



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

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TO: All Providers

SUBJECT: Billing or Balance Billing Medicaid/NJ FamilyCare Beneficiaries for Covered Services

EFFECTIVE: Immediately

PURPOSE: To inform all providers of billing and/or balance billing restrictions

BACKGROUND: It has come to the attention of the Division that some providers are billing or balance billing Medicaid beneficiaries for services that are either unpaid or not fully reimbursed by the Division for various reasons.

ACTION: The following is a description of the New Jersey Medicaid/NJ FamilyCare policies that explains the limited conditions under which a provider may bill or balance bill a beneficiary for services rendered.

In general, the practice of balance billing a Medicaid beneficiary is prohibited. As a condition of Medicaid participation, a provider of service agrees to accept any third party payment and/or Medicaid payment as payment in full. The provider's redress is to the New Jersey Medicaid Program and not the beneficiary. Any dispute, disagreement or appeal of a payment amount is to be addressed to the Medicaid Program, its Fiscal Agent, or the contracted vendor responsible for administration of the Program.

The same principle holds true for Medicaid beneficiaries participating in the managed care program, New Jersey Care 2000+. Providers may not balance bill any beneficiary enrolled in a New Jersey Care 2000+ HMO the difference between the provider's HMO reimbursement (that is, capitation and/or fee-for-service payment) and their charge amount.

EXCEPTIONS: A provider may only bill or balance bill a Medicaid beneficiary under the following three circumstances:

1. The beneficiary waives the Medicaid/NJ FamilyCare benefits and chooses to pay the provider directly as a self-pay or private patient. This customarily happens if the provider is not participating in the Medicaid Program at the time the service is rendered.

NOTE: Under this circumstance, the provider should require the beneficiary to sign a statement before services are rendered waiving the Medicaid benefits for the particular service and agreeing to pay privately for the service(s). This may avoid any difficulty in the event of any dispute.

2. The beneficiary is requesting a service that is a non-covered Medicaid/NJ FamilyCare service. In this event, the provider may bill the beneficiary for the entire charge amount less any other third party insurance payment, if the beneficiary is clearly notified, before the service is rendered, that the service is not covered.

NOTE: Under this circumstance, it is recommended that the provider have the beneficiary sign a statement before services are rendered, agreeing to receive the services as a private/self pay patient.

3. Services that are determined to be not medically necessary by the Program prior to being rendered may be billed in their entirety (full charges) to the beneficiary, if the beneficiary is notified of this determination before the services are rendered.

NOTE: Under this circumstance, it is recommended that the provider have the beneficiary sign a statement before services are rendered, agreeing to pay the bill or the balance due after all other third party liability is satisfied.

No provider may balance bill a beneficiary enrolled in an HMO, regardless of the HMO payment amount. The provider must address reimbursement issues with the HMO. The beneficiary is not responsible for any part of such a bill. In the event the HMO is in liquidation, the provider's recourse is to contact the Chief Liquidator at the New Jersey Department of Banking and Insurance to determine creditor status.

If an HMO is no longer in operation in New Jersey, providers should contact the Department of Banking and Insurance for further information.

Should you have any questions in regard to this newsletter, please call Unisys, the Medicaid/NJ FamilyCare fiscal agent, at 1-800-776-6334 for further clarification.

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