FLORIDA
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 Florida Agency for Health Care Administration 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 an FAHCA document.***

PROVIDER ENROLLMENT

In order to bill Medicaid for Medicaid Waiver services (ie Assistive Technology, Specialized Equipment and Supplies, or home modifications) an organization must use the structured process outlined by the state of FL. 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 FL **Medicaid Provider Enrollment Website** **here.** To learn more, **here** is the **Provider Enrollment Policy for Florida.**

THIRD PARTY BILLING

If you are working with a "pass-through", "billing agent", 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. Each state has it's own requirements for approving billers. If you are interested in working with one of our partners that bills in FL 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 for reference.

STEP BY STEP GUIDANCE

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

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.

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. Find eligibility information in the **Medicaid Eligibility Verification System (MEVS)**

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. Service Plans are still mandated for appropriate services being rendered.

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

Step 4: AUTHORIZATION
Obtain service authorization through the appropriate department before delivering services. Information on Prior Authorizations can be found **here.**

NOTE: "An APD document that authorizes the provision of specific waiver services to an individual and includes, at a minimum, the provider's name and the specific amount, duration, scope, frequency, and intensity of the approved service. The service authorization and any modifications to it must be received by the provider prior to service delivery. This includes changes to the authorization as a result of recipients redistributing funds within their existing cost plan. Service authorizations will not be approved retroactively. In limited circumstances, an exception may be made on a case by case basis by the APD regional office to correct an administrative error or to consider a health and safety risk or emergency situations." Florida Medicaid Manual

Waivers in FL identified to potentially reimburse for qualified individuals for AT, Specialized Equipment and Supplies, Home Modification, Supplemental Adaptive and Assistive Devices are:

- **iBudget**
  - Specialized Medical Equipment and Supplies
  - Consumable Medical Supplies (defined in FL regs as "expendable, disposable, and non-durable items used for the treatment of specific injuries or diseases, or for persons who have chronic medical or disabling conditions. These supplies exceed those routinely furnished by the provider in conjunction with skilled care and home health aide visits"
  - Durable Medical Equipment- Florida regulation "In accordance with Chapter 205, F.S., independent vendors, assistive technology suppliers and assistive technology practitioners certified by RESNA can also provide these services." &
    - "All equipment must have direct medical or remedial benefit to the recipient, must be related to the recipient's developmental disability, and must be necessary to prevent the recipient's institutionalization. Assessment and prescription by a licensed physician, ARNP, PA, physical therapist, or occupational therapist is required."
    - NOTE: "The statement from a physician, ARNP, or PA must delineate how the item is medically necessary, how it is directly related to the recipient's developmental disability, without which the recipient cannot continue to reside in the community."

- **Long Term Care**
  - Home Accessibility Adaptation
  - Medical Equipment and Supplies
- **Model**
  - Assistive Technology and Service Evaluation
  - Environmental Accessibility Adaptations

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

All services must be delivered as specified in the individual service plan and authorized by the appropriate entity. Claims are submitted through the **Florida Web portal.** Find additional Claim Submission Information **here.** Ensure that claims are submitted within appropriate deadlines in your state to avoid denials. The appropriate billing codes shall be used. Fl **Wavier Fee Schedules f**ound **here** and handbooks **here.**

Step 7: REMITTANCE AND RECONCILLIATION

As a best practice, it is important to access remittance advices 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. **More information about denials 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. More information on Fl Hearings **here.**

ADDITIONAL RESOURCES

FL Medicaid Billing FAQ

FL HCBS Medicaid Waiver Regulations

FL Provider Training Website for Medicaid Billing

FL Medicaid Provider Quick Reference Guides

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