

*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 AZ Health Care Cost Containment System 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 AHCCCS document.***

### 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 Arizona. 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 **Arizona Medicaid Provider Enrollment website** [here](#).

NOTE: Your application will be completed through [APEP](#) after reviewing the above enrollment instructional website.

### THIRD PARTY BILLING

If you are working with a “pass-through” 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. If you are interested in working with one of our partners that bills in AZ 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.

[www.etectrx.com](http://www.etectrx.com)

etectRx; eBrief, 747 SW 2nd Ave, Suite 365, IMB 24, Gainesville, FL 32601, USA, 52-443-5713

## 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 [AZAHCCCS](#).

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 Authorization (PA) should be made to the appropriate contractor or Department unit. The [AHCCCS Online Provider Portal](#) is the preferred method of submitting Prior Authorization requests.**

[Waivers in AZ](#) identified to potentially reimburse for qualified individuals for AT and/or Specialized Equipment and Supplies are:

- [Arizona Long Term Care System \(ALTCS\)](#)
  - Medical Equipment and Supplies
- [Non-Medical HCBS \(NMHCBS\)](#)
  - Adaptive Aides and Devices
- [Tribal ALTCS](#)
  - Medical Equipment and Supplies

**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 AZAHCCCS Claims Submission Guide found [here](#).

The appropriate billing codes shall be used. AZ **Wavier Fee Schedules** can be found [here](#).

Ensure that claims are submitted within the appropriate required timeframes to avoid denials.

### Step 7: REMITTANCE AND RECONCILIATION

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 AZ appeals can be found [here](#). AZ has a strict timeline for all appeals in accordance with Arizona Revised Statutes ([A.R.S. 36-2903.01.B.4](#)) and Arizona Administrative Code ([A.A.C. R9-34-401](#))

### APPEAL DEADLINE:

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

### HOW TO FILE:

You will be required to 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. See address and timelines for disputes [here](#).

### 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

[HCBS Provider Training](#)

[AZHCCCS Guides and Manuals for Providers](#)

[HCBS Provider Tools](#)

[AZAPEP Training](#)

[What to Expect When Applying in AHCCCS Provider Enrollment Portal AZAPEP](#)

[EBRIEF COMMUNITY RESOURCE PAGE](#)

[EBRIEF](#)