Billing and Medicaid (Apple Health)

Section 1: Intro

Can a provider bill me for services I got while I had Medicaid (Apple Health)?

Usually, no. Medical providers taking part in Washington's Medicaid program (Apple Health) must accept payment from the agency as payment in full. 42 C.F.R. § 447.15; WAC 182-502-0160; WAC 182-502-0010(2) (g). A provider generally cannot bill you for any service Medicaid covers even if the provider has not gotten payment from Apple Health or your managed care provider. WAC 182-502-0160(4) (b). We discuss the exceptions to this below in section 2.

- ❖ "You" here also means the provider cannot bill someone related to you, such as your family, a friend, or helper.

What if Medicaid does not cover all the cost?

A provider cannot bill you for the cost of covered services over and above what Medicaid pays. This also applies to third parties, such as your spouse or other family, a friend or a helper. Keep reading for exceptions to this.

Section 2: Exceptions

What if I do not sign documents the provider gives me?

If you refuse to complete and sign insurance forms, billing documents, or other forms the provider needs to bill a third-party insurance carrier for services you received, the provider may bill you for the service.

What if I received services from a provider who does not take Medicaid?

That provider may bill you if you chose to receive their services after it informed you of both of these:

- They do not contract with Medicaid.
- Medicaid would not pay for the services.

I am in a Managed Care Organization (MCO). What if I got services from a nonparticipating provider?

The provider can bill you if both of these are true:

- You knew the provider was outside your MCO's network.
- You chose to get nonemergency services from it anyway without the MCO's authorization.

They told me Medicaid would not cover the service. I chose to receive the service anyway. Can they bill me?

Yes, if you agreed to pay the provider after it did all these:

1) Checked if you could get Medicaid coverage for the dates of service.
2) Checked if you had coverage under an MCO.
3) Told you the limits of your coverage and services available to you.
4) Signed a written agreement with you. (The provider generally should use this agency form.)
5) Provided translation into another language if needed.
6) Did everything Medicaid/your MCO required of it to authorize services, if coverage/authorization was available.

> ❖ A provider who did not complete the right paperwork at the right times cannot bill you if Medicaid/your MCO will not pay the provider.

WAC 182-502-0160(5).

Can the provider bill someone else for the service?

A medical provider can bill a "third party" who is legally responsible for paying any of the cost of your health care. This can be

- A person/entity that has caused you mental/physical harm.
- The insurance company covering that person/entity.
- Both.

Example: You are in a car accident. The other driver is at fault. Medicaid pays for the medical services for your injuries. It will then seek to recover the cost of your medical services from the other driver or the driver's insurance company.

> ❖ You must "assign" (give) the State any right you have to payment from a liable third party for medical expenses, assistance, or residential care.

What if my Medicaid plan includes cost sharing?

Under the terms of your coverage, your medical provider can bill you for some costs. The provider can also bill you directly for

- Costs such as deductibles, coinsurance, or copayments.
- Services within your spend down amount, if you get Medically Needy Medicaid. The Medicaid Medically Needy Program: Medicaid for Adults 65 and Older or Disabled Who Don't Get SSI has more info.

What about services I received in Canada?

Medicaid will pay for those services only if you received them in British Columbia and your situation meets other requirements. For example, one of these must be true:

- You live in Point Roberts, or in a community along the Washington/British Columbia border.
- You are a member of the Canadian First Nations and live in Washington State.

What about services I received out-of-state?

Medicaid will pay for services in these bordering cities on the same basis as in-state care:

- Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho.
- Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.
  WAC 182-501-0175

Medicaid will also pay for emergency and non-emergency out-of-state care that meets the requirements of WAC 182-501-0180.

How can I find out if I was covered by Medicaid for the dates of service?

Contact the Medical Assistance Customer Service Center (MACSC):

Phone: 1-800-562-3022
Email: askmedicaid@hca.wa.gov
Online: Secure web form
Business hours: Monday through Friday 7 a.m. to 5 p.m. Pacific Time (PT) (except state holidays)

What if I did not have Medicaid for the dates I received the services?

The provider can bill you. Compare the dates you received the services to notices you got from Apple Health, your online account, or call the number on the back of your ProviderOne card. If the provider is billing you for any dates you had Medicaid, see Section 3 for sample letters you can use.

- ❖ If you tell the provider you are a private pay client and not receiving medical assistance, the provider will bill you directly, even if you do in fact get Medicaid.

What if none of the exceptions applies to me?

The provider cannot bill you. Section 3 has sample letters you could use. Or contact a lawyer.

What if an exception applies?

If the provider should have had a written agreement with you, ask them to give you a copy. See "They told me Medicaid would not cover the service. I chose to receive the service anyway," above.. Compare the agreement you signed to what WAC 182-502-0160(5) requires. If the agreement does not say what it should, sample letter 3 in this publication might convince the provider not to bill you.

Section 3: Sample letters

Keep a copy of the letters you send. Make a note on your copy of the date and how you delivered the letter. For example, "sent on 8/22/2018 by regular US mail" or "hand-delivered to [provider name] billing dept. on 8/22/2018".

Sample letter 1: if you start to get bills from a provider even though you told them at the time of service that you had Medicaid.

Sample letter 2: You sent sample letter 1. The provider keeps billing you anyway.

Sample letter 3: Medicaid covered some, but not all, of your bills. The provider claims you signed a waiver.

SAMPLE LETTER #1

<<<Date>>>

[Provider name]

ATTN: Billing

[Provider address]

Re: Account No. [# from bill]

Dear Sir/Madam:

You sent me a $_____ bill for services I received from you on _____ _____ [dates of service]. I had Medicaid when I received those services.

It is illegal for a provider to bill a Medicaid recipient. WAC 388-502-0160. The federal government provides penalties for providers who bill Medicaid recipients, up to three times the amount of the bill. 42 CFR §447.21. It is your responsibility to verify coverage. You cannot charge me even if Medicaid does not pay. WAC 388-502-0160 (1).

Please immediately correct your records to reflect that I have no liability for this bill. If you have notified any credit reporting agencies of a delinquency, please correct that report and send me proof that you have done so. Thank you for your prompt attention to this matter.

Sincerely,

[Sign and print name, print your address]

<<<Month day, year>>>

Accounts Representative

Re: Account No. *

Dear Sir/Madam:

I am receiving bills on this account despite the fact that I told you I was on Medicaid at the time of service.

The law prohibits you from billing Medicaid recipients. Enclosed with this letter is the relevant portion of the Washington Administrative Code for your information.

Please send me written confirmation that you will cease any efforts to collect this bill, or any other bill incurred while I had Medicaid coverage. Thank you.

Sincerely,

<<<Your name>>>

Encl: WAC

Dear <<<collection agency representative>>>:

I got information on my health coverage. Some or all of the bills listed on the letter you sent me from *provider* dated <<<>>> detailing the charges at issue were for Medicaid-eligible services.

Enclosed please find information from the Health Care Authority showing that, of the dates in question, I was on Medicaid from <<<date>>> through <<<date>>>. I informed the provider about my coverage. They knew I had Medicaid.

Even if you believe the provider's claim that I did not disclose my Medicaid status, it does not matter. It is the provider's responsibility to verify medical coverage. WAC 182-502-0160(2).

The provider has also argued that Medicaid may not have covered the services, and that I signed waiver forms authorizing the service. The waiver forms I signed do not comply with WAC 182-502-0160(5), which reads:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or agency-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as pre-operative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or agency-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or its designee denies a request for a noncovered service and that the client may choose not to do so;

(viii) Specify that the client may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's or its designee denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(ix) Be completed only after the provider and the client have exhausted all applicable agency or agency-contracted MCO processes necessary to obtain authorization of the requested service, except that the client may choose not to request an ETR or an administrative hearing regarding agency or agency designee denials of authorization for requested service(s); and

(x) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the agency or the client's agency-contracted MCO and the ETR process as described in WAC 182-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the agency or the client's agency-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC 182-501-0160;

(iii) Covered by the agency or the client's agency-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the agency or its designee denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by the agency or the client's agency-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it.

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of service. The agreement must be made available to the agency or its designee for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

This situation does not fall into one of WAC 182-502-0160(6)'s limited exceptions where a provider may bill a patient without executing the Agreement to Pay for Healthcare Services.

For the period I had Medicaid, representing $___.__ of the $___.__ billed, the provider violated the law by billing or trying to collect the charges from me. I have a refund coming from the provider for all improperly charged amounts you have collected from me.

Please cease all further collection attempts immediately. Thank you.

Sincerely,

<<<<Your name>>>