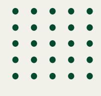
Wyoming Department of Health

Provider Documentation Standards

CCW Provider Support Call

May 18, 2026



HOME AND COMMUNITY-BASED SERVICES

WYOMING MEDICAID
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Wyoming Department of Health

Welcome

HOME AND COMMUNITY-BASED SERVICES

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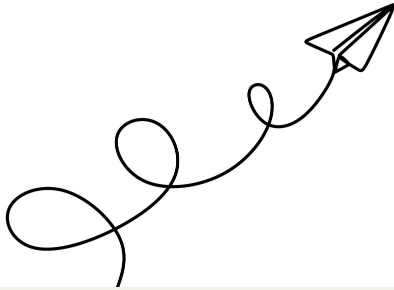
Thank you for joining us for this month's training presentation on Provider Documentation Standards. My name is Jaime Cureton, I am a Credentialing Specialist with the Home and Community-Based Service Section, Division of Health Care Financing within the State of Wyoming's Department of Health.

HOME AND COMMUNITY-BASED SERVICES

Purpose



- Clarify the purpose and requirements of service documentation as outlined in Wyoming Medicaid Rules and the Community Choices Waiver agreement.

The purpose of today’s training is to clarify the purpose and requirements of service documentation as outlined in Wyoming Medicaid Rules and the Community Choices Waiver agreement.

Acronyms & Terms

- **CCW** - Community Choices Waiver
- **HCBS** - Home and Community-Based Services
- **Division** - Division of Healthcare Financing
- **Department** - Wyoming Department of Health
- **EVV** - Electronic Visit Verification
- **PCSP** - Person-Centered Service Plan

Before we get started, we'd like to go over some of the acronyms and abbreviations we will be using in today's training. The Medicaid system in general, and the home and community-based services program, use a lot of acronyms. Although most of you know these terms, for any new providers, it can be confusing.

- The Community Choices Waiver is most commonly referred to as the CCW or CCW program.
- We will often refer to the HCBS Section or HCBS program. HCBS stands for Home and Community-Based Services.
- The HCBS Section is organized under the Division of Healthcare Financing, which is a Division of the Wyoming Department of Health. We will sometimes refer to the Division or Department, which means Division of Healthcare Financing, or Department of Health.
- EVV stands for Electronic Visit Verification.
- PCSP refers to the Person-Centered Service Plan that must be completed with each participant and their circle of support to ensure individualized care.

Choice

Participants have the right to make **choices** that affect their lives. This includes their providers and how those providers perform their services. Providers must be able to demonstrate **person-centered** service delivery through their documentation and support the veracity of the claims submitted for reimbursement.

We also want to remind everyone that home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. This includes their providers and how those providers perform their services. Providers must be able to demonstrate person-centered service delivery through their documentation and support the veracity of the claims submitted for reimbursement.

The philosophy of participant choice is fundamental to the CCW program and facilitating individual choice is a crucial part of being a service provider.

Agenda

- ➔ Review
  - Documentation purpose
  - Documentation requirements
  - Submission timeline
  - Electronic Visit Verification

HOME AND COMMUNITY-BASED SERVICES

In today's training, we will review the purpose of service documentation, documentation requirements, the timeline providers must follow when submitting documentation to the case manager and for billing, and how electronic visit verification (EVV) relates to billing and service documentation.

Person-Centered Services

- Documentation is used in the person-centered planning process.
- Providers are members of the participant's plan of care team.
- Providers must understand the participant's service plan and needs before accepting them into their services.

Documentation plays an integral role in HCBS services. Along with supporting the veracity of billing claims, documentation is used in the person-centered planning process. Details in the documentation track health and behavioral changes, help provide insight on what other services may be appropriate for the participant, monitors the progress of goals, and records updates to a participant's preferences.

The provider is a member of the plan of care team, and must actively participate in developing and maintaining person-centered service plans or PCSPs, to the extent that the participant wishes them to participate. Providers are required to follow the person-centered service plan, and if there are challenges or obstacles to delivering services in accordance with the PCSP, the provider is responsible for requesting that the plan of care team address those issues. The provider must maintain documentation to demonstrate that sufficient staff provided services, supports, and supervision to meet the needs of each participant in accordance with each participant's PCSP and according to the CCW service index.

Before agreeing to provide services to a participant, the provider must gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider must use this information to make a determination as to whether they are capable of providing services to meet the participant's needs. In order to make a responsible and informed decision, the provider must consider whether their organization has the capacity, commitment, and resources necessary to provide support to the participant.

Provider Documentation Requirements

- Participant's Name
- Location of Service
- Date of Service
- Start/End Time of Service
- Staff's Signature or Initials
- Detailed Description of the Service

Once a participant is accepted into services by a provider, the provider needs to complete and maintain service documentation.

Service documentation standards are outlined in Chapter 34, Section 20. Providers must create and maintain sufficient documentation to substantiate the claims submitted for Wyoming Medicaid reimbursement, and demonstrate that the services were delivered in accordance with Division requirements. At a **minimum**, the provider must document the following information when a service is provided:

- The participant's name
- The location of service, the physical address where the service took place;
- The date of service, including year, month, and day;
- The time services begin and end, using either AM and PM or military time, with documentation for each calendar day, even when services span a period longer than one calendar day;
- An initial or signature of the staff member performing the service; and
- A detailed description of services provided.

Some providers utilize electronic documentation systems. Please keep in mind that electronic documentation shall have automated tracking of all attempts to alter or delete information that was previously entered. Electronic documentation shall include electronic signatures and automatic date stamps.

Quality Documentation

Complete

Accurate

Unique

Detailed

Along with providing quality services, providers are expected to complete quality documentation. Quality documentation is complete with all of the Division's requirements, accurately describes the service that was provided, unique from other documented services, and provides details of the specific service provided at that time. Providers are responsible for the accuracy of the claims they submit for reimbursement. Remember that not only is documentation used to support the veracity of billing claims, but documentation is also used by the plan of care team to monitor the progress of goals, to track any changes in health or behavior, and record any updates to a participant's preferences. Documentation is a legal record of services provided and should be treated with a high level of importance.

In order to complete documentation and ensure compliance, many providers have created standard forms or templates for service documentation. While this practice is acceptable, the documentation needs to include a detailed description of the service provided. Providers cannot pre-populate information in templates or forms. All documentation must be unique and reflect the specific service provided on that date. Repetitive, "copy and paste" entries are unacceptable.

Let's take a look an example of quality documentation.

Quality Documentation

Participant's name

Location of Service

Start and End Time of Service

CCW Provider
110 Beautiful DR
Small Town, WY 80000
Phone: (307) 000-0000. Fax: (307) 000-0000

Home Health Aide Visit Note - Daily

PATIENT: Doe, Jane

PAN#: 000-00	AIDE: WHITE, ELIZABETH
ADDRESS: 982 E Mountain St, Small Town, WY 80000	DOB: 07/28/1953
ADM DATE#: 01/01/2026	SEX: F
START TIME: 01/15/2026 3:18PM	END TIME: 01/15/2026 4:16PM

Section 1: Participant & Service information

As we review this example of quality service documentation, please note that service documentation does ***not*** need to be structured in this exact format. Providers can complete quality documentation in a way that best suits them or their organization. In this example of quality documentation, we can find the participant's name, address where the service occurred, and the time the service began and ended near the top of the documentation.

Quality Documentation

Grooming and Dressing	Frequency	Status
Hair Care	Each Visit	Completed
Skin Care	Each Visit	Completed
Mouth/Denture Care	Each Visit	Patient Refused
Dressing	Each Visit	Patient Refused

Nutrition/Hydration	Frequency	Status
Prepare Meals (prescribed Diet)	Each Visit	Completed
Encourage Fluid Intake	Each Visit	Completed
Assist With Feeding	Each Visit	Patient Refused

HouseKeeping	Frequency	Status
Light Laundry	Weekly	Patient Refused
Bed Linen Change	Weekly	Patient Refused
Make Bed	Each Visit	Patient Refused

Section 2: Service details

Next, we find some preliminary details from this particular service instance. This provider has listed out the tasks that should be completed based on the participant's person-centered service plan details, the frequency at which they should be completed, and if the task has been completed during that service instance.

Quality Documentation

Nutrition/Hydration	Frequency	Status
Prepare Meals (prescribed Diet)	Each Visit	Completed
Encourage Fluid Intake	Each Visit	Completed
Assist With Feeding	Each Visit	Patient Refused

HouseKeeping	Frequency	Status
Light Laundry	Weekly	Patient Refused
Bed Linen Change	Weekly	Patient Refused
Make Bed	Each Visit	Patient Refused
Light Housekeeping: Bed/Bath/Kitchen	Each Visit	Completed
Clean Equipment	Each Visit	Completed
Sweep	Each Visit	Completed
Vacuum	Each Visit	Completed
Take out Trash	Each Visit	Patient Refused

Section 2: Service Details

From this list of tasks, we can see that the aide was able to complete many with the participant, but there are a few tasks that the participant refused to complete. CCW participants have the right to refuse services or certain tasks, but the provider should document if the participant refused to complete certain tasks or refused services entirely. Many provider documentation systems include a list of tasks that can be marked as complete, incomplete, or refused, but simply marking them in this manner is not sufficient to meet the detail standards for documentation. The staff member will have to elaborate on the service that occurred: what happened or didn't happen and why.

Quality Documentation

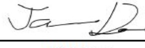
CUSTOM TASKS

Task ID	Task	Frequency	Status	Comment	Special Notes
806	peri care	Each Visit	Completed		
811	pm cares	Each Visit	Completed		
813	apply pajamas	Each Visit	Completed		

Details

COMMENTS

Jane was cheerful and energetic during my visit. When I entered her house, I first assisted with mixing her electrolyte drink. I challenged her to drink it all before I left her house. Jane completed most of her usual tasks with me including toileting, peri care, and the application of her topical gels. I checked for any visible pressure sores and asked if she was noticing any pain from pressure while in her wheelchair. She let me know that she has been feeling like she can't sit still today and has been adjusting her position in the wheelchair. All of the movements have knocked the cushions out of place. I re-adjusted the cushions on her electric wheel chair per the guidance chart in her plan. I vacuumed the carpet in her living room and vacuumed crumbs out of her power lift recliner, swept the kitchen, started the dishwasher, cleaned her C-Pap, and combed her hair. I reminded her of her medications, which she took while I was present. I assisted her to prepare with a frozen home-delivered meal, her favorite-creamed chicken, rice, and green beans. She refused assistance with her oral care as she plans on eating a scoop of ice cream in an hour or so when she watches her evening shows. She told me she would brush her teeth and use her medicated mouth wash after her shows. She is fairly independent with oral care, but I will check in with her tomorrow. Jane was able to put her pajamas on without as much assistance as normal, I just helped her adjust her shirt in the back. Jane did not wish to complete laundry this visit. I told Jane that I noticed she was spending a lot of my visit standing and holding her grab bars. She let me know that she has been feeling more energized and attributes it to the new medication. She let me know that if her energy continues to improve, she would like to start playing cards with her friends again. I let her know how happy I was to hear she had energy and she could call her case manager if she needed to coordinate a ride service. Before I left, she reminded me of the electrolyte challenge which she completed. I cheered for her and we high-fived. She asked me to send a quick text to her daughter before I left.

Patient/Patient Representative Signature:  Signed Date: 01/15/2026 04:15 PM

JANE DOE

Staff Signature

Aide Signature: *Electronically Signed by Elizabeth White, CNA* Signed Date: 01/15/2026 04:16 PM

Section 3: Service Details & Staff Signature

In this last section of the service documentation, we can see the full details from this service instance in the “comments” section. The details in the documentation are important help better understand the participant at that time, record the specifics of each task that was completed, help give some context as to why some tasks were refused, and give the staff member an opportunity to note any concerns they may have. Goals, desires, and issues should be tracked in detail. The details are what distinguishes one piece of documentation from another and shows that quality services are being delivered. The details also help to ensure the service was delivered according to the service index standards.

Here at the bottom, we can find the last documentation requirement: the staff signature. In this example of quality service documentation, you can find details that are specific to the provider organization, but all of the State requirements are met.

Deficient Documentation

Take note of the differences between these examples

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Now let's take a look at documentation that does not meet Division requirements. We'll note some common errors and issues in provider documentation.

Deficient Documentation

Participant's name

CCW Provider
110 Beautiful Dr.
Small Town, WY 80000
Phone: (307) 000-0000 Fax: (307) 000-0000

PATIENT: Doe, Jane

Location of Service

ADDRESS: Jane's House
AIDE: Elizabeth White
START TIME: 01/17/2026 11:00AM
End Time: 01/17/2026 12:00PM

Start and End Time of Service

Section 1: Participant & Service information

In this example, we see the name of the participant near the top of the page and the service location was Jane's house. Provider documentation should include the address where the service took place. At the bottom, we can see that this service started at 11 AM and ended at noon. Let's keep reviewing to see if we can get more information about what occurred during this service.

Deficient Documentation

Grooming and Dressing	Frequency	Status
Hair Care	Each Visit	Completed
Skin Care	Each Visit	Completed
Mouth/Denture Care	Each Visit	Patient Refused
Dressing	Each Visit	Patient Refused
Nutrition/Hydration	**Frequency**	**Status**
Prepare Meals (prescribed Diet)	Each Visit	Completed
Encourage Fluid Intake	Each Visit	Completed
Assist With Feeding	Each Visit	Patient Refused
HouseKeeping	**Frequency**	**Status**
Light Laundry	Weekly	Patient Refused
Bed Linen Change	Weekly	Patient Refused
Make Bed	Each Visit	Patient Refused

Section 2: Service Details

Here we we again see a list of tasks with the frequency they should occur and if they occurred during this service instance. We can see some were completed and some were not. While this sort of checklist can be a useful reminder for the staff completing the service, it does not provide the details required by the Division.

Deficient Documentation

Details?

COMMENTS

Completed the usual tasks. Left Jane's early because John Smith called and asked that I come early due to concerns about his bandage. Jane said she was ok.

Patient/Patient Representative Signature: Jane Doe Signed Date: 01/15/2026 11:36AM

Aide Signature: Signed Date:

Staff Signature?

Time Discrepancy

Section 3: Service Details & Staff Signature

In this last section of the service documentation, the comments section only includes a few sentences that do not give any details about what occurred, what didn't, and why. We see that the "usual" tasks were completed and Jane said that she was ok. We also see a note mentioning another participant's name and that the staff member left the service with Jane early. We can see that the time next to Jane's signature is 11:36, not noon, like stated at the top of the documentation. At the bottom, we find that the staff's signature or initials are missing.

Keeping this example in mind, here are some common errors the Division encounters when reviewing documentation:

- "Copy and pasted" details or using the same phrases in hand-written documentation. Ensure that each service instance is uniquely and accurately described in the service documentation. While the tasks that need to be completed may remain the same, what actually happens from day to day varies.
- Completing documentation at a later time. Ensure staff are completing documentation once the service is complete. It is difficult to remember the details of a service that occurred earlier in the week or month. It may also cause issues including time discrepancies and inaccurate billing.
- Mentioning other participants by name in documentation. This is a HIPAA violation and needs to be avoided.
- Leaving out service details entirely. The service details are a requirement for documentation.
- Including generic place names instead of physical addresses.

- If services are refused, not including the refusal or the reason in the documentation. Documentation of the refuse will need to be provided to the participant’s case manager.

Now that we’ve gotten an example of quality and deficient documentation, let’s shift to discuss submitting documentation to the participant’s case manager.

Submitting Documentation to the Case Manager

- Documentation is due to the case manager by the **10th business day** of the following month.
- Providers must submit documentation to case managers **even when no services are provided.**

As established in Chapter 34, Section 20(g), providers must make **service documentation** available to the participant's case manager each month by the tenth (10th) business day of the month following the date that the services were provided. **If services were not provided, providers are still required to report that information to the participant's case manager.** The case manager is required to review documentation to verify service delivery, ensure services are delivered according to the person-centered service plan and service idex, and to prevent mismanagement of Medicaid funds. If issues are identified, the provider must follow the necessary steps to remedy the error through documentation correction, and if applicable, void adjustment of claims in the Billing Management System (BMS).

Documentation Submission to Case Managers

This table outlines the documentation requirements that must be submitted to case managers based on the service.

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Required Provider Documentation to be made available to CCW Case Managers.

Service	Documentation
Direct Services • Adult Day • Assisted Living Facilities • Home Health Aide • Personal Support (participant-directed EORs should refer to the EOR Manual) • Respite • Skilled Nursing	• Participant name • Date and time of service • Location of service (if outside of participant's home) • Name of service provided
Home Delivered Meals	• Participant name • Month of Service • Number of meals delivered • Date of delivery or shipment
Homemaker Services	• Participant name • Date and time of service • Location of service
Non-Medical Transportation	• Participant Name • Date and Time of Service • Number of trips • Service type (accessible/non-accessible vehicle)
Personal Emergency Response System (PERS)	Monitoring • Participant name • Month of service • Date of last event (SOS call) or other "clear alert" procedure - if more than a month, case manager must follow up with participant to ensure system is working Installation • Participant name • Participant address • Date of installation

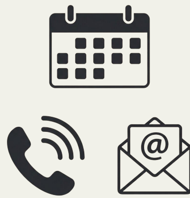
All elements required in Chapter 34, Section 20 need to be present in provider service documentation.This includes the participant's name, the physical address where the service occurred, the date the service occurred, the beginning and end time of the service, the signature or initials of the staff who provided the service, and a detailed, unique description of the service delivered.

Providers do not need to send case managers every page of documentation that is recorded in their individual documentation systems. The purpose of providing documentation is to give case managers a way to review service utilization. Some documentation that providers submit to case managers will vary slightly based on the service the provider is delivering. For example, Home Delivered Meals service documentation will include the number of meals delivered while Non-Medical Transportation will need to include the number of trips. You can find this table on service-specific documentation that is required to be submitted to the case manager in the *CCW Provider Manual* located on the HCBS Document Library under the *CCW* tab.

This is the same information that would be needed to submit a claim, so it is presumed that there is a mechanism for each provider to ensure that this information is available. Due to enhancements made within the BMS and EVV systems, providers do not need to make **billing documentation** available to case managers, unless specifically requested to do so.

Documentation Submission Non-Compliance

Case managers are required to review documentation



Providers will be contacted if documentation is not available by the 10th business day

Missing documentation requires a case manager to file a Non-Compliance form with the area IMS

Chronically late documentation may lead to a complaint and possibly corrective action

Failure to make service documentation available to the case manager by the tenth (10th) business day of the month following the date of service should result in the case manager submitting a Documentation Non-Compliance form. If the case manager has not received service documentation by the tenth business day, they will contact the provider by phone or email requesting the necessary documentation. If after being contacted by the case manager, the provider fails to submit the required documentation by the end of the month in which it is due, the case manager is required to file a Provider Documentation Non-Compliance form to report the issue to the area Incident Management Specialist (IMS). If the provider is chronically late submitting documentation, the case manager may submit a complaint through the WHP Portal, and the provider may be subject to corrective action.

Billing Submission

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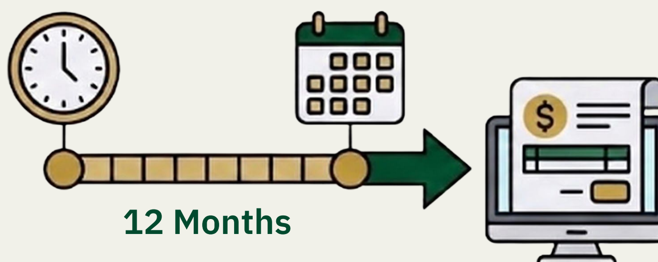
- **Billing Deadline**
  Billing must be completed within **twelve (12) months** of the service provided.
- If there is no documentation, providers cannot bill.
- Chapter 3 of Wyoming Medicaid Rules outlines the requirements for claim submission and payment.



The service documentation is needed to support the veracity of the billing claims. Chapter 3, Section 13(vi) of the Wyoming Medicaid Rules states that provider billing claims must be completed within twelve (12) months of the service provided. Remember that if there is no documentation of the service occurring, it did not happen and cannot be billed for.

Chapter 3 of Wyoming Medicaid Rules outlines the requirements for payment and submission of claims by providers. A number of requirements are included in that Chapter, including but not limited to:

- Prior authorization: All CCW services require prior authorization (PA).
- All claims submitted must include the required fields outlined in Chapter 3 of the Wyoming Medicaid Rules and are included in the Waiver & Care Management Entity (CME) Claim Submission Tutorial which can be found on the Wyoming Medicaid Provider Training, Tutorials and Workshops webpage.
- Providers must retain documentation to support the claim submitted. This service documentation also must be provided to the Division upon request.
- Providers are required to accept payment-in-full from Medicaid, and to not seek additional payment for the services rendered as outlined in Chapter 3, Section 12(b)

Documentation Retention

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- The Division recommends providers retain documentation for **seven (7) years**.
- The Division can request and review participant documentation at any time.

According to Wyoming Medicaid Rules, Chapter 3, Section 8(c), a provider shall maintain records, including information regarding dates of service, diagnoses, services furnished, and claims, for at least six (6) years after the end of the state fiscal year in which payment for services was rendered. The Division recommends that providers keep their documentation records **for at least seven (7) years** to ensure the Chapter 3 requirements are met. Providers must follow safe record storage and destruction policies that maintain participant confidentiality.

The Division may conduct audits of provider claims through an on-site evaluation or desk review. Providers must submit records requested by the Division or any other investigative authority in accordance with Chapters 3 and 16 of Wyoming Medicaid Rules. **The Division may request provider documentation for review at any time.** If documentation is requested, providers should submit the records in a timely manner.

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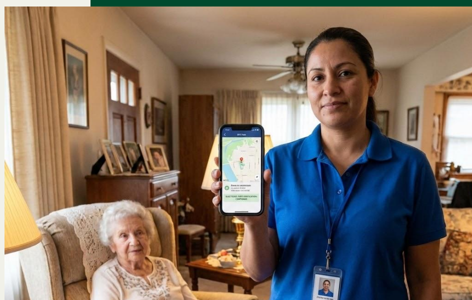
Electronic Visit Verification



21st Century Cures Act

All state Medicaid Programs are required to implement an electronic visit verification (EVV) system for services that are home health or personal care-related services.

Services Requiring EVV

- Personal Support Services
- Skilled Nursing
- Home Health Aide
- Respite

EVV ≠ Service Documentation

- EVV is not a substitute for documentation.
- EVV compliance is not the same as service index compliance.

In 2016, Congress passed the 21st Century Cures Act. As a part of that federal legislation, all state Medicaid Programs are required to implement an electronic visit verification (EVV) system for services that are home health or personal care-related services. Electronic Visit Verification (EVV) is used to confirm visit and service delivery information in real-time. It provides protection against fraud and improper spending by validating service hours billed. It uses technology to electronically capture information about when and where home and community-based services (HCBS) begin and end. Failure to comply with the EVV requirements can result in a decrease in federal funding.

This federal requirement applies to the Community Choices Waiver, and the current services that must be billed through EVV include **Personal Support Services, Home Health Aide, Skilled Nursing, and Respite**. Without EVV, these service claims will not be processed and paid.

Please keep in mind that EVV is not a substitute for service documentation. EVV requirements do not satisfy all of the elements required for service documentation outlined in Chapter 34, Section 20. A compliant EVV visit does not mean that the service provided was also complaint with the CCW Service Index. As long as a provider clocks in and out through the EVV system appropriately, it is considered an EVV complaint visit. Providers need to ensure that they are following the CCW Service Index to ensure appropriate service delivery.

Key Takeaways

- Documentation is required for all waiver services.
- Documentation must include all of the required elements outlined in Wyoming Medicaid Rules, Chapter 34, Section 20.
- Documentation is important for the plan of care team to monitor unit utilization, service provision appropriateness, and goal progress.
- Documentation must be submitted to the Case Manager by the 10th business day of the month following service delivery.
- Billing claims are supported by service documentation.
- Providers must retain service documentation according to Wyoming Medicaid Rules, Chapter 3, Section 8.
- EVV is not a substitute for documentation.

To wrap up today's presentation on service documentation standards, I want to highlight the key takeaways:

- Documentation is required for all waiver services.
- Documentation must include all of the required elements outlined in Chapter 34, Section 20.
- Documentation is important for the plan of care team to monitor unit utilization, service provision appropriateness, and goal progress. Details are critical for quality, useful documentation.
- It must be submitted to the Case Manager by the 10th business day of the month following service delivery. If issues are identified, the provider must follow the necessary steps to remedy the error through documentation correction, and if applicable void adjustment of claims in BMS.
- Billing claims are supported by service documentation.
- Providers are required to retain service documentation according to Wyoming Medicaid Rules, Chapter 3, Section 8(c). The Division recommends that providers retain the documentation for seven (7) years.
- EVV is required for a number of waiver services. Without EVV, these service claims will not be processed and paid. EVV does not meet all of the requirements outlined in Chapter 34, Section 20 and therefore is not considered a substitute for service documentation.

At this time if you have any other questions, please post them in the chat. We'll answer them in writing and get those to you by email and post them to the *CCW Providers & Case Managers* page under the *Provider Support Calls* tab in the next few days. Thank you for joining us today!