IDAHO
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 ID Department of Health and Welfare 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 IDDHWdocument.

PROVIDER ENROLLMENT

In order to bill Medicaid for Medicaid Waiver HCBS services (ie Assistive Technology or Specialized Equipment and Supplies) an organization must use the structured process outlined by the state of Idaho. 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, visit the **Idaho Medicaid Provider Enrollment website here.**

NOTE: *Providers desiring to bill Medicaid MUST register for a Trading Partner Account (TPA). Instructions* ***here.***

THIRD PARTY BILLING

If you are working with a "pass-through" or third party biller of Medcaid, then they must be enrolled in the program in the state in which the participant resides in to bill for services. If you are interested in working with one of our partners that bills in ID 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.

STEP BY STEP GUIDANCE

Step 1: ID PARTICIPANT
Identify participants using **eBrief's Potential Participant Evaluation Checklist,** found **here** to help your organization identify opportunities for enhanced incontinence care and evaluate the individualized need for such services in a personal and individualized way to incorporate into a care or service plan.

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. (***Statement of Recurring Charges***) 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 or if you want to assist the individual in applying for Medicaid. You can do so through **IdaLink**.

NOTE: If you are NOT interested in billing for reimbursement, or do not follow the required procedures to secure and maintain reimbursement, the organization will be financially responsible for any and all charges. 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.

Step 3: SERVICE PLAN DEVELOPMENT
Collaborate with the participant and case manager to develop a service plan outlining the needed services. Find some examples of needs/solutions within the eBrief community **here.** 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.

Step 4: AUTHORIZATION
Obtain service authorization through the appropriate system before delivering services.
NOTE: Our Statement of Recurring Charges may be utilized for authorization in your state. All requests for Prior Authorizatio (PA) should be made to the appropriate contractor or Department unit as listed in the ID Directory here.

Waivers in ID identified to potentially reimburse for qualified individuals for AT and/or Specialized Equipment and Supplies are:

- **Adult Developmental Disabilities Waiver Services**
  - **E1399** *Specialized Medical Equipment*-Covered at 75% of manufacturer's retail charges
  - **S5165** *Environmental Accessibility Adaptions*-no stated coverage limits
  - ***T2025*** *Specialized Medical Equipment* - no stated coverage limits
- **Aged and Disabled Waiver Services**
  - **E1399** *Specialized Medical Equipment and Supplies*-Covered no noted limits
  - **S5165** *Environmental Accessibility Adaptions*-no stated coverage limits

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
Use the general billing instructions found **here**.
The appropriate billing codes shall be used. **ID Wavier Fee Schedules** can be found **here.**
Some codes are indicated above under each waiver for convenience as used by some of our partners.

Instructions for the submission of claims can be found **here**. Ensure that claims are submitted within the appropriate required timeframes to avoid denials.

Step 7: REMITTANCE AND RECONCILLIATION
As a best practice, it is important to access remittance advices via the claim review process found **here** 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. Information on ID appeals for Prior Authorizations can be found **here.**
Additional General Claim Appeals information can be found **here.**

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

ID User Guides for Technology Tools for Billing
Trading Parnter Account (TPA) Instructions
Waiver Overview Website
IdaLink
EBRIEF COMMUNITY RESOURCE PAGE
EBRIEF