

## Billing the Member (Recipient)

Revised: [January 17, 2025](#)

State and federal laws require Minnesota Health Care Programs (MHCP) members to share in the costs of their health care. Cost-sharing includes copays and deductibles. MHCP allows providers to bill members under certain circumstances. MHCP does not allow providers to request or accept payments from MHCP members, their families, or others on behalf of the member for any of the following:

- Base rate changes made by MHCP (except copays and spenddowns)
- Missed appointments
- The difference between insurance allowed amounts and usual and customary charges (provider contract reductions)
- Services otherwise covered by MHCP, unless an MHCP copay or cap applies

If a provider has obtained a judgment against a member, the provider may not enforce the judgment against the member until at least six months after all public assistance for which eligibility existed has been terminated.

MHCP allows providers to request and accept payments from MHCP members for the following limited cost-sharing instances (more information can be found under the following headings):

- [Copays and Family Deductible](#)
- [Noncovered Services](#)
- [Retroactive Eligibility](#)
- [Spenddowns](#)

Also review information under the [Use of Collection Agencies](#) and [Waiving Member Cost-sharing](#) headings.

### Copays and Family Deductible

Effective for dates of service Jan. 1, 2025, through Dec. 31, 2025, MHCP has the following copays and family deductible:

| <b>2025 Fee-for-Service Copays</b>                           |                           |   |
|--|---------------------------|---|
|  | <b>Medical Assistance</b> | <b>MinnesotaCare</b>  |
| Service  |                           | Adults over age 21  |
| Nonpreventive* visit   | \$0                       | \$28.00; no copays for mental health visits   |
| Emergency room when not an emergency**                       | \$0                       | \$100.00  |
| Emergency room when an emergency                             | \$0                       | \$100.00  |
| Emergency room visit for toothache or other dental condition | \$0                       | \$100.00  |
| Radiology  | \$0                       | \$45.00 per visit   |
| Prescriptions  | \$0                       | \$10.00 generic<br>\$25.00 brand name<br>\$70.00 maximum per month<br>No copays for certain mental health drugs |

|  |                      |                        |
|--|----------------------|------------------------|
| Eyeglasses   | No copay             | \$10.00                |
| Inpatient hospital   | No copay or limit    | \$250.00 per admission |
| Durable medical equipment – The following items have co-insurance: canes, crutches, walkers, commodes, decubitus care equipment, heat or cold application devices, bath and toilet aids, beds, urinals, oximeters, patient lifts, standers, compression devices and appliances, ultraviolet light devices, nerve stimulators, traction equipment, orthopedic devices, wheelchairs, wound therapy devices, wound suction pumps. | No cost sharing      | No cost sharing        |
| Ambulatory surgery   | \$0                  | \$0                    |
| Nonpreventive dental   | Not applicable (N/A) | \$0                    |

| <b>2025 Family Deductible</b>   |                           |                      |
|---|---------------------------|----------------------|
|   | <b>Medical Assistance</b> | <b>MinnesotaCare</b> |
| Deductibles apply to each case only once per month for adult, fee-for-service members. Family deductible amount changes annually. | \$0                       | Not applicable       |

Effective for dates of service Jan. 1, 2024, through Dec. 31, 2024, MHCP has the following copays and family deductible:

| <b>2024 Fee-for-Service Copays</b>                           |                           |   |
|--|---------------------------|---|
|  | <b>Medical Assistance</b> | <b>MinnesotaCare</b>  |
| Service  |                           | Adults over age 21  |
| Nonpreventive* visit   | \$0                       | \$28.00; no copays for mental health visits   |
| Emergency room when not an emergency**                       | \$0                       | \$100.00  |
| Emergency room when an emergency                             | \$0                       | \$100.00  |
| Emergency room visit for toothache or other dental condition | \$0                       | \$100.00  |
| Radiology  | \$0                       | \$45.00 per visit   |
| Prescriptions  | \$0                       | \$10.00 generic<br>\$25.00 brand name<br>\$70.00 maximum per month<br>No copays for certain mental health drugs |
| Eyeglasses   | No copay                  | \$10.00   |
| Inpatient hospital   | No copay or limit         | \$250.00 per admission  |
| Durable medical equipment – The                              | No cost sharing           | No cost sharing   |

|  |                      |     |
|--|----------------------|-----|
| following items have co-insurance: canes, crutches, walkers, commodes, decubitus care equipment, heat or cold application devices, bath and toilet aids, beds, urinals, oximeters, patient lifts, standers, compression devices and appliances, ultraviolet light devices, nerve stimulators, traction equipment, orthopedic devices, wheelchairs, wound therapy devices, wound suction pumps. |                      |     |
| Ambulatory surgery   | \$0                  | \$0 |
| Nonpreventive dental   | Not applicable (N/A) | \$0 |

| <b>2024 Family Deductible</b>   |                           |                      |
|---|---------------------------|----------------------|
|   | <b>Medical Assistance</b> | <b>MinnesotaCare</b> |
| Deductibles apply to each case only once per month for adult, fee-for-service members. Family deductible amount changes annually. | \$0                       | Not applicable       |

Effective for dates of service Jan. 1, 2023, through Dec. 31, 2023, MHCP has the following copays and family deductible:

| <b>2023 Fee-for-Service Copays</b>  |   |   |
|---|---|---|
|   | <b>Medical Assistance</b>   | <b>MinnesotaCare</b>  |
| Service   | Adults  | Adults over age 21  |
| Nonpreventive* visit  | \$3.00; no copays for mental health visits  | \$30.00; no copays for mental health visits   |
| Emergency room when not an emergency**  | \$3.50  | \$100.00  |
| Emergency room when an emergency  | \$0   | \$100.00  |
| Radiology   | \$0   | \$45.00 per visit   |
| Prescriptions   | \$1.00 generic<br>\$3.00 brand name<br>\$12.00 max per month<br>No copays for certain mental health drugs | \$10.00 generic<br>\$35.00 brand name<br>\$70.00 maximum per month<br>No copays for certain mental health drugs |
| Eyeglasses  | No copay  | \$25.00   |
| Inpatient hospital  | No copay or limit   | \$250.00 per admission  |
| Durable medical equipment – The following items have co-insurance: canes, crutches, walkers, commodes, decubitus care equipment, heat or cold application devices, bath and toilet aids, beds, urinals, | No cost sharing   | No cost sharing   |

|  |     |                   |
|--|-----|-------------------|
| oximeters, patient lifts, standers, compression devices and appliances, ultraviolet light devices, nerve stimulators, traction equipment, orthopedic devices, wheelchairs, wound therapy devices, wound suction pumps. |     |                   |
| Ambulatory surgery   | \$0 | \$0               |
| Nonpreventive dental   | N/A | \$15.00 per visit |

| <b>2023 Family Deductible</b>   |                           |                      |
|---|---------------------------|----------------------|
|   | <b>Medical Assistance</b> | <b>MinnesotaCare</b> |
| Deductibles apply to each case only once per month for adult, fee-for-service members. Family deductible amount changes annually. | \$3.80 per month          | Not applicable       |

Items or services provided by a volume purchase contract are exempt from subscriber copays and deductibles.

\*Nonpreventive visits are visits that are the result of a member's symptoms, diagnosis, or established illness and delivered in an ambulatory setting by one of the following:

- Advanced dental therapist
- Advanced practice nurse
- Audiologist
- Chiropractor
- Dentist
- Dental therapist
- Nurse midwife
- Optician
- Optometrist
- Physician
- Physician ancillary
- Podiatrist

\*\*Hospital emergency rooms providing care must conduct appropriate medical screening to determine that the member does not need emergency services. Before providing nonemergency services, the hospital must:

- Notify the member of the copay
- Give the member the name and location of an available and accessible alternative nonemergency provider
- Determine the nonemergency provider can provide the services in a timely manner
- Provide a referral to coordinate scheduling the member's treatment by the nonemergency provider

If you are unable to locate a nonemergency provider for referral, you may not charge the member a copay.

### **Copay and Family Deductible Exclusions**

Copays and deductibles do not apply to the following:

- Members enrolled in Medical Assistance
- Members under 21 years old in MinnesotaCare
- Pregnant women and women in the post-partum period on MinnesotaCare
- Members in hospice care, a nursing home, or an intermediate care facility for people with developmental disabilities (ICF-DD) on MA
- Members enrolled in the MA Breast and Cervical Cancer program
- Members enrolled in the Refugee MA program
- MA members who attest to being American Indian or Alaskan Native
- American Indians and Alaskan Natives on MinnesotaCare who are enrolled in a federally recognized tribe
- Copays that exceed one per day per provider for nonpreventive visits and nonemergency visits to a hospital-based emergency department
- Family planning services and prescriptions
- Pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy
- Services paid by Medicare, resulting in MHCP payment of coinsurance and deductible
- 100 percent federally funded services that Indian Health Services (IHS) provides
- Preventative services
- Smoking cessation treatments and prescriptions
- Immunizations

In addition, the family deductible does not apply to the following:

- Access services (access and special transportation services and interpreter services)
- Chiropractic services
- Dental services
- Inpatient claims based on an emergency admission
- Prescription drugs
- Transportation services authorized through the home and community-based waiver or Alternative Care (AC) programs
- Volume-purchase contracted items (eyeglasses, hearing aids, oxygen)

### **Copay and Family Deductible Limitations**

The American Recovery and Reinvestment Act (ARRA) prohibits the following providers from charging MHCP copays to American Indian members, regardless of whether the members are enrolled in an MCO:

- Tribal health care providers
- Federal Indian Health Service (IHS)
- Urban Indian Organizations
- IHS-contracted health services (CHS) when there is an IHS referral

### **Collecting Copays and Family Deductibles**

Family deductible amounts appear on the provider remittance advice (RA) with adjustment reason code PR1. You may collect the deductible from the adult member after you see the amount on your RA.

Copay amounts appear on provider RAs with adjustment reason code PR3. You may collect the copay from the member at the time of the visit or bill them for it later. If the member paid the copay

amount and you later find out the member was not liable for the copay, you must refund the amount paid.

### **Spenddowns and Copays**

MHCP applies copays to claims after the member meets the spenddown. If a copay and spenddown apply to a service you provide, you may bill the member for both. MHCP deducts copays and spenddowns from the provider payment and reflects the deductions on RAs with appropriate adjustment codes.

### **TPL and Copays**

If a member with private health insurance primary to MHCP also has an MHCP copay, bill the member for the MHCP copay. Bill the claim to MHCP in the usual manner, reporting the insurance payment on the claim with the balance due. If the MHCP allowable payment rate covers all or part of the balance billed, MHCP will pay up to the maximum MHCP allowable, minus any applicable MHCP copay. MHCP will deduct the copay from its payment amount to the provider and report it as the copay amount on the provider's RA.

### **MCO Enrollment and Copays**

For members enrolled in a managed care organization (MCO), the MCO will notify providers of copay and deductible amounts. Copay amounts for MA members enrolled in an MCO are generally based on FFS MHCP copay guidelines. Copay amounts for MinnesotaCare enrollees may differ from MA copay amounts. [Contact the MCO](#) about your contractual requirements.

### **Member Inability to Pay Copay and Deductible**

Providers cannot deny service to members eligible for Medical Assistance, including major programs MA, RM, EH, and FP, based on inability to pay their copays or deductible as long as they inform you that they are unable to pay the copay or deductible.

Providers must continue to accept a member's assertion of inability to pay their copays or deductible. These state and federal laws do not apply to MinnesotaCare programs.

If a Medical Assistance member cannot pay the copay at the time of their visit, do the following:

- Provide services for the current visit
- Inform the member of their debt and give them the opportunity to pay using your standard office policies and procedures
- Do not deny future or ongoing service to the member

If a MinnesotaCare member cannot pay the copay at the time of the visit, do the following:

- Inform the member of his or her copay obligation for the services
- Provide services for the current visit
- Inform the member of their debt and give them the opportunity to pay using standard office policies and procedures
- Inform the member of your office policy on serving patients with outstanding debt or unpaid copays
- If it is your standard office policy to refuse services to patients who are unable to pay the copay or have outstanding debt, you may refuse to provide ongoing services because of the member's inability to pay their copay

### **Noncovered Services**

You may bill a member for a service only when all of the following conditions apply:

1. The service is not covered. A service is not covered if:

- a. It is never covered by MHCP; or
  - b. MHCP does not cover the service under the member's major program benefit or the member does not meet MHCP criteria for the service; or
  - c. It is being provided by a provider that is out of network and a single case agreement has not been established
2. You reviewed with the member:
    - a. Service limits
    - b. Reasons the service, item or prescription is not covered
    - c. Available covered alternatives
  3. You inform the member before you deliver the services that the member is responsible for payment
  4. You obtain a member signature on the appropriate form (listed in No. 5)
  5. You or an authorized health care representative complete the appropriate forms and provider fields and signs the forms:
    - a. [Advance Recipient Notice of Noncovered Service/Item \(DHS-3640\) \(PDF\)](#)
    - b. [Advance Member Notice of Noncovered Prescription \(DHS-3641\) \(PDF\)](#)

A nonpharmacy provider must also meet the following conditions:

- You must request authorization and seek payment from the other insurance or Medicare before you request authorization or payment from MHCP or the member.
- When a service or item requires authorization, request authorization through the MHCP medical review agent (review the pharmacy conditions listed after this set bullet points). If the authorization is denied for other than a billing error or lack of documentation, you may bill the member.
- Do not request payment from the member for:
  - A service that requires authorization unless authorization was denied as not medically necessary and you have reviewed all other therapeutic alternatives with the member.
  - A service MHCP denied for reasons related to billing requirements.
  - Standard shipping or delivery and setup of medical equipment or medical supplies.
  - Services included in the member's long-term care per diem.
  - More than your usual and customary charge for the service or item.
  - The difference between what MHCP would pay for a less costly alternative service and the upgraded service provided.
  - A service when the member is enrolled in the Restricted Recipient Program and the provider is one of the provider types designated for the member's health care services.
- If MHCP makes any payment, you may bill the member only for amounts designated as cost-sharing or spenddown.

Pharmacies must meet the applicable conditions listed previously for nonpharmacy providers and the following:

- Do not accept payment from a member, or from someone paying on behalf of the member, for any MHCP-covered prescription.
- Do not request payment from the member when the member is enrolled in the Restricted Recipient Program and the provider is one of a provider type designated for the member's health care services.

### **Billing a member for a noncovered prescription**

The following conditions apply for a member to pay for a prescription:

- A member may pay for a noncovered prescription for a drug other than a controlled substance or gabapentin, if the pharmacy and member have completed an Advance Member Notice and all criteria has been met.

- A member may pay for a noncovered prescription for a controlled substance or gabapentin after the pharmacy and member have completed an Advance Member Notice and the form has been signed by the physician certifying that all criteria has been met.

### **Prior authorization**

The following conditions apply when prior authorization (PA) is required for the prescription to be covered:

- Use [NDC Search](#) to find out if a drug is covered or requires authorization.
- You must request authorization and seek payment from the other insurance before you request authorization or payment from MHCP.
- When a prescription:
  - Requires authorization, request authorization through the MHCP Prescription Drug PA agent. If the PA agent denies authorization, you may bill the member unless the prescription requested is a controlled substance or gabapentin.
  - Does not require authorization, bill MHCP. If MHCP denies the prescription for other than a billing error, you may bill the member unless the prescription is a controlled substance or gabapentin.

MHCP does not cover:

- Health services for the following:
  - When a physician's order is required but not obtained
  - When the services are not in the member's plan of care, individual treatment, education or service plan
  - That are of a lower quality standard than the prevailing community standard of the provider's professional peers (providers of services that are determined to be of low quality must bear the cost of these services)
  - Other than emergency health services, provided without the full knowledge and consent of the member or the member's legal guardian
  - Provided outside the United States or by providers whose financial institutions or entities are located outside the U.S.
  - Provided by practitioners working outside their scope of practice or without appropriate credentials
- Missed appointments (do not bill MHCP members for missed appointments)
- Reversal of voluntary sterilizations
- Services primarily for cosmetic purposes
- Vocational or educational services, including functional evaluations or employment physicals, except as provided under individual education plan-related services
- Drugs when indicated or used for erectile dysfunction
- Drugs used for:
  - Fertility
  - Weight loss or weight gain
  - Any cosmetic purpose
  - Symptomatic relief of cough and cold, except those listed in the MHCP Provider Manual
- Drugs determined to be less-than-effective (DESI) by the FDA and drugs identified as identical, related or similar to DESI drugs
- Drugs made by manufacturers that do not have a rebate agreement with CMS
- Drugs limited or excluded by the state as allowed by federal law (OBRA 90)
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Drugs lost in shipping or delivery

- Drugs, legend or OTC, prescribed by practitioners not licensed to prescribe or prescribed outside their scope of practice
- Drugs prescribed by practitioners not enrolled as MHCP providers
- Herbal or homeopathic products
- Nutritional supplements or vitamins, except those listed in the MHCP Provider Manual
- Compounded drugs, except those listed in the MHCP Provider Manual

**Upgrade** An upgrade is not a separate part of a service or item; a service or item that is an increased, newer or more advanced version of its base. For example, a power wheelchair is an upgrade of a manual wheelchair, or a CT scan is an upgrade of an X-ray.

**Add-on** An add-on is a separate part of a service or item; a service or item that is added to enhance a service or item. For example, a basket is an add-on to a walker, or an ultrasound modality is an add-on to a therapy.

### **Retroactive Eligibility**

Some members may become retroactively eligible for MHCP. If a member notifies you that he or she became eligible for a retroactive period, and the member paid for an MHCP-covered service you provided during that retroactive period, you may do one of the following:

- Refund to the member the full amount the member paid you and bill MHCP your usual and customary charge for the services.
- Keep the member's payment to you and do not bill MHCP for the services.

If the service you provided during the retroactive eligibility period is a service or procedure that requires authorization, request authorization according to the guidelines for the procedure. Refer to the [Authorization](#) section of the MHCP Provider Manual.

- If authorization is approved, refund the member's payment and bill MHCP.
- If authorization is denied, keep the member's payment, as the service is considered a noncovered service and do not bill MHCP for the service.

### **Spenddowns**

You may bill a member for a spenddown after you receive the MHCP remittance advice showing the amount of the spenddown. The RA will show adjustment reason code PR142 and the dollar amount the member is to pay.

If the amount of a member's spenddown is later reduced, MHCP will automatically reprocess the previously paid claim. You will see the automatically adjusted claim on your RA. If you collected the spenddown, you may be required to pay back the member's spenddown.

If a member does not pay his or her spenddown, and it is your standard office policy not to provide services to patients with unpaid debt, you may refuse to provide ongoing services to that member, regardless of the member's program eligibility.

A provider may impose a late fee on a member's spenddown if the member doesn't pay their spenddown and the provider imposes late fees on all its patients. The provider may have to return late fees if, at a later time, it is found that the member did not have a spenddown.

Refer to [Spenddowns](#) in the Health Care Programs and Services section for additional information about:

- Spenddowns and eligibility
- Types of spenddowns

### **Use of Collection Agencies**

Providers may hire a collection agency to attempt to get payment from an MHCP member with bad debt or may sell the debt to a collection agency. The collection agency can call or mail, but cannot harass or engage in any other practices prohibited by Minnesota collection law.

The provider may also file a suit against the member, and the provider may get a judgment from the court. However, providers and collection agencies are not able to enforce the judgment against the member until the member has been off all public assistance for six months.

### **Waiving Member Cost-sharing**

Most providers cannot routinely waive member cost sharing without violating the federal Anti-Kickback law and the federal False Claims Act. MHCP does not enforce the Anti-Kickback law or the federal False Claims Act. Some situations may allow providers to not violate the Anti-Kickback law and False Claims Act. Contact your own attorney to discuss and obtain legal advice, or contact the federal [Office of the Inspector General \(OIG\)](#).

### **Legal References**

[Minnesota Rules, 9505.0210](#) (Covered Services; General Requirements)

[Minnesota Rules, 9505.0225](#) (Request to Recipient to Pay)

[Minnesota Rules, 9505.0195](#), subpart 10 (Condition of participation)

[Minnesota Statutes, 256.045](#) (Administrative and Judicial Review of Human Services Matters)

[Minnesota Statutes, 256B.0625](#), subdivision 55 (Payment for noncovered services)

[Minnesota Statutes, 256L.03](#) (MinnesotaCare cost-sharing)

[Minnesota Statutes, 256B.0631](#) (Medical Assistance Copayments)

[Minnesota Statutes, 332.37](#) (Prohibited Practices)

[Minnesota Statutes, 550.37](#), subdivision 14 (Property Exempt; Public assistance)

[Minnesota Statutes, 571.71](#) (Garnishment; When Authorized)

[Minnesota Statutes, 571.912](#) (Form of Exemption Notice)

[Minnesota Statutes, 571.914](#) (Objection to Exemption Claim)

Title XIX Section 1916(e)

[Code of Federal Regulations, title 42, section 447.54](#) (Deductible, Coinsurance, Copayment or Similar Cost-Sharing Charge; Maximum allowable and nominal charges)

[United States Code, title 42, section 1396o\(e\)](#) (Prohibition of denial of services on basis of individual's inability to pay certain charges)