Provider Billing of Medicaid Beneficiaries

General Rule 1: Providers may NOT bill Medicaid beneficiaries for missed appointments.

"This [CMS] policy is based on the reasoning that a missed appointment is not a distinct reimbursable Medicaid service, but a part of providers' overall costs of doing business."

Medi*care* Distinction: **"**CMS policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments."

General Rule 2: Providers may NOT bill Medicaid beneficiaries for *covered services* – only the allowable co-payments, co-insurance, or deductibles.

Corollary to General Rule 2:

DHHS Provider Administrative Participation Agreement Section 5(2):
"A provider may bill for goods, services, or supplies provided to a recipient if such are *not covered* under the Department *and* the recipient has been notified in advance that such services are not covered and that the recipient is financially responsible."

Exceptions to General Rule 2:

1. **10A NCAC 22J .0106(a)**: "A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services but will charge the patient for all services provided."
    a. 10A NCAC 22J .0106(f): "When a provider accepts a private patient, bills the private patient personally for Medicaid services covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for the services covered by Medicaid with the exception of any third party payments or cost sharing amounts as described in the Medicaid State Plan.
2. **N.C.G.S. §108A-55**: "A provider may seek payment for services from Medicaid enrollees who are eligible for but not enrolled in Medicare Parts B and D."

Controlling Authority:

1. There are no CMS regulations that address this policy issue.
2. There are two CMS sub-regulatory letters from 2006 and 1994.
3. DMA has one relevant administrative rule, 10A NCAC 22J .0106.
4. N.C.G.S. §108A-55.1
3. DHHS Provider Administrative Participation Agreement Section 5(2)
5. CMS Manual System Publication 100-04, Section 30.3.13

10A NCAC 22J .0106 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS

(a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services or supplies but will charge the patient for all services or supplies provided. If a provider refuses to accept a patient as a Medicaid patient, the provider shall inform the patient before providing any services or supplies, except when it would delay provision of an appropriate medical screening, medical examination, or treatment as required by 42 U.S.C. 1395dd.

(b) A provider will be deemed to have accepted a patient as a Medicaid patient if the provider files a Medicaid claim for services or supplies provided to the patient. Verification of eligibility alone shall not be deemed acceptance of a patient as a Medicaid patient. A patient, or a patient's representative, must request acceptance as a Medicaid patient by:

(1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing;

(2) stating either orally or in writing that the patient has Medicaid coverage; or

(3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.

(c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

(1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan;

(2) before the service or supply is provided, the provider has informed the patient that the patient may be billed for a service or supply that is not one covered by Medicaid regardless of the type of provider or is beyond the limits of Medicaid coverage as specified in the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-54.2(b);

(3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services or supplies are received but has failed to supply a Medicare number as proof of coverage; or

(4) the patient is not eligible for Medicaid as defined in the Medicaid State Plan.

(d) When a provider files a Medicaid claim for services or supplies provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services or supplies for which it receives no reimbursement from Medicaid when:

(1) the provider failed to follow program regulations;

(2) the Division denied the claim on the basis of a lack of medical necessity; or

(3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of this Rule.

(e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment, plus any authorized deductible, co-insurance, co-payment, and third party payment as payment in full for all Medicaid covered services or supplies provided, except that a provider shall not deny services or supplies to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance, or co-payment amount as specified in the Medicaid State Plan. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a provider may pursue recovery of third party funds that are primary to Medicaid.

(f) When a provider accepts a private patient, bills the private patient personally for Medicaid services or supplies covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for the services or supplies covered by Medicaid with the exception of any third party payments or cost sharing amounts as described in the Medicaid State Plan.

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-54.2; 42 C.F.R. 447.15; 42 C.F.R. 447.52(e); 42 C.F.R. 433.139;
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