State of Maryland

MEDICAL CARE POLICY ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

Parris N. Glendening
Governor

Martin P. Wasserman, M.D., J.D.
Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
General Provider Transmittal #51
February 16, 1999

TO: All Providers

FROM: Susan J. Tucker, Acting Director
Medical Care Policy Administration

RE: Incorrect Billing of Recipients

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

The following transmittal refers to two billing issues of concern to the Department: balance billing and billing of recipients for covered services. Please review the following information and implement accordingly. [Note: Fraud Alert No. 1 from the Medical Care Finance and Compliance Administration is attached to this transmittal.]

Balance Billing

Recipients have reported certain providers are practicing balance billing. (Note: "Balance Billing" is the practice of billing for the difference between the amount charged by the provider and the amount paid by the payor.) Please note that Medicaid regulations require that a provider *"Accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services."* Any Medicaid provider participating in balance billing is in violation of his/her agreement with the State's Medicaid Program, and is thus subject to sanctions, including termination from the Program. A provider is responsible for educating staff personnel on this issue and supervising staff so that balance billing does not occur.

Billing of Recipients for Covered Services

Except for a few unusual circumstances authorized by Program regulations, a provider may not bill a Medicaid recipient for services provided. The mandatory HealthChoice Program, the voluntary HMO Program and the fee-for-service program are programs that provide levels of medical coverage underwritten by State and Federal funds. Eligible recipients receive medical

care according to the guidelines and limits of the programs to which they are assigned. To obtain accurate daily information, all providers must access the Eligibility Verification System (EVS) through their normal phone lines. EVS, which is accessed using a recipient's Medical Assistance Number or Social Security Number, reflects the current status of the recipient with Medical Assistance and provides the caller with necessary coverage information for billing and contract purposes. Any provider who is unfamiliar with EVS may receive a brochure on the system by contacting the Provider Master File at 410-767-5340.

If, according to EVS, a recipient is in a HMO or MCO, the provider should check with the HMO or MCO to determine if they are the assigned primary care provider (as this information is not on EVS). Specialists should check with the MCO to determine if referrals or authorizations are required before serving the recipient.

It is imperative that all providers obtain necessary preauthorizations and bill the appropriate entity when a recipient is covered by Medical Assistance. Do not bill the recipient. The only exceptions to this statement are situations where a recipient knowingly chooses to be served by a provider, without the necessary preauthorization or referral, or requests an uncovered service. In such situations the provider must obtain a form, signed by the recipient or legal guardian, clearly stating that the recipient is on Medical Assistance and is knowingly choosing to be seen, even though EVS and/or their assigned MCO tells them it is an unauthorized procedure/ visit and not covered under the Medical Assistance Program.

Seeking payment from recipients to avoid working through the assigned network or doctor violates State regulations. Medical care providers must assist recipients in utilizing their Medicaid coverage appropriately.

Summary

The above discussion reflects two of the most serious billing issues that have come to the Program's attention. We require cooperation from all MCOs and providers. If there are any questions concerning this transmittal, they can be directed to Ms. Brenda Falcone, Acting Chief, Division of Managed Care at 410-767-1482.

Attachment

State of Maryland
Department of Health and Mental Hygiene
Parris N. Glendening, Governor - Martin P. Wasserman, M.D., J.D., Secretary

MEDICAL CARE FINANCE AND COMPLIANCE ADMINISTRATION, Lawrence P. Triplett, Director

March 25, 1998

TO: Managed Care Organizations

FROM: Lawrence P. Triplett, Director
Medical Care Finance and Compliance Administration

SUBJECT: Fraud Alert No. 1

It has come to the attention of the Department that some subcontractors may be collecting or attempting to collect co-pays from HealthChoice enrollees for services that are fully covered under the HealthChoice contract.

Maryland HealthChoice regulations state that Managed Care Organizations (MCOs) must provide all services which are covered by the HealthChoice contract in return for the capitation which is paid to the MCOs. Neither the MCOs nor their subcontractors may solicit or accept co-pays or additional charges for services that are covered by the HealthChoice contract. See COMAR 10.09.36.03QA(6), 10.09.65.19A(3), and 10.09.65.17(A)(4)(g).

Requesting or accepting any form of additional reimbursement for covered services is fraud and may be grounds for criminal prosecution, civil proceedings, and administrative sanctions against the MCO and/or its subcontractor.

Fraudulent conduct of this or any other type should be reported to the Maryland Medicaid Fraud Control Unit, 410-576-6521.

Please distribute this Fraud Alert to your subcontractors.