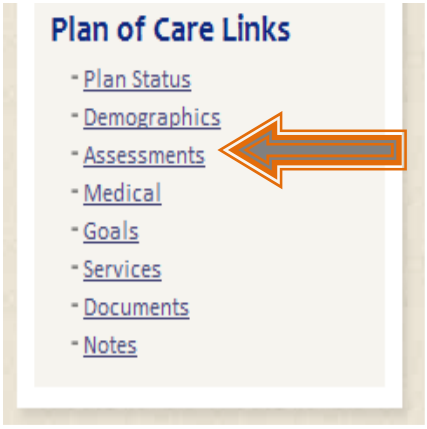
- Is this the primary email? – A check box to indicate the primary email address for the participant.

When the email address has been added, click on the "Save" Button.

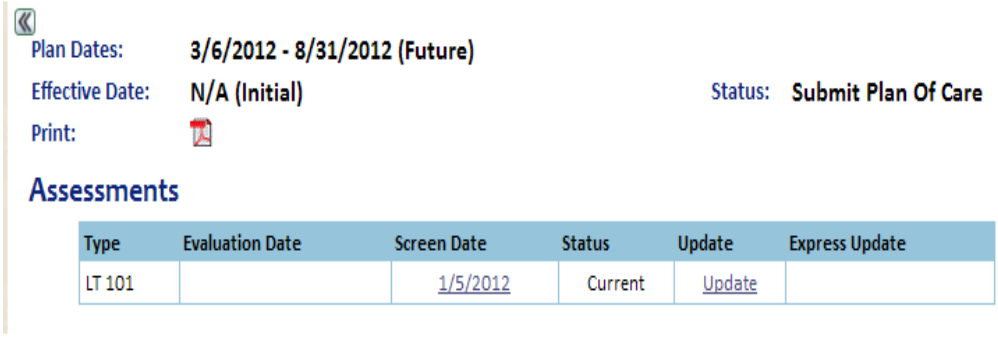
There is no "Action" button for this task.

Assessments

After client information has been verified, the Case Manager chooses the most appropriate LT101 for the Plan of Care. In the "Plan of Care Links" section to the left of the screen, choose the "Assessment" link.



Once the "Assessment" screen is open, it will show a list of all LT101's for the participant. It will only allow the user to choose a valid LT101. To choose the desired LT101, click on the LT101 with the evaluation date that has "Current" in the Status column AND a "Screen Date" with an underline (indicating a link).



There is no need to do anything on this screen, as long as there is a current LT101 in place.

Medical

(Optional screen – Information on this screen is not required.)

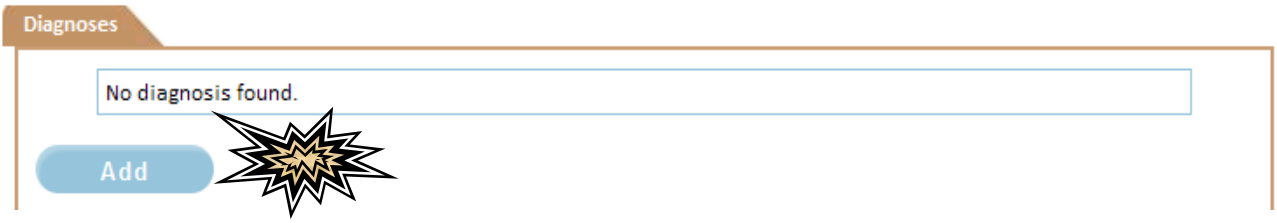
The "Medical" screen has all diagnosis and medication information stored and needs to be reviewed and updated at a minimum during each renewal period. To access the "Medical" screen, choose the "Medical" link in the "Plan of Care Links" section to the left of the screen.

Once the "Medical screen is open, it will show 2 sections:

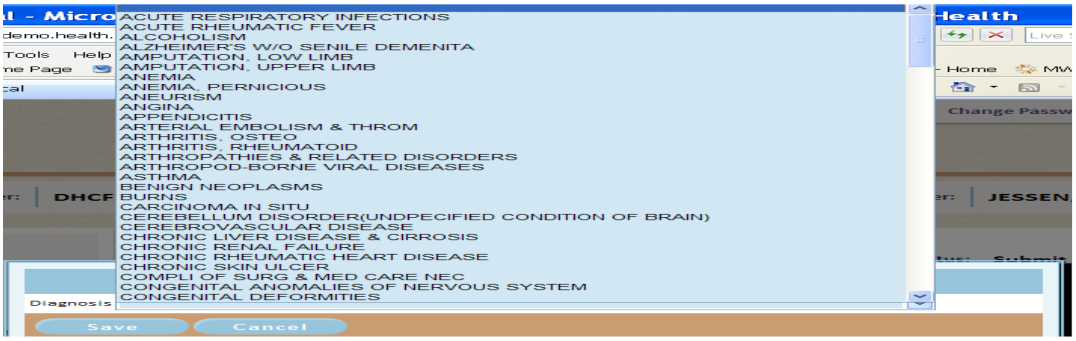
- Diagnosis
- Medications

Diagnosis

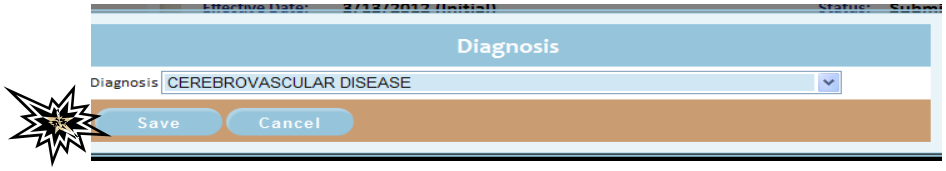
To add a diagnosis, click on the "Add" button.



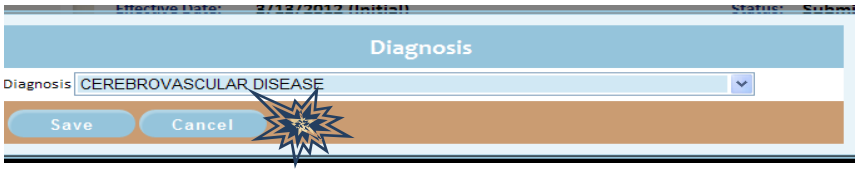
This will open a new window. Click on the drop down button to view diagnosis choices. The choices no longer have the diagnosis code just the words.



Choose the desired diagnosis and click on the “Save” button.



To cancel the choice, click on the “Cancel” button.

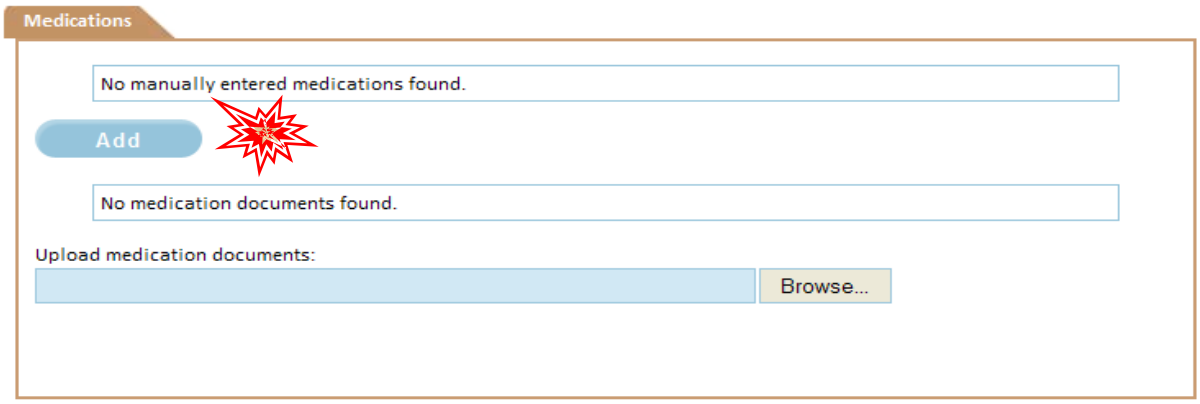


Medications

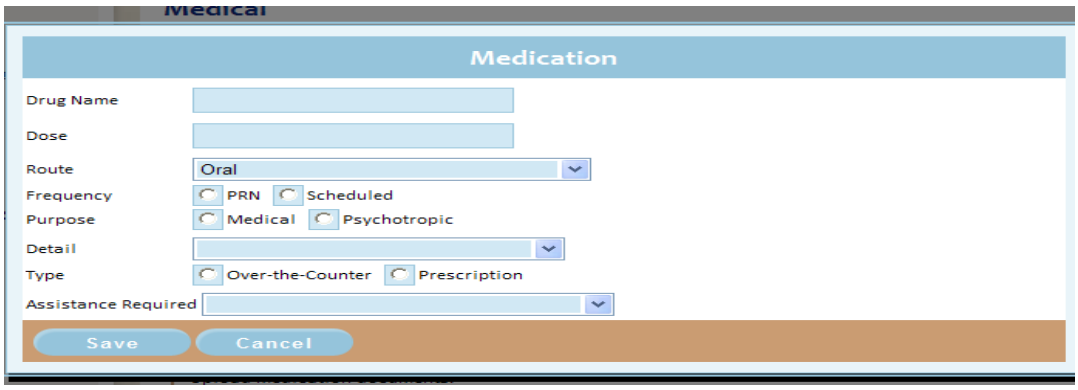
To upload a participant’s current medication list, there are 3 options:

- Enter each medication separately
- Upload a medication list
- A combination of both

To enter each medication separately, click on the “Add” button.



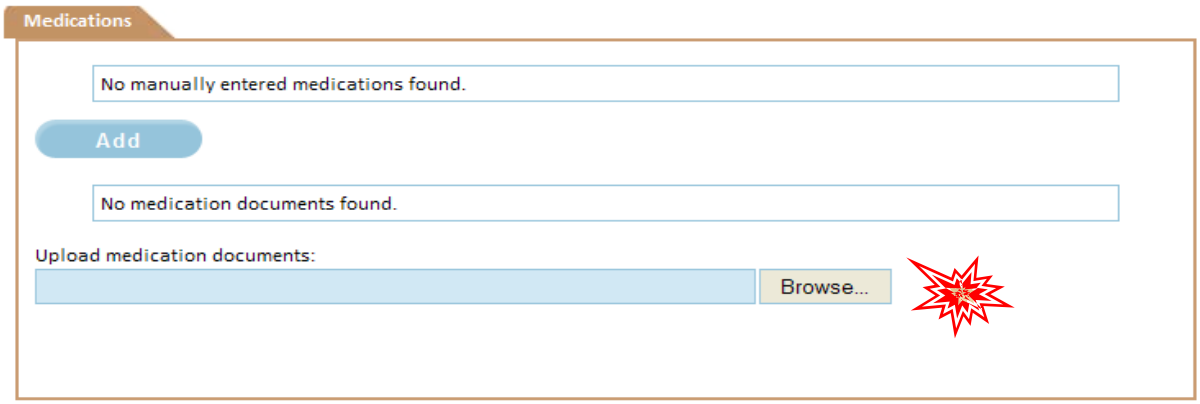
This will open the “Medication” window. Enter all available information.



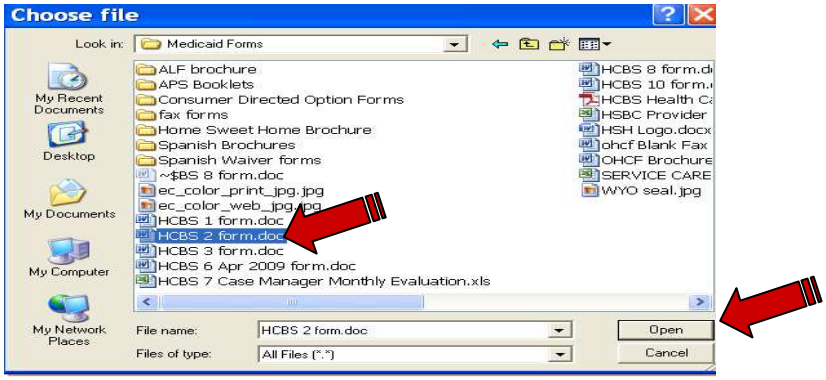
When finished click on the “Save” button.

To cancel the information, click on the “Cancel” Button.

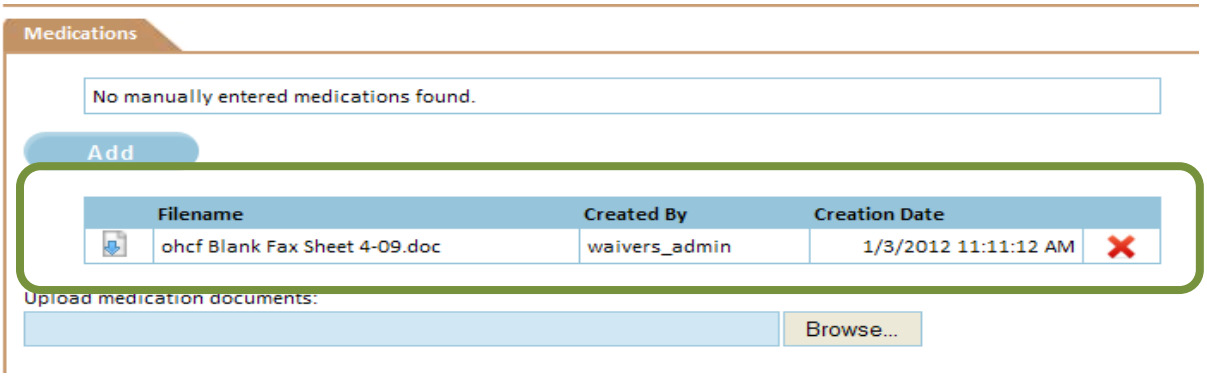
If a Case Manager/Care Coordinator already has a participant’s current list of medications and does not want to enter each one manually, the list may be uploaded into the system. To upload the scanned document, click on the “Browse” button next to the “Upload medication documents” window.



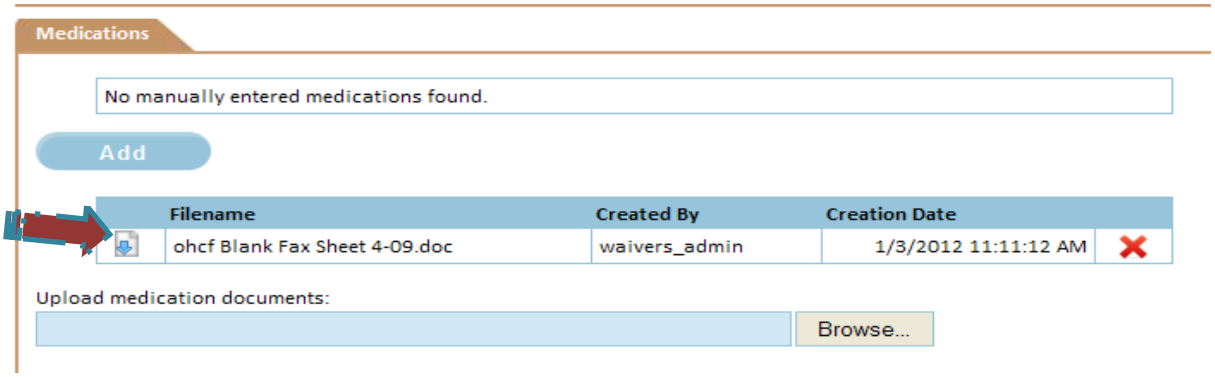
This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



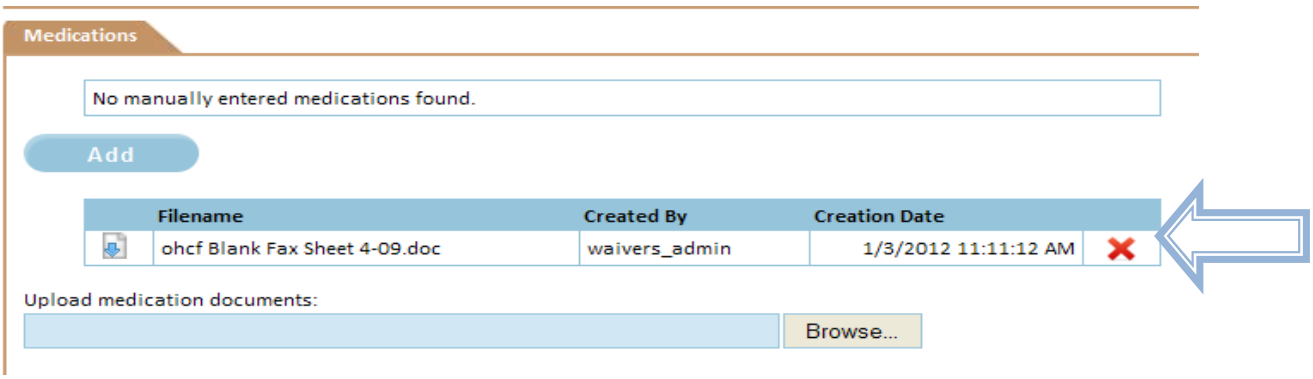
Once uploaded, the document will be available to view.



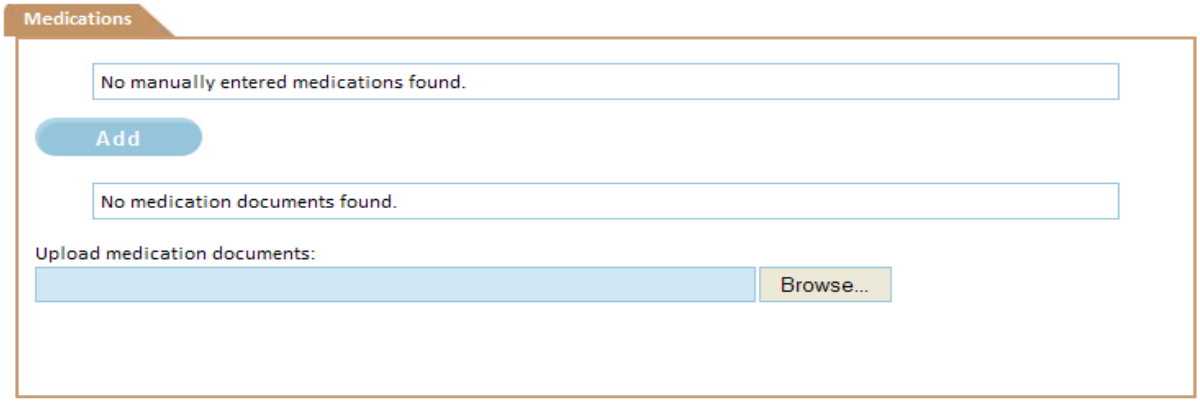
To open the document, click on the document icon located left of the “Filename”.



To delete the document, click on the red"X" located to the right of the "Creation Date".

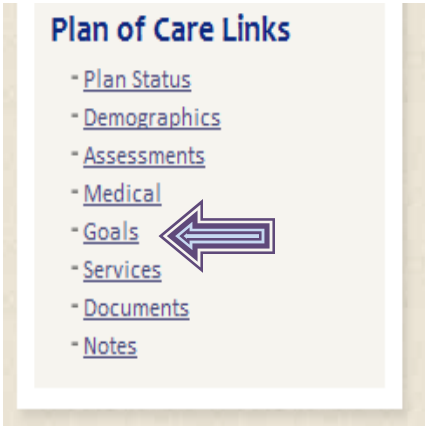


Once deleted, the document will no longer be accessible.



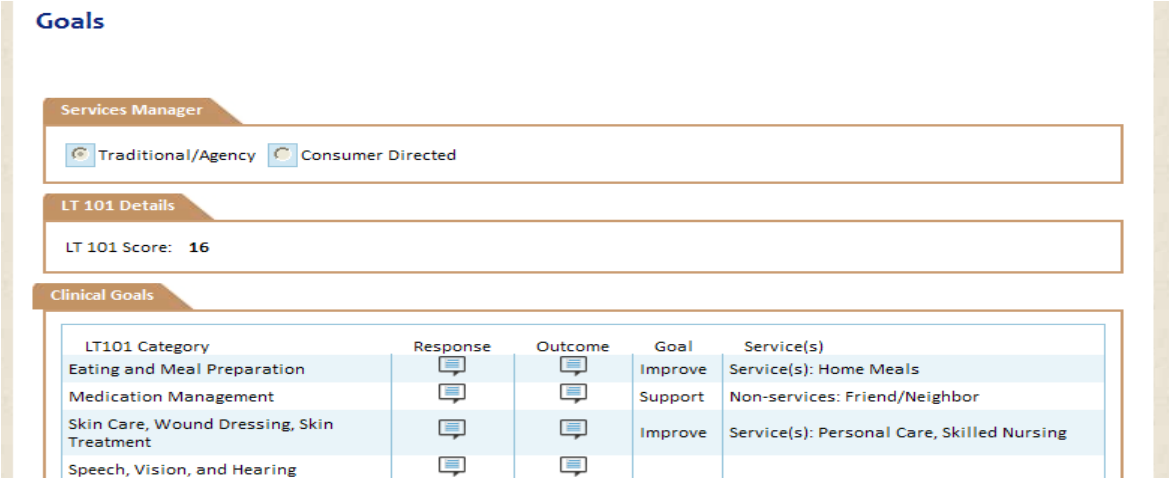
Goals

After the LT101 has been uploaded, reviewed and approved by the Home Care Services Unit, goals can be entered. To access the "Goals" screen, choose the "Goals" link in the "Plan of Care Links" section to the left of the screen.



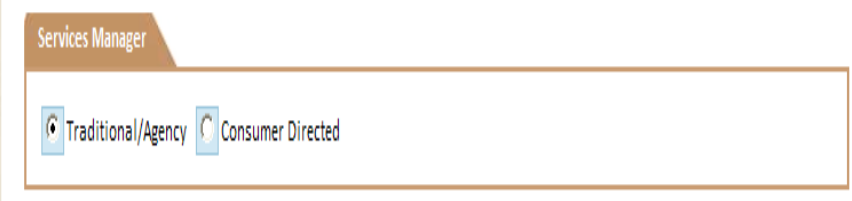
This will open the “Goals” screen. There will be 3 sections on this screen:

- Services Manager
- Clinical Goals
- LT101 Details



Services Manager

The “Services Manager” section allows the Case Manager/Care Coordinator to indicate whether the participant has chosen the traditional services or consumer directed for personal care. A user can ONLY choose one.



When choosing “Traditional/Agency”, the Case Manager/Care Coordinator **WILL NOT** be able to choose the following services:

- Care Coordination
- Self Help Assistant
- Fiscal Management

When choosing “Consumer Directed”, the Case Manager/Care Coordinator **WILL NOT** be able to choose the following services:

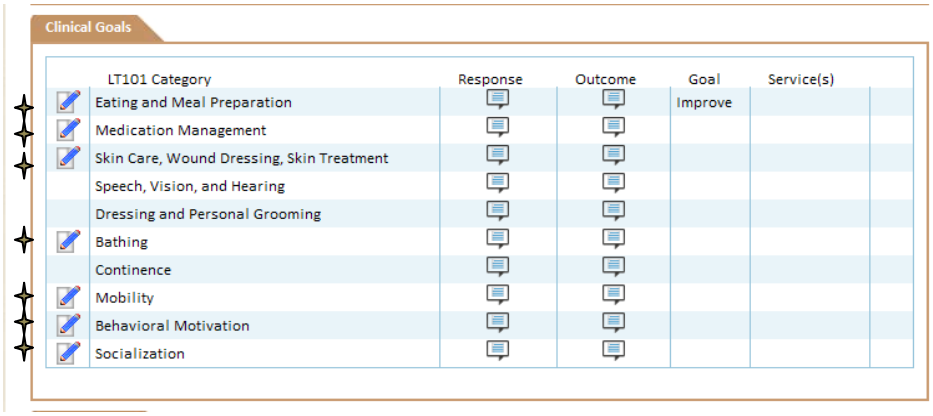
- Case Management
- Personal Care

LT101 Details

In the Case Manager/Care Coordinator view, the only item to show in the "LT101 Details" section is the points the participant received on the chosen LT101.

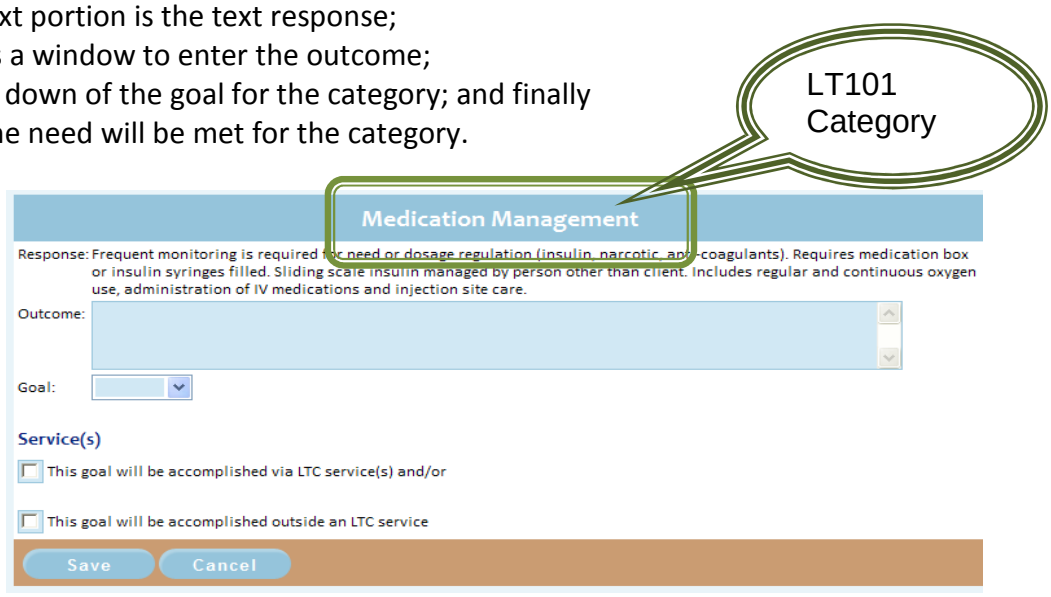
Clinical Goals

After the "Services Manager" selection has been made, goals, outcomes, and services must be chosen for each appropriate LT101 Category. Only those categories that had points will be able to be edited. If an LT101 Category can be edited, there will be a "Pencil" icon next to it. Click on the "Pencil" icon to update the information.

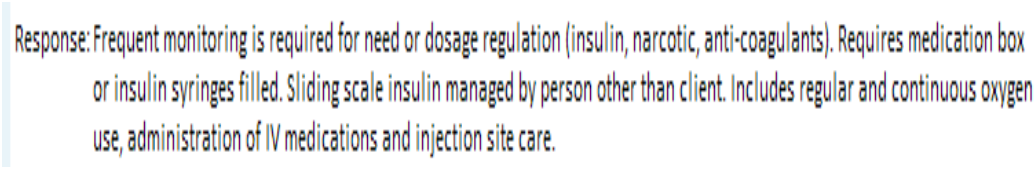


Choose the first available category. It will open a new window.

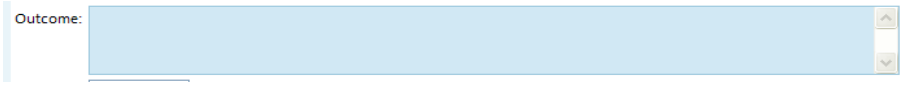
- At the top is the LT101 Category. In the example below the LT101 Category is "Medication Management";
- The next portion is the text response;
- Then is a window to enter the outcome;
- A drop down of the goal for the category; and finally
- How the need will be met for the category.



The response cannot be updated. It is for Case Manager/Care Coordinator information only.



The Case Manager/Care Coordinator enters the outcome in the "Outcome" box. This is a free form text box. Enter the desired outcome of the need.



Next the goal is chosen from the drop down box. Currently, the choices are:

- Improve
- Maintain
- Support

Finally, services will be chosen. Every LT101 Category that can be chosen (these categories will have a "pencil" icon next to them) has a need that **must be** met. A Case Manager/Care Coordinator has several options to meet the need:

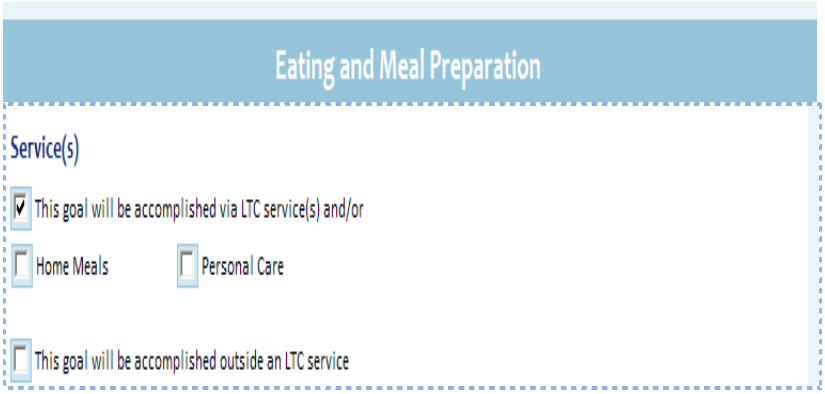
- One or more services may be provided through LTC/ALF waiver services
- One or more services may be provided through another source
- One or more services may be provided through a combination of LTC/ALF waiver services or through other sources.

On each screen is a section named "Service(s)". There are check boxes that are checked when determining how a need will be met.

If LTC/ALF services will be used to meet the need of the category, click on the option "This goal will be accomplished via LTC (ALF) service(s) and/or". When checked, services that are

appropriate for the LT101 Category will appear. In the example being used "Medication Management", there is only one service.

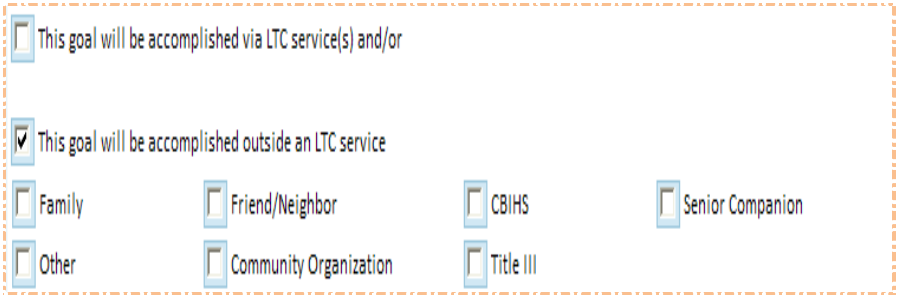
For the LT101 Category "Eating and Meal Preparation" there is a different set of services.



Choose the services that will be provided through the LTC/ALF waiver. One or multiple services may be chosen to meet the specific need.

NOTE: Services chosen in this section will be the only services initially available in the Plan of Care

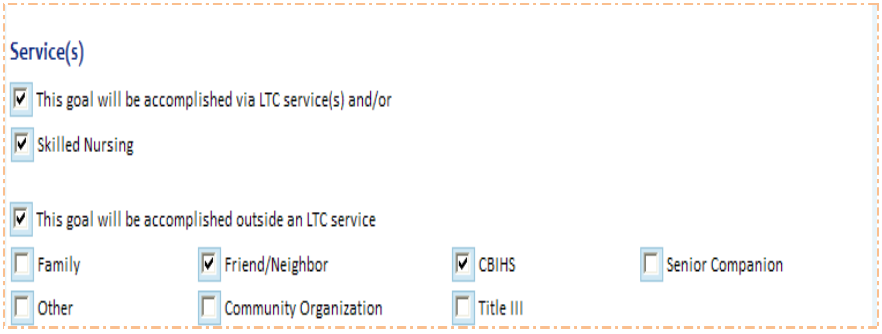
If services will be provided by a Non-waiver source, click on the option "This goal will be accomplished outside an LTC (ALF) service". When checked, outside services will appear.



This list of options is the same for all LT101 Categories.

Choose the source that will provide the need for the LT101 Category. One or multiple options may be chosen to meet the specific need.

There may be times when both an outside source and a LTC/ALF waiver provider will meet the need for a category. (For example: A provider may have staffing issues or not provide services during a specific time of day. A family member may be available to provide care at only certain times.) In instances such as these (Instances are **NOT** limited to these reasons), it may be necessary to choose from both lists.

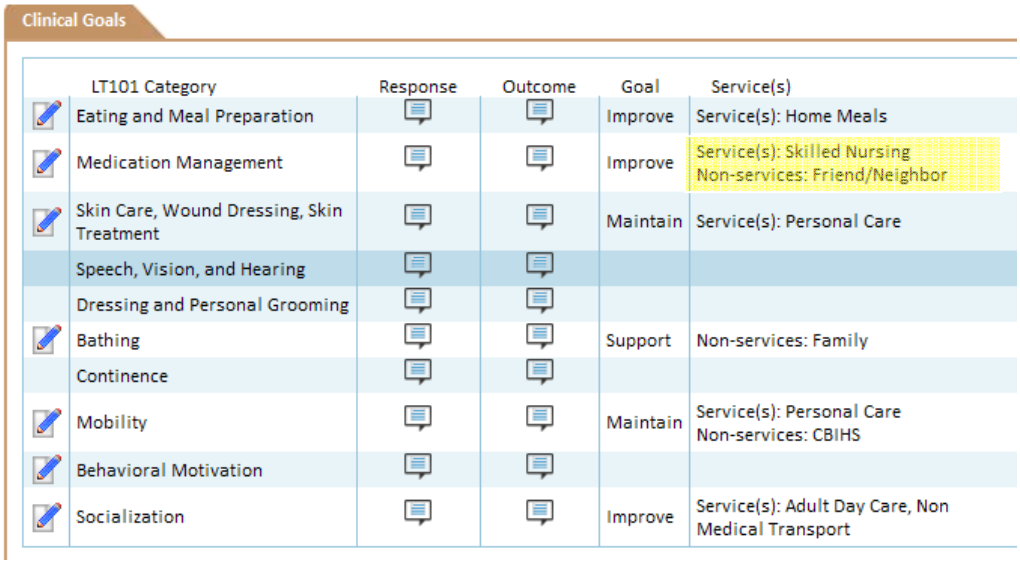


If there is someone who will meet the need, but is not listed, click the "Other" option and enter who will meet the need. This may be a specific name or a general type.

When finished click on the "Save" button.

To cancel what has been entered, click on the "Cancel" Button.

After the LT101 Category has been completed, choose the next available category. Continue until all available categories are complete. Once complete the user will be able to view choices in the "Clinical Goals" section.



Notice in the LT101 Category "Medication Management", there are both "Service(s)" **AND** "Non-services".

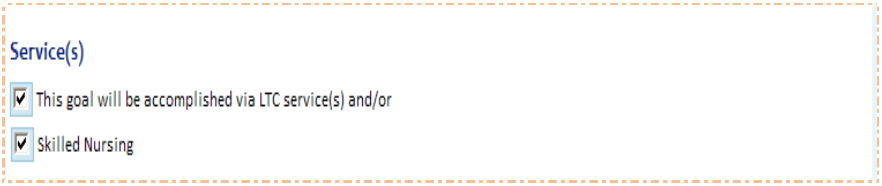
To **change or update a category**, click on the "Pencil" icon to update the information. This will open the category window to allow for any changes. Update any changes needed.

When finished click on the "Save" button.

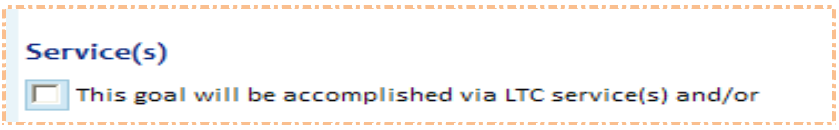
To cancel what has been entered, click on the "Cancel" Button.

To **remove a service from a category**, click on the "Pencil" icon to update the information. This will open the category window. Click in the appropriate check boxes to remove the service. Once un-checking the service, if there are no other services checked, uncheck the section.

The service will go from:



To:



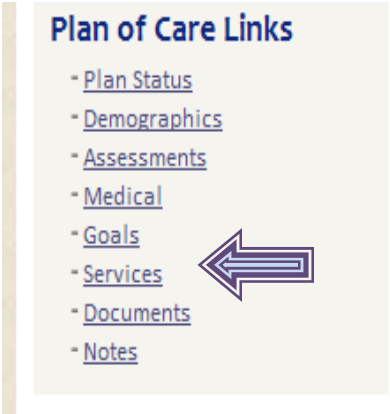
When finished click on the "Save" button.

To cancel what has been entered, click on the "Cancel" Button.

There is no "Action" button for this task.

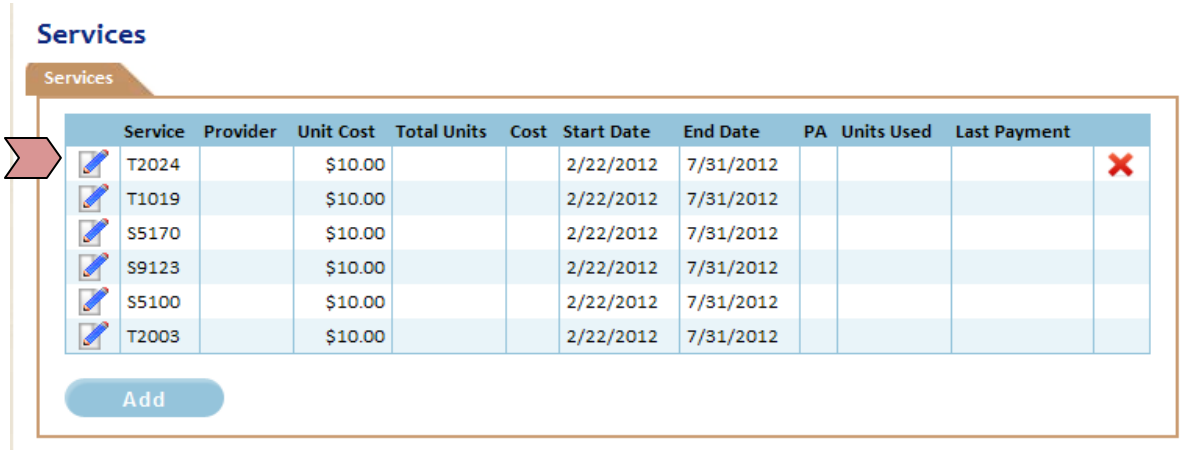
Services

After the "Goals" section is completed, services are completed. To access the "Services" screen, choose the "Services" link in the "Plan of Care Links" section to the left of the screen.



This will open the "Services" screen. The services screen will default to the services listed from the "Goals" screen, plus the mandatory services. Mandatory services are:

- Traditional/Agency
  - Case Management
- Consumer Directed
  - Care Coordination
  - Self-help Assistant
  - Fiscal Management



Each service added in the "Goals" section will be listed on the "Services" screen. Each service must be updated to indicate the provider providing the service, and the number of units to be provided monthly.

Before updating the services, the screen will list;

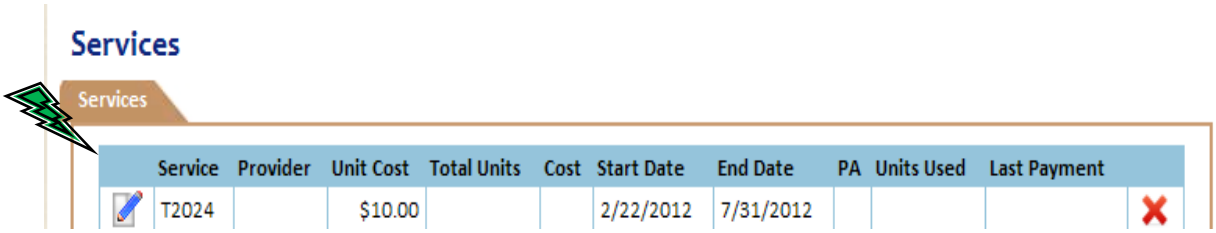
The service **-** The unit cost for the service - this will default to the maximum allowable unit cost, but can be edited in the "Service Details" screen**.**

The start date – this will default to the plan start date but can be edited in the "Service Details" screen.

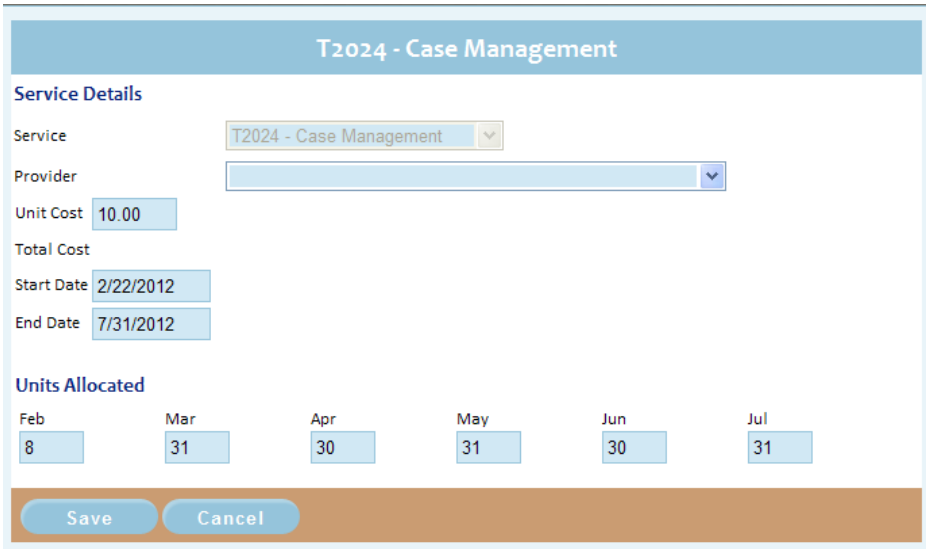
The end date - this will default to the plan end date but may be edited in the "Service Details" screen.

If a service cannot be provided through the LTC/ALF waiver, the "Goals" section MUST be updated to indicate how the need associated with the service will be met and the service deleted from the "Services" screen.

To update the service, click on the "Pencil" icon next to the service.

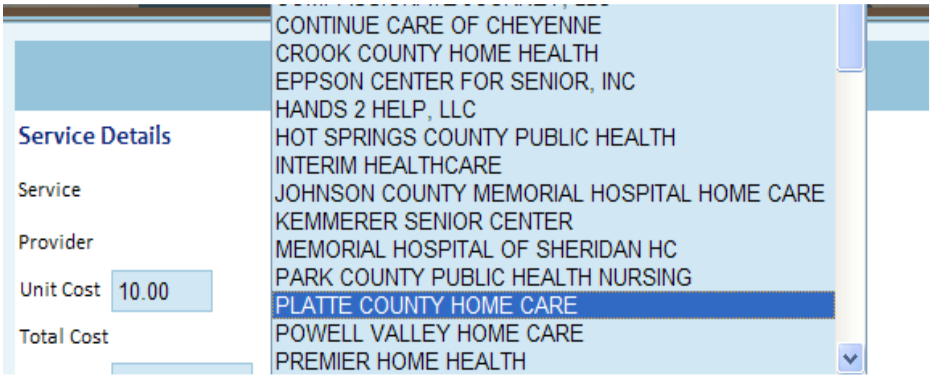


This will open the “Services Details” window.



The service cannot be edited in this window and is grayed out.

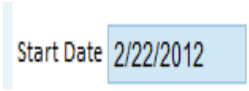
The provider is chosen from a drop down menu.



The unit cost may be changed at this point. The cost **CANNOT** be higher than the maximum allowable. Change the cost if the service provider’s unit cost is lower than the maximum unit cost.

The total cost will remain blank until the service has been entered and saved.

If the service starts later than the plan start date, change the “Start Date” to the date the service will be starting.



The end date should not change.

Enter the number of total number of units in a month for each month. Zero fill the months with no units provided.

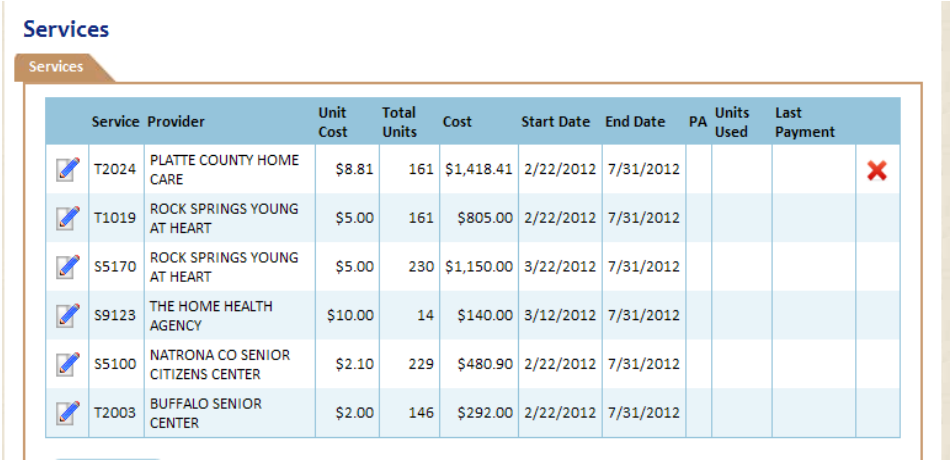
As a user enters the monthly units, remember that each service has its own service designation. Verify the service unit designation if unsure.

> ***A unit for Non-Medical Transportation is a one way trip, while a unit of Personal Care Attendant is 15 minutes.***

When finished click on the “Save” button.

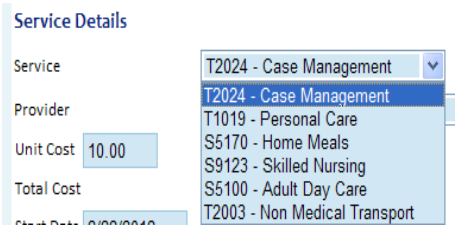
To cancel what has been entered, click on the “Cancel” Button.

Continue with each service on the “Services” screen until complete. As each service is updated, the information will appear on the “Services” screen.

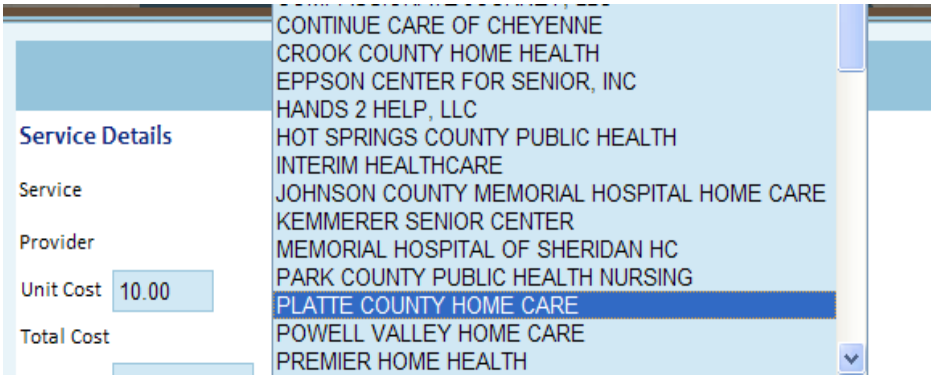


To add a service not listed by default. Click on the “Add” button under the list of plan services.

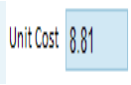
This will open the “Service Details” window. This is the same window as the window to update services, except the service may be updated. Choose the appropriate service from the “Service” drop down menu.



The provider is chosen from a drop down menu.

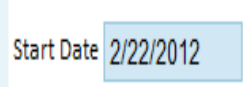


The unit cost may be changed at this point. The cost **CANNOT** be higher than the maximum allowable. Change the cost if the service provider's unit cost is lower than the maximum unit cost.



The total cost will remain blank until the service has been entered and saved.

If the service starts later than the plan start date, change the "Start Date" to the date the service will be starting.



The end date should not change.

Enter the number of total number of units in a month for each month. Zero fill the months with no units provided.

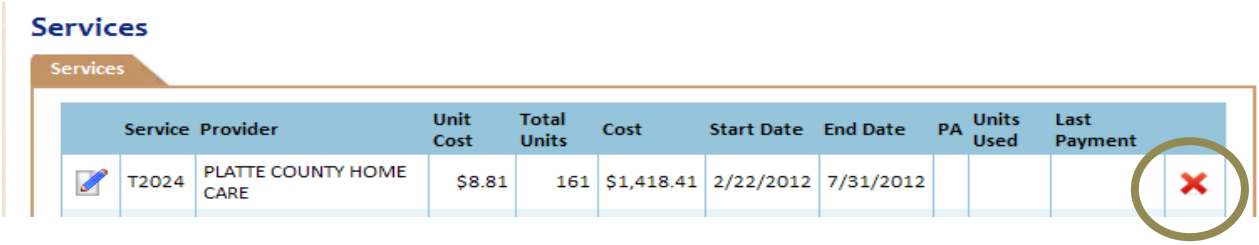
As a user enters the monthly units, remember that each service has its own service designation. Verify the service unit designation if unsure.

> ***A unit for Non-Medical Transportation is a one way trip, while a unit of Personal Care Attendant is 15 minutes.***

When finished click on the "Save" button.

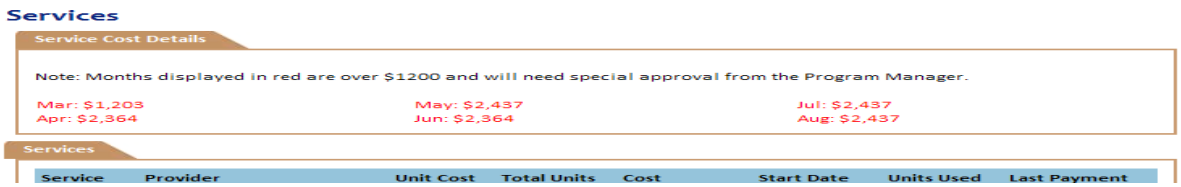
To cancel what has been entered, click on the "Cancel" Button.

To delete a service from the "Services" screen, click on the red "X" to the right of the service. If there is no red "X", the service cannot be deleted.



Plans over $1200

Above the list of services is the "Services Cost Details" section.



This section shows by month the total plan costs. **IF THERE IS AT LEAST ONE MONTH THAT IS OVER $1200, IT MUST BE APPROVED BY THE PROGRAM MANAGER.** To request approval by the program manager, the case manager must enter the following information into a note:

- Previous plan high (not necessary for new plans)
- New plan high (if this is a renewal, note if there is a plan change or not)
- Reason for new plan high (services are based upon need, not necessarily want)
- History of participant (examples: quadriplegic, has broken arm, decline in health, LT101 has increased, etc.)
- Any further information that will assist the Program Manager in making the determination

For instructions on how to enter plan notes, refer to "Notes" section on pages 86 or 122.

FAILURE TO GET APPROVAL FOR PLANS OVER $1200 WILL CAUSE DELAYS IN PLAN SUBMISSION

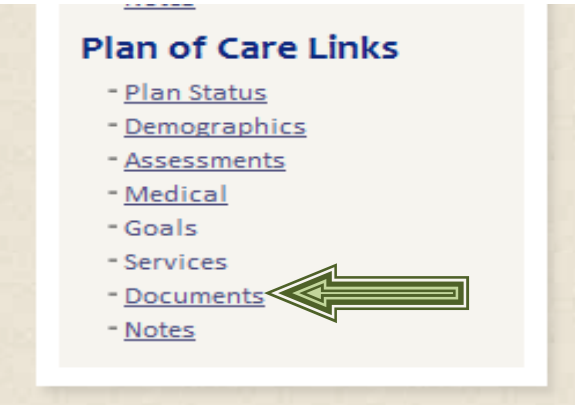
Documents

There are two documents that are required for a Plan of Care:

- ✓ Client Choice of Service (HCBS-1)
  - o Due when putting a participant on the waiting list
  - o Due when a participant has received a funding opportunity
  - o Due at each renewal plan period
- ✓ Client Rights and Responsibilities

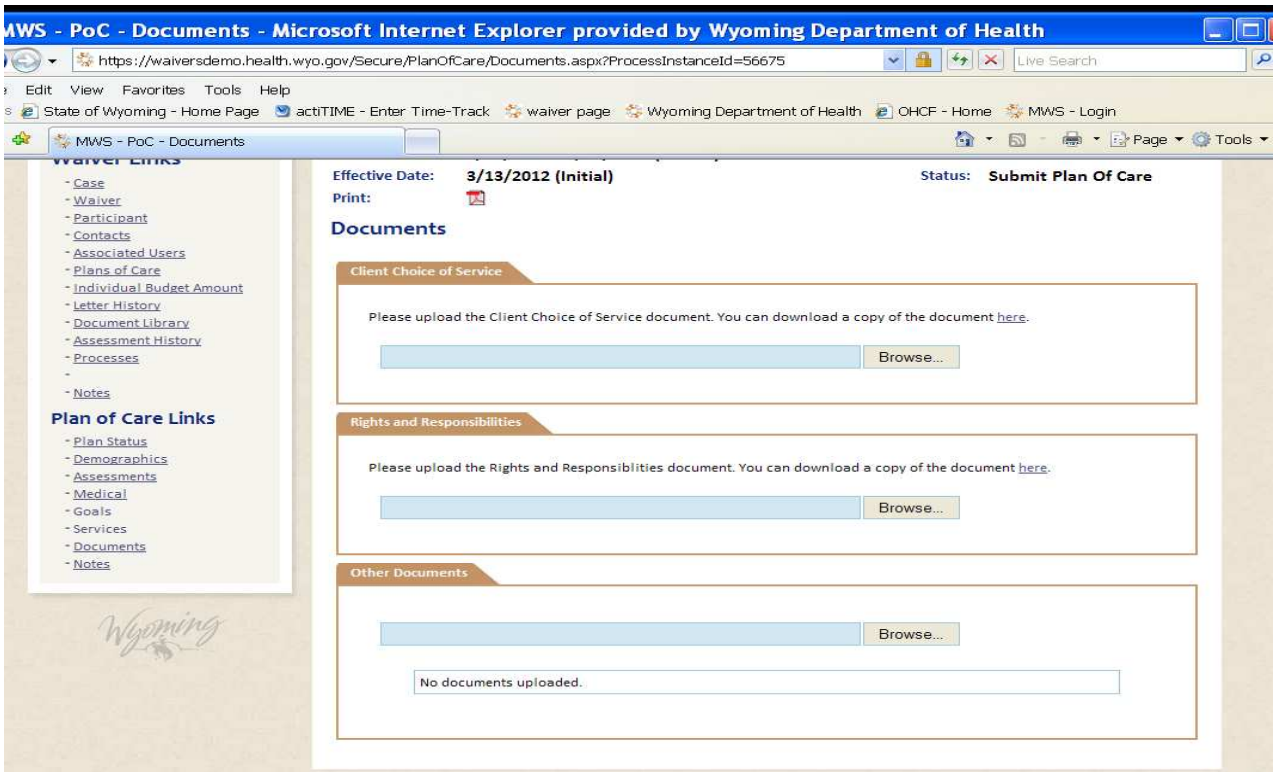
- Due when a participant has received a funding opportunity
- Due at each renewal plan period

To upload the documents into the system, click on the "Documents" link under the section "Plan of Care Links" to open the document window.



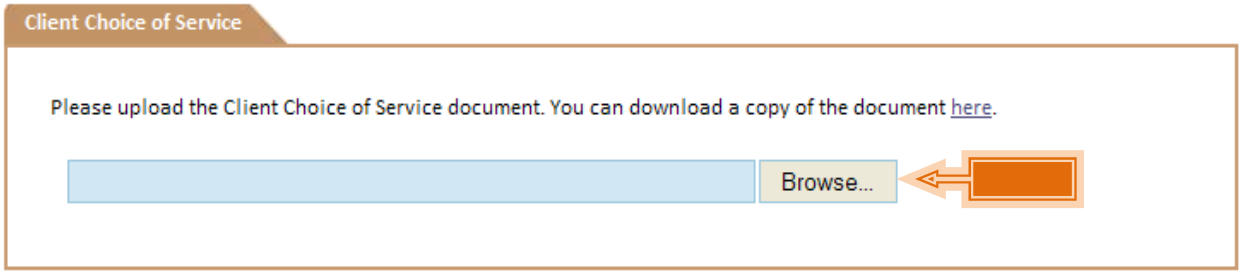
If a user is not at a participant's Plan of Care screen, please refer to sections *"Review Information through Task List Screen" on page 15 or "Search Cases Screen" on page 17* for instructions to access a participant's information.

When open, the document window should look like this.

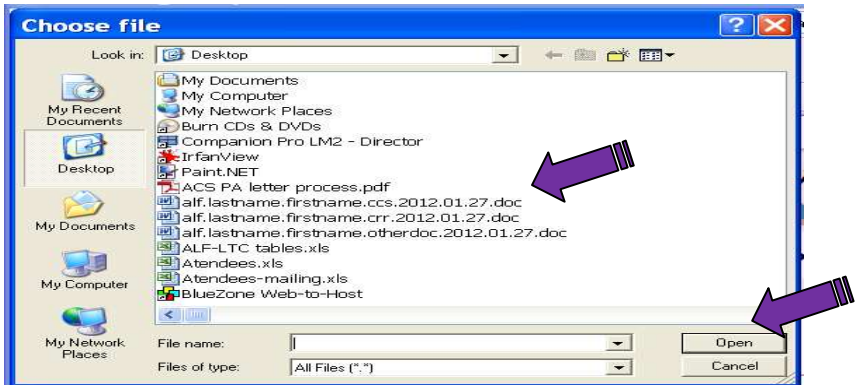


Client Choice of Service

To upload a scanned Client Choice of Service, click on the Browse button.



This will open the "choose file" window. Locate the file, highlight the file and click on the "Open" button.

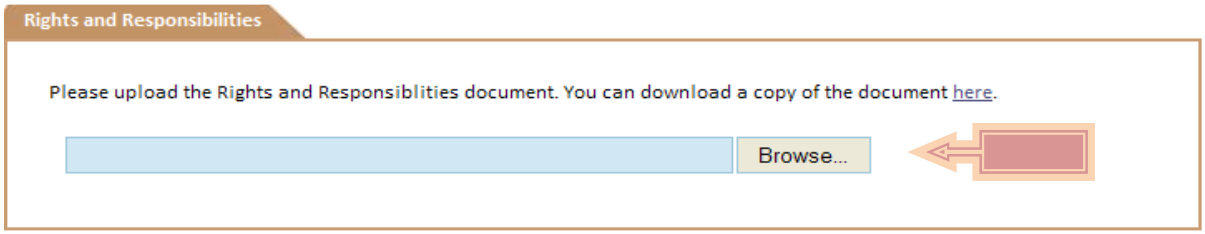


Once uploaded, a link to the document will be available.

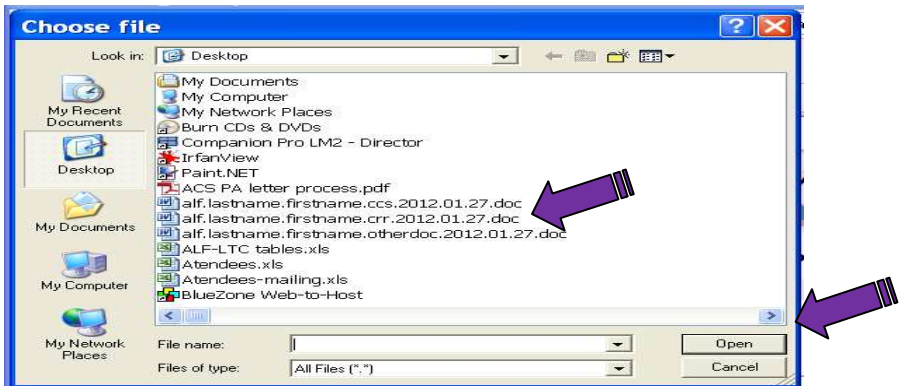
If an error is made and the wrong document is uploaded, just re-upload the correct document. It will override the incorrect document.

Client Rights and Responsibilities

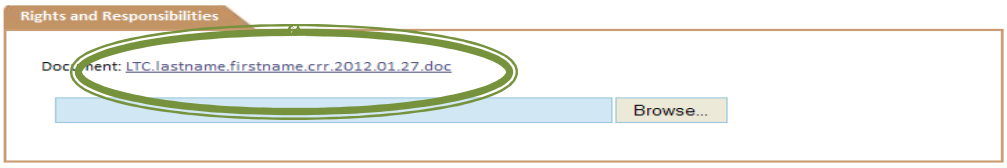
To upload a scanned Client Rights and Responsibilities, click on the "Browse" button under "Rights and Responsibilities" section.



This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



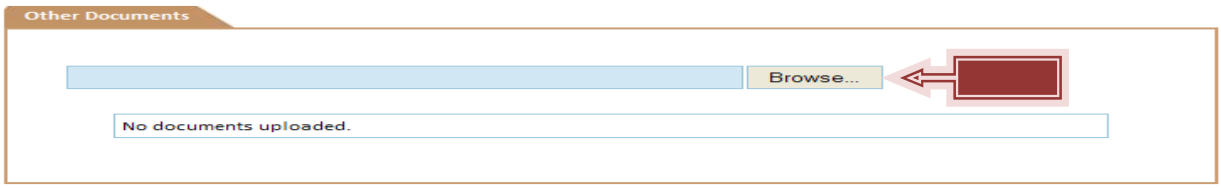
Once uploaded, a link to the document will be available.



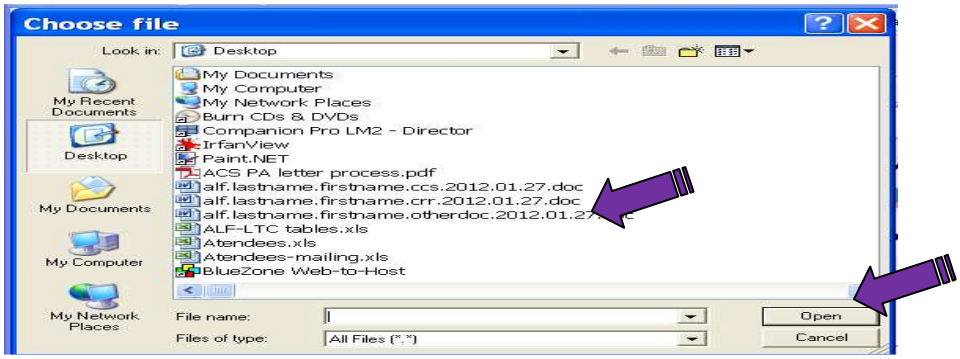
If an error is made and the wrong document is uploaded, just re-upload the correct document. It will override the incorrect document.

Other Documents

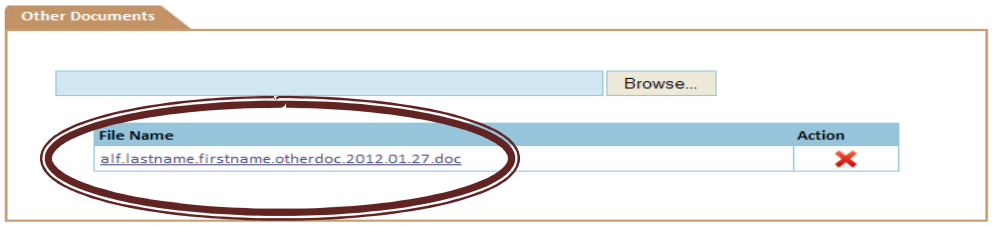
There may be times when additional documentation is required. To upload additional documents, click on the “Browse” button under “Other Documents” section.



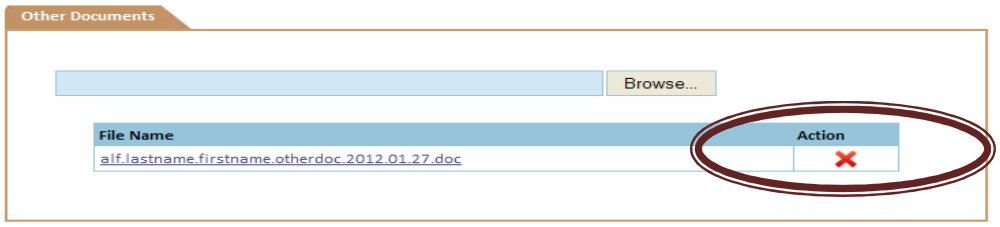
This will open the “choose file” window. Locate the file, highlight the file and click on the “Open” button.



Once uploaded, a link to the document will be available.

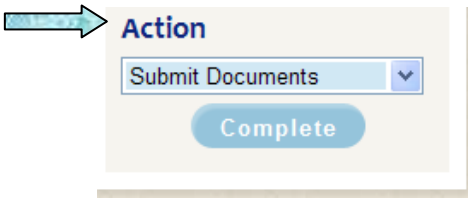


These documents may be deleted if necessary. To delete the scanned and uploaded document, click on the red "X" under "Action" to the left of the file name.

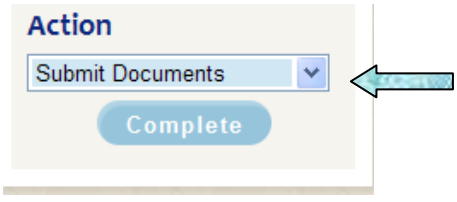


This will remove the document from the system.

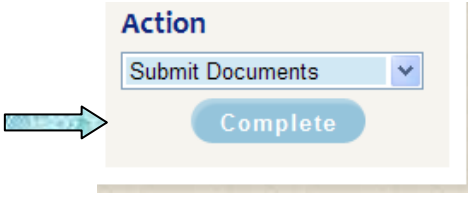
After all required documents have been scanned and uploaded in the appropriate sections, go to the "Action" drop down box to the left of the screen.



Choose "Submit Documents" and



click on the "Complete" button to finish the process.



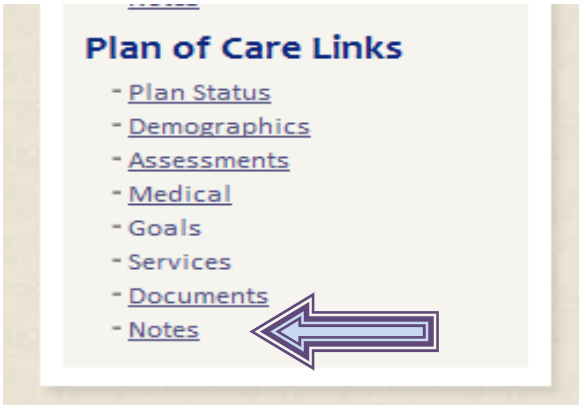
At this point the Program Manager reviews the documents. If the documents are correct, the participant's plan is ready for final submission. If the documents are NOT correct, the Case Manager/Care Coordinator will receive a notification to make corrects and re-submit.

The Case Manager/Care Coordinator is finished until the participant comes to the top of the waitlist and receives a notification that the participant has a funding opportunity.

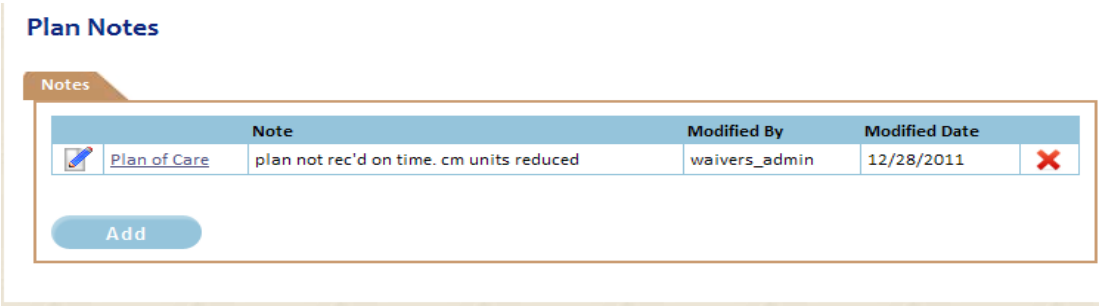
Notes

The "Notes" section allows for notes to be added to a participant's plan. ***These notes are specific to a plan, but will also show up in the "Notes" section of the "Waiver Links".***

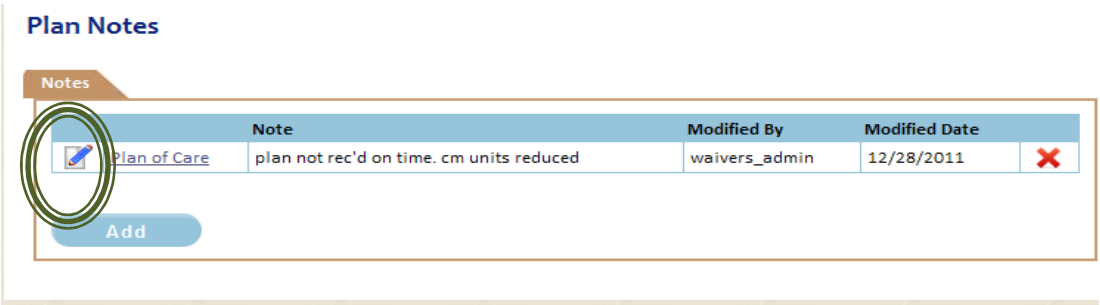
To access the "Notes" screen, choose the "Notes" link in the "Plan of Care Links" section to the left of the screen.



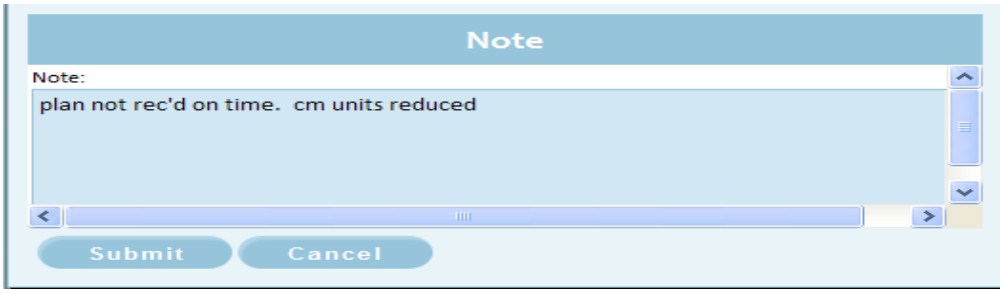
Once the screen is open, it will list all notes related to the Plan of Care.



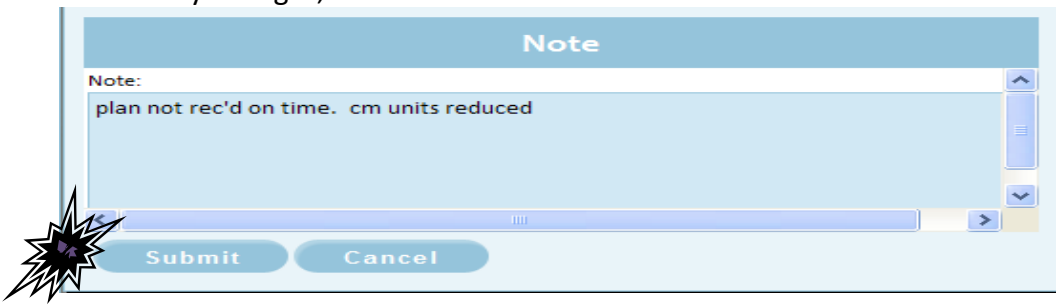
To view a note already in the system, click on the "Pencil" icon to the left.



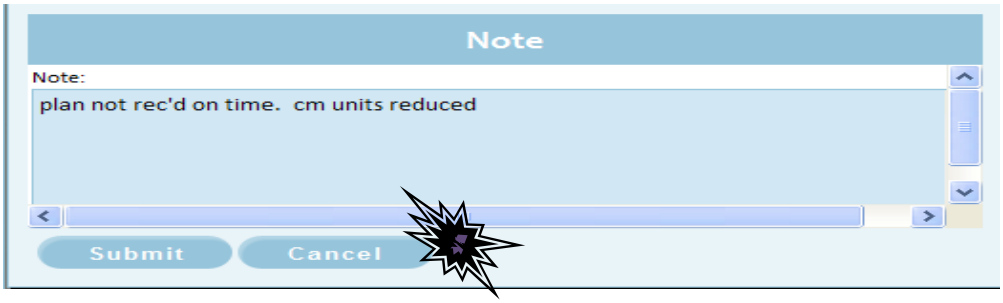
This will open the window of the note chosen.



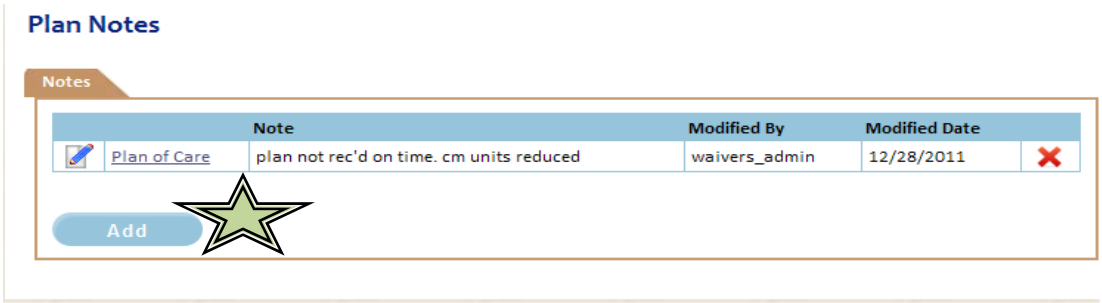
At this time, the details of the note may be viewed and/or any changes may be made. To submit any changes, click on the "Submit" button.



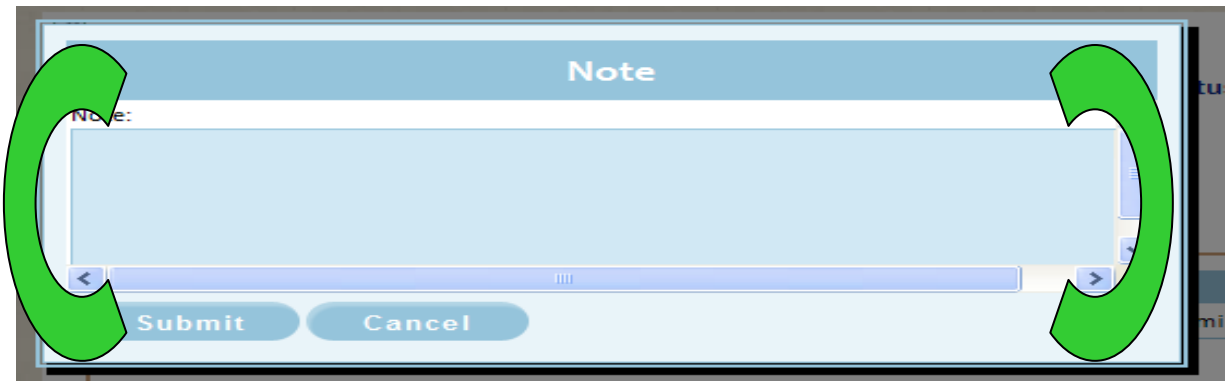
To return back to the "Notes" screen without making changes, click on the "Cancel" button.



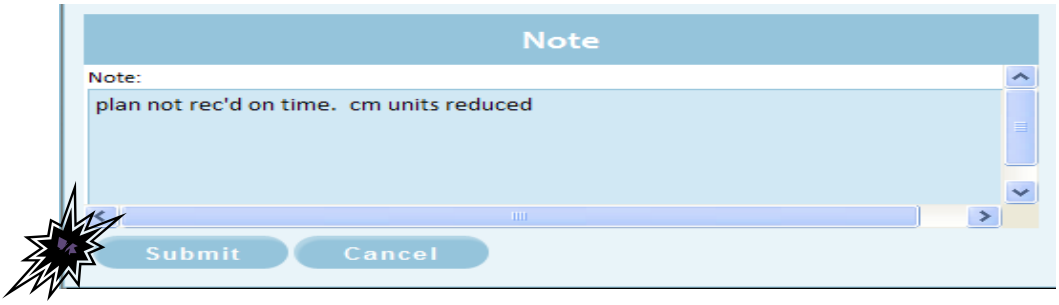
To add a new note, click on the "Add" button.



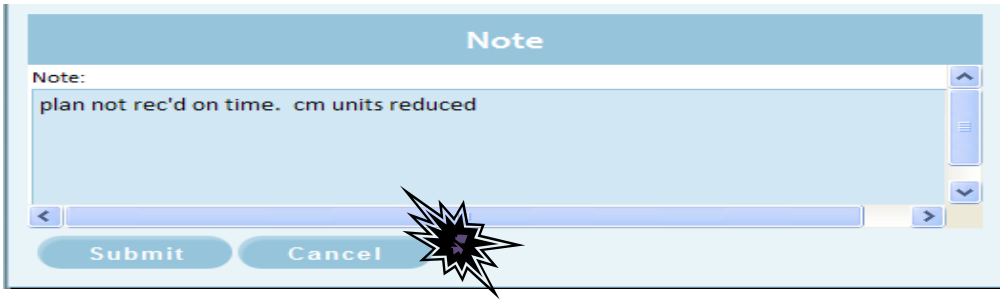
This will open a new window. Add any information pertinent to the plan in the "Note" section.



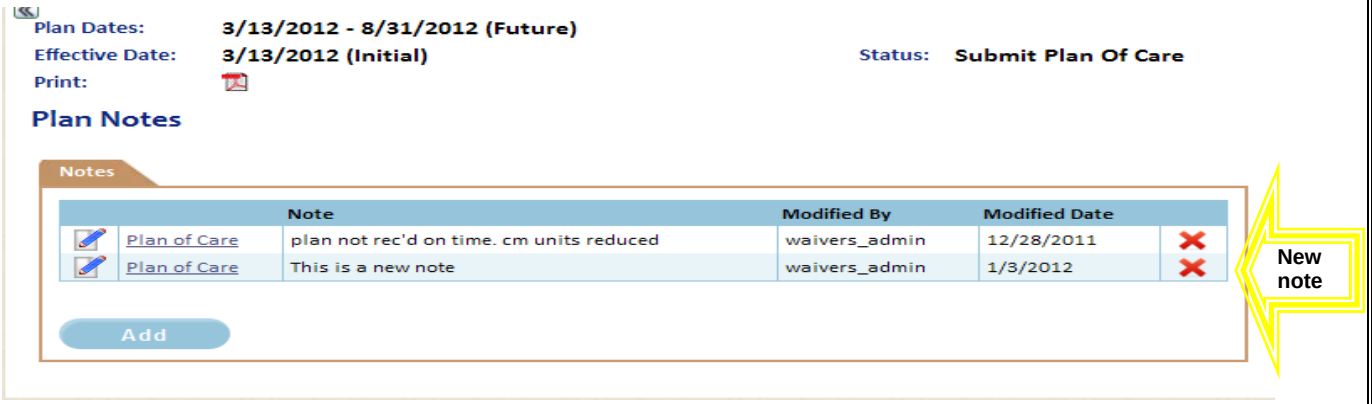
Once a note has been entered, click on the "Submit" button.



To return back to the "Notes" screen without adding a note, click on the "Cancel" button.

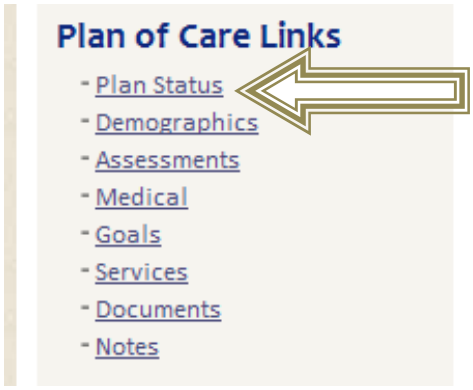


As each new note is added, it will appear on the "Plan Notes" screen.



Final Submission

Once all tasks are completed and the plan is ready for submission, click on the "Plan Status" link under "Plan of Care Links" to the left of the screen.



This will open the "Plan Details" screen.

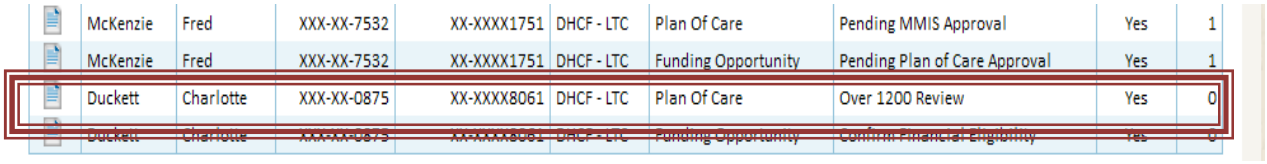
The action in the "Action" drop down box should be "Submit Plan of Care" and this should be the ONLY option.

Click on the "Submit" button to finish the process.

At this point the Case Manager/Care Coordinator is finished with their tasks and is waiting for a prior authorization from the fiscal agent.

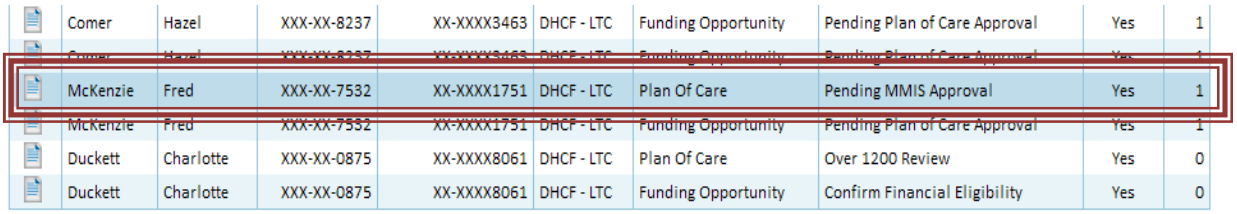
UNLESS

If the plan is over $1200 for any month, there is further review by the Program Manager. The Case Manager/Care Coordinator must monitor for the "over $1200 approval". If the approval does not happen timely, the Case Manager/Care Coordinator needs to call the Program Manager. Note the example below – the participant has a status of "Over 1200 Review".



	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Plan Of Care	Pending MMIS Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Plan Of Care	Over 1200 Review	Yes	0
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Funding Opportunity	Confirm Financial Eligibility	Yes	0

A participant that is waiting for a prior authorization number will have a notation in the bottom section of the task list. Note the example below – the participant has a status of "Pending MMIS Approval".



	Comer	Hazel	XXX-XX-8237	XX-XXXX3463	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Plan Of Care	Pending MMIS Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Plan Of Care	Over 1200 Review	Yes	0
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Funding Opportunity	Confirm Financial Eligibility	Yes	0

When a participant disappears from both tasks lists, there are no further workflow tasks to be done. At this point the renewal plan has been submitted AND service prior authorizations have been received

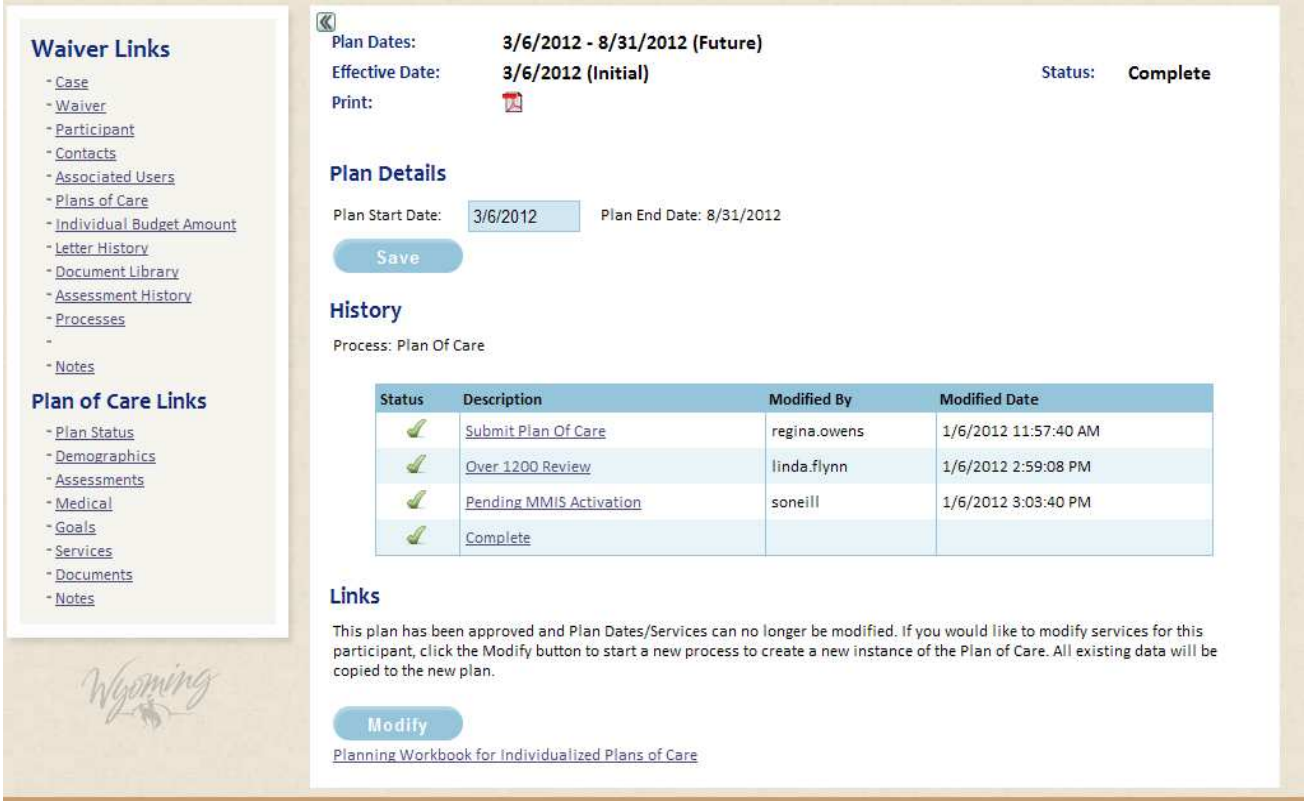
Modifying a Current Plan

After a new or renewal Plan of Care has been approved by the Home Care Services Unit and prior authorizations have been received from the fiscal agent - ACS, modifications to the Plan of Care may be performed.

Any changes to a Plan of Care must be for a time in the future.

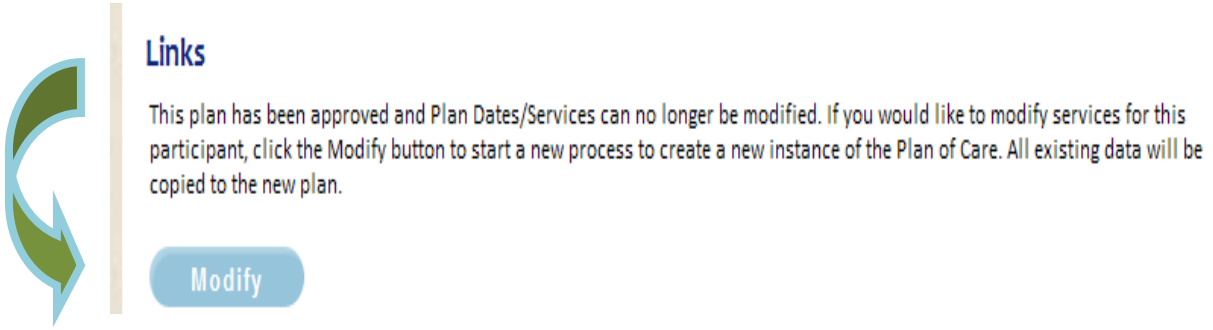
Modifications to a Plan of Care for a date previously requires additional documentation

To start the modification process, go to the current plan details screen.

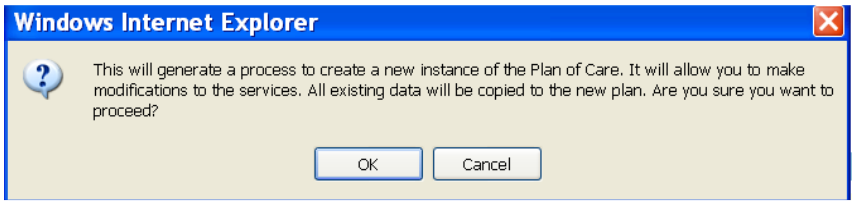


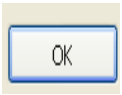
The screen will show the task history of the specific Plan of Care. **NOTE** the "Links" explanation towards the bottom of the screen. If this disclaimer is not viewable, modifications **CANNOT** be performed.

After reading the modification disclaimer, click on the “Modify” button.



Clicking on the “Modify” button will open a new window. Be sure to read the information in the box.



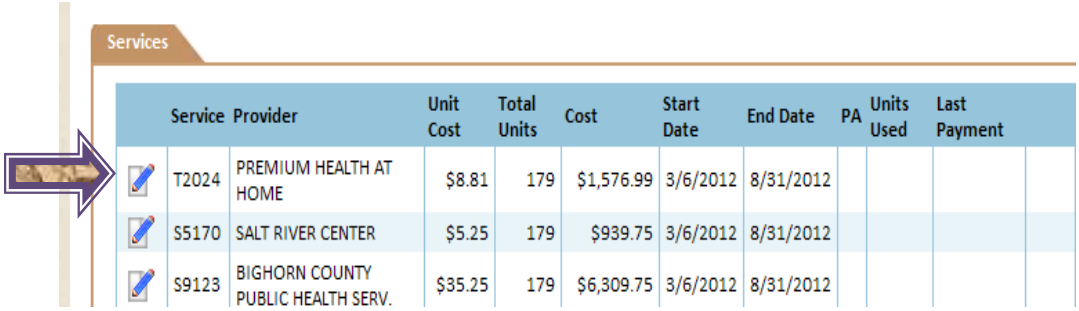
If the user still wants to perform a modification on the plan, click the “OK” button. 

Always remember

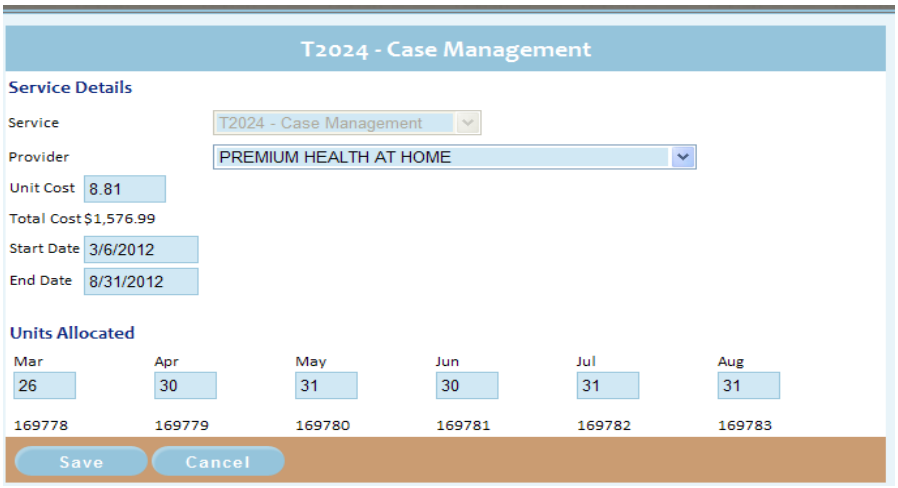
- When changing an existing service, the service start date **DOES NOT** change.
- When adding a new service **ALWAYS** change the service start date to the date the service is starting. **DO NOT** keep the date as the default date.
- Enter service units (or zero fill) in the months to be changed. **DO NOT** start at the beginning of the plan unless the change occurs in the first month of the plan.

Updating a Current Service

To update an existing service, click on the "pencil" icon to the left of the service needing modification.



This will open the "Services Details" window.



The only item that can be modified when updating a service is "Units allocated".

Any other changes must be performed through the "Changing Providers" or "Correcting Errors to Plans" processes.

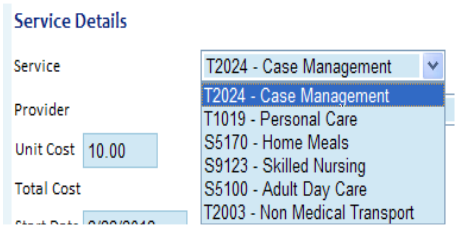
When finished with the changes, click on the "Save" button.

To cancel what has been entered, click on the "Cancel" Button.

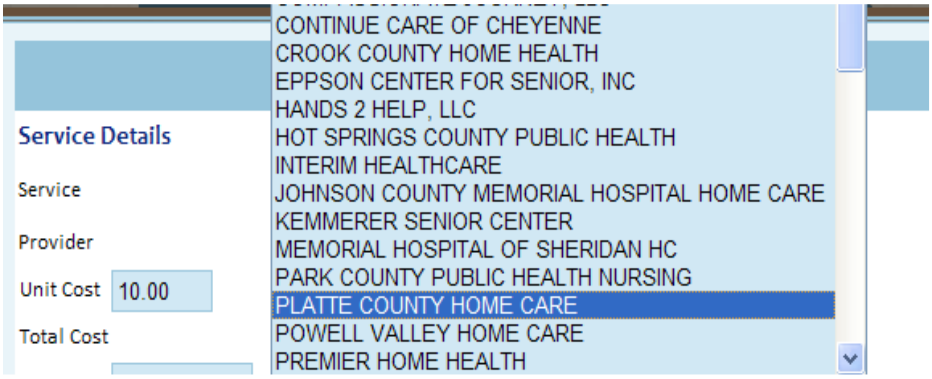
Adding a New Service

To add a service not currently on the plan, click on the "Add" button under the list of plan services. ***(Be sure to check that there isn't already an approved service with the same provider before clicking on the "Add" button.)***

This will open the "Service Details" window. In this window the service choice is editable. Choose the appropriate service from the "Service" drop down menu.



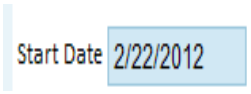
The provider is chosen from a drop down menu.



The unit cost may be changed at this point. The cost **CANNOT** be higher than the maximum allowable. Change the cost if the service provider's unit cost is lower than the maximum unit cost.

The total cost will remain blank until the service has been entered and saved.

If the service starts later than the plan start date, change the "Start Date" to the date the service will be starting. *When adding a new service after the plan has begun, the start date* ***should not*** *be the same as the plan date.*



The end date should not change.

Enter the total number of units in a month for each month. Zero fill the months with no units provided.

As a user enters the monthly units, remember that each service has its own service designation. Verify the service unit designation if unsure.

> ***A unit for Non-Medical Transportation is a one way trip, while a unit of Personal Care Attendant is 15 minutes.***

When finished click on the "Save" button.

To cancel what has been entered, click on the "Cancel" Button.

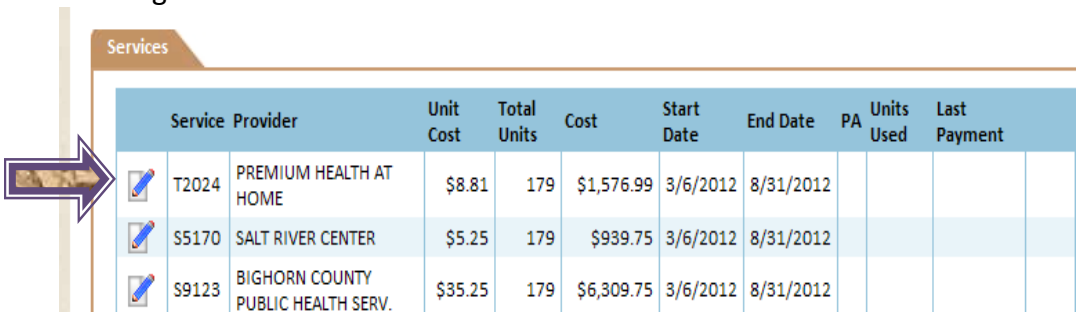
Changing Providers

Participants have the option of changing service providers during a plan period. When this occurs the Case Manager/Care Coordinator **CANNOT** change the existing service with the new provider information. The old service provider's information must be reduced as a change to an existing service and the new service provider's information must be added as a new service.

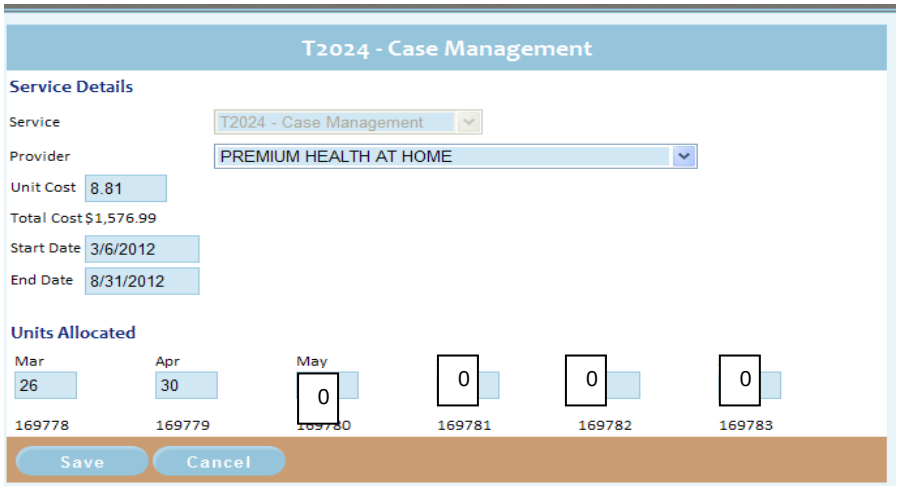
When changing Case Management/Care Coordination providers, call Home Care Services Unit.

Reduce existing service

To reduce services for the old service provider, click on the “pencil” icon to the left of the service needing modification.



This will open the “Services” window.



Put the reduced number of units or zeros (0) in each month the old service provider will no longer provide the service.

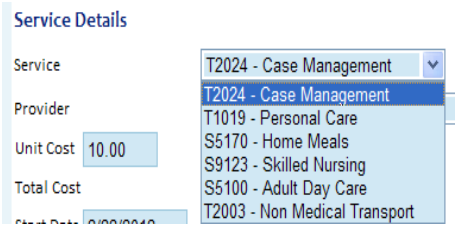
When finished click on the “Save” button.

To cancel what has been entered, click on the “Cancel” Button.

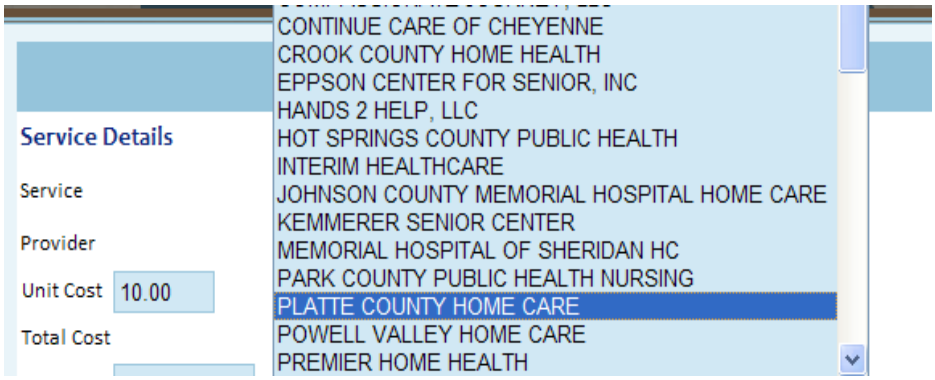
Add the new service provider

To add the new service to the plan, click on the "Add" button under the list of plan services. ***(Be sure to check that there isn't already an approved service with the same provider before clicking on the "Add" button.)***

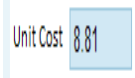
This will open the "Service Details" window. This is the same window as the window to update services, except the service may be updated. Choose the appropriate service from the "Service" drop down menu.



The provider is chosen from a drop down menu.

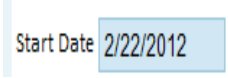


The unit cost may be changed at this point. The cost CANNOT be higher than the maximum allowable. Change the cost if the provider's unit cost is lower than the maximum unit cost.



The total cost will remain blank until the service has been entered and saved.

If the service starts later than the plan start date, change the "Start Date" to the date the service will be starting. *When adding a new service after the plan has begun, the start date* ***should not*** *be the same as the plan date.*



The end date should not change.

Enter the number of total number of units in a month for each month. Zero fill the months with no units provided.

As a user enters the monthly units, remember that each service has its own service designation. Verify the service unit designation if unsure.

> ***A unit for Non-Medical Transportation is a one way trip, while a unit of Personal Care Attendant is 15 minutes.***

When finished click on the "Save" button.

To cancel what has been entered, click on the "Cancel" Button.

REMEMBER: At the present time, when changing from one Case Management/Care Coordination provider to another agency, you will need to call the Home Care Services Unit to make that change before an amendment can be done in the new system.

Correcting Errors to Plans

Occasionally errors occur during plan submission. Modifications to a Plan of Care that have already been submitted require additional documentation. The **ONLY** way a service can be changed is if there is a **Provider Duties Sheet (HCBS6)** that has been signed, dated and returned by the service provider.

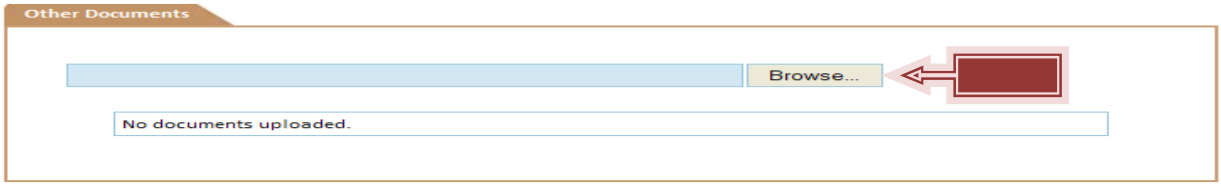
The Provider Duties Sheet is the agreement between the service provider and the Case Manager/Care Coordinator to provide the service listed on the form. The Home Care Services Unit will not penalize a service provider for providing services listed on the form.

EXCEPTION

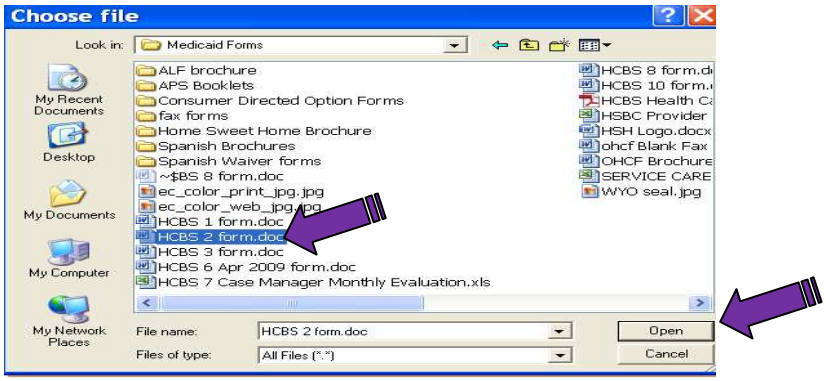
Payment for services is contingent upon a participant's ongoing eligibility. Payment is not guaranteed if a participant becomes ineligible for the LTC/ALF waiver.

Upload a valid Provider Duties Sheet

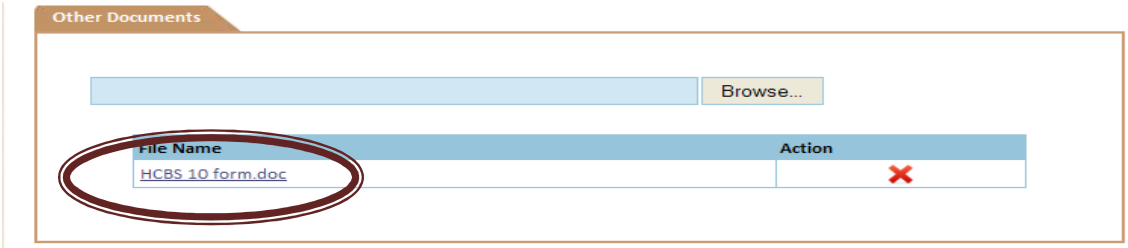
To upload additional documents, click on the "Browse" button under "Other Documents" section.



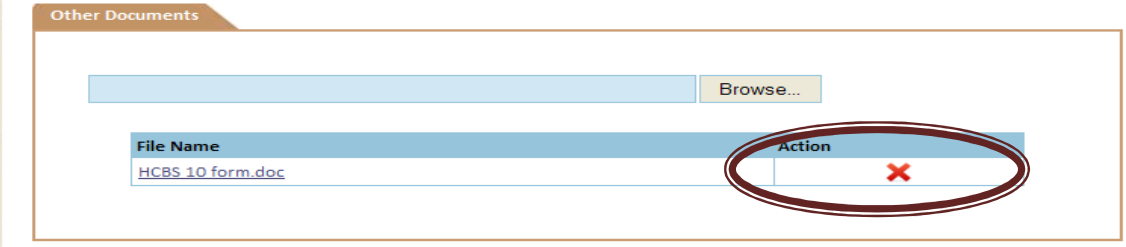
This will open the "choose file" window. Locate the file, highlight the file and click on the "Open" button.



Once uploaded, a link to the document will be available.



These documents may be deleted if necessary. To delete the scanned and uploaded document, click on the red "X" under "Action" to the left of the file name.



This will remove the document from the system.

Once the Provider Duties Sheet has been uploaded, the modification can be done. Use one of the following processes listed above:

- Updating a current service – page 126
- Adding a new service – page 128
- Changing providers – page 129

Determine which method is most appropriate. Follow the instructions in the section to make the modifications to the Plan of Care.

Final Submission

After the modifications have been made, the user will go back to the Plan of Care page. To go to the Plan of Care page click on "Plan Status" under "Plan of Care Links" to the left of the window.

This will open the “Plan Details” screen.

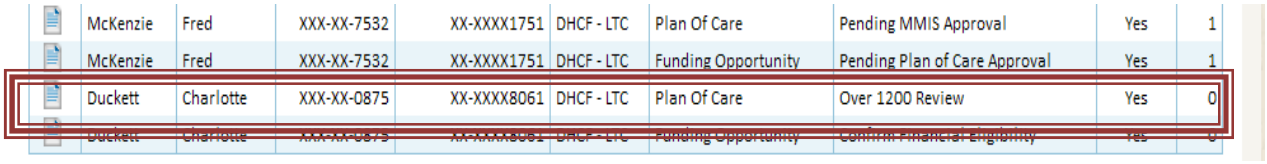
The action in the “Action” drop down box should be “Submit Plan of Care” and this should be the ONLY option.

Click on the “Submit” button to finish the process.

At this point the Case Manager/Care Coordinator is finished with all tasks and is waiting for a prior authorization from the fiscal agent.

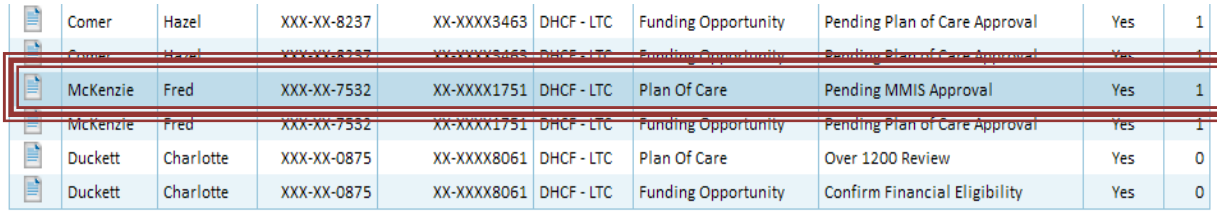
UNLESS

If the plan is over $1200 for any month, there is further review by the Program Manager. The Case Manager/Care Coordinator must monitor for the “over $1200 approval”. If the approval does not happen timely, the Case Manager/Care Coordinator needs to call the Program Manager. Note the example below – the participant has a status of “Over 1200 Review”.



	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Plan Of Care	Pending MMIS Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Plan Of Care	Over 1200 Review	Yes	0
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Funding Opportunity	Confirm Financial Eligibility	Yes	0

A participant that is waiting for a prior authorization number will have an annotation in the bottom section of the task list. Note the example below – the participant has a status of “Pending MMIS Approval”.



	Comer	Hazel	XXX-XX-8237	XX-XXXX3463	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Plan Of Care	Pending MMIS Approval	Yes	1
	McKenzie	Fred	XXX-XX-7532	XX-XXXX1751	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	Yes	1
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Plan Of Care	Over 1200 Review	Yes	0
	Duckett	Charlotte	XXX-XX-0875	XX-XXXX8061	DHCF - LTC	Funding Opportunity	Confirm Financial Eligibility	Yes	0

When a participant disappears from both tasks lists, there are no further workflow tasks to be done.

Discharging a Participant

At anytime a participant may become ineligible to remain on the LTC/ALF waiver program. A Case Manager/Care Coordinator may be notified a couple of ways of a participant's loss of eligibility:

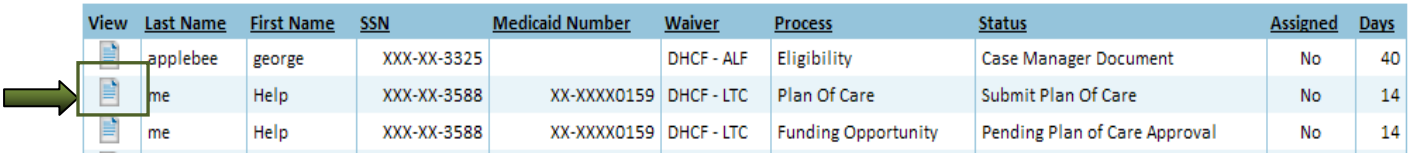
- A notice is sent to the Case Manager/Care Coordinator's email address and a task is put on the task list screen.
- Participant notifies Case Manager/Care Coordinator of reason for loss of eligibility.

Reasons a participant may no longer be eligible for LTC/ALF waiver services include (but are not limited to):

- Loss of financial eligibility - *a participant receives more resources or assets than are allowed*
- Loss of functional eligibility – *a participant receives less than 13 points on their LT101*
- Admission to a nursing facility
- Participant moves out of state
- Participant dies
- Participant non-compliant
- Admission to another institution
- Long-term admission to an acute care hospital
- Participant chooses to no longer receive LTC/ALF waiver services
- Participant has not received services for more than 30 days – *According to federal requirements a participant must receive at least one service every 30 days to remain on LTC/ALF waiver. (Only use this if no other option applies.)*

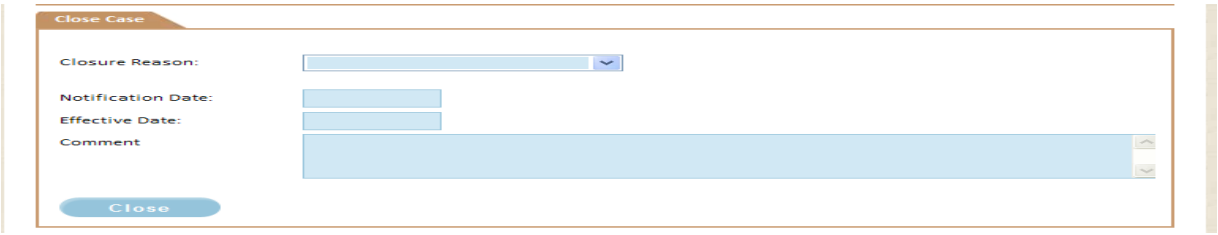
Discharging a Participant Through the Task List Screen

If a notification is sent to the Case Manager/Care Coordinator, a task will be in the top section of the Task List screen. Click on the document icon in the "View" column of the associated task.

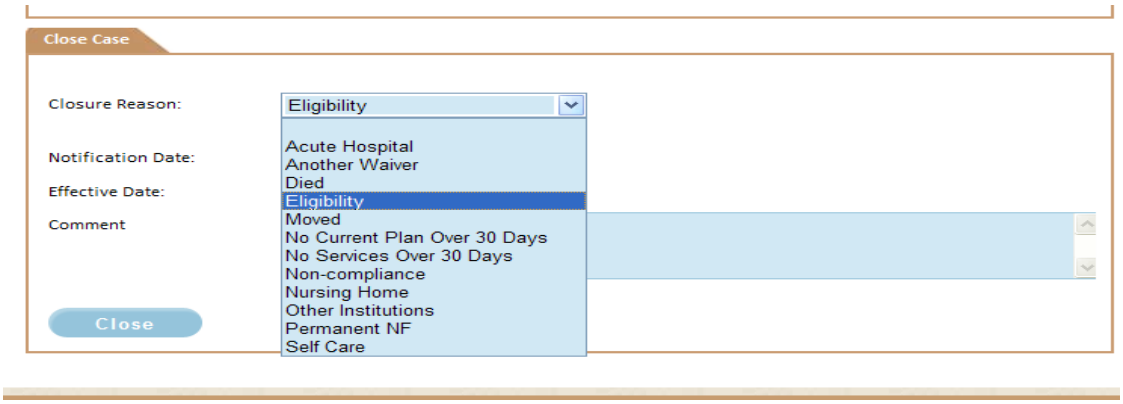


View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	applebee	george	XXX-XX-3325		DHCF - ALF	Eligibility	Case Manager Document	No	40
	me	Help	XXX-XX-3588	XX-XXXX0159	DHCF - LTC	Plan Of Care	Submit Plan Of Care	No	14
	me	Help	XXX-XX-3588	XX-XXXX0159	DHCF - LTC	Funding Opportunity	Pending Plan of Care Approval	No	14

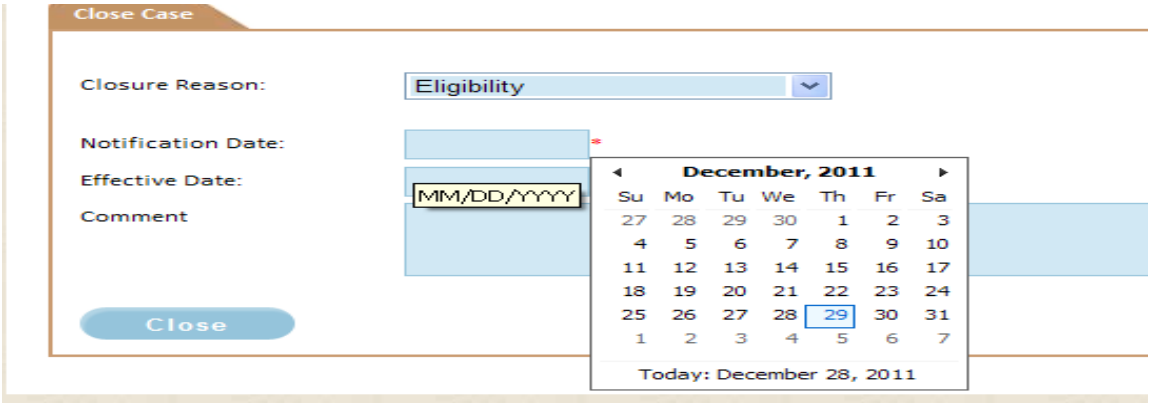
This will take you the participant “Waiver” screen. At the bottom of the screen is the “Close Case” section.



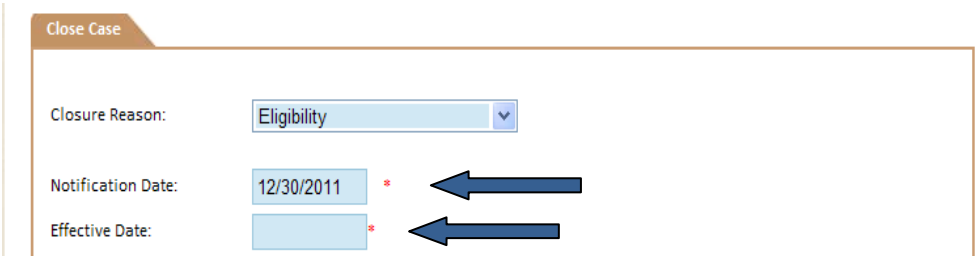
To close the participant, click on the drop down button at “Closure Reason” . This will show the choices available.



Then click in the “Notification Date” box. A calendar box will appear. A user can either choose the date from the calendar box or enter the date manually. The notification date must be the current date or a date prior. It cannot be a date in the future.

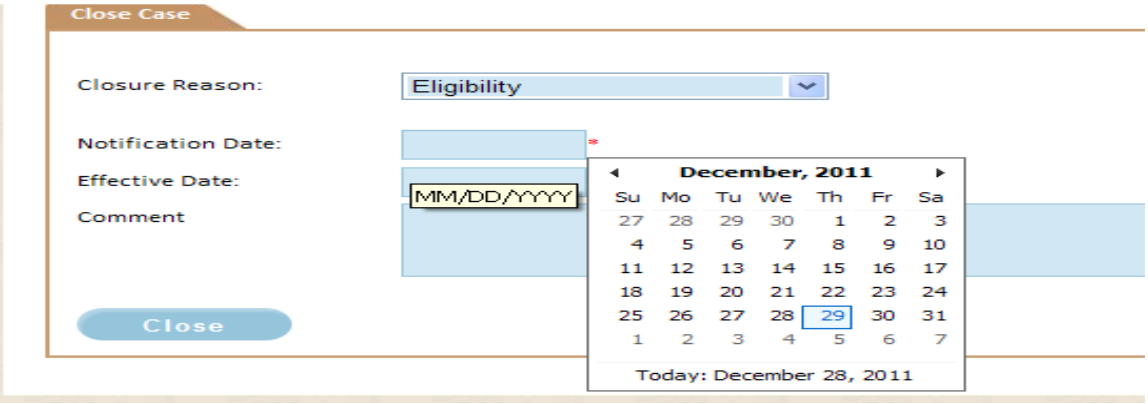


In the screen below; notice the two red dots next to the dates.

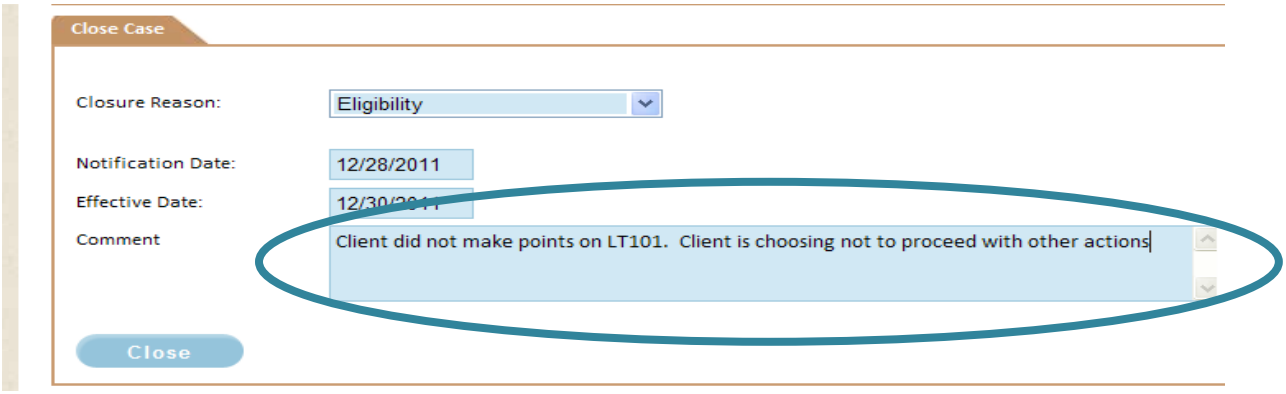


The red dot right next to the "Effective Date" box, indicates a required field. The red dot further away from the "Notification Date" indicates the data entered in the field is invalid.

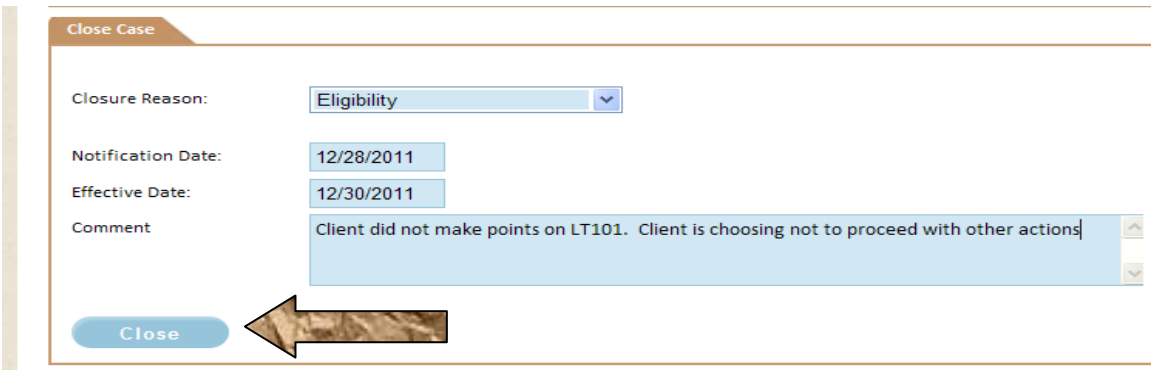
After the notification date is entered, click in the "Effective Date". A calendar box will appear. A user can either choose the date from the calendar box or enter the date manually. This date will be the date the participant's LTC/ALF waiver will close. If a participant is on the wait list, this is the date the participant will be removed from the list. If a participant is a current participant, this is the date all services will stop and providers will no longer receive payment for services.



The "Comment" box is for any additional information related to the closure. This is an optional box.

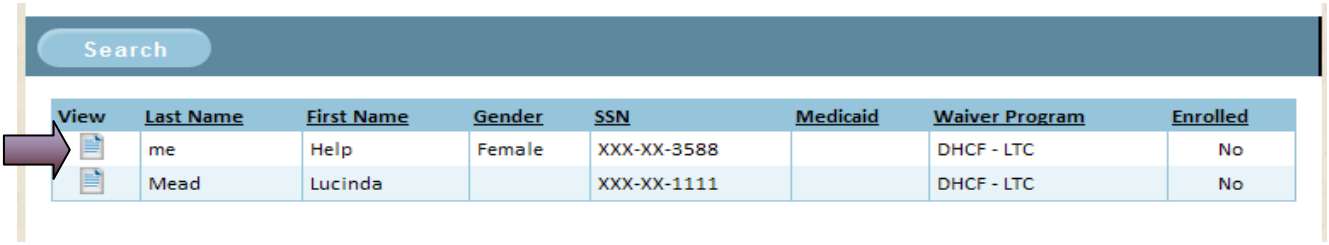


After filing out the all appropriate information, click on the "Close" button to finish the task.

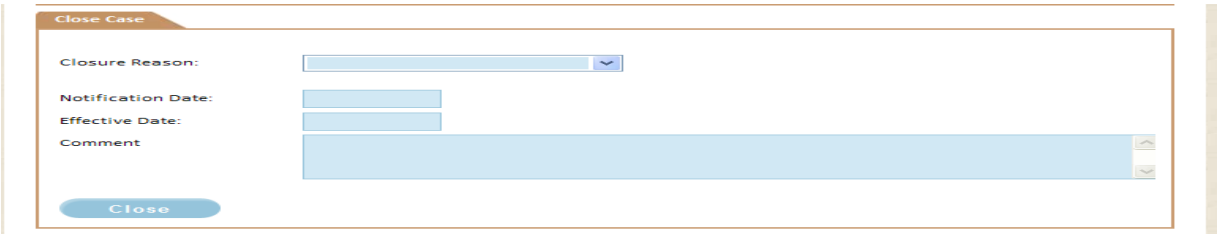


Discharging a Participant Through the Search Cases Screen

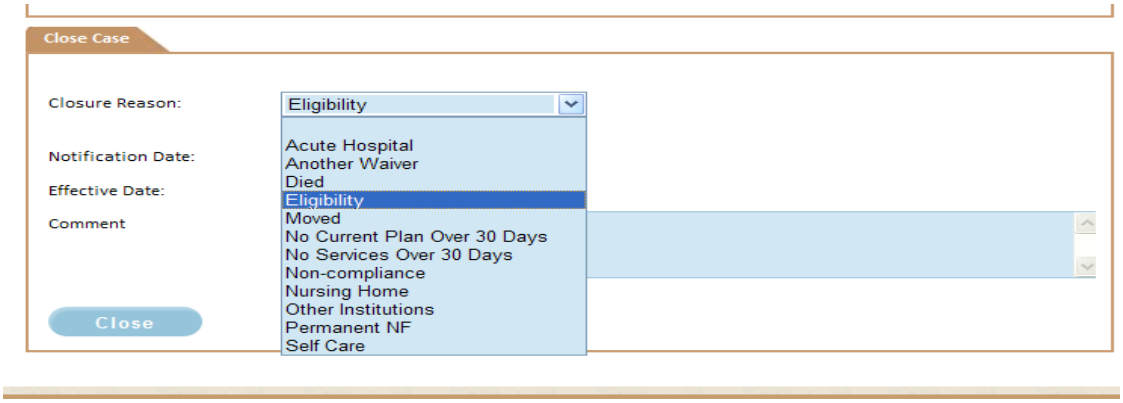
If the Case Manager/Care Coordinator is not notified of a participant discharge through the EMWS, but through other means, the Case Manager/Care Coordinator will need to search for the participant through the "Search Case" screen. Click on the document icon in the "View" column of the result set. ***Refer to section "Search Cases Screen" on page 17 for instructions.***



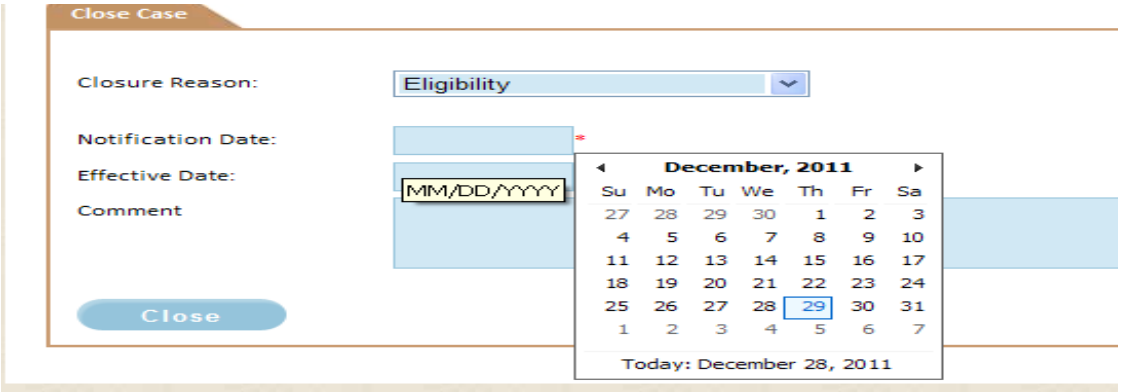
This will take you to the participant "Waiver" screen. At the bottom of the screen is the "Close Case" section.



To close the participant, click on the drop down button at "Closure Reason" . This will show the choices available.

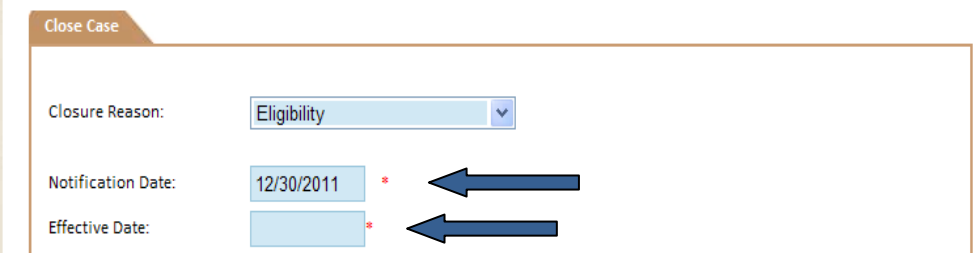


Then click in the “Notification Date” box. A calendar box will appear. A user can either choose the date from the calendar box or enter the date manually. The notification date must be the current date or a date prior. It cannot be a date in the future.



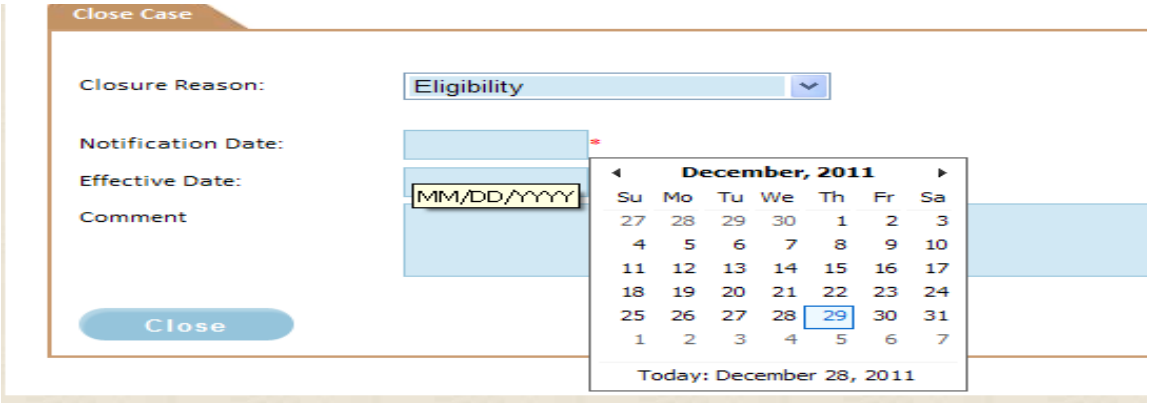
The notification date must be the current date or a date prior. It cannot be a date in the future.

In the screen below; notice the two red dots next to the dates.

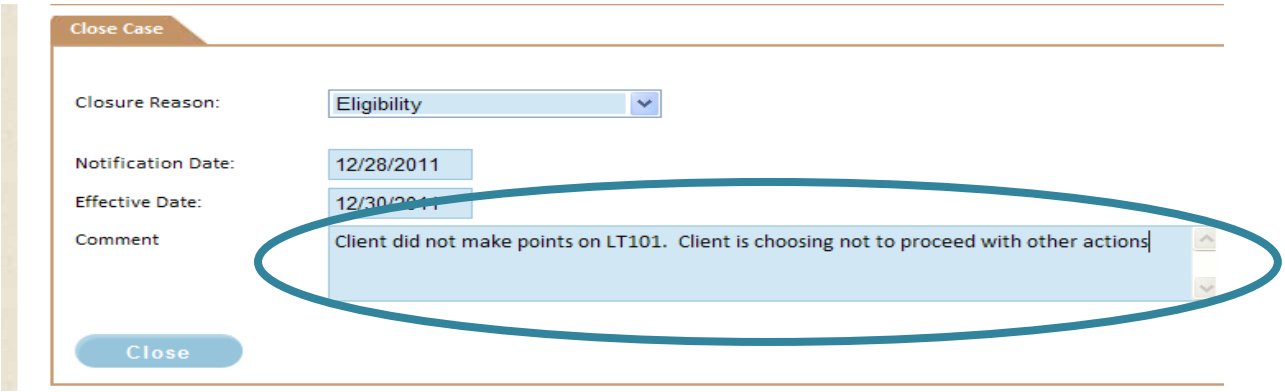


The red dot right next to the “Effective Date” box, indicates a required field. The red dot further away from the “Notification Date” indicates the data entered in the field is invalid.

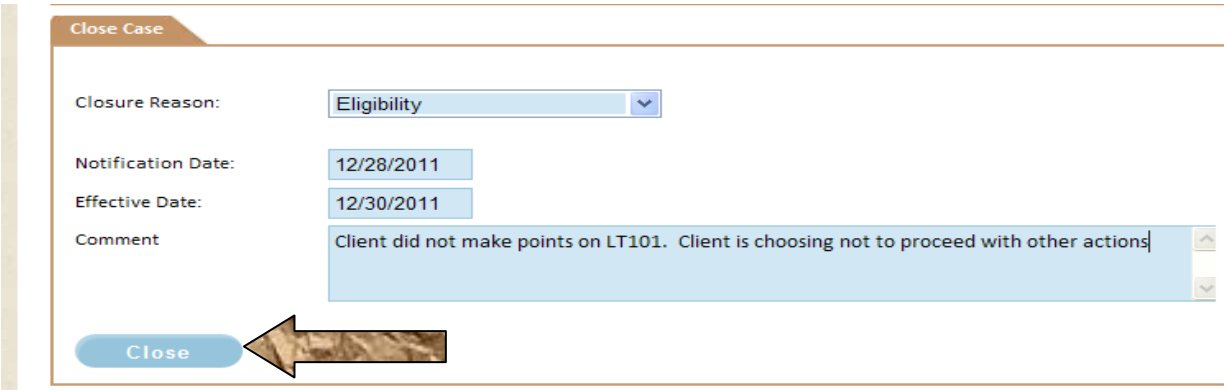
After the notification date is entered, click in the “Effective Date”. A calendar box will appear. A user can either choose the date from the calendar box or enter the date manually. This date will be the date the participant’s LTC/ALF waiver will close. If a participant is on the wait list, this is the date the participant will be removed from the list. If a participant is a current participant, this is the date all services will stop and providers will no longer receive payment for services.



The “Comment” box is for any additional information related to the closure. This is an optional box.



After filing out the all appropriate information, click on the “Close” button to finish the task.



Naming Conventions for Uploading Documents

All users of the Electronic Medicaid Waiver System (EMWS) shall use the Division's standardized naming convention for saving documents to a person's file on the Electronic Medicaid Waiver System.

Files will be named in the following manner:

1. WAIVER INITIALS: **LTC or ALF**
2. PARTICIPANT: **LAST NAME. FIRSTNAME**
3. DOC TITLE ABBREVIATED: (**see list below**)
4. **USE ONLY FOR HCBS 6 –PROVIDER DUTIES SHEETS –** Name of service provider
5. DATE: **YYYY.MM.DD**
   (This is the date the document is signed and dated by the participant.)

Example:

LTC. Jones.George.CCS. HomeStyleDirect.2011.10.28 (separate with a period)

1 2 3 4 5

Document Title Abbreviations:

Enter the following documents into the Documents History Section under "Waiver Links"	
Guard - Guardianship Papers	**ROI** – Release of Information
CIR – Critical Incident Reporting	**POA** – Power of Attorney
CPR- Complaint/Tracking/ Response	**Conflict** –Conflict of Interest Form
Term – Notice of Termination (HCBS 10)	
Enter the following documents into the Documents Section under "Plan of Care Links" for the specific plan of care the document relates to.	
CCS - Client Choice of Service (HCBS 1)	**CRR** – Clients Rights and Responsibilities (HCBS 3)
CPvdr – Client Choice of Provider (HCBS 11)	**DRO**- Doctor's Orders
MTHEV – Monthly Evaluation (HCBS 7)	**PDS** – Provider Duties Sheet (HCBS 6)
30D – Letter by provider to client giving 30 days notice terminating services/locating new provider	**CL** – Clinical notes for client. **(This can be uploaded as a document or typed directly into the plan of care notes.)**
SDCCCD- SDC Capability Document (SDC1)	**SDCCA**-SDC consumer agreement (SDC 2)
SDCCP – SDC Consumer profile (SDC3)	
FOR STATE USE ONLY	
SDCARP- SDC Authorized Representative Packet	**Appl** – Application
CHCCCM – Change of CC/CM Agency	

REMINDER!

Documents not saved using the proper naming convention will be returned for correction.

Service Rates

LTC/HCBS WAIVER RATE SCHEDULE
(Effective 2/1/2011)

T2024	Case Management Services: $8.81 per day, per client.
T1019	Personal Care Attendant Services: $20.00 per hour, $5.00 per 15 minute unit.
S5150	Respite Care Services, in home: $20.00 per hour, $5.00 per 15 minute unit.
S5170	Home Delivered Meals: Limited to $5.25 per meal, Not to exceed two meals per day.
S5160	Lifeline Installation: $70 per installation, Not to exceed one installation per lifetime.
S5161	Lifeline Monthly Service Charge: Limited to $45 per month.
T2003	Non-Medical Transportation: $5.40 per one way trip, limited to $80.00 per calendar month.
S5100	Adult Day Care: Limited to $8.40 per hour, $2.10 per 15 minute unit.
S9123	Skilled Nursing: $35.25 per hour.

Consumer-Directed Services:

T2024 TF	Care Coordinator Services: $6.00 per day, per client
T2041	Self-Help Assistant: $3.33 per 15 minute unit. Actual wage Self-Help Assistant, $12.00/hour

Total aggregate services may not to exceed $1200 per calendar month per recipient without verbal permission

ASSISTED LIVING FACILITY WAIVER RATE SCHEDULE

T2024	Case Management: $4.00 per day, per client
T2031	ALF Level I: (13 -14 points on LT101) $42.00 per day
T2031 TF	ALF Level II: (15 - 16 points on LT101) $46.00 per day
T2031 TG	ALF Level III (17 points and above on the LT101) $50.00 per day