Case Manager CMMR File Review Checklist

HOME AND COMMUNITY-BASED SERVICES
WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Participant Name: _____

Case Manager: _____ Review Date: _____

Division Staff: _____ Signature: _____

Billing Unit: ☐ Monthly Unit ☐ 15 Minute Unit

Years Reviewed (Span of last 12 months): _____

Case Manager Monthly Report Forms

Complete the following section and briefly summarize any deficiencies or identified compliance concerns in the Comments section for each question.

Months Reviewed: _____ _____ _____

Home Visit ☐ Yes ☐ No ☐ N/A (only applicable for 15 min unit)

Meets Documentation requirements? (Detailed description of what occurred and amount of time billed, interactions with the participant, environment, and other important events for the participant.)

☐ Yes ☐ No

Comments:

Monthly Case Note entries: (Includes date, start/end time, service, contact time, physical address of location where visit was conducted, and detail to support the time billed. Crisis intervention is noted when appropriate. Work on the IPC or team meetings is explained.)

☐ Yes ☐ No

Comments:

Discussion topics completed: (Responses are specific to the participant and reflect in detail what has happened in the participant's life. Responses are not repetitive from month to month.)

☐ Yes ☐ No

Comments:

Objective Progress and Goal Percentages Documented:

☐ Yes ☐ No ☐ N/A

Comments:

Provider Service Utilization Documentation reviewed and evaluated:

☐ Yes ☐ No

Comments:

Provider Documentation Non-Compliance Report submitted:

☐ Yes ☐ No ☐ N/A

Comments:

Participant Medical Needs/ Medication Monitoring:

☐ Yes ☐ No

Comments:

Incident Reports-Areas of Concern Noted:

☐ Yes ☐ No

Comments:

Follow up: (Must be noted if there is follow up to be completed in the previous month as indicated in the monthly case notes)

☐ Yes ☐ No

Comments:

Other Required Documentation Review

Review the participant's file and verify the following information is present:

Service Observations (Completed quarterly for all habilitative services and bi-annually for all others.)

☐ Yes ☐ No

Service Observation Form uploaded in CMMR:

☐ Yes ☐ No ☐ N/A

Participant Specific Training (Including evidence of the training and who was trained.)

☐ Yes ☐ No

Positive Behavior Support Plan (Review should be noted at least every six months)

☐ Yes ☐ No ☐ N/A

Evidence of quarterly meeting with back-up case manager (Documented in CMMR)

☐ Yes ☐ No

Plan submitted at least thirty (30) days prior to start date

☐ Yes ☐ No Date Submitted:

Did transitions/modifications occur during the plan period? ☐ Yes ☐ No

Was the appropriate transition checklist completed and uploaded as required?

☐ Yes ☐ No ☐ N/A

Annual Meeting Notice uploaded in EMWS ☐ Yes ☐ No

Was notification given at least twenty (20) days prior to the meeting date? ☐ Yes ☐ No

Quarterly Reviews (Submitted on time each quarter)

☐ Yes ☐ No

Monthly documentation submitted in EMWS on or after the last day of the month in accordance with the service definition

☐ Yes ☐ No

Monthly Documentation completed and submitted into EMWS within 10 days of the completion of services

☐ Yes ☐ No

Overall Comments