Appendix: State-specific Improper Billing Authorities

State	Code	Quote
ALASKA	7 AAC 145.015 ["Payment Reduced by Cost Sharing"], pg. 207	Payment provided by the department will be reduced by the amount of cost-sharing required under 7 AAC 105.610, and represents full payment from the department for those covered services authorized under Medicaid. A recipient may be charged only for the amount of cost-sharing specified in 7 AAC 105.610 and may not be charged for any additional difference between the amount billed and the amount received in payment from the department for those covered services provided. A recipient is responsible for payment of the cost-sharing amounts required under 7 AAC 105.610 and for payment of all services not covered under Medicaid.
ALABAMA	No single prohibition was found but there are service specific restrictions.	
	Ala. Admin. Code r. 560-X-9-.09 ["Sending Bills And Statements To Medicaid Recipients"]	Recipients are not responsible for the difference between charges billed and the amount paid by Medicaid for covered services.
	Ala. Admin. Code r. 560-X-16-.02 ["Requirements For Participation"]	Pharmacies and dispensing physicians must agree to abide by the rules and regulations of the program; must agree that payment for covered services will be accepted as payment in full.
	Ala. Admin. Code r. 560-X-34-.06 ["Sending Bills And Statements To Medicaid Recipients"]	Recipients are not responsible for the difference between charges billed and the amount paid by Medicaid for covered services.

State	Code	Quote
ARIZONA	Ariz. Admin. Code R9-22-702 ["Charges to Members"], pg. 46	B. Registered providers must accept payment from the Administration or a contractor as payment in full. C. Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.
ARKANSAS Arkansas Medicaid	Ark. Admin. Code 016.06.35-142.200 ["Conditions Related to Billing for Medicaid Services."]	Medicaid providers may not charge beneficiaries for the completion and submission of a Medicaid claim form. If the provider agrees to accept the patient as a Medicaid beneficiary and agrees to bill Medicaid for the services rendered, the beneficiary may not be charged for this billing procedure.
CALIFORNIA Medi-Cal	Cal. Welf. & Inst. Code § 14019.4 ["Proof of eligibility; prohibition against provider seeking reimbursement or payment for covered services; sanctions; debt collector; application."]	A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.
COLORADO Colorado Medicaid	C.R.S.A. § 25.5-4-301 ["Recoveries--overpayments--penalties--interest--adjustments--liens--review or audit procedures"], pg. 66	Except as provided in section 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act,1 by this title, or by rules promulgated by the state board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the state of Colorado, except those contributions required pursuant to section 25.5-4-209(1).

State	Code	Quote
CONNECTICUT Medical Assistance Program; HUSKY Health; MED-Connect	Regs. Conn. State Agencies § 17b-262-531 ["Payment Limitations"], pg. 76	(j) a provider shall not charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for any portion of the cost of goods or services which are covered and payable under the Connecticut Medical Assistance Program. If a client or representative has paid for the goods or services and the client subsequently becomes eligible for the medical assistance program, payment made by or on behalf of the client shall be refunded by the provider to the payer. The provider then may bill the Medical Assistance Program for the goods or services provided. The provider shall obtain appropriate documentation that the payment was refunded prior to the submission of the claim and shall maintain said documentation;
DELAWARE DE Medical Assistance Program	16 Del. Admin. Code MED 4.4 ["Medicaid/Medicare Clients"]	Participating providers agree to accept the final DMAP payment disposition as payment in full. Therefore, clients eligible for both Medicaid and Medicare should not be billed for any non-covered charges or remaining portions of the Medicare deductible and coinsurance.
DISTRICT OF COLUMBIA	No single prohibition was found but there are service specific restrictions.	
	29 DCMR § 808 ["Reimbursement"]	A participating FSMHC shall agree to accept as payment in full the amount determined by the Department of Human Services as the fee for the authorized services provided to Medicaid patients. No additional charge may be made to the Medicaid patient, any member of the family, or to any other source.
	29 DCMR § 7112 ["Reimbursement"]	The Lead Agency shall agree to accept as payment in full the amount determined by DHCF as Medicaid reimbursement for the authorized services provided to beneficiaries pursuant to § 7115. Rendering providers shall not bill the beneficiary or any member of the beneficiary's family for EI services.

State	Code	Quote
	29 DCMR § 5015 ["Reimbursement"]	Each Provider shall agree to accept as payment in full the amount determined by DHCF as Medicaid reimbursement for the authorized services provided to beneficiaries. Providers shall not bill the beneficiary or any member of the beneficiary's family for PCA services.
	29 DCMR § 5109	Each Provider shall agree to accept as payment in full the amount determined by MAA as reimbursement for the authorized services provided to clients. Providers shall not bill the patient or any member of the patient's family for services.
	29 DCMR § 4611	Each Provider shall agree to accept as payment in full the amount determined by MAA as the fee for the authorized services provided to Clients. Providers shall not bill the Client or any member of his/her family for MCOTT services.
FLORIDA	Fla. Admin. Code r. 59G-5.020 ["Provider Requirements."]	All Medicaid providers enrolled in the Medicaid program and billing agents who submit claims to Medicaid on behalf of an enrolled Medicaid provider must comply with the provisions of the Florida Medicaid Provider General Handbook, which limits the Medicaid payment as payment in full.
	Florida Medicaid Provider General Handbook, pg. 17	A provider who bills Medicaid for reimbursement of a Medicaid-covered service must accept payment from Medicaid as payment in full. This does not include Medicaid copayments and Medicaid coinsurance.
	Wellcare Medicaid Provider Handbook ["Hold Harmless Dual-Eligible Members"], pg. 72	Providers shall accept payment from WellCare for Covered Servives provided to WellCare members in accordance with the reiumbursement terms outlined in the Agreement. Payment made to providers constitutes payment in full by WEllCare for covered benefits, with the exception of member expenses. For Covered Services, porivders shall not balance bill members any amount in excess of the contracted amount in the agreement.
GEORGIA	No relevant authorities found.	

State	Code	Quote
HAWAII	Haw. Admin. Rules (HAR) § 17-1736-15 ["Requirement for participation in the program by providers"]	The provider shall accept Medicaid's established rates of payments whether based on DHS's fee schedule, negotiated rate, reasonable cost reimbursement, or other adopted rates, whichever is applicable, as payment in full for goods, care, or services furnished. The provider shall not require any participation in payment by the Medicaid recipient for goods, care, or services furnished by the provider. The provider shall not demand or receive any additional payment from any Medicaid recipient with the exception of the department's proviso for cost sharing of medical care costs.
IDAHO Idaho Medicaid State Plan	IDAPA 16.03.09.210 ["Payment in Full"], pg. 24	Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as fullpayment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount.
ILLINOIS	305 ILCS 5/11-13 ["Conditions for Receipt of Vendor Payments--Limitation Period for Vendor Action--Penalty for Violation"]	Acceptance of the payment by or in behalf of the vendor shall bar him from obtaining, or attempting to obtain, additional payment therefor from the recipient or any other person.
INDIANA	405 IAC 1-1-3 ["Filing of claims; filing date; waiver of limit; claim auditing; payment liability; third party payments"], pg. 3	A Medicaid provider shall not collect from a Medicaid recipient or from the family of the Medicaid recipient any portion of his charge for a Medicaid covered service which is not reimbursed by the Indiana Medicaid program, except for copayment and any patient liability payment as authorized by law.
IOWA	Iowa Admin. Code 441-79.6(249A), ["Provider participation agreement"] pg. 74	That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

State	Code	Quote
KANSAS	K.A.R. 30-5-59 ["Provider participation requirements"], pg. 43	Each provider shall meet the following conditions… not charge medicaid/ medikan program consumers for services covered by the program, with the exception of claims liable to spenddown or copayment;not charge medicaid/medikan program consumers for services denied for payment by the medicaid/medikan program because the provider has failed to meet a program requirement including prior authorization;not charge any medicaid/ medikan program consumer for noncovered services unless the provider has informed the consumer, in advance and in writing, that the consumer is responsible for noncovered services;
KENTUCKY	907 Ky. Admin. Regs. 1:672 ["Provider enrollment, disclosure, and documentation for Medicaid participation"]	(6) By enrolling in the Medicaid Program, a provider, the provider's officers, directors, agents, employees, and subcontractors agree to: . . . e) Accept payment from Medicaid as payment in full for all care, services, benefits, or and supplies billed to the Medicaid Program, except with regard to recipient cost-sharing charges and beneficiary liability, if any;
	Kentucky Medicaid Providers Manual, pg 73	For Covered Services, providers shall not balance bill members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of WellCare's claims policies and/or procedures does not indicate that the service provided is a non-covered service, and members are to be held harmless for Covered Services. A provider may provide a service to a recipient on a non-Medicaid basis if the recipient agrees to receive the service on a non-Medicaid basis before the service begins and the service is not a Medicaid-covered service.
LOUISIANA	LSA-R.S. 46:437.12 ["Provider Agreement Requirements"]	In addition to the requirements specified in R.S. 46:437.11, the provider agreement developed by the department shall require the health care provider to comply with the following: . . . (10)(a) Accept payment from the medical assistance programs as payment in full, and prohibit the health care provider from billing or collecting any additional amount from the recipient or the recipient's responsible party except, and only to the extent the department permits or requires, a co-payment, coinsurance, or a deductible to be paid by the recipient for the goods, services, or supplies provided.

State	Code	Quote
MAINE (MaineCare)	ME ADC 10-144 Ch. 101, Ch. I, § 1.05 ["Supplementation By Members"], pg. 20	MaineCare providers must accept the allowances for covered services established by the Department as payment in full. Providers must also comply with State and Federal law as well as the provisions of the MaineCare Benefits Manual, Chapter I, Section 1.03-3. Providers who request or require supplementary payment for MaineCare covered services are in violation of MaineCare rules and are subject to administrative sanctions. . . . Members may not be charged for covered services provided during any period of eligibility unless a member has knowingly misrepresented, in writing, his or her MaineCare status. Enrolled providers must bill the Department for covered services provided to a member during any period of eligibility for which the provider expects to be reimbursed. Nothing in this paragraph shall be construed as prohibiting a provider from providing free care.
MARYLAND	COMAR 10.09.36.03 ["Conditions for Participation"]	A. To participate in the Program, the provider shall comply with the following criteria: . . . (8) Accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services;
MASSACHUSETTS (MassHealth)	130 CMR 450.203 ["Payment in Full"], pg. 46	. . .No provider may solicit, charge, receive, or accept any money, gift, or other consideration from a member, or from any other person, for any item or medical service for which payment is available under MassHealth, in addition to, instead of, or as an advance or deposit against the amounts paid or payable by the MassHealth agency for such item or service, except to the extent that the MassHealth regulations specifically require or permit contribution or supplementation by the member or by a health insurer.

State	Code	Quote
MICHIGAN Michigan ENROLLS MI Health Link (dual-eligibles)	M.C.L.A. 400.111b ["Conditions for Participation"]	(14) . . . A provider shall not seek payment from the medically indigent individual, the family, or representative of the individual for either of the following: (a) Authorized services provided and reimbursed under the program. (b) Services determined to be medically unnecessary in accordance with professionally accepted standards.
MINNESOTA Medical Assistance (MA)	Minnesota Rules, part 9505.2165 Subpart 2(A) ["Definitions"]	The following practices are deemed to be abuse by a vendor . . . soliciting, charging, or receiving payments from recipients or nonmedical assistance sources, in violation of Code of Federal Regulations, Title 42, section 447.15, or part 9505.0225, for services for which the vendor has received reimbursement from or should have billed to the program;
	Minnesota Rules, part 9505.0225 ["Request to Recipient to Pay"]	Subp. 2. Payment for covered service. If the health service to a recipient is a covered service, a provider must not request or receive payment or attempt to collect payment from the recipient for the covered service
MISSISSIPPI	Miss. Admin. Code 23-200:3.8 ["Charges Not Beneficiary's Responsibility"], pg. 21	Providers who have agreed to be Medicaid providers are expected to bill Medicaid for Medicaid covered services and accept Medicaid payment as payment in full. . . The beneficiary may not be billed for Medicaid covered services. . . The beneficiary may not be held liable for billed charges above the Medicaid maximum allowable.
MISSOURI	13 Mo. Code of State Regulations 70-3.030 ["Sanctions for False or Fraudulent Claims for MO HealthNet Services"], pg. 5	Sanctions shall be imposed on providers for failing to accept MO HealthNet payment as payment in full for covered services or collecting additional payment from a participant or responsible person, except this shall not apply to MO HealthNet services for which participants are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.050 and 13 CSR 70-4.051;

State	Code	Quote
MONTANA Montana Medicaid	Mont.Admin.R. 37.85.406 ["BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT"]	(11) Providers are required to accept, as payment in full, the amount paid by the Montana Medicaid program for a service or item provided to an eligible Medicaid member in accordance with the rules of the department. Providers must not seek any payment in addition to or in lieu of the amount paid by the Montana Medicaid program from a member or his representative, except as provided in these rules. A provider may bill a member for the copayments specified in ARM 37.83.826 and 37.85.204 and may bill certain members for amounts above the Medicare deductibles and coinsurance as allowed in ARM 37.83.825. . . . (b) Except as provided in this rule, a provider may not bill a member after Medicaid has denied payment for covered services because the services are not medically necessary for the member.
	Mont.Admin.R. 37.83.825 ["QUALIFIED MEDICARE BENEFICIARIES, PAYMENTS TO PROVIDERS"]	(2) Payment in full, except as otherwise provided in (2)(a) below, for services provided to medicaid qualified medicare beneficiaries, is the medicaid payment as determined under ARM 37.83.811, 37.83.812 and 37.85.406 plus the qualified medicare beneficiary's copayment as provided for in ARM 37.83.826. A provider may not collect any amount from the person which is in excess of payment in full even if that payment is less than the medicare insurance deductibles and coinsurance. Where a person is eligible for medicaid under both medicaid qualified medicare beneficiary and another medicaid category, a provider must accept the medicaid payment as payment in full.

State	Code	Quote
	Mont.Admin.R. 37.83.825 cont'd	(1) Payments for services provided to medicaid qualified medicare beneficiaries may only be made to a provider. A provider in order to receive payments must be enrolled in the medicaid program. (a) Medicaid payment will be made to the provider even when the provider for medicare purposes has not accepted assignment. . . . (3) Subject to the requirements of this rule, the Montana medicaid program pays the lowest of the following for qualified medicare beneficiary services: (a) the provider's usual and customary charge for the service; or (b) the appropriate medicaid allowed amount as provided in ARM 37.85.406(18).
NEBRASKA	Neb. Admin. R. & Regs. Tit. 471, Ch. 30, § 005 ["Balance Billing"], pg. 4	(a) Medicaid payment will be made to the provider even when the provider for medicare purposes has not accepted assignment.
NEVADA	NAC 442.715 ["Eligibility of providers under program"]	1. To provide services to clients, physicians and other regular providers of services under the program must have executed a memorandum of understanding with the Division, except that providers who provide services one time or on a sporadic basis are not required to have executed a memorandum of understanding if they agree to accept reimbursement provided under the program as payment in full for those services. The memorandum of understanding must: (a) Require the physician or other provider to accept the rates of reimbursement set forth in NAC 442.751; and (b) Provide that households will not be billed by the provider for the remaining balance.

State	Code	Quote
NEW HAMPSHIRE	N.H. Rev. Stat. § 420-J:8(1)(a) ["Provider Contract Standards"]	Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person (other than the health carrier or intermediary) for services provided pursuant to this agreement.
NEW JERSEY	N.J.S.A. 30:4D-6 ["Basic medical care and services"]	(c) . . . Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, the recipient's family, the recipient's representative or others on the recipient's behalf for the services, goods, and supplies furnished pursuant to this act.
NEW MEXICO	N.M. Admin. Code 8.302.2 ["BILLING FOR MEDICAID SERVICES"]	The eligible recipient, member or his or her authorized representative is responsible for notifying the provider of MAP eligibility or pending eligibility and when retroactive MAP eligibility is received. When any provider including an enrolled provider, a non-enrolled provider, a MCO provider, and an out-of-network provider is informed of a recipient's MAP eligibility, the circumstances under which an eligible recipient, member or his or her authorized representative can be billed by the provider are limited. (4) The provider must accept MAD (medical assistance program) payment as payment in full and cannot bill a remaining balance to the eligible recipient, member or his or her authorized representative other than a MAD allowed copayment, coinsurance or deductible.
NEW YORK	No relevant authorities found.	

State	Code	Quote
NORTH CAROLINA	10A NCAC 22J.0106 ["PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS"]	(c) Providers may bill a patient accepted as a Medicaid patient only in the following situations: (1) for allowable deductibles, co-insurance, or co-payments as specified in 10A NCAC 22C .0102; or (2) before the service is provided the provider has informed the patient that the patient may be billed for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the limits on Medicaid services as specified under 10A NCAC 22B, 10A NCAC 22C, and 10A NCAC 22D; or (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services are received but has failed to supply a Medicare number as proof of coverage; or (4) the patient is no longer eligible for Medicaid as defined in 10A NCAC 21B. (d) When a provider files a Medicaid claim for services provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services for which it receives no reimbursement from Medicaid when: (1) the provider failed to follow program regulations; or (2) the agency denied the claim on the basis of a lack of medical necessity; or (3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of this Rule.
NORTH DAKOTA	NDAC 75-02-05-04 ["Provider responsibility."], pg. 4	3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established by the department. A provider performing a procedure or service may not request or receive any payment, in addition to the amounts established by the department, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a client share has been properly determined by a county social service board, the provider may hold the recipient responsible for the client share.
OHIO Ohio Medicaid	OAC 5160-1-17.2 ["Provider agreement for providers"]	The provider will not seek reimbursement for that service, except as defined in rule 5101:3-1-09 of the Administrative Code, from the patient, any member of the family, or any other person.

State	Code	Quote
	OAC 5160-1-09 ["Co-payments"]	This rule sets forth requirements regarding co-payments by consumers for medicaid-covered services. Providers can recover co-payments. Inability to pay the co-payment is not grounds for the provider to refuse to provide the service.
OKLAHOMA	Okla. Admin. Code 317:30-3-5 ["Assignment and Cost Sharing"]	(b) The OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others. . . . (2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA . . . In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider.
OREGON ("Oregon Health Plan")	OAR 410-120-1280 ["Billing"]	A provider...may not seek payment, from the client for any services covered by Medicaid fee-for-service or through contracted health care plans: (a) A client may not be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division; b) A client may not be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).
PENNSYLVANIA Medical Assistance (MA)	55 Pa. Code § 1101.63 ["Payment in Full"]	A provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment.

State	Code	Quote
RHODE ISLAND RI Medicaid	R.I. Admin. Code 39-3:0301.10, pg. 1 ["Medicaid Payment Policy"]	Payments to Medicaid providers represent full and total payment. No supplementary payments are allowed, except as specifically provided for by contract.
SOUTH CAROLINA Medicaid	No relevant authorities found.	
SOUTH DAKOTA	ARSD 67:16:01:07 ["State payment as payment in full—Individual responsible for payment of noncovered services."]	Payments under this article made on behalf of an eligible individual together with the individual's cost-sharing amount, if cost sharing is required, are considered payment in full for medical services covered under the provisions of this article. No additional charges may be made to family, friends, political subdivisions, or the eligible individual unless the service provided was a noncovered medical service. The eligible individual is responsible for the payment of any noncovered service.
TEXAS	1 TAC § 354.1131(b) ["Payments to Eligible Providers"]	The provider may not charge or take other recourse against any eligible recipient for a service for which payment is made or will be made, except as may otherwise be specifically provided.

State	Code	Quote
TENNEESSEE	Tenn. Comp. R. & Regs. 1200-13-13-.08 ["PROVIDERS"], pg. 62	(5) Providers may seek payment from a TennCare enrollee only under the following circumstances. These circumstances apply to all TennCare providers, as defined in this Chapter, including those who are Out-of-Network Providers in a particular enrollee's MCC. These circumstances include situations where the enrollee may choose to seek an out-of-network provider for a specific covered service. (a) If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered; or (b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies: (c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.
UTAH	No relevant authorities found.	
VERMONT	Vt. Admin. Code 12-7-1:7105 ["Medical Service Payment"], pg. 45	A provider must accept as payment in full the amounts paid in accordance with the rate schedule established for Medicaid. For example, a physician performing a particular surgical procedure may not request or receive any additional payment from the recipient, or anyone acting on the recipient's behalf, for the same surgical procedure, although in medical expenses spend-down cases, as specified by the Department, the recipient may be held responsible for a portion of the amount specified in the fee schedule (see Sections M400-M499).

State	Code	Quote
VIRGINIA Virginia Medicaid	12 VAC 30-120-1730 ["General Requirements for Participating Providers."]	The provider shall not attempt to collect from the individual or the individual's responsible relative or relatives any amount the provider may consider a balance due amount or an uncovered amount. Providers shall not collect balance due amounts from individuals or individuals' responsible relatives even if such persons are willing to pay such amounts. Providers shall not bill DMAS, individuals or their responsible relatives for broken or missed appointments.
WASHINGTON Washington Apple Health	WAC 182-502-0160 ["Billing a client."]	(4) A provider must not bill a client, or anyone on the client's behalf, for any services until the provider has completed all requirements of this section, including the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled, and until the provider has then fully informed the client of his or her covered options. A provider must not bill a client for: (a) Any services for which the provider failed to satisfy the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled. (b) A covered service even if the provider has not received payment from the agency or the client's MCO. (c) A covered service when the agency or its designee denies an authorization request for the service because the required information was not received from the provider or the prescriber under WAC 182-501-0165 (7)(c)(i).

State	Code	Quote
WEST VIRGINIA West Virginia Medicaid	W. Va. Code § 16-29D-4(a)(2) ["Prohibition on balance billing; exceptions"]	. . . The health care provider shall not bill the beneficiary or any other person on behalf of the beneficiary and, except for deductibles or other payments specified in the applicable plan or plans, the beneficiary shall not be personally liable for any of the charges, including any balance claimed by the provider to be owed as being the difference between that provider's charge or charges and the amount payable by the applicable department or divisions. The plan or plans may specify what sums are deductibles, copayments or are otherwise payable by the beneficiary and the sums for which the health care provider may bill the beneficiary: In addition, any health care service which is not subject to payment by the plan or plans shall be the responsibility of the beneficiary and for those health care services which are not covered by the plans, there shall be no prohibition against billing the beneficiary directly.
WISCONSIN	Wis. Adm. Code s DHS 106.04 Payment of claims for reimbursement.	(3) NON-LIABILITY OF RECIPIENTS. A provider shall accept payments made by the department in accordance with sub. (1) as payment in full for services provided a recipient. A provider may not attempt to impose a charge for an individual procedure or for overhead which is included in the reimbursement for services provided nor may the provider attempt to impose an unauthorized charge or receive payment from a recipient, relative or other person for services provided, or impose direct charges upon a recipient in lieu of obtaining payment under the program, except under any of the following conditions:
WYOMING	WY Rules and Regulations HLTH MDCD Ch. 3 s 11 ["Payment and submission of claims"], pg. 11	(b) Payment in full of covered services. If the service is a covered service, a provider may not request, receive or attempt to collect any payment from the recipient or the recipient's family for the service. The provider must accept the Medicaid allowable payment as payment in full for the services. This subsection does not apply to services provided in excess of service limitations..