NEW JERSEY
AN INSTRUCTIONAL RESOURCE GUIDE FOR MEDICAID WAIVER REIMBURSEMENT

eBrief is committed to partnering with all of our customers and assisting them in providing supporting documentation required for participants using the eBrief insert to receive appropriate reimbursement through funding sources. This guide specifically marries details from the state resources of New Jersey Department of Human Services along with our processes from eBrief to streamline obtaining assistive technology and specialized equipment for Medicaid Waiver eligible participants while reducing the financial burden to the participant or their caregivers as much as possible. ***This is not a NJDHS document.***

PROVIDER ENROLLMENT

In order to bill Medicaid for Medicaid Waiver services (ie Assistive Technology, Specialized Equipment and Supplies, or home modifications) an organization must use the structured process outlined by the state of NJ. An organization must first be enrolled in the Medicaid program in order to have authority to bill Medicaid for the waiver services. If you are interested in enrolling, please visit the **NJ Medicaid Provider Enrollment** information. It can be found **here.**

THIRD PARTY BILLING

If you are working with a "pass-through", "billing agent", or third party biller of Medicaid, then they must be enrolled in the program in the state in which the participant resides in to bill for services. Each state has it's own requirements for approving billers. If you are interested in working with one of our partners that bills in NJ for you, please contact us **here.**

BILLING MEDICAID

If you are billing Medicaid directly, we have put together the below step by step instructions as a resource tool to assist you in streamlining the eBrief implementation process within the Medicaid Waiver Reimbursement Procedures for reference.

STEP BY STEP GUIDANCE

Step 1: ID PARTICIPANT
Identify participants using **eBrief's Potential Participant Checklist** found **here** to help your organization spot opportunities for enhanced incontinence care through technology.

Once 5 or more of your organization's participants are identified needing eBrief inserts, contact your Customer Success Manager or contact us **here,** in order to receive an individualized quote for the participants one-time and ongoing costs to utilize for the application for authorization to bill for such services. At this time you will start the process with eBrief's implementation team to develop a personalized implementation plan and schedule routine check-in's with your dedicated project manager.

Step 2: PARTICIPANT ELIGIBILITY
Once a participant is identified as potentially benefitting from the eBrief insert, then you must determine their status of eligibility with Medicaid Waiver services *if* you want to bill for reimbursement. Eligibility Verification must be completed in the **NJMMIS system located here**.

NOTE: If you are not interested in billing for reimbursement and the organization will be financially responsible for any and all charges, or if the person is not eligible and you still want to provide the participant the eBrief solution for improved well-being regardless of reimbursement, you can skip the below steps and communicate this to your Customer Success Manager in order to move your implementation timeline and plan forward as appropriate. Service Plans are still mandated for appropriate services being rendered.

Step 3: SERVICE PLAN DEVELOPMENT
Collaborate with the participant and case manager to develop a person-centered service plan outlining the needed services. In addition, obtain a **Statement of Recurring Charges** and **Quote for One Time costs** to participant from your **eBrief Customer Success Manager** or inquire **here** for these documents to outline the services requested and needed for your participant which will be required for submission with the authorization request.

*NOTE: Your situation may require an assessment or reassessment of the New Jersey Comprehensive Assessment Tool (NJCAT) performed by an assigned Support Coordinator, an updated Person Centered Planning Tool (PCPT) and/or a NJ Individualized Service Plan (NJISP) according to your organization's procedures for services. More info **here.***

Step 4: AUTHORIZATION
Obtain service authorization through the appropriate department **before** delivering services. Authorization is requested and granted through the **NJMMIS system**.

Waivers in NJ identified to potentially reimburse for qualified individuals for AT, Specialized Equipment and Supplies, Home Modification, Supplemental Adaptive and Assistive Devices are:

- **Supports Program-**Assistive Technology
- **Community Care Program**-Assistive Technology

Step 5: SERVICE DELIVERY AND DOCUMENTATION
Once a participant is authorized to receive services, eBrief will schedule the implementation of your participants and start dates. eBrief will provide documentation of the service delivery and billing each month as needed for routine billing practices. These records must be maintained for the state minimum requirements after the last date a claim was paid or denied in accordance with Medicaid rules.

Step 6: CLAIM SUBMISSION
All services must be delivered as specified in the individual service plan and authorized by the appropriate entity. Claims are submitted through the **NJMMIS system**. Ensure that claims are submitted within appropriate deadlines in your state to avoid denials.

The appropriate billing codes shall be used. ***New Jersey's Fee Schedules can be found in each policy and procedure manual of the waiver services. Links above.***

Step 7: REMITTANCE AND RECONCILLIATION
As a best practice, it is important to access remittance advices to review claim statuses and reconcile payments made or due.

If a claim is denied, determine the reason (ie. missing documentation, incorrect codes) and make any adjustments or appeals within the required timeframes given by Medicaid.

APPEALS

For declinations of eligibility, each state handles the appeals process with each participant, however they do follow the federal Medicaid rules that exist for appeals. **A letter of declination** must be sent to the participant listing important information on why the claim was denied. ***Appeals procedures are listed in the policy and procedure manuals for each waiver. Links above.***

APPEAL DEADLINE:
File the appeal no later than the deadline listed in your **Medicaid Denial Letter**. Each state is different.

HOW TO FILE:
Whether or not required, you should file a written notice a request to appeal with a date with your Medicaid Agency office or caseworker. Keep any documentation of submission and receipt.

APPEAL HEARING:
Medicaid agency or a third party agency may conduct your hearing. Accept the offer to review your file they have prior to the hearing. Hiring a Medicaid Appeals lawyer is always suggested.

ADDITIONAL RESOURCES

SAMPLE NJCAT

Request for NJCAT Reassessment Form

Division Contacts

Provider Search Quick Reference Guide

Provider Search

DDD Home Page

DDD Supports Program Manual

DDD Community Care Program Policies & Procedures Manual

EBRIEF COMMUNITY RESOURCE PAGE

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