WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING
HOME AND COMMUNITY BASED SERVICES
(HCBS) SECTION

COMMUNITY CHOICES WAIVER SERVICE INDEX

Effective April 1, 2023

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Division of Healthcare Financing Service Requirements

The Community Choices Waiver (CCW) services defined in this document shall be performed in the manner described in the service definitions. Services must meet each participant's assessed needs. In accordance with the Wyoming Medicaid Provider Agreement, CCW providers and case managers must be knowledgeable of the Department of Health's Medicaid rules and guidance affecting CCW services, must meet the provider qualifications established in the CCW Agreement with the Centers for Medicare and Medicaid Services, and must comply with the provision of the Wyoming Medicaid Provider Agreement.

Many CCW service providers are required to have additional licensure or approval through other State of Wyoming entities. Obtaining and maintaining this licensure is essential to providing CCW services; entities without the appropriate licensure will be referred to Program Integrity for potential recovery of funds, and will face additional provider credentialing consequences, up to and including termination of their provider agreement.

Each service, in combination with other services included in a participant's service plan, must be determined necessary by the case manager's assessment of the participant's needs. The participant's service plan must account for services to cover the entire plan year. With the exception of case management services, which participants must receive each month, a minimum number of service units is not required.

Waiver services shall not duplicate services offered through another funding source, such as Section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services), the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), or the Medicaid State Plan.

Participant-directed services shall be performed in the manner described in the service definitions and meet the participant's assessed needs. Services offered through participant direction are only billable in 15-minute increments. The Employer of Record must ensure that all participant-directed services fit within the participant-directed budget. CCW participant-directed services allow for the hiring of any person at least 18 years of age, including relatives who are not legally responsible for the participant.

The CCW program does not allow a spouse or other legally responsible person to be reimbursed for providing CCW services.

A National Provider Identifier (NPI) number is required for providers of the following services:

- Case Management
- Personal Support (not participant-direction)
- Skilled Nursing
- Home Health Aide
- Adult Day (Health and Social Models)
- Assisted Living Facilities

Other waiver services do not require referring or ordering provider NPIs to be submitted on billing claims. The Financial Management Service (FMS) contracted to provide support to participants who direct services through participant direction on CCW shall maintain a single NPI that is associated with

the Home and Community Based Services (HCBS) within DHCF. The FMS is not required to obtain a second NPI to process CCW claims.

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* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Adult Day Services	Health Model	S5101 U7	$34.06	Half Day
	Social Model	S5101	$26.84	

Adult day services are generally furnished four or more hours per day on a regularly scheduled basis, as specified in the service plan. Services must be provided in a non-institutional, community-based setting, which may encompass health and social services needed to ensure the optimal functioning of the participant.

Health model services include group socialization and companionship, assistance with activities of daily living, and supervision as specified in a program plan. The program plan must be individualized to the participant's assessed needs, and include realistic and measurable goals.

Social model services include group socialization and companionship supports to participants at risk for isolation or loneliness. Only incidental assistance with activities of daily living may be provided. A measurable goal is not required for this service model.

Exclusions and Limitations

Health model services are limited to a maximum of 520 units per service plan year, or the prorated equivalent of five days per week at eight hours per day. Social model services are limited to a maximum of 312 units per service plan year, or the prorated equivalent of three days per week at eight hours per day. Services do not include the provision of physical, occupational, or speech, language, and hearing therapies available under the Medicaid State Plan. Adult day services may not be provided for purely diversional or recreational purposes.

Meals provided as part of these services shall not constitute a full nutritional regimen and are not intended to serve as the sole source of nutrition for the participant. If food insecurity is identified as a risk on the participant's assessment, the service plan must address how the participant's additional dietary needs are being met. Participant transportation costs are not associated with the provision of adult day services and must be billed separately.

Adult day services cannot be provided virtually.

Reimbursement is limited to the following provider types:

- Health Model - Adult day care facilities licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xxiii).
- Social Model – Eligible senior centers as established by W.S. 9-2-1201(a)(iii) and overseen by the Wyoming Department of Health, Division of Aging as credible and capable to receive grants for Older Americans Act services pursuant to W.S. 9-2-1204(a)(vii).

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* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Assisted Living Facility Services	Standard	T2031	$70.44	Daily
	Memory Care Unit	T2031 U8	$82.49	

Assisted living facility services include personal care and supportive services, to the extent permitted under state law. Services must be furnished in a residential setting that meets the home and community-based setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services include social and recreational activities, and medication assistance permitted under state law.

In the event that a participant's needs extend beyond the facility's capability to support those needs within its licensure authority, the facility may consult with the participant's case manager to coordinate additional Medicaid or non-Medicaid services to supplement, but not replace, the care provided by the assisted living facility. The assisted living facility is responsible for coordinating services that are provided by third parties.

Exclusions and Limitations

Reimbursement does not include the costs for room and board, items of comfort or convenience, or facility maintenance, upkeep, and improvement.

Participant transportation costs are not associated with the assisted living facility services and must be billed separately. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services; therefore, reimbursement does not include 24-hour skilled care.

Reimbursement is limited to assisted living facilities licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xxii).

* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Case Management	Service Plan Development /Annual Update	T2024 U6	$507.81	Initial plan/annual update
	Monthly Monitoring	T2022	$193.50	Monthly
	Monthly Monitoring - Training Certificate	T2022 UB	$203.17	Monthly

Case management services assist participants in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services being accessed.

Case management services include:

- Comprehensive assessment and periodic reassessment of participant needs to determine the need for any medical, educational, social, or other services.
- Facilitation and oversight of the development and periodic revision of a person-centered service plan. Case managers cannot add or reduce waiver services unless it aligns with the participant's assessed need and has been chosen by the participant.
- Service coordination, referral, and other related activities, such as scheduling appointments for the participant, to help the participant obtain needed services. Other needed services may include activities that link the participant with medical, social, and educational providers or other programs and services that address the participant's identified needs and achieve the goals specified in the participant's service plan.
- Service plan implementation, monitoring, and follow-up activities, including activities and contacts that are necessary to ensure that the service plan is effectively implemented and adequately addresses the needs and desires of the participant. At least one monthly contact must occur. An in-person visit to the participant's residence must be conducted at least once per calendar quarter, and a CCW Quarterly Visit Verification Form must be completed. Other contacts may be made with the participant, legally authorized representative, family members, service providers, or other entities or individuals, and must be conducted as frequently as necessary in order to:
  - Ensure services are being furnished in accordance with the participant's service plan;
  - Review service utilization, which may include evidence of EVV compliance;
  - Evaluate the effectiveness of the service plan in meeting the participant's needs;
  - Identify changes in the participant's condition or circumstances;
  - Screen for potential risks or concerns
  - Monthly, verify with the participant that the Personal Emergency Response System (PERS) equipment is operational, and report concerns to the PERS provider;
  - Assess the participant's satisfaction with services and supports; and
  - Make any necessary adjustments in the service plan and service arrangements with providers.
- Provision of information and assistance in support of participant direction as necessary to:

- Inform participants of participant direction opportunities;
- Ensure that participants who express an interest in participant direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with participant direction;
- Determine whether participants meet the additional criteria for participant direction;
- Assist the participant or designated employer of record (EOR) in obtaining and completing required documents;
- Determine the participant's monthly budget allocation;
- Coordinate with the Financial Management Services (FMS) agency;
- Review the participant-directed monthly budget allocation, which may include evidence of EVV compliance; and
- Monitor participant-directed service effectiveness, quality, and expenditures against the monthly budget allocation.

Case Management Agency Responsibilities

Case management agencies are responsible for the following:

- Assign one (1) person to act as the Division's primary contact and assume responsibility for the case management agency's administration and operation. When possible, a secondary contact should also be assigned;
- Ensure all case managers meet the requirements outlined in the approved Community Choices Waiver and the CCW Case Manager Manual, including all training required to deliver case management services;
- Have internal mechanisms for assessing and managing the performance of each case manager. If agency does not address case manager performance concerns to the Division's satisfaction, the Division may require case manager retraining or other progressive disciplinary actions, up to and including termination of the case manager's status as a CCW program case manager.
- Maintain adequate administrative and staffing resources and emergency backup systems to deliver case management services in accordance with all federal and state requirements;
- Assign one (1) person to serve as the participant's primary case manager based on the participant's preferences;
- Ensure all participants have a backup case manager in the event that the primary case manager not be able to provide case management services for any reason;
- Provide up-to-date information about public and private state and local services, supports, and resources to participants or individuals inquiring on their behalf;
- Establish and maintain working relationships with community-based resources, supports, organizations, hospitals, service providers, and other organizations that assist in meeting the participant's needs;
- Collaborate with other entities, as needed to support participants;
- Ensure that case managers have access to federal and state statutes, regulations, and other documents and information relevant to the provision of case management services;
- Ensure that case managers maintain a working knowledge of CCW policies and procedures;
- Overcome any geographic barriers, including distance to the participant, to provide timely case management services;
- Ensure that case management services are, at minimum, available during normal business hours (Monday through Friday, 9:00 AM to 5:00 PM, excluding state holidays);
- Provide access to a telephone system and trained staff to ensure timely responses to messages and telephone calls received outside of normal business hours;

- Ensure the agency meets established billing standards, including the assurance that only one (1) monthly monitoring unit per participant is billed per month;
- Submit information and reports as required by the Division;
- Maintain sufficient documentation to substantiate claims for reimbursement of case management services for six (6) years after the date of service, including all documents, records, communications, notes, case manager qualifications, and other materials related to services provided and work performed; and
- Facilitate access to telecommunication devices and interpreters for participants with hearing or vocal impairments, and access to foreign language interpreters as necessary to conduct all required case management activities. If a participant needs translation services, the case manager should contact the areas Benefits and Eligibility Specialist for further information.

Exclusions and Limitations

The participant's service plan must be reviewed and updated annually. Only one service plan development/annual update unit can be billed for each service plan or service plan renewal that is developed. Reimbursement for monthly monitoring includes any periodic service plan modification activities as necessary to ensure that the service plan is effectively implemented and adequately addresses the needs and desires of the participant. The annual service plan update and monthly monitoring units may be reimbursed in the same month if the monthly monitoring activities are conducted and documented separately from the annual service plan update activities.

Non-billable activities include:

- Ancillary, supervisory, or administrative activities, such as mailing, coping, filing, and activities associated with provider certification renewal.
- Time spent with the participant or legally authorized representative for social reasons, unless billable case management activities are also occurring. The Centers for Medicare and Medicaid Services does not consider incidental contact and social exchanges to be case management activity.
- Travel time, which has already been included as part of the rate for this service.

Reimbursement is limited to the following provider types:

- Case management agencies, which are corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State.
- County Public Health Nursing agencies.

Conflict Free Case Management

The case management agency and case manager responsible for the development of the participant's service plan must meet the following conflict of interest standards:

- The case manager must not be related by blood or marriage to the participant, or to any person paid to provide CCW services to the participant;
- The case manager must not share a residence with the participant or with any person paid to provide CCW services to the participant;

- The case manager or case management agency must not be financially responsible for the participant;
- The case manager or case management agency must not be empowered to make financial or health-related decisions on behalf of the participant; and
- The case manager or case management agency must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide CCW services to the participant. Financial interest includes a direct or indirect ownership or investment interest or any direct or indirect compensation arrangement.

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* Please note that Prior Authorization is required for Waiver Services			
Service	**Code**	**Rate**	**Unit**
Environmental Modifications	S5165NU New	PA#	Per Event
	S5165 Repair		

Environmental modifications include functionally necessary physical adaptations to the participant's residence, as outlined in the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant in order for them to remain in their home instead of an institutional setting. Adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

An assessment by a licensed occupational or physical therapist is required to demonstrate the need for the environmental modification. The cost of an assessment that is conducted for a participant who intends to transition out of a nursing facility into community services may be submitted as part of the overall environmental modification service. Assessments for current CCW participants or individuals on another Medicaid program must be paid by the Medicaid State Plan.

All services shall be provided in accordance with applicable state and local building codes

Exclusions and Limitations

A lifetime cap of $20,000 per family applies to this service.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve the entrance or egress of a residence or to configure a bathroom to accommodate a wheelchair). Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant are excluded.

Modifications of rented or leased homes shall be extraordinary alterations that are uniquely needed by the individual, and for which the property owner would not ordinarily be responsible.

Adaptations that are covered by the Medicaid State Plan, a state independent living center, or vocational rehabilitation are excluded. Case managers are required to contact Wyoming Medicaid to determine if the requested modification is covered under the Medicaid State Plan and sign a third party verification form indicating that the Community Choices Waiver is the payer of last resort. Environmental modifications shall not be furnished to modify settings that are owned or leased by providers of waiver services.

The case manager shall not obtain quotes until the overall scope of the project is approved by the Division.

The Division may use a third party to conduct an on-site visit to assess the proposed modification and need for the modification to ensure cost effectiveness.

If environmental modifications are made as part of a participant's transition out of a nursing facility, the service is not considered complete, and cannot be submitted for payment, until the first day the individual receiving services is discharged from the nursing facility and is a current CCW participant.

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* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Home Delivered Meals	Hot	S5170 SE	$10.65	1 Meal
	Frozen	S5170	$7.88	

Home-delivered meals services comprise hot or frozen meals that are delivered to the home of the participant when the participant is unable to prepare their own meal and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities. Meals provided under this service will meet the standards for the nutritional services delivered under Title III of the Older Americans Act.

Hot meals are defined as ready-to-eat meals that are delivered on a daily or semi-daily basis by the meal provider. If, during the course of delivering the meal the provider notes concerns with the participant's well-being, the provider must report the concerns to the participant's case manager and, if necessary, the Division as an incident.

Frozen meals are defined as meals that are prepared and packaged on a commercial basis, and delivered in bulk through a mail or delivery service.

Exclusions and Limitations

This service is limited to two meals per day. Meals provided as part of these services shall not constitute a full nutritional regimen and are not intended to serve as the sole source of nutrition for the participant. If food insecurity is identified as a risk on the participant's assessment, the service plan must address how the participant's additional dietary needs are being met. Hot meals cannot replace or duplicate meals provided as part of another waiver service or meals for which the participant has already paid as part of the room and board paid to a residential provider.

Providers must meet the standards established in the Community Choices Waiver agreement. Reimbursement is limited to the following provider types:

- Commercial food service operators licensed or permitted by the state in which the commercial food service preparation facility is located.
- An agency overseen by the Wyoming Department of Health, Division of Aging as credible and capable to receive grants for Older Americans Act nutritional services pursuant to W.S. 9-2-1204(a)(vii).

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* Please note that Prior Authorization is required for Waiver Services			
Service	**Code**	**Rate**	**Unit**
Home Health Aide	T1004	$10.36	15 Minute

Home Health Aide Services include part-time or intermittent assistance with personal care and other daily living needs that is within the scope of practice and required to be delivered by a Certified Nurse Aide (CNA) under the Wyoming Nurse Practice Act.

HCBS home health aide services differ in nature and scope from Medicaid State Plan home health aide services. HCBS home health aide services are not limited to rehabilitative services, may be provided on a long-term basis, are not subject to a physician's review every 60 days, and may include general household tasks, such as meal preparation, grocery or personal needs shopping, and light housekeeping when those tasks are incidental to the personal care provided during the visit, the participant is unable to complete these tasks, and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities.

Home health aide services may be provided in the home or in the community when the participant requires assistance in order to participate in community activities or to access other services. The participant must be present during the delivery of home health aide services.

Exclusions and Limitations

Home health aide services may not duplicate those available through the Medicaid State Plan, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage, Individual Educational Plan (IEP), or other funding sources. Incidental chore-type service tasks shall not comprise the entirely of this service. Home health aide and personal support services may both be present on a participant's service plan, but the services may not be provided at the same time.

Home health aide services do not include companionship or other services which are diversional or recreational in nature. Participant transportation costs are not associated with the provision of home health aide services and must be billed separately.

Reimbursement is limited to home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must be a Nursing Assistant or Nurse Aide certified by the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].

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* Please note that Prior Authorization is required for Waiver Services			
Service	**Code**	**Rate**	**Unit**
Homemaker Services	S5130	$6.49	15 Minute

Homemaker services consist of chore-type activities and routine household care that is not covered by Personal Support (PSS) or Home Health Aide Services, and is otherwise considered a non-direct services. Homemaker is not a direct care service as providers do not prompt or assist the participant in the completion of a task, and the participant is not required to be present when the service occurs.

Examples of covered tasks include but are not limited to meal preparation, shopping for groceries and personal items, laundry and ironing, and household cleaning to include regular home maintenance and more involved cleaning tasks such as cleaning appliances and washing windows. All tasks must be completed for the benefit of the participant.

Exclusions and Limitations

A maximum of three (3) hours per week per household (624 units per year) is allowed. A provider of Homemaker Services shall not bill for two participants during the same time frame.

Homemaker Services cannot duplicate incidental chore-type services provided during Home Health Aide or Personal Support Services. If Homemaker is added to a participant's service plan, the case manager must identify if PSS or Home Health Aide are also included. If Homemaker and PSS or Home Health Aide are listed on the participant's plan, the case manager must indicate how services provided through Homemaker will be different from the chore services associated with PSS or Home Health Aide. A Benefits and Eligibility Specialist (BES) will manually review all service plans containing Homemaker Services. The BES will review the information included in the service plan, and work with the case manager if additional clarification is needed or concerns are noted.

Home health agencies delivering this service must be licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must meet the training requirements established by the Aging Division's Rules and Regulations for Home Health Agency Administration.

* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Non-Medical Transportation	Public Transit Multi-pass	T2003	Variable	Per Purchase
	Service Route	A0120	$4.34	One way trip
	Wheelchair Accessible Vehicle	A0130	$9.75	
	Non Wheelchair Accessible Vehicle	T2004	$6.20	

Non-medical transportation includes participant transportation services offered in order to enable waiver participants to access waiver and other community services, activities and resources, as specified by their service plan.

This service supplements and does not supplant transportation offered through the participant's natural support system, or medical transportation services required under 42 CFR §431.53 or the Medicaid State Plan. Whenever possible, participants must utilize entities that provide this service without charge. Some examples may include family, neighbors, friends, community agencies, or other natural supports.

Exclusions and Limitations

The reimbursement for this service is limited to a total of $80.00 per month for multi-pass purchases, or 18 one way trips per month. Charges must be based on the participant's transportation needs, and not solely on the vehicle being used.

Reimbursement is limited to the following provider types:

- Public transit agencies determined by the Wyoming Department of Transportation as eligible to receive public transit funds in accordance with W.S. 24-15-101(a)(iii).
- Eligible senior centers as established by W.S. 9-2-1201(a)(iii) and overseen by the Wyoming Department of Health, Division of Aging as credible and capable to receive grants for Older Americans Act services pursuant to W.S. 9-2-1204(a)(vii).
- Contract motor carriers, which must be corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State and authorized as intrastate operating authorities through the Wyoming Department of Transportation, pursuant to W.S. 31-18-101(ii)..

* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Personal Emergency Response System (PERS)	Landline installation	S5160	$63.09	Per installation
	Cellular installation	S5160 CG	$63.73	
	Landline monitoring	S5161	$32.01	Monthly
	Cellular monitoring	S5161 U4	$41.73	

Personal Emergency Response Systems (PERS) include electronic devices that are programmed to signal a response center once a help button is activated and enable the participant to secure help in an emergency.

The monthly monitoring service includes equipment rental and maintenance; access to a 24 hour response center monitored by live, professional staff; equipment testing and troubleshooting; responses to alerts and alarms; and documentation of communications with participants, caregivers, case managers, and first responders.

The installation service is billed separately and includes the delivery, installation, and activation of all necessary equipment,as well as participant and caregiver education and training on equipment use.

Exclusions and Limitations

PERS is limited to participants who demonstrate needs based criteria for the service, including participants who:

- Live alone;
- Live with others who are unable to summon help; or
- Are alone for significant portions of the day, have no regular caregiver for extended periods of time, and would otherwise require routine supervision.

A provider can only be reimbursed for one installation per participant unless otherwise warranted by extenuating circumstances (e.g. the participant moves or a lost or stolen devices). Monthly monitoring will only be reimbursed for systems that are operational. Reimbursement for installation fees for the repair or replacement of equipment may not be granted if there has been abuse or misuse of the equipment or if the repair or replacement is sought before the equipment's ordinary life cycle.

Reimbursement is limited to PERS vendors.

* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Personal Support Services	Agency Based	S5125	$8.91	15 Minute
	Participant Directed	S5125 U5	$3.80	

Personal support services include part-time or intermittent personal support assistance to enable participants to accomplish activities of daily living, such as eating, bathing, grooming, dressing, using the restroom, and functional mobility tasks that they would normally do for themselves if they did not have a disability. Personal support assistance may take the form of hands-on assistance (actually performing a task for the person) or prompting the participant to perform a task.

Personal support services may also consist of general household tasks when those tasks are incidental to the personal support service being provided during the visit, when the participant is unable to manage the home and care for themselves, and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities. However, incidental chore type tasks shall not comprise the entirety of this service.

Personal support services may be provided in the home or in the community when the participant requires assistance with activities of daily living in order to participate in community activities or to access other services. The participant must be present during the delivery of personal support services.

This service may be participant-directed.

Exclusions and Limitations

Personal support services may not duplicate those available through the Medicaid State Plan, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage, other waiver services, or other funding sources. Incidental chore-type service tasks shall not comprise the entirely of this service. Personal support and home health aide services may both be present on a participant's service plan, but the services may not be provided at the same time.

Personal support services may not include companionship or other services which are diversional or recreational in nature. Participant transportation costs are not associated with the provision of personal support services and must be billed separately.

Personal support assistance delivered by non-licensed or non-certified employees of a home health agency is limited to prompting the participant to perform activities of daily living and may not include hands-on assistance.

Reimbursement is limited to the following provider types:

- Home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must meet the training requirements established by the Aging Division's Rules and Regulations for Home Health Agency Administration.

- Participant-directed employees hired under the participant-directed service delivery option.

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* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Respite	In Home	S5150	$10.36	15 Minute
	Assisted Living Facility	S5151	$80.38	Daily
	Skilled Nursing Facility	H0045	$185.09	

Respite includes short-term services provided to participants who are unable to care for themselves and need support because of the absence or need for relief of the individuals who normally provide care for the participant.

In-home respite services may be provided in the participant's home or in the community when the participant requires assistance with activities of daily living in order to participate in community activities or to access other services. Out-of-home respite services may be provided in an assisted living or nursing care facility.

Exclusions and Limitations

Services are limited to the prorated equivalent of thirty (30) calendar days, which is defined as a period from 12am – 11:59pm per service plan year.

Respite services may not be authorized for the purpose of companionship or for purposes that are primarily diversional or recreational in nature. Participant transportation costs are not associated with the provision of respite services and must be billed separately.

Respite providers may not bill Respite Services for the purpose of providing relief to themselves or other CCW providers. Reimbursement does not include the costs for room and board except when provided as part of respite care furnished in an assisted living or nursing care facility.

Reimbursement is limited to the following provider types:

- Home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must be a Nursing Assistant or Nurse Aide certified by the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].
- Assisted living facilities licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xxii).

* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Skilled Nursing	Registered Nurse (RN)	T1002	$26.12	15 Minute
	Licensed Practical Nurse (LPN)	T1003	$18.86	

Skilled nursing includes part-time or intermittent skilled nursing care which is within the scope of practice and required to be delivered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) within their scope of practice as defined under the Wyoming Nurse Practice Act.

HCBS skilled nursing services differ in nature and scope from Medicaid State Plan skilled nursing services. HCBS skilled nursing services are not limited to rehabilitative services, may be provided on a long-term basis, and are not subject to a physician's review every 60 days.

Skilled nursing services may be provided in the home or in the community when the participant requires assistance in order to participate in community activities or to access other services in the community.

Skilled nursing services may only be added to the plan of care after the Utilization Management vendor approval letter has been received and uploaded into the plan of care. Referrals and claims billed for this service shall include the referring entity's NPI number.

Exclusions and Limitations

Skilled nursing services may not duplicate those available through the Medicaid State Plan, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage, Individual Educational Plan (IEP) or other waiver services. Services do not include 24-hour skilled care or private duty nursing services.

Skilled nursing services may not include companionship or other services which are diversional or recreational in nature. Participant transportation costs are not associated with the provision of skilled nursing services and must be billed separately.

Reimbursement is limited to home health agencies licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual providing the service must be a Registered Nurse or Licensed Practical Nurse with the Wyoming State Board of Nursing in accordance with the Wyoming Nurse Practice Act [W.S. 33-21-120 et seq.].

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* Please note that Prior Authorization is required for Waiver Services				
Service		**Code**	**Rate**	**Unit**
Transition Intensive Case Management	No Training Certificate	T2025	$12.25	15 Minute
	Training Certificate	T2025 UB	$12.86	

Transition Intensive Case Management is intended to assist individuals who are currently residing in nursing facilities who want to transition into the community. Transition intensive case managers must perform activities necessary to arrange for the individual to live in the community, and support participants in coordinating and facilitating the purchase of one-time, non-recurring expenses necessary for the participant to establish a basic household upon transitioning from an institutional setting to a community living arrangement. Activities must be documented and not overlap the scope of case management annual service planning or monthly monitoring services.

Exclusions and Limitations

This service is only available to participants during their transition from an extended nursing facility stay to the community, and is available to a participant once during their lifetime. Case managers may assist individuals with their community transition for no more than 180 calendar days while the individual is still residing in a nursing facility.

Transition Intensive Case Management shall not overlap with the scope of other Case Management services; therefore, duplicate billing is not allowed. This service is billed in 15 minute unit increments and must not exceed 160 units per participant.

Transition Intensive Case Management services are not considered complete, and cannot be submitted for payment, until the first day the individual receiving services is discharged from the nursing facility and is a current CCW participant.

Reimbursement is limited to the following provider types:

- Case management agencies, which are corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State.
- County Public Health Nursing agencies.

* Please note that Prior Authorization is required for Waiver Services			
Service	Code	Rate	Unit
Transition Setup Expenses	T2038	PA#	Per Event

Transition Setup expenses are one-time, non-recurring expenses necessary for a participant to establish a basic household, and support the participant to transition from an extended nursing facility placement to a community living arrangement.

To access the Transition Setup, a participant must demonstrate:

- A need for the coordination and purchase of one-time, non-recurring expenses necessary for them to establish a basic household in the community;
- A health, safety, or institutional risk; and
- Verification that other services or resources are not available to meet the need.

Allowable setup expenses include:

- Security deposits that are required to obtain a lease on an apartment or home.
- Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).
- Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.
- Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings.

Exclusions and Limitations

Transition setup expenses do not cover rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes. Transition Setup does not include payment for room and board. Markups on equipment or other items or services shall not be paid through this service.

Transition Setup expenses are allowable only to the extent that they are reasonable and necessary as determined through the service plan development process, that they are clearly identified in the service plan, and that there is demonstration that the participant is unable to afford the expense or find payment through other sources, such as local and state government programs, food banks, senior centers, or charitable organizations.

Transition setup expenses must not exceed a total of $2,500 per participant, unless otherwise authorized by the Division, and must be prior approved in the participant's service plan. The Division may authorize additional funds above the $2,500 limit, not to exceed a total value of $3,000, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the participant.

This service is only available for 180 calendar days prior to a participant transitioning from an extended nursing facility stay to the community, and is available to a participant once during their lifetime. Transition services are not available to a participant who is transitioning to a provider owned or controlled setting.

Transition Setup Expenses are not considered complete, and cannot be submitted for payment, until the first day the individual receiving services is discharged from the nursing facility and is a current CCW participant.

Reimbursement is limited to the following provider types:

- Case management agencies, which are corporations, limited liability companies (LLC), non-profit organizations, sole proprietorships, or other business entities registered in good standing with the Wyoming Secretary of State.
- County Public Health Nursing agencies.