MONTANA
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 Montana DPHHS 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 DPHHS document.

PROVIDER ENROLLMENT

In order to bill Medicaid for Medicaid Waiver services (ie Assistive Technology or Specialized Equipment and Supplies) an organization must use the structured process outlined by the state of Montana. 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 **Montana Medicaid Provider Enrollment Website** that provides trainings, instructions and links to the portal required for enrollment.

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 successfully bills in the state of Montana 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.

Disclaimer: This information is provided from multiple partners in the field and is NOT provided from Medicaid or the Health Department, therefore it is subject to change and/or could contain inaccuracies, however is believed to be accurate upon development of this document.

STEP BY STEP GUIDANCE

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

Once you have identified participants that have a need for eBrief inserts, contact your eBrief 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 **here** *if* you want to bill for reimbursement. If you need assistance in applying for eligibility for the participant, please visit **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.

Step 3: SERVICE PLAN DEVELOPMENT
Collaborate with the participant and case manager to develop a 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.

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Step 4: AUTHORIZATION
Obtain service authorization through the appropriate system/department before delivering services. Prior authorization refers to services that require Department authorization before they are performed. Prior authorization has specific requirements. Some services may require both Passport referral and prior authorization. If a service requires prior authorization, the requirement exists for all Medicaid members. Prior authorization is usually obtained through the Department or a prior authorization contractor.

Waivers in Montana identified to potentially reimburse for qualified individuals for Assistive Technologies and/or Specialized Equipment and Supplies monthly.

- **Big Sky Waiver**
- **DD** Waiver
- **Severe Disabling Mental Illness (SDMI) Waiver**
- **Community First Choice Plan (CFC)**

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.

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Step 6: CLAIM SUBMISSION
Use of the **Montana Claim Instructions** and resources found **here**. Providers may only claim Medicaid reimbursement for services that are authorized on the approved Person Centered Support Plan. Claims must be consistent with the amount, frequency and duration authorized by and documented on the Person Centered Support Plan. **Here** is a **DDP Wrap Up Training Guide** from the MDOPHHS.

Montana Fee schedules are located **here.** The appropriate billing codes shall be used in order to mitigate risk of non-reimbursement. Submission during the appropriate timeframes is important to note to avoid denials. *Some codes are indicated above under each waiver for convenience as used by some of our partners.*

Step 7: REMITTANCE AND RECONCILLIATION
As a best practice, it is important to access remittance advices aka eSOR reports via the **Montana Medicaid Health Web Portal** to review claim statuses and reconcile payments made or due. If the 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. More information found **here** in this training by DPHHS.

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 intend to file a request to appeal with a date with your Medicaid Agency office or caseworker. Keep any documentation of submission and receipt.

APPEAL HEARING:
A 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. Information about Montana Medicaid Appeal hearings **here.**

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ADDITIONAL RESOURCES

Montana Provider Portal Overview Training

Big Sky Waiver Provider Manual

CFC Provider Manual

Resources for SDMI Providers

DD provider Manual

SDMI Provider Manual

EBRIEF COMMUNITY RESOURCE PAGE

EBRIEF

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