

# Billing

# Medicaid Patients

**26 September 2017**



Utah Office of  
Inspector General



# Bottom Line Up Front



Providers are prohibited from billing Medicaid patients except in certain circumstances: cost-sharing, spenddown, Primary Care Network, non-covered services, or broken appointments. For a provider to bill a patient outside of cost-sharing and spenddown, the provider must have an office policy that applies to all patients and in most situations, requires a written agreement. Providers cannot treat Medicaid patients differently from other patients of the practice.

Patients must be educated to know they must present their Medicaid card. Recipients must understand that if a provider declines to accept as a Medicaid patient, they should seek a new provider.

There is never a co-pay for pregnant women, under 18, American Indians, and Alaska Native.



# Provider Agreement

## Revised 3/1/11



- Obligates provider to be aware of and comply with policies:
  - Provider manual, MIBs, rules and regulations – state and federal.
- Prohibits billing of Medicaid recipient unless specifically allowed.
- Prohibits discrimination against recipient on the basis of race, religion, color, national origin, age, or sex.
- Abide by Americans with Disabilities Act.
- Cannot violate discrimination policy and agreement in determining which patients to accept as Medicaid and which shall be “private pay.”
- Providers are required to seek payment from all third party sources prior to billing Medicaid.
- Payment by an MCO plan is considered payment in full.



# Provider Agreement Prohibition on Billing



- Not bill Medicaid recipient or attempt to collect payment except when specifically allowed by Medicaid policy.
- May obtain agreement and consent of recipient to bill as “private pay.”
  - Cannot bill Medicaid.
- Must accept Medicaid payment as payment in full for services:
  - Unless agreement of private pay or otherwise allowed by policy.
- Refund Medicaid for overpayments.

**UTAH DEPARTMENT OF HEALTH  
DIVISION OF MEDICAID AND HEALTH FINANCING**

**PROVIDER AGREEMENT FOR MEDICAID**

This is a Provider Agreement for participation in Title XIX of the Social Security Act (Medicaid). This agreement is between the Utah Department of Health, Division of Medicaid and Health Financing, hereafter referred to as DEPARTMENT, and \_\_\_\_\_ (Provider Name), hereafter referred to as PROVIDER.



# Section I: General Information



- Provider who *accepts* a patient as:
  - Medicaid
  - Hospital Presumptive Eligibility
  - Baby Your Baby

Must accept the Medicaid payment as payment in full.

## Related Learning:

Presumptive Eligibility (PE) is a temporary Medicaid program that bases eligibility on preliminary information to make an individual 'presumptively' eligible. There are two PE programs that are administered throughout the state: Hospital Presumptive Eligibility (HPE) and Baby Your Baby (BYB).

Baby Your Baby provides temporary medical assistance for pregnant women to help pay for prenatal care.





# Section I: General Information



- Payment from Medicaid or an MCO to include any deductible, co-insurance, co-payment owed by the Medicaid patient, is payment in full.
- Providers that accept a patient enrolled in a Medicaid MCO must accept the MCO payment as payment in full.
- If patient has Medicaid and third party coverage, cannot collect a co-payment that is usually due at the time of service.
- Cannot charge for administrative cost to complete and submit a claim.

*Provider may not bill the patient for services covered by Medicaid, Hospital Presumptive Eligibility, Baby Your Baby or an MCO.*



# Section I: General Information

## Medicare Patients



- Qualified Medicare Beneficiary (QMB) Program
- Medicare pays primary portion and Medicaid pays co-insurance and deductible. Cost sharing program for QMB eligible recipients.
- Providers of QMB patients must accept the Medicare payment and the Medicaid payment for co-insurance and deductible, as payment in full.
- Cannot bill patients eligible for the QMB program for:
  - Any balance remaining after Medicare payment; and
  - The QMB co-insurance and deductible payment from Medicaid.

**Bottom Line:** QMB program patients cannot be billed for any remaining balance.



# Section I: General Information

## Exceptions



Generally, providers cannot bill patients except in the following circumstances:

- Non-Covered Services
- Serving PCN Patients
- Spenddown Medical Claims
- Cost-Sharing (co-payments and co-insurance)
- Broken Appointments

### **Spenddown Program (Medically Needy)**

If your income is over the allowable limit to be eligible for Medicaid, you may be able to spenddown. Not all Medicaid programs allow a spenddown. A spenddown can be met in cash or by using medical bills that you still owe. Contact a DWS eligibility worker for information about spending down.



# Section I: General Information

## Cost Sharing



- Provider must first confirm:
  1. Service requires a co-payment; and
  2. Medicaid patient has a co-payment requirement.
- Provider must supply receipt to the patient for all cost sharing payments.
- Providers may bill the patient for an allowed co-payment if not collected.

### No Co-Payment for:

- Baby Your Baby
- Children's Health Insurance Program (Preventative Services)
- Child Health Evaluation and Care Members
- Under the age of 18
- Pregnant Women
- American Indians
- Alaska Natives
- Third Party Coverage (pending claims processing)
- Certain services: Family planning, immunizations, preventative care

***Do not collect any co-payment until confirmed that it is required.***



# Section I: General Information

## Non-Covered Services



- Non-covered service defined as service not covered by a third party (including Medicaid).
- Provider may bill Medicaid patient for non-covered services if conditions are met:
  1. Established policy for billing all patients for non-covered services:
    - This policy cannot exist only for Medicaid members. All patients treated equally regardless of third party insurance.
  2. Member is advised prior to receiving the non-covered service that Medicaid will not pay for the service.
  3. Member agrees to be personally responsible for the payment.
  4. Agreement in **WRITING** between the provider and Medicaid patient:
    - Includes details of the service and the amount to be paid.



# Section I: General Information

## Non-Covered Services



### *KNOWLEDGE CHECK*

- How many conditions must be met to bill a Medicaid patient for non-covered services?
- What are the conditions?



# Section I: General Information

## Non-Covered Services



### *KNOWLEDGE CHECK*

- How many conditions must be met to bill a Medicaid patient for non-covered services?

### Four Conditions

- What are the conditions?
  1. Policy for billing all patients for non-covered services.
  2. Member is advised prior to receiving the non-covered service.
  3. Member agrees to be personally responsible for the payment.
  4. Agreement in WRITING between the provider and Medicaid patient.



# Section I: General Information

## Non-Covered Services



- Unless ALL conditions are met, the provider may not bill the member for non-covered services.
- Medicaid Member Card cannot be held for non-payment or as guarantee of payment.
- Provider may not place other restrictions on the patient.



*All patients are treated equally regardless of Medicaid status.*



# Section I: General Information

## PCN



- Providers may bill PCN patients for non-covered services identified in the PCN manual.
- Written agreement upon time of service recommended – *not required*.

**Are you uninsured?**

# PCN

## Primary Care Network

PCN is a health plan offered by the Utah Department of Health. It covers the services administered by a primary care provider.

**PCN Benefits Include:**

- Visits to a primary care provider
- Four prescriptions per month
- Dental exams, cleanings, fillings, routine x-rays, tooth extractions
- Immunizations
- Routine lab services and x-rays
- Limited coverage of emergency room visits
- Emergency medical transportation
- Birth control

The advertisement features a photograph of a smiling man and woman standing together against a blue background.



# Section I: General Information

## Spenddown Payment



- Spenddown payment for some members to qualify for Medicaid.
  - Member agrees to “spenddown” their monthly income to meet Medicaid income conditions.
- Can pay to DWS or may pay a medical bill and use the expense as an offset to spenddown requirement.
- Provider submits claim for full amount to Medicaid – not partial charge.
  - If patient owes full amount of service, provider may choose not to bill Medicaid.
- Medicaid deducts patient’s spenddown obligation from reimbursement.
  - Remaining is paid to the provider.
  - If patient’s spenddown is equal to or more than Medicaid reimbursement, Medicaid pays zero.



# Section I: General Information

## Broken Appointments



- Broken appointments are not covered by Medicaid.
- Provider may bill for broken appointments if three conditions are met:
  1. Provider has an established policy for acceptable cancellations.
    - Example: Member may cancel 24 hours prior to appointment.
  2. Member has signed a statement agreement to pay for broken appointments.
  3. Provider charges ALL members in the practice for broken appointments.

*All patients are treated equally regardless of Medicaid status.*



# Section I: General Information Broken Appointments



## *KNOWLEDGE CHECK*

- How many conditions must be met to bill a Medicaid patient for a broken appointment?
- What are the conditions?



# Section I: General Information

## Broken Appointments



### *KNOWLEDGE CHECK*

- How many conditions must be met to bill a Medicaid patient for a broken appointment?

Three Conditions

- What are the conditions?
  1. Provider has an established policy for acceptable cancellations.
  2. Member has signed a statement agreement to pay for broken appointments.
  3. Provider charges ALL members in the practice for broken appointments.



# When can a provider bill a patient for the full service?



- Provider that *does not accept* a patient as Medicaid.
- Not a Medicaid provider – not entered into agreement.
- If a Medicaid provider and accepts patient:
  - Obtained advance consent of patient to see recipient as “private pay” for a given service and does not bill Medicaid.

## Risks to Patients

Patient does not provide Medicaid card to the provider.  
Receiving care outside of the Medicaid or MCO network.  
Services not covered by Medicaid.



# References and Further Reading



Medicaid Publications (Section I: General Information Provider Manual)

<https://medicaid.utah.gov/publications>

Provider Agreement for Medicaid

<https://medicaid.utah.gov/Documents/pdfs/agreement2011.pdf>

About Primary Care Network (PCN)

<http://www.health.utah.gov/pcn/>

# Questions?

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# BACKUP SLIDES