WAC 182-502-0160 Billing a client. (1) The purpose of this section is to specify the limited circumstances in which:

(a) Fee-for-service or managed care clients can choose to self-pay for medical assistance services; and

(b) Providers (as defined in WAC 182-500-0085) have the authority to bill fee-for-service or managed care clients for medical assistance services furnished to those clients.

(2) The provider is responsible for:

(a) Verifying whether the client is eligible to receive medical assistance services on the date the services are provided;

(b) Verifying whether the client is enrolled with a medicaid agency-contracted managed care organization (MCO);

(c) Knowing the limitations of the services within the scope of the eligible client's medical program (see WAC 182-501-0050 (4)(a) and 182-501-0065);

(d) Informing the client of those limitations;

(e) Exhausting all applicable medicaid agency or agency-contracted MCO processes necessary to obtain authorization for requested service(s);

(f) Ensuring that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retaining all documentation which demonstrates compliance with this section.

(3) Unless otherwise specified in this section, providers must accept as payment in full the amount paid by the agency or agency-contracted MCO for medical assistance services furnished to clients. See 42 C.F.R. § 447.15.

(4) A provider must not bill a client, or anyone on the client's behalf, for any services until the provider has completed all requirements of this section, including the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled, and until the provider has then fully informed the client of his or her covered options. A provider must not bill a client for:

(a) Any services for which the provider failed to satisfy the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled.

(b) A covered service even if the provider has not received payment from the agency or the client's MCO.

(c) A covered service when the agency or its designee denies an authorization request for the service because the required information was not received from the provider or the prescriber under WAC 182-501-0165 (7)(c)(i).

(5) If the requirements of this section are satisfied, then a provider may bill a fee-for-service or a managed care client for a covered service, defined in WAC 182-501-0050(9), or a noncovered service, defined in WAC 182-501-0050(10) and 182-501-0070. The client and provider must sign and date the HCA form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished. Form 13-879, including translated versions, is available to download at http://hrsa.dshs.wa.gov/mpforms.shtml. The requirements for this subsection are as follows:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or agency-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as preoperative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or agency-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or its designee denies a request for a noncovered service and that the client may choose not to do so;

(viii) Specify that the client may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's or its designee denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(ix) Be completed only after the provider and the client have exhausted all applicable agency or agency-contracted MCO processes necessary to obtain authorization of the requested service, except that the client may choose not to request an ETR or an administrative hearing regarding agency or agency designee denials of authorization for requested service(s); and

(x) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the agency or the client's agency-contracted MCO and the ETR process as described in WAC 182-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the agency or the client's agency-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC 182-501-0160;

(iii) Covered by the agency or the client's agency-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the agency or its designee denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by the agency or the client's agency-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it;

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of

service. The agreement must be made available to the agency or its designee for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

(6) There are limited circumstances in which a provider may bill a client without executing form 13-879, Agreement to Pay for Healthcare Services, as specified in subsection (5) of this section. The following are those circumstances:

(a) The client, the client's legal guardian, or the client's legal representative:

(i) Was reimbursed for the service directly by a third party (see WAC 182-501-0200); or

(ii) Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.

(b) The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program. In this circumstance, the provider must:

(i) Keep documentation of the client's declaration of medical coverage. The client's declaration must be signed and dated by the client, the client's legal guardian, or the client's legal representative; and

(ii) Give a copy of the document to the client and maintain the original for six years from the date of service, for agency or the agency's designee review upon request.

(c) The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in chapters 182-513 and 182-515 WAC, emergency medical expense requirement, deductible, or copayment required by the agency or its designee). See subsection (7) of this section for billing a medically needy client for spenddown liability;

(d) The client is placed in the agency's or an agency-contracted MCO's patient review and coordination (PRC) program and obtains nonemergency services from a nonpharmacy provider that is not an assigned or appropriately referred provider as described in WAC 182-501-0135;

(e) The client is a dual-eligible client with medicare Part D coverage or similar creditable prescription drug coverage and the conditions of WAC 182-530-7700 (2)(a)(iii) are met;

(f) The service is within a service category excluded from the client's benefits package. See WAC 182-501-0060;

(g) The services were noncovered ambulance services (see WAC 182-546-0250(2));

(h) A fee-for-service client chooses to receive nonemergency services from a provider who is not contracted with the agency or its designee after being informed by the provider that he or she is not contracted with the agency or its designee and that the services offered will not be paid by the client's health care program; and

(i) An agency-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO, i.e., a nonparticipating provider.

(7) Under chapter 182-519 WAC, an individual who has applied for medical assistance is required to spend down excess income on health care expenses to become eligible for coverage under the medically needy program. An individual must incur health care expenses greater than or equal to the amount that he or she must spend down. The provider is

prohibited from billing the individual for any amount in excess of the spenddown liability assigned to the bill.

(8) There are situations in which a provider must refund the full amount of a payment previously received from or on behalf of an individual and then bill the agency for the covered service that had been furnished. In these situations, the individual becomes eligible for a covered service that had already been furnished. Providers must then accept as payment in full the amount paid by the agency or its designee or managed care organization for medical assistance services furnished to clients. These situations are as follows:

(a) The individual was not receiving medical assistance on the day the service was furnished. The individual applies for medical assistance later in the same month in which the service was provided and the agency or its designee makes the individual eligible for medical assistance from the first day of that month;

(b) The client receives a delayed certification for medical assistance as defined in WAC 182-500-0025; or

(c) The client receives a certification for medical assistance for a retroactive period according to 42 C.F.R. § 435.914(a) and defined in WAC 182-500-0095.

(9) Regardless of any written, signed agreement to pay, a provider may not bill, demand, collect, or accept payment or a deposit from a client, anyone on the client's behalf, or the agency or its designee for:

(a) Copying, printing, or otherwise transferring health care information, as the term health care information is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, canceled, or late appointments;

(c) Shipping and/or postage charges;

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

(e) The price differential between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 18-08-075, § 182-502-0160, filed 4/3/18, effective 5/4/18. Statutory Authority: RCW 41.05.021. WSR 13-15-044, § 182-502-0160, filed 7/11/13, effective 8/11/13. Statutory Authority: RCW 41.05.021 and section 1927 of the Social Security Act. WSR 12-18-062, § 182-502-0160, filed 8/31/12, effective 10/1/12. WSR 11-14-075, recodified as § 182-502-0160, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-502-0160, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.15. WSR 10-10-022, § 388-502-0160, filed 4/26/10, effective 5/27/10. Statutory Authority: RCW 74.08.090, 74.09.055, 2001 c 7, Part II. WSR 02-12-070, § 388-502-0160, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.08.090. WSR 01-21-023, § 388-502-0160, filed 10/8/01, effective 11/8/01; WSR 01-05-100, § 388-502-0160, filed 2/20/01, effective 3/23/01. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 00-14-069, § 388-502-0160, filed 7/5/00, effective 8/5/00.]