HOME AND COMMUNITY-BASED SERVICES

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Comprehensive and Support Waivers

Individualized Plan of Care (IPC) Guide

Revised June 2024

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PURPOSE OF THE MANUAL

The purpose of the Individualized Plan of Care Guide (IPC Guide) is to provide instructions and references on the forms, documents, and processes necessary to meet the Individualized Plan of Care (IPC) review requirements. Case managers should use these instructions to develop the IPC, after they obtain input from the participant and plan of care team. All sections of the IPC are important and should be specifically written in a way that reflects the participant's wishes, goals, medical condition(s), health and safety needs, risks, and behavioral concerns.

This manual is written primarily for the case manager, but can be used as a resource for participants, families, and teams.

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CHAPTER 1 - GETTING STARTED

Electronic Medicaid Waiver System (EMWS)

The Electronic Medicaid Waiver System (EMWS) is a web-based portal used by the case manager to navigate and manage the IPC process. Throughout the IPC process, EMWS will assign tasks to specific users, including:

- **Case Manager (CM)**
- **Benefits and Eligibility Program Manager (PM) – HCBS Section**
- **Benefits and Eligibility Specialist (BES) – HCBS Section**
- **Medicaid Eligibility Staff – Long Term Care Unit (LTC)**
- **Wyoming Institute for Disabilities (WIND) – University of Wyoming**

After a task is completed by an assigned user, EMWS automatically sends the case to the next user in the working queue. This role-based processing is referred to as **workflow**. Users are notified via email and on the EMWS task bar when a task needs to be completed.

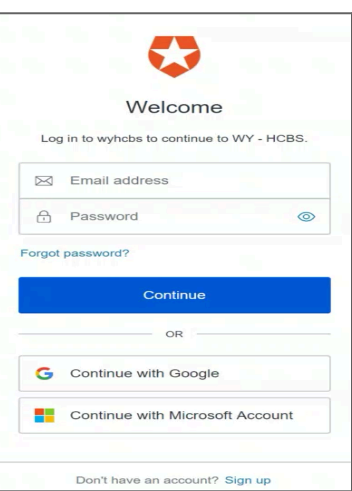
IMPORTANT: Case managers must ensure that their email address is up to date in EMWS and the Wyoming Health Provider (WHP) portal in order to receive necessary communications and EMWS tasks.

Log In

The website address to log into EMWS is:

https://wyowaivers.com

Before you can access EMWS, you must be an approved Comprehensive or Supports Waiver (DD Waiver) case manager including completion of all required training. Once you are certified as a DD Waiver case manager, you must submit a request through the web based portal by clicking on ***Continue*** with Google/ Microsoft Account or by clicking the sign up link. Once your request has been reviewed and approved, you will receive a verification email.



1. Enter username and password or click on ***Continue*** with Google/Microsoft account, depending on how you created your account. You will be directed to the Home Page.

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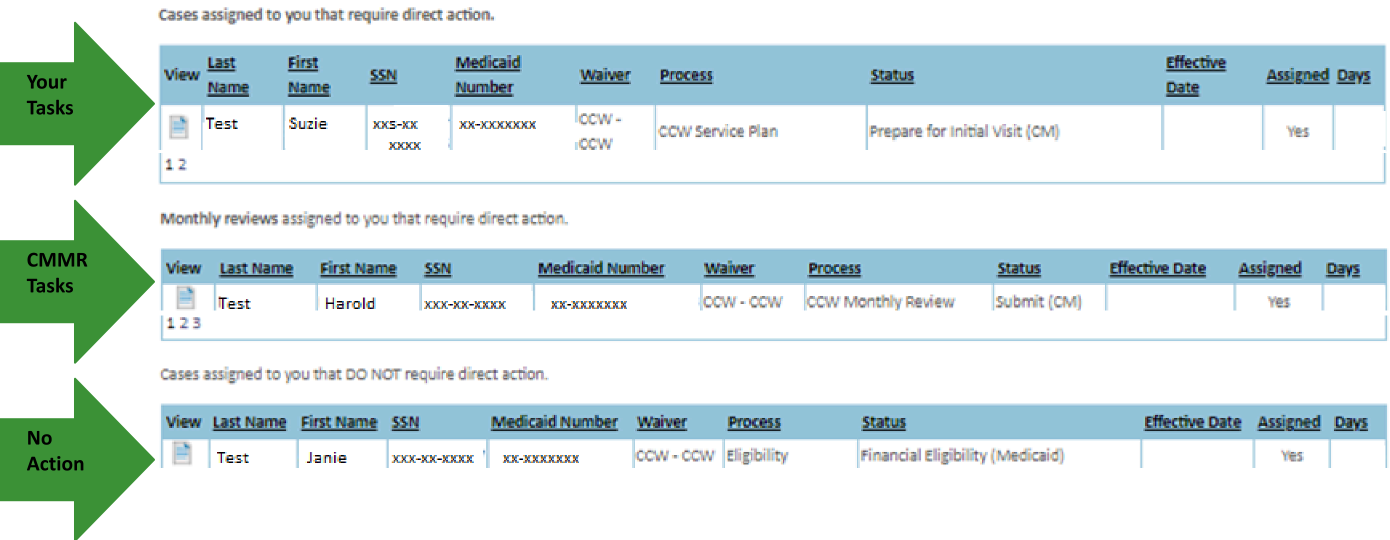
2. Case managers can reset their password by selecting ***Forgot Password?*** Users are encouraged to store their username and password in a secure location.

Medicaid Waiver System Confidentiality Agreement

When logging into EMWS for the first time and every 90 days thereafter, the user is presented with the *Medicaid Waiver System Confidentiality Agreement* known as an End License User Agreement (ELUA). Each user is responsible for reviewing, accepting, and adhering to the terms and conditions of the ELUA.

Task List Tab

When logging into EMWS, the case manager will be directed to the *Task List tab.* This tab shows the user's active working queue, which lists the user's assigned cases, the case status, and required tasks. The case manager's main task list will show **IPC and eligibility tasks**. A second task list contains **Case Management Monthly Review tasks** that require case manager action, and a third task list contains cases with which the case manager is associated but does not need to take direct action. This is designed to help users keep track of where a case is in the workflow process. The work queue is shown in a grid that contains up to 10 entries. To see additional entries, click the page numbers in the lower left corner of the grid.



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Contacts in EMWS

IMPORTANT: As established in Chapter 45 of Wyoming Medicaid Rules, the case manager is required to keep all associated contact information (e.g., case manager, participant, legally authorized representative, back up case manager, circle of support) up to date.

- ➢ Add **medical professionals** including the participant's primary physician, dentist, optometrist, neurologist, etc.
  - ○ Please note that if you delete the name of a prescribing entity from the contact list, all medication listed under that name may be deleted from the medication page.
  - ○ Please add the name of the new prescribing entity and ensure they are listed as the prescribing entity on the appropriate medications before you delete the contact.
- ➢ Add **representative payee** contact information, as applicable.
  - ○ Every five years, upload verification that the representative payee is still in place.
- ➢ Upload the most current signed **guardianship order**, as applicable.
  - ○ Upload new guardianship documentation any time a change is made to the order.
  - ○ Every five years, upload verification that the guardianship is still in place.
- ➢ Select a **backup case manager** from the drop down menu at the bottom of the page.
  - ○ The backup case manager will be utilized when the primary case manager is not able to perform case management duties.
  - ○ This information will print on the IPC.
- ➢ Add case manager and backup case manager **contact information**.
- ➢ Delete **old information** when changes are made as well as any **duplicate contacts**. Remember, all contact information in the Contacts screen under Waiver Links must be current.

EMWS Document Library

Please use the **DD EMWS File Naming Conventions** to name documents uploaded into the **EMWS Document Library screen** under Waiver Links. For example, the *Case Management Selection Form* should be named as follows: *CA.Johnson.John.CMSel.2023.04.11*.

Assessment History in EMWS

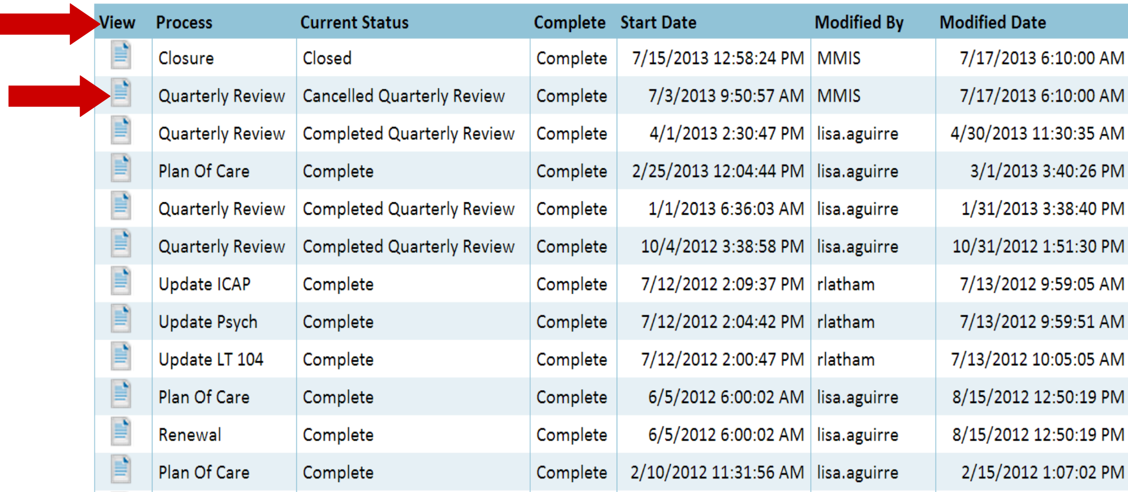
Assessments should be named using the **DD EMWS File Naming Conventions**, and uploaded in the **Assessment History** under Waiver Links. Past assessments are housed with the applicable IPC.

- Assessments include:
  - The signed psychological or neuropsychological evaluation – completed by a Wyoming Medicaid enrolled licensed psychologist
  - LT-101 – completed by a public health nurse
  - LT104 – completed by the case manager
    - The LT104 assessment is completed in the Assessment History screen. This assessment does not need to be uploaded.
  - ICAP summary – uploaded by WIND

Processes

The **Processes screen** under Waiver Links will list each process, current status, completion status, start date, modified by, and modified date. This screen will keep a complete history of each process for the participant's case. Click the icon under the ***View*** column for a more detailed view of the steps and who completed them.

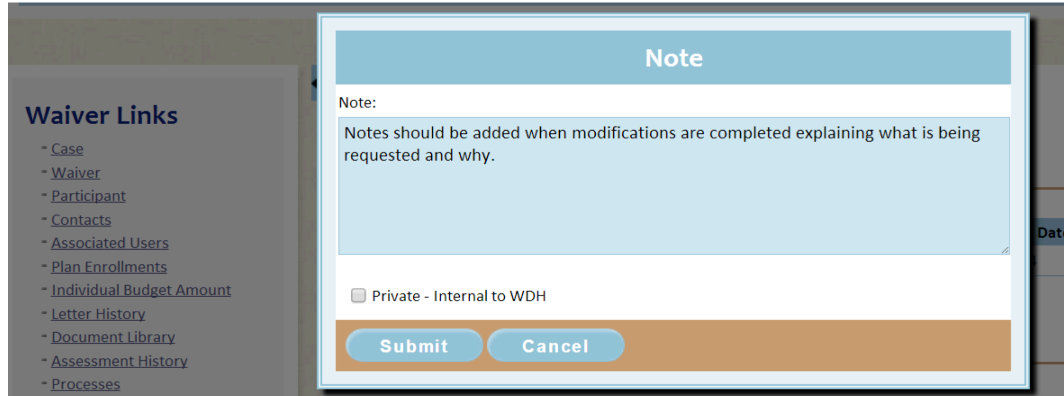
Processes



View	Process	Current Status	Complete	Start Date	Modified By	Modified Date
	Closure	Closed	Complete	7/15/2013 12:58:24 PM	MMIS	7/17/2013 6:10:00 AM
	Quarterly Review	Cancelled Quarterly Review	Complete	7/3/2013 9:50:57 AM	MMIS	7/17/2013 6:10:00 AM
	Quarterly Review	Completed Quarterly Review	Complete	4/1/2013 2:30:47 PM	lisa.aguirre	4/30/2013 11:30:35 AM
	Plan Of Care	Complete	Complete	2/25/2013 12:04:44 PM	lisa.aguirre	3/1/2013 3:40:26 PM
	Quarterly Review	Completed Quarterly Review	Complete	1/1/2013 6:36:03 AM	lisa.aguirre	1/31/2013 3:38:40 PM
	Quarterly Review	Completed Quarterly Review	Complete	10/4/2012 3:38:58 PM	lisa.aguirre	10/31/2012 1:51:30 PM
	Update ICAP	Complete	Complete	7/12/2012 2:09:37 PM	rlatham	7/13/2012 9:59:05 AM
	Update Psych	Complete	Complete	7/12/2012 2:04:42 PM	rlatham	7/13/2012 9:59:51 AM
	Update LT 104	Complete	Complete	7/12/2012 2:00:47 PM	rlatham	7/13/2012 10:05:05 AM
	Plan Of Care	Complete	Complete	6/5/2012 6:00:02 AM	lisa.aguirre	8/15/2012 12:50:19 PM
	Renewal	Complete	Complete	6/5/2012 6:00:02 AM	lisa.aguirre	8/15/2012 12:50:19 PM
	Plan Of Care	Complete	Complete	2/10/2012 11:31:56 AM	lisa.aguirre	2/15/2012 1:07:02 PM

Notes

The **Notes screen** is used to document important history of the case. It allows the case manager to document important changes to the IPC or in the participant's life, and can be used to respond to questions from the BES.



When a case manager enters a note for the BES to read, the case manager must inform the BES via email that there is a new note to review. The BES is not notified by EMWS when notes are entered.

EMWS Help Desk

Case managers should contact the EMWS Help Desk at emws-helpdesk@wyo.gov when having system issues such as an error screen. **Request a secure link if the issue is regarding a specific case or may contain protected health information.** Once a secure link is received, send a screenshot of the error message or issue, including the URL link, along with an explanation detailing the problem.

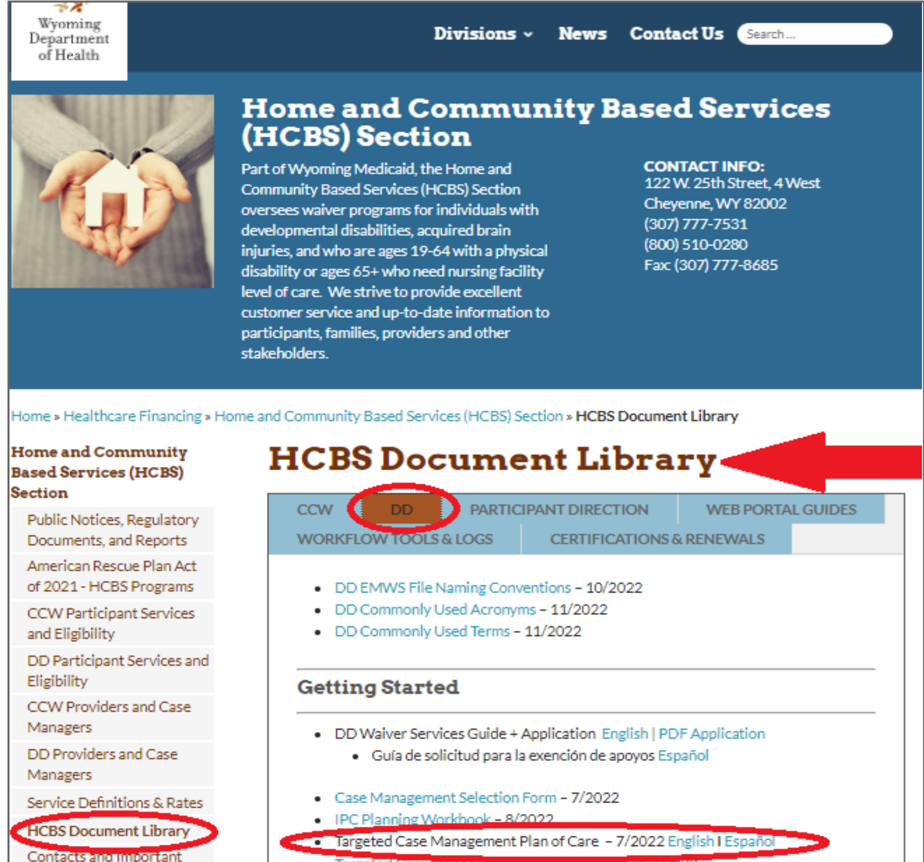
CHAPTER 2 – TARGETED CASE MANAGEMENT (TCM) SERVICES

Overview

It is a case manager's responsibility to provide **Targeted Case Management (TCM) Services** to all participants who are in the eligibility process for waiver services, or are awaiting a funding opportunity and are placed on the waiting list per Chapter 45, Section 9. Case Management is the one required service all participants must have in order to participate in waiver services. To meet our assurances with CMS a TCM plan of care must be developed and maintained while the participant is in the eligibility phase or on the waitlist.

Initiating the TCM Plan of Care

In order to initiate a Targeted Case Management task, the Case Manager must first work with participants and legally authorized representatives (LARs) to develop a **TCM Plan of Care (TCM POC)**. First, the Case Manager must download the *Targeted Case Management Plan of Care template* from the HCBS Document Library. The template is found on the *DD Forms* tab as shown below.



The case manager must complete all sections of the TCM POC with the participant and their legally authorized representative. These services include, but are not limited to, the coordination and gathering of information needed for initial and annual certification, clinical and financial eligibility, level of care determination, and referrals to community resources. All parties must sign the document.

TCM Plan of Care

HOME AND COMMUNITY-BASED SERVICES

Case Managers are required to develop this plan upon notification that the individual has been determined initially eligible, and any time there is an update to contact information or other plan of care components.

Individual Legal Name:	Case Manager:
Physical Address:	Medicaid #:
Mailing Address: ☐ Same as Physical	Birth Date:
Phone Number: ☐ Cell ☐ Home ☐ Work	Plan Start Date:

Support Needs:

For each category, briefly describe the individual's support needs. Describe how these needs may be met through natural supports or other non-waiver services.

Category	Support Needed	Natural Supports/Non-Waiver Services
MEDICAL		
SOCIAL		
EDUCATION OR EMPLOYMENT		
OTHER		

Case Manager Support:

Briefly describe the case management support plan, including the frequency of case manager check-ins or visits, and how the individual or their support network may contact you:

All parties listed on this plan are required to notify other parties of changes to contact information in a timely fashion.

Individual Signature   Date

Legally Authorized Representative (If applicable)   Date

Case Manager Signature   Date

HCBS Section
CM34 – TCM Plan of Care — Reviewed 7/2022 BES   1 | Page

Completing the TCM Plan of Care

Header

- Enter applicant/participant's full legal name.
- Enter the name of the waiver case manager.
- Enter the physical address (location that the participant lives).
- Enter the mailing address (where the participant receives their mail).
- Enter the Medicaid ID Number if already established.
- Enter the participant's date of birth.
- Enter the participant's or legally authorized representative's phone number.
- Enter the plan start date.

- **All TCM POCs begin on the first day of the month in which the plan is established**.
  - Example: Participant and case manager sign the POC on 6/5/2024; the plan start date will be 6/1/2024.

Support Needs

Medical

- Within the **Support Needed** category indicate any medical diagnosis that the participant requires routine care.
  - Example: Daniel Darling has been diagnosed with a seizure disorder and requires routine care and monitoring by a neurologist. Anyone working with Daniel needs to be aware of his seizure activity and must be schooled on what to do and how to respond in the event of a seizure.
- Within the **Natural Supports/Non-Waiver Services** section include the supports that both natural supports and non-waiver services provide.
  - Example: Daniel Darling's mother keeps a log of all seizure activity and reports these instances during regular appointments with neurologists (Dr. Eckle). Participant sees Dr. Stein for regular routine primary care appointments, and utilizes private insurance through his parent's plan.

Social

- Within the **Support Needed** category indicate what social supports the participant receives.
  - Example: Jenny Carry enjoys attending church and community events/activities. Jenny requires assistance with transportation in accessing these activities.
- Within the **Natural Supports/Non-waiver Services** include who supports participant engagement in social events.
  - Example: The members of Jenny's church work together in providing transportation so that she may attend services at her discretion. Jenny also has a very supportive family who aid her with accessing community activities/events. If Jenny's family or church friends are unable to assist her with transportation she has a monthly bus pass and knows how to utilize the public transit system.

Education or Employment

- Within the **Support Needed** category indicate what support the participant may need in accessing educational or employment opportunities.
  - Example: Joe Holliday works for Goodwill Industries sorting through donated clothing, but would benefit from a Job Coach to help keep him on task.
- Within the **Natural Supports/Non-waiver Services** category include what support the participant is receiving.
  - Example: Joe currently utilizes the public transit system in order to get to/from his job, and co-workers lend a hand when they are able to help keep Joe on task while performing his duties.

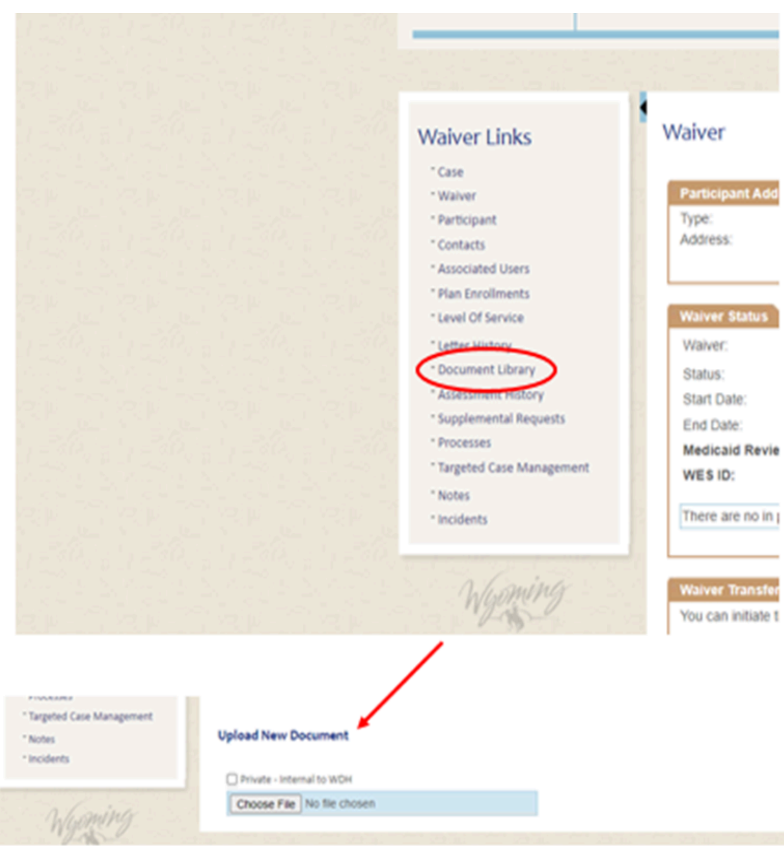
Other

- Within the **Support Needed** category enter any additional information that would be helpful in supporting the participant be as independent as possible.
  - Example: Sally Smith is good at math and can maintain her monthly budget well on her own, but needs reminders to pay her bills on time.
- Within the **Natural Supports/Non-waiver Services** category detail who currently helps the participant.
  - Example: Sally's brother calls her on the first of the month each month to remind Sally to pay her bills; he follows up with Sally after a few days to ensure that she does this. Sally's brother also helps her maintain a calendar of events that helps her keep track of appointments and special activities.

Case Manager Support

- In this section the case manager should detail the **case management services** that the case manager will perform throughout the eligibility process and while the participant is on the waiting list.
  - Example: The case manager will check in with the participant monthly to ensure that there is nothing that the participant is requiring assistance with. If the case manager identifies a need the case manager will provide referral services, and/or community resources for the participant to access in order to gain additional supports.

- The participant and the case manager must then **sign and date** the TCM POC. If the participant is over 18 and has a guardian/POA signing for them, the case manager must also upload a copy of the **guardianship/POA document.** The case manager is responsible for uploading the completed TCM POC to the Document Library within the participant's EMWS case file.



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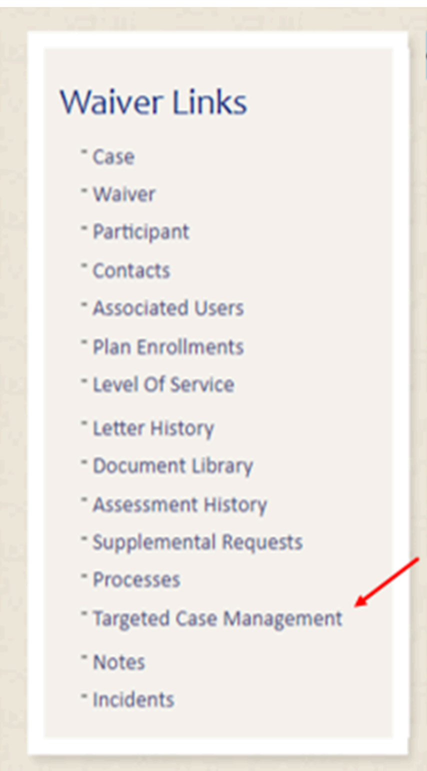
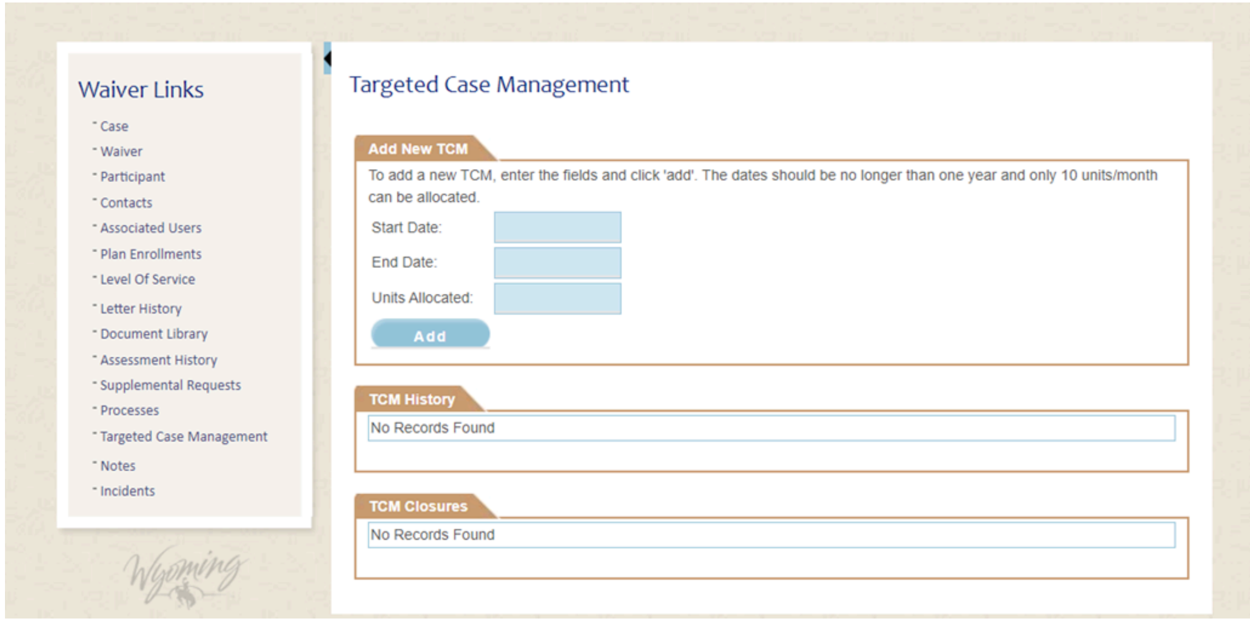
Initiating TCM Services in EMWS

Once the TCM POC is uploaded to the Document Library, the case manager must select the ***Targeted Case Management*** link under the Waiver Links:



- Once in the **Targeted Case Management screen**, enter the start date of the TCM line.
    - TCM lines can only be backdated to the current month.
    - For example, if the TCM POC is signed on May 14, 2024 and the TCM line is submitted on May 16, 2024, the TCM line will have a start date of May 1, 2024, and an end date of April 30, 2025.
- Per the Service Index, TCM may have a maximum of 120 units per year added to the TCM line (an average of 10 units per month).
- Once the units have been added, click the ***Add button***.This triggers a task for the BES to review the plan, ensure that all necessary documentation has been uploaded to the document library, and create a line in BMS for service approval.

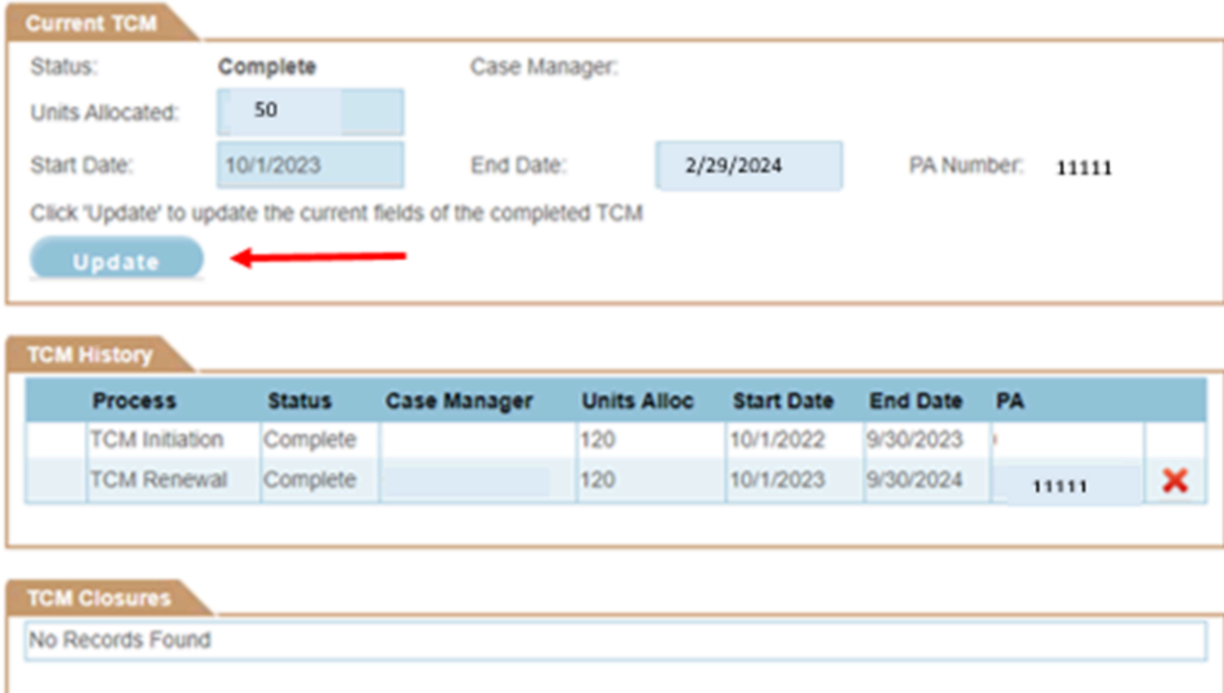


Change of Case Management, TCM Lines & Closures

Participants may remain on the waiting list for extended periods; there may come a time when a transition of case managers is required - either by request of the participant, or case manager. All changes in case management must be processed in accordance with Chapter 45 rules and Division standards applicable to active waiver participants.

The **Targeted Case Management screen** displays *all approved* TCM lines in the **TCM History** box. The **Current TCM** box displays only the *currently approved* TCM line.

- ➢ In order for the outgoing case manager to end their line in EMWS, they must adjust their units accordingly, and add an end date and click the ***Update*** button as shown below.
  - ○ This will send an alert to the BES to review.
  - ○ If the adjusted units are less than what has already been billed, the BES will roll back the task for the case manager to adjust.



Closed TCM lines are listed in the **TCM Closures** box at the bottom of the page.

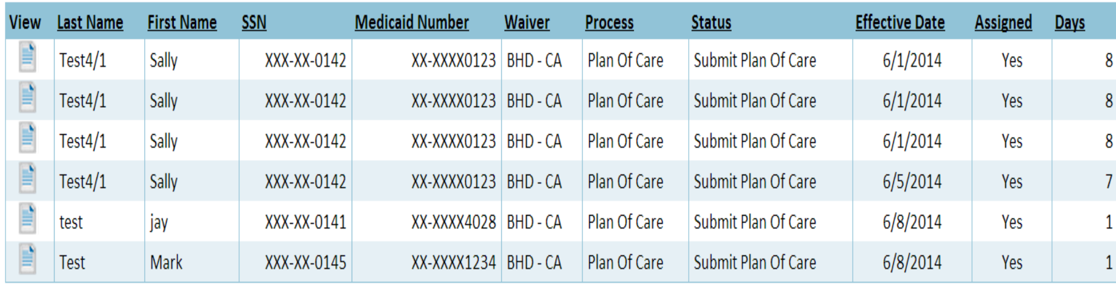
- ➢ When a participant receives their initial funding opportunity, the case manager must initiate the **TCM Closure** in EMWS and set the date to one day before the start date of the initial IPC.
  - ○ For example, if the initial IPC start date is July 1, 2024, the TCM Closure line should end June 30, 2024. All units should also be adjusted accordingly.

CHAPTER 3 - COMPLETING THE IPC

Overview

A participant's case is visible in EMWS ninety (90) days prior to the plan start date to allow the case manager time to schedule and hold a team meeting, enter the information into EMWS, and submit the plan. The IPC will appear on the case manager's top task list under processes with the status of *Submit Plan of Care*.

Cases assigned to you that require direct action.



View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Effective Date	Assigned	Days
	Test4/1	Sally	XXX-XX-0142	XX-XXXX0123	BHD - CA	Plan Of Care	Submit Plan Of Care	6/1/2014	Yes	8
	Test4/1	Sally	XXX-XX-0142	XX-XXXX0123	BHD - CA	Plan Of Care	Submit Plan Of Care	6/1/2014	Yes	8
	Test4/1	Sally	XXX-XX-0142	XX-XXXX0123	BHD - CA	Plan Of Care	Submit Plan Of Care	6/1/2014	Yes	8
	Test4/1	Sally	XXX-XX-0142	XX-XXXX0123	BHD - CA	Plan Of Care	Submit Plan Of Care	6/5/2014	Yes	7
	test	jay	XXX-XX-0141	XX-XXXX4028	BHD - CA	Plan Of Care	Submit Plan Of Care	6/8/2014	Yes	1
	Test	Mark	XXX-XX-0145	XX-XXXX1234	BHD - CA	Plan Of Care	Submit Plan Of Care	6/8/2014	Yes	1

To develop an IPC, the case manager is required to work through each of the steps outlined in the *Plan Mod Links* list.

IPC Requirements

As outlined in Chapter 45 of Wyoming Medicaid Rules, the complete IPC must be submitted, including all required components, before the intended start date. The Division will not accept mailed or faxed documents, with the exception of the *Case Management Selection Form*. Case managers who submit late plans may cause a gap in services for participants.

If all components of the IPC are completed at the end of the team meeting, the participant and team members can sign the *Team Signature Page*. However, if the team makes changes to the IPC after the meeting or during the review process, **team members must sign a new signature page before the changes are completed**. If a participant has a legally authorized representative (LAR), the LAR must sign the required forms.

Training Providers

Case managers are responsible for ensuring that all providers on the IPC receive training on all components of the IPC, and receive additional training if changes are made to the IPC during the year. In some cases, the training may need to be performed by a medical professional or a family member. At the team meeting, the team will identify and document who is responsible for training team members and provider staff members. The case manager can help coordinate the training between all providers included in the IPC. Organizations can provide **participant**

specific training to their employees once the organization's designated trainer has been trained by the case manager.

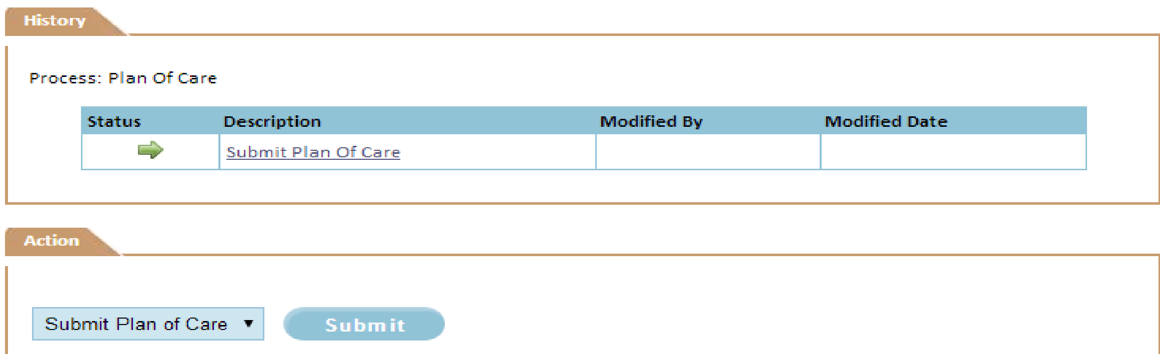
The *Participant Specific Training Form* is a helpful tool to document the training. Teams are encouraged to utilize the *IPC Planning Workbook*, this *IPC Guide*, and any other forms and documents referenced within the guide to assist in developing an IPC. These documents can be found on the Division website, HCBS Document Library page, *DD* tab.

Schedules

- The Division does not require the submission of service pages, schedules, or objectives; however, they are required documents for provider reimbursement.
- Objectives and schedules are developed by the provider, approved by the participant and team, and **must be submitted to the case manager** prior to the submission of the IPC, or more frequently, as changes are needed.
- The case manager documents the participant's progress toward achieving objectives on the ***Monthly Review and Quarterly Review forms***, which are submitted in EMWS.
- The case manager must receive monthly documentation from the provider, including progress on the objectives, **by the 10th business day** of the next calendar month. If the case manager does not receive the documentation, the case manager must complete a *Provider Documentation Noncompliance Form*, and submit it to the Division.
- Service providers must maintain schedules that meet the documentation standards identified in Chapter 45 of Wyoming Medicaid Rules.

Plan Status

After all the required steps have been completed to finalize the IPC, return to the **Plan Status screen** and click the ***Submit button*** under the *Action* tab.



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If the case manager receives the error:
"This participant could not be matched in WES"
the assigned BES is automatically notified in EMWS and will submit the IPC or contact the case manager if further action is needed.
If the case manager encounters other problems when submitting an IPC, they should contact the BES assigned to the county in which the participant resides.

Once the IPC has been submitted, the **Plan Status screen** will indicate *Pending BMS Approval*. Pending BMS Approval means that the IPC has completed, a system review of the IPC has been conducted, no preliminary issues have been identified, and the IPC has been submitted to the **Benefit Management System (BMS)** for prior authorization. BMS is the system that processes all provider billing claims and adjustments.

Process Instance

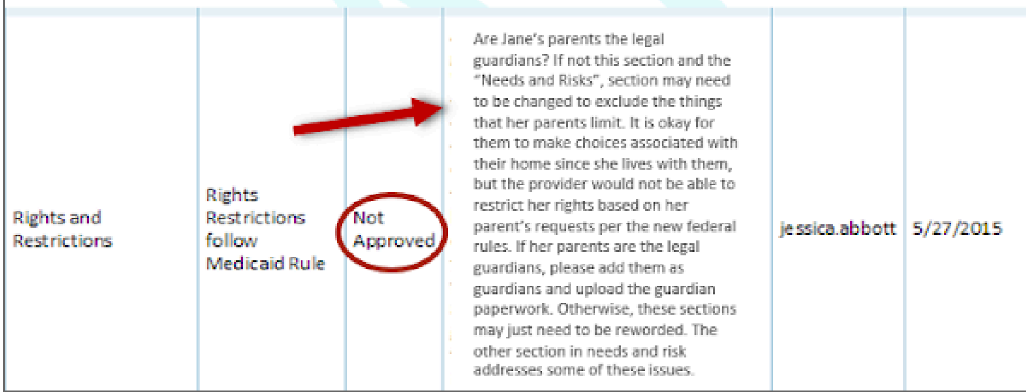
Process: Plan Of Care

Status	Description	Modified By	Modified Date
✓	**Initiated by:**	System	9/6/2023 12:05:30 PM
✓	Submit Plan Of Care (CM)	System	9/6/2023 12:26:15 PM
✓	Review Plan of Care (BES)	System	9/6/2023 12:26:16 PM
➡	Pending BMS Approval		

Quality Improvement Reviews and Roll Backs

Typically, IPCs submitted through EMWS undergo a system review that identifies preliminary issues; IPCs that are flagged through this review are manually reviewed by the BES. A **quality improvement review (QIR)** is a manual review of *randomly selected* IPCs and IPC modifications.

- The BES manually reviews the selected IPCs, and focuses on specific requirements in Chapter 45 of the Wyoming Medicaid Rules. This review is intended to ensure that IPCs meet the minimum standard by federal and state regulations.
- The BES may send an IPC back to the case manager for corrections or clarifications, commonly known as a **"roll back."** Access the ***BES Review Summary for All Sections*** tab to review the BES' comments regarding needed corrections.



Rights and Restrictions	Rights Restrictions follow Medicaid Rule	Not Approved	Are Jane's parents the legal guardians? If not this section and the "Needs and Risks", section may need to be changed to exclude the things that her parents limit. It is okay for them to make choices associated with their home since she lives with them, but the provider would not be able to restrict her rights based on her parent's requests per the new federal rules. If her parents are the legal guardians, please add them as guardians and upload the guardian paperwork. Otherwise, these sections may just need to be reworded. The other section in needs and risk addresses some of these issues.	jessica.abbott	5/27/2015

- ➢ The case manager should make the necessary corrections or clarifications throughout the IPC, as requested, and then click ***Submit*** on the **Plan Status screen** to submit the corrected IPC.
- ➢ If an IPC is rolled back to the case manager for corrections, case managers must resubmit the IPC at least seven (7) business days prior to the end of the month to ensure enough time for plan review.
    - ○ If the case manager does not make corrections to an IPC within the established time frame, the provider and staff may not have time to receive training prior to the plan start date. If this occurs, a letter may be sent to the legally authorized representative, participant, and the provider(s), informing them that the IPC has not been completed so they can plan accordingly.

Individual Preferences

- ➢ Enter the dates for the six month review and annual team planning meeting.
- ➢ Teams are encouraged to utilize the IPC Planning Workbook worksheet to complete this section.
- ➢ Do not include references to rights restrictions in this section.
- ➢ **At a minimum, this section must be updated annually.**

Guidelines

Person-Centered Planning Approach

- ➢ Under the Home and Community Based (HCB) Settings rule through the Center of Medicaid Services (CMS), a person must have an IPC that is truly **individualized and person-centered**. The participant should lead the process of creating the IPC as much as possible, and the team members should support this process.
- ➢ The case manager is responsible for advocating for the participant, and must ensure that planning discussions capture ways in which the participant wants to be involved in the community, and identifies the participant's strengths and preferences, support needs, goals, and existing safety risks. The resulting IPC should align with the participant's choice of services, locations, and providers.

- The case manager must ensure that the IPC complies with federal and state requirements related to person-centered planning, including requirements on rights restrictions. Training on these concepts is available on the Division website.
- The case manager must document planning activities on the ***Case Management Monthly Review Form*** in EMWS.
- Teams should identify what is important to and for the participant, and develop the IPC with this information in mind. The IPC needs to be accessible and written in common language that is easily understood by everyone.
- Information must portray a comprehensive picture of the participant so the team and providers working with them will understand how to deliver services and supports around their individualized needs and preferences.

Appropriate Language for Responses

- At a minimum, the IPC must be understandable to the participant, LAR, and the individuals supporting the participant.
- For the written plan to be understandable, it must be written in **plain language** and in a manner that is accessible to the participant and people who are limited English proficient.

Review Questions at the Team Meeting

- The questions addressed on the **Individual Preferences screen** can be discussed with the participant, with help from the provider, when the case manager is completing the monthly home visit. This information should also be reviewed at the annual and six month review team meetings. Use the Team Meeting Checklist for guidance.

Information in this section must be updated annually. Simply copying information from the previous year is not adequate.

- The **Individual Preferences screen** is also visible on the **Service Authorization screen**; therefore services, objectives, and schedules must support the information within this section.

Participant's Desired Accomplishments for the Upcoming Plan Year

- Identify the accomplishments the participant would like to achieve over the upcoming year.
    - Example of a question the participant can answer:
        - What would I like to do this year that I have not been able to do previously?

- Summarize progress made on habilitation objectives in the past year, and include the participant's new habilitation service objectives. Habilitative service objectives need to be person-centered, and must meet the service definition in the Comprehensive and

Supports Waiver Service Index. The current Service Index is available on the HCBS website.

- Include an overview of important events that occurred in the past year, which are relevant to the participant's goals and planning.

Participant's Personal Preferences

- Activities identified in this section should be reflected in the schedules of the services the participant is receiving.
    - Example of a question the participant can answer:
        - Who do I like to spend time with?
        - What things do I do, or like to do?
        - What help do I need in order to get to where I want to go?

Important Things to Know About Participant

- See the IPC Planning Workbook to assist the participant in answering the following questions:
        - What causes me to feel sad, hurt, angry, or scared?
        - What can providers do to help me when I feel these things?
        - What are the things I absolutely need in my life?
        - What are my interests? (e.g. hobbies, cultural, or religious traditions, sports teams, local events, etc.)
        - What are the things I do not like or want?

Demographics

- Enter the participant's legal name. A preferred name can be entered in the specified box provided.
- Indicate gender, ethnicity, preferred method of contact, and county of residence. If "Non Verbal" is selected under method of contact, a drop down menu will populate to select the participant's preferred contact person.
- Document any potential communication barriers (i.e., participant needs an interpreter, is non-verbal, uses sign language, uses a communication device), or any other significant barriers to communication.
- Enter complete addresses including: street, P.O. Box, city, state, and zip code.
    - Indicate if the address is the physical, the mailing, or both. Enter both addresses if they are different.
    - Verify that the address is current by checking the box.
- Enter email addresses, if applicable.
- Enter the participant's phone number, if applicable.
- If demographic information such as an address, phone number, etc. changes, update the **Demographics screen** within seven business days of the notification.
- Delete old information (addresses, phone numbers, email addresses) by clicking on the red X.

Rights and Restrictions

For a right to be restricted, the information in the IPC must meet criteria established in Chapter 45 of Wyoming Medicaid Rules, related to rights restrictions. The plan of care must identify a health or safety concern that would justify a restriction. **A restriction must not be based on general fears or concerns because of the person's disability, or be based on provider convenience because of other people served.** Also, LAR preference in the absence of a health and safety risk cannot be used as a reason to limit participants' rights. CMS guidance mandates a process in order to restrict a right for any participant receiving HCB waiver services. Case managers must attest that they have reviewed rights and restrictions (if applicable) with the participant and/or LAR before the IPC can be submitted. The Division has developed a *Rights Restriction Review Tool* to help all parties understand rights restrictions and determine if a restriction meets the provisions established in Chapter 45 of Wyoming Medicaid Rules.

Rights Restrictions

Rights may need to be restricted to assure the health and safety of a participant (i.e., a restriction to address a specific behavioral or medical concern).

- When rights restrictions are deemed necessary, the individualized plan of care shall include a **rights restriction protocol** that addresses the reasons for the rights restriction(s), including the legal document, court order, guardianship papers, or medical order, that allows a person other than the participant to authorize a restriction to be imposed.
- If physical or mechanical restraints have been authorized in emergency circumstances to ensure immediate safety of the participant, provider staff, or other persons, then the appropriate box on the page shall be marked and listed as a restriction.

Rights are not privileges and should not be earned through good behavior. The participant must have all rights honored until there is a reason to restrict a right.

- Rights are listed in the **Rights screen**. Mark if a right is restricted.

Provisions in Rule to Determine if a Right Restriction Meets Criteria

The IPC must identify and document a health or safety need that requires a right restriction, and note how the right restriction will support the participant in addressing that specific need.

Rights cannot be restricted unless there is medical or legal authority allowing for the rights restriction (medical note from a doctor, legal order, guardianship documents, or representative payee documentation). The case manager must reference the required documentation in the IPC when completing the rights restriction section in the IPC. Additionally, each of the following components must be addressed for each restriction within the IPC. If any one of these components is not addressed, the rights restriction will not be allowed in the IPC.

1. The IPC must reflect the assessed **health and safety need** and how the restriction addresses that specific need. The plan should also explain the expectations of the provider should they have to restrict the participant's right. - *Chapter 45 Section 4.*
   - Example:
     Instead of saying, "Suzie has Polydipsia, providers should limit liquids," the IPC should say: "Suzie has a medical condition known as **polydipsia**. This condition makes her extremely thirsty. Because of Suzie's **medical condition (noted in the attached doctor's note)**, providers should limit her fluid intake to 20 ounces every three hours. The consequences of water intoxication include nausea and vomiting, headache, confusion and delirium, seizures, and coma. Suzie cannot have more than 100 ounces of fluid in a 12 hour timeframe. Suzie has a designated container in her refrigerator with the ounces labeled. Suzie knows that once it's empty, it will not be refilled until the next day. The provider needs to track the ounces and times she drinks in the notebook on the refrigerator. This information will be used in assessing the success of this rights restriction. Suzie should be involved in this process in order to have as much control as possible and make decisions for herself. She can choose what goes into the container (lemonade, tea, water, juice, etc.). This choice also helps Suzie maintain a sense of respect and dignity in this process."

2. The IPC must show **less restrictive alternatives** and positive supports that have been tried in the past. The IPC must also address why these alternatives were not successful. - *Chapter 45 Section 4.*
   - Example:
     In the past, Suzie was tasked with **monitoring her own fluid intake**, but she often forgot and became extremely ill. Her ankles began to swell and her behavior changed. Providers were asked to give her smaller cups, she just became angry and filled them up more often. Another alternative that was tried in the past, was having **providers write down the times when Suzie was asking for drinks and documenting the amount she would drink each time**. They'd show Suzie the chart every evening to help her understand when she had consumed more than the recommended amount of liquid. **She didn't want to participate and would still become ill**. After discussing this data with her plan of care team and her doctor, Suzie's doctor recommended that Suzie and her providers plan out the amount of liquid during the day, identify a drinking pattern, and use a designated container. This seems to work. Suzie should be involved in this process in order to have as much control and make decisions for herself to the extent possible. Suzie can choose what goes into the container (lemonade, tea, water, juice, etc.). This choice also helps Suzie maintain a sense of respect and dignity in this process.

3. A **clear description** of the condition that is directly proportionate to the specific assessed need must be addressed in the rights restriction. - *Chapter 45 Section 4*

- Example:
  Limiting Suzie's fluid intake throughout the day is proportional to the assessed need for the rights restriction, because when Suzie drinks too much, she becomes ill, and her feet and ankles swell. Her behavior also becomes increasingly aggressive when she exceeds the recommended amount of liquid in a given time period. **The attached doctor's note** explains this condition and his recommendations for Suzie's health in more detail.

- The doctor will not approve a restriction of rights; rather, they will provide information on the specific medical condition that the right's restriction will address. The note, letter, or medical order must include the following:
  - It should be on letterhead from the physician, or there should be clear identifying information that it came from the physician's office.
  - The document must include the diagnosis, the specific risk being addressed, the reason the right restriction is needed, and how it is tied to the participant's medical or mental health condition.
  - These letters must be updated annually to ensure ongoing monitoring of the restriction and evaluation as to the need for it to continue.

NOTE: A doctor's prescription stating that a participant's right should be restricted is not sufficient.

4. **Specific times and dates** must be addressed for the rights restriction section.
   - Example:
     Providers should limit her fluid intake to 20 ounces **every three hours**. Suzie cannot have more than 100 ounces of fluid in a **12 hour timeframe**. Suzie has a jug in her fridge with the ounces labeled.

5. The rights restriction section must also include a description of how the provider is expected to **collect data** on the restriction and how and when the team will assess the data that is collected. - *Chapter 45 Section 4*
   - Example:
     The provider needs to **track the ounces and times in the notebook on the refrigerator** before refilling the jug. This information **will be used in assessing the success of this rights restriction**. If Suzie is able to stick with this restriction without becoming ill, the restriction will be seen as successful. If Suzie is still becoming ill or aggressive, the IPC team will meet and discuss other options. This **data will be reviewed monthly by the provider and case manager, and every six months with the entire plan of care team**, unless things need to change sooner.

6. The rights restriction section must specifically state **when a provider can restrict a right**.

- Example:
  The provider will **need to restrict this right daily** as it is addressing a medical condition.   Suzie cannot have more than 20 ounces of fluid in a three hour time frame. Providers should check to see if she is drinking her fluids on a regular basis, and **can only restrict this right if she has exceeded the 20 ounce limit**.

7. The rights restriction must include **informed consent** of the individual. If the individual does not consent, but the guardian would like the restriction enforced, that needs to be noted in the section as well. - *Chapter 45 Section 4*
   - Example:
     The team discussed this restriction with Suzie. She said she didn't like it because she's always thirsty and wants to drink whenever she feels that way. However, her guardian explained to her that the restriction was necessary, because she can get really sick if she drinks too much of anything. **Suzie agreed to trying this restriction out**, but wanted everyone to know that she didn't like it.

8. The IPC must provide assurances that any interventions and supports discussed in the section will **cause no harm** to the individual.

9. The IPC must address how the team will work to **restore the rights** described in the section.
   - Example:
     While Suzie's fluid intake will need to be controlled for her entire life, the plan of care team and provider will monitor her data closely. **The team is working on helping Suzie follow her daily schedule for fluid intake on her own**. If Suzie can monitor and control her own fluid intake, providers will no longer need to restrict her right to access fluids. **Once this schedule and limitation becomes routine for Suzie and the team (including Suzie) agrees that she can safely monitor her own fluid intake**, this restriction will be removed.

Important Reminders

- ➢ The entire team has to agree on the rights restriction and is responsible for understanding that **a rights restriction that does not address all components established in Chapter 45 of Wyoming Medicaid Rules cannot be part of the IPC**. Case managers need to explain to the plan of care team that a provider cannot bill for any services if they are enforcing rights restrictions that are not written into a participant's IPC.
- ➢ If the requirements established in Chapter 45, Section 4(h) of Wyoming Medicaid Rules cannot be addressed, the provider cannot restrict the right, even if the LAR wants to have a rights restriction enforced.

Guidance on Specific Rights

The following information is not meant to cover all possible questions on rights and restrictions, but serves as a guideline. If there are specific questions, the case manager should consult with the assigned BES or the Benefits and Eligibility Unit Manager.

All provisions established in Chapter 45 of Wyoming Medicaid Rules must be met in order for a rights restriction to be included in an IPC.

Differences Between Rights of Children and Adults

- Parents typically exercise control of the rights of children while they are not in waiver services. These limitations do not need to be documented in the IPC.
- While receiving waiver services, it is not necessary to include rights restrictions for children under 18 in the rights restriction section of the IPC if limitations are imposed by the custodial parent; however, the IPC must describe the limitation and include detailed information on how the provider will implement the limitation that the parent has imposed. This information must be documented on the **Needs and Risks screen** of the IPC. Please note that restraint, seclusion, or any form of restriction or punishment that would be considered unsafe or that could cause physical or mental harm to the child is not permitted.
- Wyoming law considers all persons 18 or older as adults.
- Applicable rights restrictions ***must be documented for participants 18 and over, even when a LAR has been appointed.***

1. Privacy in my home (including activities of daily living)

List as a restriction if:

- Anyone needs assistance with completing **personal hygiene tasks**.
    - A letter from a medical professional that documents the medical condition that necessitates the health and safety need for the rights restriction will be considered adequate documentation. Guardianship paperwork or a copy of the ICAP assessment is not adequate documentation.
    - Letters from a medical professional must be obtained annually and uploaded in EMWS. If a psychological evaluation addresses specific lifelong mobility issues, a psychological evaluation will be acceptable documentation and an annual letter from a medical professional is not needed.
- Audio monitors or movement **sensors** are **used in the bedroom** of a residence, regardless of intent. Monitors used for seizure safety are still considered a restriction of privacy.
    - The use of monitors should be noted in the provider's policies or in other documentation to assure people are aware that conversations may not be private.

    - Video monitors are never allowed in bedrooms or bathrooms while the participant is receiving waiver services.
    - List as a restriction if audio monitors, visual monitors, or movement sensors are used in residential areas. Do not list as a restriction if they are used in day program sites.
- ➢ For a privacy restriction, include procedures or information that the provider will use to ensure dignity and as much privacy as is safe for the person.
- ➢ The use of monitors should be noted in the provider's policies or in other documentation to assure people are aware that conversations may not be private. Included in the policy should be a statement indicating who will be viewing or listening to the monitors and how this information will be used to better serve the participants at the location.
- ➢ Providers cannot restrict the right to privacy due to behavior (i.e. room searches) unless the restriction is addressing a documented health or safety need and the proper documentation has been uploaded in EMWS.

2. Locks on sleeping and living quarter doors

List as a restriction if the participant is not allowed to access their home and/or sleeping quarters without provider supervision due to a documented health and safety concern.

3. Choose with whom and where to live

List as a restriction if the participant has an LAR and is over 18 years of age.

4. Freedom to furnish and decorate

List as a restriction if:

- ➢ The participant cannot furnish or decorate their room as they choose and this is not reflected in the lease or residential agreement.
- ➢ The restriction is due to a documented health or safety concern.

5. Control over own schedule and activities

List as a restriction if the participant is not involved in developing their schedule.

- ➢ Explain how the provider will assist the participant in accessing the community. Providers are obligated to provide transportation when the rate includes transportation services.

NOTE: Participants who are 18 years or older have the right to control their own schedule and activities including their preferences, work hours, community/club memberships, social media and screen time, and other interests. This includes what time they choose to go to bed, and when, what, and where they want to eat.

6. Freedom and support to access food at any time

List as a restriction if:

- ➢ The participant's regimented, doctor-ordered meal schedule does not allow for flexibility, or deviations would result in significant health risks.
- ➢ Food or beverages are locked up due to health and safety concerns that meet a specific assessed need for the participant.

NOTE: The HCB settings rules prohibit dietary restrictions or limitations related to an individual's access to food and beverages unless there is a participant specific assessed need that is documented by a letter from a medical professional and justified within the IPC. Under these rules, participants must have freedom to choose whether or not to eat food without undue restrictions or regimens.

- ➢ The plan of care team should discuss and plan services that provide appropriate options for any participants with a medical condition where having access to food might be harmful.
  - ○ It is not acceptable to restrict a housemate's food and beverages due to a health and safety concern for a fellow housemate. Providers must come up with creative ways to allow access to food and beverages for participants who do not require this restriction.
  - ○ A restriction cannot be imposed for staff (supervision) convenience.
  - ○ A restriction cannot be imposed based upon fear or at the request of the guardian or legally authorized representative without meeting the guidelines in Chapter 45 of Wyoming Medicaid Rules.
  - ○ If food or beverages are restricted due to the health and safety needs of the participant, the restriction must be reviewed annually by the licensed medical professional (defined as someone who can prescribe medications). A letter that is signed and dated by the medical professional, explaining why the restriction is necessary, is *required*.

7. Have visitors at any time and associate with persons of one's choice

List as a restriction if:

- ➢ The restriction is due to terms of a court order, custodial rights, or condition of probation.
- ➢ The participant has an approved visitors list due to health and safety concerns.

Do not list as a restriction if organizational policy limits the number of visitors a participant can have.

- ➢ This should also be listed in the lease/rental agreement and explained to the participant. Restrictions on visitors specified in the lease should be comparable to restrictions found in leases for people who are not on the HCB Waiver.

8. Communicate with People of their choosing (includes make and receive phone calls)

List as a restriction if:

- ➢ The restriction is due to health and safety concerns.

Do not list as a restriction if the participant requests assistance with phone calls.

9. Keep and use personal possessions and property

List as a restriction if:

- ➢ There is a temporary removal of possessions, such as clothing, bedding, games, toys, books, crafts, movies, CDs, etc. for health and safety issues.

Restrictions will not be permitted unless there is documentation of direct harm caused by having access to the items. People must have access to their possessions unless they pose a threat to themselves or others. Once they are no longer a threat, access to possessions must be restored.

Each participant's right to access their possessions (i.e., money, clothes, games, hobby supplies, furniture, papers, pictures, etc.) is outlined in Chapter 45, Section 4 of Wyoming Medicaid Rules. Participants must be afforded the same opportunities to control personal resources as individuals not receiving HCB waiver services.

10. Keep and spend money

List as a restriction if:

- ➢ The participant has a **representative payee**.
  - ○ Upload evidence from the Social Security Administration that a payee has been assigned. Please note that a representative can only restrict benefits from the Social Security Administration.
- ➢ The participant has a **conservator**.
- ➢ The participant's **account requires two signatures**.

If funds are not restricted in any way but the provider reports expenditures to the LAR and case manager, do not list this as a restriction.

- ➢ When the participant has a **representative payee**:
  - ○ Check ***Yes*** under the right to Keep and spend money.
  - ○ Upload payee documentation.
  - ○ Indicate if the right is limited in any way other than the representative payee.
    - ■ If marked Yes, address the provisions established in Chapter 45 of Wyoming Medicaid Rule for right restrictions in the indicated boxes.

- If marked No, address how and why the right is limited in the indicated box. Include the name of the assigned representative payee and how the participant can access their money.

A representative payee is only authorized to manage the spending of a participant's social security or supplemental security income. Representative payees do not have the authority to manage wages or other funds that a participant receives.

NOTE: Money cannot be taken away and earned back through a reward system in a behavior plan. Standard monetary rewards as a behavioral device are not compliant with rule because people have a right to their money, possessions, furnishings, etc.

11. Right to access the community

List as a restriction if:

- A signed and dated note from a licensed medical professional (defined as someone who can prescribe medications) is obtained and uploaded.
  - The note must include a description of the risk to the community and the specific measurable and observable criteria for restoring access to the community.

Do not list as a restriction if the participant is an immediate safety risk to self or others, and therefore should not go out into the community. Once the participant is back in control and no longer a safety risk, they must be offered choice as to whether or not they feel comfortable to access the community.

NOTE: Community access may not be restricted as a consequence of not attending a service or not completing a goal or training activity. Participants cannot be rewarded with something they already have the right to, such as accessing the community.

12. Be free of physical and mechanical restraints

A ***mechanical restraint*** *is any device attached or adjacent to a participant's body, which he or she cannot easily remove, and which therefore restricts freedom of movement or normal access to the body.*

List as a restriction if the mechanical restraint is:

- ➢ An item such as a weighted blanket/vest/body sock, and the participant cannot remove the item on his/her own, unless the item is used in an approved therapeutic program.
- ➢ A lap belt, strap, glove, or other item that restricts movement of the body due to behavioral considerations, and the participant cannot remove the item.

Do not list as a restriction if used for standard safety reasons, such as:

- ➢ Seatbelt/car seat
- ➢ Wheelchair lap belt
- ➢ Specialized harness, car seat for adults, safety belt, head supports, bed rails, etc.
    - ○ These items should be included in Needs and Risks and Specialized Equipment sections of the IPC.

A ***physical restraint*** *is the application of physical force without the use of any device, for the purposes of limiting the free movement of the participant's body.*

List as a restriction if a physical restraint may be used.

- ➢ If a physical restraint is included as a restriction due to the health and safety needs, a court, the participant, or the participant's legally authorized representative must authorize the limitation in writing and the request shall be accompanied by letters from a licensed medical and behavioral professional that detail medical and psychological contraindications that may be associated with a restraint.
- ➢ The entire plan of care team shall agree to the use of restraints, confirmed with a signature from the participant, legally authorized representative, and all providers involved, and be consistent with Chapter 45, Section 18 of Wyoming Medicaid Rules.

Do not list as a restriction if the action is:

- ➢ Holding a person's hand to cross the street safely
- ➢ Helping a person get into or out of a place such as a vehicle

NOTE: Providers must complete training on positive behavior supports through any program approved by the Division prior to restraints being added to the PBSP.
The provider and provider staff shall maintain certification, and the provider shall require employees to receive ongoing training in de-escalation techniques, crisis prevention/intervention, and proper restraint usage from entities certified to conduct the training, such as Crisis Prevention Intervention (CPI), MANDT, or other entity approved by the Division.

13. Be free of chemical restraints

A drug used as a restraint is generally **NOT ALLOWED** to be in a participant's plan of care.

- PRNs used for behavioral modifications, which are prescribed by a licensed medical professional, must be part of a participant's standard treatment plan for their diagnosis or medical condition. These drugs are not considered restraints when used as prescribed.
- If a drug is used to restrict free movement of the participant's body, but it is not a part of the participant's standard treatment plan, it is considered a restraint. The Division will not allow waiver providers to administer chemical restraints. A chemical restraint shall not be used unless ordered by a licensed medical professional chosen by the participant or any legally authorized representative(s), and administered by a person licensed to administer the medication.

Plan for Restoration of Rights

For every restriction, there must be a plan to restore the participant's rights. The restoration plan should be added on the **Rights screen**, under each specific right.

Each plan MUST:

- **Minimize the effect** of the restriction
- **Set goals** for restoration of rights (training)
- Include **skills taught** regarding the restriction.
  - Example:
    If a participant has a restriction in place regarding money, the plan should include the skill/and or training the participant will receive regarding the restriction, i.e. identify coins, handing money to person at checkout when at the store, counting money, etc.
- **Include spending time** with the participant to assist and guide the participant with restoring rights.
- Set a **timeline for review** of the restriction and the skills the participant has learned.
- Assist the participant with **exercising rights more fully**. Even though a participant has a LAR, what part of that right is restricted and what part of that right is the participant able to exercise?

Restoration Plan Examples

The following examples answer the questions of *why is the right restricted and what is the assessed health or safety need that necessitates the restriction?*

Restriction: Right to keep and spend money

- Example:

When I became eligible to receive social security benefits, based on the information and letters that were required, I was required to have a representative payee. My payee is to maintain a separate checking account. The money is to be used for addressing my basic needs. My payee can only restrict my access to my Social Security money. My payee should monitor my finances and work with the LTC worker regarding continued eligibility.

- Restoration Plan:
  My payee ensures I have spending money to purchase items I want/need and I am able to participate in community activities. Staff takes me shopping where I can choose what items I want to purchase. My payee sends me a $200 check monthly. I am responsible for cashing this check and returning it to my home for safekeeping. I can have up to $20 on my person. Staff will assist me with creating a budget for the $200 I receive monthly so I can learn how to save money. Staff will provide me with training on calculating and budgeting my expenses. My progress will be monitored monthly by my case manager. Once I have demonstrated that I am able to budget my money wisely, my case manager will assist me with petitioning Social Security to remove my representative payee.
- Restoration Plan:
  My team helps me communicate with my payee when I want to purchase something, need money for an activity, or need personal items. I can have $5 on my person; however, staff assists me with all purchases. I can point to items I want to purchase or be given the choice between two items. Staff help me identify coins and I hand money to the person at checkout for my purchases. I will receive continuous training on identifying coins and dollar bills. If I am able to learn how to manage my current amount of spending money, then gradual increases will occur with the amount of money I am able to keep on my person. My case manager will monitor my progress every 3 months.

Restriction: Privacy in my home

- Example:
  I have cerebral palsy as confirmed by my physician. I require staff support to complete my ADL's, and I use a wheelchair to get around. I need assistance during showers and with all personal hygiene. Staff are required to provide me with verbal prompts and physical assistance as needed.
  - Restoration Plan:
    The door to my bathroom and the shower curtain are used for my privacy. My goal this year is to become more independent in my hygiene routine. Staff will assist me with this goal by providing me with verbal prompts and physical assistance as needed. Physical assistance will be limited to health and safety needs. My team will help me develop a visual checklist of my hygiene routine that I can follow. Documentation will be kept and reviewed monthly by my case manager to track my progress. As I become proficient with each hygiene task, I will require less staff support and complete them independently.

Restriction: Have visitors at any time and associate with persons of one's choice

➢ Example:
In the past I have assaulted visitors that have come into my home. I need supervision when around vulnerable individuals.
   ○ Restoration Plan: Provider will encourage education on developing healthy relationships, and appropriate touch. I will attend counseling per my counselor's recommendation to work on these. My counselor would provide input as to whether I am making progress and the restriction may be lessened.

Every participant must have the opportunity to work toward having their rights restored. The Division will not accept a restoration plan that states the LAR will decide when the restriction can be lifted or right can be restored. The plan of care team must work with the participant and LAR to identify skills or knowledge that the participant will need to obtain, and how the team will support the participant in acquiring that knowledge or skill.

Just because an individual is on probation does not give the provider the authority to restrict a right. The IPC must address all provisions established in Chapter 45 Section 4 of Wyoming Medicaid Rules. However, providers can assist the participant in making good choices. If the provider has concerns about health or safety, they should report those concerns to the appropriate authorities in accordance with Chapter 45, Section 20 of Wyoming Medicaid Rules.

Assessments

Use the **Assessments History screen** under Waiver Links to access and upload assessments.

➢ **LT-101 and LT104** assessments must be performed every year.
➢ The **neuropsychological** evaluations are valid for five years.
➢ **Psychological** evaluations must be updated every five years for those up to age 21. The Division may request updated evaluations after age 21.
➢ **ICAP** assessments are updated every five years for those on the Comprehensive Waiver.
➢ Any request by the plan of care team for a **psychological evaluation must have prior approval** from the Division.

LT101 Level of Care Assessments (For Participants with an Acquired Brain Injury)

The LT-101 assessment provides a method of determining initial and on-going eligibility based on the functional needs of the individual in performing activities of daily living and instrumental

activities of daily living, as well as the individual's social and cognitive functioning. The LT101 is presently used in Wyoming for establishing nursing facility level of care.

- The LT-101 assessment is performed by a public health nurse in the participant's county of residence.
- The process for completing the LT101 is task driven in EMWS, and those tasks are completed by other user roles. Case managers will receive an ***Awaiting LT101 Assessment*** task. This task does not require any action from the case manager. The purpose of the task is to inform the case manager that the LT101 assessment is due and has been referred to a public health nurse to schedule and complete.
- Case managers are responsible for explaining the LT101 assessment process to participants, LARs, or family members, and ensuring they understand the importance of completing the assessment.

LT104 Level of Care Assessments

The LT104 is an assessment that is used to indicate the initial and on-going need for waiver services for participants with an intellectual or developmental disability.

- The screening date, which is the date the assessment was completed, must be entered into the box provided.
- The county of the participant's physical address must be selected from the drop down menu.
- The ICF/ID date should be left blank unless the participant has been admitted into an intermediate care facility.
- The diagnosis is automatically populated from a previous LT104, if applicable. The diagnosis must match the current psychological evaluation. If it does not match, it needs to be corrected.
    - The individual must have a qualifying diagnosis to be considered eligible for the waiver. For new applicants, a possible diagnosis may be entered. Once the case manager receives the official eligible diagnosis from a licensed psychologist, the LT104 should be updated based upon the psychological evaluation.
    - In order for the need for wavier services to be indicated, the individual is assessed to determine if they meet at least one criterion in either the ***Medical or Psychological*** field and at least one criterion in the ***Functional*** field. Case managers MUST ensure that the boxes checked during the assessment align with the assessed needs of the participant. Case managers must assess and substantiate this information within the IPC.

Medical Field

Daily monitoring due to medical condition where overall care planning is necessary.
In order to answer this question, the case manager needs to verify that the participant has a medical diagnosis that requires daily monitoring. How is that daily monitoring occurring now? The case manager also needs to refer to the **Medical screen**, and if there is supporting documentation of a medical diagnosis, then this box can be checked.

Supervision due to medication effects.
What medications does the participant take? Does the participant need to be monitored for side effects? As an example, a participant diagnosed with brittle diabetes may have insulin reactions that require ongoing monitoring. If there is supporting documentation within the IPC, then this box can be checked.

Psychological Section

Supervision due to behavior, abusiveness, or assaultiveness.
Are there challenging behaviors that have been identified as moderate, severe, or critical? Is there a PBSP in place to address the identified behaviors? If there is supporting documentation within the IPC, then this box can be checked. However, if challenging behaviors are identified but the behaviors are not addressed in the IPC or there is not a PBSP in place to support the participant, then this box should not be checked. This should not be marked if the participant has a history of being abusive or assaultive but the *behaviors are no longer occurring*.

Supervision due to impaired judgment and limited capabilities.
The case manager should review the psychological evaluation, the diagnosis, and information within the IPC.

Supervision due to psychotropic medications.
Refer to the **Medical screen** to review the participant's current medications and identify if any are prescribed to treat a psychiatric condition. Most psychotropic medications require regular blood testing and follow up with the psychiatrist.

Functional Section

A structured and safe environment that provides supervision as needed to keep the person safe.
Refer to the Housing section, which describes the supports the participant requires at home. The **Needs and Risks screen** (supervision and vulnerability) may also include supporting information. What supports does the participant need? Are the supports addressed within the IPC?

Assistance with activities of daily living and self-help skills such as eating, using the restroom, dressing, and bathing.
Refer to the **Needs and Risks screen** (meal time and self-care) and the psychological evaluation. Does the participant currently require staff assistance to complete these tasks?

Assistance with ambulation, mobility.
Refer to the **Needs and Risks** (mobility) and **Specialized Equipment** screens. Does the participant use a walker, wheelchair, etc.? The participant's ICAP also addresses mobility and may be used as a reference.

Routine incontinence care, catheter care, and ostomy.
Refer to the **Needs and Risks screen** (self-care) for supporting documentation. Are any protocols within the IPC which address the participant's specific care needed in this area?

Determination

Once completed, if the individual has an eligible diagnosis, meets at least one criterion in either the *Medical or Psychological* sections, and meets at least one criterion in the *Functional* section, then the case manager can complete the "Action" step, moving the LT104 forward for review and final determination for ICF/ID level of care.

- A new LT104 must be submitted to the Division via EMWS annually within 365 days of the previous LT104 assessment, or when making a change to a different waiver program. The LT104 prior screening date(s) can be viewed on the **Assessment History screen** under Waiver Links.

Psychological/Neuropsychological Assessments

Psychological and neuropsychological evaluations must be completed and uploaded in the **Assessments History** screen under Waiver Links.

- **Psychological evaluation reports must include:**

  1.) All related diagnoses.
  2.) The full scale IQ score or an indication of a non-standard IQ score, or explanation as to why IQ testing could not be completed.
  3.) An assessment of adaptive functioning, such as the most recent version of the Adaptive Behavior Assessment System (ABAS) or Vineland Adaptive Behavior Scales (VBAS).
  4.) The clinician's professional opinion as to the level of deficit in each of the seven areas of functional limitation.
  5.) Autism Spectrum Disorders testing, as applicable.
  6.) The report must be signed and dated by the qualified clinician.

Refer to the Criteria for DD Psychological Evaluations. Psychological evaluations may be updated at the request of the Division. If a participant has an IQ that is on the borderline of being ineligible, or if the psychological evaluation is old or doesn't include the most currently required components, an updated evaluation may be requested by the Division. If the participant is under the age of 21, an updated psychological evaluation may be requested every five years until age 21.

- **Neuropsychological evaluation reports must include:**

  1.) A statement from the qualified clinician confirming the diagnosis of an acquired brain injury through record review.
  2.) Mayo Portland Adaptability Inventory (MPAI) Standard Score.
  3.) California Verbal Learning Test II, Trials 1-5, T-score.

4.) Supervision Rating Scale (SRS).

Refer to the Criteria for DD NeuroPsychological Evaluations. Neuropsychological evaluations must be updated every five years, unless approved more frequently by the Division.

- Recommendations from the evaluation reports should be considered and incorporated in the appropriate sections in the IPC.
    - These sections include the Needs and Risks, Rights, and Behavioral Supports.
    - Training methods, objectives, guidance on how staff interact with participants, and environments in which the participant is most likely to be successful may also be shared with the team.
- If an existing psychological or neuropsychological evaluation is being used to transfer to a different waiver, or to age up within a waiver, select ***Copy*** to duplicate the information.
- An out-of-date psychological or neuropsychological evaluation may affect the participant's continued funding.

Billing for Psychological and Neuropsychological Assessments

- Upload the evaluation report into the *Document* tab on the **Assessments History screen** under Waiver Links. Rename files using the DD EMWS File Naming Conventions.
- A new task will populate that requires the case manager to upload the invoice for the assessment. Upload the invoice, select ***Submit Invoice***, then select ***Complete*****.**
- Once the invoice is received, the BES will create the billing span, and send a task back to the case manager via EMWS.
- When the task that includes the billing date is received, notify the psychologist that they may now bill for the date provided, using the **T2024 billing code**.
- In order for a psychological evaluation to be paid through the DD Waiver, it must have **prior authorization** from the Division. The Division will not pay for evaluations conducted before the date the Division requests the evaluation in EMWS.

Inventory for Client and Agency Planning (ICAP)

The ICAP is an assessment tool used to identify objectives, medical needs, supervision needs, activities of daily living, and behavior supports in order to determine the level of service score for a participant on the Comprehensive Waiver. **Participants on the Supports Waiver are not required to have an ICAP assessment.**

- After the initial ICAP, ongoing ICAP assessments are completed every five years, unless requested by the team or the Division and pre-approved by the BES. An expired ICAP may affect a participant's continued funding.
- If the ICAP evaluation expires before the next plan year, the case manager should work with the participant or LAR to identify respondents and start the ICAP process. EMWS will initiate a case manager task ninety (90) days prior to the ICAP expiring.
- If an existing ICAP is being used to transfer to a different waiver or to *age up* within a waiver, select the ***Express button***, scroll to the bottom of the page and click ***Copy*** and the information will automatically populate.

- Complete the *ICAP Authorization form*, obtain participant or LAR signatures for permission for WIND to interview respondents, and enter the respondent information into EMWS.
  - Case managers must use their knowledge of the participant when completing the authorization and identifying respondents.
  - Respondents should be those who have known the participant for at least three (3) months and work closely with the participant in residential, vocational, educational, or other day settings. **Case managers can be respondents for an ICAP only as a last resort**.
- Upload the*ICAP Authorization form* under the first respondent. Then click the ***Action button*** to submit the ICAP.
- Upon completion, WIND will upload the ICAP into the participant's case in EMWS. Once WIND enters the information, the BES will review the information for accuracy, and may make changes, if necessary.

Circle of Supports

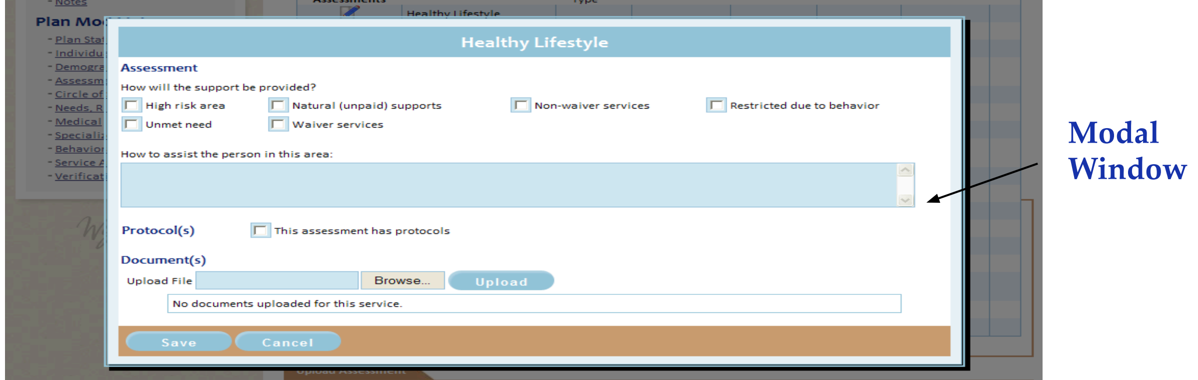
Home Setting Tab

- Select the appropriate home setting situation for the participant. Only one home setting may be chosen in this section. If the participant is receiving community living services, the ***community living services box*** needs to be selected, and a new box will populate to enter the number of individuals living in the residence. Select ***Save***.
- Information previously entered on the **Contacts screen** needs to be associated on this page. Contacts may be family members, relatives, friends, neighbors, representative payee, landlord, school supports, employment supports, natural supports, community members, or agencies, local emergency agencies, doctors, therapists, providers, DFS worker (if participant is a ward of the state), etc. The case manager and back up case manager must also be listed on this page. Click the ***Add button*** and select ***case worker*** from the drop down menu.
- If the participant has a power of attorney or LAR, upload the legal document on the **Contacts screen**. Use the appropriate **DD EMWS File Naming Conventions**.
- Enter the phone number and address for each contact, and remove duplicate entries. Remember to update the number and address contacts if either changes.
- Individuals listed on the **Circle of Supports screen** should be made aware that they are on the participant's contact list, unless it is a general community business or emergency agency.
- The team is responsible for teaching the participant to use their circle of supports, and providing the participant with a list of their contacts. This list should be programmed into the participant's cell phone, if applicable, or kept in a convenient and visible area in the participant's home.

Housing

- Although we encourage all participants to have a lease agreement in place, a lease or written residency agreement is *required* for individuals receiving Community Living

Services and residing in a location owned, leased, or operated by a provider or provider staff. All participants over the age of 18 who reside outside of their family home must have a signed lease or residency agreement if they receive Community Living Services. The lease must ensure equal protection for all tenants and comply with all relevant state and local tenant/landlord laws, rules, and regulations.



- During the IPC meeting, the case manager must confirm that the participant has a lease agreement for any HCBS certified location in which they reside. The case manager and care team should help the participant review the terms of the lease and assist in renewing it if needed. Even though the lease will not be uploaded into EMWS, the Provider Support Unit will review the lease during the provider's certification renewal.

- Each unit must have a lockable entrance door. Participants should have the opportunity to decorate their bedrooms and shared living space within the reasonable limitations specified in a lease. Participant's choice in housemates or roommates should be explained in this section. If the participant shares a bedroom, explain how privacy is honored and supported by the provider and roommate. This section should not be left blank. **Regardless of the services the participant receives, their living situation should be described in this section.**

Examples of statements found under Housing:

- My team will help me be safe in my home by __________. (Describe the strategies to minimize the occurrence of risky behavior and identify special accommodations or items used to help me be safe, etc.)
- I can talk with my guardian about where I want to live and with whom I want to live.
- I am not able to leave my home without supervision.
- I am free to decorate my room how I like, and my guardian listens to me if I have likes or dislikes I want addressed.
- I have poor mobility so I require supervision to ensure my safety and well-being.
- I live with a housemate. I have my own room which is decorated in a Star Wars theme.

Other Services Tab
Check all non-waiver services the participant is receiving (i.e. Department of Education, Department of Vocational Rehabilitation, Medicare, housing assistance, etc.)

Needs and Risks

If there are formal guidelines or protocols the provider must follow, the case manager should upload the document(s) in the modal window for the corresponding support area. To get to the **modal screen**, click the ***pencil icon*** next to the support area and the modal window will open.

- If the participant will be utilizing the remote monitoring option, check the box in this section and upload the required documents into the *Supervision* section. More information on remote monitoring can be found on the HCBS Service Definitions & Rates page.
- For each support area, identify *'How to assist the person in this area'*, which may include guidelines provided in the psychological or neuropsychological evaluation.
- ***High Risk Area*** should be selected if the particular area of support is a health or safety concern for the participant. Include the supports required to keep the participant safe and healthy.

The team is responsible for reviewing each applicable support area and documenting behaviors or conditions that pose a health and safety risk to the participant.

- The team will identify the necessary details needed to provide support to the participant in each area.
- If the support area is not applicable, such as employment for a 12-year old, enter a brief statement such as*, "I am going to school and too young for employment."*
- If this section includes a restriction, this must also be reflected on the **Rights screen**.
- When a participant has formal guidelines or protocols, such as mealtime guidelines, feeding protocol, special safety precautions, equipment guidelines, etc., include them in the appropriate support area by selecting ***Yes*** to *"This assessment has protocols"* and uploading the corresponding document in the box provided.
- Parents have the right to raise their minor children according to their wishes and desires. If a custodial parent chooses to delegate parental authority to the provider, this authority must be fully outlined on the **Needs and Risks screen**.
    - This requirement applies to any parental decision that would be considered a restriction for an individual over the age of 18.
    - Examples could include bedtimes, eating healthy meals and snacks, limitations on media consumption, and other parental decisions.
    - Providers and case managers must assure the health and safety of participants who are minor children, and must abide by Wyoming Medicaid Rule in order to provide Waiver services. Restraint, seclusion, or any form of restriction or punishment that would be considered unsafe or that could cause physical or mental harm to the child is not permitted.

Details for Each Support Area

1. **Communication**

   Describe how the participant communicates and the support needed to express needs and wants, or to better understand another individual.

   ➢ Examples of Communication:
   - I can verbally communicate.
   - I communicate using _______. (gestures, sounds, sign language, communication device, etc.
   - I verbally communicate but need time to process information. Please allow me extra time to process when asking me a question
   - Help me communicate by ________. (explain).

2. **Community**

   Participants should give input on with whom and where they want to interact, and choose the events and activities in which to be involved. Identify how to support the participant to access and be involved in their community.

   ➢ Example of Community:
   - I need staff assistance in public places due to ________. (document items such as falling risks, quick to develop sun burns, elopement, etc.)
   - My team will help me be safe in these situations by _______. (In the Protocols section, describe special accommodations, or items used to assist with safety.)

3. **Employment/Employment Training**

   Address the support needed for the participant to seek employment, if desired, and identify employment preferences. If employed, identify the place of employment, type of employment and average hours worked. Describe supervision and accommodations needed during work or training. The Third Party Liability Form must be uploaded for participants who are receiving individual or group supported employment services.

   ➢ Examples of Employment and Training:
   - The work I do _______. (Describe)
   - My average days and hours worked are _____.
   - I work at _____.
   - My work is considered ______. (Independent employment, individual community integrated employment, group supported employment)

NOTE: Restrictions cannot be applied to employment unless they are due to health and safety concerns.

4. **Family and Friends**

   Participants are encouraged to host friends and families in their home settings. Participants are encouraged to have visitors during day services to improve the quality of their social life.

5. Financial and Property

The least amount of control over a participant's personal resources should be exercised. Any required control of funds must be detailed in the IPC and specific to the participant. Specify if the participant has a representative payee, and identify the payee. The payee's contact information should be included on the **Contacts and Circle of Supports screens**.

- Examples of Money Transactions:
  - I can manage and budget my money independently. I need assistance with budgeting and check writing. I can keep up to $_____ on my person. I can exchange money for purchases.
  - My mother is my payee. I can carry $35 in cash and use this money to make purchases with staff assisting me in my spending decisions.
  - Staff hand me my money when I make a purchase so I can begin to understand what money is used for, and assist me in verifying that I receive the correct change.

6. Healthy Lifestyle

This section should include things like drinking more water, exercise options, choosing healthy snacks, seeking better habits, participation in recreational activities or organized sports.

- Examples of Healthy Lifestyle:
  - Please encourage me to drink more water throughout the day.
  - I enjoy being active and participating in the Special Olympics. My favorite events are golf, bowling, and swimming.

7. Meal Time

Participants have the right to access food at any time. Mealtime schedules should be personalized, and participants should be able to decide with whom, where, and what to eat. Restrictions must be detailed on the **Rights screen**. Needs and additional supports to achieve these rights should be detailed in this section.

- Mealtime includes formal **guidelines or protocols** that have been developed by a prescribing medical professional, nurse, dietician, or speech therapist to assist the participant with safe eating. Protocols for a feeding tube, or a meal plan created by a therapist to address a risk of aspirations are examples of a mealtime protocol.
  - **Dietary protocols a**ddress formal **nutritional guidelines** from those identified above or can be informal guidelines that the team has outlined such as the participant does not like pasta.
  - Upload protocol(s), if applicable.
  - Explain the assistance needed for grocery shopping, meal planning, and cooking.
- Examples of Mealtime Support:
  - I can prepare my own meals and eat independently.

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- I need assistance planning meals and grocery shopping. My goal is to cook at home with staff assistance four times weekly.
- I need assistance in making healthy food and drink choices, and I need assistance to eat safely. Please follow my protocol.

8. Mobility

All settings in which services are provided should be fully accessible to the participant. Accommodations to allow for participation in activities should be detailed in this section. Protocols for positioning and transfers are uploaded or entered directly into this section.

➢ Examples of Mobility Support:
- I am at risk of falling when I first stand up. Staff should remind me to ask for assistance before standing. I will hold a staff's arm when getting up and hold on to staff or furniture during the first few steps I take.
- I can walk independently, but often need support on icy and uneven surfaces. Please offer me your arm to hold for support.
- I can walk with assistance or ________assistive equipment. (specify type of equipment)
- I use a wheelchair __________. (specify part or all of the time)

9. Physical Conditions

Accommodations to enable the participant to access the community should be detailed in this section.

➢ Document specific support and safety precautions and describe any special equipment or environmental supports needed. This could include safety risks in the home.

➢ Include occupational or physical therapy goals.

10. Self-Advocacy

Participants should be encouraged to advocate for themselves to the extent possible. In some instances, due to limitations, a participant may require the assistance of others to advocate on their behalf. This section should capture how the participant self-advocates, explain how others may advocate for the participant and identify those individuals who will advocate on the participant's behalf.

➢ Examples of Self-Advocacy:
- I can make my desires and concerns known to people who can fix them.
- Although I can make known my desires and concerns to the people I know well, I do need assistance advocating for myself by ____________________.
- Staff will teach me advocacy skills so I can learn how to advocate for myself. My case manager will help me understand my rights and help me exercise those rights as much as possible.

11. Self-Care/ Personal Hygiene and Bathing

If a participant needs physical support beyond verbal prompting in this area, there *must be a restriction* on the participant's right to privacy indicated in their IPC if the participant is eighteen or older.

- Examples of Self-care:
  - I can use the restroom independently, but need reminders to take a shower and assistance with my laundry.
  - I need someone to wait outside the bathroom door while I shower in case I fall or need assistance.
  - I do not enjoy showers or baths, and will often refuse to take them. I need the following encouragement to bathe, but if I refuse _____ reminders, it is best to not push me any further. *(Describe encouragement needed.)*
  - I need verbal prompts ______ (specify how often) to use the restroom.
  - I need _________ (specify instructions) assistance with peri-care or during menses.
  - I require medical equipment _______ (document type) supports in the bathroom.
  - I can complete personal hygiene tasks independently.
  - I use checklists or other reminders for _______ (document specifics).

12. Supervision

Assistance during times of more intensive needs: Describe the support needed during critical care times.

- Examples of Support During Emergencies:
  - I can evacuate independently.
  - I can evacuate independently but I need verbal prompts. (Describe)
  - During critical care times or crises, this is how my support needs and supervision should change and how the extra assistance should be accessed: ___.

Staffing patterns for habilitation services: Describe the staffing support for the participant.

- Examples of Habilitation Supports:
  - On a typical day, my usual support is____.
  - I can have less support when___ (in my room, watching TV, doing sedentary activities, etc.). I need closer support when ____ (as documented in my Positive Behavior Support Plan, during personal care, mealtime, community outings, etc.).

Supervision while sleeping: Describe the supports the participant needs while sleeping, if receiving waiver services.

- Examples of Supervision While Sleeping:
  - Due to my seizure disorder, I need a safety check every two hours.
  - I need to be within hearing distance while sleeping.
  - During sleeping hours, I need to be repositioned every ____ hours.

How to assist the person: Summarize supports needed in the different settings for all waiver services.

- Example of Supports Summary:
  - My level of support may change in different environments. I may require more supervision in the community and less supervision while at home.

13. Transportation

Participants should have transportation options that result in the ability to access the community whenever they please. Specific details of how the participant can use transportation should be detailed in this section. Include who may be providing the transportation, and detail if transportation is accessible, affordable, and available upon request. Any health and safety concerns during transport should be addressed.

- Examples of Transportation:
  - I do not need assistance with transportation.
  - I use public transportation.
  - I need transportation assistance to __________ activities. (specify the activities)
  - I sit in the front seat of the van because__________________.

14. Vulnerability

- Examples of Special Safety Precautions:
  - I am at risk because _____ and I need ____ support to decrease the likelihood of this occurring.
  - I am at risk because I don’t communicate verbally, and therefore could be easily taken advantage of as I cannot voice to you why I am uncomfortable.
  - I am at risk because I use a wheelchair and am unable to leave situations that make me uncomfortable.

Medical

Case managers are responsible for educating the participant and team on the importance of receiving regular medical care. Case managers are responsible for documenting who is responsible for medical appointments, the results of medical appointments, appointment refusals, and strategies to encourage the participant to receive medical treatment.

Medical Professional Tab

- List any medical professionals with whom the participant works, including the primary physician, dentist, and optometrist in this section. Medical professionals included in the **Contacts screen** will automatically populate to the **Medical screen**. To add a medical professional, select “Add”, or add to the **Contacts screen** under Waiver Links. Either link can be used to add or modify this section.
- Include the last appointment date and any recommendations. If the participant has not seen the medical professional in more than a year, state the reason why.

Diagnoses Tab

- Diagnoses are automatically populated from the ICAP and psychological or neuropsychological assessments. Additionally, any medical diagnoses should be added. All diagnoses should be current.

Medications Tab

- When providers are responsible for assisting with medications, select ***Yes*** from the drop down box, and upload the completed *Medication Consent Form* under the *Medications* tab.
- Add all medications the participant is taking in this section. Please note that if you delete the name of a prescribing entity from the contact list, all medication listed under that name may be deleted from the medication page.
    - Please add the name of the new prescribing entity and ensure they are listed as the prescribing entity on the appropriate medications before you delete the contact.
    - Keep the medication list as current as possible.
- Case managers can choose to upload the **Medication Assistance Record (MAR)**, if applicable instead of manually entering each medication and dose. A new MAR must be submitted with each supplemental request or modification to the IPC.

Medical Regimen

- Upload specific medical protocols to include feeding tube, PRN, meal time, seizure, positioning, Vagus Nerve Stimulator, and medication assistance (i.e. participant needs to take medications in applesauce; medications need to be locked-up in the home, etc.).
- Providers that assist with medications must have a valid **Medication Assistance Training (MAT) certificate**.
- A *Medication Consent Form* must be completed annually if medications are not self-administered.

If a participant has been prescribed a behavior modifying PRN medication, **a corresponding protocol must be included in the IPC.**

Although it is not necessary for every participant to have a PBSP, one must be developed if a participant has restraint written into their IPC.

It is also best practice for participants who have targeted behaviors rated as *moderate or high* identified on an ICAP assessment - or for those who have had an increase in incidents related to their behavior - to have a PBSP as part of their IPC.

- Case managers may obtain a release of information form to authorize the discussion of medical issues with the participant's physician. The case management organization is responsible for developing a release form and keeping this form in their own files. Case managers do not upload a copy to the Division, but do have it on hand if requested for review by a PVS.
- Provide information on who is responsible for scheduling, transporting, and supporting participants during their medical appointments in the *Assistance needed at medical appointments* box.

Known Allergies Tab

- Select all known allergies. Once an allergy is selected, a drop down box will populate for the case manager to document serious reactions or other important notes. If a protocol is more appropriate, it should be uploaded into the *Medical Regimen* section.

Specialized Equipment

- Enter all of the equipment that the participant is using (i.e. wheelchairs, walkers, shower chairs, glasses, communication devices, and hearing aids).
- Enter all equipment purchased with waiver funds within the last IPC year, even if no longer used.
- **Enter equipment that the participant needs, but has not yet purchased.**
  - The plan of care team should discuss community resources and waiver options that can be explored to help the participant obtain the equipment they need.

Behavioral Supports and PBSP

EMWS automatically populates ICAP targeted behaviors that are identified as *moderate, serious, or critical* on this screen. If an identified behavior is not specifically addressed on an assessment, it can be added.

- Previous targeted behaviors that are not reflected in the current ICAP are to be removed by clicking the red **X**, but targeted behaviors from the current ICAP should remain.
- There will be a prompt to *"Include a Positive Behavior Support Plan (PBSP)"*.
  - The team should complete a PBSP based on a Functional Behavior Assessment (FBA). The FBA should be used to help guide the team in developing the PBSP.
    - A PBSP can be created for any targeted behavior, not just those identified by the FBA/ICAP.
    - If a PBSP is not needed due to the participant only needing occasional intervention, then these **strategies must be clearly defined in the IPC**.
- If a participant uses a PRN medication that has been prescribed by a licensed medical professional to help manage stress, anxiety, or behaviors, they should have a **PRN protocol**, which can be presented as part of the PBSP. The protocol must be included as a formal component of the individualized plan of care.

- In the Positive Behavior Support Plans section, select ***Add***, complete the checklist, and upload the completed PBSP form which includes a FBA and summary of the behavioral data collected over the past plan year as it relates to the targeted behaviors.
    - If the team no longer considers an ICAP targeted behavior to be moderate or above, and the ICAP was completed more than one year prior, select the ***pencil icon*** next to the behavior and select ***"****No behavior plan needed****"***. In the screen that populates, document why the team has determined that a PBSP is no longer needed.
- Refer to the *Positive Behavior Support Plan Manual* available on the HCBS Document Library for detailed information on positive behavioral supports and developing a PBSP.
    - The *Positive Behavior Support Plan Manual* is a reference tool for case managers and providers to use when a team is working with a participant who is demonstrating an increase in challenging behaviors, or is experiencing a behavioral crisis.
    - It provides a systematic process to guide teams in developing positive behavior support plans, and serves to reduce aversive or restrictive procedures that are used to manage challenging behaviors.

Service Authorization

- All waiver services must be prior authorized by the Division.
- Add the participant's desired services and units to the **Services Authorization screen**. The requested units for each service should cover the entire plan year.
- For services delivered in the traditional way, only certified providers can be chosen from the drop down menu under the *Services* tab. If a provider is not in the drop down menu, they are not certified to provide the service. Contact the provider if this is believed to be an error.
- If a participant is self-directing services, add the service under the *Self-Directed Services* tab.
- Mark the box that certifies that all service caps and definitions have been followed.

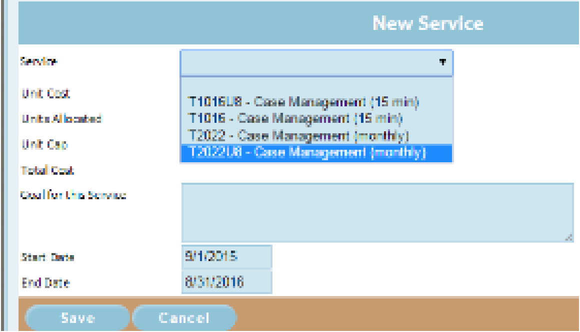
IBA Section

1. Use the current individual budget amount (IBA) to determine services and utilization on the IPC. The requested services and units must stay within the allotted IBA amount. If the request exceeds the IBA, the amount will be displayed in parenthesis ($420.00). *"Plan is over the IBA"* will also appear at the top of the **Plan Status screen**. If the request exceeds the IBA, the team will need to meet to adjust the services to fit within the assigned IBA. If the team determines that a participant needs an IBA adjustment, refer to the Chapter 4 - Supplemental Request section in this guide.

    - If a child will age up during the plan year, calculate units to reflect the correct number of days in service through the end of the month of their 21st birthday.
        - *Example:*

If the participant turns 21 on May 8th, calculate the units through May 31st. A new adult plan will start June 1st.

- The case manager will be notified that a participant is aging up ninety (90) days before the new adult plan becomes effective and should follow the eligibility tasks assigned in EMWS. The case manager can monitor the participant's transition status throughout the eligibility process by looking at the **Waiver Links screen** under **Processes**.
- Complete the LT104. When the task for the psychological evaluation populates, open the ***task*** and click the ***Copy*** at the bottom of the screen. This will copy the evaluation into the new adult case. Contact the BES to cancel the invoice task.
- In the Comprehensive Waiver adult case, open the ***ICAP request*** task. Select ***Express*** at the bottom of the screen and then click ***Copy***. This will copy the current ICAP from the child case to the adult case.



2. A history of the participant's IBAs can be found by selecting the **Individual Budget Amount screen** under Waiver Links.
3. If the IBA is believed to be inaccurate due to a system error, contact the BES.

Case Management Section

To add case management:

1. Select the service provider from the drop down menu.
2. Enter units allocated.
3. Enter *"Not Applicable"* in the ***Goal for this Service*** box.

Services Section

For traditional services:

1. Enter the requested services and units, assuring all information is accurate and complete.
2. Upload supporting documentation required for the following services: Crisis Intervention, Dietician Services, Occupational Therapy, Physical Therapy, Skilled Nursing, Speech, Language and Hearing Services, Environmental Modifications, Specialized Equipment, Supported Employment, and Behavioral Support Services.
3. List the goal for each habilitation service during the IPC year. Goals should align with the participant's desired accomplishments for the IPC year, which are also documented on the **Individual Preferences** screen.
4. For non-habilitation services in which a specific objective is not required, the case manager may enter *"Not Applicable"* in the ***Goal for this Service*** box.

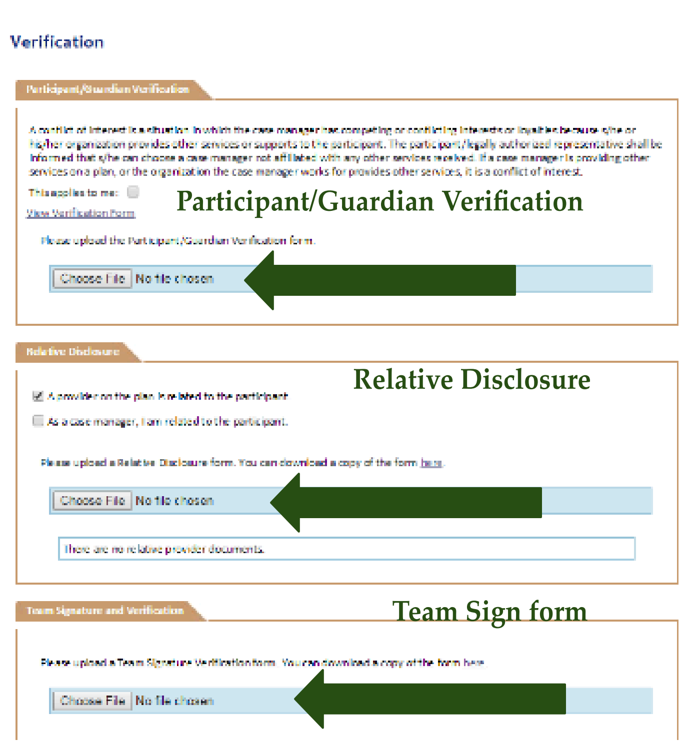
In the team meeting, the participant should identify a long-term goal for the future. A goal is a brief, clear statement of an outcome the participant wants to achieve. The goal should not indicate how to do something, but rather what the results will look like.

Examples:
- I will be able to prepare my own meals.
- By the end of the year, I will be able to ride my bike independently.

Participant-Directed Services Section
1. If the participant has completed the self-direction enrollment process, add the self-directed services in the *Self-Directed Services* tab on the **Service Authorization screen**.
2. Enter and save the budget amount allocated to self-direction through the fiscal intermediary.
3. The self-directed budget will be submitted to the fiscal intermediary. The case manager is responsible for allocating the budget within the approved services.
4. Participants who direct their services must receive services that meet the service definition as stated in the most current Service Index. Any service that requires the establishment of a goal must have that goal indicated in the IPC.

Verification

Participant and Legally Authorized Representative Verification Form
- The *Participant and Legally Authorized Representative Verification form* (often referred to as the Verification form) can be downloaded under the *Participant/Guardian Verification* tab in the **Verification screen**.
- The LAR and/or participant will complete and sign the form.
- The case manager must answer the questions on the Verification screen. Answers must coincide with the responses provided by the participant and legally authorized representative on the Verification form.
- Upload the completed form to the *Participant/Guardian Verification* tab.



Relative Disclosure Form

- ➢ The case manager must verify when a participant's relative (defined as a biological, adoptive, or step parent) is providing services on the IPC by selecting ***"Yes "*** in the box provided and uploading the *Relative Disclosure form*. Once ***"Yes"*** is selected, this form can be downloaded.
- ➢ The *Relative Disclosure form* must be signed by the authorized Division representative prior to uploading it into EMWS. Obtaining this signature may take up to seven (7) business days.
- ➢ A new *Relative Disclosure form* must be completed if the relative provider, services being provided, legally authorized representative, or waiver type changes. This form must be uploaded annually with the IPC.

Team Signature and Verification Form

- ➢ After the IPC is fully developed, all team members are required to read, sign, and date the *Team Signature and Verification form* (often referred to as the *Team Sign form*) and upload it under the *Team Signature and Verification* tab. This form is located in EMWS in the **Verification** link.
- ➢ If a team member's signature is unable to be obtained due to an extraordinary situation, the case manager can work with the assigned BES on a timeline for submitting the signature.
- ➢ Providers who fail to sign the *Team Signature and Verification form* will not be authorized to provide services on the IPC.
- ➢ If changes are made in the review process, all team members must be notified and sign a new or revised *Team Signature and Verification form*.

Finalize IPC

After all the steps for developing the IPC are completed, the case manager must check the box certifying that all documents are current and signed. The IPC is then ready to be submitted for review. Go to the **Plan Status screen** and select ***Submit***. If the IPC is missing required items, a description of the missing information will populate, and the case manager will not be able to submit the IPC until all items are included.

NOTE: When the status is *Reviewed Plan of Care*, it is not possible to make changes to the IPC. Changes can be made when the status is *Submit Plan of Care.*

Once reviewed, the IPC, including the PBSP and protocols, must be distributed to team members. Protocols do not automatically print when *"Print IPC'* is selected. These items will need to be printed separately.

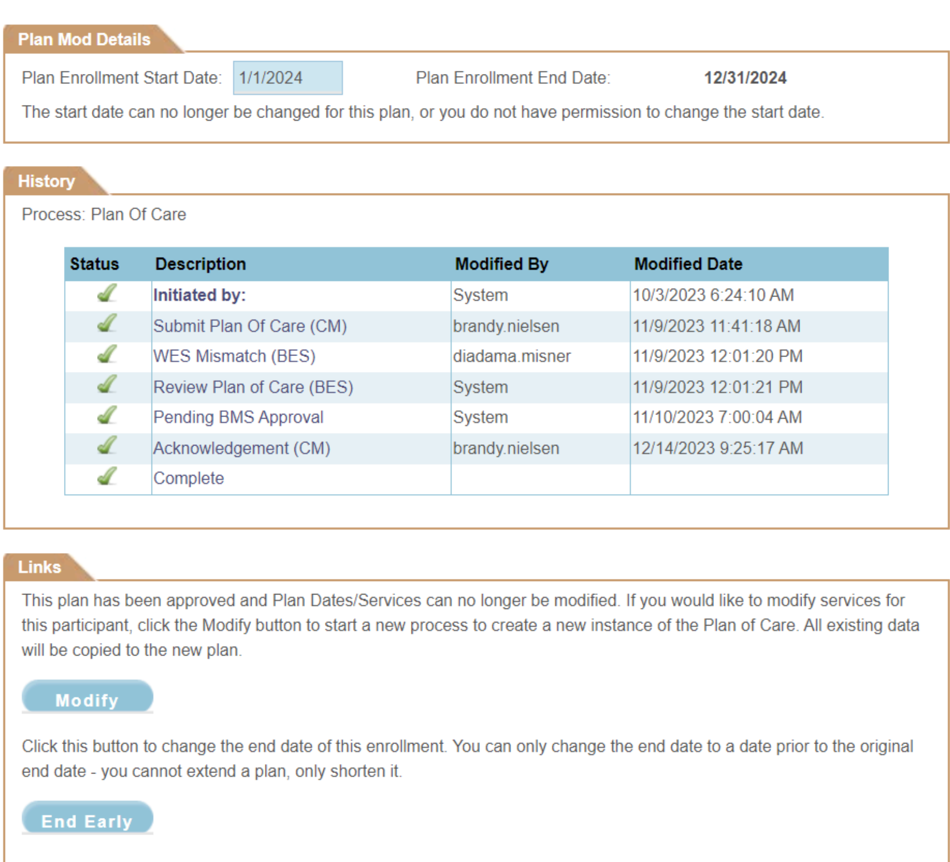
Modifications to an IPC

Modifications can only be made to the most current completed IPC. For example, if the status of the IPC is *Pending BMS Approval*, it cannot be modified. Modifications to a complete current plan are required to be submitted when there is a change in traditionally provided services, service rates, service units, providers, self-direction dollars, rights restrictions, or the PBSP.

Modifications cannot be made to closed IPCs. It is imperative that all units have been moved or changed prior to the end of the plan year.

A modification is initiated by the case manager by clicking the ***Modify button*** on the **Plan Status screen**.

- An explanation of the modification should be detailed in the box provided on the **Plan Status screen**. A modification should not be submitted unless a reason is noted.
- ***Modification Effective Date:*** Note the date the modification is effective on the Plan Status screen.
    - This date must be at least seven calendar days after the submission date of the modification. The modification effective date must be at least one day after the IPC start date or the last plan modification.
        - Example:
          If a modification is submitted on March 16, the modification effective date would be March 23.
- Make changes to the services and upload any required documents, per the service definition, on the **Service Authorization screen**.
    - Services added to the IPC on the **Service Authorization screen** must have the same start date listed as the modification effective date.



Plan Mod Details

Plan Enrollment Start Date: 1/1/2024 Plan Enrollment End Date: **12/31/2024**

The start date can no longer be changed for this plan, or you do not have permission to change the start date.

History

Process: Plan Of Care

Status	Description	Modified By	Modified Date
✓	**Initiated by:**	System	10/3/2023 6:24:10 AM
✓	Submit Plan Of Care (CM)	brandy.nielsen	11/9/2023 11:41:18 AM
✓	WES Mismatch (BES)	diadama.misner	11/9/2023 12:01:20 PM
✓	Review Plan of Care (BES)	System	11/9/2023 12:01:21 PM
✓	Pending BMS Approval	System	11/10/2023 7:00:04 AM
✓	Acknowledgement (CM)	brandy.nielsen	12/14/2023 9:25:17 AM
✓	Complete		

Links

This plan has been approved and Plan Dates/Services can no longer be modified. If you would like to modify services for this participant, click the Modify button to start a new process to create a new instance of the Plan of Care. All existing data will be copied to the new plan.

Modify

Click this button to change the end date of this enrollment. You can only change the end date to a date prior to the original end date - you cannot extend a plan, only shorten it.

End Early

- Upload a signed copy of the *Team Signature Verification form* in the **Verification screen**.
  - Signatures from all providers affected by the change must be obtained. In extraordinary situations, the case manager should work with the BES if signatures on the *Team Signature and Verification forms* cannot be obtained from the necessary parties.
- The Division has seven (7) days from the date that the modification has been submitted to process a modification.
  - The BES has the ability to change the modification date if the submitted information is incomplete.
  - If an exception to this timeline is necessary, submit a request on the **Notes screen** under Waiver Links, and notify the assigned BES via email or phone call, that an exception is needed.
- If the modification is needed to change the case manager, residential placement, or provider, upload the *Transition Checklist* into the **EMWS Document Library screen**.
- Once a modification is submitted and reviewed, the modification to an existing plan and corresponding modification start date will be listed on the **Plan Enrollments screen** located under Waiver Links.

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If the modification is not reviewed by the suggested IPC start date, the BES may work with the Case Manager to change the modification effective date or service start dates. The case manager may be required to provide a new *Team Signature Verification Form.*

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CHAPTER 4 - SUPPLEMENTAL REQUESTS

Overview

In order to submit a supplemental request for an Extraordinary Care Committee (ECC) review or reconsideration, the case manager will select the **Supplemental Requests screen** under Waiver Links. The specific type of supplemental request can be selected from this screen.

Extraordinary Care Committee (ECC)

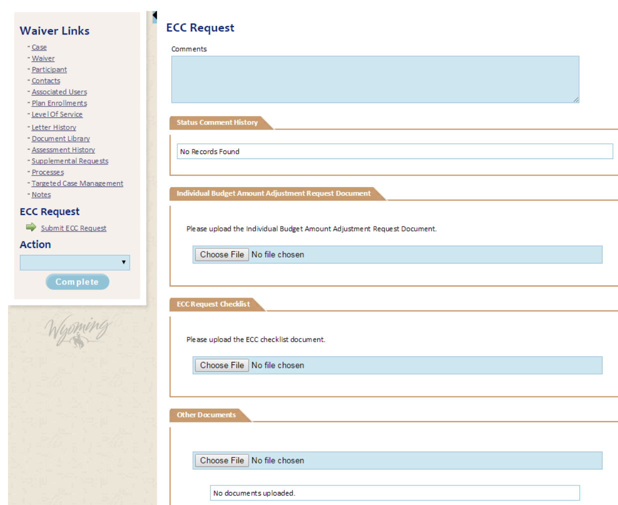
The Extraordinary Care Committee (ECC) has the authority to approve, modify, deny, or provide consultation on a submitted request. The ECC will carefully consider any request that meets the criteria established in Chapter 46 Section 15 of Wyoming Medicaid Rules. ECC requests that do not meet the criteria as stated in Chapter 46, Section 15 shall not be considered by the ECC.

A participant's IBA shall not change unless there is a significant change in service need due to the onset of a behavioral or medical condition, or injury, or if the team can demonstrate that a participant's Level of Service Score does not reflect the participant's assessed need. A request to adjust a participant's IBA **requires supporting evidence**.

An IBA is based on assessed needs of each participant. Due to changes in the assessed needs, changes in circumstances, or due to other emergency situations, the Division may change the IBA either *permanently or temporarily*, to address the changes in need or circumstances. Budgets can only be assigned that correlate with the assigned Level of Service (LOS) - not higher. There is a possibility of the budget being reduced based on updated LOS and current funding models.

Case managers have the following responsibilities when making a request to the ECC:

1. Identify how the request meets criteria as outlined in Chapter 46, Section 15.
2. Gather all pertinent information for the request from providers, psychologists, family members, medical professionals, or other contributors.
3. Provide evidence of the emergency situation from a professional(s) or agency. Ideally, all supporting documentation should be signed and dated **within the last 30-90 days** and must demonstrate that the individual is actively being followed by a physician or other medical professional.

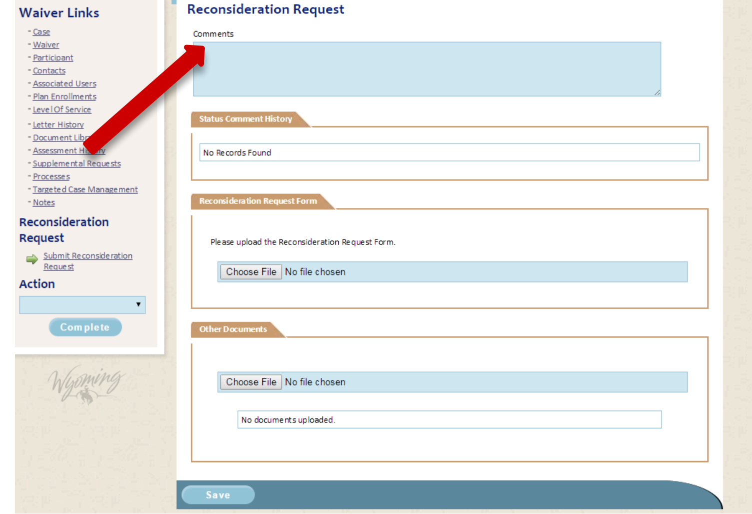


4. Work closely with the BES to ensure that all required documents are ready for submission, the request is complete, and scheduled for review.
5. Initiate a review of the request by uploading the completed *ECC Checklist*, *ECC Request Form*, *ECC Team Consensus Form* and all other documentation listed on the ECC Checklist.
    - If the ECC request is part of an annual plan of care submission, submit the request 60 calendar days prior to the plan start date.
6. Once submitted, EMWS will create a task for the area BES to review the request. This can be tracked through the ECC process flow in EMWS and case managers should check the *Task List tab* frequently.
    - The BES has seven (7) calendar days to review the request and evaluate the justification and supporting documentation.
    - If the request is incomplete, the BES will roll it back to the case manager with a request for additional information. Failure to submit required information will cause a delay in the case being reviewed by the ECC.
7. Once the BES finds the request complete, they will forward it to a Division Manager to verify its completeness and schedule the case for review by the ECC.
    - The ECC has twenty (20) business days to review the request and make a decision. Participants or LARs will be notified of the committee's decision in writing within twenty (20) business days of the decision. **The case manager must acknowledge the decision in EMWS.**

Reconsideration Request

When a participant or LAR requests a reconsideration based upon an adverse action notification, the case manager will:

1. Select ***Reconsideration Request*** under the **Supplemental Requests screen**, and upload the supporting documentation (i.e., letter from participant and/or LAR, letter from physician or other professional; medical documentation; behavioral tracking that includes frequency, duration, and severity; progress notes; etc.).
2. ***Submit*** the task.
3. Check the EMWS *Task List tab* frequently to see if the request has been rolled back due to missing or incomplete information. Upload any additional information that is requested, and resubmit.
4. Once a reconsideration decision is made, the Benefits and Eligibility Unit Manager will upload a reconsideration decision letter into EMWS. **A task will populate for the case manager to acknowledge the final decision.**



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CHAPTER 5 - Incident Reporting

Overview

Incident reporting requirements are established in waiver agreements with the Centers for Medicare and Medicaid Services (CMS) and Chapter 45, Section 20 of Wyoming Medicaid Rules. According to these authorities, providers must meet the following requirements:

- ➢ Providers must report all **critical incidents** to the Division of Healthcare Financing (Division), the Department of Family Services, Protection & Advocacy, the case manager, legally authorized representative, and law enforcement immediately after assuring the health and safety of the participant and other individuals. Critical incidents include suspected abuse and self-abuse, suspected neglect and self-neglect, and suspected abandonment, exploitation, and intimidation.
- ➢ Providers must report circumstances outlined in Section 20(b) to the Division, Protection & Advocacy, the case manager, and legally authorized representative within **one business day.**
- ➢ Providers must report **medication errors** outlined in Section 20(c) to the Division, the case manager, and legally authorized representative within three business days.
- ➢ Finally, providers must report any situation that is identified as a **significant risk** to a participant's health and safety to the Division.

If an incident occurs while the participant is receiving services from a provider, the provider must report the incident. Providers do not have the authority to delegate their responsibility to report incidents to another party, such as a case manager.

Case managers also have specific obligations related to the reporting of incidents.
If the incident occurs while the case manager is delivering case management services, they must meet all incident reporting standards established for waiver providers.

- ➢ As established in Section 9, as part of their monitoring activities, the case manager must report to the provider any concerns they have with the provider's implementation of the participant's IPC, or concerns with the participant's health and safety. They must also report identified rule violations to the Division through the incident reporting or complaint processes.
- ➢ As established in Section 18, the case manager must **follow-up on each incident within two (2) business days of notification** of an incident involving restraint to ensure the participant is safe and uninjured, ensure the participant's restraint protocol and positive behavior support plan were implemented appropriately, and verify that

documentation demonstrates that less restrictive intervention techniques were used prior to the use of restraint. They must report any suspected non-compliance to the Division.

- Additionally, if a case manager receives notice that an **unauthorized restraint** has been used, they must call a **team meeting within two (2) weeks** to discuss the incident and decide if the participant's IPC needs to be modified to include a crisis intervention protocol, or if the positive behavior support plan needs to be revised.

Waiver Links

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plan Enrollments
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes
- Incidents

If a case manager identifies an incident that a provider failed to report, the case manager must submit that situation to the identified agencies immediately. If a case manager is aware of an incident, but has additional information or a different perception of the situation, they should submit a report of the incident from their perspective.

Case managers can submit incidents through EMWS. Select ***Incidents*** in the left hand navigation bar and complete the report as directed.

Please note that failure to comply with rules established in Chapter 45 could result in corrective action. Questions should be directed to the area Incident Management Specialist.

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CHAPTER 6 - FORMS AND HELPFUL TOOLS

IPC Required Forms

Guardianship Orders
Typically, parents are the legally authorized representative (LAR) of children under 18 years of age, and can make decisions regarding services. In these circumstances, a guardianship order is not required.

- ➢ If a court order is in place that identifies another legal representative for the child, upload the current guardianship order, signed by the court, to the **Contacts screen** under Waiver Links.
- ➢ If a child does not live with the parents and guardianship orders are not available, submit other legal documentation.

When a child turns 18 years of age, they are legally an adult, and are responsible for signing all IPC documents unless there is a court order that appoints someone as a LAR.

- ➢ If there is a **court appointed LAR**, upload the current guardianship order, signed by the court, to the **Contacts screen**.
  - ○ The Division cannot accept guardianship orders that state "minor child" if the participant is 18 or older, unless they meet the following criteria: "A guardianship, initiated while the ward is a minor, does not lapse at the age of majority under Wyo. Stat.Ann.3-3-1101, if it is based on incompetency as defined in Wyo. Stat. Ann. 3-1-101(a)(ix) or (xii)."
  - ○ The case manager is responsible for having the participant sign IPC forms until the signed guardianship order can be corrected.
- ➢ If there is **not a court appointed LAR**, *do not* identify the parents as guardian or LAR on the **Contacts screen**.
- ➢ If there is a limited guardianship in place, assure that the dates are current and the document is uploaded to the **Contacts screen**.

Guardianship must be verified every five (5) years to ensure that the guardianship remains in place. Guardianship documentation and ongoing verification must be uploaded in the Contacts screen.

ICAP Authorization and Information Form
Complete the ICAP Authorization and Information form, which requires the participant or LAR (if applicable) signature authorizing permission for the ICAP vendor to interview respondents for the ICAP assessment. Complete the respondent information, and upload the form on the *ICAP*

section under the **Assessment screen**. Select the ***Action button*** to submit the ICAP request.This document can be found on the Division website, HCBS Document Library, *DD* tab *Assessments* section.

Medication Consent Form
This form is completed and signed by the participant or LAR (if applicable) authorizing providers to assist the participant with medications. If a provider assists the participant with medications, select the **Medical screen** and upload the Medication Consent form in the *Medications* section. This document can be found on the Division website, HCBS Document Library, under the *DD* tab *Planning* section.

Participant and Legally Authorized Representative Verification Form
The participant and LAR (if applicable) must answer the questions on the Participant and Legally Authorized Representative Verification form (often referred to as the Verification form) annually. Once signed, the case manager will answer the questions on the **Verification screen**, which must coincide with the answers provided on the Verification form, and upload the form under the *Participant/Guardian Verification* tab on the **Verification screen**. The blank form can be downloaded from EMWS under the *Participant/Guardian Verification* tab.

Team Signature Verification Form (Team Sign form)
Before an IPC or modification to an IPC can be submitted, all team members are required to review and sign the *Team Signature Verification form* (often referred to as the *Team Sign form*). The team member's signature documents that they were involved in the planning meeting and agree to the service(s) and units requested. Once the form is signed by all team members, upload the form under the *Team Signature and Verification* tab on the **Verification screen**. A blank form can be downloaded from EMWS under the *Team Signature and Verification* tab.

Additional IPC Forms, Tools and Examples

All documents uploaded into EMWS should be named using the DD EMWS File Naming Conventions.

Criteria for DD Psychological Evaluation
This document outlines clinician qualifications, approved testing instruments, and diagnostic criteria that must be met to establish clinical eligibility for participants with a developmental or intellectual disability. This document is found on the Division website, HCBS Document Library, under the *DD* tab *Assessments* section.

Criteria for Neuropsychological Evaluation
This document outlines clinician qualifications, approved testing instruments, and diagnostic criteria that must be met to establish clinical eligibility for participants with an ABI. This document is found on the Division website, HCBS Document Library, under the *DD* tab *Assessments* section.

Environmental Modification Request Worksheet
The Environmental Modification Request Worksheet is used to summarize a request for an environmental modification. Follow the steps for submitting a modification and upload the Environmental Modification Request Worksheet into the **Document Library screen** under Waiver Links. This document is found on the Division website, HCBS Document Library, under the *DD* tab *Supplementals/Protocols* section.

Positive Behavior Support Plan (PBSP) with Functional Behavior Assessment (FBA)
The participant's plan of care team should complete the Functional Behavior Assessment (FBA), which is used to identify the underlying causes of behavior. The Positive Behavior Support Plan (PBSP) is completed by using the information gathered from the FBA. The FBA should be updated at least annually.

The PBSP template is used to help the team develop a PBSP. Other PBSP versions are acceptable as long as the components of the PBSP align with Wyoming Medicaid Rules. Upload the FBA and PBSP on the **Behavioral Supports screen**. This document and the corresponding *Positive Behavior Support Plan Manual* is found on the Division website, HCBS Document Library, under the *DD* tab *Supplementals/Protocols* section.

IPC Planning Workbook
The IPC Planning Workbook is designed to encourage a person-centered planning approach when developing the IPC. This document is found on the Division website, HCBS Document Library, under the *DD* tab *Getting Started* section.

Medication Assistance Record Form (MAR)
The Medication Assistance Record (MAR) is used to document medication usage. The MAR includes detailed information on the participant's scheduled and PRN medications, including strength, dosage, route, special instructions, and date and time that the medication assistance is needed. Upload the participant's MAR OR enter all medication information manually under the **Medical screen**. Medications must be updated, or a new MAR must be uploaded, with each supplemental request or modification to the IPC. This document is found on the Division website, HCBS Document Library, under the *Workflow Tools & Logs* tab.

Participant Specific Training Form
All providers must verify that they have been trained on the IPC and all protocols annually *and* when there have been revisions to the IPC. This verification must be kept in the provider's records and be available upon request by the Division. The case manager is responsible for ensuring this training has taken place, and can use the Participant Specific Training form to document this training. This document is found on the Division website, HCBS Document Library, under the *Workflow Tools & Logs* tab.

Relative Disclosure Form
The Relative Disclosure Form is used to identify relatives (defined as biological, step, or adoptive parents), LARs, or spouses who may be providing services to participants. A blank

form can be downloaded from EMWS under the *Relative Disclosure* tab on the **Verifications screen**.

WY Referral Form (ACES$ FMS - for Self-Direction)
For case managers requesting packets and referring new or returning participants to self-direction; or making changes to the employer of record. This document can be found on the ACES$ FMS Document Center.

Specialized Equipment Request Worksheet
The Specialized Equipment Request worksheet is used to assist teams in determining if an item will meet the criteria outlined in Chapter 44 of Wyoming Medicaid Rules. This document can be found on the Division website, HCBS Document Library, under the *DD* tab, *Supplementals/Protocols* section

IPC Team Meeting Checklist
The IPC Team Meeting Checklist is used to organize and prepare for the annual IPC meeting and six month team meetings. This document is found on the Division website, HCBS Document Library, under the *DD* tab *Planning* section.

Third Party Liability Form
The Third Party Liability form is required for services that could be paid for through a funding source other than the waiver. This form demonstrates that no other funding options are available, and must be signed by the appropriate agency. This document is found on the Division website, HCBS Document Library, under the *DD* tab, *Supplementals/Protocols* section.

Transition Checklist
The Transition Checklist is used to guide teams through the transition process. Complete and submit the Transition Checklist in the Document Library. Examples of transitions include a change in case manager, change in location, and a residential move within provider organizations. This document is found on the Division website, HCBS Document Library, under the *DD* tab *Supplementals/Protocols* section.

DD Waiver Services Guide + Application – Supports Waiver
This guide provides the details for the Supports waiver eligibility and application process. This document is found on the Division website, HCBS Document Library, under the *DD* tab *Getting Started* section.

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Commonly Used Terms and Acronyms

Other helpful documents are available on the HCBS Document Library including lists of Commonly Used Acronyms, Commonly Used Terms, and the HCBS Sites and Emails Quick Reference.

Wyoming Medicaid Rules

Chapter 44, 45, and 46 of Wyoming Medicaid Rules can be found on the Division website at https://health.wyo.gov/healthcarefin/hcbs/hcbs-public-notices/. Additional Medicaid rules can be found at https://rules.wyo.gov/.

1. Select *Current Rules*
2. Select *Health, Department of (048)*
3. Select *Medicaid (0037)*
4. Select the Chapter you wish to review