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

COMPREHENSIVE AND SUPPORTS WAIVER SERVICE INDEX

Effective April 1, 2024

PARTICIPANT DIRECTED SERVICES AVAILABLE
Child Habilitation
Community Living Services (excluding Host Home)
Companion
Homemaker
Individual Habilitation Training
Personal Care
Respite
Supported Employment (excluding Group Supported Employment)

Table of Contents

Adult Day Services 5
Behavioral Support Services 7
Case Management 9
Child Habilitation Services *(May be participant-directed)* 13
Cognitive Retraining 15
Community Living Services (May be participant-directed) 17
Community Support Services 22
Companion Services *(May be participant-directed)* 24
Crisis Intervention Support 26
Dietician Services 27
Environmental Modification 28
Homemaker Services *(May be participant-directed)* 29
Individual Habilitation Services *(May be participant-directed)* 30
Occupational Therapy 31
Personal Care Services *(May be participant-directed)* 32
Physical Therapy 35
Respite Services *(May be participant-directed)* 36
Skilled Nursing Services 38
Specialized Equipment 40
Speech, Language, and Hearing Services 42
Supported Employment *(May be participant-directed)* 43
Transportation Services 46

Division of Healthcare Financing Service Requirements

The home and community-based Supports and Comprehensive Waiver (DD Waiver) services defined in this document shall be performed in the manner described in the service definitions. Services must meet each participant's assessed needs. Certified DD Waiver providers and case managers must be knowledgeable of the Department of Health's Medicaid Rules affecting DD Waiver programs.

Prior authorization is required for waiver services. Each service, in combination with other services included in an individualized plan of care (IPC), must fit within the individual budget amount (IBA) assigned to each participant. The IPC must account for services to cover the entire plan year. The Division of Healthcare Financing (Division) will adhere to service caps identified in service definitions. 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. Daily rates are not available through participant-direction. The Employer of Record must ensure that all participant-directed services fit within the participant-directed budget, and must cover the entire plan year.

For the purposes of these service definitions, a relative is defined as a biological, adoptive, or step parent. Relatives, spouses, and legally authorized representatives are prohibited from providing participant-directed services. Additionally, legally authorized representatives are prohibited from providing waiver services, with the exception of personal care services for an individual under the age of 18, as established in the personal care service definition.

Many of the services offer an agency and independent billing rate. In order to qualify for the agency rate, the agency must, at a minimum:

- Employ one or more individuals other than themselves;
- Attain and maintain a Division certification for the service; and
- Demonstrate the legal payment of employee compensation (e.g., IRS Form 1096 that proves the issuance of one or more Form 1099, IRS Form W-3 that proves the issuance of one or more Form W-2) upon request.

Habilitation services, which require training on objectives as part of the provision of services, include the following:

- Child habilitation services
- Community living services (all levels, including host home)
- Community support services
- Individual habilitation services
- Supported employment services

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

- Case Management
- Dietician
- Occupational and Physical Therapy
- Skilled Nursing
- Speech, Language, and Hearing

As of January 1, 2017, 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 the DD Waivers shall maintain a single NPI that is associated with the Home Care Services Unit (HCSU) within the Division. The FMS is not required to obtain a second NPI to process DD claims.

Adult Day Services							
Agency Provider				Independent Provider			
Service	Code	Rate	Unit	Service	Code	Rate	Unit
Basic	S5100	$2.78	15 Minute	Basic	S5100	$2.58	15 Minute
Intermediate	S5100 UA	$3.91		Intermediate	S5100 UA	$3.59	
High	S5108	$6.73		High	S5108	$6.18	

Adult Day Services (ADS) consist of meaningful daytime activities that maximize or maintain a participant's skills and abilities; keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, and maintain personal skills; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; or build on previously learned skills. ADS provides active, person-centered supports that foster independence as identified in the participant's IPC.

ADS includes personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by unlicensed, DHCF certified direct support professionals. Personal care must not exceed 20% of the provided service.

ADS may be provided in the participant's home if the participant or legally authorized representative and the plan of care team decides the home is a more appropriate place to receive the service and the IPC supports the medical, behavioral, or other reason for the service to be provided in the participant's home. The participant and legally authorized representative must have a choice in where and how the service will be received, and this choice must be documented in the participant's IPC. Documentation must demonstrate that opportunities for community integration, support for employment, and social interactions are still incorporated in the participant's life. Transportation is a component of adult day services and is included in the rate to providers.

As authorized in 42 U.S.C 1396a(h), this service may be provided in an acute care hospital if the services are:

- Identified in the participant's IPC;
- Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
- Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

A participant receives a tiered service approved in the IPC based upon need, according to the following tier descriptions:

Return to Table of Contents

Basic Level of Care

A participant with a Level 1 or 2 Level of Service (LOS) score will generally be in this tier. This service tier requires limited staff supports for, and personal attention to, a participant due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are onsite and available within hearing distance. This service may be provided through virtual supports.

Intermediate Level of Care

A participant with a Level 3 or 4 LOS will generally be in this tier. Service tier requires full-time heightened supervision with staff available as indicated in the IPC due to significant functional limitations, medical or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing environment. Regular personal attention is given throughout the day for personal care, reinforcement, community, or social activities. This service may be provided through virtual supports.

High Level of Care

A participant with a Level 5 or 6 LOS will generally be in this tier. Service tier requires full-time supervision with staff available within close proximity and as indicated in the IPC. Frequent staff interaction and personal attention for significant functional limitations and medical or behavioral needs is provided. Support and supervision needs are moderately intense, but can still generally be provided in a shared staffing environment unless otherwise specified in the IPC. Frequent personal attention is given throughout the day for reinforcement, positive behavior support, personal care, community, or social activities.

Scope and Limitations

ADS is available to individuals who are 18 years of age or older. ADS must not duplicate or replace services covered under IDEA. Evidence demonstrating that school district services have been exhausted must be submitted for participants under the age of 21. ADS is not a habilitation service.

Approved units will be based on the participant's needed level of support and must fit within the assigned budget. ADS is billed as a 15 minute unit.

A relative provider (defined as a biological, adoptive, or step parent) may provide ADS subject to compliance with Chapter 45, Section 31 of Wyoming Medicaid Rules. ADS must not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but cannot comprise the entirety of the service. Personal care services must not be billed at the same time as this service. Participants who receive ADS cannot be paid for work activities performed during this service.

A participant shall not receive a service tier that is higher than the tier level associated with their level of service score. A participant's IPC may include two or more types of non-residential services as long as service times do not overlap. (Comp) Non-residential services must not exceed an average weekly amount of 35 hours if the participant receives Community Living Services levels 3-6.

Return to Table of Contents

Behavioral Support Services			
Service	**Code**	**Rate**	**Unit**
BCBA Level	97151	$32.27	15 Minute
BCaBA Level	97152	$20.56	
RBT Level	97153	$19.23	

Behavioral Support Services are used to develop and implement individualized behavior plans based on behavioral sciences that focus on positive behaviors and identified challenges to improve a variety of well-defined skills. This service includes development of a functional behavior analysis, positive behavior support plan, training in appropriate expression of emotions and desires through the implementation of positive behavior support, and interventions to increase adaptive replacement behaviors. Behavioral Support Services can also be accessed for the purpose of reducing the use of restrictions and restraints within a participant's current IPC.

Definitions:

- BCBA – Board Certified Behavior Analyst
- BCaBA – Board Certified Assistant Behavior Analyst
- RBT – Registered Behavior Technician

Activities required for reimbursement:

- Direct contact and observation with the participant (and collaterals as necessary) for the purposes of baseline determinations and positive behavior support plan (PBSP) development, which must comply with Chapter 45, Section 17 of Wyoming Medicaid Rules.
- Completing a functional behavior analysis and developing a PBSP and subsequent revisions utilizing positive behavior supports and interventions.
- Conducting participant training to support effective implementation of an individual's desired outcomes through comprehensive Positive Behavior Support.
- Creating templates and providing training and technical assistance with primary caregiver(s) on the implementation of the participant's PBSP.
- Documenting work completed, including case notes on training provided to primary caregivers and participants.
- Regularly reviewing the effectiveness of the PBSP with the participant and team.
- Generating summary documents to include baseline data regarding the behaviors, any progress has been made, intervention strategies have been implemented, and identified barriers that may inhibit progress

Scope and Limitations

Behavioral Support Services are available for participants who are 21 and older. Participants under the age of 21 can access this service through early education programs, school programs, and the Medicaid State Plan (for individuals with an Autism diagnosis).

Behavioral Support Services require a service request form, are subject to prior authorization by DHCF, and are not be covered under any billable service through the Medicaid State Plan.

Return to Table of Contents

A maximum of 120 units per plan year are available at the BCBA/BCaBA levels for initial assessment, completion of a functional behavior analysis, and PBSP development. A maximum of 960 units per year are available at the RBT level for measurement assessment, skill acquisition, behavior reduction, and documentation and reporting.

Documentation must be submitted to substantiate the need for continued Behavioral Support Services on subsequent plans as this service isn't meant to be a continuous long term service.

Activities that are not allowed under this service:

- Aversive techniques or any other technique not approved by the participant's person centered planning team and the provider's human rights committee, if applicable.
- Restrictive interventions described in Chapter 45 of Wyoming Medicaid Rules.
- Direct care services.
- Counseling, therapy, or other services covered under the Medicaid State Plan.

Relative providers (defined as biological, step, or adoptive parents) cannot provide this service.

Provider Qualification Note

A provider of behavioral support services shall follow the requirements and certifications established by the Board of Certified Behavior Analysts, per **https://www.bacb.com**, in order to provide behavioral support services. Each individual providing this service must meet the certification standards for the service that is being provided.

Return to Table of Contents

Case Management

Service	Code	Rate	Unit
Case Management	T2022	$341.67	Monthly
Case Management	T1016	$21.36	15 Minute
Case Management – Certificate Tier	T2022 UB	$358.75	Monthly
Case Management – Certificate Tier	T1016 UB	$22.43	15 Minute
Targeted Case Management	T2023	$8.00	15 Minute

Case Management is a required service that is intended to 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.

Case managers are responsible for conducting the following functions:

- Assessing and reassessing a participant's need for waiver services;
- Initiating a participant's level of care evaluation and re-evaluation process;
- Linking a participant to other federal, state, and local programs;
- Providing choice of services and providers;
- Developing person centered IPCs in accordance with DHCF policies and procedures;
- Coordinating multiple services and providers;
- Coordinating participant transitions between providers, services, and settings;
- Monitoring the implementation of participant's PCs in accordance with Chapter 45 and 46 of Wyoming Medicaid Rules;
- Monitoring the participant's IBA to assure that services are provided within the IBA, and addressing identified concerns;
- Verifying with applicable providers that they are in compliance with EVV requirements;
- Monitoring participant health and welfare, and addressing identified concerns;
- Responding to participant crises;
- Conducting semi-annual service observations of each non-habilitative service received;
- Conducting quarterly service observations of each habilitation service received, and
- When a participant chooses the participant-directed service delivery model:
    - Completing referral forms and submit all required information to the Financial Management Services Agent (FMS);
    - Interacting with the FMS to assist participants with enrollment in participant-direction;
    - Assisting the employer of record (EOR) with completing employee paperwork, and addressing questions or issues that arise.

Monthly Requirements

Each month, the case manager must:

- Maintain direct contact with the participant and legally authorized representative (if applicable), which may include the visit to the participant's place of residence, service observations, and virtual or in-person interactions.
- Follow-up on concerns or questions raised by the participant, legally authorized representative, or plan of care team, or identified through incident reports, complaints, or service observations.
- Review service utilization and documentation of traditional and participant-directed services to assure the amount, frequency, and duration of services is appropriate.

- Monitor and evaluate the positive behavior support plan, as applicable, and complete follow-up on concerns.
- Evaluate the use of restraints and complete follow-up on concerns.
- When a participant chooses the participant-directed service delivery model, use the FMS portal to review provider time sheets, determine budget usage, and provide ongoing monitoring of the participant's budget, and report improper budget usage to the assigned DHCF staff member.

Billable Activities

A billable case management activity is any task or function defined by DHCF as an activity that only the case manager or case management agency can provide to, or on behalf of, the participant or legally authorized representative. Billable time may be cumulative during the span in which a case manager bills. The monthly case management review must be completed prior to billing for services, and must be submitted by the 10th business day of the month following the month that the services were rendered.

Billable case management services include:

- Plan development;
- Plan monitoring and follow-up, including documentation review;
- Second-line medication monitoring;
- Service observations and interviews;
- Visits to the participant's place of residence;
- Team meetings;
- Participant specific training;
- Face to face meeting with participants, legally authorized representatives, and family;
- Advocacy and referral;
- Crisis intervention and management;
- Coordination of natural supports;
- Offering and discussing choice;
- Completing monthly responsibilities;
- DHCF required reporting; and
- Quarterly meetings with the back-up case manager.

Non-billable activities include:

- Ancillary activities, such as mailing, copying, filing, faxing, drive time, or supervisory/ administrative activities. The administrative costs of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.
- Time spent with the participant or guardian for social reasons, unless billable case management activities are also occurring. Incidental contact and social exchanges are part of conducting and building a business and offering customer service, and are not considered a case management service by the Centers for Medicare and Medicaid Services (CMS).
- Time spent acquiring continuing education units.
- Travel time, which has already been included as part of the rate for the service.
- Time spent when a participant is incarcerated or in a state institutional facility.

Scope and Limitations

Case management is available as a 15-minute unit or a monthly unit. Monthly and 15-minute units shall not be billed for the same participant in the same month.

Monthly Unit

The monthly unit may only be billed on or after the last day of the month. A minimum of two hours of billable services must be documented in order to bill, but all billable services must be documented each month.

- A monthly visit to the participant's place of residence, with the participant present, is required to monitor the participant's health and welfare, discuss satisfaction with services, and identify needed changes to the IPC.
- At least one hour of person to person contact with the participant or legally authorized representative is required.

15 Minute Unit

The rate for the 15 minute unit is based on the same methodology as the monthly unit, and allows for an average of four (4) hours per month of case management to be billed.

- One unit a month of case management must be provided each month to discuss participant satisfaction and address any needs or concerns.
- Units must be used based on the needs of the participant or legally authorized representative, up to the amount approved in the IPC.
- The number of units on the IPC may not exceed 224 units annually.
- Monthly visits to the participant's place of residence are required if a participant receives community living services. The participant must be present during the visit.
- Quarterly visits to the participant's place of residence are required if a participant does not receive community living services. The participant must be present during the visit.
- A case manager may complete additional visits to the participant's place of residence during times of crisis or when requested by the participant or legally authorized representative.

Conflict Free Case Management

In order for a case manager to have the authority to develop, implement, and monitor IPCs in the best interest of the participant, the case manager must not have a conflict of interest. To address conflicts of interest, DHCF has implemented exclusions for case managers, which are outlined in Chapter 45 of Wyoming Medicaid Rules. Relatives (defined as biological parents, step parents, or adoptive parents) and legally authorized representatives, must not provide case management services. Additionally, case managers must not serve participants to whom they are related by blood or marriage within the third degree. Relationships within the third degree include the spouse; mother, father, sister, or brother in-law; children (including step and adoptive); siblings; grand and great grandparents; and aunts, uncles, nieces or nephews.

DHCF may establish caseload limits to ensure the case manager effectively coordinates services with all participants on their caseload.

Targeted Case Management

Targeted Case Management (TCM) allows a case manager to be paid for the time that they spend working with a new waiver applicant. This service may be used while an applicant is applying for the waiver and after they have been placed on the waiting list. A targeted case manager may bill for up to 120 fifteen

minute units of TCM per 12 month time period for new applicants. A case manager may provide and bill for the following functions:

- **Gathering Information**: Completing the level of care screening (LT104) and assisting the individual to gather necessary documentation, such as the ICAP assessment, medical records, psychological or neuropsychological assessment, etc. to enable the Division to determine eligibility.
- **Linkage:** Working with individuals and service providers to secure access to services. Activities include making telephone calls to agencies to arrange for appointments, or services following the initial referral process, and preparing new applicants and their families for these appointments.
- **Monitoring/Follow up**: Contacting the individual or others to ensure a new applicant is moving through the eligibility process, is still interested in pursuing a waiver spot, and that all demographic information is up to date in EMWS on an ongoing basis. It is expected that, while the applicant is on the waiting list, contact is made with some regularity to ensure that the applicant's needs are being met.
- **Referral:** Arranging initial appointments for individuals with service providers, informing individuals of services available, and providing addresses and telephone numbers of agencies and service providers.
- **Advocacy:** Providing advocacy for a specific person for the purpose of accessing needed services.
- **Crisis Intervention:** Providing crisis intervention and stabilization in situations requiring immediate attention or resolution for a specific individual
- **Direct service such as transportation is NOT a billable service.**

Case Manager Responsibilities for Institutional Placements

Case managers supporting a participant who is placed in the Wyoming State Hospital or Wyoming Life Resource Center must work with the assigned Benefits and Eligibility Specialist for that participant to understand the case manager's role in supporting the participant, as well as the documentation that will be required in order to bill for services during the institutional placement of the participant. It is the expectation that the case manager will continue to follow and monitor the participant while they are in the institutional placement.

Return to Table of Contents

Child Habilitation Services *(May be participant-directed)*							
Agency Provider				**Independent Provider**			
Service	**Code**	**Rate**	**Unit**	**Service**	**Code**	**Rate**	**Unit**
Ages 0 – 12	T2027 HA	$4.15	15 Minute	Ages 0 – 12	T2027 HA	$3.65	15 Minute
Ages 13 – 17	T2027	$4.15		Ages 13 – 17	T2027	$3.91	

Child Habilitation Services provide regularly scheduled activities and supervision to children for a portion of their day. Services include training, coordination, and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management. This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children. This service excludes any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA).

Services may be provided at various times of the day in multiple settings, when other waiver services would not be more appropriate, such as Respite or Personal Care. Service may occur in a single physical environment or in multiple environments, including settings in the community.

For children ages 0-12, this service includes the provision of supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting. This service does not include the basic cost of child care, which is the rate charged by and paid to a child care center or worker for children who do not have special needs.

For children ages 13-17, this service is available for the cost of child care, which is no longer required after age 12. Transportation is included in the reimbursement rate.

Scope and Limitations

Child Habilitation Services are limited to children under age 18. On the Comprehensive Waiver, there is an annual cap of 9,400 units a year. Approved services must be based on assessed need and fit within the participant's assigned budget.

A provider of Child Habilitation Services may receive reimbursement for up to two (2) participants at one time, but must limit the total combined number of people to whom they are providing services to no more than three, unless approved by DHCF. The provider must adhere to the supervision levels identified in each participant's IPC.

A relative provider (defined as a biological, adoptive, or step parent) cannot provide this service. Child Habilitation Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but may not comprise the entirety of the service. Personal Care Services cannot be billed at the same time as Child Habilitation Services.

Return to Table of Contents

This service is subject to electronic visit verification.

Return to Table of Contents

Return to Table of Contents

Cognitive Retraining			
Only available to participants with an ABI	**Code**	**Rate**	**Unit**
	H2014	$13.57	15 Minute

Cognitive retraining provides training and rehabilitation services to the participant and family members that assists in the restoration of cognitive function (e.g. ability or skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the IPC. This service is specifically for individuals with an acquired brain injury (ABI), who meet the clinical eligibility diagnosis criteria outlined in Chapter 46 of the Department of Health Wyoming Medicaid Rules.

Activities include:

- Direct contact and observation with the participant (and collaterals as necessary) for the purposes of baseline determinations and treatment plan development. Treatment may focus on safety in the community, interacting with others, initiation and goal setting and money management skills. Vocational evaluation and training may also be a component of this service.
- Conducting participant training to support effective implementation of an individual's desired outcomes. Training generally focuses on developing higher level motor, social, and cognitive skills in order to prepare and support the participant to return to independent living and potentially to work.
- Creating templates and providing training and technical assistance with primary caregiver(s) on the implementation of the participant's treatment plan.
- Documenting work completed, including case notes on training provided to primary caregivers and participants.
- Regularly reviewing the effectiveness of the treatment plan with the participant and team.
- Generating summary documents to include baseline data, progress made, intervention strategies that have been implemented, and identified barriers that may inhibit progress.

Scope and Limitations

Cognitive Retraining Services are available for participants who are 21 and older and have an acquired brain injury.

Documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) must be maintained in the case manager and provider file. A third party liability form may be required by DHCF.

A maximum of 520 units per plan year are available. Documentation must be submitted to substantiate the need for continued Cognitive Retraining Services on subsequent plans as this service isn't meant to be a continuous long term service.

Activities that are not allowed under this service:

- Aversive techniques or any other technique not approved by the participant's person centered planning team.
- Restrictive interventions described in Chapter 45 of Wyoming Medicaid Rules.
- Direct care services.
- Counseling, therapy, or other services covered under the Medicaid State Plan.

Return to Table of Contents

Relative providers (defined as biological, step, or adoptive parents), spouses, and legally authorized representatives cannot provide this service.

Community Living Services (May be participant-directed) *(Only Basic Level Services are available on the Supports Waiver)*							
Agency Provider				**Independent Provider**			
Service	**Code**	**Rate**	**Unit**	**Service**	**Code**	**Rate**	**Unit**
Basic - Individual	T2017	$9.41	15 Minute	Basic - Individual	T2017	$8.84	15 Minute
Basic – Group of 2	T2017 UN	$5.24		Basic – Group of 2	T2017 UN	$4.74	
Basic – Group of 3	T2017 UP	$3.86		Basic – Group of 3	T2017 UP	$3.52	
Basic	T2031	$152.66	Daily	Basic	T2031	$136.33	Daily
Level 3	T2016	$161.71		Level 3	T2016	$144.41	
Level 4	T2016 U7	$198.22		Level 4	T2016 U7	$177.01	
Level 5	T2016 U6	$289.75		Level 5	T2016 U6	$258.75	
Level 6	T2016 U5	$495.18		Level 6	T2016 U5	$442.21	
				Host Home	T2016 UD	$260.11	
Participant Direction (Level 3 – 6)	T2017 UC		15 Minute	Participant Direction (Level 3 – 6)	T2017 UC		15 Minute

Community Living Services (CLS) are individually-tailored supports that assist the participant with the acquisition, retention, or improvement of skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living including medication assistance, light housekeeping, community inclusion, transportation, adult educational supports, and social and leisure skill development that assist the participant to reside in the most integrated setting appropriate for their needs. CLS includes personal care, protective oversight, and supervision as indicated in the IPC.

- CLS is reimbursed based on the participant's Level of Service (LOS) score, and includes some level of ongoing 24-hour support (e.g., 24-hour on-call support) by a provider, as defined in the level of service and outlined in the participant's IPC.
- A participant who lives in a setting that is owned or leased by a provider, the participant, or the participant's family may receive the level of CLS that aligns with their level of service score and can be supported by their IBA. A participant who is *living with their family* is only eligible to receive CLS - Basic to the extent that the service can be supported by their IBA.
- A participant who receives CLS must have one primary residence. CLS may be provided in the participant's primary residence or in other community settings the participant chooses.
- Provider owned or leased settings where CLS is furnished must be fully accessible to the participants living in that setting.
- With the exception of host homes, CLS may be delivered through participant-direction.
- Transportation between the participant's residence, other service sites, or places in the community is included in the rate.

- CLS is a habilitation service. This means training on objectives is expected as part of the provision of services, and the participant's progress must be documented and made available to the participant, legally authorized representative, and case manager each month.
- Participants are encouraged to take vacations and travel. If a participant takes a trip outside of CLS, the provider may be reimbursed on the days the participant leaves for and returns from that trip if they provide services to the participant on those days. If a participant takes a vacation while receiving CLS, the provider must adhere to all supervision and support requirements identified in the service definition and the participant's IPC. If service definitions and supervision levels cannot be met, case managers must work with the plan of care team to identify an alternative waiver or non-waiver service.
- Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and documentation of training is evident.
- Respite cannot be used to relieve a paid caregiver, including an independent CLS provider.
- Independent CLS providers must be able to demonstrate how they can provide the 24-hour support, which is outlined in the CLS definition, in the event they have competing priorities such as daytime employment.

As authorized in 42 U.S.C 1396a(h), CLS may be provided in an acute care hospital if the services are:

A. Identified in the participant's IPC;
B. Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
C. Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
D. Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Host Home

Host home services consist of participant specific, individually designed and coordinated services within a family (other than biological, step or adoptive parents) host home environment. Host homes differ from other community living settings by featuring one sponsor working with one participant living together in the sponsor's home. A sponsor must be an independent certified provider, and can only provide CLS services to one participant. The sponsor cannot employ staff, and cannot be a subcontractor. The sponsor assumes 24-hour care of the participant. Relative providers (defined as biological, step, or adoptive parents) cannot provide this service. Host home services cannot be participant-directed. This service is not open to new participants without going through the Extraordinary Care Committee (ECC) approval process for an out of home placement.

Tiered Levels

A participant receives a tiered service approved in the IPC based upon need, according to the following tiers descriptions. Tier levels for this service align with the participant's assessed LOS, and the expectations of the service as specified in the definition. All supervision and support must align with the participant's IPC, and meet the needs of each participant present as appropriate to assure health and safety.

Return to Table of Contents

Basic Level – Due to the participant's high to moderately high level of independence and functioning, and few significant behavioral or medical issues that require minimal staff support, monitoring, or personal care, this tier requires periodic face-to-face staff availability during awake hours on each day billed to provide general supervision, support, monitoring, and training. On-call 24-hour support is not required for this tier level, but a contingency plan for emergency situations must be outlined in the IPC. Personal care cannot exceed 20% of the provided service.

This service may be provided through virtual supports, as described below. The participant and legally authorized representative must have a choice in where and how the service will be received, and it must be documented in the participant's IPC. Documentation must demonstrate that opportunities for community integration, support for employment, and social interactions are still incorporated in the participant's life. If virtual support does not facilitate the wishes and desires of a participant, it is not an option.

Level 3 – Due to the participant's moderate functional limitations in activities of daily living, and possible behavioral support needs, this tier requires regular staff availability within hearing distance of the participant, and meeting periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, and training. Behavioral and medical supports are not intense and may be provided in a shared staffing setting. Staff support must be available through the night, and overnight expectations must be stipulated in the IPC.

Level 4 – Due to the participant's significant functional limitations and medical or behavioral support needs, this tier requires full-time staff to be available when the participant is in this service, with regular personal attention given throughout the day for training, personal care, reinforcement, positive behavior support, and community or social activities. Behavioral and medical supports are not generally intense and may be provided in a shared staffing setting. There must be staff support through the night as indicated in the IPC, and overnight expectations must be stipulated in the IPC.

Level 5 – Due to the participant's significant and somewhat intensive functional limitations and medical or behavioral support needs, this tier requires one or more full-time staff support to be in close proximity during most awake hours when the participant is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, and community or social activities. Behavioral and medical supports and personal care may be somewhat intense, but service may be provided in a shared staffing setting. There must be in-person staff support throughout the night, as indicated in the IPC. Participants who receive this service tier are not eligible for remote monitoring.

Level 6 – Due to the participant's high medical, behavioral, or personal care needs, this tier requires frequent personal support and supervision with full-time staff within immediate proximity during most awake hours. The expectation is that the participant will receive the personal attention of at least one staff person unless otherwise outlined in the IPC and approved by DHCF. Occasional 2:1 support is included in this rate, and must be specified in the IPC. There must be in-person staff support available to the participant through the night, as indicated in the IPC. Participants who receive this service tier are not eligible for remote monitoring.

Remote Monitoring

Remote monitoring, as specifically defined in the HCBS Waiver Remote Monitoring Requirements, may be utilized for supervision for individuals at the **Basic Daily Level, Level 3, or Level 4 tier**. Remote monitoring

will be based on an individual risk assessment and protocol, and as outlined in the IPC. Remote monitoring shall be reviewed by the Division prior to implementation. Providers and plan of care teams must follow all requirements and standards established in the HCBS Waiver Remote Monitoring Requirements document, which is located on the Services Definitions and Rates page of the HCBS Section website.

In order to consider remote monitoring as a support for the participant:

- The participant must have an informed choice between in person and remote support services.
- The participant must choose service delivery through remote monitoring, and that choice must be documented in the participant's IPC, and demonstrated through a signed consent form.
- Remote monitoring must fit within the scope and definition of the community living service being received.
- Remote monitoring must not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's IPC.
- The use of the remote monitoring option must not block, prohibit or discourage the use of in-person services or access to the community. Participants must be encouraged to engage with friends and family and actively participate in their community.
- If remote monitoring does not facilitate the wishes and desires of a participant, it is not an option.

Scope and Limitations

Participants must be at least 18 years old to receive CLS. Services must not duplicate or replace services covered under IDEA or through Department of Family Services programs.

Community living is a 24 hour service. The following requirement must be met in order for payment to be allowed:

- Basic daily rate – a minimum of 4 hours of documented service per calendar day. Providers are required to provide overnight and crisis support as indicated in the participant's IPC.
- Levels 3-6 daily rate – a minimum of 8 hours of documented provider support in a 24 hour period (from 12:00am-11:59pm) unless the participant is leaving for or returning from a vacation outside of waiver services. Providers are required to provide overnight support as indicated in the participant's IPC.

CLS basic services may be billed as a 15 minute unit for a maximum of 5,475 units per plan year for individual services, or for a maximum of 5,475 per plan year for group services. The 15 minute unit and daily rate cannot be billed for a participant on the same day.

Participants who choose remote monitoring as a supervision option must complete a risk assessment prior to utilization. Additional standards apply to providers that implement remote monitoring practices.

Participants who are not receiving CLS Levels 3-6, and who are at significant risk due to extraordinary needs that cannot be met in their current living arrangement, may request 24-hr CLS if the participant meets the definition of an emergency, as outlined in Chapter 46, Section 14 of Wyoming Medicaid Rules.

Support with personal care needs is a component of CLS, so service times for CLS and personal care services cannot overlap. Payment will not be made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. The method by which the costs of room and board are excluded from payment for CLS is specified in Appendix I-5 of this Application.

Return to Table of Contents

A relative provider (defined as the biological, adoptive, or step parent of a participant) may provide all components of this service as defined, but must form a Limited Liability Company (LLC) or a corporation,

Return to Table of Contents
be a certified provider or an employee of a certified provider, and must not reside in the same primary residence as the participant.

Return to Table of Contents

Community Support Services							
Agency Provider				Independent Provider			
Service	Code	Rate	Unit	Service	Code	Rate	Unit
Basic	T2021	$3.06	15 Minute	Basic	T2021	$2.83	15 Minute
Intermediate	T2021 U1	$4.60		Intermediate	T2021 U1	$4.25	
High	T2021 HB	$9.11		High	T2021 HB	$9.11	

Community Support Services (CSS) offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Services include activities designed to keep participants engaged in their environment, develop and maintain relationships, and build on previously learned skills. Services must be furnished in accordance with the participant's IPC and include full access to the community to the same degree as community members who do not receive HCBS. Supporting the participant in adult educational pursuits is an approved activity of this service.

CSS must be scheduled in settings separate from the participant's residence. Services must be furnished in a variety of settings in the community and cannot be limited to only fixed-site or congregate settings. Activities and environments must foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Transportation is a component of community support services and is included in the rate to providers.

CSS should focus on enabling the participant to attain or maintain their maximum functional level and should serve to reinforce skills or lessons taught in other settings, including skills learned during therapy services.

CSS is a habilitation service. Training on objectives is expected as part of the provision of services, and the participant's progress must be documented and made available to the participant, legally authorized representative, and case manager each month.

A participant receives a tiered service approved in the IPC based upon need, according to the following tier descriptions:

Basic Level of Care
A participant with a Level 1 or 2 Level of Service (LOS) score will generally be in this tier. This service tier requires limited staff supports for, and personal attention to, a participant due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The participant may have periods of time with indirect staff supervision where staff are available within hearing distance.

Intermediate Level of Care
A participant with a Level 3 or 4 LOS will generally be in this tier. Service tier requires full-time heightened supervision with staff available as indicated in the IPC due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community, or social activities.

Return to Table of Contents

High Level of Care

A participant with a Level 5 or 6 LOS will generally be in this tier. Service tier requires full-time supervision with staff available within close proximity and as indicated in the IPC. Frequent staff interaction and personal attention for significant functional limitations and medical or behavioral needs is provided. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the IPC. Frequent personal attention is given throughout the day for reinforcement, positive behavior support, personal care, community, or social activities.

Scope and Limitations

CSS is available for participants ages 18 and older. Services must not duplicate or replace services covered under IDEA. Evidence demonstrating that school district services have been exhausted must be submitted for participants under the age of 21.

Approved units must be based on the participant's needed level of support and must fit within the participant's assigned budget. CSS is reimbursed at a 15 minute unit.

The CSS high level of care tier is available to participants who want help building meaningful relationships and social connections in the community with a more individualized approach from the provider. A participant with any LOS score may add the high level of care tier for this service to their IPC for individual services with up to one other waiver participant where the entire time is spent solely in the community and not in a provider setting.

A relative provider (defined as a biological, adoptive, or step parent) may provide this service subject to compliance with Chapter 45, Section 31 of Wyoming Medicaid Rules. CSS must not be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency.

Support with personal care needs, including medication assistance, is a component of the service, but cannot comprise more than 20% of the service. Personal care services must not be billed at the same time as this service. Participants cannot be paid for work activities performed during this service.

A participant's IPC may include two or more types of non-residential services as long as service times do not overlap. Non-residential services must not exceed an average weekly amount of 35 hours if the participant receives Community Living Services levels 3-6.

Return to Table of Contents

Companion Services *(May be participant-directed)*							
Agency Provider				**Independent Provider**			
Service	**Code**	**Rate**	**Unit**	**Service**	**Code**	**Rate**	**Unit**
Individual	S5135	$8.51	15 Minute	Individual	S5135	$7.60	15 Minute
Group up to 3	S5135 TT	$3.49		Group up to 3	S5135 TT	$3.20	

Companion Services include supervision, socialization, and assistance for a participant to maintain safety in the home and community, and to enhance independence. Companions may assist or supervise the participant with tasks such as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. The provision of Companion Services does not entail hands-on nursing care, but does include personal care, such as medication assistance, and assistance with activities of daily living, as needed, during the provision of services. Routine transportation is included in the reimbursement rate.

As authorized in 42 U.S.C 1396a(h), CLS may be provided in an acute care hospital if the services are:

A. Identified in the participant's IPC;
B. Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
C. Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
D. Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Scope and Limitations

This service is available to participants ages 18 and up. It is reimbursed at a 15-minute unit and is available as a 1:1 service or as a group service 2 or 3 people. Service can be provided for no more than nine (9) hours a day except for special events or out of town trips. This service cannot be used to provide monitoring while a participant sleeps.

Companion Services provided to participants ages 18 through 21 must not duplicate or replace services that are covered under IDEA. Providers cannot serve children and adults at the same time unless authorized in advance by DHCF. Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit.

A participant’s IPC may include two or more types of non-residential services as long as service times do not overlap. Non-residential services must not exceed an average weekly amount of 35 hours if the participant receives Community Living Services levels 3-6.

Relative providers (defined as biological, adoptive, or step parents) cannot provide this service.

Return to Table of Contents

This service is subject to electronic visit verification.

Return to Table of Contents

Crisis Intervention Support

	Code	Rate	Unit
	H2011	$8.99	15 Minute

Crisis Intervention Services are available for situations in which a participant's tier level may not provide sufficient support for specific activities, medical conditions, or occurrences of behaviors or crisis, but extensive supervision is not needed at all times. Crisis Intervention provides funding for extra staff support in order to supervise a participant during times of periodic behavioral episodes when a participant is a danger to themselves or others, or if the participant has an occasional or temporary medically fragile situation and is at risk of imminent harm without the extra staff support. Intervention for behavioral purposes is not intended for monitoring the participant should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and interventions outlined in the IPC to de-escalate a situation, teach appropriate behaviors, and keep the participant safe until they are stable.

Scope and Limitations

Crisis Intervention can only be provided to a participant who is age 18 or older in a habilitation day service.

Crisis Intervention units are based on the participant's verified need and evidence of the diagnosis or condition requiring this service. Documentation of progress and data on behaviors and outcome of the intervention services must be submitted to the case manager and DHCF at the frequency specified in the IPC.

Relatives (defined as biological, adoptive, or step parents) cannot provide this service.

Return to Table of Contents

Dietician Services

	Code	Rate	Unit
	S9470	$31.47	Session

Dietician services shall be provided by a registered dietician, and include services such as menu planning, consultation with and training for caregivers, and participant education. The service does not include the cost of meals. This service shall be cost effective and necessary to prevent institutionalization.

Scope and Limitations

Dietician services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Dietician services are available on the Medicaid State Plan; therefore, the waiver service shall not be used unless the state plan services are exhausted. Dietician services shall be designated in the participant's IPC. Services shall be supported by a formal assessment completed by a registered dietician, and ordered by a licensed medical professional. Referrals and claims billed for this service shall include the referring entity's NPI number. A third party liability form shall be required.

Relative providers (defined as biological, adoptive, and step parents) shall not provide this service.

At least 30 minutes of service shall be provided per session in order to bill.

Return to Table of Contents

Environmental Modification

Service	Code	Rate	Unit
New	S5165 NU	PA#	Per Event
Repair	S5165		

Environmental modifications include functionally necessary physical adaptations to the participant's residence, as outlined in the participant's IPC, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. 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 needed for the welfare of the participant.

All services must be provided in accordance with applicable State and local building codes.

Scope and Limitations

A lifetime cap of $30,000 per family per any current or previous DHCF waiver will be calculated for purchases made after July 1, 2013. A request that addresses a critical health or safety need and exceeds the lifetime cap is subject to available funding and approval by the ECC.

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 entrance/egress to 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 must 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. The provider must then sign a third party verification form indicating that the Waiver is the payer of last resort. Environmental Modifications cannot be used to modify settings that are owned or leased by providers of waiver services.

Pursuant to Chapter 44 of Wyoming Medicaid Rules, the case manager should not obtain quotes until the overall scope of the project is approved by DHCF. DHCF 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.

Sale of environmental modifications cannot profit the participant or family.

Relative providers (defined as biological, adoptive, or step parents) may provide this service in accordance with Chapter 45 of Wyoming Medicaid Rules, and must adhere to the following requirements:

- They must be a certified Environmental Modification provider; and
- At least one other bid must be submitted to ensure cost effectiveness.

Return to Table of Contents

Homemaker Services *(May be participant-directed)*							
Service	**Code**	**Rate**	**Unit**	**Service**	**Code**	**Rate**	**Unit**
Agency Provider	S5130	$6.62	15 Minute	Independent Provider	S5130	$6.62	15 Minute

Homemaker services consist of chore-type activities such as meal preparation and routine household care. Services are available when the individual who is regularly responsible for these activities is temporarily unavailable or unable to manage the home and care for him or herself or others in the home.

Examples of covered tasks include but are not limited to 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.

Homemaker is not a direct care service.

Scope and Limitations

A maximum of three (3) hours per week per household (624 units per year) is allowed. Relative providers (defined as biological, adoptive, and step parents) cannot provide this service.

This service is not available to participants who receive Host Home Services or CLS level 3-6.

- A provider of homemaker services shall not bill for two participants during the same time frame.

Return to Table of Contents

Individual Habilitation Services *(May be participant-directed)*							
Service	**Code**	**Rate**	**Unit**	**Service**	**Code**	**Rate**	**Unit**
Agency Provider	T2038	$8.34	15 Minute	Independent Provider	T2038	$7.49	15 Minute

Individual Habilitation Training is a specialized 1:1 intensive training service to assist a participant with the acquisition or improvement in skills that will lead to more independence and a higher level of functioning. Individual Habilitation Training services are available for participants who live with unpaid caregivers or who need less than 24-hour paid supervision and support.

- Training objectives are required, must be meaningful to the participant, and may include: adaptive skill development; assistance and training on activities of daily living; transportation safety and navigation; building social capital and connections; and hobby skill development for work on fine or gross motor skills.
- Objectives must be specific and measurable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be provided to the case manager and participant or legally authorized representative monthly. Objectives must be revised as needed when skills are acquired or the objective is not yielding any progress.
- Services may be provided in the participant’s home, a provider setting, or in the community.
- Services may include supporting the participant to be included and involved in associations and community groups, and a broad range of community activities including opportunities to pursue social and cultural interests, choice making, and volunteering.
- Transportation relating to the participant's training objective must be provided by the service provider and is included in the rate for the service.
- This service includes services not otherwise available through IDEA or other public education programs in the participant’s local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children

Scope and Limitations

Individual Habilitation Training is an intensive training service; therefore, it is expected that training is occurring at all times this service is being provided. If the participant is unable to sustain intensive training, the IPC must identify an alternate service to be used during times in which supervision is provided but training is not conducted.

Individual Habilitation Training is a 1:1 service. It is available to participant’s ages 0 through 20, and must be provided based upon the participant’s needs and IBA. Individual Habilitation Training is limited to 4 hours a day. Individual Habilitation Training cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the State Medicaid Agency

Relative providers (defined as a biological, adoptive, or step parent) cannot provide this service.

Return to Table of Contents

Occupational Therapy

Service	Code	Rate	Unit
Individual	97139	$25.17	Session
Group	97150	$18.80	

Occupational Therapy (OT) Services consist of the full range of activities, which include assessing needs, developing a treatment plan, determining therapeutic intervention, and training and assisting with adaptive aids. OT Services through the waiver may be used for maintenance and the prevention of regression of skills.

Scope and Limitations

OT Services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units are subject to prior authorization and require a prescription and treatment letter or recommendation from a licensed medical professional. The referral and any claims billed for these services must include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy may be provided under the waiver, and must be supported with a third party liability form. Medicaid State Plan restorative therapy and waiver maintenance therapy cannot be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) cannot provide this service.

Services are available as an individual 15 minute unit or as a group session unit, which requires a minimum of 30 minutes in service in order to bill.

Return to Table of Contents

Personal Care Services *(May be participant-directed)*							
Service	**Code**	**Rate**	**Unit**	**Service**	**Code**	**Rate**	**Unit**
Agency Provider	T1019	$8.25	15 Minute	Independent Provider	T1019	$7.36	15 Minute

Personal Care Services (PCS) consist of a range of assistance to enable participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may include hands-on assistance or prompting the participant to perform a task. PCS may be provided on an episodic or on a continuing basis. Health-related services that may be provided include care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical professional, and documentation of training is evident.

PCS may include assistance in performing activities of daily living (ADLs) (e.g., bathing dressing, personal hygiene, bathroom assistance, transferring, maintaining continence) and more complex instrumental activities of daily living (IADLs) on the participant’s property (e.g., light housework, laundry, meal preparation exclusive of the cost of the meal, medication and money management).

The participant must be physically present during this service. PCS must be provided in the participant's home or on their property. PCS must be essential to the health and welfare of the participant rather than that participant’s family.

As authorized in 42 U.S.C 1396a(h), CLS may be provided in an acute care hospital if the services are:

A. Identified in the participant's IPC;
B. Provided to meet needs of the participant that are not met through the provision of acute care hospital services;
C. Not a substitute for services that the acute care hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
D. Designed to ensure smooth transitions between the acute care setting and the home and community-based settings, and to preserve the individual's functional abilities.

Case managers and providers must coordinate with hospital staff and plan of care team members in order to ensure that the participant's transition from a temporary hospital stay to their home is seamless.

Scope and Limitations

PCS is available to all ages and is a 1:1 service. The number of units authorized by DHCF are based on the participant’s extraordinary care needs as specified in their IPC and other assessments, and shall not exceed 7,280 units for the Comprehensive Waiver. The Supports Waiver does not have a unit cap.

PCS is included in ADS, Companion, Child Habilitation, CSS, Supported Employment, and CLS, and cannot be billed during the same time frame as these services, which is subject to audit by the Program Integrity

Return to Table of Contents

Unit within the Single State Medicaid Agency. PCS cannot be provided on the same IPC as host home services.

PCS offered through the Medicaid State Plan can only be provided through a home health agency. Being a rural state, many Wyoming communities do not have home health providers to serve their community. Those that do often do not have enough employees to meet the extensive needs of some waiver participants. Participants who need PCS must utilize providers that can provide the type, amount, and flexible hours of services deemed most appropriate for them. This waiver service allows the plan of care team to find and utilize providers that can best meet the participant's needs.

A relative provider (defined as a biological, adoptive, or step parent) may provide PCS with certain restrictions:

- A relative may only provide this service if they are either a certified provider and form a limited liability company (LLC) or other corporation, or they work for a certified provider.
- The number of units approved for a relative provider will depend on the participant's needs and must not exceed four (4) hours per day or 5,840 units per year. The number of service units must be justified in the IPC.
- If the participant is under 18 years of age, PCS provided by a relative will only be authorized for assessed extraordinary care services as documented in the IPC.

Extraordinary care cases must meet the following criteria:

1. The participant's Adaptive Behavior Quotient is 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and
2. The participant needs assistance with ADLs or IADLs exceeding the range of expected activities that a legally responsible individual would ordinarily perform on behalf of a person without a disability or chronic illness of the same age, that are necessary to assure the health and welfare of the participant, and that will avoid institutionalization. (Example: a 12 year old needing assistance with dressing and bathing, whereas the average 12 year old does not.); or
3. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's medical professional and DHCF.

A legally authorized representative of a participant under the age of 18 may provide PCS to their ward if they meet the restrictions noted above. A legally authorized representative will not be authorized to provide PCS to a participant who is 18 years of age or older.

If a legally authorized representative is providing PCS to their minor ward, the IPC must be developed and monitored by a case manager without a conflict of interest to ensure the services are in the best interest of the participant.

Relative providers and legally authorized representatives cannot provide this service through participant-direction.

Return to Table of Contents

The IPC must state that services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Transportation costs are not included as part of this service.

This service is subject to electronic visit verification.

Return to Table of Contents

Physical Therapy

Service	Code	Rate	Unit
Individual	97110	$29.69	Session
Group	97150	$18.80	

Physical Therapy (PT) Services consist of the full range of activities that preserve and improve a participant's abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation

Scope and Limitations

PT Services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units are subject to prior authorization and require a prescription and treatment letter or recommendation from a licensed medical professional. The referral and any claims billed for this service must include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy may be provided under the waiver, and must be supported with a third party liability form. Medicaid State Plan restorative therapy and waiver maintenance therapy cannot be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) cannot provide this service.
Services are available as an individual 15 minute unit or as a group session unit, which requires a minimum of 30 minutes in service in order to bill.

Return to Table of Contents

Respite Services *(May be participant-directed)*							
Agency Provider				**Independent Provider**			
Service	**Code**	**Rate**	**Unit**	**Service**	**Code**	**Rate**	**Unit**
Individual	T1005	$8.39	15 Minute	Individual	T1005	$7.50	15 Minute
Group of 2	T1005 HQ	$4.68		Group of 2	T1005 HQ	$4.23	
Individual	S5151	$302.30	Daily	Individual	S5151	$269.96	Daily
Group of 2	S5151 U8	$168.41		Group of 2	S5151 U8	$152.25	

Respite services are intended to be utilized on a short-term basis to provide relief for an unpaid caregiver from the daily burdens of care. Respite includes assistance with personal care and activities of daily living, medication assistance if needed, and supervision.

Respite may be provided in the caregiver's home, the provider's home, the participant's home, or in community settings. The respite setting and services must support the identified needs of the participant. Respite cab only be provided for up to two participants at the same time. Three participants may be supported in this service if they are family members, live in the same household, and can be safely supported by one provider. A provider may also supervise other children under the age of 12, or other individuals requiring support and supervision, but must limit the total combined number of people under their care to no more than three, unless approved by DHCF. The provider must adhere to the supervision levels identified in each participant's IPC.

Routine transportation is included in the service rate.

Scope and Limitations

Respite must not be used to substitute care while the primary caregiver is at work, or during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services to preschool age children. The participant may choose to receive a more appropriate service, such as Child Habilitation or Companion Services, for support and supervision while their primary caregiver is working. Respite cannot be used to relieve a Community Living, Community Supports, or Adult Day Services provider.

Respite cannot be provided to individuals under the age of 18 and individuals 18 and older at the same time, unless participants are members of the same family and the situation has been approved by DHCF, In these situations, a detailed description of how Respite will be provided must be included in each participant's IPC.

- Respite is billed at a 15 minute or daily unit. The 15 minute and daily unit cannot be billed on the same day. Any use of respite over nine (9) hours a day must be billed as a daily unit.
- There is an annual cap of 5616 individual 15-minute units for the Comprehensive Waiver. Each daily unit counts as **37** units against the 5616 individual 15-minute units.
- Approved service units are based upon the participant's need and budget limit

Return to Table of Contents

- Relative providers (defined as biological, adoptive, or step parents) cannot provide this service.
- Respite services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. This prohibition includes billing for or providing Respite on the same day the participant receives a daily unit of CLS.

This service is subject to electronic visit verification

Skilled Nursing Services			
Service	**Code**	**Rate**	**Unit**
Skilled Nursing	T1002	$19.77	15 Minute
Skilled Nursing Assessment	T1001	$77.52	Session

Skilled Nursing Services are medical services delivered on an intermittent or part time basis to participants who have complex chronic medical conditions. Skilled Nursing Services are performed within the Nurses' scope of practice as defined by Wyoming's Nurse Practice Act, and include:

- The application of the nursing process including assessment, diagnosis, planning, intervention and evaluation;
- The administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice; and
- The execution of the medical regimen.

Services must require a level of expertise that is undeliverable by non-medically trained individuals. Services must be supported by an order from a licensed medical professional. The referral and any claims billed for this service must include the referring entity's NPI number. A Request for Prior Authorization of Skilled Nursing Services form must be submitted to the DHCF contractor that approves Skilled Nursing Services, and a prior authorization must be obtained before services can be added to the participant's IPC.

One skilled nursing assessment per year is allowed. An in-person assessment of the participant's skilled nursing needs is required as part of the assessment, and a Request for Prior Authorization of Skilled Nursing Services form, which includes a plan to address the identified needs, must be submitted in order to bill for the assessment or request prior authorization of Skilled Nursing Services

Scope and Limitations

Skilled Nursing Services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Skilled Nursing Services are an extension of the Medicaid State Plan. Skilled nursing services may be used when Medicaid State Plan services have been exhausted, are not available in the participant's area, or the participant's needs cannot be met by the home health agency.

- Skilled Nursing Services cannot be used if trained provider staff can deliver the service, such as medication assistance or support for a medical appointment.
- A billable Skilled Nursing Service unit is considered to be a service that is provided up to 15 minutes and that involves one-on-one direct participant care.
- Providers cannot be reimbursed for Skilled Nursing Services that do not include direct participant care or services that do not include skilled nursing duties. For example, Skilled Nursing providers cannot be reimbursed for participant supervision, transportation to and from doctor

Return to Table of Contents

appointments, time spent in a waiting room with the participant, or time spent charting or completing paperwork.

- Relative providers (defined as biological, adoptive, or step parents) cannot provide this service.
- Certified Nursing Assistants and other non-licensed individuals cannot provide this service.

This service is subject to electronic visit verification

Return to Table of Contents

Specialized Equipment

Service	Code	Rate	Unit
New	T2029 NU	PA#	Per Event
Repair	T2029		

Specialized Equipment includes:

1. Devices, controls, or appliances that enables a participants to increase their ability to perform activities of daily living;
2. Devices, controls, or appliances that enable a participant to perceive, control, or communicate with the environment or community in which they live;
3. Approved remote monitoring equipment;
4. Items necessary for life support or to address physical conditions, including ancillary supplies and equipment necessary for the proper functioning of such items;
5. Other durable and non-durable medical equipment not available under the Medicaid State Plan or IEP that is necessary to address participant functional limitations; and,
6. Necessary medical supplies not available under the Medicaid State Plan or other insurance held by the participant. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

The participant's IPC must reflect the need for equipment, how the equipment addresses health, safety, or accessibility needs of the participant or allows them to function with greater independence, and specific information on how often and where the equipment is used. Criteria for approval, allowable items, and limitations of this service are outlined in Chapter 44 of Wyoming Medicaid Rules.

Specialized Equipment must be functionally necessary and meet at least two of the following criteria, and is subject to DHCF approval:

1. Be necessary to increase the participant's ability to perform activities of daily living or to perceive control, or communicate with the environment in which the participant lives;
2. Be necessary to enable the participant to function with greater independence and without which the participant would require institutionalization; or
3. Be necessary to ensure the participant's health, welfare, and safety.

Relative providers (defined as biological, adoptive, and step parents) may provide this service if they meet the following requirements:

- They are a certified Specialized Equipment provider;
- They do not impose a mark-up to the total cost of the equipment when providing this service to their relative (unless they operate a non-profit corporation); and
- At least one other bid for the equipment is submitted to ensure cost effectiveness.

Case managers are responsible for searching and coordinating the purchasing of specialized equipment according to the service definition.

Scope and Limitations

Specialized Equipment has a $4,000 annual limit and is subject to prior authorization through DHCF. The cost of the assessment must be funded as a part of the $4,000 cap.

Case managers are responsible for checking with Medicaid, Medicare, and a participant's other insurance carrier, as applicable, to see if the requested equipment is covered under their plans. The provider must then sign a third party verification form indicating that the Comprehensive Waiver is the payor of last resort.

If the participant has an Individualized Education Plan or Individualized Family Service Plan, the case manager is required to submit a copy of that document, along with documentation as to why the equipment is not available through those services.

The purchase of electronic technology devices is allowed once every five (5) years, and like items cannot be purchased during those five (5) years unless the device is used as a primary means for communication and the request is accompanied by a letter of necessity from a Speech Language Pathologist. DHCF will limit the purchase of general items (i.e., iPad, electronic tablet), and requires a written recommendation by a Certified Specialized Equipment professional before such an item is approved

Return to Table of Contents

Speech, Language, and Hearing Services

Service	Code	Rate	Unit
Individual	92507	$42.86	Session
Group	92508	$16.04	

Speech, Hearing, and Language Services consist of a full range of activities that include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy.

Scope and Limitations

Speech, Hearing, and Language Services are available for participants who are 21 and older. Participants under the age of 21 can access this service through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Units are subject to prior authorization and require a prescription and treatment letter or recommendation from a licensed medical professional. The referral and any claims billed for this service shall include the referring entity's NPI number. Restorative services are available on the Medicaid State Plan. Maintenance therapy may be provided under the waiver, and must be supported with a third party liability form. Medicaid State Plan restorative therapy and waiver maintenance therapy cannot be billed on the same day.

Relative providers (defined as biological, adoptive, or step parents) cannot provide this service.

Services are available as an individual or group session unit, which requires a minimum of 30 minutes in service in order to bill.

Return to Table of Contents

Supported Employment *(May be participant-directed)*							
Agency Provider				Independent Provider			
Service	Code	Rate	Unit	Service	Code	Rate	Unit
Individual	T2019	$9.22	15 Minute	Individual	T2019	$8.23	15 Minute
Group	T2019 UQ	$3.09		Group	T2019 UQ	$2.85	
SEFA	T2019 TS	$9.22		SEFA	T2019 TS	$8.23	

Supported Employment Services are intended to help a participant find and maintain a job that meets their personal and career goals. Supported Employment Services offer a variety of supports to assist a participant who is age 18 or older and, because of their disability, needs intensive support to find and maintain self-employment or a job in a competitive, integrated work setting for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

Services are conducted in a variety of settings, particularly work sites where people without disabilities are employed. Services include activities needed in order for a participant to sustain paid work, including supervision and training. Payment is made only for the adaptations, supervision, and training required by participants as a result of their disability, but does not include payment for the supervisory activities rendered as a normal part of doing business.

Consistent with the Olmstead decision and with person-centered planning, a participant's IPC must be developed in a manner that reflects individual choice and goals relating to employment, and ensures provision of services in the most integrated setting appropriate. Objectives that support the need for continued job coaching with a plan to lessen the job coaching over time, if possible, should be identified in the participant's IPC.

Small Group Supported Employment

Small Group Supported Employment may be provided under a group rate for groups ranging from 2 to 8 participants, and include mobile work crews or enclaves. Group employment for groups larger than 8 people will not be reimbursed by the waiver.

The job coach must be in the immediate vicinity and available for immediate intervention and support. Services will ideally be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in these workplaces. Small Group Supported Employment may include employment in community businesses or businesses that are part of a provider organization.

Individual Supported Employment

Individual Supported Employment services are 1:1 supports available to a participant, and include customized and self-employment. Individual Supported Employment also includes 1:1 career planning and discovery support services that focus on individualized determination of the strengths, needs, and interests of the participant, and are designed to meet the specific needs of the employee and employer relationship. These services include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants. These

services presume the provision of reasonable accommodations and supports necessary to perform functions of a job that is individually negotiated and developed.

A final component of Individual Supported Employment is a direct follow along service, which enables a participant who is paid at or above minimum wage to maintain employment in an integrated community employment setting. This service is provided for a participant through job support and communication with the participant's supervisor or manager, while the participant is present. Reimbursable activities include teaching job tasks and monitoring performance to ascertain the success of the job placement, support services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting, and time spent at the participant's work site conducting observation and supervision of the participant.

Individual Supported Employment must be provided in a community employment setting, unless the support is to address issues necessary to maintain a current job, or to develop customized employment, self-employment, or home-based employment, subject to prior approval of DHCF.

Supported Employment Follow Along

Supported Employment Follow Along (SEFA) services enable a participant, who is paid at or above the federal minimum wage, to maintain employment in an integrated community employment setting. SEFA is intended to be an indirect service, meaning the service is provided for, or on behalf of, a participant through intermittent and occasional job support and communication with the participant's supervisor or manager, while the participant is not present. However, this definition does not preclude the participant from being present during the provision of this service. SEFA may include phone calls between support staff and the participant's managerial staff. SEFA reimburses up to 100 units annually; approved units are based upon the participant's need in order to maintain employment. SEFA services shall be specifically outlined in the IPC.

SEFA reimbursable activities include:

- Regular contact and follow-up with the employer in order to reinforce and stabilize the job placement
- Facilitation of natural supports at the work site
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs
- Advocacy on behalf of the participant, but only with people at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment
- Staff time to travel to and from a work site

SEFA non-reimbursable activities include:

- Transportation of a participant
- Observations of activities taking place in a group, i.e., work crews or enclaves
- Public relations
- Community education
- In-service meetings, department meetings, individual staff development

Approved services must be directly related to a participant's employment needs and fit within the participant's assigned budget

Scope and Limitations

Documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) must be maintained in the case manager and provider file. Services cannot be provided during the same timeframes that a participant is receiving services through an Individualized Educational Plan (IEP). A third party liability form may be required by DHCF unless the participant is using the first 100 units of this service to help access assistance from the Division of Vocational Rehabilitation (DVR), to complete a career planning assessment tool, or for indirect SEFA services.

This service cannot be used to fund incentive payments including:

1. Payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program.

Relative providers (defined as a biological, adoptive, or step parent), spouses, and legally authorized representatives cannot provide these services.

Transportation is included in the reimbursement rates for a direct service, but cannot be used for SEFA services or solely for the purpose of transporting a participant to and from work.

Return to Table of Contents

Transportation Services							
Agency Provider				**Independent Provider**			
Service	**Code**	**Rate**	**Unit**	**Service**	**Code**	**Rate**	**Unit**
5 Mile Trip	A0090	$14.77	15 Minute	5 Mile Trip	A0090	$13.57	15 Minute
10 Mile Trip	T2001	$18.25		10 Mile Trip	T2001	$17.04	
Multi-Pass	T2003	Variable	Per Purchase				

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's IPC. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Scope and Limitations

Services that are reimbursed by trip may be rounded up to 5 miles if at least 2 miles are traveled. A trip may be rounded up to 10 miles if at least 7 miles are traveled. Service is capped at $2,000 per year.