Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services, such as enrollment fee payments, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. ~~Please refer to the specific services section for co-payment amounts.~~

~~The following beneficiaries and services do not require co-payments:~~

~~Infant Exception Code (For newborn only)~~

~~K Infant~~

~~Co-Payment Exception Codes~~

~~C Children~~
~~P Pregnant Women~~
~~N Nursing Facility Residents~~
~~F Family Planning Services~~
~~E Emergency Room Services**~~

~~** Certified by the physician as true emergencies and so recorded in the medical record.~~

~~The following are the established co-payments:~~

~~Co-Payment Amounts~~

~~Ambulance~~	~~$3.00 per trip~~	~~Hospital Outpatient~~	~~$3.00 per visit~~
~~Dental~~	~~$3.00 per visit~~	~~Physician (any setting)~~	~~$3.00 per visit~~
~~FQHC~~	~~$3.00 per visit~~	~~Vision~~	~~$3.00 per pair of eyeglasses~~
~~Home Health~~	~~$3.00 per visit~~	~~Rural Health Clinic~~	~~$3.00 per visit~~
~~MSDH~~	~~$3.00 per visit~~		
~~Hospital Inpatient~~	~~$10.00 per day up to one-half the hospital's first day per diem per admission~~		
~~Prescription~~	~~$3.00 per prescription, including refills~~		
~~DME, orthotics, and prosthetics (excludes medical supplies)~~			~~Up to $3.00 per item (varies per State payment for each item)~~

~~Collection of Co-payment~~

~~In the absence of knowledge or indication to the contrary, the provider may accept the beneficiary's assertion that he/she cannot afford to pay the cost sharing co-payment amount. The provider may not deny services to any eligible Medicaid individual due to the individual's inability to pay the cost of the co-payment. However, the individual's inability to pay the co-payment amount does not alter the Medicaid reimbursement amount for the claim, unless the beneficiary or service is excluded from the co-payment policy as listed.~~

~~Collecting the co-payment amount from the beneficiary is the responsibility of the provider. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing co-payments from the beneficiary remains the responsibility of the provider.~~

The Division of Medicaid applies co-payments to the following beneficiary group or services.

Beneficiary Group / Service	Co-Payment Amount
Ambulance	$ 3.00 per trip
Dental	$ 3.00 per visit
DME, Orthotics, Prosthetics (excludes medical supplies)	Up to $ 3.00 per item (varies per State payment for each item)
FQHC	$ 3.00 per visit
Home Health	$ 3.00 per visit
MS State Department of Health	$ 3.00 per visit
Hospital Inpatient	$10.00 per day up to one-half the hospital's first day per diem per admission
Hospital Outpatient	$ 3.00 per visit
Physician (and setting)	$ 3.00 per visit
Prescription	$ 3.00 per prescription, including refills
Vision	$ 3.00 per pair of eyeglasses
Rural Health Center	$ 3.00 per visit

In the absence of knowledge or indication to the contrary, the provider may accept the beneficiary's assertion that he/she cannot afford to pay the cost sharing co-payment amount. The provider may not deny services to any eligible Medicaid individual due to the individual's inability to pay the cost of the co-payment. However, the individual's inability to pay the co-payment amount does not alter the Medicaid reimbursement amount for the claim, unless the beneficiary or service is excluded from the co-payment policy.

Collecting the co-payment amount from the beneficiary is the responsibility of the provider. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing co-payments from the beneficiary remains the responsibility of the provider.

The following beneficiary groups or services are exempt from payment of the above co-payments.

When the beneficiary or service is exempt from the co-payment, the applicable co-payment exception code must be indicate on the claim in the recipient ID field as a suffix to the Medicaid number; otherwise, a co-payment will be deducted.

Example: 123456789C
Example: 999999999N
Example: 100100100P

Exception Code	Description	Applicable On CMS 1500	Applicable On UB92
K	**Infant**	Yes	Yes
C	**Children Under 18**	Yes	Yes
P	**Pregnant Women** Prenatal Care Labor and Delivery Routine Postpartum Care (the immediate postpartum period which begins on the last day of the pregnancy and extends through the end of the month in which the 60 day period following termination of the pregnancy). Complications of pregnancy likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy.	Yes	Yes
N	**Nursing Facility** Services furnished to any individual who is a resident in a nursing facility, ICF/MR or PRTF. This exception code is applicable to the facility charges, professional fees, and pharmaceuticals.	Yes	Yes
F	**Family Planning** Family planning services and supplies.	Yes	Yes
E	**Emergency Services** Services performed in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. The documentation in the medical records must justify the service as a true emergency.	Yes	Yes
O	**Chemotherapy (Drug Therapy for Cancer)** Applicable only to facility charges for chemotherapy services performed in the outpatient department of the	No	Yes

	hospital. • Treatment of cancer with drugs that can destroy cancer cells. This exception code does not apply to the physician charges.		
T	**Radiation Therapy** Applicable only to facility charges for radiation therapy performed in the outpatient department of the hospital. • Therapeutic radiology services. • Nondiagnostic in nature. • Includes therapy by injection or ingestion of radioactive substances. This exception code does not apply to physician charges.	No	Yes
L	**Laboratory/ Laboratory Pathology** Applicable only to facility charges when beneficiary is **ONLY** receiving laboratory services in the outpatient department of the hospital. • Diagnostic and routine clinical laboratory tests. • Diagnostic and routine laboratory tests on tissues and cultures. This exception code does not apply to physician charges.	No	Yes
No Exception Code Required	**Dialysis Facility** Hospital based or freestanding dialysis facility charges are exempt from co-payment. However, the provider is not required to indicate an exception code when billing the claim. This exception code does not apply to physician charges.	No	Yes

For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the Waiver. If services are being paid through regular Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services listed above.

~~Providers are responsible for collecting a three-dollar ($3.00) co-payment per trip on ambulance services. This fee should be collected from the beneficiary at the time of service and retained by the provider. This amount will then be withheld from the payment when the claim is processed.~~

~~Co-payment, by federal law, cannot be collected in certain instances. The following groups of beneficiaries and services are excluded from co-payment:~~

~~GROUPS AND SERVICES~~	~~EXCEPTION CODES~~
~~Children under eighteen (18) years of age~~	~~C~~
~~Pregnant Women~~	~~P~~
~~Nursing Facility Residents~~	~~N~~
~~Family Planning~~	~~F~~
~~Emergency Room services~~	~~E~~

~~When the beneficiary is exempt from rendering co-payment, one of the above exception codes **must be** indicated on the claim in the Medicaid ID number field as a suffix to the Medicaid number, otherwise co-payment will be deducted from the claim's payment amount.~~

~~When filing claims where a co-payment has been collected, **DO NOT** reduce your submitted charges by $3.00 and **DO NOT** enter this amount on the claim. The co-payment amount will be automatically deducted on all applicable services.~~

~~Providers shall not refuse service because of the beneficiary's inability to pay the co-payment.~~

Refer to Provider Policy Manual Section 3.08 for Beneficiary Cost Sharing policy.

~~Providers are responsible for collecting a three-dollar ($3.00) co-payment on certain Medicaid services. This fee should be collected from the beneficiary at the time of service and retained by the chiropractor. This amount will then be withheld from the payment when the claim is processed.~~

~~Co-payment, by federal law, cannot be collected in certain instances. The excluded beneficiary groups and services, with the exception codes, are listed below:~~

~~GROUPS AND SERVICES~~	~~EXCEPTION CODES~~
~~Children under age eighteen (18)~~	~~C~~
~~Pregnant women~~	~~P~~
~~Nursing facility residents~~	~~N~~
~~Family planning services~~	~~F~~

~~When the beneficiary is exempt from rendering co-payment, one of the above exception codes **must be** indicated on the claim in the Medicaid ID number field as a suffix to the Medicaid number, otherwise co-payment will be deducted from the claim's payment amount.~~

~~When filing claims where a co-payment has been collected, **do not** reduce your submitted charges by $3.00 and **do not** enter this amount on the claim. The co-payment will be automatically deducted on all applicable services.~~

~~The co-payment amount deducted from the Medicaid allowed amount will be indicated in the remittance advice in the "COPAY AMT" column.~~

~~Providers shall not refuse services because of the beneficiary's inability to pay the co-payment.~~

Refer to Provider Policy Manual Section 3.08 for Beneficiary Cost Sharing policy.

~~Providers are responsible for collecting the appropriate co-payment on the services listed below. This fee should be collected from the beneficiary at the time of service and retained by the provider. This amount will then be withheld from the payment when the claim is processed. All non-exempt Medicaid beneficiaries will be responsible for co-payment for the following hospital services:~~

- ~~Inpatient days: $10.00 per day~~
- ~~Emergency room facility visits: $3.00 per visit~~
- ~~Emergency room physician visits: $3.00 per visit~~

~~If the patient is admitted directly through the emergency room, the $3.00 co-payment for the emergency room visit is not to be collected from the beneficiary. Only the $10.00 per inpatient day should be billed to the beneficiary.~~

~~Co-payment, by federal law, cannot be collected in certain instances. The following groups of beneficiaries and services are excluded from co-payment.~~

~~GROUPS AND SERVICES~~	~~EXCEPTION CODES~~
~~Children under eighteen (18) years of age~~	~~C~~
~~Pregnant women~~	~~P~~
~~Nursing facility residents~~	~~N~~
~~Family planning services~~	~~F~~
~~Emergency room services certified by the physician as true emergencies and so recorded in the medical record~~	~~E~~

~~When the beneficiary is exempt from rendering co-payment, one of the above exception codes **must be** indicated on the claim in the Medicaid ID number field as a suffix to the Medicaid number. Otherwise, co-payment will be deducted from the claim's payment amount.~~

~~When filing claims where a co-payment has been collected, **DO NOT** reduce your submitted charges by the co-payment amount and **DO NOT** enter this amount on the claim. The co-payment amount will be automatically deducted on all applicable services.~~

~~The provider may bill the Medicaid beneficiary for the co-payment if it is not collected at the time of service. In addition, providers do have the option of writing off the co-payment or billing the beneficiary. Collecting the co-payment amount from the beneficiary is the responsibility of the provider.~~

~~The provider may not deny services to any eligible Medicaid beneficiary due to the beneficiary's inability to pay the cost of the co-payment.~~

Refer to Provider Policy Manual Section 3.08 for Beneficiary Cost Sharing policy.

~~Refer to Hospital Inpatient, Section 25.14, in this manual. Section 25.14 applies to both inpatient and outpatient.~~

Refer to Provider Policy Manual Section 3.08 for Beneficiary Cost Sharing policy.

~~Providers are responsible for collecting applicable co-payment on covered Medicaid prescriptions. The prescription co-payment is $3.00 per prescription. CMS regulations establish the acceptable range of co-payment allowed. The co-payment is to be collected from the beneficiary at the time of service and retained by the provider. This amount will then be withheld from the payment when the claim is processed.~~

~~The following groups of beneficiaries and services do not require co-payments:~~

~~GROUPS AND SERVICES~~	~~EXCEPTION CODES~~
~~Children under eighteen (18) years of age~~	~~C~~
~~Pregnant women~~	~~P~~
~~Newborns~~	~~K~~
~~Nursing Facility residents~~	~~N~~
~~Family Planning~~	~~F~~
~~Emergency Room Services**~~	~~E~~

~~**Certified by the physician as true emergencies and so recorded in the medical record.~~

~~To use the pregnant women exception code, the prescribing physician must boldly indicate a **"P"** on the prescription. This "P" is an indicator to the pharmacist not to collect co-payment when the claim is processed.~~

~~Providers filing claims where a co-payment has been collected should **NOT** reduce submitted charges by the co-payment amount and should **NOT** enter this amount on the claim. The co-payment amount is automatically deducted on all applicable services.~~

~~Collecting the co-payment amount from the beneficiary is the responsibility of the provider. In cases of claims adjustments, the responsibility of refunding or collecting additional cost sharing co-payments from the beneficiary remains the responsibility of the provider.~~

~~The provider may not deny services to any eligible Medicaid individual due to the individual's inability to pay the cost of the co-payment. However, the individual's inability to pay the co-payment amount does not alter the Medicaid reimbursement claim form.~~

Refer to Provider Policy Manual Section 3.08 for Beneficiary Cost Sharing policy.

~~Home health agencies are to collect a $3.00 co-payment from Medicaid eligible beneficiaries upon each skilled nurse, physical therapy, speech therapy, or home health aide visit.~~

~~The following categories are exempt from co-payment:~~

~~GROUPS AND SERVICES~~	~~EXCEPTION CODES~~
~~Children under eighteen (18) years of age~~	~~C~~
~~Pregnant Women~~	~~P~~
~~Family Planning~~	~~F~~

~~The provider is responsible for collecting the appropriate co-payment when services are provided. The co-payment is retained by the provider when a claim is filed. The amount of the co-payment will be withheld when the claim is processed.~~

~~The provider should not reduce the submitted charges for co-payments collected and the amount of the co-payment should not be entered in the field on the claim. The co-payment amount will be automatically deducted on all applicable services.~~

Refer to Provider Policy manual Section 3.08 for Beneficiary Cost Sharing policy.

Effective for dates of services on and after May 1, 2002, providers are responsible for collecting a co-payment as described in this section. The co-payment is to be collected from the beneficiary ~~at the time of service~~ and retained by the provider. This amount will then be withheld from the payment when the claim is processed. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing co-payments from the beneficiary remains the responsibility of the provider.

Refer to Provider Policy Manual Section 3.08 for Beneficiary Cost Sharing policy.

The DME co-payment will **only** apply to durable medical equipment (rental and purchase) and orthotics and prosthetics. This is applicable to DME modifiers RR, KR, NU and UE.

Modifier RR = Rental
Modifier KR = Rental item, billing for partial month
Modifier NU = New Equipment
Modifier UE = Used durable medical equipment

The DME co-payment will **not** apply to repairs, or medical supplies. This is applicable to DME modifiers RP and SC.

Modifier RP = Replacement and Repair
Modifier SC = Medically necessary service or supply

For DME billed with HCPCS unspecified or miscellaneous codes and modifiers RR, KR, KH, and SC, a $3.00 co-payment must be collected.

The co-payment amounts for HCPCS codes other than unspecified or miscellaneous codes are listed in the chart below.

Modifier	Modifier Description	Co-payment
RR	Rental	If the Medicaid allowable fee for the specific HCPCS code/modifier is: $10.00 or less: co-payment is $0.50 $10.01 - $25.00: co-payment is $1.00 $25.01 - $50.00: co-payment is $2.00 $50.01 or more: co-payment is $3.00
KR	Rental item, billing for partial month	If the Medicaid total allowable fee for the partial month for the specific HCPCS code/modifier is: $10.00 or less: co-payment is $0.50

Modifier	Modifier Description	Co-payment
		$10.01 - $25.00: co-payment is $1.00 $25.01 - $50.00: co-payment is $2.00 $50.01 or more: co-payment is $3.00 Example: Daily rental allowance of $0.60 x 5 units (days) = $3.00 allowance; a co-payment of $0.50 applies. Example: Daily rental allowance of $0.60 x 20 units (days) = $12.00; a co-payment 0f $1.00 applies. Note: This co-payment is calculated based on the total payment for the partial month, not daily payment.
NU	New Equipment	If the Medicaid allowable fee for the specific HCPCS code/modifier is: $10.00 or less: co-payment is $0.50 $10.01 - $25.00: co-payment is $1.00 $25.01 - $50.00: co-payment is $2.00 $50.01 or more: co-payment is $3.00
RP	Replacement and Repair	No Co-payment
UE	Used durable medical equipment	If the Medicaid allowable fee for the specific HCPCS code/modifier is: $10.00 or less: co-payment is $0.50 $10.01 - $25.00: co-payment is $1.00 $25.01 - $50.00: co-payment is $2.00 $50.01 or more: co-payment is $3.00
SC	Medically necessary service or supply	No Co-payment

~~Exceptions~~

~~Co-payment, by federal law, cannot be collected in certain instances. The following groups of beneficiaries and services are excluded from co-payment:~~

~~GROUPS AND SERVICES~~	~~EXCEPTION CODES~~
~~Newborns~~	~~K~~
~~Children under eighteen (18) years of age~~	~~C~~
~~Pregnant women~~	~~P~~
~~Nursing facility resident~~	~~N~~
~~Family planning~~	~~F~~
~~Emergency room services (certified by the physician as true emergencies and so recorded in the medical record)~~	~~E~~

~~When the beneficiary is exempt from rendering co-payment, one of the above exception codes must be indicated on the claim in the Medicaid ID number field as a suffix to the Medicaid number. Otherwise, co-payment will be deducted from the claim's payment amount.~~

~~To use the pregnant women exception code, the prescribing physician must boldly indicate a **"P"** on the certificate of medical necessity at the end of the Medicaid identification number. This "P" is an indicator to the DME supplier not to collect co-payment when the claim is processed.~~

~~When filing claims where a co-payment has been collected, **DO NOT** reduce your submitted charges by the co-payment amount and **DO NOT** enter this amount on the claim. The co-payment amount is automatically deducted on all applicable services.~~