



Published by the  
N.J. Dept. of Human Services,  
Div. of Medical Assistance & Health Services  
& the N.J. Dept. of Health

# Newsletter

Volume 23 No. 15

September 2013

**TO:** All Providers, Health Maintenance Organizations – For Action

**SUBJECT:** Limitations Regarding the Billing of Medicaid/NJ FamilyCare (NJFC) Beneficiaries

**EFFECTIVE:** Immediately

**PURPOSE:** The purpose of this Newsletter is to reiterate the policies of the New Jersey Division of Medical Assistance and Health Services and the New Jersey Department of Health regarding situations whereby a provider of a Medicaid/NJFC-covered service may bill a fee-for-service (FFS) or managed care beneficiary for services rendered.

**BACKGROUND:** The Newsletter Volume 11, No. 60, originally distributed in July 2001, notified providers regarding the State's policy regarding the billing or balance billing of Medicaid/NJFC beneficiaries. Balance billing occurs when a billing provider seeks to recover from a beneficiary all or part of the difference between a provider's charge for a rendered service and the payment amount received from Medicaid/NJFC, Medicare, and/or a third party payer. **Balance billing does not include any authorized cost-sharing responsibilities on the part of the beneficiary.**

**ACTION:**

The practice of balance billing Medicaid/NJFC beneficiaries, whether eligible for FFS benefits or enrolled in managed care, is prohibited under both federal and State law. These prohibitions apply to both Medicaid/NJFC-only beneficiaries, as well as those eligible for Medicare coverage or other insurance.

A provider enrolled in the Medicaid/NJFC FFS program or in managed care is required to accept **as payment in full** the reimbursement rate established by the FFS program or managed care plan.

All costs related to the delivery of health care benefits to a Medicaid/NJFC eligible beneficiary, other than authorized cost-sharing, are the responsibility of the FFS program, the managed care plan, Medicare (if applicable) and/or a third party payer (if applicable).

If a provider receives a Medicaid/NJFC FFS or managed care payment, the provider shall accept this payment as **payment in full** and shall not bill the beneficiary or anyone on the beneficiary's behalf for any additional charges.

## **MCO Referrals**

Services rendered by a provider who does not participate with a Medicaid/NJFC managed care plan as the result of any referral by a primary care provider (PCP) or network specialist shall be paid by the managed care plan. This includes referrals made under the Medicaid/NJFC beneficiary's Medicare or other insurance plan (such referrals must be made for services covered by that payer). Under no circumstances shall a Medicaid/NJFC beneficiary be billed a provider's charge(s) for services that resulted from an erroneous referral issued by a PCP or network specialist. In addition, if a service is rendered by a specialist in the same group practice as the specialist to whom a beneficiary has been referred, and that specialist does not participate in the Medicaid/NJFC program, the beneficiary shall not be responsible for any portion of the cost of care.

## **Emergency Treatment at a Hospital**

A Medicaid/NJFC beneficiary shall not be responsible for the cost of care, except for any authorized cost sharing, when services are provided in association with an emergency department visit or related inpatient stay at a Medicaid/NJFC-participating network hospital, whether or not the servicing provider(s) or the admitting physician participates in the network of the Medicaid/NJFC managed care plan.

A hospital or physician not participating in the network of a Medicaid/NJFC managed care plan that renders emergency services to a Medicaid/NJFC beneficiary enrolled in managed care shall accept as **payment in full** the payment amount (95% for hospitals, 100% for physicians) the hospital or physician would otherwise have received from the Medicaid/NJFC FFS program for the emergency services and any related hospitalization.

## **Qualified Medicare Beneficiaries (QMBs)**

Providers may not bill a QMB for either the balance of the Medicare rate or the provider's charges for Medicare Part A or Part B services. The QMB beneficiary is protected from liability for Medicare Part A or Part B charges, even when the amounts the provider gets from Medicare and Medicaid are less than the Medicare rate or less than the provider's customary charges, as specified in the Balanced Budget Act of 1997. Providers who bill a QMB for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. Providers may not accept QMB patients as "private pay" in order to bill the patient directly. Providers must accept Medicare assignment for all Medicaid patients, including QMBs.

## **Non-Medicaid/NJFC-Covered Benefits**

If a managed care plan provides a benefit not covered by Medicaid/NJFC, neither the State nor the Medicaid/NJFC beneficiary shall be responsible for any portion of the cost of the non-covered benefit.

## **When May a Provider Bill or Balance Bill a Medicaid/NJFC Beneficiary (who is not a QMB) for Services Rendered?**

If the criteria at letter A or all of the criteria at letters B through G apply, a Medicaid/NJFC beneficiary may be liable for some or all of the payment due:

- A. When the Medicaid/NJFC beneficiary has been paid for a service by a primary payer and the Medicaid/NJFC beneficiary fails to remit to the

provider of services that portion of the primary payer's payment which the provider is entitled to receive under law.

When all of the following apply:

- B.** Either: (1) the service is not a Medicaid/NJ FamilyCare covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in a program administered in whole or in part by the DMAHS either generally or for that service (Federal law precludes Medicare providers from balance-billing QMBs, and precludes Medicare providers from accepting QMBs as "private pay").
- C.** Either: (1) the Medicaid/NJ FamilyCare beneficiary is informed in writing before the service is rendered that one or more of the criteria listed in 'B' above exists and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; or (2) the Medicaid/NJ FamilyCare beneficiary seeks self-initiated care from a non-Medicaid/NJ FamilyCare-participating provider without referral or authorization and, prior to receiving the service, is fully informed by the provider of the requirement to seek care when it is available within the network and of the consequences of obtaining unauthorized out-of-network care for covered services.
- D.** The service is not an emergency or related service covered by the provisions of 42 U.S.C. § 1396u-2 (b)(2)(A)(i), 42 CFR 438.114, N.J.S.A. 30:4D-6i, N.J.S.A. 30:4J-4.1, or NJAC 10:74-9.1.
- E.** The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3i.
- F.** The protections afforded to Medicaid/NJ FamilyCare beneficiaries under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n), 42 U.S.C. § 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9 and/or 15.2(b)7ii do not apply (Federal law precludes Medicare providers from balance-billing QMBs, and precludes Medicare providers from accepting QMBs as "private pay").
- G.** The provider has received no program payments from either DMAHS or the Medicaid/NJ FamilyCare beneficiary's Medicaid/NJ FamilyCare MCO for the service.

See NJAC 10:74-8.7(a) for additional information regarding balance billing exceptions.

If there are any questions regarding this Newsletter, please contact Molina Medicaid Solutions Provider Services at 1-800-776-6334.

**RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE**