

Question and Answers on Participant Liability and Co-payments

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

- a. Is the participant responsible for the private insurance co-payment?
Response: If a provider accepts the participant as covered under HFS' medical programs the provider may not charge the participant for co-payments, participation fees, deductibles, or any other form of participant cost-sharing, except as specifically allowed under the participant's coverage with HFS. In no other instance may any form of participant cost sharing be charged to eligible participants for any service covered by HFS.
- b. Is the participant 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 participant'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 participant as "private insurance only" and then collect the private insurance co-payment?
Response: Yes, if the provider accepts the participant with their private insurance only, they can collect the private insurance co-payment from the participant. Please refer to the response to 1.a. above: "If a provider accepts a participant as covered under HFS Medical programs . . ."

2. Under what circumstances is a participant liable for payment?

- a. For non-covered services?
Response: All providers may charge a participant they have accepted as covered by Medicaid for non-covered services. The provider must inform the participant before services are rendered that they will be responsible for payment. The participant then has the choice to receive the services or not.
- b. What if the provider is the IHC PCP and the participant is enrolled with the IHC PCP for their medical home?

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

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

Response: Yes, if the provider is not the participant'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 participant's insurance coverage, that policy may be applied to HFS participants for covered services. In all cases, the provider must inform the participant, before services are rendered, that they will be responsible for payment. The participant 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. As a reminder, direct access services do not require PCP referral. For a complete list of direct access services please refer to the IHC handbook at <http://www.illinoishealthconnect.com/provider/providerhandbook.aspx#blpPdf>

- d. Participant has Illinois Healthy Women coverage only. The service is not covered under IHW, and HFS denied the service with A43, Service not covered under IHW. Is the participant liable?

Response: Yes. Billing the participant or balance billing the participant is only prohibited if reimbursement for the service would have been available if the provider had timely and properly billed the Department. In this case no reimbursement was available.

- e. Can a provider charge a co-payment for Medicaid family planning services? Federal regulations stipulate that participants receiving family planning medical services and contraceptive methods (billed with a V25 series diagnosis code) cannot be charged a co-pay. This applies to all participants covered under the Department of Healthcare and Family Services (HFS)' medical programs.

- f. Provider bills for medical services on a DHS service package only (community mental health center services) participant, no regular Medicaid eligibility. HFS rejects the claim, H03, recipient not eligible for service. Is participant liable?

Response: Yes. See answer to 2. d.

- g. An anesthesiologist provides anesthesia for a surgery that turns out to be a non-covered service. The anesthesiologist has no opportunity to verify eligibility, nor does he have the opportunity to inform a participant before rendering services if the service will not be covered by Medicaid. Can the anesthesia provider bill the participant?

Response: Yes. See answer to 2. d.

- h. Participant is a 30-year-old female who has regular Illinois Medicaid. Physician orders a screening mammogram for the participant to be performed at an outpatient hospital. Independent radiologist performs interpretation of the mammogram, which is subsequently denied because the service is not covered for participants under age 35 years. The radiologist has no opportunity to verify eligibility, nor does he have the opportunity to inform the participant before rendering services that the services are not covered by Medicaid. Can the radiologist bill the participant?

Response: Yes. See answer to 2. d.

- i. Participant receives services on 071212 and the provider bills HFS. HFS rejects the claim, R03, Recipient Not Eligible on Date of Service. Provider then bills the participant, receives no payment, and eventually sends participant's account to a collection agency. In the meantime, the participant is approved for eligibility backdated to 070112. Is the participant liable?

Response: No, the participant is not liable. The provider billed HFS and by doing so, the provider has agreed to accept the patient as a Medicaid recipient. Because the provider accepted the patient as a Medicaid recipient, it cannot ask that individual for payment.

- j. Participant is in an MCO. Participant goes to a provider not enrolled with the MCO and therefore the services are not covered by the MCO. Is the participant liable?

Response: Participant is not liable. Provider should have verified eligibility on MEDI prior to rendering services. Provider's only option is to contact the MCO to see if anything can be arranged between the MCO and the provider.

- k. Participant is Medicare primary, Medicaid secondary, but is NOT QMB eligible. Participant has a Medicare replacement plan that is not a PFFS. Provider cannot bill HFS secondary; is the participant liable?

Response: Yes. Refer to [Medicaid Coverage of Medicare Beneficiaries \(Dual Eligibles\) At A Glance](#) Chart on page 3.

- l. Participant is Medicare primary but not QMB or DUAL (Medicare – all else). Provider renders a service covered by Medicare but not Medicaid, so Medicaid has no financial liability on the claim. However, Medicare automatically crosses the claim over to HFS. Provider cannot stop this crossover process. Is participant liable?

Response: Yes. See answer to 2. d.

m. Can a provider charge an HFS participant for missing appointments?

Response:

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

n. Can a provider charge an HFS participant for copies of their medical records?

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

o. Can a provider charge an HFS participant to transfer medical records to another provider?

Response: No, medical records are to be made available to other health care providers who are treating or serving the participant, without charge and in a timely manner, when authorized by the participant in writing.

p. Can a provider charge a co-payment for a resident of a Nursing Facility, Supported Living Facility or an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)?

Response: No. Refer to [Provider Notice](#) dated August 20, 2012.

3. If a provider does charge cash, what release or steps are necessary? Does the participant have to agree in writing?

Response: Providers should apply the same standing office policy they use to inform any participant 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 participant and maintained in the participant's file.

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

Response: Yes, if the provider is not the participant'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 participant's insurance coverage, that policy may be applied to HFS participants for covered services. In all cases, the provider must inform the participant, before services are rendered, that they will be responsible for payment. The participant 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.

5. Collecting HFS co-payments.

- a. Participant refuses to pay his co-pay. What can provider do in this case if anything?

Response: Federal regulations stipulate that a provider **cannot deny services** to an individual covered under a Title XIX program or a Title XXI program due to the person's inability to pay a co-payment. Providers may apply their standard office policies relating to the collection of co-payments to participants covered under these programs.

- b. Can a provider discharge a participant 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/participant relationship.

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

Response: Yes