

Billing a Medicaid Client Frequently Asked Questions (FAQs)

- Q:** What if the client receives services not stating they are signing up for benefits at the time of service, then comes back a month or two down the road and states that Medicaid will pay for it. Are we obligated to bill and accept the ProviderOne Services card, or can we refuse it and have the patient pay?
- A:** Yes, you are obligated to bill and accept HCA payment upon notice of retroactive eligibility. You have a year from the date of service to bill us.
- Q:** Can we bill family planning only clients also?
- A:** If you are a family planning only provider and if it is an excluded service from their benefit service package. Or a noncovered service and the client waives the ETR option, you would need the form signed by the client.
- Q:** For a patient with a spenddown, do we bill ProviderOne first even if we know they still have a spenddown amount to satisfy?
- A:** Yes
- Q:** How long are we obligated to wait to bill the client when they state at the appointment they are signing up for benefits before holding the patient responsible for the fees?
- A:** You don't have to wait to bill the client, but if the client receives eligibility you would need to reimburse the patient and then bill the agency.
- Q:** Does bathroom equipment qualify as excluded services or noncovered?
- A:** Some bathroom equipment may be covered with prior authorization. Please refer to the Medical Equipment and Supplies billing guides for more information.
- Q:** What about billing a code that is allowed by some providers but not others? The code I am having trouble with is 90807 which is a mental health code. They won't allow mental health nurse practitioners to bill it but I am assuming that other mental health providers can. Can I bill the patient for it if HCA won't cover it for my type of provider?
- A:** No, you cannot bill a client for a service we do not allow you to bill us for. You should only be billing the codes that are allowed for the mental health ARNP per the billing guidelines. Please review the Mental Health billing guide.
- Q:** Can we bill clients for required forms that need to be filled out as a clerical charge?
- A:** No. If the client requests printed or copied records, the Department of Health has established a policy for this noted at WAC 246-08-400.
- Q:** What happens when the client gets retroactive coverage after the services have been rendered?
- A:** You would need to refund the patient after eligibility is verified and bill Medicaid.

- Q:** Do you need a 13-879 for a crown that is not a covered benefit?
- A:** Yes. Crowns for adults are not covered per WAC 182-535-1100(2)(c)(v) If the patient presented with pain, infection or trauma and the client chooses the crown treatment option instead of a covered service, you need the form signed.
- Q:** If a patient claims that they are a self paid patient and we bill them, then they come back with the ProviderOne Services card. Do we have to bill Medicaid?
- A:** Yes, after you verify eligibility, you would need to refund the patient and bill Medicaid.
- Q:** If a patient comes in and pays for a service prior to the service but we do not have the Medicaid form 13-879 filled out (example circumcision) do we need to refund the patient?
- A:** We do not require repayment under these circumstances, but the provider needs to know this is not a practice they want to repeat. If they were audited and there was a pattern of this, it could be a finding and result in their termination for not following our policies and rules.
- Q:** If a patient is APPROVED for orthodontic treatment by the agency, and then loses coverage can the parent be billed and made to sign a payment contract?
- A:** You can't "make" a client sign a payment contract. If this situation occurs, and the client is not willing to sign a payment contract, you will need to discontinue treatment.
- Q:** Can a client be billed for a second set of duplicate x-rays if the first set of duplicates is lost by the client, postal service, or another clinic?
- A:** No
- Q:** For a high deductible 3rd party plan, can the deductible be billed to Medicaid for reimbursement, or can we bill the client if the department does not cover it?
- A:** You would bill the agency if it were a covered service. If the third party paid more than the Medicaid allowable you would not be able to balance bill the client.
- Q:** Can Washington Apple Health (Medicaid) clients be billed for mailing fees and missed appointment fees?
- A:** No
- Q:** We are an optometrist. If a child receives glasses through Apple Health and then wants to pay for a 2nd pair of glasses, do we need to have them sign a 13-879?
- A:** This would be a limitation extension since we allow one pair every 12 months. This additional pair would be considered through the prior authorization process. However, if the client wants glasses that are not what we allow under our program, they can sign the waiver and purchase the item of their choice.
- Q:** If a patient has CNP coverage but are admitted for detox, can we bill the patient without a form 13-879?
- A:** The CNP coverage includes coverage for the detox program. The agency should be billed according to the billing instructions for Inpatient services and the Physician Related Services.
- Q:** Adult yearly exams are an excluded service, so if a patient wanted to be seen we would be able to bill the patient for a yearly exam and a PAP?
- A:** Please follow the billing guidelines. A yearly exam for adults is not covered but a PAP is a covered service under the OB/GYN in the reproductive services section of the physician related billing instructions.

- Q:** Does the Form have to be completed 90 days before the services are performed?
- A:** It must be completed no more than 90 days prior to the date of service. It cannot be done after the service has been rendered.
- Q:** When primary insurance terms or has a temporary lapse, and the client does not inform HCA, claims deny for other payer. Can the client be billed?
- A:** No. You need to verify eligibility. You can bill ProviderOne with a copy of the denial EOB from the insurance company.
- Q:** What if you cannot locate any benefit information, say the patient just signed up and has not yet been added to ProviderOne. Can we bill the patient?
- A:** You can bill the client but must refund and bill ProviderOne if the client receives coverage.
- Q:** Once the physical therapy units have been exhausted, how do we proceed?
- A:** If you determine the client still requires therapy you may fill out the limitation extension/authorization form to request authorization for additional units. If Medicaid denies that additional care and the client wants to continue that care, the client may pay for the additional services after you and the client complete the form.
- Q:** Can a client with Apple Health as secondary be billed for the primary insurance deductible?
- A:** No. Bill the agency for the service. If the insurance payment is more than the Medicaid allowed amount and we pay no more, you cannot balance bill the client.
- Q:** Can you bill a client for remainder of a bill if they suddenly become ineligible during the course of treatment you have been authorized for?
- A:** You should be able to bill the client for services on or after the date the eligibility for benefits ends. The loss of coverage should be discussed with the client as the client may choose not to complete the authorized treatment at their own expense. If the client is reinstated, you cannot bill the client.
- Q:** Can a range of typical office call CPT codes (such as 99212 - 99215) be used as the CPT billing code on form 13-879 when the patient seeks medical care for a noncovered diagnosis?
- A:** Yes
- Q:** What is the definition of noncovered versus excluded?
- A:** Excluded services are a set of healthcare services that we do not include in the client's benefit package. These are services that are not funded or not available because of federal or state law. There is no Exception to Rule (ETR) process available for these services. A noncovered service - is a specific healthcare service contained within a service category that is included in a medical assistance benefits package, for which the agency requires an approved Exception to Rule (ETR) (see WAC 182-501-0070).
- Q:** On QMB patients do they need a waiver signed for eye exams since it is noncovered by Medicare?
- A:** Medicaid has its own policy for covering eye exams. If it is an exam that Medicare deems noncovered, the claim could be billed to Medicaid to see if the client is on a QMB program that covers routine eye exams. If the client is QMB only, we will pay nothing because Medicare didn't pay anything. You will not need a waiver form if Medicare allows you to bill the client for this service. If the client is QMB dual coverage, then our coverage policy on eye exams would be applied for claims adjudication.

- Q:** Can you please clarify that RCT for an adult patient needs form 13-879?
- A:** If RCT needs to be completed for a permanent posterior tooth, form 13-879 is required. The agency pays for root canal treatments for adults when the service is completed on a primary tooth or permanent anterior tooth per WAC 182-535-1086 (3) and (4)(a).
- Q:** Circumcision is a noncovered benefit by Medicaid so this would not apply in this instance, correct?
- A:** Circumcisions are a covered service for medical issues. Because it is considered noncovered normally you would need to follow the exception to rule policy if the client wanted to see if we would pay for it. The client could choose to waive the ETR and sign the form to pay for the service. Please note: It seems highly unlikely we would ever pay for a circumcision under an ETR.
- Q:** Where can you find a more detailed description on the benefit packages?
- A:** The [ProviderOne Billing and Resource Guide](#) will explain how to determine if the services are covered and what the benefit package descriptions are. Also, you can refer to the program specific [fee schedules](#).
- Q:** Can you bill the remainder of orthodontic treatment to the patient if they lose coverage during the course of orthodontic treatment?
- A:** You should be able to bill the client for services on or after the date the eligibility for benefits ends. The loss of coverage should be discussed with the client as the client may choose not to complete the authorized treatment at their own expense. Be careful though, as the client may be reinstated.
- Q:** Can a patient choose to waive the prior authorization process and sign form 13-879 and pay for the service? Assuming the service could be covered under PA.
- A:** You would need to follow the PA process. A client cannot waive the prior authorization requirement for a covered service. It is the provider's responsibility to follow the agency or managed care organization's PA process, ensure translation or interpretation is provided to limited english proficiency clients who agree to be billed, and retain all documentation which demonstrates compliance.
- Q:** Is authorization required when billing for the primary's deductible portion? Is there specific billing codes used for a deductible portion?
- A:** We currently have a recorded webinar and PowerPoint on how to bill DSHS secondary to a commercial insurance. It can be located at the Health Care Authority [Learn ProviderOne webpage](#).
- Q:** We are contracted with some of the managed care plans. If a managed care patient that is assigned to Molina or Regence BlueShield seeks non emergent care at our clinic, can we bill the patient WITHOUT form 13-879?
- A:** The client should be referred to a provider that is contracted with their health plan and you should document if you choose to provide services for the client. Form 13-879 doesn't need to be signed.
- Q:** Would we be correct in assuming that when a routine eye exam is denied as a maxed benefit and no waiver was signed, we can bill the patient?
- A:** There is a limit on routine frequency so the provider would need to have checked and told the

client it was used and then if the client still wanted it and no diagnosis was made, they could bill the client without the waiver but they should have the client sign the office's financial responsibility form.

Q: From what I can get from your website and webinar excluded services are services that are no longer covered, such as glasses and contacts for adult?

A: Not just "no longer covered," they are no longer available under any circumstances.

Q: Do noncovered services require a waiver?

A: Correct - noncovered services require a waiver but an excluded service does not.

Q: Is there somewhere that explains the difference between excluded services versus noncovered services?

A: Excluded services are those optional services under CFR for which we have no funding and cannot provide to clients (i.e. vision aids for adults). The new WAC 182-501-0060 may help you as will our new definitions WAC.