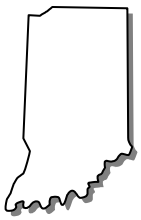
Indiana Health Coverage Programs



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

B T 2 0 0 5 2 7 N O V E M B E R 1 5 , 2 0 0 5

To: All Providers

Subject: Automation of Spend-down

Overview

Beginning on January 1, 2006, the Family and Social Services Administration (FSSA) will implement the amended spend-down regulation published in *405 IAC 2-3-10*. Medicaid provider responsibilities to members enrolled under the spend-down provision are contained in *405 IAC 1-1-3.1*. This bulletin details claim billing, processing, payment enhancements, and member-specific information. If there are questions about the information contained in this bulletin, contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278.

Automating spend-down affects providers, members, and caseworkers, by reducing paperwork and expediting claims payment.

Member Eligibility

The member is eligible for Medicaid at the beginning of the month, but payments are subject to reduction, based on the amount of spend-down liability remaining for the month. Providers may not refuse service to a member pending verification that the member's spend-down has been met.

If a married couple is on spend-down, they have one spend-down for both of them. If either spouse incurs a medical expense by a Medicaid provider, the claim for the expense may be billed to Medicaid. If the claim is payable, the billed amount of the claim is used to credit the spend-down for both of them. More information about creditable spend-down expenses is covered in the *Crediting Spend-down* section of this bulletin.

Billing a Member on Spend-down

Only state-mandated co-payments may be collected at the time of service. A provider may not bill a member for any part of the provider's charge for a service billed to Medicaid until Medicaid has adjudicated the provider's claim for the service, and has notified the provider what portion of the claim is credited to the member's spend-down.

A provider may bill a member for the amount listed as *Amount Applied to Spend-down*; however, with the exception of point of sale (POS) pharmacy claims, the member is not required to pay the provider until the member receives the *Medicaid Spend-down Summary Notice* listing the amount applied to spend-down. Pharmacists will be notified of the amount the member owes at the time the POS claim adjudicates, so they can collect from the member at the time of service. *Medicaid Spend-down Summary Notice* is mailed to a member on the second business day of the month after the month in which a claim is adjudicated. An example of this notice is included in the *Medicaid Spend-down Summary Notice* section of this bulletin.

When a provider is permitted to bill a member, the provider may not apply a more restrictive collection policy to spend-down members than to other patients or customers. If a provider has a general policy to refuse service to a patient or customer with an unpaid bill, that policy may not be applied to a spend-down member before the member receives the *Medicaid Spend-down Summary Notice* for the bill in question.

Providers must bill their usual and customary charge to Medicaid. In general, the maximum amount that a provider may bill a member is the lesser of the spend-down obligation remaining at the time the claim adjudicates or the usual and customary charge on the claim.

Elimination of Form 8A – Notice to Provider of Recipient Deductible

To support the changes to the Indiana Administrative Code (IAC), Indiana Medicaid is implementing an automated process for spend-down-related claims. This new process begins on January 1, 2006. For claims with a date of service on or **after** January 1, 2006, the Form 8A is no longer required.

For claims with dates of services **before** January 1, 2006, the following applies:

- If a spend-down effective date is not already established in the system, the new automation process is applicable and the Form 8A is not required.
- If a spend-down effective date is already in the system, the provider must submit the Form 8A with any claim with a date of service *equal to* the spend-down effective date.
- If the date of service is *before* the met date, the claim will deny with Explanation of Benefit (EOB) codes *387* (detail level) or *388* (header level) – *This service is not payable. The recipient has not satisfied spend-down for the month.*
- If the date of service is *after* the met date, the claim will process according to Indiana Health Coverage Programs (IHCP) policy and the Form 8A is not required.

Eligibility Verification Systems and Spend-down

The Eligibility Verification Systems (EVS) maintains all historical spend-down information to ensure all spend-down claims prior to this new automation process apply the correct methodology for adjudication. On January 1, 2006, the EVS will include a spend-down indicator that displays *Y – Yes* if the member is on spend-down and *N – No* if the member is not on spend-down. No dollar amounts or spend-down effective dates will be displayed

effective January 1, 2006. For those months prior to January 2006, which have a spend-down *met-date* on file, the EVS will continue to display the met-date.

Crediting Spend-down

The provider's billed amount, **minus any third party liability (TPL) payments**, is used to credit spend-down. Claims processed by Medicaid apply toward spend-down based on the adjudication date and time. Payable claims credit spend-down for the month of service when the service is incurred.

Under the automated process, the member, or someone on behalf of the member, is no longer required to provide proof of the incurred medical expenses to the caseworker or spend-down clerk, except in certain circumstances. These exceptions will continue to be handled by the caseworker or spend-down clerk, and will be transmitted from the Indiana Client Eligibility System (ICES), the eligibility system, to Medicaid claims processing system. These exceptions are referred to as ***non-claims***. Members will be required to submit bills or receipts from the provider of the service for non-claim items. If provider statements of services rendered are submitted prior to adjudication by a third party, the expense will not be allowed to satisfy spend-down. Examples of non-claims include:

- Expenses incurred before the individual was eligible for Medicaid
- Expenses incurred by the member's non-member spouse or parent, in certain circumstances.
- Allowable expenses incurred for services provided by a non-Medicaid provider.
- Allowable expenses that are reimbursed by a state or local program such as CHOICE or Township Trustee assistance.

When a claim is determined payable, the system credits spend-down in the following order:

1. Non-claim items
2. State-mandated co-payments
3. Denied details, when permitted (See the *Benefits Limits* section of this bulletin for more information)
4. Paid details

Claims that contain state-mandated co-payments will use the co-payment amount to credit spend-down first, and then the amount of the claim. (If the spend-down has been satisfied for the month, the co-payment amount will roll forward to the next available spend-down month.)

> *Note: Claims for Medical Review Team (MRT), Pre-Admission Screening and Resident Review (PASRR), and HoosierRx services are not used to credit spend-down.*

Federally Qualified Health Centers and Rural Health Clinics

The spend-down credit for home health and Federally-Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers will be based on the greater of the billed amount or IHCP-allowed amount for the claim.

Outpatient Hospitals and Ambulatory Hospitals

As a reminder, per version 5.2 of the *IHCP Provider Manual, Chapter 8, page 8-66*, outpatient surgeries provided in a hospital or an ambulatory surgical center are reimbursed an all-inclusive flat fee based on an ambulatory surgical center (ASC) assignment that includes all related procedures. All charges and services associated with the surgical procedure must be bundled together on each line item. Providers must follow this billing procedure to ensure the spend-down credit is applied correctly.

QMB-Also and Spend-down

Some members on spend-down have another type of Medicaid coverage under the Medicare Savings Program, known as Qualified Medicare Beneficiary (QMB). This coverage is often referred to as QMB-Also. Medicaid pays the Medicare co-insurance and deductibles and, therefore medical services covered by Medicare are not used to credit the spend-down. The EVS that providers use to verify a member's eligibility indicates QMB coverage.

Services, such as dental and certain transportation, which are covered by Medicaid but not covered by Medicare, may be used to credit spend-down for QMB-Also members.

Benefit Limits

In general, denied services do not credit spend-down. For example, a service that is not covered by Medicaid under *405 IAC 5*, therefore, denied by Medicaid, does **not** credit spend-down. However, a service that is denied because the member exceeds a benefit limitation which **cannot** be overridden with prior authorization (PA), may credit spend-down.

Note the following examples:

- **Example 1:** A dental cap audit occurs because a member, age 21 or older, has exhausted the $600 benefit limit for dental services. The member has an $800 spend-down for January 2006. The member incurs a dental claim for $700. The claim adjudicates and the entire billed amount of $700 is credited towards the member's spend-down for January 2006, even though the dental cap is exhausted
- **Example 2.** The member, age 21 or older, has not exhausted any of the $600 dental benefit limit. The member has an $800 spend-down for February 2006. The member incurs a dental claim for $700. The claim adjudicates with the entire $700 applied to spend-down, though $0.00 is applied toward the dental cap. While the services may be subject to the $600 dental cap rule, nothing will accrue towards the dental cap until the member satisfies the monthly spend-down and claims are paid.
- **Example 3:** The member, age 21 or older, has not exhausted any of the $600 dental benefit limit. The member has a $400 spend-down for March 2006. The member incurs a dental claim for $700. The allowable amount for billed charges is $500. The claim adjudicates with $400 applied to spend-down and $100 paid and applied to the dental cap.

> *Note: In the event a denied service is used to credit spend-down, and the provider rebills the claim in error, the Medicaid system will recognize the second claim as an exact duplicate and not allow the service to credit spend-down.*

Table 1 – Benefit Limitation Audits that Credit Spend-down

EOB Code	Description
6099	Reimbursement limited to 50 physical medicine treatments
6231	D0230 Each additional film is limited to seven
6232	Prophy limited to one per six months for institutionalized patients
6233	Prophy and fluoride allowed a maximum of $47.75
6236	Dental services limited to $600 for 21 years of age and over (dental claims)
6237	Comprehensive oral exam limited to two per year
6238	Dental services limited to $600 for 21 years of age and over (HCFA claims)
6239	Multiple extractions on the same DOS
6519	Analgesia is limited to one unit per day
6910	Disease management education is limited to six units per year
6920	Diabetes management is limited to eight units in 12 months

Medicare Part A and B Crossover Claims

Medicare crossover claims credit the spend-down with the combined sum of the amounts shown as the co-insurance, psych reduction, blood deductible, and deductible.

- The billed amount of a crossover claim **cannot** be used to credit spend-down.
- The co-insurance and deductible amounts for Medicare Part A claims are prorated based on the number of days billed.
- Medicare Part B claims that span more than one month are credited to the month of the first date of service.
- Co-insurance and deductible amounts on crossover claims for members that are eligible as QMBs do not credit spend-down.

Claims with Span-dates

There are instances in which claims must include span dates, such as claims for inpatient care. The following outlines the claim types and the methodology used to credit spend-down for each type:

- **UB-92 – Inpatient:** Inpatient claims with dates of services that span more than one month are prorated on a daily basis, not counting the discharge date. Spend-down is credited in each month based on the number of days of service reported on the claim for each month minus the day of discharge. The reimbursement is based on the total claim allowed minus the sum of the spend-down credits..

- **UB-92 – Outpatient:** Outpatient hospital claims that span more than one month are credited to spend-down based on individual dates of services as reported on the detail lines of the claim.
- **CMS-1500:** Medical claims with dates of services that span multiple months are credited to spend-down the month of the first date of service.

Voids and Replacements

A member's spend-down can be affected by provider-initiated voids and replacements, systematic mass adjustments, or amounts entered by the caseworker. All types of claims adjustments credited to spend-down show the balance debited for the same amount as the original claim. A claim that is paid, reversed, and rebilled credits spend-down once.

Provider initiated adjustments will re-use the spend-down amount allocated to the original claim. Only IHCP-initiated adjustments (such as a retroactive rate increase) reduce the spend-down amount and increase the paid amount to the provider. Providers that receive payment from the member for the original claim are required to issue a refund to the member. All activity that impacts amounts owed by the member and due to the provider are reported on the Remittance Advice statement (RA). The member receives notification on the member's *Medicaid Spend-down Summary Notice*.

It is important to emphasize that, regardless of the adjustment activity, the amount the member owes for a month will **never** exceed the total monthly spend-down amount.

Spend-down Credit Auto Adjustments

Sometimes the Medicaid system must perform systematic adjustments to claims due to changes in the spend-down amount or non-claim items that must be applied to a month where the spend-down has already been satisfied. Each month, a systematic *auto-adjustment* will occur to balance spend-down activity to ensure the hierarchy of crediting is applied correctly as stated in the *Crediting Spend-down* section of this bulletin.

Claims that are affected by the auto-adjustment balancing, will be identified with an Internal Control Number (ICN) Region of *64*.

Pharmacy Claims Considerations

The state-mandated pharmacy co-payment portion of the claim will credit spend-down first. If spend-down is met for the month, the system rolls over the co-payment amount to the next month. Denied pharmacy claims do not credit spend-down. The billed amount and applicable state-mandated co-payment amount for compounded drugs apply at the header level, not the detail or ingredient level.

Claim Examples

Example 1 – Spend-down Activity for January - $500.00

Claim Order Crediting Spend-down	Date of Service	Provider Type	Amount Incurred	Method of Claim Submission	Claim Processing Date	Claim Status	Spend-down Balance for January
1	1/02/06	Pharmacy	$50.00	POS	1/02/06	Paid $0.00	$450.00
2	1/05/06	Physician	$100.00	Web interChange	1/05/06	Paid $0.00	$350.00
3	1/08/06	Pharmacy	$50.00	POS	1/08/06	Paid $0.00	$300.00
4	1/07/06	Non-claim[1]	$50.00	ICES (County office)	1/10/06		$250.00
5	1/08/06	Outpatient hospital	$300.00	837I (Electronic)	1/15/06	Paid $0.00[2]	$0.00
6	1/02/06	Dental	$100.00	Paper	1/20/06	Paid IHCP-allowed	

[1] A non-claim amount entered by the caseworker.

[2] The claim paid $0.00, because the Medicaid-allowed amount is less than the remaining spend-down for the month.

Example 2 – Spend-down Activity for January - $500.00

Claim Order Crediting Spend-down	Date of Service	Provider Type	Amount Incurred	Method of Claim Submission	Claim Processing Date	Claim Status	Spend-down Balance for January
1	1/02/06	Pharmacy	$50.00	POS	1/02/06	Paid $0.00	$450.00
2	1/05/06	Physician	$100.00	Web interChange	1/05/06	TPL Paid $25.00 Paid $0.00	$375.00[3]
3	1/08/06	Pharmacy	$50.00	POS	1/08/06	Paid $0.00	$325.00
4	1/08/06	Outpatient Hospital	$200.00	837I (Electronic)	1/15/06	Paid $0.00	$125.00
5	1/02/06	Transportation	$100.00	Paper	1/20/06	Paid $0.00	$25.00[4] $100.00 Credit Spend-down to include $2.00 member co-payment
6	1/15/06	Home Health	$200.00	Web interChange	1/25/06	Paid $50.00 IHCP allowed is $75.00	$0.00 $25.00 Credit Spend-down

[3] TPL paid $25.00, therefore, only $75.00 of the claim billed amount is creditable to spend-down.

[4] Member is responsible for the state-mandated transportation co-payment. For this claim example, the co-payment is $2.00. Refer to the *IHCP Provider Manual* for specific transportation co-payment rules.

Example 3 – Spend-down Activity for November - $300.00

Claim Order Crediting Spend-down	Date of Service	Provider Type	Amount Incurred	Method of Claim Submission	Claim Processing Date	Claim Status	Spend-down Balance for November
1	11/02/05	Pharmacy	$20.00	POS (10 a.m.)	11/02/05	Paid $0.00	$280.00
2	11/02/05	Physician	$50.00	Web interChange (2 p.m.)	11/02/05	Paid $0.00	$230.00
3	11/08/05	Dental	$100.00	Web interChange	11/08/05	Paid $0.00	$130.00
4	11/25/05	Physician	Void of Claim #2 for $50.00	Web interChange	11/25/05	Void Entire Claim	$180.00
5	11/28/05	Dentist	$100.00	Paper	12/15/05	Paid $0.00	$80.00
6	11/29/05	Transportation	$150.00	Paper	12/20/05	$0.00[6] IHCP Allowed = $50.00	$0.00 Credit Spend-down

[6] System calculates claim allowance minus credit to spend-down, then allows up to the IHCP maximum fee.

Example 4 – Spend-down Activity for January – $200.00
Spend-down Activity for February – $100.00

Claim Order Crediting Spend-down	Date of Service	Provider Type	Amount Incurred	Claim Allowed	Claim Processing Date	Claim Status	Spend-down Balance
1	1/15/06 – 2/15/06	Durable Medical Equipment (DME)	$100.00	$38.00	2/15/06	Paid $0.00	January: $100.00
2	1/28/06 – 2/02/06	Inpatient	$1200.00	$1153.00	2/15/06	Paid $953.00[7]	January: $0.00 February: $0.00
3	2/10/06 – 2/10/06	Medical Crossover	$75.00	$10.00[8]	2/26/06	Paid $10.00	

[7] The paid portion of this claim represents the total claim allowed (diagnosis-related grouping (DRG) plus capital, medical education, and outlier, as appropriate) minus the spend-down credit.

[8] The paid amount for this claim represents the less of the coinsurance and deductible portion or the ICHP-allowed amount for the service.

Remittance Advice Statement

The RA will clearly identify the amounts credited to spend-down, including any member co-payments that are used to credit spend-down. For complete details about the paper RA and HIPAA 835 Transaction, refer to IHCP *provider bulletin BT200402*, dated February 2004. The following EOBs will be used to help identify claim adjudication activity:

Table 2 – Explanation of Benefits for Identifying Claim Adjudication Activity

Code	Explanation
9015	The IHCP-allowed amount is adjusted by the spend-down amount
9018	No payment made, spend-down is more than the IHCP-allowed amount
9019	Payment adjusted because the patient has not met the spend-down requirements

Adjustment Reason Codes (ARC) 178, will identify the exact amount that was applied to spend-down for each line item of the claim. The provider may bill the member for the amount displayed with ARC 178. Refer to section *Member Eligibility, Billing a Member*, in this bulletin for specific requirements for billing a member. The following is an example of how the RA for CMS-1500 claims will display the spend-down claim.

> *Note: There are different ARCs for dental and inpatient, such as **68** - DRG Weight. (Handled in CLP12), **75** – Direct Medical Education Adjustment, **84** – Capital Adjustment. (Handled in MIA), **94** – Processed In Excess Of Charges.*

- Member's spend-down..... $200.00
- IHCP-allowed for the transportation claim..... $60.00
- Transportation claim billed amount $120.75
- Member co-payment amount $3.00
- ARC 178 – Amount applied to spend-down..... $117.75
- ARC 3 – Co-payment amount..... $3.00
- ARC A2 – Contractual adjustment[9] $60.75
- ARC 132 – Prearranged demonstration project adjustment[10] $60.75

[9] The difference between the billed and allowed amounts.

[10] Used to balance all ARCs on the claim.

Figures 1 – 3 provide examples of RAs for dental claims, CMS-1500 claims, and inpatient claims.

PROVIDER REMITTANCE ADVICE
DENTAL CLAIMS PAID

999999999 X
JONES DENTAL CLINIC
1212 SOUTH SMITH STREET
P.O. BOX 30303
ANYTOWN, IN 99999-9999

CHECK/EFT NUMBER 999999999

RECIPIENT NAME	RID NO.	SERVICE DATES FROM THRU	BILLED AMOUNT	TPL AMOUNT	PAID AMOUNT
XXXXXXXXXXX X X	999999999999	011506 011506	85.50	0.00	11.00

PL SERV	PROC CD/	MODIFIERS	Units	REND PROV	TOOTH	SURF	DATE SVC PERF	Billed Amount	Patient Responsible	Paid
11	DXXXX		1.000	XXXXXXXX			011506	30.00		0.00
11	DXXXX		1.000	XXXXXXXX	K		011506	55.50		11.00

EOBS	001	9000	9018	9019					
	002	9000	9015						
ARCS	001	178	30.00	94	2.25	132	27.75		
	002	178	40.50	94	4.00				
REMARKS	001	N45							
	002	N45							

Figure 1 – Remittance Advice, Dental Claims Paid

PROVIDER REMITTANCE ADVICE
HCFA 1500 CLAIMS PAID

999999999 X

1212 SOUTH SMITH STREET
P.O. BOX 30303
ANYTOWN, IN 99999-9999

RECIPIENT NAME / XXXXXXXXXXX X X	RID NO./ PL SERV	--ICN-- PROC CD MODIFIERS	PAT NO./ UNITS	SERVICE DATES FROM	THRU	RENDERING PROVIDER	BILLED AMOUNT	TPL AMOUNT	CO-PAY	PAID AMOUNT
	999999999999	RRYYJJJBBBSSS	999999999999	011506	011506	9999999999X	120.75		3.00	0.00
	99	XXXXX XX XX	1.00	011506	011506	9999999999X	120.75			

EOBS	001	9000	9015					
	002	9000						
ARCS	001	178	117.75	003	A2	60.75		
	002	132	-60.75	004	3	3.00		
REMARKS	001	N45						
	002	N45						

Figure 2 – Remittance Advice, CMS-1500 Claims Paid

PROVIDER REMITTANCE ADVICE
INPATIENT CLAIMS PAID

999999999 X
JONES HOSPITAL
1212 SOUTH SMITH STREET
P.O. BOX 30303
ANYTOWN, IN 99999-9999

CHECK/EFT NUMBER 999999999

RECIPIENT NAME	RID NO.	ICN/DAYS	PAT NO./DRG	FROM \THRU ADMIT	OUTLIER/ DRG-LOC BASE	MED ED/ CAPITAL COST	TPL/ RESP	PATIENT	BILLED/PAID
XXXXXX X X	9999999999	RRYYJJJBBBSSS	XXXXXXXXXX	012206 012806		390.35	0.00		2,500.25
		6	0629	012605	617.34	135.45	0.00		1,043.14

EOB	000	9015	9041	9042	9043	9070

ARCS	000	68	(1,882.91)	75	390.35	84	135.45	178	100.00

REMARKS

Figure 3 – Inpatient Claims Paid

Medicaid Spend-down Summary Notice

Each month, the member receives a summary of the medical bills that are processed and credited towards spend-down during a calendar month. The summary includes both claims and non-claims for the member and the member's spouse or parent, if applicable. Each member, including both spouses of a married couple on spend-down, receives his or her own summary notice. The *Medicaid Spend-down Summary Notice* is mailed to the member on the second business day immediately following the last day of the calendar month. The following is an example of the *Medicaid Spend-down Summary Notice*:

MARION COUNTY D.F.C.
129 E Market, Suite 120
Indianapolis, IN 46205

MEDICAID SPEND-DOWN SUMMARY NOTICE

RECIPIENT NAME
1234 ANY STREET

INDIANAPOLIS, IN 46205

Mailing Date of Notice: April 4, 2006
Member Name: RECIPIENT NAME
Medicaid ID Number: 999999999999
Case Worker ID: W99999

This is a summary of your medical bills that were processed from 03/01/06 through 03/31/06 for spend-down. Some bills are not filed with Medicaid until after Medicare or other insurance has paid. This notice includes claims filed by your medical providers. It also includes non-claims, which are any medical expenses that you submitted to your local Office of Family Resources.

THIS IS NOT A BILL

Keep this notice and compare it to the bills sent by your medical providers.

Your medical providers may bill you for the amounts shown in the column marked 'Amount Applied to Spend-down'. Medicaid will not pay the amounts in this column.

Medical Expenses Processed for your March, 2006 Spend-down

Date of Service	Date Processed	Provider/ Service	Amount Charged	Paid by Other Insurance	Billed to Medicaid	Amount Applied to Spend-down	See Notes Section	Future Credit	Possible Refund
03/25/06		TRANSPORTATION 1234 ANY AVENUE INDIANAPOLIS, IN 46205 COPAY					C, X	$2.00	

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Figure 4 – Medicaid Spend-down Summary Notice, Page 1 of 4

Medical Expenses Processed for your March, 2006 Spend-down (continuation)

Date of Service	Date Processed	Provider/ Service	Amount Charged	Paid by Other Insurance	Billed to Medicaid	Amount Applied to Spend-down	See Notes Section	Future Credit	Possible Refund
03/01/06	03/19/06	TRANSPORTATION 1234 ANY AVENUE INDIANAPOLIS, IN 46205 COPAY	$2.00	$0.00	$0.00	$2.00	C		
03/01/06	03/19/06	TRANSPORTATION 1234 ANY AVENUE INDIANAPOLIS, IN 46205 NON-EMERGENCY TRANSPO	$60.00	$5.25	$54.75	$52.75	A, F		
03/19/06	03/23/06	MEDICAL PROVIDER 1234 N. ANY STREET INDIANAPOLIS, IN 46205 OFFICE VISIT LOW	$255.65	$15.25	$240.40	$240.40	A		
03/20/06	03/23/06	DENTAL PROVIDER 1234 N. ANY STREET INDIANAPOLIS, IN 46205 PROPHYLAXIS - ADULT	$255.65	$0.00	$255.65	$4.85	B		

Medical Expenses Processed for your February, 2006 Spend-down

Date of Service	Date Processed	Provider/ Service	Amount Charged	Paid by Other Insurance	Billed to Medicaid	Amount Applied to Spend-down	See Notes Section	Future Credit	Possible Refund
02/28/06	03/03/06	TRANSPORTATION 1234 ANY AVENUE INDIANAPOLIS, IN 46205 COPAY	$2.00	$0.00	$0.00	$2.00	C		

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Figure 5 – Medicaid Spend-down Summary Notice, Page 2 of 4

Medical Expenses Processed for your February, 2006 Spend-down (continuation)

Date of Service	Date Processed	Provider/ Service	Amount Charged	Paid by Other Insurance	Billed to Medicaid	Amount Applied to Spend-down	See Notes Section	Future Credit	Possible Refund
02/28/06	03/03/06	TRANSPORTATION 1234 ANY AVENUE INDIANAPOLIS, IN 46205 NON-EMERGENCY TRANSPO	$120.00	$0.00	$120.00	$118.00	F		

Notes Section:

A Our records show that Medicare and or other health insurance paid on this claim. Check your Medicare Summary Notice or other insurance explanation of benefits for details of what they paid. Amounts paid by other insurance are not applied to your spend-down obligation. Legal Authority: 405 IAC 2-3-10

B Any amount of the provider's bill to Medicaid that is more than your spend-down obligation will be paid by Medicaid in accordance with reimbursement rules.

C This co-payment amount is itemized on the Summary Notice as a separate line item and is part of the total medical expense for the service you received.

F The co-payment amount for this service is itemized on a separate line.

X The medical expense exceeded your spend-down obligation and was carried forward to be applied to a future month.

Summary of your spend-down status for the months listed in this notice as of 04/01/06.

Month / Year	Spend-down Amount	Status
March 2006	$300.00	Spend-down satisfied
February 2006	$300.00	$180.00 remaining spend-down balance

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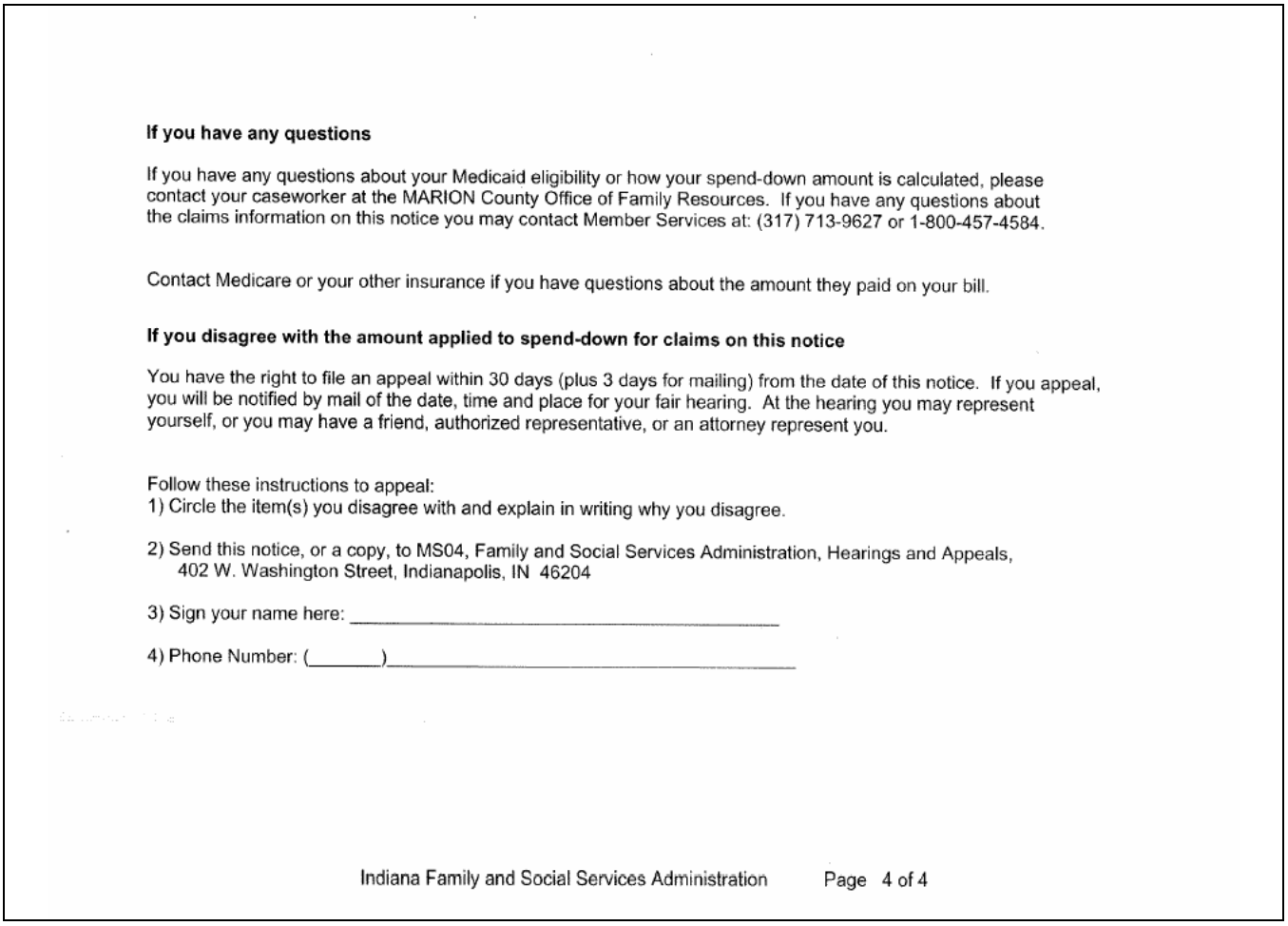
Figure 6 – Medicaid Spend-down Summary Notice, Page 3 of 4



If you have any questions

If you have any questions about your Medicaid eligibility or how your spend-down amount is calculated, please contact your caseworker at the MARION County Office of Family Resources. If you have any questions about the claims information on this notice you may contact Member Services at: (317) 713-9627 or 1-800-457-4584.

Contact Medicare or your other insurance if you have questions about the amount they paid on your bill.

If you disagree with the amount applied to spend-down for claims on this notice

You have the right to file an appeal within 30 days (plus 3 days for mailing) from the date of this notice. If you appeal, you will be notified by mail of the date, time and place for your fair hearing. At the hearing you may represent yourself, or you may have a friend, authorized representative, or an attorney represent you.

Follow these instructions to appeal:
1) Circle the item(s) you disagree with and explain in writing why you disagree.

2) Send this notice, or a copy, to MS04, Family and Social Services Administration, Hearings and Appeals, 402 W. Washington Street, Indianapolis, IN 46204

3) Sign your name here: _____

4) Phone Number: (_____)_____

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Figure 7 – Medicaid Spend-down Summary Notice, Page 4 of 4