

Question and Answers on
Billing Co-payments
August 2009

1. If a patient has private insurance as primary, and has Medicaid as secondary:

- a. Is the patient responsible for the private insurance co-payment?

Response: If a provider accepts the patient as covered under HFS' medical programs the provider may not charge the patient for co-payments, participation fees, deductibles, or any other form of patient cost-sharing, except as specifically allowed under the patient's coverage with HFS. In no other instance may any form of patient cost sharing be charged to eligible patients for any service covered by HFS.

- b. Is the patient responsible for the private insurance deductible?

Response:
Please refer to the response to Question 1.a. above.

- c. Can the provider bill HFS for the private insurance co-payment or deductible?

Response:
Providers cannot bill HFS for the co-payment. When private insurance does not pay on a claim because the patient's deductible has not been met, the provider may bill HFS with TPL status code 10 – deductible not met. HFS' reimbursement will be based on its fee schedule.

- d. Should the provider collect the HFS co-payment?

Response:
Yes

- e. Can a provider accept a patient as "private insurance only" and then collect the private insurance co-payment?

Response:
Yes, if the provider accepts the patient with their private insurance only, they can collect the private insurance co-payment from the patient. Please refer to the response to 1.a. above: "If a provider accepts a patient as covered under HFS Medical programs . . ."

- f. What document can providers show patients to explain this?

Response:
There is no specific document explaining cost-sharing responsibilities when the patient has primary insurance through another payer source. However, they are probably told that they will not owe anything above the Medicaid co-payments, and this has likely been incorrectly interpreted to mean that HFS will pay the provider for those charges.

- g. What are clients instructed to do about this by DHS? (Patients have reported to us that they are instructed that Medicaid, as secondary, will pay for the co-payments and deductibles for the private insurance.)

Response:
DHS caseworkers are instructed to provide brochure HFS 2875 – Medical Assistance and Third Party Liability to patients with primary insurance. This brochure is available on the HFS Web site at: www.hfs.illinois.gov/medicalbrochures

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All patients enrolled in any of the All Kids programs receive a notice informing them of their cost sharing responsibility. The Department is currently working on consolidating cost-sharing information for all of its programs into one reference document. Until this is completed, there are several sources for this information. Providers may refer to General Appendix 12, 13 and 14 in the Chapter 100 Handbook for Providers, available on the HFS Web site at: <http://www.hfs.illinois.gov/handbooks/chapter100.html>

In addition, cost-sharing information is also located on the following program pages:

- All Kids Premium Level 1 through 8: <http://www.allkidscovered.com/pocket.html>
- FamilyCare: <http://www.familycareillinois.com/cost.html>
- Veterans Care: <http://www.illinoisveteranscare.com/about.html>

2. What is the correct procedure for billing when the patient denies having Medicaid, pays cash for a visit, but later the client is found to have Medicaid? Does the provider need to refund the money? This typically happens in two scenarios: One; the patient has applied for Medicaid, but has not been accepted yet, but requires care (e.g., newborn visit), and Two; sometimes patients deliberately pay cash to a provider to get “in” to the practice and then reveal that they have Medicaid hoping that the provider will then keep them.

Response:

The provider has no obligation to refund payment for a service that was provided without the provider’s knowledge of the patient’s Medicaid coverage as long as the provider does not bill Medicaid. However, once the patient’s Medicaid eligibility is known and the provider chooses to bill the Department for the services rendered, the portion of any payment that exceeds the Medicaid co-payment for the service must be returned to the patient. A provider has complete discretion regarding the ‘payer’ mix of their patient population, and they may make a patient-by-patient determination as to whether or not they accept the patient as Medicaid.

3. Under what circumstances can a provider charge cash?
- a. For covered services? If the provider is not the IHC PCP?

Response:

All providers may charge a patient they have accepted as covered by Medicaid for non-covered services. And, although it is not likely, if a non-IHC PCP provider has a written office policy that allows for a service-by-service determination as to whether or not they accept the patient’s insurance coverage, that policy may be applied to HFS patients for covered services. In all cases, the provider must inform the patient before services are rendered that they will be responsible for payment. The patient then has the choice to receive the services, or to find another provider who will accept their Medicaid coverage.

- b. What if the provider is the IHC PCP and the patient is enrolled with the IHC PCP for their medical home?

Response:

As an IHC PCP the provider has agreed to accept the patient as Medicaid, and is receiving a PMPM from HFS for providing care to the patient, and therefore, cannot charge the patient for any service covered by HFS.

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- c. If the provider is an IHC PCP, but the patient is not enrolled with the IHC PCP for their medical home, can the IHC PCP charge cash if the patient is not on their panel, and is seeking services without a referral?

Response:

Yes, if the provider is not the client's IHC PCP and has a written office policy that allows for a service-by-service determination as to whether or not they accept the patient's insurance coverage, that policy may be applied to HFS patients for covered services. In all cases, the provider must inform the patient, before services are rendered, that they will be responsible for payment. The patient then has the choice to receive the services, go to their IHC PCP for services, or to find another provider who will accept their Medicaid coverage.

- d. For missing appointments?

Response:

All providers who have a written office policy to charge all patients for missed appointments may also charge patients covered under HFS' medical programs for missed appointments.

- e. What if the patient offers to pay cash?

Response:

Please refer to response to Questions 3.a. and 3.b. above. However, if the provider accepts cash above the Medicaid co-payment, the provider may not bill Medicaid for the service.

- f. Can providers charge additional cash to patients for additional services such as an urgent-care appointment?

Response:

No. If the provider bills HFS for a service, they must accept the Department's reimbursement as payment in full. In addition, providers may not make arrangements to furnish more costly services or items than those covered by the Department on condition that patients supplement payments made by the Department.

- g. Does being a participating provider with HFS preclude a provider from ever accepting cash?

Response:

No. Please refer to responses above.

- h. Can a participating provider make a decision to accept a patient one-day as Medicaid, and not Medicaid the next day?

Response:

Yes, if the provider is not the client's IHC PCP, and has a written office policy that allows for a service-by-service determination as to whether or not they accept the patient's insurance coverage, that policy may be applied to HFS patients for covered services. In all cases, the provider must inform the patient, before services are rendered, that they will be responsible for payment. The patient then has the choice to receive the services, go to their IHC PCP for services, or to find another provider who will accept their Medicaid coverage.

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- i. Once a participating provider accepts a patient as Medicaid, is that patient always accepted as Medicaid?

Response:

No. If the provider is not the client's IHC PCP, and has a written office policy that allows for a service-by-service determination as to whether or not they accept the patient's insurance coverage, that policy may be applied to HFS patients for covered services. In all cases, the provider must inform the patient, before services are rendered, that they will be responsible for payment. The patient then has the choice to receive the services, go to their IHC PCP for services, or to find another provider who will accept their Medicaid coverage.

- 4) If a provider does charge cash, what release or steps are necessary? Does the patient have to agree in writing?

Response:

Providers should apply the same standing office policy they use to inform any patient of their responsibility to pay for a service. The Department does, however, recommend that the notification be in writing, dated and initialed, or signed by the patient and maintained in the patient's file.

- 5) Please clarify the rules about collecting the HFS co-payments. Some documents state that you cannot refuse care based on the patient's inability to pay the co-payment.

- a. Does this apply to **all HFS** clients?

Response:

No. Federal regulations stipulate that a provider **cannot deny services** to an individual covered under a Title XIX program (AllKids Assist, Medicaid, Moms and Babies and FamilyCare) or a Title XXI program (AllKids Share and All Kids Premium Level 1) due to the person's inability to pay a co-payment. This requirement does not apply to patients enrolled in AllKids Premium Levels 2 through 8, or Veterans Care. Providers may apply their standard office policies relating to the collection of co-payments to patients covered under these programs.

- b. Can a provider discharge a patient from the practice for repeated failure to pay the co-payment?

Response:

Federal regulations stipulate that a provider **cannot deny services** to an individual covered under a Title XIX or Title XXI program due to the person's inability to pay a co-payment. The provider may, however, apply their standard office policies relating to the termination or discharge of the physician/patient relationship.

- c. Can the doctor bill the patient for the co-payment later, if the patient cannot pay at the time of service?

Response:

Yes

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- 6) Please clarify the bundling/unbundling language. Several providers have questioned that if they unbundle the charges for HFS clients for vision and developmental screening, can they still charge the bundled WCC visit for insurance and cash-pay patients. The previous provider notice is unclear.

Response:

Providers should bill each payer according to each payer's policies.

HFS' policy is that subjective screenings are part of the well child visit and are **not** billed separately. The subjective screening results should be recorded in the child's medical record, and any referrals that result should also be recorded. However, the Department does require providers to individually bill for each objective screening they provide using an objective instrument that has been approved by HFS (i.e., an objective vision screening using an approved eye chart or instrument; an objective hearing screening using approved hearing screening equipment; an objective risk assessment using approved risk assessment tools, etc.) In addition to all findings and referrals resulting from the objective screenings being documented in the child's medical record, the objective-screening instrument used (e.g., individualized, completed objective developmental screening form) should also be documented in the medical record.

The specific codes, approved screening tools and periodicity schedules are identified in the Chapter HK-200, Handbook for Providers of Healthy Kids Services located on HFS Web site at: <http://www.hfs.illinois.gov/handbooks/chapter200.html>

It should be noted, that providers rendering preventive services to children are not required to bill a patient's primary insurance carrier prior to billing HFS. Charges for these services may be billed immediately to the Department. The Department will collect information regarding paid services and assume responsibility for the collection of the third party benefits. However, in making the decision to bill HFS, the provider should be cognizant of the possibility that the third party payor might reimburse the service at a higher rate than HFS, and once the Department makes payment, no additional billing to the patient or the third party payer is permitted.

- 7) Can a provider charge cash if HFS denies a claim?

Response:

No. As stated in response to 3.e. above, if the provider bills the Department for a service, they must accept the Department's reimbursement determination as payment in full.

- 8) Can a provider charge cash if HFS is late in paying claims, and then later refund the money when HFS pays?

Response:

No. However, interest may be available from HFS under the Prompt Payment Act. Information on requesting interest can be found on HFS' Web site at: <http://www.hfs.illinois.gov/billing/interest.html>

- 9) Since the co-payment is not listed on the card, what document or proof can providers show to patients that reflects the co-payment? (Especially since providers believe that they cannot refuse services, arguing about paying the co-payment at the front desk is a particularly nettlesome issue.)

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Response:

Providers may verify a patient's eligibility and co-payment responsibility through the MEDI IEC system. For additional information, and to register for MEDI, go to:

<http://www.myhfs.illinois.gov/>

Also refer to responses to Questions 1.e. and 1.f. above for links to cost-sharing information on HFS' Web site.

- 10) Can a provider charge an HFS patient for copies of their medical records, or to transfer a patient's medical records to another provider.

Response:

Yes, if the provider has a written office policy to charge all patients for these services, that policy may be applied to HFS patients.