THE OPERATING RESOURCE FOR MEDICAID HOME CARE

My Care Operator

Revenue on the Line: Fixing EVV Billing Leaks in 2026 – The Operators Claim Method

Closing the gaps that quietly drain Medicare & Medicaid revenue — and the repeatable process that stops them.

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THE PROBLEM HIDING IN PLAIN SIGHT

You're delivering more care than ever.
So why is the money still slipping away?

Tens — even hundreds — of thousands of dollars

in backlogged claim denials. Sitting there. Recoverable. And most owners don't know the number.

It's not one big leak

It's a dozen small ones — denials, doc gaps, EVV mismatches, late filing — each forgivable, together fatal.

It's invisible on the P&L

Revenue you never billed doesn't show up as a loss. It just never arrives. You feel it as 'cash is tight.'

It compounds every cycle

The same five mistakes repeat every month because nothing in the process changed to stop them.

WHY LISTEN TO ME

I've seen the same leaks in hundreds of agencies — across eight states.

20+ years inside home care & post-acute software

8 states of Medicaid operations, side-by-side

100s of agencies' billing realities, up close

What I do now

My Care Operator

- State-specific operating resources
- Plain-language regulatory updates
- A private operator community
- Built for Medicaid home care — only

THE REAL DIAGNOSIS

Denials aren't bad luck. They're a process that was never built.

The four things agencies get wrong — and don't know they're getting wrong:

No consistent process The same claim is handled differently depending on who's at the desk that day.

Falling behind regulations Rules move; the workflow doesn't. The gap becomes denials.

Not tracking MCO changes Each plan changes rules on its own schedule. Nobody owns watching for it.

No QA on data entry Whatever staff type into the software goes out unchecked — straight into a denial.

Here's the good news

Every one of these is fixable with the same thing:

a process that runs the same way every time, no matter who's at the desk.

That process has a name. And five stages.

The Operator's Claim Method →

THE FRAMEWORK

The Operator's Claim Method

Five stages every clean claim moves through. A leak at any stage costs you the whole claim.

1

Eligibility & Intake

Confirm coverage, plan, and auth path before a single visit.

2

Authorization

Get it, track it, and never deliver beyond it.

3

Documentation & EVV

Make the visit provable — and the EVV record match.

4

Clean Submission

Right codes, right plan, right window — first time.

5

Denial QA & Recovery

Catch, work, and learn from every denial — fast.

We'll walk each stage — what's the same for Medicare and Medicaid, and where Florida changes the rules.

STAGE 1

Eligibility & Intake

Same for both: Verify coverage and the correct payer BEFORE care starts. A wrong payer on day one is a denial on day thirty.

MEDICARE

Verify Part A/B, check for Advantage (MA) plans — an MA plan means you bill the plan, not traditional Medicare. Confirm the benefit period.

MEDICAID

Confirm the member's MCO and plan type, recipient eligibility for the month, and which waiver or state-plan benefit applies. Eligibility can change month to month.

FLORIDA WATCH-OUT

Florida members are enrolled across five MCOs with different rules. Re-verify plan enrollment every month — members move between plans and your last-month assumption may already be wrong.

STAGE 2 Authorization

Same for both: No auth, no pay. Track the units you have, the units you've used, and the expiration — and never deliver past any of them.

MEDICARE

Home health operates under the plan of care and certification; track the cert period and ensure orders are timely and signed.

MEDICAID

Prior authorization is plan-specific. Units and date ranges are finite. Delivering beyond the authorized units or after expiration is unrecoverable revenue.

FLORIDA WATCH-OUT

Each Florida MCO runs its own PA portal, timelines, and renewal quirks. Build a single auth tracker that watches expiration dates across ALL plans — don't rely on each portal to warn you.

STAGE 3

Documentation & EVV

Same for both: The visit must be provable and the EVV record must match the claim. Documentation gaps and EVV mismatches are the #1 denial engine.

MEDICARE

Visit notes must support medical necessity and match the plan of care; mismatches between documentation and billed services trigger review and denial.

MEDICAID

EVV data must reconcile with the claim — same dates, times, units. A claim that doesn't match the EVV record denies automatically in hard-edit states.

FLORIDA WATCH-OUT

Florida's 85% EVV threshold counts override submissions AGAINST your compliance rate — even legitimate ones. A caregiver calling from the client's landline is valid EVV, not an override. Configure telephony backup NOW, before an outage forces overrides.

STAGE 4 Clean Submission

Same for both: Right codes, right modifiers, right plan, right filing window — the first time. Every resubmission is unpaid labor.

MEDICARE

Correct HCPCS/CPT and modifiers, correct billing to MA plan vs traditional Medicare, within timely filing. Watch place-of-service and units.

MEDICAID

Bill the correct MCO with plan-specific codes and modifiers, through the required channel (e.g., the right EVV aggregator/portal), inside that plan's timely filing window.

FLORIDA WATCH-OUT

Timely filing windows differ BY Florida MCO. Submitting to the wrong plan or channel burns days you can't get back. Confirm the submission channel per plan — what's correct for one Florida MCO denies at another.

STAGE 5

Denial QA & Recovery

Same for both: Catch denials within days, not weeks. Work them on a schedule. And feed every denial reason back upstream so it stops recurring.

MEDICARE

Track remittance advice for denials and adjustments; appeal within Medicare's timelines; reconcile every ERA against expected payment.

MEDICAID

Read the RA/835 promptly, work denials before the appeal window closes, and watch RA alerts in soft-launch EVV states as an early warning before hard edits deny.

FLORIDA WATCH-OUT

Waiting too long is the killer — Florida agencies sit on denials until the filing/appeal window has closed, turning recoverable money into a permanent write-off. Set a fixed cadence: pull denials weekly, not when cash gets tight.

THE 60-SECOND DECISION

Fight it, or write it off?

Not every denial is worth chasing. The discipline is deciding fast — and never letting the window close while you decide.

FIGHT IT

- The dollar amount justifies the labor to appeal
- The denial reason is correctable (auth, code, EVV match)
- You're inside the appeal/filing window
- It's a recurring reason — winning fixes future claims too

WRITE IT OFF

- The window has already closed — chasing it wastes more labor
- The reason is uncorrectable and won't survive appeal
- Recovery cost exceeds the claim value
- BUT log the reason — a write-off you don't learn from will repeat

KNOW YOUR BATTLEFIELD

The Florida MCO landscape

Five plans. Five sets of rules. One tracker should watch them all.

MCO	Where it differs	Operator move
Sunshine Health	Own PA portal & filing window	Verify monthly — large SMMC footprint
Humana	Plan-specific codes & channels	Confirm submission channel per claim
Molina	Distinct auth renewal cadence	Track expiration dates centrally
Simply Healthcare	Own portal & timely-filing rules	Don't assume another plan's window
UnitedHealthcare	Separate credentialing & PA flow	Re-verify enrollment at month start

The pattern that matters: the differences aren't random — they're predictable. Once you map them per plan, they stop being surprises and become a checklist.

MAKE IT A HABIT, NOT A HEROIC

The monthly billing audit

The method only works if it runs on a schedule. One internal pass a month catches leaks before they become a backlog.

- Eligibility re-verified for every active member this month
- Claims aging report reviewed — nothing nearing timely filing
- Auth units & expirations reviewed across all five MCOs
- Denials worked this week, reasons logged and categorized
- EVV reconciliation run — mismatches found and fixed
- Top denial reasons fed back to fix the upstream stage
- EVV compliance rate checked against the 85% threshold
- Recovered vs written-off tracked — know your real number

WALK OUT AND USE THIS

Three moves you can make this week

1

Find your real number

Pull your denial backlog and your write-offs for the last 90 days. Most owners have never seen this figure. You can't fix what you refuse to measure.

2

Build one auth tracker

Stop living in five MCO portals. One sheet, every plan, every expiration date in view. This alone recovers delivered-but-unauthorized revenue.

3

Set a weekly denial cadence

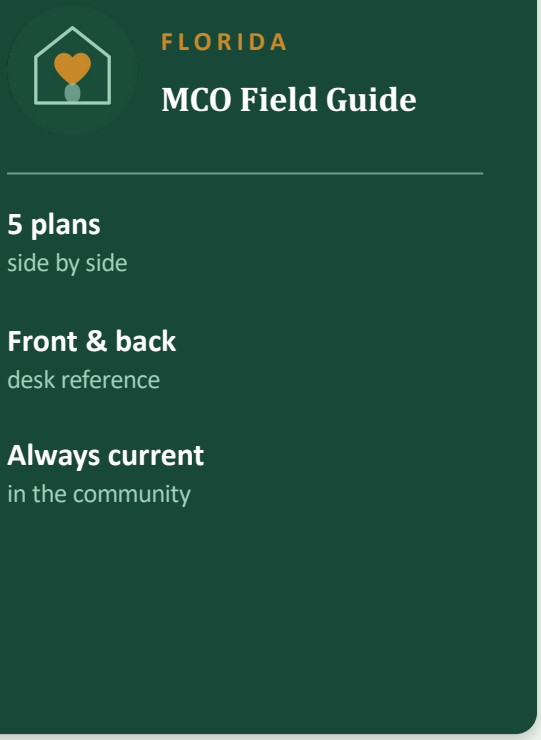
Pick a day. Work denials every week — not when cash gets tight. Waiting past the window is the single most expensive habit in this room.

YOUR LEAVE-BEHIND

The Florida MCO Field Guide

Keep it at the desk. One reference for all five Florida plans — the differences that cause denials, in one place.

- Prior auth path & portal — per plan
- Timely filing window — per plan
- EVV rules & the 85% threshold trap
- Submission channel — per plan
- Top denial reason to watch — per plan



THE OPERATING RESOURCE FOR MEDICAID HOME CARE

My Care Operator

The method you saw today isn't a one-time talk. It's how operators run — every month, in good company.

State-specific resources

The templates, trackers, and checklists behind every stage — built for Florida, kept current.

Regulatory updates, in plain language

When an MCO or AHCA changes the rules, you hear it here first — before it becomes a denial.

A private operator community

Real owners solving the same problems, plus the always-current field guides for all eight states.

Founding members are building this now. Get in early — shape the resource you wish you'd had when you started.

Two ways to start today

Join the community

Get the method, the templates, and the always-current Florida field guide — and stop running your agency alone.

Get a billing review

Let's find your real number together. Bring me your denials — I'll show you where the leaks are and what they're worth.

mycareoperator.com

Come find me after the session — let's talk about your number.