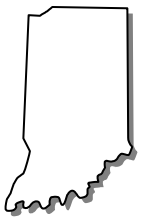

**P R O V I D E R  B U L L E T I N**

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## To: To All Indiana Health Coverage Programs Providers

## Subject: Changes to Spend-down Regulations

The Family and Social Services Administration (FSSA) amended the spend-down regulation published in *402 IAC 2-3-10*. This rule will be implemented beginning April 1, 2005. The changes affect the way in which Medicaid spend-down members meet their monthly spend-down. Provider claim processing is not affected, however, providers who submit statements of services rendered to the local Offices of Family and Children will now be asked to indicate whether the service will be billed to Medicare. The following explains the changes in the regulation:

- Medical services covered by Medicare will not be used to meet the spend-down of members who are also entitled as *Qualified Medicare Beneficiaries (QMB)*. These individuals, whose Medicaid coverage is often referred to as *QMB-also*, have no out-of-pocket expense for the Medicare coinsurance and deductibles, regardless of whether they meet their spend-down in a given month. The eligibility verification systems (EVS) that providers use to verify a member's eligibility also indicate QMB coverage.
- If the above paragraph about QMB coverage is not applicable, medical expenses will be allowed to meet spend-down as follows:
  - If a medical expense covered by Medicare or other insurance is submitted to the caseworker or spend-down clerk *in the month* that the service is rendered, the Medicare approved amount, if known, will count toward spend-down in the month of service. If the provider does not know the Medicare approved amount, the provider's usual and customary charge will be used.
  - If a medical expense covered by Medicare or other insurance is submitted to the caseworker or spend-down clerk in any month *following the month* the service was rendered, the amount remaining after Medicare or other insurance has paid will count toward spend-down for the month of service. In these situations, the provider or member must provide a bill or receipt that shows the remaining balance owed by the member.
- If a member does not meet spend-down for four consecutive months, the member's Medicaid will be discontinued. If the member contacts the caseworker or spend-down clerk before the date of discontinuance and provides information that indicates he or she will meet spend-down in the current or following month, the member's Medicaid eligibility will be reinstated. Any member who is discontinued can reapply for Medicaid at any time.

**To summarize, all providers who submit statements of medical expenses for spend-down purposes must indicate whether Medicare has been or will be billed for the service, and the Medicare approved amount for the service, if known.**

The FSSA sent a letter to all spend-down members and their authorized representatives on February 17, 2005, to explain the revised spend-down rules.