

# DD Waiver Program Case Manager Support Call Case Management Monthly Review Expectations

Wyoming Department of Health  
Division of Healthcare Financing  
Home and Community Based Services Section  
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HOME AND  
COMMUNITY-  
BASED  
SERVICES

WYOMING MEDICAID  
DIVISION OF HEALTHCARE FINANCING



Wyoming  
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of Health

Good Afternoon. My name is Jennifer Adams, and I am a Benefits and Eligibility Assistant Manager for the Home and Community-Based Services (HCBS) Section of the Division of Healthcare Financing (Division). Today we will be discussing the standards and expectations that case managers must meet when they complete the Case Management Monthly Review form, or CMMR.



Review case manager expectations related to the CMMR.

The purpose of this training is to review the case manager expectations related to the completion and submission of the CMMR in order to ensure compliance with federal and state regulations and justify the payment for case management services.

# Training Agenda

- Discuss the importance of the CMMR and the existing rules that support expectations.
- Review documentation and billing standards.
- Review the expectations that case managers must meet in completing and submitting the CMMR.
- Discuss mechanisms to ensure case managers bring CMMRs into compliance.

3

At the end of this training, the following topics will have been introduced and explained:

- We will discuss the purpose and importance of the CMMR, as well as the rules and guidance that authorizes the HCBS Section to set standards and expectations for the CMMR.
- We will review billing and documentation standards, and provide examples of acceptable documentation.
- We will review the specific expectations that case managers must meet when completing each section of the CMMR.
- Finally, we will discuss mechanisms that the HCBS Section may use to ensure that case managers bring CMMRs into compliance with State and Federal regulations.



The CMMR is an important tool in documenting that a participant's right to choose is respected.

Choice is a basic tenet of home and community-based waiver services. Participants must have the freedom to choose the services they receive and who provides their services, where they live, with whom they spend time, and what they want for their future. Having choice is paramount to human dignity.

The CMMR is an important tool that is used to assure that a participant's right to choose is respected. Participant satisfaction is one topic covered on the form, and dissatisfaction with services or providers is an indication that the participant should be offered a choice of new providers or different services. The form is also used to document how providers are respecting a participant's choice as they deliver services.

# Authorities and Resources That Support HCBS Section Expectations

- Chapter 45, Sections 8 and 9 - Department of Health's Medicaid Rules.
- Comprehensive and Supports Waiver Service Index



Chapter 45 of the Department of Health's Medicaid Rules establishes rules related to DD Waiver Provider Standards, Certification, and Sanctions.

Section 8 of this Chapter establishes documentation standards. These standards require that service documentation, which includes documentation for case management services, provide a detailed description of the services provided. Section 9, which addresses case management services, specifically outlines case management tasks, which are required to be documented in accordance with HCBS Section standards.

The Comprehensive and Supports Waiver Service Index, commonly referred to as the Service Index, defines case management services, and outlines specific tasks and requirements of this service.

Chapter 45 can be found on the [Public Notices, Regulatory Documents, and Reports](#) page of the HCBS Section website, under the *Rules* tab. The Service Index is located on the [Service Definitions and Rates](#) page.

# The CMMR - A Quick Review



The CMMR is the formal documentation that the HCBS Section requires case managers to complete each month for each participant on their caseload. This documentation demonstrates the work that the case manager has completed throughout the month, and justifies the payment that they receive for the services they have provided. When completed in accordance with established standards, the CMMR provides a detailed accounting of what a participant is doing, where they are struggling, and where they are finding success. The information that the case manager documents on the CMMR is an extremely important piece of the participant's overall case file, and is often used to provide context for the HCBS Section when an incident or complaint is being investigated, or when the Extraordinary Care Committee needs information on a request for additional funding.

The CMMR is part of the Electronic Medicaid Waiver System (EMWS) platform, and must be completed and submitted through EMWS. Let's quickly review the components of the CMMR.

# Billable Services



- Describe the work that was conducted during any visit or contact.
- Detail home visits and service observations.
- Do not combine activities into one billable service.

7

Case managers should use the **Billable Services** section to clearly describe the work that they do during any visit or contact with the participant. They should include who was involved in the contact or visit, what happened or was discussed, when and where it occurred, why it happened, and how the activity or visit went. Include details and specifics of conversations so that the reader can clearly understand what happened, as well as any follow up needed or resolution that occurred. Every entry needs to have a detailed description.

Home visit and service observations should be documented in this section, and the Home Visit and Service Observation Form should be uploaded in the *Documents* section at the bottom of the CMMR, which will be discussed shortly. As a reminder, case managers should not combine activities into one billable service notation. As an example, several things can occur in a person's home during a single hour. The team may meet at the participant's home, at the request of the participant, to have a team meeting. After the meeting, the case manager may conduct a home visit and talk about the participant's satisfaction with their services and providers. Finally, the case manager may conduct a service observation to ensure the community living service provider is delivering services as outlined in the participant's individualized plan of care, or IPC. Each of these tasks is very different, and each must be documented separately with different time spans.

As a reminder, home visits must be conducted in the participant's home while they are present. Meeting at Starbucks for coffee is not a home visit.

## Discussion Topics

- Topics should be discussed during the home visit or other face to face time.
- Topic areas guide the case manager as they check in to ensure that participant choice is offered and respected.
- Documentation must not be copied from participant to participant or month to month.

Case managers should complete the **Discussion Topics** section during the participant's home visit or during face to face time with the participant.

The topic areas guide the case manager as they regularly check in with the participant and their legally authorized representative to ensure that participant choices are being respected and determine the participant's satisfaction with their services and their life. Case managers must complete all applicable topic areas, and should include a detailed description of what has occurred for the participant during that month. All entries should be individualized and should change from month to month in order to reflect what is happening in the participant's life. Documentation should not be copied from month to month or from participant to participant. Discussion related to the topic areas should cover the participant's entire life and not just what occurred during waiver services. Incomplete discussion topics or generic responses are not considered acceptable and will result in the failure of a quality improvement review, or QIR.

The case manager must note any areas of concern when completing these topics, and include any follow-up actions that they need to take in the Follow-ups section. For example, if the participant indicates that they are unhappy with a provider, the case manager should note the information under the provider satisfaction topic area, and should list the specific follow-up action they intend to take, such as scheduling a meeting with the provider or assisting the participant in finding a new provider, in the Follow-Ups section. The Follow-Ups section will be discussed shortly.



# Service Observations and Objective Progress

- Conduct service observations as required in Service Index.
  - Note the month the last service observation was completed if an observation isn't completed in the current month
- Review provider documentation to calculate and document participant progress on objectives.

9

As established in the Services Index, case managers are required to conduct service observations every quarter if the service is habilitative, which means the participant must have identified and is working on a specific objective in order to meet a goal. If a service is non-habilitative, meaning no goal is required, then the case manager must conduct a service observation every six months. The case manager must observe each habilitation service provider as they deliver services to the participant. Visiting the provider while the participant is not in services is not acceptable. Case managers are required to meet the same service observation requirements for participant-directed services.

The case manager must enter the training objective that the participant is working toward, and review provider documentation to calculate and document the progress that the participant has made as a percentage. The service observations should be detailed in the Documentation of Billable Services section, so the case manager can simply note the date the observation was completed in the **Service Observation and Objective Progress** section, and direct the reader to the Documentation of Billable Services section for further detail. Service observations don't have to be completed every month, so the case manager should note the month the last service observation was completed if an observation isn't completed in the current month.

## Service and Billing Documentation

- Review unit utilization and make necessary adjustments to assure participant has enough services for the plan year.
- Review documentation to ensure the provider met the service definition.
- If billing information isn't available, add as a follow-up item.

10

Case managers are responsible for reviewing provider service and billing documentation for each service the participant receives. When reviewing billing documentation, remember that you are reviewing the prior month's documentation. For example, if you are completing the CMMR for June, you will be reviewing and reporting on the provider documentation for May.

As established in Chapter 45, Section 8(n) of the Department of Health's Medicaid Rules, the provider must make service documentation available to the case manager by the 10th business day of the month following the date that services were rendered. So again, if the services were delivered in May, the provider must make that documentation available by the 10th business day of June. If the provider does not make the required documentation available to the case manager by the 10th business day of the month, the case manager must submit a *Provider Documentation Non-Compliance Report* form to the provider and the Provider Credentialing Specialist by the end of the month in which the documentation was to be submitted, which for our example would be June 30th. More information about this form and process is explained on the form, which can be found on the [HCBS Document Library](#) page of the HCBS Section website, under the *DDForms* tab.

Providers have up to one year to bill Medicaid for the services they perform. Providers are required to submit billing documentation by the 10th business day of the month after the billing is submitted. If the provider does not have billing documentation available, the case manager should add billing review as a follow up item in the Follow-Ups section, which will be discussed shortly. As a reminder, providers, including case managers, cannot bill for services prior to completing and submitting their service documentation. If a case manager identifies situations in which a provider's documentation is entered or altered after they date they bill

for the service, they must submit a complaint through the Wyoming Health Provider (WHP) portal.

Case managers should review the participant's use of service units to ensure that they are not receiving more or fewer units than what has been agreed upon in the IPC. If a participant is receiving fewer units than they should, then the case manager should follow-up to determine the reason. If the case manager identifies overutilization of the units, the case manager should notify the provider and set up a team meeting to discuss how the remaining units will be used in a way that ensures the participant has enough units for the plan year. A participant cannot request additional funding, so it is imperative that case managers identify issues with overutilization and make adjustments quickly. These concerns should be explained in the **Billing Documentation Concerns** section.

Case managers must remember that they should be reviewing case management units as well. Oftentimes, case managers are required to bill a 15-minute case management unit rather than a monthly unit. Modifications to add 15-minute case management services to a participant's IPC cannot be made retroactively, or after the participant's IPC has ended. Case managers must review units and make modifications proactively.

During the documentation review, case managers should be looking for evidence that the services delivered by the provider met the service definition, as well as the wants and needs of the participant that are outlined in the IPC. Simply put, the case manager is performing an audit of the provider's documentation to identify any potential concerns with the documentation or the services provided.

# Incident Reports

- Document the number of incidents that were reported and not reported to the HCBS Section.
- Review incident trends to identify root cause of the incident.
- Review trends related to over-the-counter and as needed medications.

12

A crucial part of the case manager's job is to review incident reports. This review is necessary so that case managers are knowledgeable of medical and behavioral concerns, and are able to provide follow-up or intervention as needed. Case managers are required to document their review of incident reports on the CMMR.

The case manager must document the number of internal incidents that occurred during the month that did and did not get reported to the HCBS Section. If, during the review of internal incidents, the case manager identifies an incident that should have been reported to the HCBS Section, they should do so immediately and note this as a specific concern in the **Incident Reports** section. Remember, the HCBS Section recently implemented an incident reporting option into EMWS to make incident reporting easier for case managers.

The review of incidents isn't just about counting the number of incidents that occurred. More importantly, reviewing incidents trends may help the case manager identify the root cause of an incident, which could prevent similar incidents from happening in the future. It may also help the case manager identify underlying medical or environmental changes that are affecting the participant adversely. The team may need to make changes to a positive behavior support plan, or the provider may need to make an appointment for the participant to see the doctor. When the case manager reviews the incidents, they must summarize the findings and note any concerns or items that need follow-up in the appropriate sections. Follow-up items should be transferred to the Follow-Up section.

Chapter 45, Section 9, which establishes specific rules for case managers, states that case managers shall be the second-line monitor for participants receiving medications. The

purpose of second-line monitoring is to help ensure that the participant's medical needs are addressed and medication regimens are delivered in a manner that promotes the health, safety, and well-being of the participant. Part of this monitoring is a review of trends related to the usage of the participant's over the counter and prescription medications, including as needed, or PRN, medications. The case manager is responsible for reviewing the medication assistance record of each participant, and noting any trends or concerns with PRN psychoactive medications. Again, trends may highlight changes in the participant's medication or environment that are adversely affecting the participant.

## Follow-Up and Uploading Documents

- As concerns or action items are identified, add them to the Follow Ups section.
  - Information is essential if a back-up case manager must step in.
  - Information is essential to HCBS Section staff members.
- Upload the Home Visit and Service Observation form, as well as other relevant evidence of the case manager's work.

14

As the case manager completes the sections of the CMMR, they are expected to document concerns that they identify. But documenting the concerns is only one piece of the puzzle. The case manager is also expected to follow-up and resolve those concerns.

As the case manager identifies a concern, they should note the steps they need to take to follow-up on that concern in the **Follow-Ups** section. Include a target date by which the follow-up should be completed, and mark it as complete once it is done. A benefit of using the Follow-Ups section is that the information automatically populates to the next month if the follow-up isn't completed, so important follow-up tasks don't fall through the cracks. This section is especially important for back-up case managers. If a backup case manager needs to step in for any reason, it is critical that they know what follow-up tasks are outstanding so they are able to provide the services that the participant needs. It is also important for HCBS Section staff members to have this information available as they regularly review this section as part of incident and complaint investigations, Extraordinary Care Committee requests, and other follow-up activities.

The purpose of the Home Visit and Service Observation form is to ensure that the participant is aware of the general topics that will be documented in EMWS. The documentation, after all, is about them, so they should be aware of and verify that the topics being documented are the topics that were actually discussed with them during the visit. Case managers must ensure that these forms are completed, signed, and dated by the participant or legally authorized representative and provider representative, if they were present during the visit. The case manager should then document a more detailed account of the visit in the CMMR and upload the form in EMWS. The topic areas that are noted on the form must align with

the more detailed documentation that is included in the CMMR documentation in EMWS. Although it may feel redundant, it is important that the participant have a general understanding of the information that the case manager will be including in the participant's permanent record. This is the only document that the case manager is required to upload in the **Documents** section. However, this is a great place to upload team meeting notes, participant specific training forms, or other documents that provide evidence of the case manager's monthly work.

# Common Reasons for Failed QIRs



13

The HCBS Section would like to take a minute to congratulate case managers on the overall improvement we've seen related to the documentation on discussion topics and the reporting on the number of incidents. Thank you so much for your work on generating this important documentation.

However, we do still regularly fail QIRs if the case manager does not provide sufficient documentation. Let's take a minute to review the most common deficiencies that the HCBS Section encounters.



# Documentation Doesn't Justify Time



- Service plan development
- Home visit and service observations
- Other contacts

14

When documenting a billable service it is important to ensure that the documentation you provide justifies the time that you are billing.

**Every** entry needs to have a detailed description. Merely stating that you developed the IPC or that you conducted a home visit doesn't support the time that is being documented. If you worked on developing an IPC, you need to explain the sections you completed and any documents you uploaded. You need to be able to explain the work that you did during the time you billed for services. If you document a 20 minute phone conversation with a legally authorized representative, you need to document more than the fact that the conversation occurred. You must provide information on the topics of discussion, specific concerns, and any action or follow-up that is needed.

If documentation detail does not adequately justify the time that is documented, the CMMR may result in the failure of a QIR.

# Insufficient Trend Identification

- Incidents
- Over the counter and as needed medications
- Unit over or under utilization



15

Monitoring service implementation and utilization is one of the most important tasks the case manager must complete. The case manager is responsible for ensuring that the services are being delivered in a manner that ensures participant choice, addresses participant specific needs, and is in alignment with what was agreed upon during the person-centered planning process and outlined in the participant's IPC. It is important that data is reviewed, but it is helpful to understand why this review is so critical. In reviewing this information you may be able to identify the ultimate cause of the incident, which could prevent similar incidents from happening in the future.

Although providers are also responsible for identifying the trends, trend information is critical for the whole plan of care team to have and review. The case manager should review the information that is available to them, including incident reports, billing documentation, and medication assistance records to identify potential concerns.

If the case manager does not include an explanation of the review of this information and any trends that were identified, the CMMR may cause the QIR to fail.

# Insufficient Follow-Up Information



- Billing documentation
- Medical concerns
- Provider and satisfaction concerns
- General participant concerns

As mentioned earlier in the training, case managers are expected to document concerns that they identify as they conduct home visits, service observations, and documentation reviews. These concerns, and any follow-up that needs to be addressed, must be added to the Follow-Ups section. If follow up activities aren't completed, this could have a negative impact on a participant's life. If required follow up actions are identified through the QIR, but no documentation on that follow up is available in future CMMRs, the CMMR may result in the failure of the QIR, and the BES may contact the case manager for an explanation on what actions have been taken or an explanation as to why action has not been taken.

# When Failed QIRs are a Chronic Concern



Many of the issues that result in a failed QIR are “one and done” concerns that are easily fixed and don’t happen again. However, there are situations in which errors or inadequate documentation are chronic issues for a case manager. In these cases, the HCBS Section may take additional steps. These actions are not taken to punish case managers, but rather to ensure that they are meeting the requirements they are obligated to meet, in order to promote and improve a participant’s quality of life.



21

HCBS Section staff may issue informal or formal technical assistance, commonly referred to as TA. Although case managers generally work with the area Benefits and Eligibility Specialist (BES) on concerns related to service plans, it is important to note that other HCBS Section staff can issue technical assistance as well.

In addition to the red flags mentioned earlier in the training, if case managers do not respond to requests that are sent through EMWS or email, or do not return email or phone calls, they will receive TA. Case managers are required to follow established Division policy, as well as State and Federal rules and regulations. If a case manager violates these authorities, they will be subject to TA. The Service Index clearly outlines what is expected of case managers as they provide case management services. If a case manager is not providing case management services as defined in the Service Index, they will receive TA.

The HCBS Section wants to collaborate and partner with case managers, and is committed to working with case managers to address and resolve identified problems as informally as possible. With this commitment in mind, HCBS Section staff will always try to provide informal TA rather than imposing a more formal option to ensure that problems are resolved; however, the case manager must work to fix the identified problems. If a case manager is not responding, the problem isn't fixed within established timelines, or there are other chronic issues, the HCBS Section may issue formal technical assistance. Please understand that health and safety concerns may not be addressed through informal TA but may automatically be escalated to formal TA or a more serious action, based on the nature of the issue.

If the case manager is unresponsive to informal TA, the BES will submit the concern to the

Technical Assistance Coordinator, who will issue a formal TA letter. This letter will detail the specific concern, cite the Division authority or policy that is being violated, and provide additional information on the expectations that the case manager must meet in the future. If the concern is still present, then the letter may list the steps the case manager needs to take to fix the concern and establish a time frame by which the problem must be fixed. This is still technical assistance, but this more formal approach means that the letter will become part of the case manager's file within the Information Management for Providers (IMPROV) system.



The HCBS Section has the option to impose corrective action. This more formal action requires the case manager, as a provider of waiver services, to submit a corrective action plan that details how they will correct the problem, and what they will do in the future to ensure that the problem does not recur.

The HCBS Section may impose corrective action if the case manager continues to make the same errors after informal and formal technical assistance has been provided. The HCBS Section may also impose corrective action if the case manager is uncooperative, is not responding to emails or other requests, or is unable to resolve the original problem that was identified. Additionally, if the case manager submits a claim for payment prior to submitting documentation for the services they provided, they will be subject to corrective action and may be referred to Program Integrity for recovery of payment.

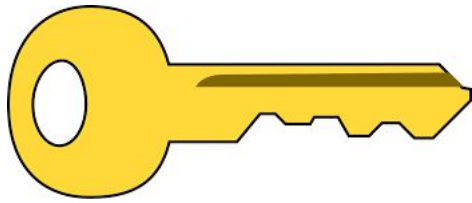


Chapter 1 of the Wyoming Medicaid Rules defines adverse action as the termination, suspension, or other sanction of a provider. Chapter 16, which addresses program integrity, includes a comprehensive list of reasons that adverse actions may be imposed, including but not limited to:

- Failure to comply with the provisions of the provider agreement;
- Failure to render requested documentation;
- Situations that pose a threat to the health, safety, or welfare of the clients or general public;
- Lack of or repeated failure to provide documentation of Medicaid services;
- Failure to maintain current contact information;
- Refusing to complete required education;
- Failure to submit an acceptable corrective action plan, or failure to implement the corrective action plan approved by the Department;
- The chronic failure to provide services pursuant to the service plan;
- Providing services that fail to meet the applicable standard of care for the profession or service involved; and
- Violations of Medicaid, Department, or other State or Federal statute, rule, or law relating to provisions of services.

Adverse action, which includes educational interventions, recovery of overpayments, suspension of payments, monetary penalties, and termination of the provider agreement, may be imposed after technical assistance and corrective action have been attempted. However, in some cases, the HCBS Section may impose adverse action immediately without addressing a deficiency at a less formal level.





# TAKEAWAYS

1. The CMMR is legal documentation that explains the services the case manager provided and justifies the billing claim.
2. The CMMR must be completed in its entirety.
3. Inadequate documentation will result in a failed QIR, and may result in additional action.

21

Before we end today, we'd like to remind case managers of the key takeaways of today's training.

1. The CMMR is the formal documentation that the HCBS Section requires case managers to complete each month for each participant on their caseload. The documentation demonstrates the work that the case manager has completed, and justifies the payment that they receive for the services they have provided. This documentation is available to HCBS Section staff, Program Integrity and the Medicaid Fraud Control Unit, and CMS.
2. The CMMR must be completed in its entirety. When completed in accordance with established standards, the CMMR provides a detailed accounting of what a participant is doing, where they are struggling, and where they are finding success.
3. If the case manager does not complete the CMMR, the IPC to which the CMMR is attached will fail the quality improvement review. If a case manager's documentation results in chronic failure of quality improvement reviews, the case manager will be subject to technical assistance and, in some cases corrective or adverse action.

# Questions???

## Contact your Benefits and Eligibility Specialist

<https://health.wyo.gov/healthcarefin/hcbs/contacts-and-important-links/>

22

Thank you for taking time to participate in today's training on the expectations that case managers are required to meet when completing the CMMR. If you have questions related to the information in this training, please contact your Benefits and Eligibility Specialist. Contact information can be found by clicking on the link provided in the slide.