Medicaid Member Billing Policy

As outlined in the Pennsylvania DHS MA bulletin 99-99-06 entitled ‘Payment in Full’, Providers requiring Medicaid recipients to make cash payment for Medicaid covered services or refusal to provide medically necessary services to a Medicaid recipient for lack of pre-payment for such services are illegal and contrary to the participation requirements of the Pennsylvania MA program. Payment by the Plan is considered payment in full. Under no circumstance, including but not limited to non-payment by Highmark Wholecare for approved services, may a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Highmark Wholecare member.

As outlined in the Pennsylvania DHS MA Bulletin 99-10-14 entitled Missed Appointments, MA providers are prohibited from billing MA recipients for missed appointments, also known as No Show.

Refer to the Benefits and Special Services section of the **Medicaid Provider Manual** for information on copayments. Members cannot be denied a service if they are unable to pay their copayment. The provider must provide the service and then bill the Member for the copayment. Members are responsible up to a maximum of $90 for adult MA $180 for adult GA every six months. The plan will reimburse the member for any applicable copays based upon claims submission that exceed the maximum from January through June and again from July through December of each year.

This provision shall not prohibit collection of copayments on the Plans’ behalf made in accordance with the terms of the enrollment agreement between the Plan and the member/subscriber/enrollee.

Practitioners may directly bill members for non-covered services; provided, however, that prior to the provision of such non-covered services, the practitioner must inform the member:

- Of the service(s) to be provided.
- That the Plan will not pay for or be liable for said services.
- Of the member's rights to appeal an adverse coverage decision as fully set forth in the Provider Manual.
- Absent a successful appeal, that member will be financially liable for such services.