

Billing the Medicaid Beneficiary Tips

Policy: [Medicaid Provider Manual](#), Chapter: General Information for Providers, Section: 11- Billing Beneficiaries.

- Eligibility Criteria: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-35199--,00.html
- Eligibility verification tools: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546-57088--,00.html
- Co-payment descriptions: http://www.michigan.gov/documents/mdch/WebCo-PayTable_11-02-06_182172_7.pdf
- Verifying the patient spend-down amount/liability and or the 1038 exception determinations: <https://healthplanbenefits.mihealth.org>

Providers may bill the beneficiary when:

1. A Medicaid co-payment is required.
2. A monthly patient pay amount is owed.
3. When a responsibility for the state-owned and operated facility or CMHSP service's ability-to-pay amount has been determined.
4. Services applied to the beneficiary's Medicaid Deductible/Spenddown amount.
5. If the beneficiary is enrolled in a Medicaid Health Plan (MHP) and the health plan did not authorize a service, and the beneficiary had prior knowledge that he would be liable prior to services being rendered.
6. Medicaid does not cover the service. (List of non-covered services are in the Medicaid Provider Manual, Chapter: General Information for Providers, Section: 8.3 Non-covered Services. (The provider must notify the beneficiary in writing prior to rendering the service.)
7. Beneficiary's refuses to obtain Medicare coverage.
8. Any amount paid to the beneficiary from any commercial or Medicare plan.
9. Beneficiary did not follow the rules of the primary payer.
10. If the provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge. (Provider is advised to notify the beneficiary in writing prior to rendering services.)

Frequently Asked Questions regarding when the provider can bill the Medicaid beneficiary

1. How does the State of Michigan decide that the provider has accepted the patient's Medicaid coverage?
 - A. MDHHS generally determines the provider has accepted the patient as a Medicaid beneficiary when they send a bill to the CHAMPS on-line claims processing system.

2. If a beneficiary is on Spend-down are they going to get Medicaid coverage?
 - A. Spend-down is not a guarantee that the beneficiary will ever obtain eligibility as there are many conditions that may affect the "first date of eligibility". If the local county MDHHS office caseworker does not receive the charges incurred in the order that the services were rendered the beneficiary may get coverage where possibly not all expenses are being considered. If a bill is received after the first date of eligibility has been determined the caseworker may use the expense prospectively to apply them in the next several months but in no case does eligibility policy allow the budget to be reran to recalculate a first date of eligibility.

3. What about the new "Cost-sharing Limits"?
 - A. Providers were advised to always verify coverage prior to rendering services and that per [MSA Bulletin 15-49](#) a Medicaid household may not exceed an aggregate limit of 5% of family income owing to Medicaid cost-sharing responsibility. This means that the provider must verify if the cost-share has been met, if there is a cap amount remaining and of course the copayments that will be applied to their services. This is all detailed to the provider in the eligibility response within CHAMPS. Because CHAMPS will be tracking beneficiary costs-incurred as claims are adjudicated, providers are directed to bill all claims in a timely fashion. Providers are expected to utilize the information in CHAMPS to determine whether cost-sharing may be assessed at the time of the visit and inform the beneficiary of his or her cost-sharing obligations. Beneficiary may not be charged cost-sharing in excess of the limit, and are not required to track cost-sharing charges.

4. Does the beneficiary have a way to check on their cost-sharing responsibility?
 - A. Yes they may use the myHealthButton, the myHealthPortal application or by calling the Beneficiary Helpline.

5. What if the patient is covered by Healthy Michigan Plan (HMP)?
 - A. Providers were advised via [MSA Bulletin 17-02](#) that the HMP co-pays were increased to certain HMP households. Again the policy emphasized the importance of checking coverage prior to rendering services as there is now a tiered co-pay amount due-one set of amounts for those with income less than or equal to 100% Federal Poverty Level (FPL) and those with income more than 100% FPL.

6. Is their co-pay amount due and payable at the time services are rendered?
 - A. The HMP Beneficiary's in a MHP will pay their co-pays through the MI Health Account and therefore should not be charged at point of service. Fee for Service (FFS) HMP members that are not enrolled in a MHP may be subject to co-pays at the point of service.

7. Can Medicaid beneficiaries in MHPs have different co-pays then FFS?
 - A. Yes, contact the appropriate plan for copayment information.

8. Can a provider refuse to render services to a Medicaid beneficiary that cannot or is unable to pay the copayment amount at the time the care or service is provided?
 - A. No, a provider must accept the beneficiary's assertion that he/she is unable to pay and no additional proof is required. Uncollected co-payments are considered to be debt.

9. Can a provider refuse to render services to a Medicaid beneficiary with copayment debt?
 - A. Yes, but first the provider must give the beneficiary an appropriate notice of the debt and have given them a reasonable opportunity to pay the debt.

10. How could a provider notify a Medicaid beneficiary in the case of an emergency?
 - A. The beneficiary needs to be informed before the service is provided if the service is not covered. This can be documented and signed by the beneficiary and the provider can keep a copy for their files. If the provider is unable to do this prior to rendering services they will be unable to bill the beneficiary.

11. If a Medicare dual eligible beneficiary signs the Medicare Advanced Beneficiary Notification of Non-coverage (ABN) and both Medicare and Medicaid deny may the provider bill the beneficiary?
- A. No, please see the most recent guidelines from CMS via their [MLN Matters SE1128](#). Providers are not allowed to balance bill dually eligible beneficiaries. Medicare providers must accept the Medicare payment and Medicaid payment, if any, as payment in full for services rendered to a QMB individual. Even if the Medicare provider is not an enrolled Medicaid provider they may suffer Medicare sanctions for balance billing the dually eligible.
12. If a beneficiary with spend-down contacts the provider six months after services were rendered to inform the provider that they have received retroactive coverage does the provider have to bill Medicaid?
- A. No, it is the provider's option to bill Medicaid however MDHHS encourages the provider to return the beneficiary's payments, if any, and bill Medicaid for the service. If the provider decides to bill Medicaid, all money the beneficiary paid over and above the amount identified as the beneficiary responsibility on the Medicaid deductible letter, must be returned to the beneficiary.
13. If the beneficiary has services rendered to them due to a car accident but they won't tell us who the Auto Carrier is, can provider bill the beneficiary?
- A. No, and it is sometimes difficult to determine the responsible party when car accidents occur. If liability is in question, Medicaid may be billed. Per the Medicaid Provider Manual, Chapter: Coordination of Benefits, Section: 2.2 Automobile Insurance, Medicaid or the Medicaid managed care plan pursues reimbursement from the other auto insurance carriers through subrogation.
14. If provider has received denials from the Primary commercial or Medicare plan for noncompliance can the beneficiary be billed?
- A. No, Medicaid liability is both the provider and the beneficiary's equal responsibility for compliance with the primary plan requirements. Policy was clarified via [MSA Bulletin 12-51](#) to describe common noncompliance denials due to:
- i. Failure to obtain a referral from a participation primary care provider
 - ii. Failure to be seen by a participating provider
 - iii. Failure to be seen in a participating place of service
 - iv. Failure to obtain a second opinion
 - v. Failure to obtain prior authorization

In any of the above cases the beneficiary may not be billed but the provider must remediate with the primary payer.

15. Will MDHHS provide us with an acceptable Medicaid ABN?

****For Hospital claims only.** There is not a Professional ABN.

- A. There are two examples in the Medicaid Provider Manual >> Forms Appendix
1. Specifically for Inpatient Hospitals when MPRO denies authorization of a continued stay.
 2. Another example where MPRO has denied the entire request from the beneficiary's provider for admission to an inpatient setting as not medically necessary. These forms give the appeal rights to the beneficiary. If an outpatient hospital wants to design a Medicaid ABN we would advise that the document include all of the below listed specificities and be reviewed and approved by your legal counsel:
 - i. Beneficiary's Name, Gender, Date of Birth and identifying Demographics.
 - ii. Anticipated Dates of Services (for repetitive or continuous non-covered care, the notification must specify the frequency and or duration of the item or service).
 - iii. Anticipated Cost-estimate should be within \$100 of the actual costs and shall be documented as such.
 - iv. Description of the services to be rendered and that Medicaid coverage is not being accepted by the provider.
 - v. Payment plan/Signature of who is financially responsible/Date of signature.
 - vi. The reason why Medicaid will not pay for the service-an example might be "Medicaid does not pay for experimental or research services".
 - vii. Signature, date and title of the person that explained the Medicaid ABN to the Medicaid beneficiary/responsible party.

In any case, when a Medicaid beneficiary/responsible party agrees to an ABN the services must also not be billed to MDHHS.