# BILLING

## May a physician charge interest or a late fee on an unpaid balance?

Generally, yes. Regularly extending credit to patients, especially credit payable in four or more installments, however, could require a physician to comply with strict state and federal rules governing retail installment credit.[1]

If a physician intends to charge interest or assess a late fee on unpaid balances, the physician should notify patients in writing, through a disclosure statement on bills and a sign conspicuously posted in the office, of the amount of, and the terms and conditions under which, interest or a late fee will be charged.[2]

## What is the maximum rate of interest which a physician may charge on an unpaid balance?

Generally, the maximum rate of interest that may be charged in Washington is 12% per annum.[3] The actual maximum rate varies monthly. The current rate may be obtained by calling the State Treasurer's Office in Olympia (360-902-0200), or visiting the Washington State Treasurer's website, http://www.tre.wa.gov/investments/historicalUsuryRates.shtml.

## May a physician "balance bill" a patient for amounts not paid by third-party payors?

It depends upon who the third party payor is and what payment rules the third party payor has established.

- ***Managed Care Organizations***

If the patient is a managed care subscriber, the physician's contract with the managed care organization (MCO) may require the physician to accept the MCO's payment as payment in full and may preclude the physician from billing the patient for any additional amounts other than co-insurance and deductibles. The extent to which a physician may bill a patient for services will generally be governed by the terms of the managed care contract.

Under state law, except with respect to emergency care by a non-participating provider, out-of-area services,[4] and certain other exceptional situations approved in advance by the insurance commissioner, contracts between a health maintenance organization and its participating providers must set forth that, in the event the health maintenance organization fails to pay for health services as set forth in the agreement, the enrolled participant shall not be liable to the provider for any sums owed by the health maintenance organization.[5]

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[1] RCW 63.14.010(12); 15 U.S.C. § 1602(g)(1).
[2] RCW 63.14.120(1); 15 U.S.C. §§ 1602(k), .
[3] RCW 19.52.020(1).
[4] RCW 48.43.093.
[5] RCW 48.46.243.

- ***Medicare***

If the patient is a Medicare beneficiary and the physician is a Medicare participating provider or has agreed to accept assignment, the physician must accept Medicare's payment as payment in full and may not charge the patient for any additional amounts other than the Medicare Part B deductible and co-insurance.[6] If a patient is eligible for both Medicare and Medicaid, charges for services covered under Medicare must be submitted first. Medicaid may make additional payment after Medicare reimburses the physician.[7]

If the patient is a Medicare beneficiary and the physician is not a Medicare participating provider and has not agreed to accept assignment, Medicare will pay the patient directly. The patient is then responsible for paying the physician. The nonparticipating physician is not required to accept Medicare's payment amount as payment in full, but cannot charge the patient more than the Medicare "limiting charge" which, for nonparticipating physicians, is 15% above the Medicare-approved charge.[8]

There are two other limitations on what a nonparticipating physician can charge a patient on nonassigned Medicare claims:

- A physician generally cannot charge a Medicare patient anything for services which Medicare finds were not reasonable and necessary.[9]

- A physician cannot charge a Medicare beneficiary more than the Medicare-approved charge for elective surgery costing more than $500 unless the patient is informed in writing of the difference between the physician's charge and the approved charge.[10]

- ***Medicaid***

If the patient is a Medicaid patient, the fees and rates the Department of Social and Health Services (DSHS) establishes are the maximum allowable payments to physicians for covered medical care and services.[11] Generally, a physician may not bill a Medicaid patient for a service included in the patient's Medicaid scope of benefits and must refund any payment received from a Medicaid patient for which DSHS is responsible for payment.[12] A Medicaid patient is not liable for services included in the patient's scope of benefits even if DSHS denies payment if the physician failed to properly bill DSHS for services DSHS was responsible to pay or failed to satisfy DSHS' conditions for payment.[13]

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[6] 42 U.S.C. § 1395u(b)(18(B)
[7] 42 U.S.C. § 1396a(n).
[8] 42 U.S.C. §§ 1395w-4(g)(1), (2).
[9] 42 U.S.C. § 1395u(l)(1)(A).
[10] 42 U.S.C. § 1395u(m)(1).
[11] WAC 182-502-0100(9).
[12] WAC 182-502-0160.
[13] WAC 182-502—150(13).

**Must a physician refund a payment that is over the Medicare "limiting charge"?**

Yes. A nonparticipating physician who charges and collects from a patient more than the limiting charge must, not later than 30 days after the date the physician is notified by the carrier of a violation, refund the difference.[14]

**Is there a penalty for purposely billing over the Medicare "limiting charge"?**

Yes. If a nonparticipating physician knowingly and willfully bills or collects an amount above the limiting charge or fails to refund such an excessive charge, the physician could be sanctioned, including: (1) exclusion from participation in the Medicare program for up to five years, and/or (2) imposition of a civil monetary penalty or assessment.[15]

**May a physician routinely waive Medicare Part B co-insurance and deductibles?**

No. The Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) has issued a Fraud Alert indicating that the routine waiver of Medicare Part B co-insurance and deductibles is unlawful because it results in false claims, violation of the Medicare-Medicaid anti-kickback statute and excessive utilization of items and services payable under Medicare.[16] The routine waiver of Medicare Part B co-insurance and deductibles can result in severe penalties such as imprisonment, criminal fines, civil monetary penalties, civil damages and forfeiture, and exclusion from participation in Medicare and Medicaid.[17]

The OIG has acknowledged one important exception to the prohibition against waiving Medicare Part B copayments and deductibles. A physician may on occasion forgive a copayment in consideration of an individual patient's special financial hardship or special financial needs. It may not be done, however, on a routine basis.[18]

**Where can a physician find out more information about Medicare compliance?**

A Medicare compliance guide for individual and small practices is available from the DHHS at: http://oig.hhs.gov/authorities/docs/physician.pdf. Physician education training materials may be found at: https://oig.hhs.gov/compliance/physician-education/index.asp.

**How long does a physician have to submit a Medicaid claim?**

Physicians must submit initial claims and have a Transaction Control Number (TCN) assigned within 365 from the date the service was provided, the date a final hearing decision is rendered that impacts the claim, the date a court orders coverage of the service, or the date that DSHS grants delayed certification.[19] Physicians may resubmit, modify, or adjust any timely

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[14] 42 U.S.C. § 1395w-4(g)(1)(A)(iv). Or
[15] 42 U.S.C. § 1395w-4(1)(B); 42 U.S.C. § 1935u(j)(2).
[16] OIG Fraud Alert *available at*: https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.
[17] 18 U.S.C. §§ 287, 1001; 31 U.S.C. § 3729; 42 C.F.R. § 1320a-7a; 42 U.S.C. 1320a-7b(b); 42 U.S.C.1320a-7(b)(7); 42 U.S.C. 1320a-7(b)(6)(B).
[18] OIG Fraud Alert, *supra*.
[19] WAC 182-502-0150(3).

initial claim except prescription drug claims, or claims for major trauma services, for a period of 24 months from the date of service.[20] Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.[21]

**Under what circumstances may a physician bill a Medicaid patient for services not covered by the Medicaid program?**

The physician may bill a Medicaid patient for a noncovered service only when one of the following conditions is met:

- The patient signs a specific written agreement with the physicians that states:[22]
    - The anticipated date the service will be provided (which must be less than 90 days from the date of the signed agreement).
    - Each service that will be furnished.
    - Treatment alternatives that may have been covered by DSHS or managed care organization.
    - The total amount the patient must pay for the service(s).
    - What items or services are included in this amount (such as pre-operative care and post-operative care).
    - That the patient has been fully informed of all available medically appropriate treatments, including services that may be paid for by DSHS or managed care organization, and that the patient chooses to get the specified service(s).
    - That the patient may request an exception to the rule when DSHS denies a request for a noncovered service other than a nonformulary drug, and that the patient may choose not to do so.
    - That the client and the physician may request a nonformulary justification for a nonformulary drug, and that the patient may choose not to do so.
    - That the patient may request an administrative hearing to appeal a DSHS denial of a request for prior authorization of a covered service, and that the client may choose not to do so.

The agreement may only be completed after the physician and the patient have exhausted all applicable DSHS or managed care processes necessary to obtain authorization of the requested service, except that the patient may choose not to request an exception to the rule or an administrative hearing regarding denial of authorization for the requested service.[23]

The agreement must specify that one of the reasons below applies:[24]

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[20] WAC 182-502-0150(8).
[21] WAC 182-502-0150(9).
[22] WAC 182-502-160(5)(a).
[23] *Id*.
[24] WAC 182-502-160(5)(b).

- The service(s) is not covered by Medicaid or the Medicaid managed care plan, and the exception to the rule process, or nonformulary justification process, has been exhausted and the services(s) denied; or
- The service(s) is not covered by Medicaid or the Medicaid managed care plan, and the client has been informed of his or her rights to the exception to the rule, or nonformulary justification, process, and the patient has chosen not to pursue the relevant process; or
- The service(s) is covered by Medicaid or the Medicaid managed care plan, requires authorization, the physician has completed all necessary requirements, but DSHS has denied the service as not medically necessary; or
- The service(s) is covered and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which DSHS or the Medicaid managed care plan does not pay for and the specific type is not medically necessary for the patient.

- The patient received reimbursement directly from a third party for services for which DSHS has no payment responsibility.[25]

- The patient refuses to sign insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered during a period of eligibility.[26]

- The provider has documentation that the client represented himself/herself as a private pay client and was not receiving medical assistance, when the client was eligible for, and was receiving benefits under a Medicaid program.[27]

- The bill counts toward a spenddown liability, emergency medical expense requirement, or copayment as described under DSHS regulations.[28]

**How should a physician handle a patient who becomes eligible for a covered service after that service has been provided?**

If a client becomes eligible for a covered service because the client applied for benefits later in the same month that the service was provided, receives a delayed certification, or receives a retroactive certification for benefits, the physician must:[29]

- Not bill, demand, collect or accept payment for the service.

- Promptly refund the total payment received from the patient, and then bill Medicaid for the services.

[25] WAC 182-502-160(6)(a)(i).
[26] WAC 182-502-160(6)(a)(ii).
[27] WAC 182-502-160(6)(b).
[28] WAC 182-502-160(6)(c).
[29] WAC 182-502-160(8)

**May a physician bill services provided to minors to the minor's parents or guardians?**

Generally, yes. A physician, however, may not, without the minor's consent, release information concerning a minor's care to the minor's parent, if the minor was entitled to receive the care without the parent's consent.[30] In this situation, the physician should not bill a minor's parent for the treatment provided absent the minor's consent. See **MINORS, TREATMENT OF**. A minor receiving mental health treatment, and responsible others, is liable for the costs of such treatment, care, and transportation to the extent of available resources and ability to pay.[31] Moreover, under Washington law, a minor's parent or guardian is not liable for:

- Care rendered to a minor age 14 or older who requests treatment for a sexually transmitted disease.[32] See **AIDS/HIV/STD**.

- Treatment for alcoholism, intoxication or drug addiction of a minor age 13 or older to which the parent or guardian did not join in giving consent.[33]

**May a physician charge for producing copies of medical records?**

Yes, generally. See **PHYSICIAN AS WITNESS** and **DISCLOSURE OF HEALTH CARE INFORMATION** for permissible charges. However, a physician may not bill a patient receiving Medicaid benefits, or anyone on that patient's behalf, for copying or transferring health care information to another health care provider. Such information includes, but is not limited to:[34]

- Medical charts.

- Radiological or imaging films.

- Laboratory or other diagnostic test results.

**Are there any other prohibitions on charging a Medicaid patient?**

Yes. Regardless of any written, signed agreement to pay, a physician may not bill, demand, collect, or accept payment from a patient, or anyone on the patient's behalf for:[35]

- Missed, cancelled, or late appointments.

- Shipping and/or postage charges.

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[30] RCW 70.02.130(1).
[31] RCW 71.34.405(1).
[32] RCW 70.24.110.
[33] RCW 70.96A.240.
[34] WAC 182-502-160(9)(a).
[35] WAC 182-502-160(9)(b-(e).

- "Boutique," "concierge," or enhanced service packages (such as newsletters, 24/7 access to the physician, and health seminars) as a condition for access to care.

- The difference in price between an authorized service or item and an "upgraded" service or item.

**Is there any generally applicable legal requirement that physicians bill for services within a specified period of time?**

No, apart from specific contractual, regulatory, or other payor-specific billing requirements, there is no generally applicable legal requirement that physicians bill within a specified period of time. As a matter of sound business practice, physicians are well-advised not only to comply with all contractual, regulatory, and other payor-specific billing requirements, but also, in the absence of such specific requirements, to bill for services in a prompt and timely manner.

**What should a physician practice do if it owes the patient a refund, but cannot locate the patient?**

If a physician practice owes the patient a refund, but cannot locate the patient, the practice should either file an electronic report with the Department of Revenue at: http://ucp.dor.wa.gov/holderContent.aspx, or forward the refund, together with any report the Department of Revenue may require, to:

Washington State
Department of Revenue
Unclaimed Property Section
P.O. Box 34053
Seattle, Washington 98124-10537477
(360) 570-3264 (option 4)

Upon payment or delivery to the department, the state assumes custody and responsibility for the money, and the person who delivered the payment in good faith is relieved of liability to the extent of the value paid or delivered.[36]

**Is there a deadline by which health carriers must request a refund from a physician?**

Yes, generally. Except in specified circumstances, a carrier may not request a refund unless it does so in writing within 24 months after the date of the payment.[37] If the carrier is involved in a coordination of benefits with another carrier, or an entity responsible for payment, a request for a refund must be made in writing with 30 months of the date of the payment.[38] A

[36] RCW 63.29.200.
[37] RCW 48.43.600(1).
[38] RCW 48.43.600(b).

carrier may not request that a contested refund be paid sooner than 6 months after receipt of the request.[39]

At any time, a carrier may request a refund of a payment previously made if a third party is found legally liable for satisfaction of the claim, and the carrier is unable to recover directly from the third party because the third party has already paid, or will pay, the physician for the health care services covered by the claim.[40]

[39] *Id*.
[40] RCW 48.43.600(3).