Understanding the Case Management Monthly Review (CMMR): Part 1

DD Case Manager Support Call

September 14th, 2026

WYOMING DEPARTMENT OF HEALTH

DIVISION OF HEALTHCARE FINANCING

HOME AND COMMUNITY BASED SERVICES SECTION

HOME & COMMUNITY-BASED SERVICES

WYOMING DEPARTMENT OF HEALTH

DIVISION OF HEALTHCARE FINANCING

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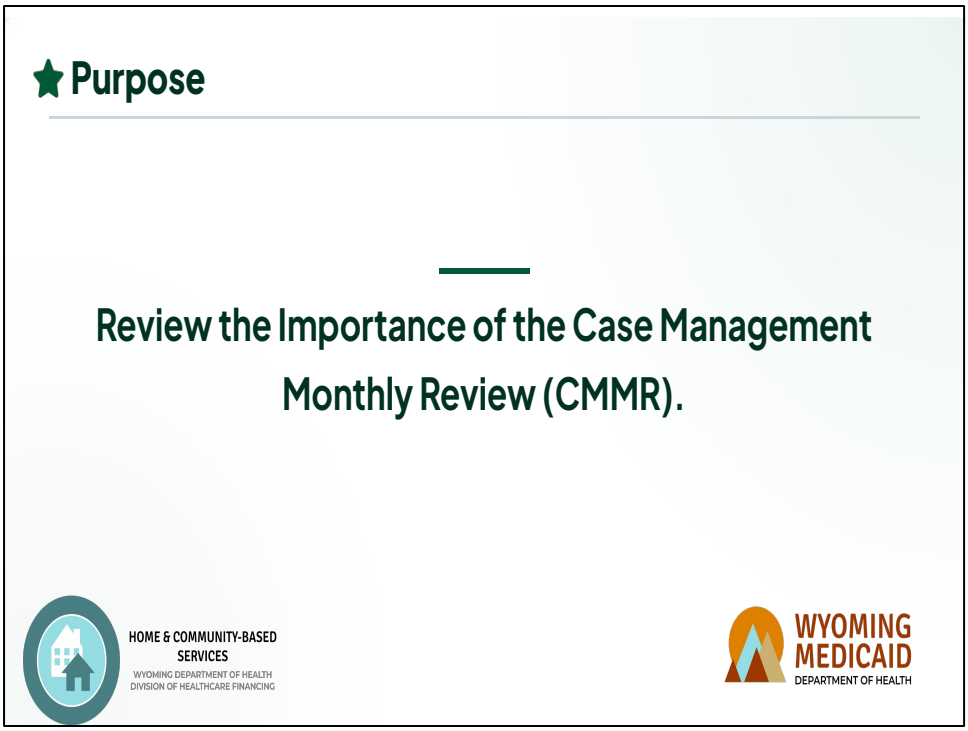


This training reviews case management expectations for completing and submitting Case Management Monthly Reviews (CMMRs) in compliance with state and federal regulations to support Medicaid claims. As part one of a two-part series, this session covers CMMR fundamentals, purpose, statutory authority, and documentation standards.

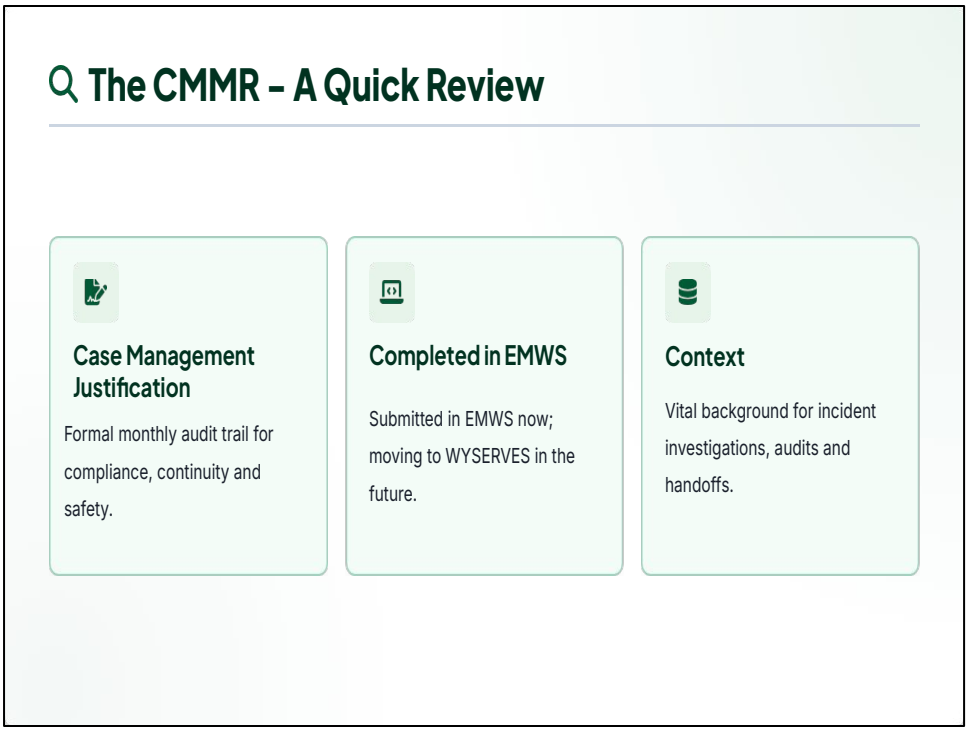
Part two will take place in early 2027 and will detail the specific CMMR components, as well as, the Division's standards for completing CMMRs.

We will kick off with a CMMR Overview and Purpose, where we'll define the Case Management Monthly Review and explore its role within the Electronic Medicaid Waiver System (EMWS), as well as how it provides essential context for audits and handoffs.

From there, we'll move into Statutory Authority and Billing Rules, taking a closer look at Chapter 45, the DD Waiver Service Index, and the legal justifications that ground the day-to-day practices that a case manager should use when completing the CMMR for each participant they serve.

Next, we will shift our focus to Quality Oversight and Participant Rights. In this section, we'll discuss best practices for safeguarding participant choice and health and welfare, while actively monitoring participant services within the Individualized Plan of Care (IPC). We will tie this into documentation of these activities within the CMMR and the importance of this oversight.

Finally, we will wrap up with Claim Accuracy and Service Verification, reviewing high-level expectations for accurate documentation, managing unit utilization, and upholding overall program integrity.



The CMMR is the formal documentation that the HCBS Section requires case managers to complete each month for each participant on their caseload. This documentation demonstrates the work that the case manager has completed throughout the month, and justifies the payment that they receive for the services they have provided. When completed in accordance with established standards, the CMMR provides a detailed accounting of what a participant is doing, where they are struggling, and where they are finding success. The information that the case manager documents on the CMMR is an extremely important piece of the participant's overall case file, and is often used to provide context for the HCBS Section when an incident or complaint is being investigated. Additionally, it provides critical continuity of care if a backup case manager needs to assume responsibility for the participant.

Division staff and the backup case managers must be able to review the CMMR to clearly understand the participant's status. All documentation must be accurate and complete, including clear indications of required follow-up to ensure continuity of care.

The CMMR is part of the Electronic Medicaid Waiver System (EMWS) platform, and must be completed and submitted through EMWS. In the future, this will

be completed and submitted through WYSERVES. Documentation must be completed within the CMMR and all notes, if taken in a separate manner, must be transferred into the body of the CMMR prior to final submission into EMWS.

Chapter 45 of the Department of Health's Medicaid Rules establishes rules related to DD Waiver Provider Standards, Certification, and Sanctions.

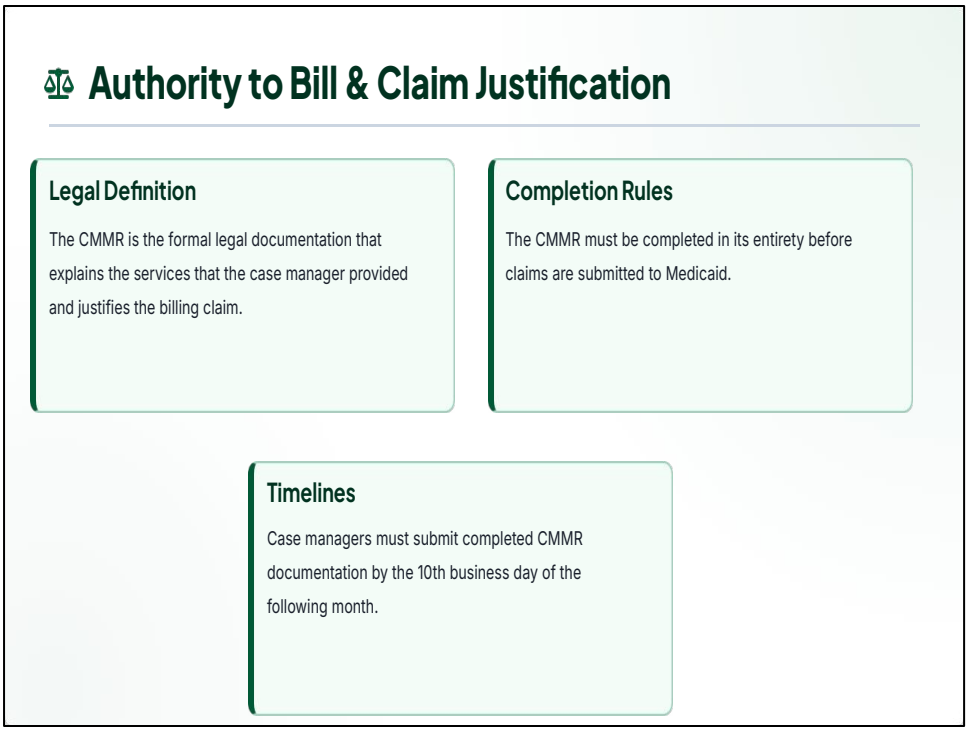
Section 8 of this Chapter establishes documentation standards. These standards require that service documentation, which includes documentation of case management services, contain a detailed description of the services provided. The completion of the CMMR is required prior to submitting Medicaid billing claims.

Section 9, which addresses case management services, specifically outlines case management tasks, which are required to be documented in accordance with HCBS
Section standards. The responsibilities listed in this section should be the framework for the case management services that are provided. The CMMR documentation should reflect the work performed.

The Comprehensive and Supports Waiver Service Index, commonly referred to as the Service Index, defines case management services, and outlines specific tasks and requirements of this service. The Service Index also clearly defines *all* waiver services and should be used as a reference tool to ensure that

services are being delivered as required when monitoring the plan of care.

Chapter 45 can be found on the Services & Regulations page of the HCBS Section website, under the *State Rules & Regulations* tab. The Service Index is also located on the Services & Regulations page under the *Waiver Service Indexes & Fee Schedules* tab.



Now, we will cover the critical regulatory framework for our billing process.

First, let's look at the legal definition: The Case Management Monthly Review or (CMMR) functions as official documentation validating the delivery of services. It establishes the necessary legal basis supporting billable claims for every unit of case management rendered.

Second, regarding completion requirements: The CMMR must be finalized in full prior to submitting claims for Medicaid reimbursement. The submission of incomplete records or retroactive documentation is strictly prohibited. Billing before the CMMR is fully executed and submitted constitutes Medicaid fraud and may lead to a Program Integrity referral as well as the recoupment of funds.

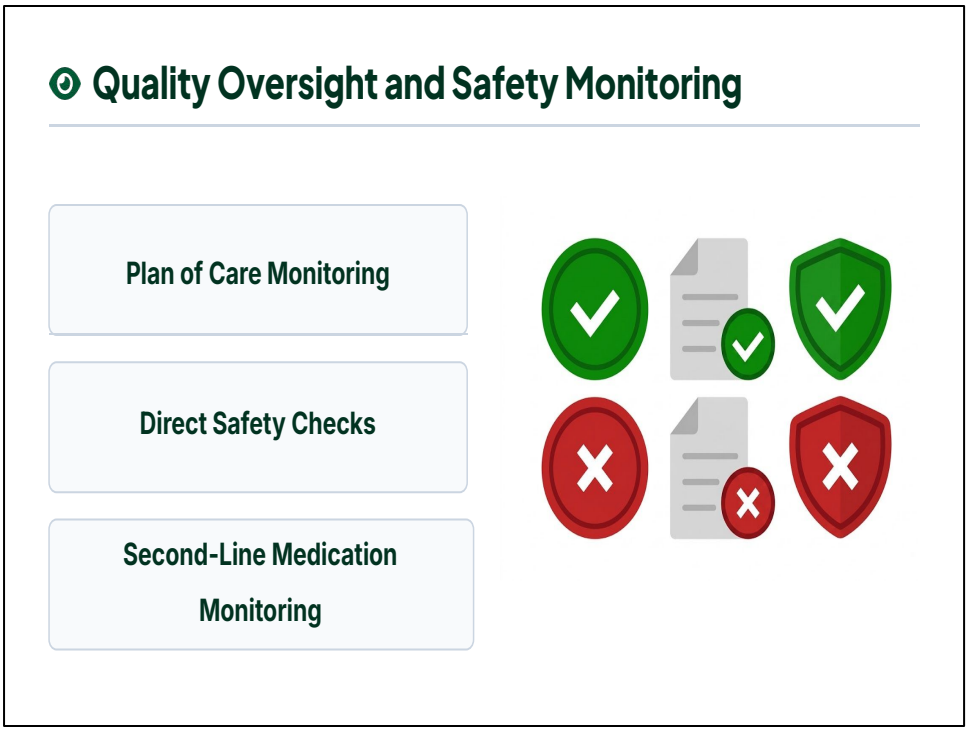
Per Medicaid Rules, case managers must complete and submit their CMMR documentation by the 10th business day of the month following the month in which the service was provided. Case managers cannot not submit the CMMR and state that they have not billed as a reason for late submissions. Compliance with this mandated timeline is required for all case managers, and

the Division expects full adherence to these standards.

Choice is a basic tenet of home and community-based waiver services. Participants must have the freedom to choose the services they receive and who provides their services, where they live, with whom they spend time, and what they want for their future. Having choice is paramount to human dignity.

Participant choice is the lynchpin of person centered planning. The case manager is responsible for this coordination as well as providing documentation that supports that person centered planning is occurring.

The CMMR is an important tool that is used to assure that a participant's right to choose is respected and documented. Participant satisfaction is one topic covered on the form, and dissatisfaction with services or providers is an indication that the participant should be offered a choice of new providers or different services. The form is also used to document how providers are respecting a participant's choice as they deliver services. As stated earlier in this training, we will provide more detailed information regarding the specifics of this form in part 2 of this training series early next year.

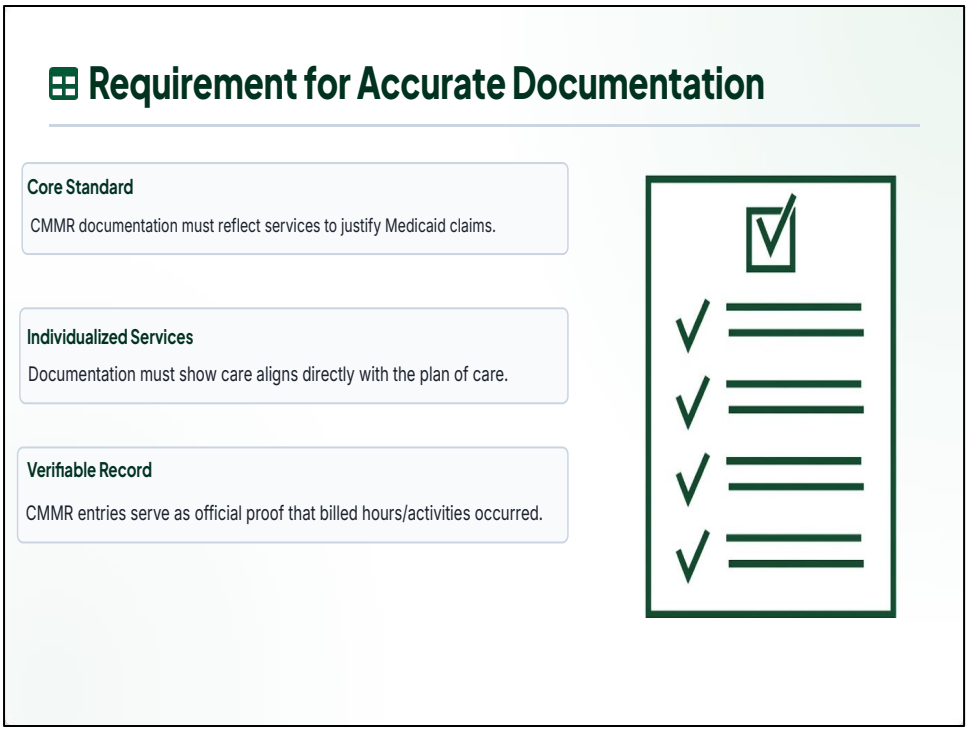


Turning our attention to Quality Oversight and Safety Monitoring, our primary goal is to ensure participant safety and the consistency of services and supports.

Under Plan of Care Monitoring, case managers must verify that service delivery strictly aligns with the approved frequency, scope, and duration specified in the Individualized Plan of Care (IPC). Any inappropriate utilization or delivery of services must be addressed immediately to guarantee that support remains person-centered and reflects the expectations established by the team. This verification is required on a monthly basis and represents a critical component of the review process.

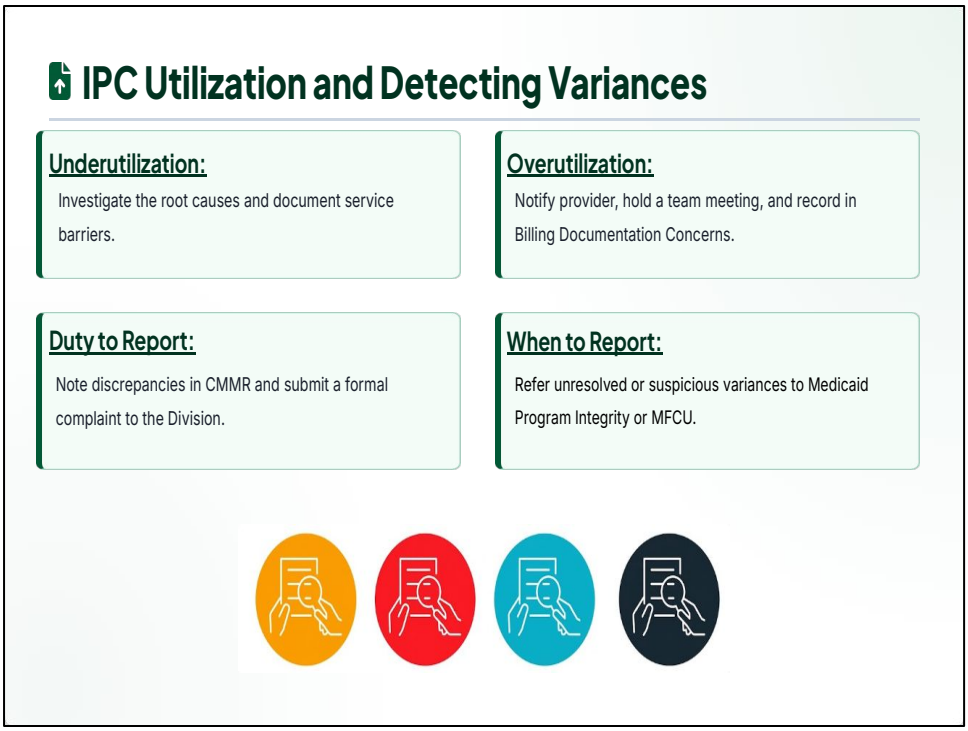
Next, for Direct Safety Checks, case managers must document face-to-face contacts, home visits, and behavioral evaluations in the designated section of the CMMR to evaluate wellness in real time. The time spent with the participant in their living environment is essential to verify that they remain safe and actively supported in their personal choices and living the life they choose. In addition to serving as a formal record of these interactions, the CMMR functions to document necessary follow-up actions whenever potential issues or concerns are identified.

Finally, through Second-Line Medication Monitoring, the case manager must monitor prescription and over-the-counter drug usage to ensure medical safety, establishing a vital protective framework that supports participant health and mitigates potential risks. This monitoring is required to verify that prescribed medications are administered as directed and that all required follow-up takes place regarding any variances, errors or trends discovered. Case managers record these evaluations within the CMMR, providing essential documentation to guide subsequent actions by both the participant's team and the Division.



Moving on to the Requirement for Accurate Documentation, our core standard centers on ensuring that all CMMR documentation accurately reflects the specific services delivered throughout the billing cycle to legally justify every Medicaid claim. This is ***the*** documentation that is required to validate the services provided by the case manager.

Crucially, this documentation must demonstrate that care was provided in direct alignment with each participant's individualized plan of care rather than a generalized approach. Ultimately, CMMR entries serve as the definitive record, verifying that all billed hours and activities were delivered as reported..

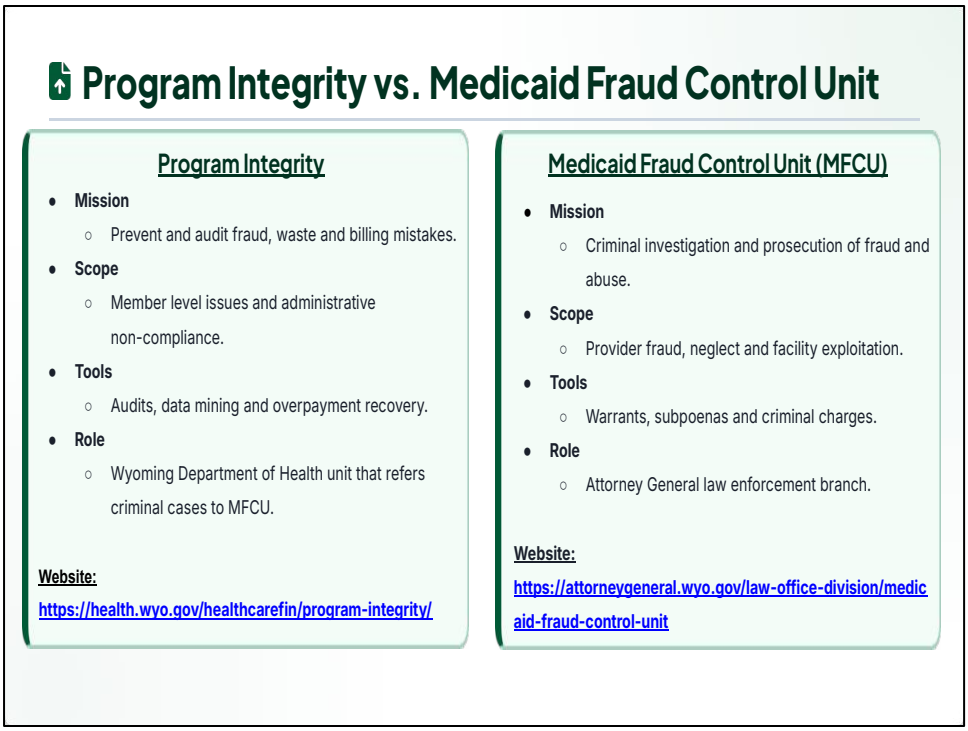


Case managers must perform monthly reviews of service unit utilization and detect service variances. When underutilization occurs, case managers must investigate root causes, identify barriers, and collaborate with the participant to adjust support. In cases of overutilization, case managers must immediately notify the provider, convene a team meeting, and document the issue within the Billing Documentation section of the CMMR .

The case manager is responsible to review all provider documentation. Providers are required to supply service documentation by the 10th business day of the following month in which services were rendered. Case managers are responsible for reviewing this documentation and when applicable, following-up, as previously described. When a provider fails to furnish required documentation to the case manager, case managers must file a Provider Documentation Non-Compliance Report prior to the end of the current month. Remember that documentation must always be completed before billing, and any post-billing alterations mandate filing a formal complaint submission through the Wyoming Health Provider (WHP) portal.

Additionally, documentation review ties directly into the duty to report; if a case manager identifies documentation discrepancies or service variances,

they are required to note them in the CMMR. The case manager should initially attempt to resolve discrepancies directly with the provider. However, if the discrepancy cannot be resolved or is significant, a formal complaint must be submitted to the Division. To safeguard program integrity, any unresolved variances may be referred directly to Medicaid Program Integrity or the Medicaid Fraud Control Unit.



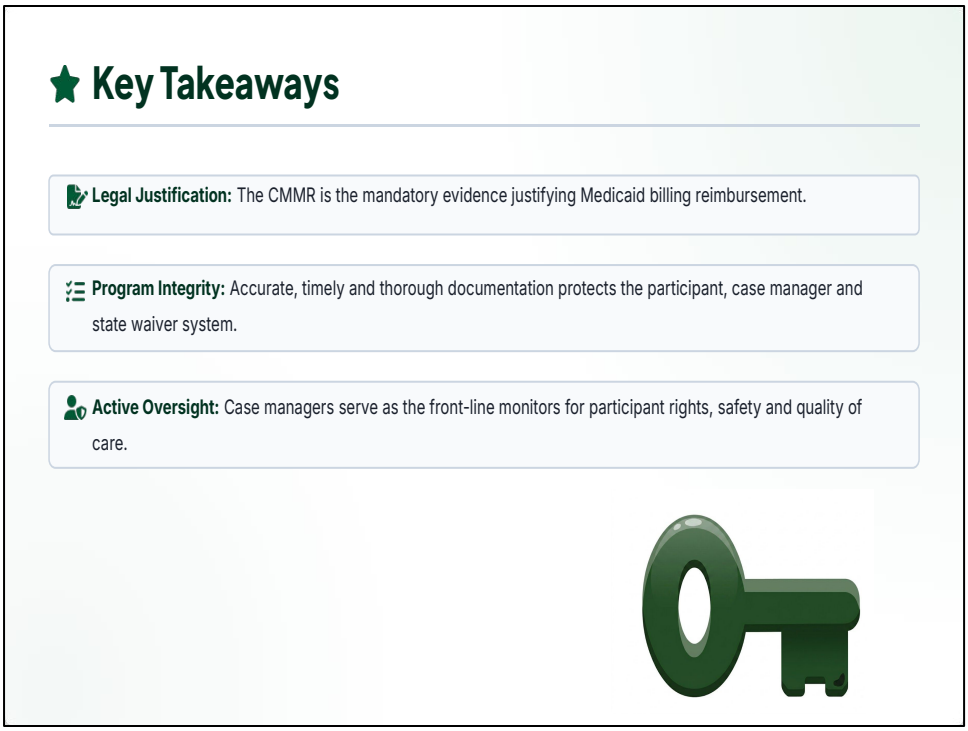
When discussing Wyoming Medicaid oversight, it helps to view Program Integrity and the Medicaid Fraud Control Unit as complementary partners with distinct roles.

On the left, Program Integrity acts as our front-line administrative filter within the Wyoming Department of Health. Its primary mission is the prevention, detection, and auditing of program waste, abuse, and recipient-level fraud. Using tools like data mining, audits, and payment suspensions, Program Integrity focuses on catching administrative errors, billing mistakes, and non-compliance to recover overpayments and keep the system financially healthy. If they uncover evidence of intentional criminal activity during an audit, their job is to refer those findings directly over to law enforcement.

That brings us to the right side of the slide, the Medicaid Fraud Control Unit, or MFCU. Housed separately under the Wyoming Attorney General's Office, the Medicaid Fraud Control Unit serves as the law enforcement arm. Their scope is specifically focused on criminal provider fraud as well as cases of patient abuse, neglect, and exploitation in healthcare facilities. Because they handle criminal matters, they utilize formal legal tools like search warrants, subpoenas, and court prosecutions to hold Medicaid providers accountable.

In short, Program Integrity manages the administrative oversight of the Medicaid program and catches the mistakes, while the Medicaid Fraud Control Unit provides the legal authority to investigate and prosecute criminal wrongdoing. We have included links to both the Program Integrity and Medicaid Fraud Control Unit websites for additional information.

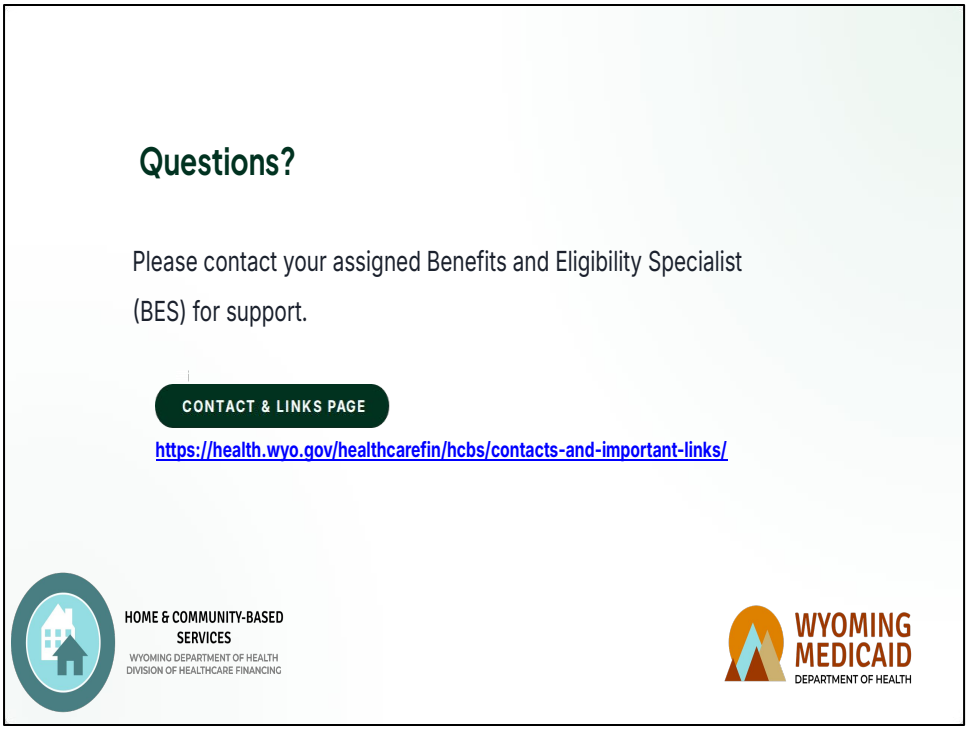
If a case manager needs additional guidance regarding suspected fraud activity, please reach out to the Provider Support Unit or a Benefits and Eligibility Specialist.



Before we end today, we'd like to remind case managers of the key takeaways from today's training.

It is important to remember that the CMMR is not just paperwork—it serves as the mandatory legal justification required for Medicaid billing reimbursement. Maintaining accurate, timely, and thorough documentation is essential to verify that the participant is receiving the services as outlined within their IPC and ensure continuous person-centered planning. This monitoring and documentation is also critical for program integrity, as it directly protects the participant, the case manager, and the overall state waiver system. Above all, through active oversight, case managers serve as front-line monitors dedicated to safeguarding participant rights, ensuring safety, and upholding high standards of care.

Thank you for taking the time to attend part one of this important training regarding the CMMR. The Division will follow up with part two of this training series: Understanding the Case Management Monthly Review in 2027. Part two will outline the core components of the CMMR and clarify the Division's expectations for satisfying these documentation requirements.



Thank you for taking time to participate in today's training on the importance of the CMMR. If you have questions related to the information in this training, please contact your Benefits and Eligibility Specialist. Contact information can be found by clicking on the link provided in the slide.