SECTION 6
COPAYMENT – COINSURANCE

Providers of service are responsible for collecting copayment and coinsurance amounts from participants, unless otherwise exempt. The provider shall collect copayment or coinsurance from the participant at the time each service is provided or at a later date. Providers may not deny or reduce services to participants, otherwise eligible for benefits, solely on the basis of the participant's inability to pay. Whether or not the participant is able to pay the required amount at the time the service is rendered, the amount is a legal debt and is due and payable to the provider of service. The MO HealthNet program shall not increase its reimbursement to a provider to offset any uncollected copayment or coinsurance from a participant.

Copayment

The following copayment amounts are applied to *dental* services; CPT or surgical procedures are not subject to copayment. The amount of copayment to be collected from the participant is based on the MO HealthNet maximum allowed amount for each procedure code billed according to the following schedule:

MO HealthNet Maximum Allowed Amount for Each Procedure	Participant Copayment
$10.00 or less	$ .50
$10.01 - $25.00	$ 1.00
$25.01 - $50.00	$ 2.00
$50.01 or more	$ 3.00

Exemptions to Copayment

- Participants under the age of 19 or receiving MO HealthNet with ME codes 06, 33, 34, 36, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87 and 88;
- Foster Care participants under the age of 21 receiving MO HealthNet with ME codes 07, 08, 28, 29, 30, 37, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Participants receiving MO HealthNet services for the blind under ME codes 02, 03, 12 and 15;
- Participants receiving MO HealthNet services for pregnant women under ME codes 18, 43, 44, 45, 58, 59 and 61;
- Services provided to Managed Care enrollees;
- Participants residing in a skilled nursing facility, an intermediate care nursing facility, a residential care home, an adult boarding home or a psychiatric hospital; or participants receiving MO HealthNet under ME codes 23 and 41;
- When coinsurance is charged for dentures

Denture Coinsurance

The coinsurance amount applies to each interim, partial and full denture unless one of the following exceptions applies. The amount collected from the participant is 5% of the lesser of MO HealthNet's maximum allowable amount or the provider's billed charge.

- Participants under the age of 19;
- Foster Care participants under the age of 21
- Participants residing in a skilled nursing facility, psychiatric hospital, residential care facility or an adult boarding home; and
- Managed health care plan enrollees for services provided by the plan.

Procedure Code	MO HealthNet Maximum Allowable
D5110	$ 503.75
D5120	$ 504.53
D5130	$ 549.86
D5140	$ 550.25
D5211	$ 377.81
D5212	$ 379.75
D5213	$ 542.50
D5214	$ 542.50
D5225	$ 466.16
D5226	$ 467.33
D5820	$ 286.00
D5821	$ 286.00
D5860	$ 621.94
D5861	$ 620.00

Denture procedure codes D5110 through D5821 are a covered service for participants under the age of 21 or under a category of assistance for pregnant women, the blind or vendor nursing facility residents. Procedure codes D5860 and D5861 require an approved prior authorization and are restricted to participants under the age of 21.

Federally Qualified Health Centers (FQHC) are to collect copayment and coinsurance amounts from MO HealthNet participants according to the maximum allowed amounts on the MO HealthNet fee schedule available at http://dss.mo.gov/mhd/providers/. The FQHC should not collect copayments and coinsurance according to the reimbursement amount received from the MO HealthNet program.