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New Case Manager Training

2025

Welcome to the Division of Healthcare Financing Case Manager Training!

- Training is formatted in sections. You can choose to review a specific section, or proceed through the training from start to finish.
- Links to the HCBS Document Library are included within each slide. Just click on the link and you can navigate to the correct tab and download the form or document.
- In addition to this training, new case managers must complete Provider Training found on the DD Initial Certification page, which is required for all new providers.
- If you have questions about the content of this training, please contact your Benefits and Eligibility Specialist (BES).

Case Manager Training Modules

- HCBS and the Case Manager's Role
- Accessing the Electronic Medicaid Waiver System (EMWS)
- Eligibility and Assessments
- Participant-Directed Services
- Team Meetings
- Contacts Screen
- Individualized Plan of Care (IPC)
- Provider Transitions
- Extraordinary Care Committee (ECC)
- Reconsiderations and Administrative Hearings
- Case Management Billing Requirements
- Case Management Certification
- Additional Links and Tools
- Commonly Used Acronyms

Home and Community-Based Services (HCBS) and the Case Manager's Role

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What are Home and Community-Based Services?

Home and community-based services (HCBS) provide opportunities for a Medicaid beneficiary to receive services in their own home or community, rather than an institution or other isolated setting.

The Case Manager's Role in HCBS

- You play a pivotal role in ensuring that each participant receives the supports and services outlined in their individualized plan of care (IPC).
  - Services must be provided in a manner that is consistent with what is important to, and important for, the participant.
- You must help the participant and legally authorized representative become well-informed about all choices that may address the needs and outcomes identified in the IPC.
- You must write and monitor the IPC to assure the rights of the participant are respected.

Targeted Case Management (TCM)

TCM services can be billed, up to 120 fifteen (15) minute units per plan year (T2023), for the services provided while an applicant is applying for the waiver, and after they have been placed on the waiting list.

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Targeted Case Manager Expectations

- **Gather information:** Complete the LT104 assessment or explain the LT101 assessment process, and assist individuals to gather necessary documentation (medical records, psychological or neuropsychological assessment, etc.) for eligibility determination.
- **Linkage and Referral:** Work with individuals and service providers to secure access to non-waiver services while the individual is on the waiting list. This includes informing individuals of services available, arranging appointments with service providers, and providing contact information of service providers.
- **Monitoring/Follow-up:** Maintain regular contact with individuals on the waiting list and assist with any questions or concerns they may have.
- **Update:** Assure individuals and the legally authorized representative's information is up-to-date, including physical and mailing addresses, phone numbers, and email addresses.

Targeted Case Manager Expectations (cont.)

- **Advocacy:** Advocate for the individual for the purpose of accessing needed services.
- **Crisis Intervention:** Connect the individual with crisis intervention and stabilization services in situations requiring immediate attention or resolution.
- **Documentation:** Write the TCM plan of care, which must be approved by the Division, and document services provided. When a funding opportunity is granted, follow the process for team meetings and IPC development.

Transportation services are NOT covered under TCM.

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Institutional Transitions and TCM

- You cannot provide traditional case management services during the time that a participant is institutionalized.
  - Institutionalization results in termination of services as cited in Chapter 46.
  - Institutionalization includes placement in a nursing home, hospital, residential treatment facility, inpatient hospice, or a state institution such as the Wyoming State Hospital or Wyoming Life Resource Center.
- When a participant is preparing for discharge, the participant will require your assistance.
- These services are typically provided under TCM.
  - These services will be paid with state funds.
  - You must document duties performed and then submit an invoice to the Benefits and Eligibility Unit Manager.

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Accessing the Electronic Medicaid Waiver System (EMWS)

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Accessing the Electronic Medicaid Waiver System (EMWS)

EMWS is the web-based portal you will use to develop the IPC, store important documents, and generate plan modifications and supplemental requests for each participant on your caseload.

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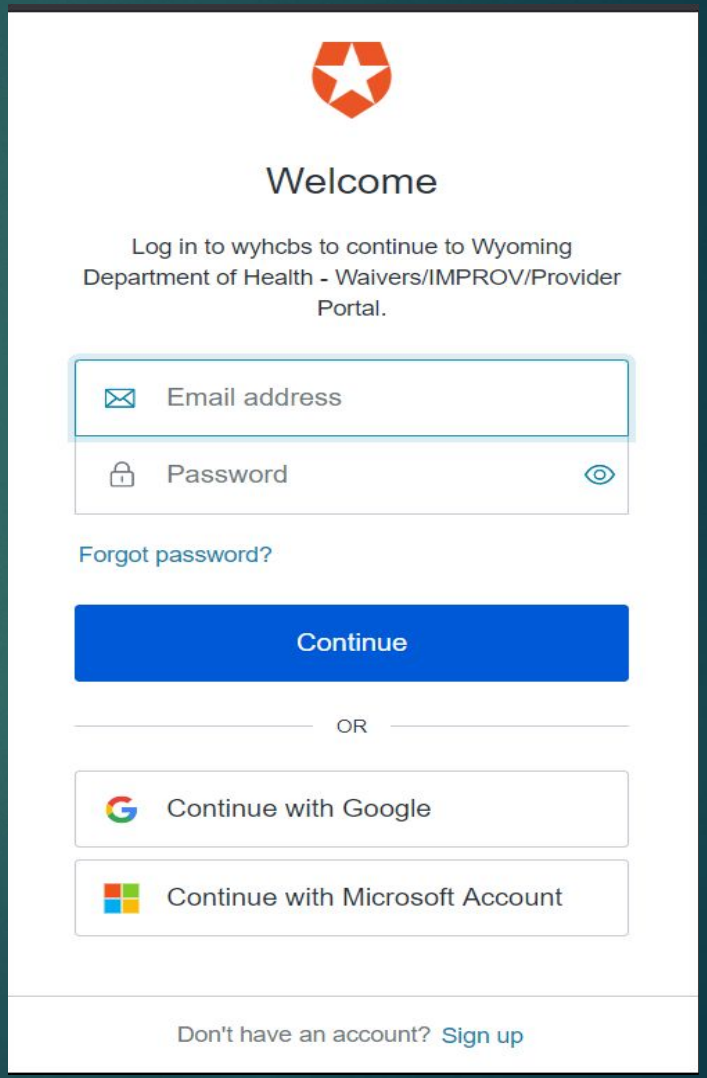
Accessing the Electronic Medicaid Waiver System (EMWS)

After you have completed the certification process, you must submit a request for access to EMWS through the web based portal. Select the "Continue with Google" or "Continue with Microsoft Account", or select the Sign up link located at the bottom. Once your request has been reviewed and approved, you will receive an email verifying that the request has been approved.



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Accessing the Electronic Medicaid Waiver System (EMWS)

- https://www.wyowaivers.com
- 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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EMWS Naming Conventions

EMWS contains various documents, letters, assessments, and requests. In order to easily identify information contained within EMWS, please follow the EMWS File Naming Convention Guidelines. The naming convention guidelines can be found on the HCBS Document Library page of the Division website, at the top of the *DD Tab*.

Eligibility and Assessments

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Assessment Categories

LT-101 or LT-104	Psychological/ Neuropsych Evaluation
Assessment to determine intermediate care facility for individuals with intellectual disabilities (ICF/ID) or nursing facility level of care.	Assessment to determine diagnosis and intelligence quotient (IQ)

Both assessment categories are required to determine participant eligibility. Please refer to the Supports Waiver Application Guide under the *DD Tab, Getting Started section* for further guidance.

LT-104 Assessment

(For individuals with an intellectual or developmental disability)

- Completed in *Assessment History Section* of EMWS
  - For applicants, assessment should be completed within thirty (30) days of receiving the Case Management Selection Form.
  - Assessment must be completed annually thereafter.
- The county of the individual's physical address must be selected.
- The ICF/ID date should be left blank.

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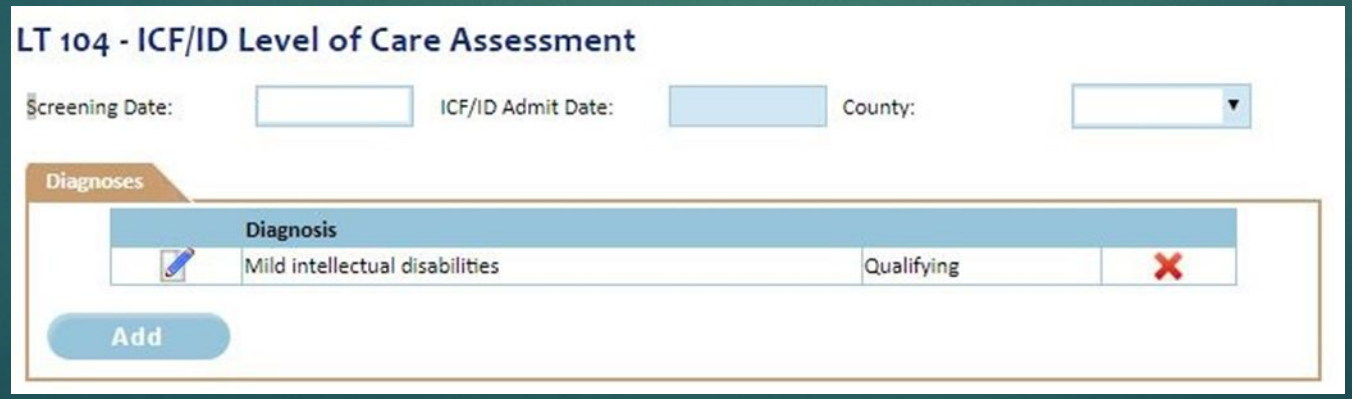
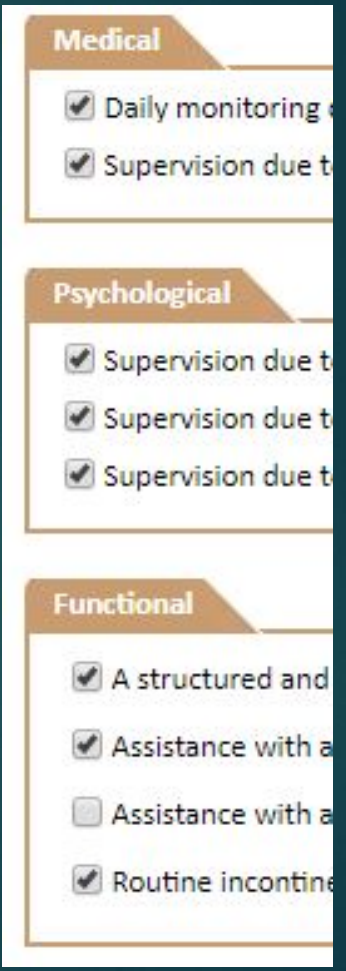
LT-104 Assessment (cont.)

- The individual must have a qualifying diagnosis to be eligible for a waiver.
  - For existing participants, the diagnosis will populate from the previous LT-104 assessment.
  - For new applicants, enter a preliminary diagnosis.
    - You must update the diagnosis once the psychological/neuropsychological evaluation is received.



LT-104 Assessment (cont.)

- Does the individual meet the following criteria?
  - Have an eligible diagnosis;
  - Meet at least one criterion in either the *Medical* or *Psychological* sections; and
  - Meet at least one criterion in the *Functional* section
- If all three criteria are met, submit the LT-104 for review and final determination for ICF/ID level of care.



LT-104 Assessment (cont.)

- You MUST ensure that the boxes selected on the LT-104 assessment align with the assessed needs of the participant.
- Substantiate this information within the IPC.
  - Detailed information on how you should substantiate the medical, psychological, and function questions can be found in the IPC Guide.

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LT-101 Assessment (For individuals with an Acquired Brain Injury)

- The LT-101 is a functional assessment that determines nursing facility level of care for individuals with an acquired brain injury (ABI).
- Assessment determines 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.
- A Public Health Nurse (PHN) from the individual's county of residence will schedule and perform the assessment.

LT-101 Assessment (For individuals with an Acquired Brain Injury)

- You will receive an *Awaiting LT-101 Assessment* task in EMWS.
  - This task does not require any action from you.
  - The purpose of the task is to inform you that the LT-101 assessment is due and has been referred to a PHN to schedule and complete.
- You are responsible for explaining the LT-101 assessment process to participants, legally authorized representatives, or family members, and ensuring that they understand the importance of completing the assessment.

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LT-101 Assessment (cont.)

- New Applicants
  - The PHN must complete the LT-101 assessment within seven (7) days of the referral, unless an extension has been requested.
- Continued Eligibility
  - The LT-101 assessment must be completed annually, at the time the IPC is renewed.
  - The PHN must complete the assessment at least 30 days prior to the IPC start date.

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Psychological/Neuropsychological Evaluations

- A psychological or neuropsychological evaluation is required to determine a participant's clinical eligibility for the Comprehensive and Supports Waiver.
- Psychological evaluations are required for applicants or participants with a diagnosis of an intellectual or developmental disability.
  - Psychological evaluations are updated on a case by case basis and at the request of the Division.
- Neuropsychological evaluations are required for participants with a diagnosis of an ABI, and a new evaluation is required every five years.

Psychological/Neuropsychological Evaluations (cont.)

- You must help the applicant or participant schedule a psychological or neuropsychological evaluation.
- Evaluation must be performed by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and free of conflicts with other providers chosen by the participant.

Psychological Evaluations

- A psychological evaluation report must include:
  - All related diagnoses;
  - The full scale IQ score or an indication of a non-standard IQ score;
  - An assessment of adaptive functioning, using a standard measurement such as the Adaptive Behavior Assessment System (ABAS) or Vineland Adaptive Behavior Scale;
  - The clinician's professional opinion as to the level of deficit in each functional limitation area; and
  - The signature of the licensed clinician and the date the report was signed.

Neuropsychological Evaluations

- A neuropsychological evaluation report must include:
  - All related diagnoses;
  - Must include all three scores from the following tests and meet one or more of the following criteria:
    - Mayo Portland Adaptability Inventory (MPAI), score of forty-two (42) or higher);
    - California Verbal Learning Test II Trials 1-5 T, score of forty (40) or lower; or
    - Supervision Rating Scale, score of four (4) or higher.
  - Acknowledgement that the clinician has reviewed medical records and confirms the diagnosis of an ABI.
  - The signature of the licensed clinician, and the date the report was signed.

Psychological/Neuropsychological Evaluations

- Refer to the Criteria for Developmental Disability Psychological Evaluations or Criteria for Neuropsychological Evaluations documents for more detailed information.
- The applicant/participant is encouraged to take the evaluation criteria, which starts on Page 17 of the Application Guide for the Supports Waiver, to their evaluation appointment. These documents can be found on the *DD Tab* of the HCBS Document Library.

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Criteria for Psychological Evaluations

A person is determined eligible for the Supports or Comprehensive Waiver when eligibility criteria are met. Specifically, the criteria related to the diagnosis of an intellectual disability or a developmental disability due to a related condition is described in detail. This document shall serve as a reference to clinicians of Division expectations when completing these evaluations and provide information related to the evaluation process, the use of assessment instruments, interpretation of results, the formulation of diagnoses, and compilation of the assessment report.

Examiner Qualifications:

Psychological evaluations are conducted by a Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and is free of conflicts with other providers chosen by the participant. The psychological testing is provided and administered on a face-to-face basis and conducted by a clinician licensed to practice independently and trained to administer the appropriate assessment instruments.

Approved Psychological Tests:

An individual may qualify for the Supports and Comprehensive waivers with a diagnosis of an intellectual disability or a developmental disability due to a related condition. This eligibility determination relies heavily on the use of objective, standardized assessment instruments. In this section, the Division approved instruments are described in detail.

Only valid, reliable, and appropriate instruments are used in the evaluation process. The choice of testing instruments is based on the unique clinical presentation of the individual and the specific referral question. The most current versions of tests supported by scientific research and for which appropriate normative information is available are used. The following instruments have been approved for use when evaluating eligibility. The most current versions of these instruments must be used. Projective tests, such as the Rorschach shall not be used.

Assessment Instruments approved by Division:

INTELLIGENCE (one of the following & most recent version)

- Kaufman Assessment Battery for Children (KABC)
- Wechsler Pre-School and Primary Scale of Intelligence (WPPSI)
- Wechsler Intelligence Scale for Children (WISC)
- Wechsler Adult Intelligence Scale (WAIS)
- Sanford-Binet Intelligence Scale (SB)
- Test of Nonverbal Intelligence (TONI)

FUNCTIONAL/ADAPTIVE (one of the following & most recent version)

- Adaptive Behavior Assessment System

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Psychological/Neuropsychological Evaluations

- Once the evaluation is complete and the report is received, upload the evaluation to the *Assessment History Screen* of EMWS, using the DD EMWS File Naming Convention.

- Enter the date of the evaluation, the name of the clinician who completed the evaluation, and the IQ into the corresponding boxes.

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Psychological/Neuropsychological Evaluations

- Once the BES acknowledges that the report has been received, a *Submit Psych Invoice* task will populate on your task list.
- Upload the invoice into EMWS and submit.
- After you *Acknowledge Psych Invoice Eligibility,* the clinician will be able to bill for the evaluation.
  - Notify the clinician that they can bill for the assessment using the code T2024 and the date the assessment was conducted.
  - If you don't notify the clinician that the billing line has been created, the clinician will not know that they are cleared to bill for the assessment.

ICAP

Inventory for Client and Agency Planning (ICAP)
Assessment to determine level of service (LOS) score and individual budget amount (IBA) for the Comprehensive Waiver

The ICAP assessment is also required to demonstrate applicable criteria for a relative provider to offer personal care services to a child.

Inventory for Client and Agency Planning (ICAP)

- You will receive notification via EMWS that an ICAP needs to be scheduled.
- You must help the participant choose people (respondents) to answer assessment questions.
  - Respondents should be people who have known the participant for at least three (3) months and work closely with the participant in residential, vocational, educational, or other settings.
  - Ensure respondents are available to be interviewed by a representative from the Wyoming Institute for Disabilities (WIND).
  - Provide each respondent with the ICAP Information page, which is found on Page 2 of the ICAP Authorization and Information Form.
  - You should not be a respondent unless there is no one else on the participant's team who is able to do so and it is approved by the Division.

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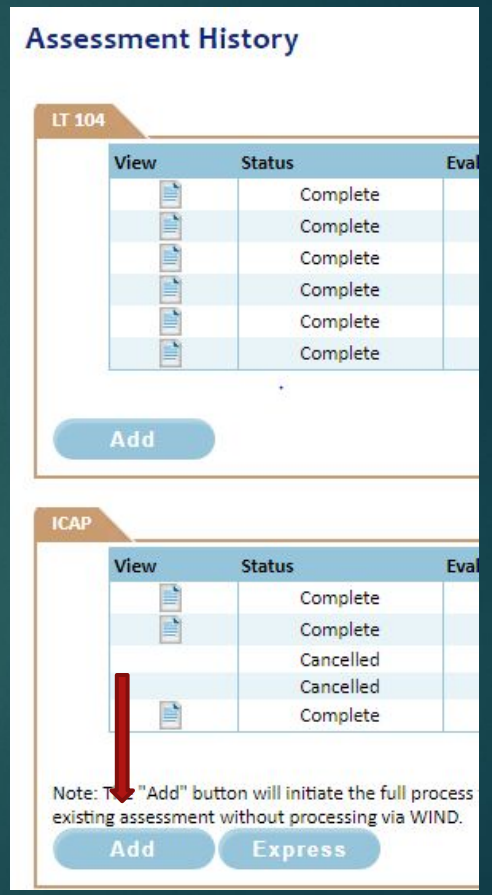
Inventory for Client and Agency Planning (ICAP)

- Complete the ICAP Authorization and Information Form
- Enter respondents and their contact information in the *Assessment History* Section of EMWS
- Upload the ICAP Authorization and Information Form, then click the *Action* button to submit the request
- A representative from WIND will be responsible for entering the ICAP results into EMWS



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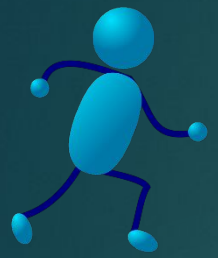
Assessment Process Flow



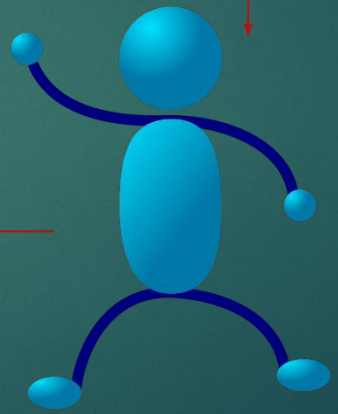
Jake the applicant

- Apply
- Select case manager (CM)
- CM completes LT104 or Public Health Nurse completes the LT101
- Submit Medicaid Financial Application
- Complete psychological or neuropsychological evaluation
- Determined eligible for Supports Waiver services.

Supports Waitlist

When a Supports Waiver participant receives funding on the Supports Waiver, Jake will advance based on his position on the waitlist.
Criteria:

1) Time on waitlist first
2) Case Manager Selection Date



Jake the Supports Waiver Participant

Jake can only receive comprehensive waiver services if he meets the criteria for emergency services. Jake will need to complete an ICAP assessment before he is placed on the Comprehensive Waiver

Participant-Directed Services

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Participant-Directed Services

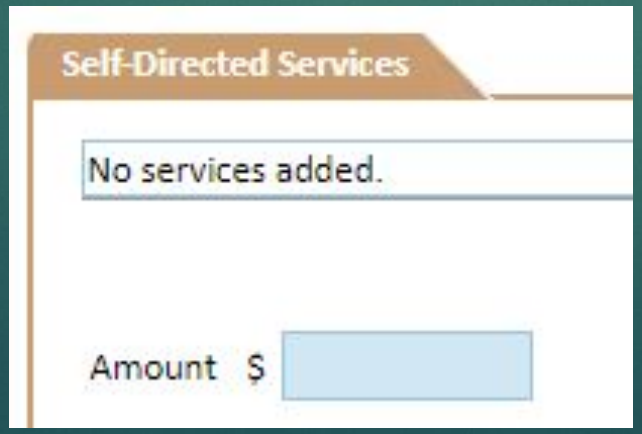
Participant-directed services allow a participant, or their representative if applicable, to take direct responsibility for managing services. This includes establishing payment rates, and hiring, firing, and training their own employees.

Participant-Directed Services: The Case Manager's Role

- Work with the participant to determine if participant-direction is right for them.
- If participant-direction is appropriate, help the participant complete the Self Direction Referral Form, and submit it to ACES$.
  - ACES$, the Financial Management Service, performs a variety of payroll-related tasks.
  - ACES$ ensures that the participant's employees meet the basic requirements needed to provide waiver services.

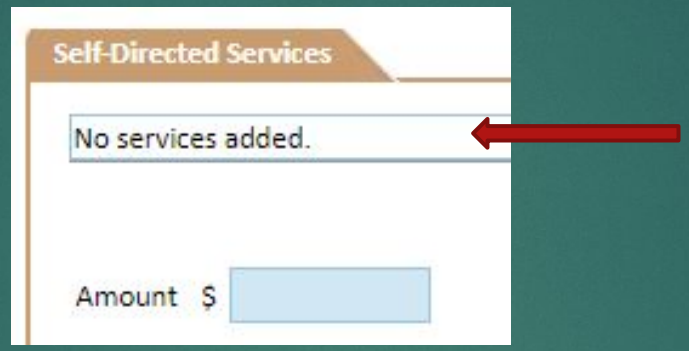
Participant-Directed Services and EMWS

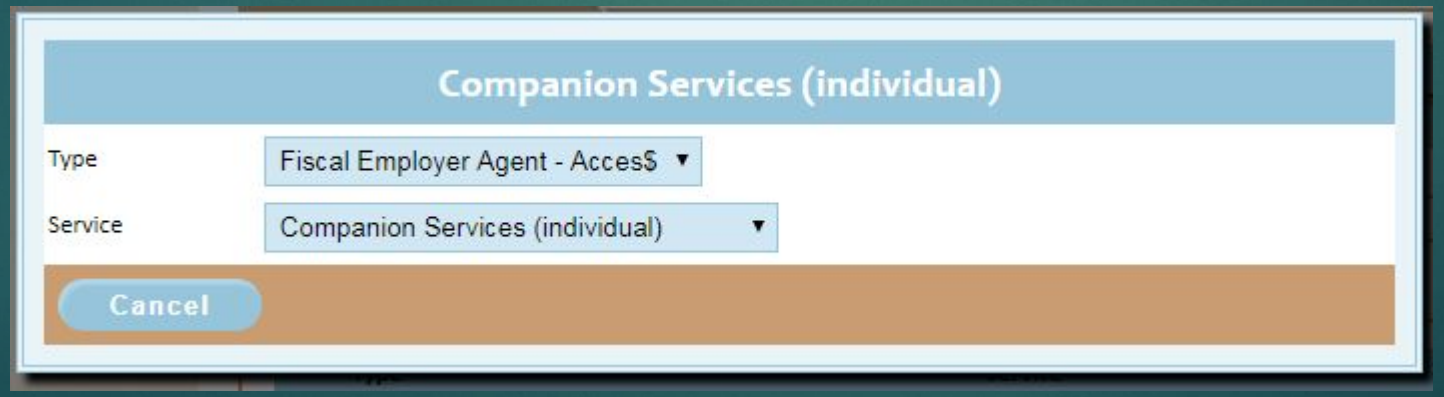
- Once the participant is enrolled in participant-directed services, work with the participant and legally authorized representative to determine the budget to be allocated to participant-directed services.
- Enter the amount in the *Self-Directed Services* section of the Service Authorization Page.



Participant-Directed Services and EMWS

- Select the services that the participant has chosen to direct.





Participant-Directed Services and EMWS (cont.)

- The total IBA, including the amount appropriated to participant-directed services, will be calculated in the IBA Section of the *Service Authorization* Section.

Participant-Directed Services – Monitoring and Advocacy

- Once participant-direction services have been added, monitor implementation of the IPC, and ensure that participant-directed employees are following service definitions. Address any issues that may arise.
  - If a participant exceeds the established participant-directed budget, they may lose the opportunity to direct services through participant-direction.
- Conduct observations of each participant-directed employee on the IPC; every three (3) months for habilitation services and every six (6) months for all other services.
- Advocate for the participant, and assist the participant and their legally authorized representative when there are issues or concerns with employees or the financial management service provider (ACES$).

Team Meetings

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Team Meetings

Team meetings are vital to supporting the participant in their community.

Team Meetings

- Team meetings should involve all of the important people in the participant's life.
- The variety of perspectives are important in coordinating all services, waiver and non-waiver, for the participant.
- Ongoing meetings will ensure the needs of the participant are met initially, and as needs change in their life.

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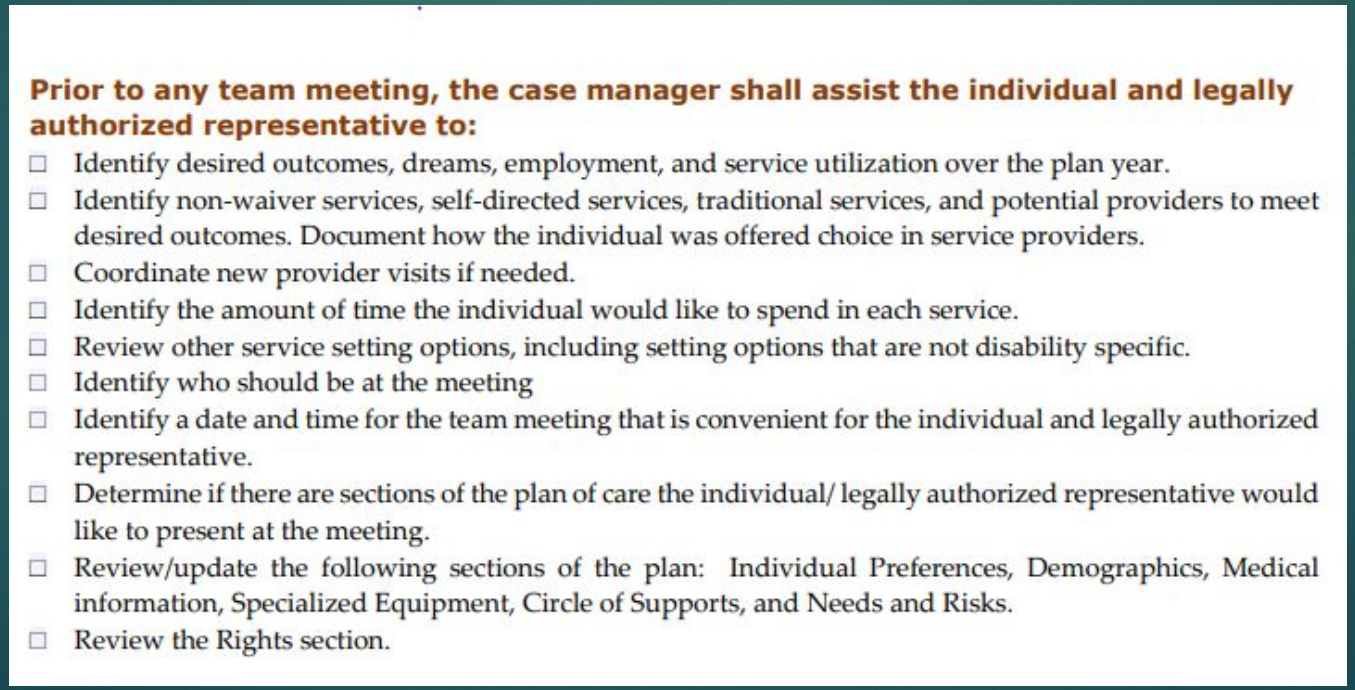
Team Meeting Guidance

- The IPC Team Meeting Checklist is found under the Planning heading on the DD tab of the HCBS Document Library.
  - The checklist walks you and the team through a team meeting.
  - Many components of the checklist should be completed prior to the meeting so the meeting is more effective and productive.



Prior to any team meeting, the case manager shall assist the individual and legally authorized representative to:

- ☐ Identify desired outcomes, dreams, employment, and service utilization over the plan year.
- ☐ Identify non-waiver services, self-directed services, traditional services, and potential providers to meet desired outcomes. Document how the individual was offered choice in service providers.
- ☐ Coordinate new provider visits if needed.
- ☐ Identify the amount of time the individual would like to spend in each service.
- ☐ Review other service setting options, including setting options that are not disability specific.
- ☐ Identify who should be at the meeting
- ☐ Identify a date and time for the team meeting that is convenient for the individual and legally authorized representative.
- ☐ Determine if there are sections of the plan of care the individual/ legally authorized representative would like to present at the meeting.
- ☐ Review/update the following sections of the plan: Individual Preferences, Demographics, Medical information, Specialized Equipment, Circle of Supports, and Needs and Risks.
- ☐ Review the Rights section.

Team Meeting Guidance (cont.)

- You are required to send written notice to all team members at least twenty (20) days in advance of the annual and six month review meetings. A copy of the notice must be uploaded in the *Document Library* in EMWS.
- You are required to send written notice to all team members at least two (2) weeks in advance of any transition meeting. A copy of the notice needs to be uploaded in the *Document Library* in EMWS.
- A special team meeting may be requested by any team member at any time during the plan year.
- Team members include the participant, legally authorized representative, family members, providers, unpaid supports in the participant's life (i.e., employer, coworkers, friends) and any others the participant chooses to have participate.

Contacts Screen

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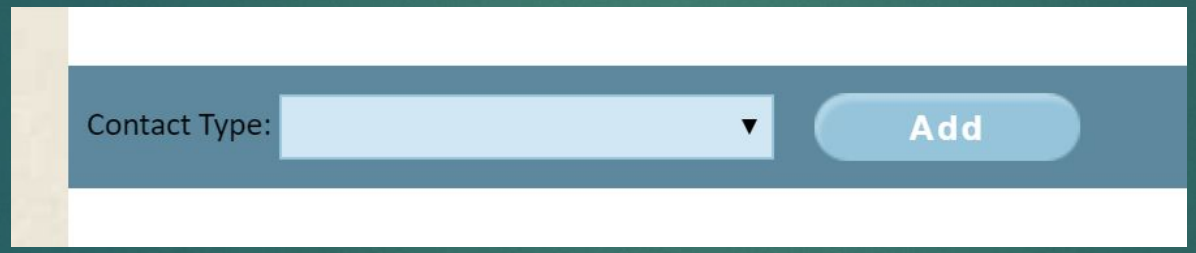
Contacts Screen

- The *Contacts* screen is found under Waiver Links on the left hand side of EMWS. This screen contains contact information for everyone that is important in the participant's life, including family members, friends, providers, employers, therapists, etc.
- Select a contact type and click "Add" to add a contact.



- When entering a contact, the contact information should include the name, address, phone number, and email address of the contact.

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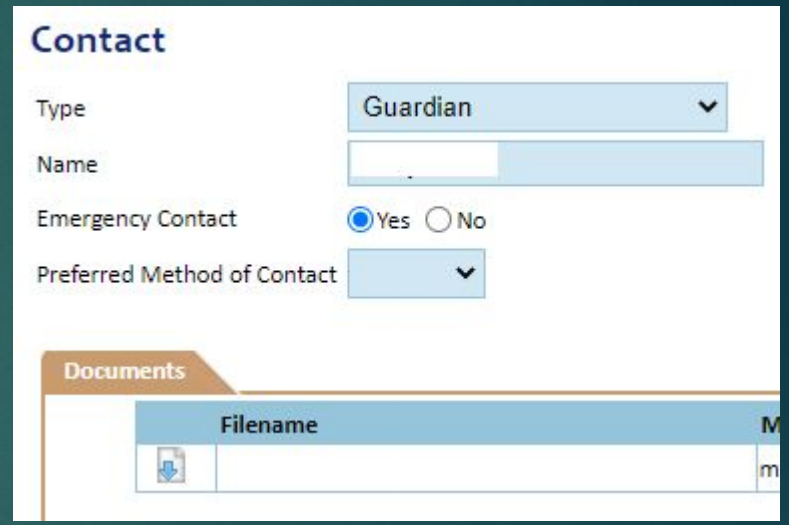
Important Contacts

- All medical professionals must be listed.
- The contact information for the representative payee must be listed. The documentation that identifies the payee must be uploaded under the *Documents* tab of the contact.
- The contact information for all legally authorized representatives must be listed. The documentation that identifies the legally authorized representative must be uploaded under the *Documents* tab of the contact.



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Backup Case Manager

- It is critical that the backup case manager is included on the *Contacts* screen. This information will print on the IPC, and will be necessary if you as the primary case manager are not able to perform case management duties.
- Use the drop down menu at the bottom of the *Contacts* screen to add a backup case manager.

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Ensure Accurate Contact Information

- Ensure contact information is accurate at all times. The Division will use this information to send necessary communications to family members and legally authorized representatives, and conduct follow-up on complaints and incident reports.
- Delete old and duplicate contacts by clicking on the **X** to the right of the contact's name.
- Some of the contacts in this section will also need to be listed on the *Circle of Supports* screen. You can go to the *Circle of Supports* screen and click "Associate" to bring information over and alleviate the need to enter the information twice.
  - The backup case manager will not automatically associate. You will need to add the backup case manager to the *Circle of Supports* screen manually. Select *Provider* or *Case worker* from the drop down menu since the backup case manager isn't a contact option.

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Individualized Plan of Care (IPC)

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Individualized Plan of Care

The IPC identifies the wants, needs, goals, and potential risks of the participant. It is the primary document that guides how services should be provided in order to best support the participant.

IPC Guide

- The purpose of the IPC Guide is to provide instructions and references on the forms, documents, and processes necessary to meet the IPC review requirements.
- Use these instructions to develop the IPC, after you obtain input from the participant and plan of care team.
- This guide is written primarily for the case manager, but can be used as a resource for participants, families, and teams.
- The IPC Guide can be found under the Planning heading on the DD tab of the HCBS Document Library.

The IPC Guide is an extremely helpful tool and all case managers are strongly encouraged to utilize it.

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Person-Centered Planning

State and Federal Authorities that establish person-centered planning

- 42 CFR 441.301(c) – Federal Law establishing criteria for person-centered planning and a participant's individualized plan of care.
- Wyoming Medicaid Rule - Chapter 45, Section 9 - Case Management Services
  - Section 9(c) - *The case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant. The case manager shall coordinate and assist the participant in accessing all needed and available resources, such as natural, paid, and community support. The case manager shall develop and monitor the implementation of an individualized plan of care.*
- Wyoming Medicaid Rule - Chapter 45, Section 10 – Individualized Plan of Care

Person-Centered Planning (Continued)

- A participant should have a plan of care that is truly individualized and person-centered.
- The participant should lead the process of creating the plan of care as much as possible, and the team members should support this process.
- The resulting IPC should align with the participant's choice of services, locations, and providers.

Completing the Individualized Plan of Care (IPC) in EMWS

Plan Mod Links

- Plan Status
- Individual Preferences
- Demographics
- Rights
- Assessments (Slides 16-35)
- Circle of Supports
- Needs and Risks
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization
- Verification
- Final Submission

Refer to the IPC Planning Workbook to help you develop an IPC.

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IPC – Plan Status Section

- The status of the individualized plan of care (IPC) can be monitored through the *Plan Status* screen under Waiver Links. This screen shows the IPC progress from plan submission to completion.
- Plans must be submitted thirty (30) days prior to the plan start date.
- Submit the final IPC after completing all sections of the plan.

IPC Work Flow

The workflow diagram below illustrates the steps required for the IPC to be considered complete. The same workflow process is necessary for a modification to the IPC.

IPC – Individual Preferences Section

IPCs must be person centered, and focus on the participant's wants and needs.

Individual Preferences should:

- Give providers a well-rounded understanding of the participant
- Be reflected throughout the IPC
- Align with service goals
- Be free of any discussion of rights restrictions
- Be updated at least annually
- Include the dates for the six month review and annual team planning meeting.

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

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IPC – Individual Preferences Section (Continued)

Participant's Desired Accomplishments for the Upcoming Year

- Identify the accomplishments the participant would like to achieve over the upcoming year.
- Summarize progress made on habilitation objectives in the past year, and include the participant's new habilitation service objectives.
- Include an overview of important events that occurred in the past year, which are relevant to the participant's goals and planning.

IPC – Individual Preferences Section (Continued)

Identify Personal Preferences

- Examples of questions 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 to get to where I want to go?

Activities identified in this section should be reflected in the schedules of the services the participant is receiving.

IPC – Individual Preferences Section (Continued)

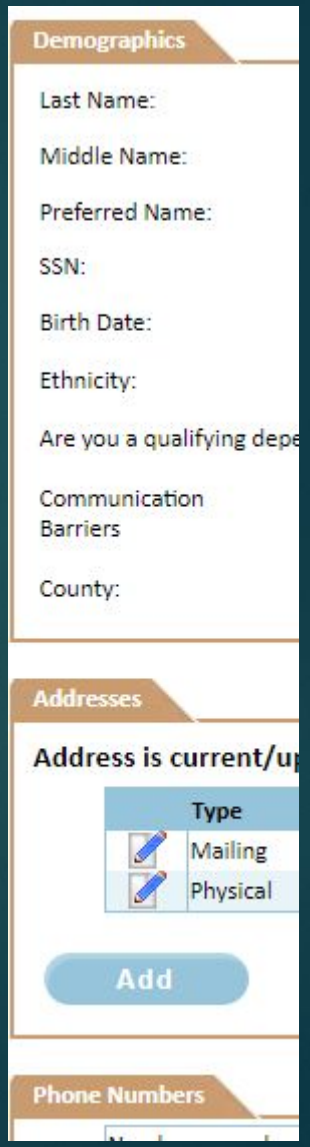
Important Things to Know About the Participant

- 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?

IPC – Demographics Section

Demographic information must be kept current so the Division can send important information and notifications to the participant.

- Include the participant's legal name, gender, ethnicity, mailing and physical address, and phone number in this section.
- Update information within seven (7) calendar days of being notified of a change.
- Delete old information by clicking on the **X** next to the information – only current information should be reflected.



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IPC – Demographics Section (Continued)

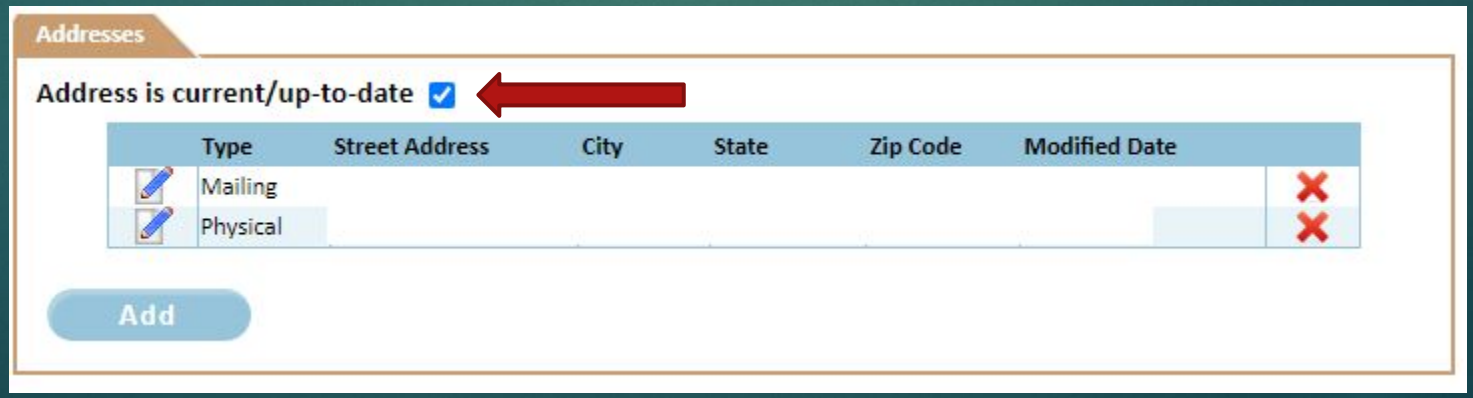
Communication preferences and barriers must be identified in this section.

- If non-verbal communication is selected, the participant's preferred contact person will need to be identified.
- Potential communication barriers (i.e., uses an interpreter, sign language, or a communication device) or other significant barriers to communication must be documented in this section.
- It is not acceptable to state that the person cannot communicate, and refer the reader to a parent, guardian, or other representative. Everyone has some form of communication, so it is important that this section is individualized and very specifically describes how the participant communicates.

IPC – Demographics Section (Continued)

Chapter 45 requires you to ensure that all contact information, including but not limited to physical and mailing addresses, is updated and accurate at all times.

- Once information is entered, verification that the participant's address is current and accurate is required.



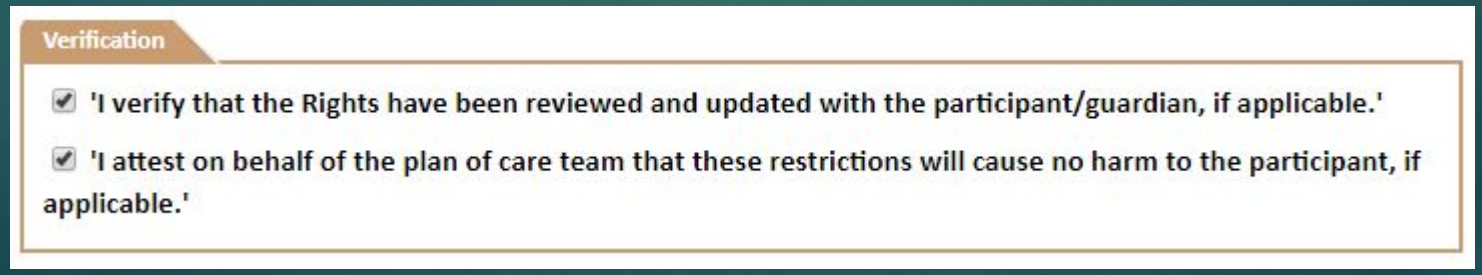
Participant Rights

- The right to privacy, dignity, and respect
- The right to freedom from coercion or restraint
- The right to privacy in the home, including:
  - Activities of daily living
  - Locks on sleeping and living spaces
- The right to choose with whom and where to live
- The right to furnish and decorate individual living space
- The right to control schedule and activities.
- The right to access food at any time
- The right to have visitors at any time, and associate with people of one's choice
- The right to communicate with people of one's choice, including the right to make and receive phone calls
- The right to keep and use personal possessions and property.
- The right to keep and spend money
- The right to access the community
- The right to full access of provider owned or operated settings in which services are received

IPC – Rights Section

Restricting the rights of a participant is serious, and must be done thoughtfully. Please view the training on rights restrictions, and review the Rights Restriction Review Tool before including a rights restriction in an IPC

- Rights cannot be restricted based solely upon the legally authorized representative's preference.
- Rights restrictions require additional documentation and/or follow up, which is required annually.
- You must verify that a participant's rights have been reviewed, and attest that the restrictions will cause no harm.



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IPC – Circle of Supports Section

- Select the participant's home setting from the drop down menu, and explain what supports they may need when at home.
  - If the participant receives Community Living Services, you will need to include the number of people who live in the home.
- Document important people and providers in the participant's life.
  - Include people who are important to the participant
    - Friends and family
    - Waiver and medical providers
    - Employers and school contacts
- Document non-waiver services the participant receives.
- Upload guardianship or power of attorney documents, if applicable.
- Assure information is correct and isn't duplicated.

Wyoming Department of Health

IPC – Circle of Supports Section - Housing

- Each participant receiving waiver services in a provider owned or operated residential setting must have:
  - A signed lease or written residency agreement;
  - A lockable entrance door and a secure place for personal belongings, which the participant must be able to freely access;
  - An opportunity to decorate their bedrooms and shared living space within the reasonable limitations specified in a lease.
- Provide detailed information on how the provider should support the participant in this area. If there are specific concerns, these should be listed.
- Explain how the participant was offered and exercised choice in their housemates or roommates.
  - If the participant shares a bedroom, explain how privacy will be honored and supported by the provider and roommate.

IPC – Circle of Supports Section – Back up Case Manager

- Every active case manager must identify a back up case manager.
  - The backup case manager is expected to continue case management services if you are unable to either temporarily or permanently continue as a participant's case manager.
- If you have a larger caseload, consider having more than one back up case manager to ensure that all participants' needs will be met should you not be able to continue as a case manager.
- You must meet with your back up case manager at least quarterly, and must document this in the participant's Case Management Monthly Review.

IPC – Circle of Supports Section – Back up Case Manager (cont.)

- The back-up case manager should be listed in EMWS under the Contacts link.

- The backup case manager will not automatically associate. You will need to add the backup case manager to the *Circle of Supports* screen manually. Select Provider or Case worker from the drop down menu sinc the backup case manager isn't a contact option.

IPC – Needs and Risks Section

This section outlines areas in which a specific risk to the participant has been identified. Please be detailed in this section.

- Document how to assist the participant in each support area.
- Include information regarding health and safety concerns.
- Upload guidelines and protocols providers need to be utilizing. Be sure to include emergency evacuation instructions in the Supervision Needs section.
- If restrictions are included in this section, they must be reflected on the *Rights* screen.

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IPC - Needs and Risks Section (Cont.)

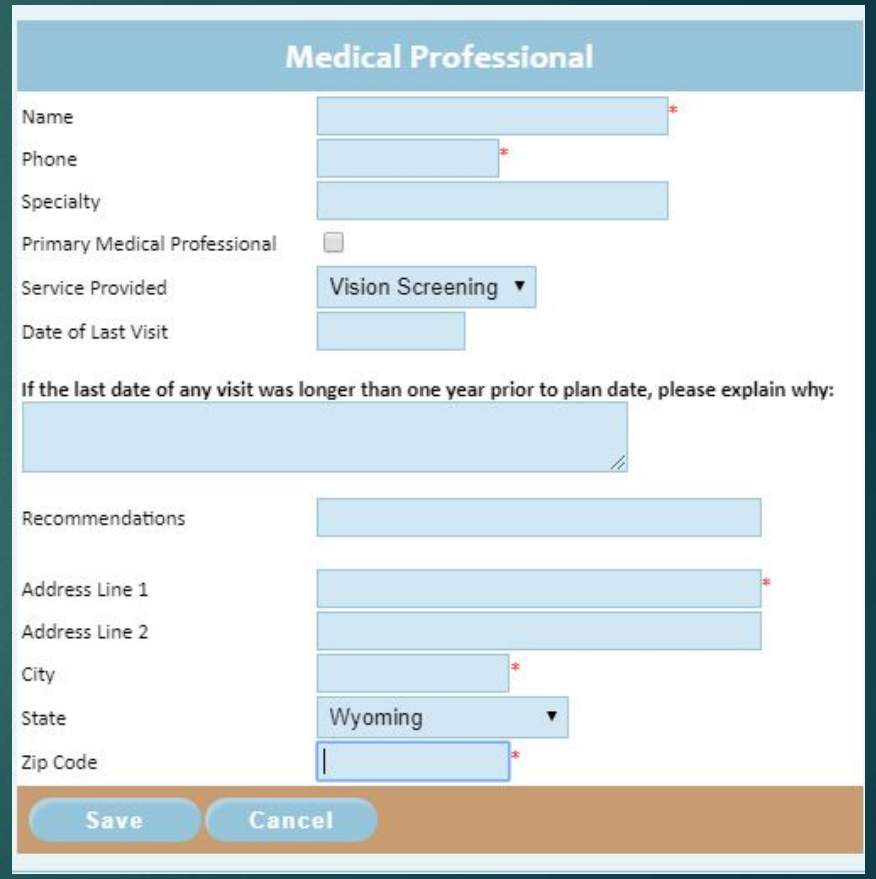
- The plan of care team is responsible for reviewing each support area on the *Needs & Risks* screen, and documenting behaviors or conditions that pose a health and safety risk to the participant.
- The team should identify the necessary detail needed to provide support to the participant in each area.
- 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 am too young for employment".
- When a participant has formal guidelines or protocols, such as mealtime guidelines or feeding protocols, include them in the appropriate support area, and upload the corresponding document.

IPC - Medical Section - Medical Professionals

- Under the Medical Professional tab, list all medical professionals with whom the participant works, including the primary physician, dentist, and optometrist.
  - Medical professionals included on the *Contacts* screen will automatically populate to the *Medical* screen.
- Include the last appointment date and any recommendations made during that appointment.
  - If the participant has not seen the medical professional in more than a year, state the reason why.

IPC – Medical Section – Medical Professionals (Cont.)

- Select the edit icon to document the date of the last visit and any recommendations made by the medical professional.
- Unless otherwise directed by the participant's licensed medical professional, providers should ensure that participants receiving community living services receive a medical evaluation every twelve months.
- If a participant has not received a medical evaluation within the last twelve months, explain why the visit hasn't occurred, and what strategies the team is implementing to encourage regular medical care, under the Medical Regimen tab.



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IPC – Medical Section – Diagnoses

- Diagnoses will automatically populate from the ICAP information entered in the *Assessment History* Section.
- A mental health diagnosis should be added if the participant is prescribed a psychotropic medication.
- All diagnoses should be current.

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IPC – Medical Section – Medications

- Indicate if the provider assists with medications. Upload the signed Medication Consent Form under the Medications tab by clicking *Choose File*.

- Add participant medications ***OR*** upload the Medication Assistance Record (MAR).

OR

- Medications must be updated during the annual and six month IPC review.
- An up-to-date- MAR must be available upon request.

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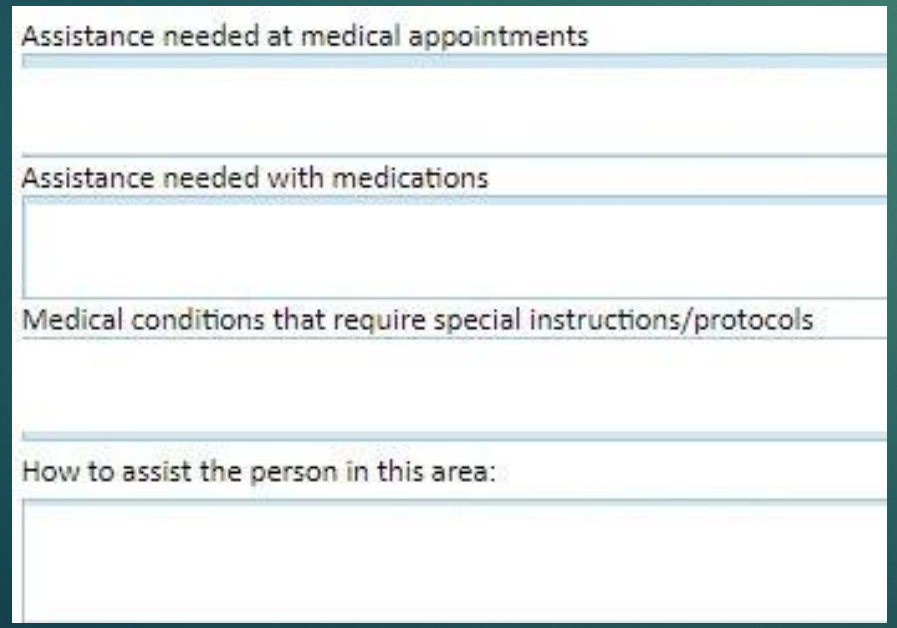
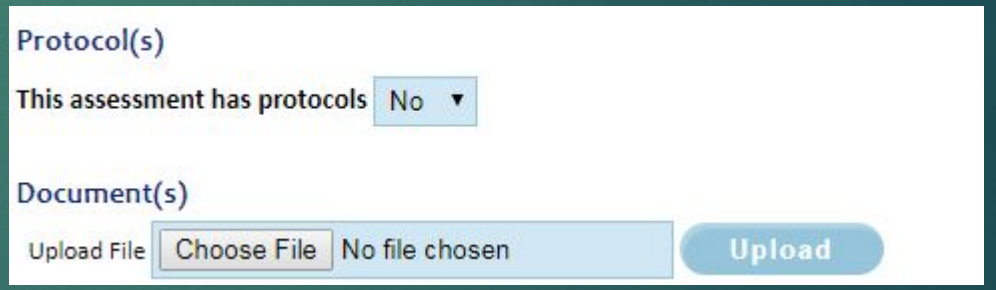
IPC – Medical Section – Medication Regimen

- Mark the support level that best describes the participant's needs.
- For each area, provide detailed information on the supports the participant will need.
- Upload medical protocols (i.e., seizure protocol) here.





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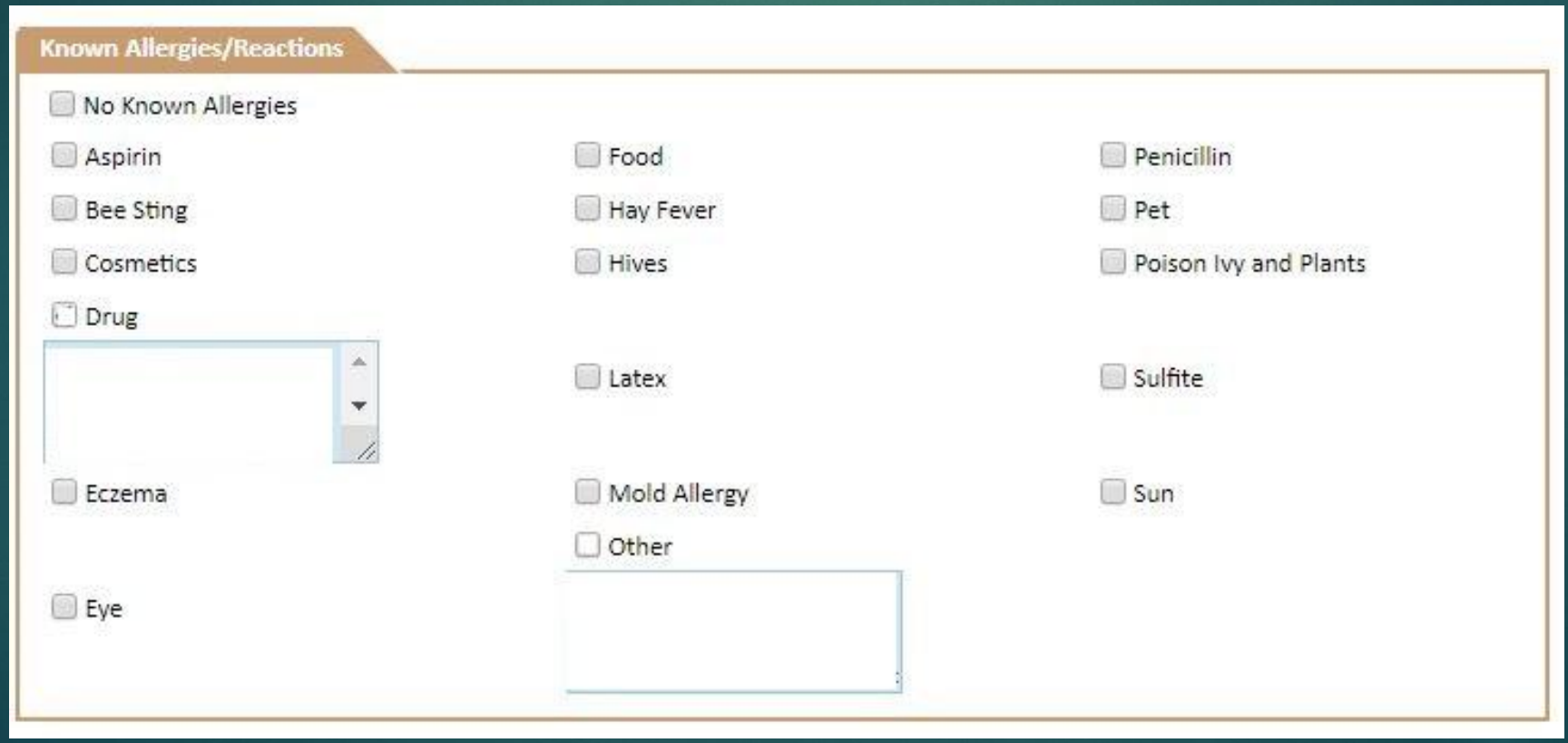
IPC – Medical Section – Known Allergies

Mark allergies and possible reactions



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IPC – Specialized Equipment - Medicaid Rule Authority

- **Chapter 44, Section 6** establishes that the IPC must reflect the need for specialized equipment; how the equipment addresses health, safety, or accessibility needs of the participant; and how and where the equipment will be used.
- **Chapter 45, Section 10** establishes that the IPC must include information related to what is important to and for the participant. It is reasonable to expect that specialized or adaptive equipment that a participant uses to access their home and community is extremely important information.
- **Chapter 45, Section 15** establishes that waiver providers must receive training on specific assistive technology devices, which must be listed in the IPC. You are required to conduct IPC training for one employee from each provider listed on the IPC, including training on specialized equipment.

IPC – Specialized Equipment

- If the participant does not have specialized equipment, do not complete this section
- Add specialized equipment in this section. Equipment commonly listed includes:
  - Medical equipment that is not considered to be of general use
  - Mobility devices
  - Communication devices
- Specialized equipment does not include:
  - Items paid by another entity
  - Items that are an extension of services provided through school services
  - Items of general use that are not specific to a disability
  - Items of recreational or diversional use
- Refer to the IPC Guide for instructions on how to complete this section

IPC – Behavioral Supports Section

- Behaviors identified as moderate, serious, or critical in the ICAP information will populate to the *Behavioral Supports* Section.
  - The following prompt will be displayed: *Include a Positive Behavior Support Plan (PBSP)*. The team completes a PBSP based on a Functional Behavior Assessment (FBA).
- If the team no longer considers a targeted behavior to be moderate or above, click the pencil icon next to the behavior and click No behavior plan needed.
  - Document the reason a behavior plan is not needed.

Previous targeted behaviors that are not reflected in the current ICAP are to be removed by clicking the **X**, but targeted behaviors from the current ICAP should remain

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

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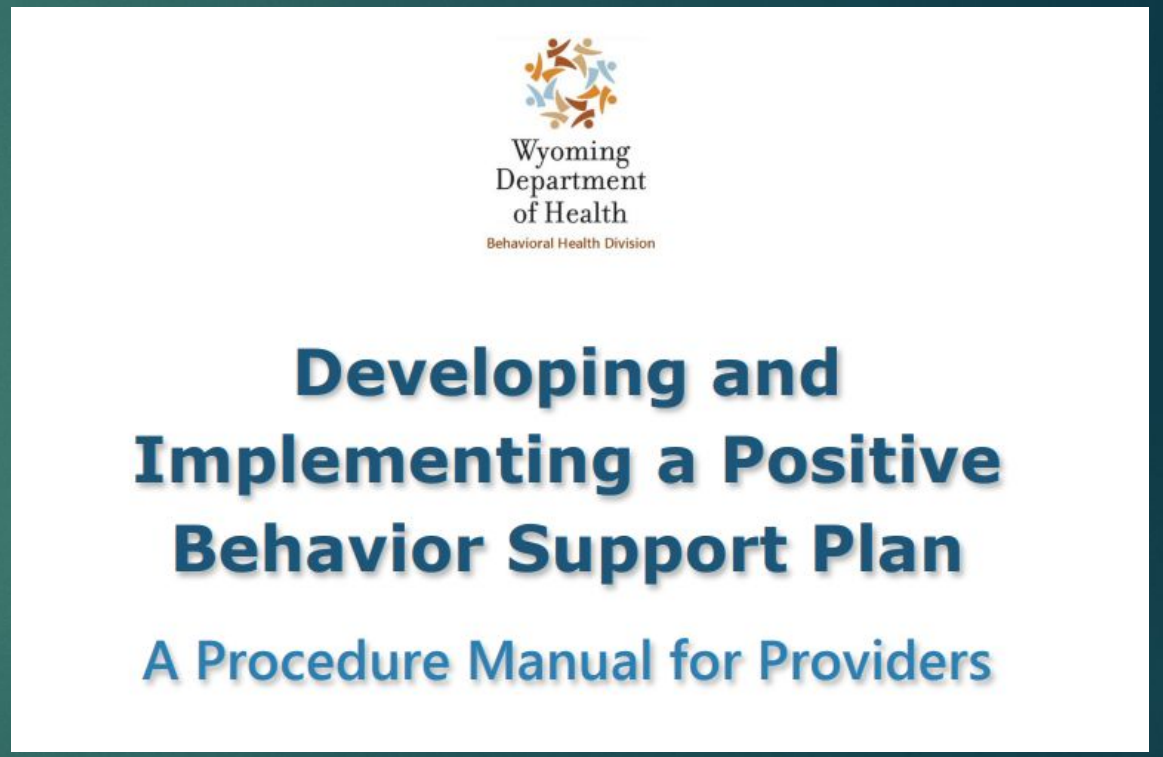
IPC – Behavioral Supports Section

- The FBA must be completed annually, and should guide the team during the development of the PBSP.
- Complete the FBA and PBSP and upload the document to EMWS.
- For assistance on developing and implementing a PBSP, refer to the Positive Behavior Support Plan Manual and Positive Behavior Support Plan and FBA template Both are found on the DD tab of the HCBS Document Library under the Supplementals/Protocols heading.



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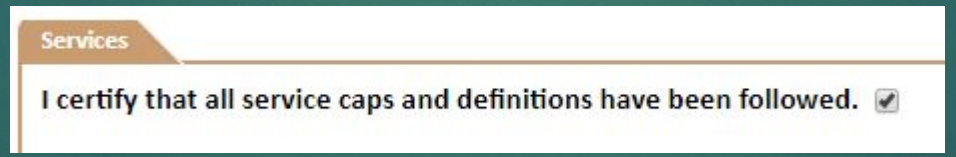
IPC – Service Authorization Section

- Waiver services must be prior-authorized.
- Service levels must be consistent with the participant's level of service.
  - If the service definition is met, community living services (CLS) may be rounded up one level. CLS is the only service that can be rounded up.
- Services must meet service definitions, and cannot exceed established caps. You must certify that all caps and definitions have been followed.



- The participant's service goal must align with their desired accomplishments, which are documented in the *Individual Preferences* Section.

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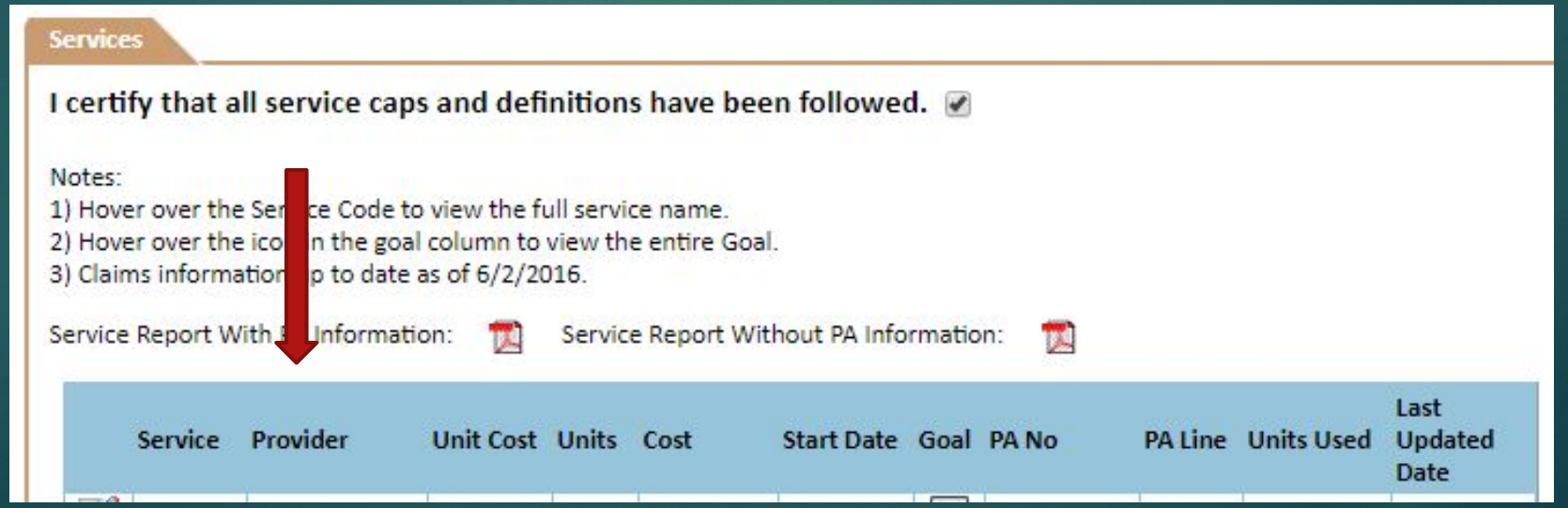
IPC - Service Authorization Section

- Planned service units must be sufficient to last the entire plan year.
- For traditionally delivered services, only providers certified for the service can be chosen from the drop down menu under *Services* tab.
  - If a provider is not in the drop down menu, the provider is not certified to provide the service. Contact the provider if you feel this is an error.



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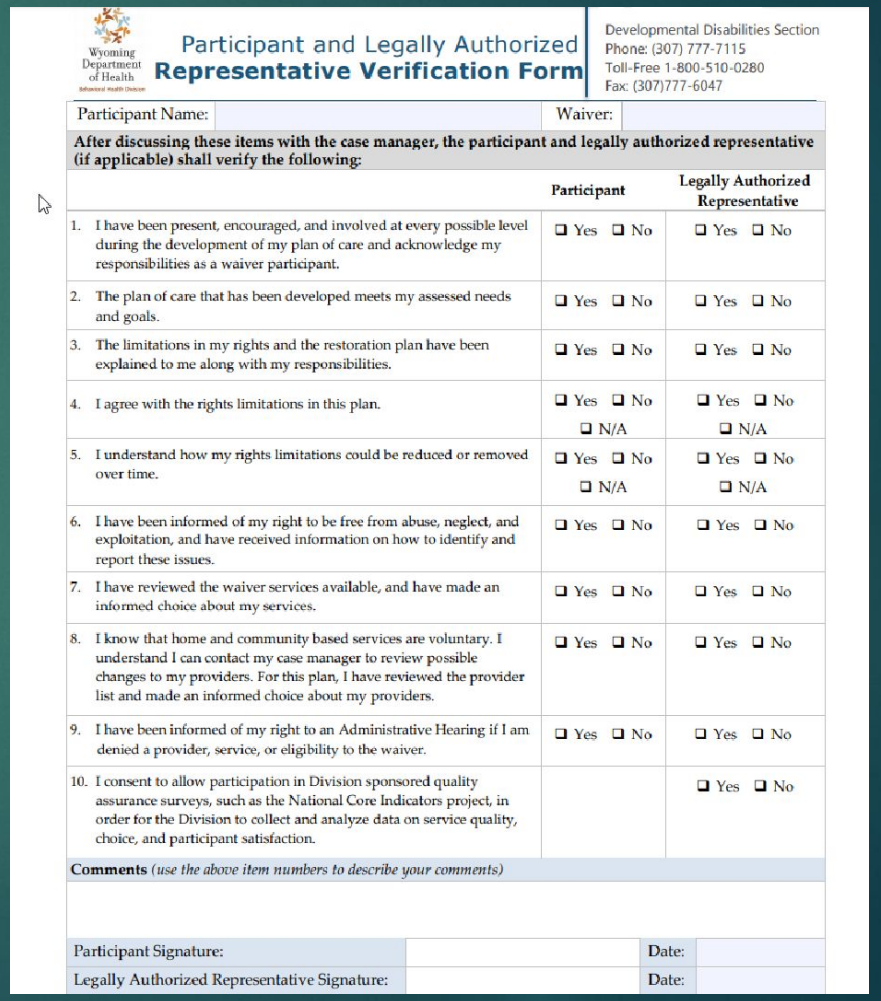
IPC - Service Authorization Section

Participant Direction

- If a participant has completed the participant-direction enrollment process, add the service under the *Self-Directed Services* tab.
- Enter the allocated budget for the participant-directed services.

IPC – Verification Section

- Download the Participant and Legally Authorized Representative Verification Form, which is located in EMWS.
- The participant and legally authorized representative will complete and sign the form.



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Participant and Legally Authorized Representative Verification Form

Developmental Disabilities Section
Phone: (307) 777-7115
Toll-Free 1-800-510-0280
Fax: (307)777-6047

Participant Name:		Waiver:	

After discussing these items with the case manager, the participant and legally authorized representative (if applicable) shall verify the following:

	Participant	Legally Authorized Representative
1. I have been present, encouraged, and involved at every possible level during the development of my plan of care and acknowledge my responsibilities as a waiver participant.	❑ Yes ❑ No	❑ Yes ❑ No
2. The plan of care that has been developed meets my assessed needs and goals.	❑ Yes ❑ No	❑ Yes ❑ No
3. The limitations in my rights and the restoration plan have been explained to me along with my responsibilities.	❑ Yes ❑ No	❑ Yes ❑ No
4. I agree with the rights limitations in this plan.	❑ Yes ❑ No ❑ N/A	❑ Yes ❑ No ❑ N/A
5. I understand how my rights limitations could be reduced or removed over time.	❑ Yes ❑ No ❑ N/A	❑ Yes ❑ No ❑ N/A
6. I have been informed of my right to be free from abuse, neglect, and exploitation, and have received information on how to identify and report these issues.	❑ Yes ❑ No	❑ Yes ❑ No
7. I have reviewed the waiver services available, and have made an informed choice about my services.	❑ Yes ❑ No	❑ Yes ❑ No
8. I know that home and community based services are voluntary. I understand I can contact my case manager to review possible changes to my providers. For this plan, I have reviewed the provider list and made an informed choice about my providers.	❑ Yes ❑ No	❑ Yes ❑ No
9. I have been informed of my right to an Administrative Hearing if I am denied a provider, service, or eligibility to the waiver.	❑ Yes ❑ No	❑ Yes ❑ No
10. I consent to allow participation in Division sponsored quality assurance surveys, such as the National Core Indicators project, in order for the Division to collect and analyze data on service quality, choice, and participant satisfaction.		❑ Yes ❑ No

Comments *(use the above item numbers to describe your comments)*

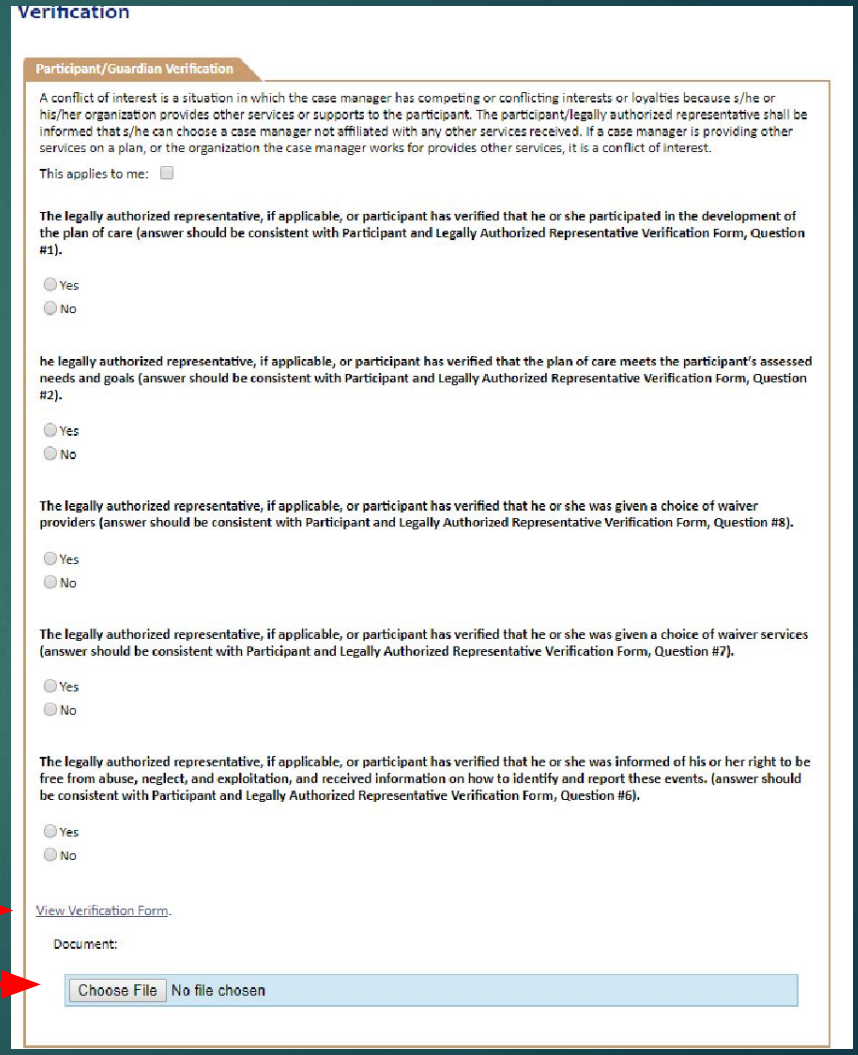
Participant Signature:		Date:	
Legally Authorized Representative Signature:		Date:	

IPC – Verification Section

- Answer the questions on the *Verification* screen.
- Verify the answers reflect the answers of the participant and legally authorized representative.
- Upload the completed form to the *Participant/Guardian Verification* tab.

Download blank form for signature here.

Upload signed form here.



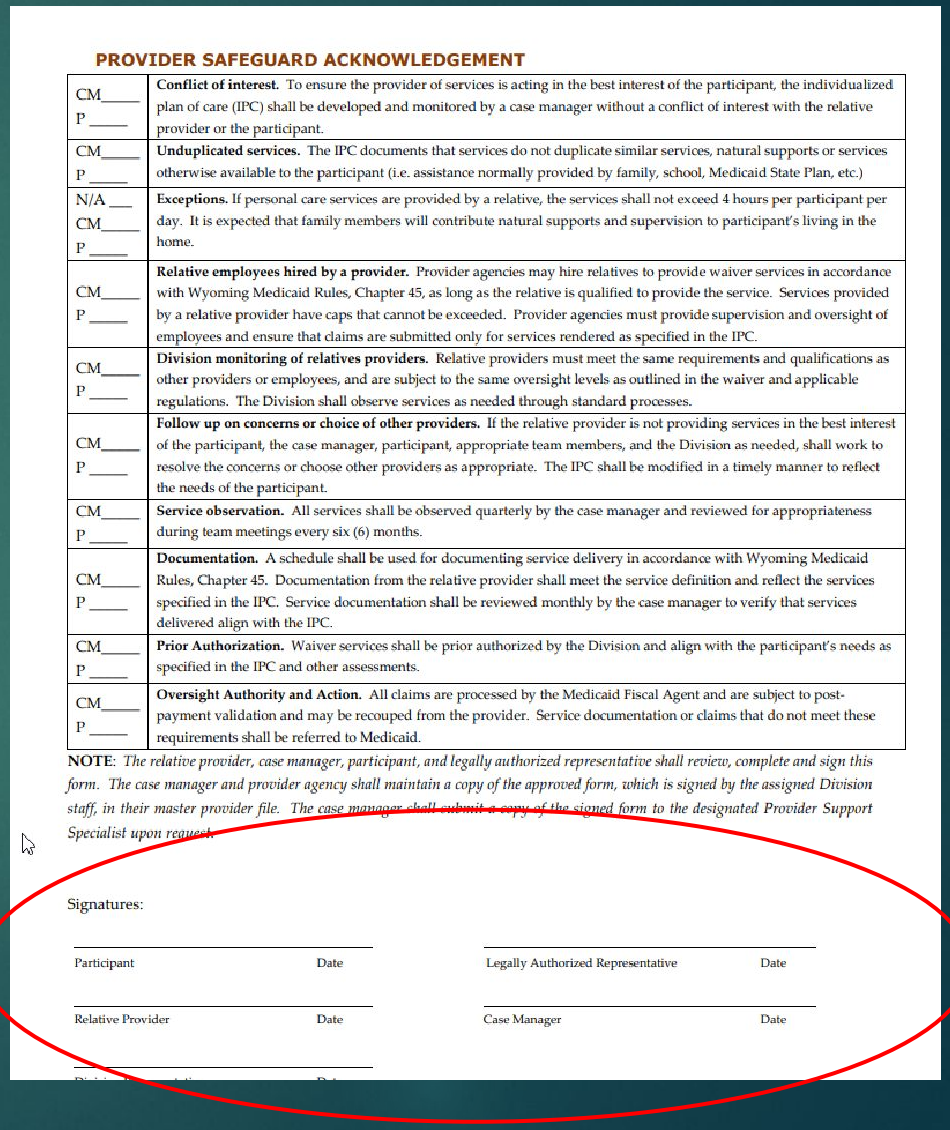
IPC – Relative Disclosure

You must indicate if a participant's relative is providing services by selecting "Yes" in the box provided and uploading the Relative Disclosure Form.

Once "Yes" is selected, the form can be downloaded from EMWS.

IPC – Relative Disclosure Form

- The relative must complete the form
  - Form must include the signature of the relative, participant, and case manager.
- A Division representative must sign the form before you upload it into EMWS.
- A new form is required if there are changes to the relative's services, the waiver type, or the legally authorized representative.
- This form must be uploaded annually.



PROVIDER SAFEGUARD ACKNOWLEDGEMENT

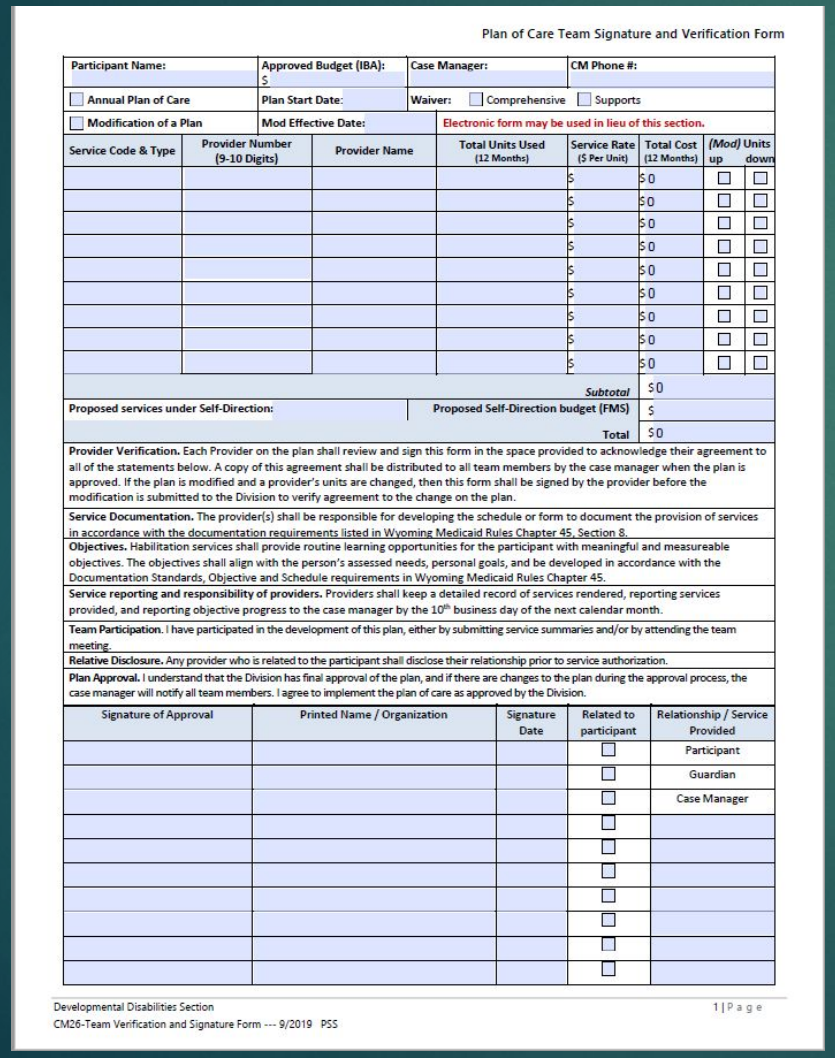
CM____ P____	**Conflict of interest.** To ensure the provider of services is acting in the best interest of the participant, the individualized plan of care (IPC) shall be developed and monitored by a case manager without a conflict of interest with the relative provider or the participant.
CM____ P____	**Unduplicated services.** The IPC documents that services do not duplicate similar services, natural supports or services otherwise available to the participant (i.e. assistance normally provided by family, school, Medicaid State Plan, etc.)
N/A___ CM____ P____	**Exceptions.** If personal care services are provided by a relative, the services shall not exceed 4 hours per participant per day. It is expected that family members will contribute natural supports and supervision to participant's living in the home.
CM____ P____	**Relative employees hired by a provider.** Provider agencies may hire relatives to provide waiver services in accordance with Wyoming Medicaid Rules, Chapter 45, as long as the relative is qualified to provide the service. Services provided by a relative provider have caps that cannot be exceeded. Provider agencies must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered as specified in the IPC.
CM____ P____	**Division monitoring of relatives providers.** Relative providers must meet the same requirements and qualifications as other providers or employees, and are subject to the same oversight levels as outlined in the waiver and applicable regulations. The Division shall observe services as needed through standard processes.
CM____ P____	**Follow up on concerns or choice of other providers.** If the relative provider is not providing services in the best interest of the participant, the case manager, participant, appropriate team members, and the Division as needed, shall work to resolve the concerns or choose other providers as appropriate. The IPC shall be modified in a timely manner to reflect the needs of the participant.
CM____ P____	**Service observation.** All services shall be observed quarterly by the case manager and reviewed for appropriateness during team meetings every six (6) months.
CM____ P____	**Documentation.** A schedule shall be used for documenting service delivery in accordance with Wyoming Medicaid Rules, Chapter 45. Documentation from the relative provider shall meet the service definition and reflect the services specified in the IPC. Service documentation shall be reviewed monthly by the case manager to verify that services delivered align with the IPC.
CM____ P____	**Prior Authorization.** Waiver services shall be prior authorized by the Division and align with the participant's needs as specified in the IPC and other assessments.
CM____ P____	**Oversight Authority and Action.** All claims are processed by the Medicaid Fiscal Agent and are subject to post-payment validation and may be recouped from the provider. Service documentation or claims that do not meet these requirements shall be referred to Medicaid.

NOTE: *The relative provider, case manager, participant, and legally authorized representative shall review, complete and sign this form. The case manager and provider agency shall maintain a copy of the approved form, which is signed by the assigned Division staff, in their master provider file. The case manager shall submit a copy of the signed form to the designated Provider Support Specialist upon request.*

Signatures:

Participant	Date	Legally Authorized Representative	Date
Relative Provider	Date	Case Manager	Date

IPC – Team Signature and Verification Form



Plan of Care Team Signature and Verification Form

Participant Name:	Approved Budget (IBA): $	Case Manager:	CM Phone #:
☐ Annual Plan of Care	Plan Start Date:	Waiver: ☐ Comprehensive ☐ Supports	
☐ Modification of a Plan	Mod Effective Date:	Electronic form may be used in lieu of this section.	

Service Code & Type	Provider Number (9-10 Digits)	Provider Name	Total Units Used (12 Months)	Service Rate ($ Per Unit)	Total Cost (12 Months)	(Mod) Units up	(Mod) Units down
				$	$0	☐	☐
				$	$0	☐	☐
				$	$0	☐	☐
				$	$0	☐	☐
				$	$0	☐	☐
				$	$0	☐	☐
				$	$0	☐	☐
				$	$0	☐	☐
				$	$0	☐	☐
				Subtotal	$0		

Proposed services under Self-Direction:	Proposed Self-Direction budget (FMS)	$
	Total	$0

Provider Verification. Each Provider on the plan shall review and sign this form in the space provided to acknowledge their agreement to all of the statements below. A copy of this agreement shall be distributed to all team members by the case manager when the plan is approved. If the plan is modified and a provider's units are changed, then this form shall be signed by the provider before the modification is submitted to the Division to verify agreement to the change on the plan.

Service Documentation. The provider(s) shall be responsible for developing the schedule or form to document the provision of services in accordance with the documentation requirements listed in Wyoming Medicaid Rules Chapter 45, Section 8.

Objectives. Habilitation services shall provide routine learning opportunities for the participant with meaningful and measureable objectives. The objectives shall align with the person's assessed needs, personal goals, and be developed in accordance with the Documentation Standards, Objective and Schedule requirements in Wyoming Medicaid Rules Chapter 45.

Service reporting and responsibility of providers. Providers shall keep a detailed record of services rendered, reporting services provided, and reporting objective progress to the case manager by the 10th business day of the next calendar month.

Team Participation. I have participated in the development of this plan, either by submitting service summaries and/or by attending the team meeting.

Relative Disclosure. Any provider who is related to the participant shall disclose their relationship prior to service authorization.

Plan Approval. I understand that the Division has final approval of the plan, and if there are changes to the plan during the approval process, the case manager will notify all team members. I agree to implement the plan of care as approved by the Division.

Signature of Approval	Printed Name / Organization	Signature Date	Related to participant	Relationship / Service Provided
			☐	Participant
			☐	Guardian
			☐	Case Manager
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	

Developmental Disabilities Section 1 | Page
CM26-Team Verification and Signature Form --- 9/2019 PSS

- The Team Signature and Verification Form must be completed in full, including the participant's name, plan of care dates, services, units, budget amount allocated and, if applicable, the modification effective date.
- After the IPC is completed, all team members are required to read, sign, and date the Team Signature and Verification Form.
- 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.

IPC - Finalizing the IPC

- After all sections are complete, submit the IPC for review.
  - Return to the *Plan Status* Section and click *Submit*.
- The IPC will be reviewed
  - The IPC may be automatically reviewed by the system.
  - The IPC may be reviewed by a BES during a Quality Improvement Review. If reviewed by a BES
    - The IPC may be returned to you for corrections, additions, or clarifications.

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IPC - Finalizing the IPC

- Once the IPC is reviewed, you are responsible for distributing the IPC to team members
  - Team members must receive a copy of the IPC, along with copies of any protocols and the PBSP.
- You must train providers on the new IPC, and document the training.
  - An example of a Participant Specific Training form is available on the *Workflow Tools & Logs* tab of the HCBS Document Library.

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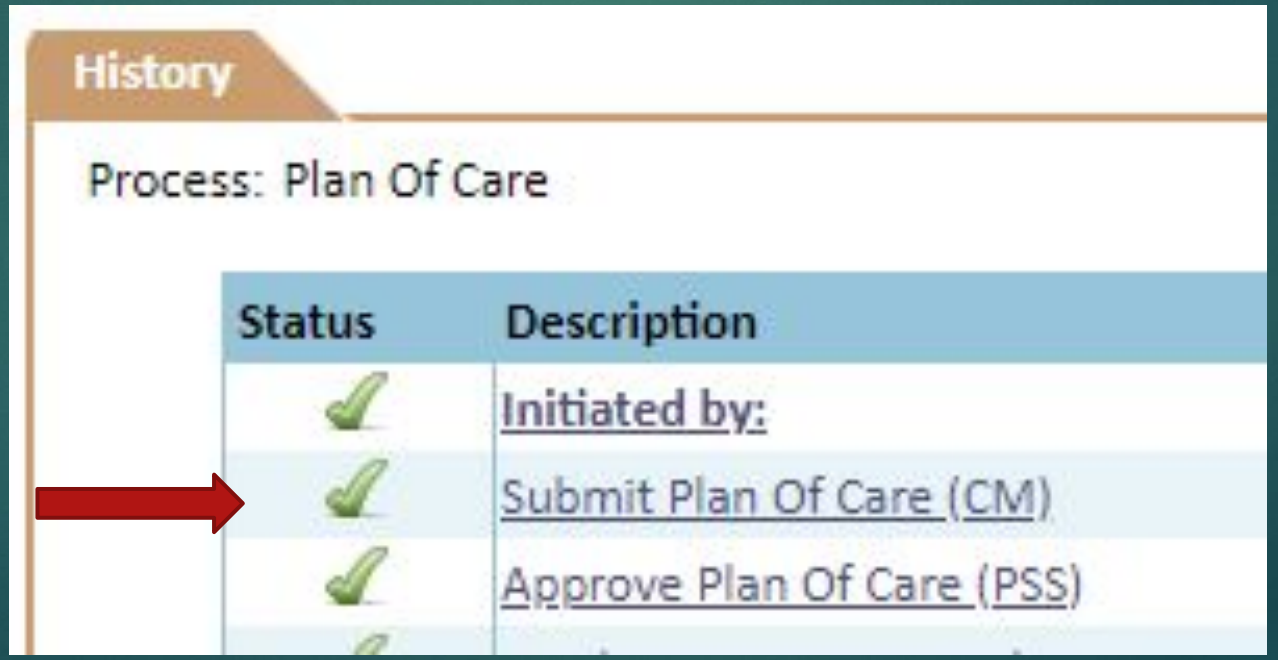
IPC - Finalizing the IPC

- Changes to the IPC can be made when the status says *Submit Plan of Care*.
  - Once plan status says *Approve Plan of Care (PSS),* you cannot make changes.



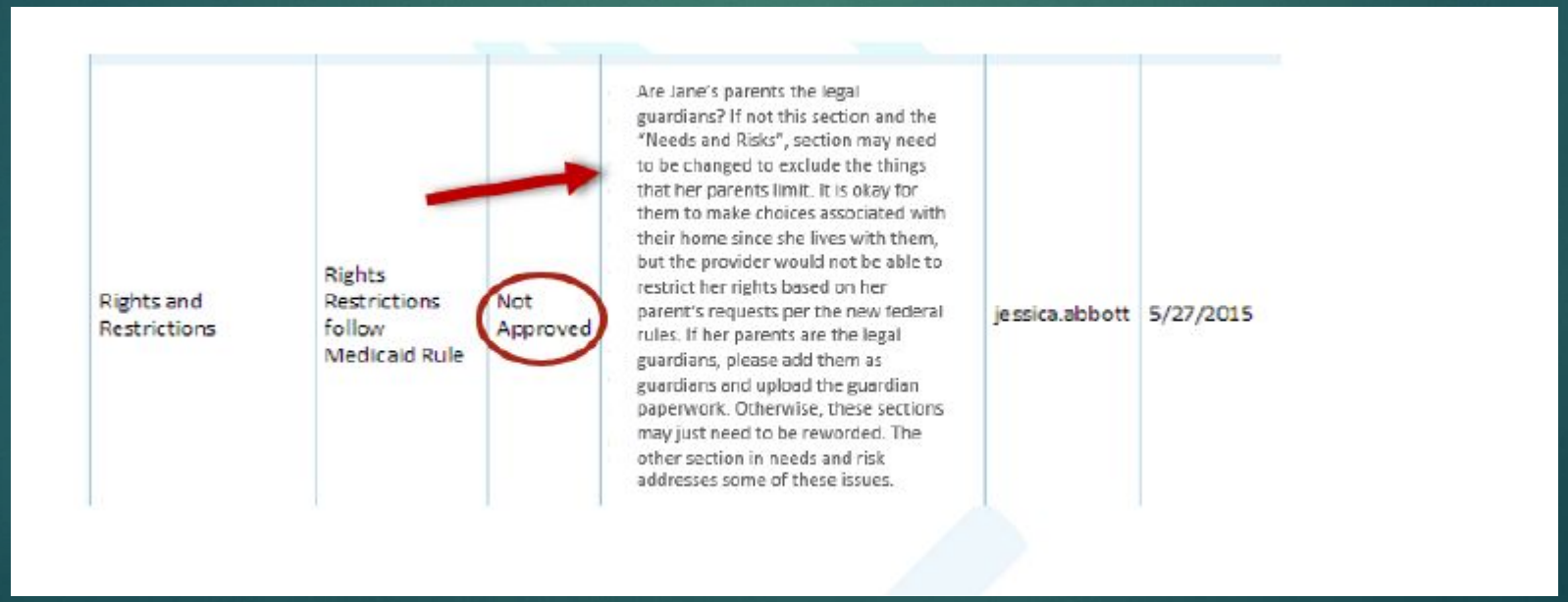
Wyoming Department of Health

Plan Modifications

- Make sure the IPC is complete before you submit it to the Division.
- Click the *Modify* button on the *Plan Status* screen. It takes time to load, so please be patient and don't click more than once.
- Submit the modification at least seven (7) calendar days before the modification is effective.
  - **Example:** If a modification is submitted on January 13, the modification effective date would be January 20.
- Modifications may be selected for a quality improvement review (QIR).

IPC and Modification Rollbacks

If the plan is rolled back review the BES' comments regarding needed corrections, access the Plan Status link 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

BMS Approval

- BMS is the system that processes all provider billing claims and adjustments.
- Once the IPC has been reviewed, the Plan Status screen will indicate ***Pending BMS Approval***.
- ***Pending BMS Approval*** means that the IPC has completed the Division's review process and is awaiting prior authorization numbers.

Quality Improvement Review

- Most IPCs will be reviewed by the EMWS system.
- In order to assure the quality of IPCs, a percentage of system reviewed plans will be checked for quality.
- The Division will identify areas for programmatic improvement and provide you with formal or informal technical assistance, if needed.

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Provider Transitions

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Provider Transitions

A participant may choose to change any provider at any time for any reason.

- You must work with the participant and LAR to review choice and current provider lists.
- You must inform the participant and LAR of the transition process when making a provider change
  - Explain that choice will be honored, but timelines must be followed
  - A provider may not be immediately available to begin services
- You must complete the Transition Checklist, found on the DD tab of the HCBS Document Library under the Supplementals/Protocols heading.

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Provider Transitions Process Flow

- Notify the Division of the request for change within three (3) business days of the transition request.
- Review choice and provider lists with the participant or LAR
- Schedule a team meeting, notify current and new providers, the participant, LAR, and Division two (2) weeks prior to the meeting.
- Follow the transition timeline. Complete ALL applicable items on the Transition Checklist, seeking input from the team.
- Upload the Transition Checklist with all other applicable forms into EMWS *Document Library*.
- Modify the IPC at least seven (7) days prior to the start of the new service(s).
- Guide participants through smooth, coordinated transitions to assure success.

Extraordinary Care Committee (ECC)

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Extraordinary Care Committee (ECC)

The ECC reviews requests regarding Level of Service (LOS) scores, extraordinary services or supports, temporary or permanent increases in a participant's IBA, and 24-hour services.

Criteria for ECC Requests

- Criteria for ECC requests is established in Chapter 46, Section 15.
- The ECC shall review:
  - Emergency cases as defined by Chapter 46, Section 14;
  - Extraordinary cases that include a significant change in service need due to the onset of a behavioral or medical condition or injury including:
    - A temporary change in circumstances, which requires a higher level of service or support to ensure the health, safety, and welfare of the participant;
    - Temporary funding increases under Chapter 46, Section 11(d); and
    - Requests requiring ECC approval under Chapter 46.

Please be aware that the ECC will base funding on the current IBA calculator. If the participant is currently funded at a level that is more than the currently calculated IBA, the request could result in a decrease to the participant's IBA.

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Inappropriate ECC Requests

- Requests for additional funding due to mismanagement of the IBA.
- Requests for residential services for someone under the age of eighteen (18).
- Requests for more than 24 hours of service within a 24 hour period.
- Requests for more than 7,280 units of Adult Day Services for someone who receives residential habilitation.
- Requests for additional funding or an increased level of service although there has not been a significant change in circumstances, the plan of care team has not considered alternatives to waiver funded services, or natural supports are available as an alternative to additional waiver services.

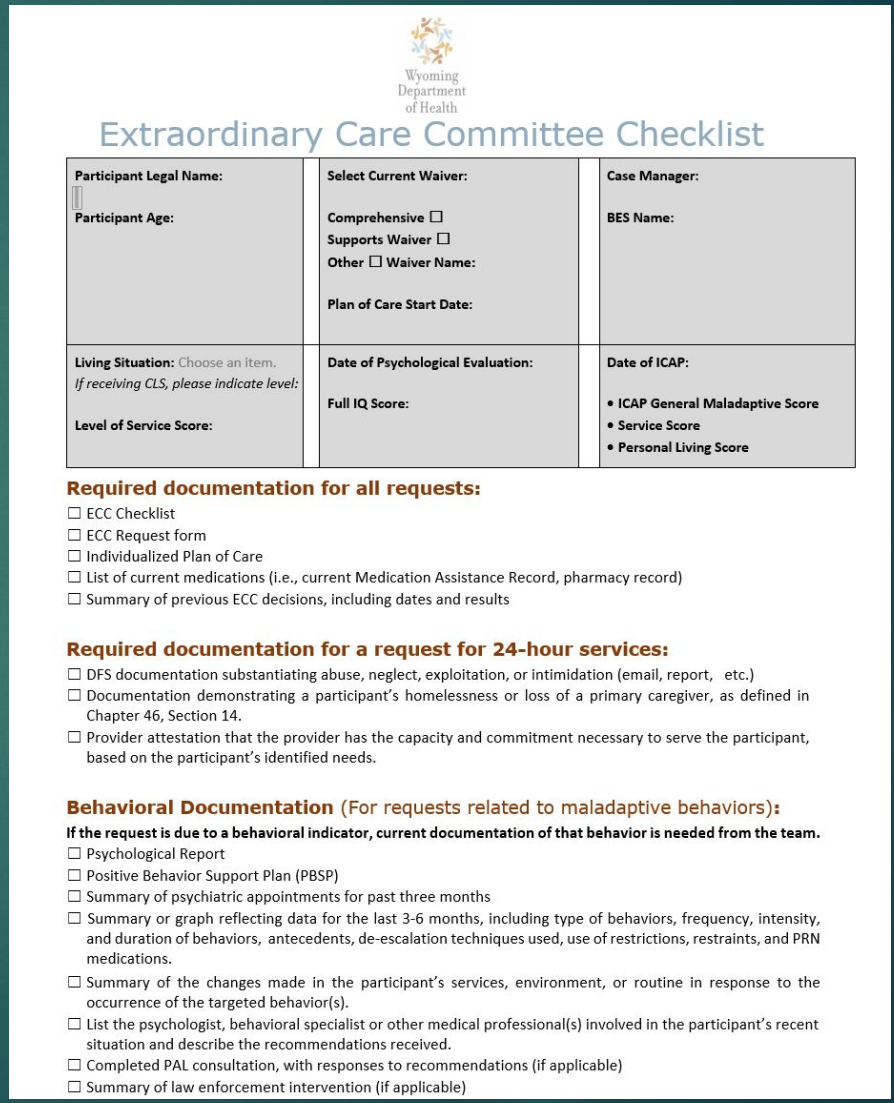
ECC Requests – The Case Manager's Role

When submitting an ECC request, ensure the following:

- Supporting documents are included.
  - A signed letter from the physician listing recommendations, if medical needs are addressed
  - Documentation to support the intensity, frequency, and duration behaviors, if an increase in problematic behaviors is addressed
  - A summary of incident reports
- The IPC reflects the need for additional funding
  - The *Needs and Risks* Section of the IPC reflects the additional need for support.
  - The PBSP is up-to-date and reflects an increase in problematic behaviors.

ECC Requests – The Case Manager's Role

- Complete the ECC Checklist. Upload the ECC Checklist and requested documents in the *Supplemental Requests* Section of EMWS



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Extraordinary Care Committee Checklist

Participant Legal Name: **Participant Age:**	**Select Current Waiver:** **Comprehensive** ☐ **Supports Waiver** ☐ **Other** ☐ **Waiver Name:** **Plan of Care Start Date:**	**Case Manager:** **BES Name:**
Living Situation: Choose an item. *If receiving CLS, please indicate level:* **Level of Service Score:**	**Date of Psychological Evaluation:** **Full IQ Score:**	**Date of ICAP:** • **ICAP General Maladaptive Score** • **Service Score** • **Personal Living Score**

Required documentation for all requests:

☐ ECC Checklist
☐ ECC Request form
☐ Individualized Plan of Care
☐ List of current medications (i.e., current Medication Assistance Record, pharmacy record)
☐ Summary of previous ECC decisions, including dates and results

Required documentation for a request for 24-hour services:

☐ DFS documentation substantiating abuse, neglect, exploitation, or intimidation (email, report, etc.)
☐ Documentation demonstrating a participant's homelessness or loss of a primary caregiver, as defined in Chapter 46, Section 14.
☐ Provider attestation that the provider has the capacity and commitment necessary to serve the participant, based on the participant's identified needs.

Behavioral Documentation (For requests related to maladaptive behaviors)**:**

If the request is due to a behavioral indicator, current documentation of that behavior is needed from the team.

☐ Psychological Report
☐ Positive Behavior Support Plan (PBSP)
☐ Summary of psychiatric appointments for past three months
☐ Summary or graph reflecting data for the last 3-6 months, including type of behaviors, frequency, intensity, and duration of behaviors, antecedents, de-escalation techniques used, use of restrictions, restraints, and PRN medications.
☐ Summary of the changes made in the participant's services, environment, or routine in response to the occurrence of the targeted behavior(s).
☐ List the psychologist, behavioral specialist or other medical professional(s) involved in the participant's recent situation and describe the recommendations received.
☐ Completed PAL consultation, with responses to recommendations (if applicable)
☐ Summary of law enforcement intervention (if applicable)

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ECC Requests – The Case Manager's Role

- Complete the ECC Request Form. Upload the ECC Request Form in the *Supplemental Requests* Section of EMWS. Form should include:
  - A description of how the request meets the criteria specified in Chapter 46 of the Department of Health's Medicaid Rules.
  - If the request is for 24-hour support, a description of the change in the participant's living situation.
  - If the request is due to the onset of the medical or behavioral condition, or injury that indicates a significant change in service need, a description of the circumstances.
  - A description of why the request is functionally, behaviorally, or medically necessary.
  - A description of other non-waiver service options, such as natural and paid supports, that were explored and implemented to meet the participant's needs.

Denied ECC Requests

- If a request is denied by the ECC, the decision can be appealed.
- If the participant chooses to appeal the decision, follow the Reconsideration or Administrative Hearing Process.

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Reconsiderations and Administrative Hearings

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Reconsiderations and Administrative Hearings

If a Division decision results in an adverse action affecting a waiver applicant or participant, the Division is required to provide a notice to inform the applicant or participant of their right to request a review of the decision.

Adverse Actions

- Adverse action is defined as a denial, reduction, or termination of services or eligibility, including a reduction in the level of care.
- The Division will provide written notification of any adverse action. Notification will include:
  - A statement of the intended action;
  - The reason for the decision; and
  - An explanation of the applicant's or participant's right to request a reconsideration and/or an administrative hearing.

Reconsiderations

- The participant/applicant has thirty (30) days to request a reconsideration.
- A request for reconsideration will be reviewed if:
  - Information used to make the decision that resulted in an adverse action was misrepresented;
  - Information used to make the decision that resulted in an adverse action was not represented to the fullest extent needed;
  - There was a misapplication of Division standards or policy during the decision process; or
  - The criteria used to make the decision was misunderstood.

Reconsiderations

- To submit a reconsideration on behalf of a participant or a legally authorized representative:
  - Add the request under Reconsideration Requests in the *Supplemental Requests* Section of EMWS.
  - Submit a letter requesting a reconsideration, along with supporting documentation.
  - Provide additional information, if requested.
- The reconsideration will be reviewed by the Section Administrator.

A request for reconsideration does not affect the availability of an administrative hearing

Administrative Hearings

- Requests for an administrative hearing are handled through the Office of Administrative Hearings.
- If a participant or LAR chooses to request an administrative hearing, you must assist the participant in submitting the request
  - Instructions are provided on the notification of the adverse action.

Case Management Billing Requirements

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Monthly and 15 Minute Unit Billing Requirements

MONTHLY

- Must be billed on or after the last day of the month.
- A minimum of two hours of billable services are required
  - Includes one (1) hour of person to person contact with the participant and/or LAR
- All billable services must be documented prior to billing.
- A home visit, with the participant present, is required

15 MINUTE

- At least one (1) unit per month must be billed
  - Based on the needs of the participant or the LAR
- Monthly home visit, with the participant present, is required for participants who receive any type of community living service
- Quarterly home visit, with the participant present, is required for participants who do not receive community living services
- All billable services must be documented prior to billing.
- IPC may not exceed 224 units annually, which is an average of 4.5 hours per month.

Billable Time vs. Non Billable Time

Billable time may be cumulative during the span for which you bill. *All billable time must be documented.*

Billable case management activities:

- Plan development
- Plan monitoring/follow up/documentation review
- Second-line medication monitoring
- Home visits
- Team meetings
- Participant specific training
- Face to face meetings with participants, LAR, and family
- Advocacy and referral for waiver and non-waiver services
- Crisis intervention and management
- Coordination of natural supports
- Offering and discussing choice
- Completing and documenting monthly and quarterly responsibilities
- Quarterly or bi-annual service observations, depending on the service
- Quarterly meetings with back-up case manager

Non-billable case management activities:

- x Ancillary activities such as mailing, copying, filing, and faxing
- x Supervisory or administrative activities
- x Social time spent with the participant or LAR
- x Incidental contact or social exchanges
- x Travel time, as this is included in the rate

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In-Home Visits

Home visits provide an opportunity to see the participant in their home environment. Home visits must be conducted based on the service definition and as outlined in previous slides.

- Have a purpose – know what you intend to accomplish and monitor during your visit.
- Use a checklist to help you stay focused. Share your checklist with the participant/LAR.
  - Topics might include medical appointments, medication changes, providers/services used during the month, activities completed during the month, etc.
- Discuss other ways you can monitor the participant's plan if they are receiving limited services or case management services only.
- Develop and document strategies to include other waiver and non-waiver services.
  - Discuss community resources that are available, and how they can be accessed.
- Note any changes needed, and your plan to follow-up.
  - Discuss how and when this follow-up should occur.

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In-Home Visits (cont.)

Tips

- If a team meeting is held in the participant's home, document this separately from the home visit on the Case Management Monthly Review Form in EMWS.
- Ask the participant or LAR to sign the Home Visit and Service Observation Form. If the participant or LAR is not able to sign, ask the provider staff to sign the form. Upload the form as part of the Case Management Monthly Review.
- You must conduct a home visit for each participant at least once a quarter (see Monthly and 15 Minute Billing Requirements on Slide 119). It is always acceptable and appropriate to visit a participant in their home more than once a month if there is a reason that would warrant additional home visits.

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Monthly Review

Billable activities are documented on the Case Management Monthly Review Form, located in EMWS

- Document all activities you complete on behalf of each participant you serve.
- Documentation must occur within sixty (60) days
  - Timely documentation is critical to allow for Division follow-up on reported concerns
- Complete documentation *before* you bill, in accordance with Medicaid rule.
- Complete every category with as much detail as possible, to demonstrate the service provided and participant response.
  - Brief notes that do not capture the who, what, why and where are *not* acceptable documentation.

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Quarterly Review

You must complete a quarterly review (January, April, July, October) for each participant on your caseload.

- Quarterly reviews contain important information used to track trends and concerns for each participant.
  - Information should add supplemental detail to information recorded in the monthly reviews.
  - Information is reported to the Centers for Medicare and Medicaid Services (CMS) to demonstrate statewide system improvement.
- The quarterly review will populate on your EMWS task list at the beginning of the month it is due.
  - The quarterly review is due on the last day of the month after the quarter ends (i.e., Report for January – March is due April 30, Report for April – June is due July 31)
- **Quarterly reviews cannot be submitted late**. If quarterly reviews are submitted late, you will be required to submit a corrective action plan (CAP) that details how you will ensure future submissions are on time.

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Submitting claims

- All DD Waiver claims are submitted through an online provider portal: https://www.wyomingmedicaid.com/portal/
- **Acentra** is the fiscal agent for Wyoming Medicaid.
  - Acentra processes all billing claims and adjustments.
  - Acentra answers provider inquiries regarding claim status, payments, client eligibility, and known third party insurance information.
  - For billing questions, contact wyprovideroutreach@acentra.com.

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Case Management Certification

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Case Management Certification

Case managers are certified in accordance with Chapter 45, Section 28, and may receive a one, two, or three year certification.

Case Management Certification Options

- Certification renewal can be conducted as a desk audit or site inspection, based on additional factors.
- Desk audit
  - No direct services are provided by the case management agency.
  - Multiple files per case manager are reviewed.
  - Agency policies and procedures are reviewed, along with any other pertinent information.
- Certification renewal that includes a site inspection
  - Review of same information reviewed during a desk audit.
  - If services other than case management are provided, a review of these services will occur as well.

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Case Management Training Requirements

- Each year, you must submit evidence of the following to your Provider Credentialing Specialist (PVS):
- CPR, First Aid, and Medication Assistance (if applicable) Training
- Eight (8) hours of continuing education, in addition to the trainings listed above.
  - Continuing education must be related to your caseload, or the direct case management services you provide.
  - Ongoing trainings offered by the Division do not count toward continuing education credits.
  - Contact your PVS for questions regarding continuing education requirements.

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Additional Links and Tools

HCBS Section Website

- Waiver services & regulations (rules & waiver documents)
- Public notices
- Division staff contacts
- Provider and case manager information, including support call notes, bulletins and training
- HCBS Document Library

HCBS Document library

- Commonly Used Terms - DD Tab
- Application Guide for the Supports Waiver - DD Tab Under Getting Started
- IPC Guide (Reference Materials) - DD Tab Under Planning
- Positive Behavior Support Plan Manual - DD Tab Under Individualized Plan Development Supplementals/Protocols

Commonly Used Acronyms

ABI: Acquired Brain Injury
BES: Benefits and Eligibility Specialist
BMS: Benefit Management Services
CAP: Corrective Action Plan
CIR: Critical Incident Report (DD Critical Incident)
CM: Case Manager
CMMR: Case Management Monthly Review
CMS: Centers for Medicare & Medicaid Services
DD: Developmental Disabilities
DFS: Department of Family Services
DHCF: Division of Healthcare Financing, or the Division
DSP: Direct Support Professional
DVR: Division of Vocational Rehabilitation
ECC: Extraordinary Care Committee
EMWS: Electronic Medicaid Waiver System
FBA: Functional Behavior Analysis
HCBS: Home and Community-Based Services (Waiver Services)
HIPAA: Health Insurance Portability and Accountability Act
IBA: Individual Budgeted Amount
ICAP: Inventory for Client and Agency Planning
ICF/IDD: Intermediate Care Facility for persons with Intellectual or Developmental Disabilities
IMPROV: Information Management for Providers
IPC: Individualized Plan of Care
IQ: Intelligence Quotient
IR: Incident Report (Internal)
LAR: Legally Authorized Representative
LOS: Level of Service
LTC: Long Term Care
MAR: Medication Assistance Record
MFCU: Medicaid Fraud Control Unit
NCI: National Core Indicators
PA: Prior Authorization
PAL: Partnership Access Line
PBSP: Positive Behavior Support Plan
PHI: Protected Health Information
PRN: (Pro re nata) As Needed Medication
PVS: Provider Support Specialist
QIR: Quality improvement review
TBI: Traumatic Brain Injury
TCM: Targeted Case Management
WDH: Wyoming Department of Health
WIND: Wyoming Institute for Disabilities

Waiver Participant Distinctions

CA, CC, CABI

Adult, Child, or Person with an ABI on the Comprehensive Waiver

SA, SC, SABI

Adult, Child, or Person with an ABI on the Supports Waiver

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To demonstrate completion of this training, please complete the Linked Survey.

Thank You!

FOR QUESTIONS, CONTACT YOUR
BENEFITS AND ELIGIBILITY SPECIALIST (BES)

COMPLETION OF THIS TRAINING IS TRACKED BY THE DIVISION AND WILL BE VERIFIED, SO A CERTIFICATE WILL NOT BE ISSUED.

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