

# CASE MANAGER SUPPORT CALL

## INDIVIDUAL PLAN OF CARE

### SERVICE AUTHORIZATION AND VERIFICATION SCREENS

Wyoming Department of Health  
Division of Healthcare Financing  
Developmental Disabilities Section  
August 10, 2020



The Participant Support Unit is continuing to provide trainings covering the Plan Mod Links Section of the Electronic Medicaid Waiver System (EMWS) during Case Manager Support Calls. These links are located to the left of the individualized plan of care (IPC). Today's training will be focusing on the Service Authorization and Verification screens. Just a reminder to please hold your questions until the end of the presentation. Please submit your questions in the chat box and they will be answered at the end of the presentation.



### **Review the case manager's role when completing the Service Authorization and Verification sections of the IPC.**

- ✓ Participant services are appropriate for the assigned level of service and fall within the IBA.
- ✓ Services comply with service definitions.
- ✓ Providers are aware of services and units.
- ✓ Relative providers have been approved by the Division.
- ✓ The participant or legally authorized representative (LAR) has participated in the development of the IPC.

**Rules can be found on the Public Notices, Regulatory Documents, and Reports page of the Division website, under the *Rules* tab.**



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The purpose of today's training is to review the case manager's role when completing the Service Authorization and Verification sections of the IPC. It is important these sections are developed accurately and completely in compliance with Wyoming Medicaid Rule.

The sections ensure:

1. Participants are receiving appropriate services that fall within their individual budget amount and Division service definitions.
2. All providers on the plan are aware of the services and units being provided.
3. Relative providers have been approved by the Division.
4. The participant or legally authorized representative (LAR) has participated in the development of the IPC.

Wyoming Medicaid Rules can be found on the Public Notices, Regulatory Documents, and Reports page of the Division website, under the *Rules* tab.



# Individual Budget Amount



Stay within the individual budget amount (IBA) when determining services and units on the IPC.

- ✓ If the request exceeds the IBA, the team will need to meet to adjust the services to fit within the assigned IBA.
- ✓ If a child will turn 21 during the plan year, the IBA will be prorated. Calculate units to reflect the correct number of days in service through the end of the month of their 21st birthday.

## Waiver Services

IBA	
Individual Budget Amount:	\$
Traditional Services:	\$
Case Management Services:	\$
Self-Directed:	\$
Amount Remaining:	\$0.00



The *IBA* tab is found on the Service Authorization screen. Teams must stay within the participant's individual budget amount (IBA) when determining services and units on the IPC. The number of units for each service must stay within the service cap limits. Please refer to the most recent version of the Comprehensive and Supports Waiver Service Index for service cap information.

If the request exceeds the IBA, the amount will be displayed in parenthesis. "Plan is over the IBA" will also appear at the top of the Plan Status screen.

If the request exceeds the IBA, the team will need to meet to adjust the services to fit within the assigned IBA.

If a child will turn 21 during the plan year, the IBA will be prorated. Calculate units to reflect the correct number of days in service through the end of the month of their 21st birthday.

A history of the participant's IBAs can be found by selecting the Individual Budget Amount screen under Waiver Links. If the IBA is believed to be inaccurate, contact the assigned PSS.

# Service Authorization

All Waiver Services must be prior-authorized by the Division.



**Services**

I certify that all service caps and definitions have been followed. ☐

Notes:  
 1) Hover over the Service Code to view the full service name.  
 2) Hover over the icon in the goal column to view the entire Goal.  
 3) Claims information up to date as of 6/2/2016.

Service Report With PA information: ☐ Service Report Without PA information: ☐

Service	Provider	Unit Cost	Units	Cost	Start Date	Goal	PA No	PA Line	Units Used	Last Updated Date
T2021U1		\$4.28	0	\$0.00	4/1/2020					
S5100UA		\$5.61	1818	\$6,562.98	4/1/2020					
T2019TS		\$8.12	13	\$105.56	4/1/2020					

[Add](#)

- ✓ Participant's desired services and units.
- ✓ Certified Waiver providers.
- ✓ Supporting documentation, if applicable.
- ✓ Goal information, if applicable.
- ✓ Verification that all service caps and definitions have been followed.



The participants waiver services are added under the *Services* tab of the Service Authorization screen. As a reminder, all waiver services must be prior-authorized by the Division. Providers must have a prior authorization (PA) number in order to bill for services. Providers should not provide services without an active PA number.

Remember, the requested units for each service should cover the entire plan year. Please refer to the most recent version of the Comprehensive and Supports Waiver Service Index for additional information on service caps.

To add a service or provider, click the add button. For traditional services, only certified waiver providers can be chosen from the drop down menu under the Services tab. If a provider is not showing in the drop down menu, they are not certified to provide the service. Contact the provider if this is believed to be an error. The provider should contact their assigned Provider Support Specialist for assistance.

Enter the requested services and units, assuring all information is accurate and complete. Be sure that all service start dates and providers are listed correctly. This section can be edited by clicking the pencil and paper icon to the left of the service code. To delete a provider or service entered in error, click on the red "x".

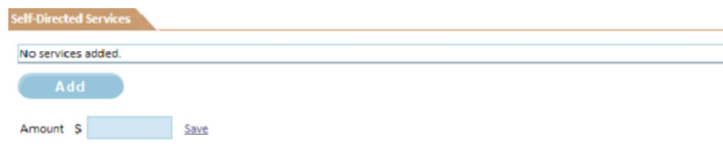
Upload all supporting documentation required for the following services: Crisis Intervention, Dietician Services, Occupational Therapy, Physical Therapy, Skilled Nursing, Speech, Language and Hearing Services, Specialized Equipment, Supported Employment, and Behavioral Support Services.

List the goal for each habilitation service during the IPC year. Goals should align with the participant's desired accomplishments for the IPC year, which are also documented on the Individual Preferences screen. For non-habilitation services in which a specific objective is not required, the case manager may enter "Not Applicable" in the Goal for this Service box.

Mark the box that certifies that all service caps and definitions have been followed.

## Self Direction

- ✓ If a participant is self-directing services, add the service under the Self-Directed Services tab.
- ✓ Enter the allocated budget for the self-directed services.



The screenshot shows a web interface for 'Self-Directed Services'. At the top, there is a tab labeled 'Self-Directed Services'. Below the tab, a message states 'No services added.' followed by an 'Add' button. At the bottom of the interface, there is a label 'Amount \$' followed by a text input field and a 'Save' button.



If the participant has completed the self-direction enrollment process, add the self-directed services in the *Self-Directed Services* tab on the Service Authorization screen. Enter and save the budget amount allocated to self-direction.

## Case Management Section



- ✓ Select the case manager.
- ✓ Enter units allocated.
- ✓ Enter "Not Applicable" in the Goal for this Service box.

Case Management Services

Service	Provider	Unit Cost	Units	Cost	Start Date	Goal	PA No	PA Line	Units Used	Last Updated Date
T2022		\$289.39	12	\$3,472.68	4/1/2020					

Add



The *Case Management Services* tab is also found on the Service Authorization screen. Select the case manager from the from the down menu.

Enter the number of units being requested. This can be the monthly unit or the fifteen minute unit or a combination of both. Please refer to the most recent version of the Comprehensive and Supports Waiver Service Index for information on case management service caps.

Case management is not considered a habilitative service so a participant goal is not required for the service.

# Verification

- ✓ Download the Participant and Legally Authorized Representative Verification form.
- ✓ The participant and LAR will complete and sign the form.

**Participant and Legally Authorized Representative Verification Form**

Developmental Disabilities Section  
Phone: (307) 777-7115  
Toll Free: 1-800-510-0280  
Fax: (307) 777-6807

Participant Name: \_\_\_\_\_ Waiver: \_\_\_\_\_

After discussing these items with the case manager, the participant and legally authorized representative (if applicable) shall verify the following:

	Participant	Legally Authorized Representative
1. I have been present, encouraged, and involved at every possible level during the development of my plan of care and acknowledge my responsibilities as a waiver participant.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The plan of care that has been developed meets my assessed needs and goals.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The limitations in my rights and the restriction plan have been explained to me along with my responsibilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I agree with the rights limitations in this plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. I understand how my rights limitations could be reduced or removed over time.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6. I have been informed of my right to be free from abuse, neglect, and exploitation, and have received information on how to identify and report these issues.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7. I have reviewed the waiver services available, and have made an informed choice about my services.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. I know that home and community based services are voluntary. I understand I can contact my case manager to review possible changes to my providers. For this plan, I have reviewed the provider list and made an informed choice about my providers.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. I have been informed of my right to an Administrative Hearing if I am denied a provider, service, or eligibility to the waiver.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. I consent to allow participation in Division sponsored quality assurance surveys, such as the National Core Indicators project, in order for the Division to collect and analyze data on service quality, choice, and participant satisfaction.		<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments (use the above item numbers to describe your comments):  
\_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Legally Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_



The Division must assure that participants have choice in the services they receive and the providers that deliver the services. This assurance is a requirement of the State's agreement with the federal government. The Division uses the Participant and Legally Authorized Representative Verification form to demonstrate that the participant or LAR had choice in these areas.

The Participant and Legally Authorized Representative Verification form (often referred to as the Verification form) can be downloaded under the Participant/Guardian Verification tab in the Verification screen.

The LAR and participant will complete and sign the form. Even if the participant has an LAR, it is important that the participant answer the questions on the form, if they are able to.



- ✓ Answer the questions on the Verification screen.
- ✓ Verify the answers reflect the answers of the participant and LAR.
- ✓ Upload the completed form to the Participant/Guardian Verification tab.

Download blank form for signature here. 

Upload signed form here. 

#### Verification

**Participant/Guardian Verification Form**

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

The legally authorized representative, if applicable, or participant has verified that he or she participated in the development of the plan of care (answer should be consistent with Participant and Legally Authorized Representative Verification Form, Question #1).

☐ Yes  
☐ No

The legally authorized representative, if applicable, or participant has verified that the plan of care meets the participant's assessed needs and goals (answer should be consistent with Participant and Legally Authorized Representative Verification Form, Question #2).

☐ Yes  
☐ No

The legally authorized representative, if applicable, or participant has verified that he or she was given a choice of waiver providers (answer should be consistent with Participant and Legally Authorized Representative Verification Form, Question #3).

☐ Yes  
☐ No

The legally authorized representative, if applicable, or participant has verified that he or she was given a choice of waiver services (answer should be consistent with Participant and Legally Authorized Representative Verification Form, Question #4).

☐ Yes  
☐ No

The legally authorized representative, if applicable, or participant has verified that he or she was informed of his or her right to be free from abuse, neglect, and exploitation, and received information on how to identify and report these events. (answer should be consistent with Participant and Legally Authorized Representative Verification Form, Question #5).

☐ Yes  
☐ No

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Document

[Choose File](#) [No file chosen](#)



The case manager must answer the questions on the Verification screen. Answers must coincide with the responses provided by the participant and LAR on the Verification form.

Upload the completed form to the Participant/Guardian Verification tab.



## Relative Disclosure

The case manager must verify if a participant's relative is providing services by selecting "Yes" in the box provided and uploading the Relative Disclosure form.


here.' Below this is a file upload area with a 'Choose File' button and the text 'No file chosen'. At the bottom, there is a text box containing the message 'There are no relative provider documents.' A red arrow points from the text below to the 'here' link in the form."/>

Once "Yes" is selected, the form can be downloaded.



Relative Disclosure: The case manager must verify when a participant's relative (defined as a biological, adoptive, or step parent) is providing services on the IPC by selecting "Yes" in the box provided and uploading the Relative Disclosure form. Once "Yes" is selected, this form can be downloaded.

The Relative Disclosure form must be signed by the designated Provider Support Specialist (PVS) prior to the case manager uploading it into EMWS.



## Relative Disclosure and Acknowledgement Form

Developmental Disabilities Section  
Phone: (307) 777-7124  
Toll-Free: 1-800-532-0280  
Fax: (307) 777-6067

Per Chapter 45, Section 31 of Wyoming Medicaid Rules, a relative provider (defined as a biological, step, or adoptive parent) who provides or intends to provide services to a related waiver participant shall disclose the relationship to the participant's team, and acknowledge and address safeguards set forth by the Behavioral Health Division.

**FORM INSTRUCTIONS:**  
A relative provider shall complete one form for each participant served. The form is to be reviewed, completed, and signed by the provider, the participant's case manager, the participant, and the legally authorized representative, as applicable.

Participant Name:	Participant Birthdate:	Waiver:
	Is the Participant Under the Age of 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Comprehensive <input type="checkbox"/> Supports
Relative Provider Name:	Case Manager Name:	CM Organization (if applicable):

The relative provider is also:  
☐ Certified provider      ☐ Employee of certified provider  
 Provider/Agency Name: \_\_\_\_\_

Do you live in the same residence/home address as the waiver participant? ☐ Yes ☐ No

Please indicate the relationship with the participant:  
☐ Relative\*      ☐ Legally authorized representative      ☐ Spouse\*\*

\* A relative who provides services must be a certified waiver provider and establish Limited Liability or other Corporation. Relatives cannot provide services through self-direction.  
 \*\* A spouse may not also be the participant's legally authorized representative.

Please check the services you will provide to the related waiver participant:  
☐ Personal Care\*      ☐ Community Living Services\*      ☐ Specialized Equipment  
☐ Adult Day Services      ☐ Community Support Services      ☐ Environmental Modifications

### PROVIDER SAFEGUARD ACKNOWLEDGEMENT

**CM** \_\_\_\_\_ **Conflict of interest.** To ensure the provider of services is acting in the best interest of the participant, the individualized plan of care (IPC) shall be developed and monitored by a case manager without a conflict of interest with the relative provider or the participant.

**P** \_\_\_\_\_ **Unduplicated services.** The IPC documents that services do not duplicate similar services, natural supports or services otherwise available to the participant (i.e., assistance normally provided by family, school, Medicaid/Medicaid Plus, etc.).

**N/A** \_\_\_\_\_ **Exceptions.** If personal care services are provided by a relative, the services shall not exceed 6 hours per participant per day. It is expected that family members will contribute natural supports and supervision to participant's living in the home.

**CM** \_\_\_\_\_ **Relative employees hired by a provider.** Provider agencies may hire relatives to provide waiver services in accordance with Wyoming Medicaid Rules, Chapter 45, as long as the relative is qualified to provide the service. Services provided by a relative provider have caps that cannot be exceeded. Provider agencies must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered as specified in the IPC.

**P** \_\_\_\_\_ **Division monitoring of relative providers.** Relative providers must meet the same requirements and qualifications as other providers or employees, and are subject to the same oversight levels as outlined in the waiver and applicable regulations. The Division shall oversee services as needed through standard processes.

**CM** \_\_\_\_\_ **Follow up on income or choice of other providers.** If the relative provider is not providing services in the best interest of the participant, the case manager, participant, appropriate team members, and the Division as needed, shall work to resolve the income or choice of other providers as appropriate. The IPC shall be modified in a timely manner to reflect the needs of the participant.

**CM** \_\_\_\_\_ **Service observation.** All services shall be observed quarterly by the case manager and reviewed for appropriateness during team meetings every 90 days.

**P** \_\_\_\_\_ **Documentation.** A schedule shall be used for documenting service delivery in accordance with Wyoming Medicaid Rules, Chapter 45. Documentation from the relative provider shall meet the service definition and reflect the services specified in the IPC. Service documentation shall be reviewed monthly by the case manager to verify that services delivered align with the IPC.


**CM** \_\_\_\_\_ **Prior authorization.** Waiver services shall be prior authorized by the Division and align with the participant's needs as specified in the IPC and other assessments.

**P** \_\_\_\_\_ **Oversight Authority and Action.** All claims are processed by the Medicaid Fiscal Agent and are subject to post-payment validation and may be recouped from the provider. Service documentation or claims that do not meet these requirements shall be referred to Medicaid.

**NOTE:** The relative provider, case manager, participant, and legally authorized representative shall review, complete and sign this form. The case manager and provider agency shall maintain a copy of the approved form, which is signed by the assigned Division staff, in their master provider file. The case manager shall submit a copy of the signed form to the designated Provider Support Specialist upon completion.

**Signatures:**

Participant _____ Date _____	Legally Authorized Representative _____ Date _____
Relative Provider _____ Date _____	Case Manager _____ Date _____
Division Representative _____ Date _____	



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The relative is responsible for completing the form, which must include the signature of the relative, participant and case manager. The case manager is then responsible for sending the Relative Disclosure form to Bethany Zaczek (bethany.zaczek@wyo.gov) and Jessica Abbott (jessica.abbott2@wyo.gov) at the Division. Jessica or Bethany must sign the Relative Disclosure Form, authorizing the relative provider, before the case manager uploads it into EMWS. If you do not know who the authorized Division representative is, please contact your local Participant Support Specialist for assistance.

A new Relative Disclosure form must be completed if the relative provider changes the services being provided, the waiver type changes, or there is a change in the legally authorized representative.

This form must be uploaded annually with the IPC.

After the IPC is completed, all team members are required to read, sign, and date the Team Signature and Verification form.

If changes are made in the review process, all team members must be notified and sign a new or revised Team Signature and Verification form.

John Hancock →

[illegible]

**Team Signature and Verification:** After the IPC is fully developed, all team members are required to read, sign, and date the Team Signature and Verification form, often referred to as the Team Sign form.

The signed form must then to be uploaded under the Team Signature and Verification tab on the Verification screen.

It is important that this form be completed in full, including the participant's name, plan of care dates, services, units, budget amount allocated and, if applicable, the modification effective date.

All modifications submitted in EMWS must have a new Team Signature and Verification page uploaded, even if there are no changes to the providers, services, or units.

It is acceptable to upload a printed copy of the Service Authorization page, which shows services and units initialed by team members, along with the required signed Team Signature and Verification page.

If changes are made to the services or units in the review process, all team members must be notified and sign a new or revised Team Signature and Verification form.

- ✓ Providers who fail to sign the Team Signature and Verification form will not be authorized to provide services on the IPC.
- ✓ The Case Manager uploads the signed form under the Team Signature and Verification tab.

View Verification Form

Document:

Choose File No file chosen

Relative Disclosure

A provider on the plan is a parent, step-parent or legally authorized representative.

Team Signature and Verification

Please upload a Team Signature Verification form. You can download a copy of the form [here](#).

Choose File No file chosen

Save

Upload signed form here.

Download blank form for signature here.



The Team Signature and Verification form is located in EMWS in the *Team Signature and Verification* tab.

Providers who fail to sign the Team Signature and Verification form will not be authorized to provide services for the participant. If changes are made in the review process, all team members must be notified and sign a new or revised Team Signature and Verification form.

If a team member's signature cannot be obtained due to an extraordinary situation, the case manager can work with the assigned PSS on a timeline for submitting the signature.



## Key Take Aways



1. Services must be appropriate to the assigned level of service, fall within the IBA, follow service definitions and last the entire plan year.
2. The Team Signature Verification Form must be complete and signed by all team members.
3. Relative providers must be approved by the Division, and the Relative Disclosure form must be uploaded annually with the IPC.
4. The Verification Form must be signed by the participant or LAR, and the responses must be accurately reflected on the Verification screen.

Thank you for attending today's training. Before we conclude, we'd like to address some of the key points to remember from today's meeting.

1. All services must be appropriate to the assigned level of service, fall within the individual budget amount, follow the Division service definitions, and be sufficient to last the entire plan year.
2. The Team Signature Verification Form must be complete and signed by all team members. The most recent version of this form may be accessed by clicking on the blue link on the Verification screen in EMWS.
3. All relative providers must be approved by the Division. The Relative Disclosure form must be uploaded annually with the plan of care. Once "yes" has been selected, the most recent version of this form may be accessed by clicking on the blue link under the *Relative Disclosure* tab on the Verification screen.
4. The Verification Form must be signed by the participant or LAR, acknowledging they are aware of their rights and have participated in the development of the Individualized Plan of Care. The responses given by the participant and LAR must be accurately reflected on the *Participant/Guardian Verification* tab on the Verification screen. The most recent version of this form may be accessed by clicking on the blue link under the *Participant/Guardian Verification* tab.

# Questions?

Please use the chat box feature!

We encourage case managers to provide us with feedback, as well as any preferences on areas in the plan you would like covered. All recommendations or comments can be referred to Alex Brooks at [cm.consultant@wyo.gov](mailto:cm.consultant@wyo.gov)



This concludes the case management training on Individualized Plan of Care Service Authorization and Verification screens.

We encourage case managers to provide us with feedback, as well as any preferences on areas in the plan you would like covered. All recommendations or comments can be referred to Alex Brooks at [cm.consultant@wyo.gov](mailto:cm.consultant@wyo.gov)

We will take this time to answer any questions.