MINNESOTA
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 MN DHS 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 DSS 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 Minnesota. 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 **Minnesota Health Care Programs Enrollment Information Website here.** Minnesota DHS provides monthly trainings **here** for those wanting to become a provider.

NOTE: "Whether materials are submitted using MPSE or by fax, Provider Eligibility and Compliance processes complete requests within 30 days of receiving the request. Each request, including newly submitted, corrected, and resubmitted requests are subject to the same processing timelines (30 days) as an initial request.."-MN Medicaid

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 MN 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 Checklist** found **here** (under ALERT and RESOURCE HUB) to help your organization spot opportunities for enhanced incontinence care. This could potentially meet the requirements for documentation of the participant's "assed need" for specialized equipment and supplies.

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. Additional resource: **"Simply Said" video** explaining Assistive Technology.

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. If you need assistance in applying for eligibility for the participant, please visit **here.** and look up your local county agency ho will assist in he application of services for a participant.

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 and support plan (CSSP) outlining the needed services utilizing the **Rate Management System (RMS)**. Find some examples of needs/solutions with eBrief 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 process/waiver to obtain a service authorization. Utilization of the **Minnesota Medicaid Management Information System (MMIS)** is required for documentation and authorizations to be submitted to DHS for authorization.

For specialized equipment and supplies, additional documentation is required under MN statutes:

- The person's assessed need for the equipment or supply.
- The reason why a Medicaid state plan does not cover the equipment or supply.
- The cost, quantity, type and brand of the equipment or supply delivered or purchased
- If the item is rented or purchased.
- The shipping invoice or documentation proving the date of delivery to the person, or receipt if purchased by the person.

If the person receives or was receiving services through a managed care organization (MCO), the lead agency contacts the specific MCO about procedures it needs to follow for reimbursement. An MCO may not request reimbursement from DHS under unforeseen circumstances

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

- **ELDERLY WAIVER (EW)**
  - *Specialized Medical Equipment*-The person may receive specialized equipment and supplies up to the case mix budget cap, as authorized in the person's support plan.
- **ALTERNATIVE CARE (AC) PROGRAM**
  - *Specialized Medical Equipment-The person may receive specialized equipment and supplies up to the case mix budget cap, as authorized in the person's support plan.*
- **Brain Injury Waiver (BI)**
  - *Specialized Medical Equipment & Supplies*- up to $10,000 per waiver year
- **Community Alternative Care (CAC) Waiver**
  - *Specialized Medical Equipment & Supplies*- up to $10,000 per waiver year

- **Community Access for Disability Inclusion (CADI) Waiver**
  - *Specialized Medical Equipment & Supplies*- up to $10,000 per waiver year
- **Developmental Disabilities DD waiver**
  - T2029 UB — Assistive Technology/Equipment
- **Consumer Directed Community Supports CDCS**
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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. See also MN Waiver & Alternative Care (AC) Programs Specialized Equipment & Supplies Authorization & Billing Responsibilities here.

Step 6: CLAIM SUBMISSION
Use the **CMS-1500 Claim form** and general claim instructions found **here**.
The appropriate billing codes shall be used. **SD Wavier Fee Schedules** Found **here.**
Some codes are indicated above under each waiver for convenience as used by some of our partners.

Submit claims through the **SD Medicaid Provider Online Portal** and 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 **Provider Online Portal** 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.

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

SEARCH FOR LOCAL DSS LOCATIONS THROUGHOUT SD

Specialized Equipment and Supplies Provider Assurance Statement form DHS-6189T

Explore AT in Minnesota

Health plan contacts for care coordinators or navigators

MN List of Forms for Download

EBRIEF COMMUNITY RESOURCE PAGE

FAMILY SUPPORT 360 WAIVER FOR CHILDREN AND ADULTS WITH DISABILITIES

SOUTH DAKOTA OTHER MEDICAID COVERAGE GROUPS

EBRIEF