

59G-1.050 General Medicaid Policy.

(1) Purpose. This rule specifies requirements that apply to all providers rendering Florida Medicaid services to recipients.

(2) Billing the Recipient. Providers must inform a recipient of his or her responsibility to pay for services that are not covered by Florida Medicaid, and document in the recipient's file that the recipient was informed of his or her liability, prior to rendering each service.

(a) Providers may seek reimbursement from a recipient under the following circumstances:

1. The recipient is not eligible for Florida Medicaid on the date of service.

2. The service rendered is not covered by Florida Medicaid, if the provider seeks reimbursement from all patients for the specific service.

3. The provider verifies that the recipient has exceeded the Florida Medicaid coverage.

4. The recipient is enrolled in a Florida Medicaid managed care plan (plan) and is informed that:

a. The plan denies authorization for the service.

b. The treating provider is not in the plan's provider network (with the exception of emergency services).

(b) Providers may not seek reimbursement from recipients for missed appointments.

(c) Providers may not seek reimbursement from the recipient if the provider fails to bill Florida Medicaid correctly and in a timely manner. Providers who submit a claim to Florida Medicaid for reimbursement of a covered service whether the claim has been approved, partially approved, or denied, may not:

1. Seek reimbursement from the recipient, the recipient's relatives, or any person, or persons, acting as the recipient's designated representative.

2. File a lien against the recipient, the recipient's parent, legal guardian, or estate.

3. Apply money received from any non-Florida Medicaid source to charges related to a claim paid by Florida Medicaid (also known as "balance billing").

4. Turn a recipient's overdue account over to a collection agency, except in circumstances as specified in paragraph (2)(a), above.

(3) Cost of Doing Business. Florida Medicaid does not reimburse for time spent completing and submitting Florida Medicaid claims or time spent responding to an audit.

(4) Emergency Medicaid For Aliens. Florida Medicaid covers emergency services provided to aliens who meet all Florida Medicaid eligibility requirements except for citizenship or alien status, as follows:

(a) Eligibility is only authorized for the duration of the emergency.

(b) Florida Medicaid does not cover continuous or episodic services after the emergency has been alleviated.

(c) Providers must submit documentation establishing the emergency nature of the service with the claim for reimbursement. Exceptions are labor, delivery, and dialysis services, which are considered emergencies and are payable without documentation when the emergency indicator is entered on the claim form.

(5) Free Choice of Providers. Recipients may obtain services from any qualified Florida Medicaid provider that agrees to provide the services in accordance with Title 42, Code of Federal Regulations (CFR), section 431.51, except:

(a) Allowable restrictions specified in section 1915(a) of the Social Security Act.

(b) When the recipient is enrolled in a Florida Medicaid managed care program. Managed care plans may not restrict enrollee choice for a family planning provider and must cover family planning services regardless of whether the provider is in the managed care plan's provider network.

(6) Inmates of a Public Institution. Florida Medicaid does not cover services provided to individuals residing in public institutions as defined in 42 CFR 435.1009 and Section 409.9025, F.S. These individuals include those residing in correctional and holding facilities for prisoners who meet either of the following:

(a) Have been arrested or detained pending disposition of charges.

(b) Held under court order as material witnesses or juveniles.

(7) Gender Dysphoria.

(a) Florida Medicaid does not cover the following services for the treatment of gender dysphoria:

1. Puberty blockers;

2. Hormones and hormone antagonists;

3. Sex reassignment surgeries; and

4. Any other procedures that alter primary or secondary sexual characteristics.

(b) For the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the services listed in subparagraph (7)(a) do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

(8) Out-of-State Services.

(a) Emergency. Florida Medicaid covers emergency services provided out-of-state without a referral, or authorization, when the recipient's health will be endangered if the care and services are postponed until returning to Florida.

(b) Non-Emergency. Florida Medicaid covers services performed out-of-state, in accordance with the service-specific coverage policy, when both of the following are met:

1. The recipient's primary care or specialist physician refers the recipient for services.

2. Services are prior authorized by the Florida Medicaid quality improvement organization in accordance with Florida Medicaid's Authorization Requirements Policy, as incorporated by reference in Rule 59G-1.053, F.A.C.

(c) Florida Medicaid does not cover services for recipients living out-of-state who are enrolled under the Title-IV-E Florida foster or adoption subsidy.

(9) Payment in Full. Providers must accept payment from Florida Medicaid as payment in full, except for Florida Medicaid copayments and coinsurance. For information on copayment requirements and exemptions, refer to Florida Medicaid's General Policies on copayment and coinsurance.

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

(11) Refusal of Services.

(a) 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, if the recipient has a valid temporary proof of eligibility from the Department of Children and Families, or proof of presumptive eligibility.

(b) Right to Refuse Services. Providers may limit the number of Florida Medicaid recipients the provider serves, and accept or reject recipients in accordance with the policies of the facility or practice, except as follows:

1. A hospital may not refuse to provide emergency services in accordance with the 1986 Emergency Medical Treatment and Active Labor Act.

2. Providers may not deny services to recipients based solely upon race, creed, color, national origin, disabling condition, or disability, in accordance with federal anti-discrimination laws.

(12) Solicitation (Patient Brokering). Providers may not knowingly solicit, offer, pay, or receive any payment, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for furnishing, or arranging for the furnishing of, any item or service for which payment may be made, in whole or in part, under the Florida Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for, or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Florida Medicaid program.

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