

## Medicaid Provider Manual, Section I Updated October 2013

### 6 - 8 Exceptions to Prohibition on Billing Patients

The four circumstances explained in this chapter, items 1 through 4, are the ONLY circumstances in which a provider may bill a Medicaid patient. They are non-covered services, spend down medical claims listed on the back of the Medicaid Identification Card; Medicaid co-payments and co-insurance; and broken appointments. The specific policy in each item must be followed before the Medicaid patient can be billed.

#### 1. Non-Covered Services

A non-covered service is a service not covered by a third party, including Medicaid. Since the service is not covered, any provider may bill a Medicaid patient when **four conditions are met:**

- A. The provider has an established policy for billing all patients for services not covered by a third party. (The charge cannot be billed only to Medicaid patients.)
- B. The patient is advised **prior to receiving** a non-covered service that Medicaid will not pay for the service.
- C. The patient agrees to be personally responsible for the payment.
- C. The agreement is made in writing between the provider and the patient, which details the service and the amount to be paid by the patient.

Unless all conditions are met, the provider may not bill the patient for the non-covered service, even if the provider chooses not to bill Medicaid. Further, the patient's Medicaid Identification Card may not be held by the provider as guarantee of payment by the patient, nor may any other restrictions be placed upon the patient.

#### 2. Client Responsibility Notification Attached to Medicaid Identification Card

The patient's Medicaid Identification Card has the message, "This medical card includes a client responsibility notification" printed in the special instructions. An example of the card is included with the Medicaid Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual. When you see this message, look at the back of the medical card for additional information.

Any provider, whose service is listed under the Client Responsibility Notification section of the card, should collect from the patient the amount the patient is responsible to pay. Information includes the provider's name, date of service, type of service, the total bill for that service, and the recipient's financial obligation, as determined by the eligibility worker at the time the form was issued. Collect from or bill the patient for the amount indicated.

Bill Medicaid the full charge for the service. Do NOT bill a partial charge to Medicaid. If the recipient owes you the full amount of the charge, you may choose not to bill Medicaid.

When your claim is received, Medicaid bases the reimbursement amount on the amount you billed, or the standard reimbursement amount, whichever is less. (This is why a provider should not bill a partial charge. A partial charge might be less than the Medicaid reimbursement amount.) Medicaid deducts the client's obligation from the Medicaid reimbursement amount. The remainder is paid to the provider. When the client's obligation to pay is equal to or more than the Medicaid reimbursement amount, the Medicaid payment will be zero.

For more information on this financial obligation, refer to Chapter 1 - 1, Applying for Medicaid, subsection titled Medicaid Medically Needy Program (Spend down).

### 3. Medicaid Co-payments, Co-insurance

Many adult Medicaid clients are required to make a co-payment or co-insurance for the types of services listed below. Co-pay refers to either a co-payment or co-insurance. The effective date of the requirement is in parentheses below: pharmacy (July 1, 1997), non-emergency use of a hospital emergency department (January 14, 1994), office visits performed by a physician or podiatrist and for outpatient hospital services (November 1, 2001), rural health clinic services (April 1, 2002), inpatient hospital services (January 1, 2002).

Both health plan and fee-for-service clients can have a patient responsibility. The client's Medicaid Identification Card will state when a co-pay is required. The provider is responsible to collect the co-pay at the time of service or bill the client. The amount of the client's co-pay will automatically be deducted from the claim reimbursement.

#### Co-Pay Message on Medicaid Card, by Client

The Medicaid Card will have a code under the Co-Pay column by the individual client's name if he or she has a co-pay. View the definition of the codes under the section titled, Co-Pay codes on the medical card. The definition will say what type of co-pay to collect.

NAME Smith, John Q Copoly/co-ins for: non-emergency use of the ER, output hosp & physician svcs, pharmacy, inpat hosp
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The co-pay message may vary by client and whether the client is in a health plan or is fee-for-service. If there is no co-pay code by a client's name, the client does not have a co-pay. A family may contain an adult with a co-pay and children who are exempt. So, you must verify whether the individual patient has a co-pay for the type of service.

#### No Co-pay for Exempt Services

Some services are exempt from co-pay. It does not matter whether the client has a co-pay or not. Do not collect a co-pay for the following types of service:

1. Family planning services have NO co-pay.
2. Emergency services in a hospital emergency department have NO co-pay. However, non-emergency use of a hospital emergency department may require a co-pay. Refer to SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 2 - 1, Co-payment Requirement: Outpatient Hospital and Non-emergency Use of a Hospital Emergency Department.
3. Lab and X-ray services, including both technical and professional components, have NO co-pay.
4. Anesthesia services have NO co-pay.

#### Collecting a Co-pay

Before you collect a co-pay, be sure the client has a co-pay and that the service requires a co-pay. For more information on the co-pay requirement for specific types of services, refer to SECTION 2 of the appropriate Utah Medicaid Provider Manual:

- Physician Services, Chapter 1 - 5
- Podiatry Services, Chapter 1 - 3

- Hospital Services, Chapter 2 - 1
- Pharmacy Services, Chapter 1 - 8
- Rural Health Clinic Services, Chapter 1 - 5

Please give the client a receipt for the co-pay collected. We will urge clients to keep co-pay receipts in case of delayed billings by providers or discrepancies. If you do not collect a co-pay owed at the time of service, you may bill the client for the amount that should have been paid.

### **Clients Exempt from Co-pay**

The Medicaid Card states whether an individual client has a co-pay. A client in one of the following groups does not have a co-pay.

- Child under age 18
- Pregnant woman
- Total gross income, before exclusions or deductions, is below the Temporary Assistance to Needy
- Families (TANF) standard payment allowance, as determined by an eligibility worker.
- Resident of a nursing home
- QMB ONLY [Qualified Medicare Benefits]
- Medicaid/QMB clients, except for pharmacy services and non-emergency use of the emergency room as stated on the Medicaid ID Card. 18.
- Co-payment maximum out-of-pocket has been met.

### **Pregnant Women Exempt from Co-Pay**

Do not require a co-pay for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the eligibility worker, who can change her co-pay status to exempt on future Medicaid Cards.

### **Co-pay Maximums Per Client**

There is no maximum on co-pays for non-emergency use of the Emergency Department. Other co-pays and co-insurance have a maximum out-of-pocket per client, per type of service. When a client meets the maximum out-of-pocket payment for a type of service, as determined by Medicaid billing information, the following month the co-pay message will change. For example, a client may meet the maximums for physician and inpatient hospital services and continue to have a co-pay for pharmacy and non-emergency use of the Emergency Department.

## **4. Broken appointments**

A broken appointment is not a service covered by Medicaid. Since the charge is not covered, any provider may bill a Medicaid patient when **three conditions are met**:

- A. The provider has an established policy for acceptable cancellations. For example, the patient may cancel 24 hours before the appointment.
- B. The patient has signed a statement agreeing to pay for broken appointments.
- C. The provider charges all patients in the practice for broken appointments. The charge cannot be billed only to Medicaid patients.

