



Billing a Client

WAC 182-502-0160

Background

Washington Administrative Code (WAC) 182-502-0160, Billing a Client, allows providers, in limited circumstances, to bill fee-for-service or managed care clients for covered healthcare services. It also allows fee-for-service or managed care clients the option to self-pay for covered healthcare services.

Note: The full text of WAC 182-502-0160 can be found on the [Apple Health \(Medicaid\) manual WAC index](#) page.

Background

- Providers need to understand when they can and cannot bill a client for healthcare services.
- It is important to know when to use form 13-879 Agreement to Pay for Healthcare Services.
- Also, when the form 13-879 is not required.
- These rules apply to providers who have completed a Core Provider Agreement (CPA) with the agency or are contracted with an agency-contracted Managed Care Organization (MCO).

Why is this important?

Following these rules may protect you from:

- Termination of CPA or MCO contracts
- Being excluded from participation in federal contracting, including Medicare
- Audit
- Fraud charges and prosecution

Billing a Client

Healthcare Service Categories

The groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's **Benefit Service Package (BSP)**.

Excluded Services

A set of services that we do not include in the client's BSP. There is no Exception To Rule (ETR) process available for these services (e.g. Family Planning Only).

Covered service

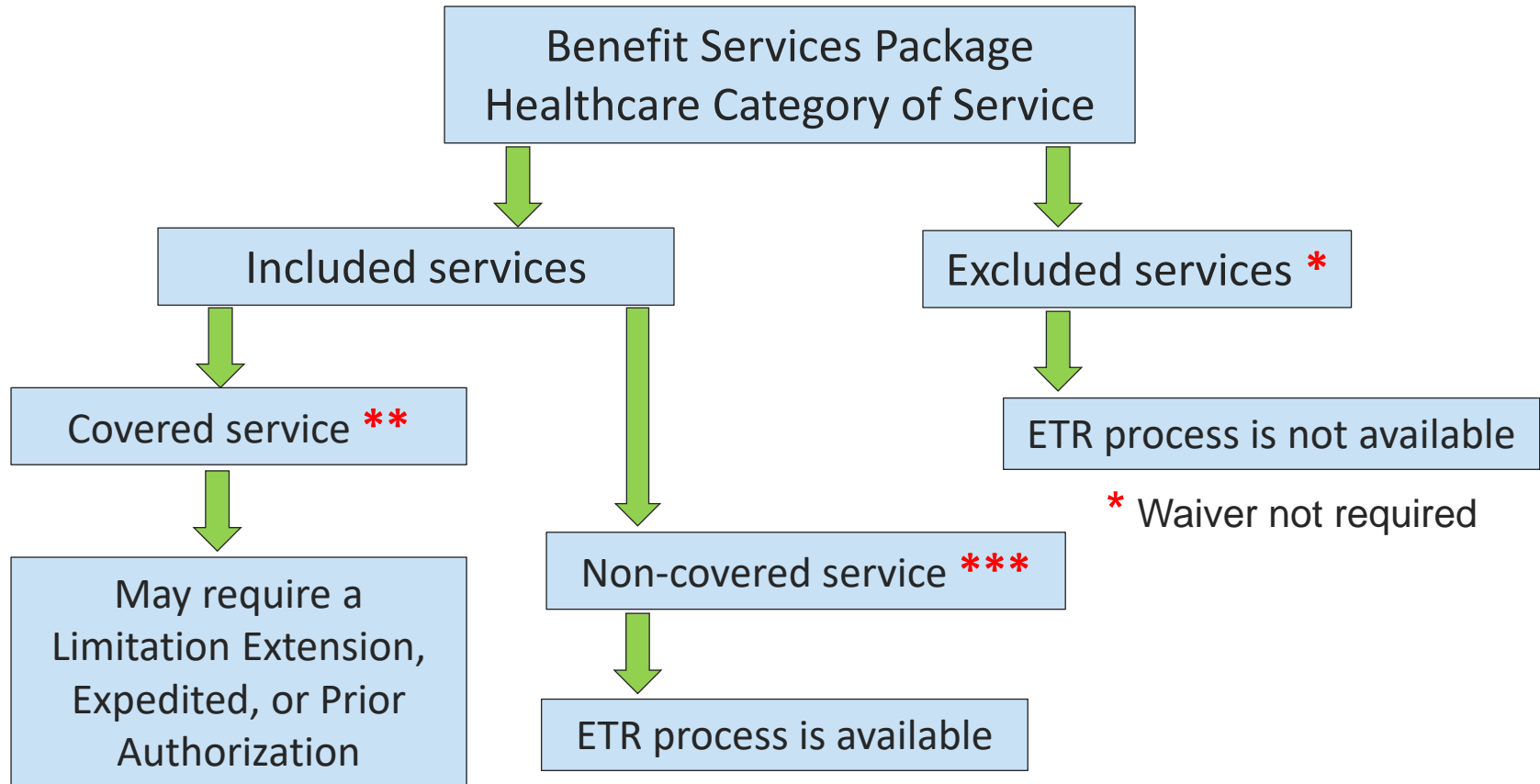
A healthcare service contained within a "service category" that is included in a medical assistance BSP as described in WAC 182-501-0060.

Non-covered service

A specific healthcare service (e.g., crowns for 21 and older) contained within a service category that is included in a medical assistance BSP, for which the Agency does not pay without an approved exception to rule (ETR) (see WAC 182-501-0160). **A non-covered service is not an excluded service** (see WAC 182-501-0060). Non-covered services are identified in WAC 182-501-0070 and in specific health-care program rules.

Billing a Client

- Included services vs. excluded



** Waiver MAY be required

*** Waiver required

* Waiver not required



Agreement to Pay for Healthcare Services
WAC 182-502-0160 ("Billing a Client")

Form 13-879

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

Client - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.

Provider - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

| | |
|-------------------------|--------------------|
| CLIENT'S PRINTED NAME | CLIENT'S ID NUMBER |
| PROVIDER'S PRINTED NAME | PROVIDER NUMBER |

Directions:

- Both the provider and the client must fully complete this form **before** an HCA client receives any service for which this Agreement is required.
- You must complete this form no more than 90 calendar days before the date of the service. If the service is not provided within 90 calendar days, the provider and client must complete and sign a new form.
- The provider and the client must complete this form **only after** they exhaust all applicable HCA or HCA-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 182-501-0160 or the administrative hearing process, if the client chooses to pursue these processes.
- Limited English proficient (LEP) clients must be able to understand this form in their primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. Both the client and the provider must sign a translated form.

Fully complete the table on back of this form. If needed, attach another sheet for additional services. The client, provider, and interpreter (if applicable) must sign and date each additional page.

Important Note from HCA:

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 182-502-0160 or does not satisfy HCA conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 182-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client's medical record for 6 years from the date this agreement is signed. Give a copy of this completed, signed agreement to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at <http://hrsa.dshs.wa.gov/mpforms.shtml>.

| SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE | CPT/CDT/ HCPC CODE (BILLING CODE) | AMOUNT TO BE PAID BY CLIENT | REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE) | COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT | DATE(S) ETR/NFJ REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE | |
|---|-----------------------------------|-----------------------------|--|---|---|--------------------------------|
| | | | | | ETR REQUESTED OR WAIVED | ETR DENIAL (ATTACH HCA NOTICE) |
| | | | <input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional | | ETR REQUESTED OR WAIVED | ETR DENIAL (ATTACH HCA NOTICE) |
| | | | <input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional | | PA REQUEST | PA DENIAL (ATTACH HCA NOTICE) |
| | | | <input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional | | ETR REQUESTED OR WAIVED | ETR DENIAL (ATTACH HCA NOTICE) |
| | | | <input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional | | PA REQUEST | PA DENIAL (ATTACH HCA NOTICE) |
| <ul style="list-style-type: none"> I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not. I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; 2) submit a Non-Formulary Justification (NFJ) with the help of my prescriber for a non-formulary medication; or 3) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service. I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above. I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC. <i>I agree to pay the provider directly for the specific service(s) listed above.</i> I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form. I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care. | | | | | | |
| I AFFIRM: I understand and agree with this form's content, including the bullet points above. | | | CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE | | DATE | |
| I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160. | | | PROVIDER OF SERVICE(S) SIGNATURE | | DATE | |
| I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above. | | | INTERPRETER'S PRINTED NAME AND SIGNATURE | | DATE | |

How to find the form

- The form is available in both PDF and Word formats.
- There are several languages available.
- Click on the [Billers and Providers webpage](#)
- Then click on the [Forms & publications link](#).
- On the search field enter form number 13-879 and in the Document Type dropdown, choose “Form” then click the Search button.

Billers and providers

[Forms & publications](#)

Forms & publications

Notice: If you are looking for Apple Health (Medicaid) client forms and publications, please [visit our Free or low-cost forms library](#).

Search Topic Document Type Sort by

Q 13-879 - Any - Form Name (A-Z)

Search

The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the agency.)

Printed or copied records requested by the client. Department of Health has established a policy noted at WAC 246-08-400.

**WHEN CAN A PROVIDER BILL A CLIENT WITHOUT
FORM 13-879**

The client represented as private pay and not receiving medical assistance when they were already eligible for and receiving benefits under a Washington Apple Health program.

The client refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill a third party insurance carrier for a service.

The client chose to receive services from a provider who is not contracted with Washington Apple Health.

The service is covered by the agency with prior authorization, all the requirements for obtaining authorization are completed and was denied, the client completes the administrative hearings process or chooses to forego it or any part of it, and the service remains denied by the agency as not medically necessary.

The service is covered by the agency and does not require authorization, but the service is a specific type of treatment, supply, or equipment based on the client's personal preference that the agency does not pay for. The client completes the administrative hearings process or chooses to forego it or any part of it.

**WHEN CAN A PROVIDER BILL A CLIENT WITH
FORM 13-879?**

If the service is not covered, the provider must inform the client of his or her right to have the provider request an ETR, and the client chooses not to have the provider request an ETR .

The service is not covered by the agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.

Services for which the provider did not correctly bill the agency.

If the agency returns or denies a claim for correction and resubmission, the client cannot be billed.

WHEN CAN A PROVIDER NOT BILL A CLIENT?

Services for which the agency denied the authorization because the process was placed on hold pending receipt of requested information but the requested information was not received by the agency. (WAC 182-501-0165(7)(c)(i)). This includes rejected authorizations, when the authorization request is returned due to missing required information.

The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (e.g., precious metal crown vs. stainless steel).

Providers are not allowed to:

- “Balance bill” a client
- Bill a client for missed, cancelled, or late appointments
- Bill a client for a “rescheduling fee”

"Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care.

WHEN CAN A PROVIDER **NOT** BILL A CLIENT?

Services for which the provider has not received payment from the agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment (example: billing using a diagnosis code which is not a primary diagnosis code per ICD10).

Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to:

- Medical/dental charts,
- Radiological or imaging films
- Laboratory or other diagnostic test results
- Postage or shipping charges related to the transfer

Online Resources

- Programs and Services information:
 - [Program billing guides and fee schedules](#)
 - [Hospital rates](#)
- Learn ProviderOne [webpage](#)
- HCA Forms [webpage](#):
- Washington Administrative Code [webpage](#) – Administration of Medical Programs

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