BENEFICIARY CO-PAYMENT REQUIREMENTS

The co-payment requirements listed in the tables below apply to most Michigan Medicaid Fee-for-Service (FFS) beneficiaries age 21 and older. For detailed information about a specific co-payment requirement, refer to the Medicaid Provider Manual. Exceptions to some co-payment requirements may apply and are noted in the tables. There are no co-payment requirements for the Maternity Outpatient Medical Services (MOMS), MIChild, and Children's Special Health Care Services (CSHCS) programs.

Providers may not refuse to render services if a beneficiary is unable to pay the co-payment amount at the time the service is provided, nor can they refuse to render future services due to unpaid co-payments unless the MDHHS provider co-payment policy is followed. Refer to the Medicaid Provider Manual, General Information for Providers Chapter, Billing Beneficiaries Section for co-payment policy requirements.

People excluded from the co-payment requirement are:

- Medicare/Medicaid dually eligible beneficiaries
- CSHCS/Medicaid dually eligible beneficiaries
- Individuals residing in a nursing facility
- Native American Indians and Alaskan Natives consistent with Federal regulations at 42 CFR 447.56(a)(1)(x)
- Individuals receiving hospice care
- Individuals who receive Medicaid services through the Breast and Cervical Cancer Control Program (BCCCP)

Co-payment requirements for Medicaid beneficiaries enrolled in Medicaid Health Plans may differ from those listed in the table. Contact the appropriate health plan for plan-specific co-payment requirements.

Services excluded from the co-payment requirement are:

- Pregnancy-related services
- Family planning-related services
- Preventive care services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF) and all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration
- Mental health specialty services and supports provided/paid through the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP)
- Mental health services provided through state psychiatric hospitals, the state Developmental Disabilities Center, and the Center for Forensic Psychiatry
- Services provided by a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Tribal Health Center (THC)

MEDICAID SERVICE	CO-PAYMENT
Physician Office Visit Procedure codes 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350	$2
Outpatient Hospital Visit Revenue code 51x	$2
Emergency Room Visit for Non-Emergency Service No co-payment for emergency services Revenue code 451 billed without 452, or revenue code 456	$3
Inpatient Hospital Stay	$50
Pharmacy	$1 generic/preferred brands $3 brand/non-preferred brands
Chiropractic Visit	$1
Dental Visit	$3
Hearing Aid	$3 per aid
Podiatric Visit	$2
Vision Visit	$2
Urgent Care Center Visit Procedure codes 99201-99205, 99211-99215	$2