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1.0 Introduction

1.1 Description
This policy contains general requirements for providers and recipients regarding Florida Medicaid.

1.1.1 Florida Medicaid Policies
This policy is intended for use by all providers that render services to eligible Florida Medicaid recipients, unless otherwise specified. For recipients enrolled in a managed care plan, providers should also refer to the recipient’s managed care plan for any additional requirements. This policy must be used in conjunction with any applicable service-specific and claim reimbursement policies with which providers must comply.


1.2 Definitions
The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.2.1 Health Insurance Portability and Accountability Act
Federal law that protects health insurance coverage for workers and their families when they change or lose their jobs (also known as HIPPA). Additionally, administrative simplification provisions of HIPPA require the United States Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. Other provisions address the security and privacy of health data, including the HIPAA Privacy Rule, the HIPPA Security Rule; and the HIPPA Breach Notification Rule. These rules are in place to protect the privacy of an individual’s health information; set national standards for the security of protected health information sent electronically; and to require notification following a breach of unsecured protected health information.

1.2.2 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.2.3 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 General Provider Requirements

2.1 Eligibility Identification and Verification
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in the appropriate service-specific coverage policy.

Recipients must provide proof of eligibility when obtaining Florida Medicaid services. Florida Medicaid issues an identification card (ID) to Florida Medicaid recipients; however, possession of an ID card does not constitute proof of eligibility.

Provider(s) must verify each recipient’s eligibility each time a service is rendered.

2.1.1 Refusal of Services
Providers may not refuse to provide a covered Florida Medicaid service to a recipient solely because the recipient’s eligibility does not display in the Florida Medicaid
Management Information System (FMMIS), if the recipient has proof of eligibility documented by DCF Form CF-ES 2014, with the “Proof of Eligibility” box checked.

2.2 Protecting Recipient Information
Providers must comply with HIPPA. For the complete text of the HIPAA privacy rule, see http://www.hhs.gov/ocr/privacy/. Federal regulations in Title 42, Code of Federal Regulations (CFR), section 431, Parts F and G, allow exchange of Medicaid information with the following entities:

- Agencies that determine Florida Medicaid eligibility (e.g., DCF and the Social Security Administration, and agencies whose information is used to verify income and assets, such as the Internal Revenue Service).
- The Florida Department of Health, Vocational Rehabilitation, and Title V (Maternal and Child Health) grantees that are providing services or benefits to applicants and recipients. The information must be necessary for applicants and recipients to receive services or benefits.
- Health oversight agencies that survey certain institutions, such as nursing facilities, which provide services to applicants and recipients.

2.3 Right to Refuse Services
Providers may limit the number of Florida Medicaid recipients they serve, and accept or reject recipients in accordance with the policies of the facility or practice, except as follows:

- A hospital cannot refuse to provide emergency services in accordance with the 1986 federal Emergency Medical Treatment and Active Labor Act (EMTALA).
- Providers cannot deny services to recipients based solely upon race, creed, color, national origin, disabling condition, or disability, in accordance with the federal anti-discrimination laws.
- Providers cannot deny services to a recipient due solely to the presence of third-party insurance coverage or the recipient’s inability to pay a Florida Medicaid copayment or coinsurance amount. If the recipient is unable to pay at the time services are rendered, the provider may bill the recipient for the unpaid charge.

2.4 Solicitation (Patient Brokering)
Providers must not knowingly solicit, offer, pay, or receive remuneration, directly or indirectly, overtly or covertly, in cash or in kind:

- For referring an individual for the furnishing of or arranging for the furnishing of any service or item that may be paid for by Florida Medicaid.
- In return for obtaining, purchasing, leasing, ordering, or arranging for, or recommending any good(s), facility, item, or service(s) that may be paid for by Florida Medicaid.

2.5 Recipients or Providers that are Out of the Country
Florida Medicaid does not reimburse for services provided to recipients when they are out of the United States (U.S.), or for services rendered by providers who are not in the U.S.

2.6 Out-of-State Services-Emergency
Florida Medicaid reimburses for emergency services provided out-of-state without a referral, or prior authorization, in the following circumstances:

- An emergency arising from an accident or illness that occurs while the recipient is out-of-state.
- The recipient’s health will be endangered if the care and services are postponed until returning to Florida.

2.7 Out-of-State Services-Non-Emergency
Florida Medicaid reimburses for services performed out-of-state, in accordance with the service-specific coverage policy, when the following are met:
Florida Medicaid
General Medicaid Policy

- The recipient has a referral from a physician for the service(s)
- There is not an available provider in Florida to perform the service(s)
- The service(s) are prior authorized by the Florida Medicaid Quality Improvement Organization (QIO)

Florida Medicaid does not reimburse for services for recipients who are enrolled under the Title-IV-E Florida foster or adoption subsidy, when the child is living out of state.

Providers located in Alabama and Georgia are considered in-state providers, except for durable medical equipment providers that may be located no more than 50 miles from the Florida border.

2.8 Recipient Eligibility Information

2.7.1 Institutional Care Program

The Florida Medicaid Institutional Care Program (ICP) as defined in 59G-1.010, F.A.C., provides Medicaid assistance to pay for the cost of an eligible recipient’s nursing facility care and general medical coverage, when determined by the Department of Elder Affairs (DOEA) Comprehensive Assessment and Review for Long-Term Care Services (CARES) to be in need of nursing facility services.

Qualifying individuals must be enrolled with one of the following program codes: MI I, MI A, MI M, MI P, MI S. Eligibility for ICP must be approved prior to reimbursement under the Florida Medicaid program.

Exception: Recipients in the Medicare Part A coinsurance period, “Level of Care X,” who are either enrolled in the MS benefit plan for the date(s) of service, or have QMB coverage (with or without other Florida Medicaid coverage) for the date(s) of service are not required to have ICP coverage. The Department of Children and Families (DCF) provides a disposition notice to the facility and the recipient when ICP eligibility is approved. This form must be retained by the facility in the recipient’s file.

Institutional care program recipients are eligible for full Florida Medicaid medical coverage in addition to the Florida Medicaid services listed in the nursing facility, ICF/IID, and state mental hospital Florida Medicaid policies.

2.7.2 Medically Needy Program

The Medically Needy program is for individuals who would be eligible for Florida Medicaid except for income or assets that exceed the limit for eligibility. If the household’s income is greater than the income limit, the exceeding amount is determined as the share of cost. The individual is enrolled month-to-month but is not eligible for Medicaid until the share of cost is met by incurring medical bills that meet their share of cost.

Providers may be reimbursed for authorized services if the recipient becomes Florida Medicaid eligible for that month.

Florida Medicaid does not reimburse for the following:

- Any services, until the share of cost is met each month
- Assistive care services
- HCBS waiver programs
- ICF/IID
- Nursing facility services
- Regional perinatal intensive care center services
- Services, until the share of cost is met each month
- State mental hospital services
- Statewide Inpatient Psychiatric Program services
The recipient must submit proof of medical expenses to DCF, and DCF makes the eligibility determination.

Eligibility is displayed in FMMIS for the date the recipient attains Florida Medicaid eligibility through the end of the month.

For more information on an individual recipient’s share of cost, contact the DCF service center. For more information on the Medically Needy program, visit www.dcf.state.fl.us/ess/.

### 2.7.3 Newborn Eligibility

#### 2.7.3.1 Unborn Child’s Florida Medicaid Identification Number

A pregnant recipient may obtain a Florida Medicaid Identification (ID) number and Florida Medicaid ID card (gold card) for her unborn child. Providers may use the gold card to inquire about the unborn baby’s eligibility.

The baby’s Florida Medicaid ID number will not be active until after the baby is born.

#### 2.7.3.2 If the Newborn Does Not Have an Identification Number

If the provider knows the recipient is pregnant, Florida Medicaid eligible, and that her unborn child does not have a Florida Medicaid ID number, the provider may request a number assignment for the newborn by sending a Medical Assistance Referral Form, CF-ES 2039, to the DCF regional office. These forms are available on the DCF Web site at http://www.dcf.state.fl.us/dcf/forms/Search/DCFFormSearch.aspx.

#### 2.7.3.3 Activating the Florida Medicaid Identification Number

Providers may activate a newborn’s Florida Medicaid ID by submitting a completed Unborn Activation Form ___________, incorporated by reference in Rule 59G-1.045, to the Florida Medicaid fiscal agent. The fiscal agent will activate the recipient’s Florida Medicaid ID number within two working days of receipt.

#### 2.7.3.4 When Coverage Will Be Denied

The fiscal agent will not activate a newborn’s Florida Medicaid coverage if:

- The mother is not eligible for Florida Medicaid at the time of the baby’s birth.
- The mother is eligible under the PEPW (eligibility code MU) or Family Planning Waiver (eligibility code FP) coverage groups.
- The Unborn Activation Form is incomplete.

#### 2.7.3.5 Mother is in Statewide Florida Medicaid Managed Care

A newborn, whose mother is enrolled in a Florida Medicaid managed care plan, is automatically covered by the plan. The Florida Medicaid managed care plan must notify DCF immediately of the pregnancy and any known relevant information.

The Florida Medicaid managed care plan must indicate its name and number as the entity initiating the referral. The DCF Excel spreadsheet and directions for completion are located on the Florida Medicaid Web site at http://ahca.myflorida.com/Medicaid/Newborn/index.shtml.

### 2.9 Billing the Recipient

Other than Medicaid copayments and coinsurance, the provider cannot seek payment from a recipient for a Florida Medicaid compensable service, when a claim has been submitted, whether the claim has been approved, partially approved, or denied except under the following circumstances:
The recipient is not eligible to receive Florida Medicaid services on the date of service.

- The service the recipient receives is not covered by Florida Medicaid.
- The provider has verified that the recipient has exceeded the Florida Medicaid coverage limitations or frequency cap:
  - The provider must inform the recipient that he has exceeded the frequency cap for the specific service to be rendered.
  - An exception is prenatal visits: Payment for prenatal care is based on a total amount for complete care. Reimbursement for the 10 to 14 visits is the maximum reimbursement for the full course of prenatal care. If additional visits are provided, payment is considered made in full. The provider may not bill the additional visits to Florida Medicaid or the recipient.

- The provider has informed the recipient in advance that he does not accept Florida Medicaid payment for the specific service to be rendered. The provider must document in the recipient’s medical record that the recipient was informed and agrees to the service.

### 2.10 Billing for Missed Appointments
Providers may not bill recipients for missed appointments.

### 2.11 Billing for Administrative Costs
Florida Medicaid does not reimburse providers for time spent completing and submitting claims for payment or time spent responding to an audit.

### 2.12 Contributions to a Facility
For any contribution made to a facility on behalf of a specific recipient, the facility must treat the contribution as a third-party payment and deduct the contribution from the Florida Medicaid payment for the cost of the recipient’s care.

If a contribution is made to a facility that is not for a specific recipient, but for the benefit of all residents, the facility does not have to report the contribution to Florida Medicaid.

### 3.0 Recipient Information

#### 3.1 Who Can Receive
Low-income families and children and aged and disabled adults must meet specific eligibility requirements such as citizenship or resident alien status, Florida residency, and income and asset criteria for Florida Medicaid eligibility.

Florida residents who meet specific financial eligibility criteria and are classified as one of the following may be eligible for Florida Medicaid:

- Aged and disabled adults
- Children under the age of 21 years
- Former foster care recipients up to the age of 26 years
- Non-citizens with medical emergencies
- Parents or caretakers with minor children
- Pregnant women

Individuals who receive Supplemental Security Income (SSI) are automatically eligible for Florida Medicaid.

#### 3.2 Freedom of Choice of Providers
Recipients may obtain services from any qualified Florida Medicaid provider in accordance with 42 CFR 431.51.

#### 3.3 Eligibility Determination
Florida Medicaid eligibility is determined by the following:

- Social Security Administration – for individuals receiving SSI.
Department of Children and Families (DCF) – for all other individuals except as specified below.

Information about SSI eligibility is available on the Social Security Administration website at http://www.ssa.gov/disabilityssi/ssi.html.

Information about Florida public assistance and Florida Medicaid eligibility requirements is available at any DCF service center, on the Web site at www.myflfamilies.com, and in Rule Chapter 65A-1, F.A.C.

3.3.1 Presumptive Eligibility Determined by Qualified Designated Providers
Presumptive eligibility for pregnant women (PEPW) may be determined by the Florida Department of Health, regional perinatal intensive care centers, and other qualified designated providers as approved by DCF.

The presumptive period begins on the date the determination is made. The end date of the presumptive period is the earlier of:

- The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made
- The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date

3.3.2 Presumptive Eligibility Determinations by Qualified Hospitals
Qualified hospitals can make presumptive Florida Medicaid eligibility determinations for the groups listed below:

- Former foster care children
- Infants and children under the age of 19 years
- Parents and other caretakers or relatives
- Pregnant women

The presumptive period begins on the date the determination is made. The end date of the presumptive period is the earlier of:

- The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made
- The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date

3.4 Inmates of a Public Institution
Individuals residing in public institutions, including correctional and holding facilities for prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles, are not eligible for Florida Medicaid, in accordance with 42 CFR 435.1009 and section 409.9025, F.S.