AGENDA

- **Program Updates & Reminders**
  - National Core Indicator Letters to Participants
  - Case Manager Guidance to Providers
  - Documentation Requirements
  - Functional Behavioral Analysis and Positive Behavior Support Plans
  - Electronic Visit Verification and Carebridge Billing
- **Monthly Training Session - ICAP Assessments - Dawn Rudolph - Wyoming Institute for Disabilities**

TOPICS

National Core Indicator Letters to Participants

The National Core Indicators® - Intellectual and Developmental Disabilities (NCI®-IDD) survey will be kicking off soon. The primary aim of this survey is to collect and maintain information about the outcomes experienced by participants who utilize the public IDD systems. In early September, participants who have been randomly selected will receive a letter to notify them of their selection to participate, and provide them with more information about the process.

The Home and Community-Based Services (HCBS) Section has been notified by several providers and case managers that a common provider practice is to encourage participants to decline to participate. Participants absolutely have the right to decline participation, but as providers, you should never discourage a participant from having a voice and providing feedback on their experiences. If a participant wants to talk to a surveyor, you can support participants in setting up and attending interviews, and answering any questions they may have. Please support participants in being as involved as they would like to be.

Case Manager Guidance to Providers

On several occasions, the HCBS Section has had to provide technical assistance or issue corrective action to providers who are not in compliance with Wyoming Medicaid rules. Providers are stating that they are doing things based on guidance from their case manager. Although we appreciate all that case managers do to help providers come into compliance, if a provider has a question about a rule or a specific concern, we have strongly encouraged them to refer providers back to the Incident Management or Credentialing Specialist assigned to their area. This will alleviate any confusion on your part, and ensure that the case manager is not put in the position of giving inaccurate guidance.

The HCBS Section reaches out to providers on a regular basis. We would appreciate any help you can offer with reminding your colleagues and other providers in your area of the bi-monthly provider support calls. Call times and login information can be found on the DD Providers and Case Managers page of the HCBS Section website, under the Provider Support Call Notes toggle.

Documentation Requirements

The HCBS Section has seen an influx of Provider Documentation Non-Compliance Reports. These are the reports that case managers send to the HCBS Section when providers do not meet the documentation submission requirements set forth in Chapter 45 of Wyoming Medicaid rule.

Chapter 45, Section 8(n) establishes that providers must make service documentation available to the case manager each month by the tenth (10th) business day of the month following the date that the services were rendered. If the provider does not make documentation available to the case manager as required, case managers have been asked to contact the provider to get the necessary documentation. If the provider does not submit the required documentation by the end of the month, the case manager must submit the Non Compliance report to the area Incident Management Specialist (IMS), and if the provider is chronically late with submitting documentation, the case manager should submit a complaint through the Wyoming Health Provider (WHP) portal.

Providers need to follow through on their responsibility to make documentation available to case managers as required.

Functional Behavioral Analysis and Positive Behavior Support Plans

In accordance with Chapter 45, Section 17 of Wyoming Medicaid rules, a participant who has a challenging behavior identified by the plan of care team must have a current functional behavioral analysis (FBA) conducted within the last year in order to:

- Identify what the participant is trying to communicate through the behavior;
- Identify the function or possible purpose for the behavior;
- Explore antecedents and contributing factors to behaviors; and
- Review and describe potentially positive behavioral supports and interventions in order to develop a positive behavior support plan.

An FBA must be conducted by a **provider** who is familiar with the participant and is present when the behavior occurs. It must be based on direct observation of and interviews with the participant, interviews with people who know the participant well, and a review of available information including incident reports.

An FBA is not a guess as to why a participant uses a particular behavior, but rather a systematic process that the team must use to define, analyze, and determine the reason a behavior is occurring.

A positive behavior support plan (PBSP) should then be developed to increase the participant's quality of life and decrease their identified challenging behavior by teaching them new skills and making changes in their environment. Unfortunately, many of the PBSPs that are submitted as part of a participant's overall plan of care are not in any way positive, but rather punitive or punishing in nature. This needs to change.

The FBA and PBSP are two very specific processes that are intended to lead to the participant experiencing success, personal satisfaction, and positive social interactions. The provider plays a pivotal role in both of these processes; as the entity that often experiences a participant's more challenging behaviors first hand, the provider and their staff should be closely involved in the development and implementation of both.

The HCBS Section has developed a PBSP procedure manual, based on best practices, to help teams conduct the FBA and develop a PBSP. Please refer to the manual before conducting the FBA or developing the PBSP. It is located in the HCBS Document Library, under the DD Tab.

Electronic Visit Verification and Carebridge Billing

The HCBS Section is regularly called upon to troubleshoot provider billing issues associated with electronic visit verification (EVV) and Carebridge. As a reminder, the HCBS Section is not the first stop if you are experiencing billing issues. Please contact Carebridge or your third party vendor if you are having difficulty billing for services that are subject to EVV.

When we troubleshoot EVV billing issues, one of the common themes is the number of deleted and double billed claims that providers submit. To decrease the confusion associated with EVV billing, providers should use the Carebridge app to avoid duplicate or inaccurate visits. Providers should review visits prior to creating and submitting claims, and if possible, should only submit claims once a week. If a provider submits a claim for a span of time and then makes any changes for the same period of time, the system will automatically submit an adjustment claim to credit units for the previous claim, then submit a new claim with the revised units. Before you create a billing span and submit a claim, make sure it is accurate, and includes all of the visits in the time period for which you are billing.

Also, keep in mind that if an adjustment is made for more than one billing period, it may look like money and units are being taken from you, as the provider. In reality, an adjustment may be applied to more than one remittance advice (RA). We have seen many cases where an adjustment is applied from a claim that was originally submitted months before. When this occurs, you must go into BMS, or contact the BMS help desk, to review which original claim is being adjusted.

WRAP UP

Next call is scheduled for October 28, 2024.