Title 23: Division of Medicaid

Part 200: General Provider Information

Chapter 3: Beneficiary Information

Rule 3.7: Beneficiary Cost Sharing

A. 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.

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

1. Beneficiary Group/Service and Co-Payment Amounts are as follows:

a) Ambulance is $3.00 per trip,

b) Ambulatory Surgical Center is $3.00 per visit,

c) Dental is $3.00 per visit,

d) Durable Medical Equipment (DME), Orthotics, Prosthetics (excludes medical supplies) is up to $3.00 per item (varies per State payment for each item). Items priced as listed:

1) $10.00 or less: co-payment is $0.50,

2) $10.01 - $25.00: co-payment is $1.00,

3) $25.01 - $50.00: co-payment is $2.00,

4) $50.01 or more: co-payment is $3.00.

e) Federally Qualified Health Center (FQHC) is $3.00 per visit,

f) Home Health is $3.00 per visit,

g) MS State Department of Health is $3.00 per visit,

h) Hospital Inpatient is $10.00 per day,

i) Hospital Outpatient is $3.00 per visit,

j) Physician (office, home, emergency room, ophthalmological) is $3.00 per visit,

k) Prescriptions are $3.00 per prescription, including refills,

l) Vision is $3.00 per pair of eyeglasses, and

m) Rural Health Clinic (RHC) is $3.00 per visit.

2. 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 rule.

3. 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.

C. The following beneficiary groups or services are exempt from payment of the co-payments. When the beneficiary or service is exempt from the co-payment, the applicable co-payment exception code must be indicated on the claim. If the exception code is not present, a co-payment will be deducted.

1. Infant

2. Children Under Eighteen (18)

3. Pregnant Women

a) Prenatal Care

b) Labor and Delivery

c) 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 sixty (60) day period following termination of the pregnancy.

d) 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.

4. Nursing Facility

a) Services furnished to any individual who is a resident in a nursing facility, ICF/MR or PRTF.

b) This exception code is applicable to the facility charges, professional fees, and pharmaceuticals.

5. Family Planning - applicable to family planning services and supplies.

6. Emergency Services

   a) 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.

   b) The documentation in the medical records must justify the service as a true emergency.

7. Chemotherapy Drug Therapy for Cancer

   a) Applicable only to facility charges for chemotherapy services performed in the outpatient department of the hospital. Treatment of cancer with drugs that can destroy cancer cells.

   b) This exception code does not apply to the physician charges.

8. Radiation Therapy

   a) Applicable only to facility charges for radiation therapy performed in the outpatient department of the hospital.

      1) Therapeutic radiology services.

      2) Non-diagnostic in nature

      3) Includes therapy by injection or ingestion of radioactive substances.

   b) This exception code does not apply to physician charges.

9. Laboratory/Laboratory Pathology

a) Applicable only to facility charges when beneficiary is only receiving laboratory services in the outpatient department of the hospital.

1) Diagnostic and routine clinical laboratory tests.

2) Diagnostic and routine laboratory tests on tissues and cultures.

b) This exception code does not apply to physician charges.

10. Dialysis Facility - No Exception Code Required

a) 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.

b) This exception does not apply to physician charges.

D. 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 (1) of the beneficiary groups or services listed above.

Source: Social Security Act § 1902(a)(14); 42 CFR § 447.50 – 447.59; Miss. Code Ann. §§ 43-13-117(49), 121.

History: Revised Miss. Admin. Code Part 200, Rule 1.2.B.h) to correspond with SPA 2012-008 (eff. 10/01/2012) eff. 05/01/2014.