Frequently Asked Questions (FAQ)

CCW Service Index

1. **Q: Will a separate training session be scheduled to address updates to the service index?**

   A: Yes. The Division is excited about the new and revised offerings within the Service Index and plans to provide a number of trainings, including training on new services such as Assistive Technology and Companion Services. In the meantime, the Division encourages case managers and providers to thoroughly review the Service Index regarding these changes.

2. **Q: Please provide guidance on when and how the Case Management T1016 (15-minute) code should be utilized.**

   A: The intent of the 15-minute Case Management Unit (T1016) is to allow some flexibility and support both to program participants and to case managers. The appropriate uses of T1016 may include:

   - The participant wishes to change case managers mid-month: T1016 allows for a participant to leave the outgoing case manager mid-month, and receive services from the incoming case manager, without either case manager sacrificing payment for their work. Both case managers can bill for the time during the transition month.
   - The case management agency has unanticipated staff changes: Occasionally case management agencies have unanticipated staff changes that may require the transfer of the case. Again, T1016 allows for each appropriate case manager to bill for services rendered.

   Please note that this 15-minute unit usage is aimed at supporting clients during transitional periods. A monthly visit must still be performed. Please contact the Division for further guidance in these situations on who has or will perform the home visit to support the client's well-being during this transition.

3. **Q: Will there be additional training on how to implement new services, add them to plans, and complete the necessary documentation? Will a new naming convention be sent out?**

   A: Yes, the Division will provide additional training on the new services. While the core workflow for adding services to a Plan of Care will remain highly similar to current processes, detailed guidance is forthcoming. New naming convention guidance will be posted to the HCBS Document Library July 1st.

Assistive Technology (AT) & Companion Services

4. **Q: Are there currently any Assistive Technology or Companion providers listed in Laramie County? How can a participant utilize these services?**

   A: Because these waiver updates do not take effect until July 1, 2026, new service providers will not appear in the IMPROV system prior to that date. Providers may begin the certification process for these new services starting July 1, 2026.

5. **Q: Must Assistive Technology (AT) services professionals be Medicaid providers?**

   A: Yes, that is correct.

6. **Q: Who conducts the professional evaluation for AT, and how do we initiate it?**

   A: The professional evaluation can be completed by a physical therapist, occupational therapist, speech therapist, etc. The Division acknowledged this is an important area and noted that more in-depth training will be provided on this topic in the future.

7. **Q: Will participants need to provide proof of exhaustion of all other resources when adding in AT, and who can provide this service?**

   A: Yes, you must exhaust all other resources. Medicaid is the payer of last resort, meaning alternative funding sources (such as the Medicaid state plan, Medicare, or private insurance) must be explored and utilized first. More detailed guidance on AT providers is forthcoming.

8. **Q: If companionship covers meal prep, laundry, shopping, and housekeeping, what prevents everyone from billing under Companionship for the higher rate instead of Personal Support Services (PSS)?**

   A: Providers are required to bill for the most appropriate service rather than the most profitable one. According to the Service Index, PSS is intended for part-time or intermittent assistance with Activities of Daily Living (ADLs) like eating, bathing, grooming, and mobility. For PSS, chores and meal prep are merely incidental, whereas Companion services focus on active supervision and socialization as outlined in the Service Index. The Division relies on case managers to coordinate the most appropriate service mix for each participant, as well as to monitor these services on a monthly basis to ensure services are being delivered in alignment with the Service Index.

   If a case manager knows or suspects that a provider is inappropriately billing for a service, the first step is to advise the provider that they are inappropriately billing. This practice may be considered Medicaid fraud. The case manager is then required to submit a complaint to the HCBS Section via the HCBS website.

Per the Medicaid Provider Agreement signed by all providers and case managers, following Medicaid rules is mandatory. Billing for an unneeded, higher-rate service constitutes a waste of services or overserving for financial gain. Providers failing to deliver services appropriately may be reported to Program Integrity for a waste, fraud, or abuse investigation. Ultimately, case managers are responsible for reviewing all services and promptly reporting concerns.

9. **Q: If companionship and transportation are added, overall plan costs will rise. Will this be assumed during plan approvals?**

   A: The Division is tasked with being good stewards of taxpayer funds, while also supporting the needs of CCW participants. The Division monitors and intends to continue monitoring plan costs closely as the renewal takes effect. Please keep in mind that the CCW is not a full-time residential-type waiver, and services are instead intended to be part-time and intermittent, provided in the individual's home. The Division plans for a more diverse offering of services to meet needs, not to create the expectation of 24-hour care and support.

10. **Q: How would a participant on the Participant Directed Option (PDO) utilize companion services for a Direct Support Worker (DSW), especially if they provide 9 hours per day? Can they have additional DSW services without overlapping tasks, even if the plan exceeds 40 hours per week? Will this be allowed?**

    A: Please carefully review the Service Index effective July 1, 2026, for all details regarding Companion Services. Companion Services have a maximum limit of nine (9) hours per day. This maximum is for the person *receiving* the service. Please keep in mind that this service is intended to be part-time and intermittent, and no participant should be receiving Companion Services on a full-time basis. Additionally, a participant-directed employee can only work 40 hours per week per employer, and employers must follow state and federal labor laws.

    If a participant is utilizing companion services, no other direct service can overlap. If the participant has hired two participant-directed employees, one could provide an indirect service, like Homemaker Services, while the other provides Companion Services. Please be sure to consult the Service Index to determine what is a direct and indirect service.

11. **Q: What is the difference between companionship and respite services?**

    A: As outlined in the Service Index, Respite Services provides relief for an unpaid caregiver. If an individual is delivering unpaid care, Respite Services allows for an occasional break from that care. Respite is the only service on the waivers for the direct benefit of the unpaid caregiver.

On the other hand, Companion Services are intended to reduce isolation and provide assistance in the home and community to the participant. The case manager must work with the participant to find the service that best meets their needs.

12. **Q: Can Homemaker and Companion services be provided at the same time?**

    A: Yes. Because Homemaker is categorized as an indirect service, it can be provided concurrently with direct waiver services (like Companion services), provided they are delivered by different staff or providers. Please be sure to review the Service Index to determine what services are direct and indirect.

Non-Medical Transportation & Code Changes

13. **Q: Do we need to modify existing plans to reflect the new 15-minute units for non-medical transportation prior to July 1st?**

    A: Please review the needs of the client and what type of transportation they require. If they are utilizing the multipass option, changes may not need to occur. If the client is utilizing a discontinued service code, then the plan will need to be modified.

14. **Q: As a provider, what steps do we need to take regarding the new billing code for Non-Medical Transportation?**

    A: Providers will need to add the new billing code through a Provider Change Request in the Wyoming Health Provider (WHP) portal.

15. **Q: Why was transportation shifted from flat units to 15-minute increments? It complicates plan of care calculations**.

    A: The new rate takes into account the time spent on travel, not simply the mileage. A participant may only need to go 10 miles, but if it is through a winding mountain road, the five miles would take longer than 20 flat highway miles. Similarly, a participant may need assistance safely loading and unloading from the vehicle. This time was previously not paid to the provider. Case managers can contact their assigned county BES for assistance with plan of care calculations. Providers can work with the case manager of the participant or email the HCBS credentialing team (wdh-hcbs-credentialing@wyo.gov) for asssistance.

Case Management Service

16. **Q: Regarding the one-hour minimum service requirement, must the "one hour of direct contact" be 60 minutes of face-to-face contact? Specifically, would a 30-minute face-to-face visit supplemented by 30 minutes of contact via phone, text, or email with the participant fulfill this requirement?**

    A: The one hour requirement includes face-to-face interactions as well as other direct contact. We expect the case manager to maintain regular contact, which is

now required monthly, and can be done by home visit, phone calls or other means of direct contact with the participant. The Case Manager Monthly Review (CMMR) will need to reflect this contact time with a separate entry for each interaction that captures the time spent and a detailed description of what occurred.

17. **Q: If a one (1) hour in-home visit is required, what if we don't have enough time to complete the requirement for a participant? Will we still get paid the full monthly case management fee?**

    A: As noted above, the one (1) hour of person to person contact does not have to be completed in its entirety during the monthly home visit. It can be split between the visit and phone calls, for example. In order to bill for a monthly unit of case management you will need to fulfill the requirements. Other waivers already utilize this standard, and case managers have generally found it manageable to complete the required hour of person-to-person contact.

18. **Q: If the participant does not want us in their home for that length of time, do we have to make up that time for a total of an hour?**

    A: No, as noted above the entire hour of person to person contact does not need to be at the participant's home. Some can be accomplished through phone calls or other times in which you make direct contact with the participant. It is important to remind participants who agree to services on this waiver that this is a waiver of choice. Part of their agreement to participate in this waiver is to allow for regular, ongoing contact with their case manager. Making up time does not focus on the overall expectations of case management, instead the focus should be on meaningful interactions and support for the participant to assist them in achieving their goals and maintaining as independent life as possible.

19. **Q: What if the client ends up in the hospital and then goes into a SNF for rehab a couple weeks before we see them in their home?**

    A: If your client is in a hospital or other institutional setting throughout the month, they are not able to receive waiver services and you should not bill for case management services.

    If you are concerned about the ability to manage your schedule throughout the month and plan for unforeseen events, we suggest planning home visits during a week at the beginning of the month. If the visit is completed within the first weeks, the monthly requirement is fulfilled. If a participant is unable to meet during the first week of the month, then case managers can schedule a time for later in the month when the participant's conflict has ended.

20. **Will case managers have to start the EVV process for the case management visits in their home?**

    A: Case Management is not currently an EVV-required service in Wyoming. The Division continues to evaluate the benefits and drawbacks of implementing EVV for additional services.

21. **What changes are being made to the Case Manager Monthly Review (CMMR), and when will the monthly visit verification form be available in the document library?**

    A: A change being made to the CMMR is to eliminate the free-text notes field from the bottom of the page. The intent of this change is to support case managers in filling in relevant information in the appropriate fields. The Monthly Home Visit Verification form effective July 1st has been posted to the HCBS Document Library under the current Quarterly Visit Verification form.

22. **Q: During a survey that was completed with random Waiver participants, the Division reported that some participants didn't know who their case managers were or that they stated that they hadn't even seen them or talked to them for several months. Was the monthly home visit requirement a result to ensure that they get their time with their case managers? Case managers and/or agencies of these participants should be audited and dealt with rather than enforcing such extreme requirements on us each month for each client.**

    A: Thank you for this feedback. While the Division addresses individual performance issues as they arise, we hold all case managers to high standards due to the critical nature of the services they provide to CCW participants. These standards require thorough documentation of time spent with clients and confirmation of monthly contact. The current Medicaid reimbursement rate is based on an assumed four hours of work per client each month. As with all Medicaid transactions, providers must maintain sufficient documentation to support their claims. To ensure the responsible management of taxpayer funds, the Division must apply this standard to CCW case managers uniformly. Because the lack of required documentation is a widespread issue rather than an isolated one, enforcing this baseline expectation is necessary to ensure all case managers can verify the work they are being paid to perform.

23. **Q: The service index mentions that socialization is not covered, but if case managers are in fact expected to complete a one-hour visit with the participant in their home, most likely, a lot of that time will be a social call in order to make up that hour.**

    A: As noted previously, the entire hour of person-to-person contact for the month does not need to be completed during the home visit. The Division feels confident that the skilled case managers working with CCW clients will be able to be deliberate and reflective in their conversations, diligent with follow up, and use a variety of interview techniques. Current practices may need to be altered to ensure that conversations are person-centered, go beyond the surface, and discuss client needs. Motivational interviewing or other techniques should be explored to be able to have more structured and meaningful conversations regarding a participant's needs. If you need additional training and support regarding how to conduct interviews and why certain topic areas are included on

the Case Manager Monthly Review, please feel free to contact your assigned Benefits and Eligibility Specialist.

24. **Q: When will case management rates increase to accommodate these new responsibilities?**

    A: The Division has completed the CCW rate study and is actively pursuing the appropriate avenues for rate increases. Please keep in mind that the current rate paid for monthly monitoring for case management includes an assumption of four (4) hours of casework throughout the month. Review of all CMMRs indicate that case managers currently spend an average of 37 minutes with clients, which is substantially below the level of work the rate pays. In addition, the requirement for monthly visits was established due to consistent health and safety concerns of participants identified by the Division.

25. **Q: How should case managers document client phone calls?**

    A: All case management documentation must be entered into the Case Management Monthly Review (CMMR). Each entry must be individualized to that specific interaction and recorded in the case note section with a detailed description. Time spent documenting these monthly activities is considered billable time.

26. **Q: May we use our agency's internal monthly home visit verification form instead of the one in the document library if we write extensive handwritten notes?**

    A: No, case managers must use the official state form. While extensive note-taking is acceptable, those notes must ultimately be transcribed into the CMMR within EMWS. This standardized data entry is critical for the state to pull statistics, perform consistent reviews, and ensure case managers document activities to support paid claims.

27. **Q: Are we expected to bring a computer into the field to log notes in real time? Can we download or upload our notes directly into the CMMR?**

    A: Case managers are encouraged to reflect on the most appropriate methods to accomplish the requirements of including all notes appropriate in the CMMR. Methods may include using a tablet while in the field or other methods. While case managers can still take handwritten notes, those handwritten notes must be transcribed appropriately in the Case Manager Monthly Review.

28. **Q: When documenting monthly visits, do we include travel times, UR reviews, and note-writing in the same case note?**

    A: Travel time is built directly into the service rate and is considered a non-billable activity; therefore, it cannot be captured within billable case notes. Furthermore, effective July 1, the master note box is being removed from the

CMMR. Case managers must log individual, broken-out entries for each distinct activity to ensure real-time accountability and clearer tracking.

29. **Q: Is a monthly visit verification form required?**

    A: Yes, the Monthly Home Visit Verification form located in the HCBS Document Library is required to be completed and uploaded to the Case Manager Monthly Review.

30. **Q: Can you clarify the 1-hour person-to-person contact requirement? Does the in-person home visit itself need to last a full hour, or can it be a combination of a shorter visit and phone calls?**

    A: The full hour does not have to be spent entirely inside the home. Please keep in mind that the requirement for contact in the home is to evaluate the state of the home, the participant's ability to navigate their surroundings, and gather other important information to help identify any new or changing needs. The 1-hour direct contact minimum can be achieved through a combination of the required monthly home visit, follow-up phone calls, or other direct, natural person-to-person interactions.

31. **Q: What other aspects of communication equal suitable person-to-person contact besides face-to-face? If a client does not enjoy talking for more than 10 minutes during a home visit, how do we demonstrate compliance to the State?**

    A: As noted, phone calls and other direct, natural person-to-person interactions would be considered person-to-person contact. The Division feels confident that the skilled case managers working with CCW clients will be able to be deliberate and reflective in their conversations, diligent with follow up, and use a variety of interview techniques. Current practices may need to be altered to ensure that conversations are person-centered, go beyond the surface, and discuss client needs. Motivational interviewing or other techniques should be explored to be able to have more structured and meaningful conversations regarding a participant's needs. If the case manager struggles with specific participants, please reach out to the assigned BES for additional support.

32. **Q: How is a 35-client caseload considered "full-time" if direct contact requirements were reduced from 2 hours to 1 hour?**

    A: The underlying rate study assumes 4 hours of total monthly casework per client. That overall volume of work (4 hours per month) has not changed. The state is simply shifting the framework so that 1 of those 4 hours must be dedicated to direct client contact every month, replacing the previous quarterly in-person visit schedule.

33. **Q: If we are supposed to do 4 hours of casework per client monthly, will we eventually be able to bill for all 4 hours? Will we be required to hire more case managers if our caseload exceeds 35 clients?**

    A: The monthly case management rate currently has a built-in assumption that case managers will spend roughly 4 hours of work per month per client. Please note that this is the assumption that goes into the rate buildup; at this point in time, there are no limits or minimums to caseload size. If a case manager wishes to carry a higher or lower caseload with corresponding payment, that is currently allowable. When considering hiring additional case managers for larger caseloads, please be reflective of the quality and quantity of work a case manager is able to carry. Are current caseloads so heavy that clients are not receiving adequate support? How much time is a case manager able to spend on a monthly basis working each case? What are the needs of each client, which may vary from month to month?

    The Division considers the questions above when reviewing CMMRs and caseload size. It is recommended that each case manager or case management agency be deliberate and thoughtful when hiring case managers and assigning caseloads.

34. **Q: Is the 35-client caseload strictly a guideline, since many case managers currently manage more than that?**

    A: The 35-client caseload is the assumption of full-time work. This assumption is used in the rate buildup as the rationale for establishing the rate of payment. It is not a requirement for a case manager to have a specific caseload size.

35. **Q: Can we meet face-to-face with clients anywhere outside of their homes and have it count as a billable service?**

    A: If there is meaningful case management support outlined in the service index occurring outside of their home, it can count as a billable service. The monthly home visit is still required, but contact can be made outside of their home.

36. **Q: What is the definition of "real time" regarding documentation?**

    A: The Division has noted a common practice of writing a brief undated summary of monthly activities in the overall notes box at the end of the CMMR. This practice will no longer be allowed. The appropriate use of the CMMR form is to record dated activities within the appropriate subject area throughout the month. For example, if a phone call with the participant occurred on the 4th of the month where health concerns were noted, the case manager should record the contents of the conversation after it occurs, not at or after the 30th of the month. The Division considers at the point of service “real time”. Once the interaction or service has concluded, it should be documented as soon as possible. Please also note that all topics included in the CMMR should be addressed each month.

37. **Q: Is there a specific point of contact at the Division to discuss individual participant circumstances regarding the monthly home visit?**

    A: Case managers can contact their assigned County Benefits and Eligibility Specialist if they are having difficulty completing a home visit with a participant.