Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200219 MAY 15, 2002

To: All Providers

Subject: Spend-down, Co-payments, and QMB Policies

Overview

This bulletin defines spend-down and the process for submitting claims for Indiana Health Coverage Programs (IHCP) members with spend-down, including members who are Qualified Medicare Beneficiaries (QMBs). This bulletin also provides policy related to collection of delinquent spend-down and co-payment amounts. The following information is included:

- Spend-down definition
- Eligibility
- Qualified Medicare beneficiary (QMB) and spend-down
- *FI 006A* form
- *FI 008A* form
- Pharmacy claims
- Third party liability
- Adjustments
- Helpful hints
- Multiple claims
- Collecting delinquent spend-down and co-payment amounts
- Hoosier Healthwise policy on primary medical provider (PMP) collection of delinquent accounts prior to a member's enrollment in Hoosier Healthwise

Spend-down

Members with income in excess of the Traditional Medicaid threshold are eligible to enroll in Medicaid with a spend-down, which is similar to a deductible in that the spend-down represents the amount of monthly medical expenses that Medicaid will not pay. Members' medical expenses must equal or exceed their spend-down (each month) before becoming eligible for the Traditional Medicaid program.

Eligibility

Members are responsible for providing verification of incurred medical expenses to the county Office of Family and Children. After the monthly spend-down is met, the member is eligible for program benefits the remainder of the month.

Members in the following categories are eligible for assistance under spend-down:

- Age 65 and over
- Blind
- Disabled
- Refugee

Qualified Medicare Beneficiary

Qualified Medicare Beneficiary (QMB) is a limited coverage Medicaid category for low-income Medicare beneficiaries. The income and asset limits for eligibility are somewhat higher than those of the Traditional program. For members who are eligible under QMB, Medicaid must pay the Medicare premiums, coinsurance, and deductibles. QMB is distinctive in that a member can have QMB coverage only, or QMB coverage in addition to Traditional Medicaid coverage. The terms *QMB-only* and *QMB-also* are explained below.

The IHCP Eligibility Verification System (EVS), that includes AVR, OMNI, and Provider Electronic Solutions, is designed to inform a provider of a member's Traditional Medicaid/QMB dual eligibility status when spend-down has not been met for the month. For example, if spend-down has not been met on the date of service, the AVR, OMNI, and Provider Electronic Solutions informs the provider that the member's spend-down has not been met, but the member is

eligible as a QMB. If the member is QMB-also, and spend-down has been met, the date spend-down was met will be provided. See *Chapter 3, Eligibility Verification*, of the *IHCP Provider Manual* for further details.

QMB-Only

For members eligible as QMB-only, Medicaid pays Medicare deductibles, coinsurance, and the Part B premium. Therefore, only services covered by Medicare are reimbursable by the IHCP. For these claims, IHCP pays the member's Medicare deductible or coinsurance. Claims received for Medicare non-covered services, when rendered to a QMB member, are denied as non-covered. The member is responsible for paying medical supplies, equipment, and services not covered by Medicare, such as routine physicals, dental care, hearing aids, and eyeglasses.

QMB-Also

A QMB can also be enrolled in Traditional Medicaid with or without a spend-down. In these situations, it is important to remember that until spend-down has been met for the month, the member is only eligible for coverage as a QMB, and the IHCP pays only Medicare deductibles and co-insurance. IHCP covered services that are outside the scope of Medicare coverage such as pharmacy services, non-emergency transportation, or optometry services are not covered by the IHCP until the member's spend-down has been met for the month. Once spend-down is met, the member becomes eligible for the full array of services covered by the Traditional Medicaid Program.

FI 006A Form

When a member has met spend-down a system-generated notice is sent to the member explaining the effective date and, if applicable, the deductible, on the effective date. If members need to obtain medical care on the same day as their effective date, they may ask the county Office and Family and Children to give them a manual notice of spend-down eligibility. This form is the *FI 006A* and proves that a member has met spend-down. With the *FI 006A*, providers can render services to the member and submit claims for payment after the member's file is updated. Spend-down updates are processed and the information is available on EVS devices in approximately three days (72 hours).

FI 008A Form

Providers use the *FI 008A* form, also referred to as form *8A*, when they render a service to a member on the date the spend-down is met. The provider must attach the *FI 008A* form to the claim or claim correction form to receive payment. The *FI 008A* form is available from the county Office of Family and Children.

The FI 008A form shown in Figure 1.2 indicates the date spend-down was met and the dollar amount to be applied as the deductible for each prescription number.

> *Note: An* 8A *form should be attached to the claim when services are provided on the date spend-down is met. When the member's* date of service *is the same as the date spend-down is met, the IHCP is able to process claims that have a completed* FI 008A *form attached. However, the* 8A *form can only be used when the caseworker has entered the data into the Indiana Client Eligibility System (ICES). If the information is not entered into ICES, the IndianaAIM system will continue to deny the claim for edits 387 and 388, spend-down not met for the month. If more than two weeks have passed since the data has been given to the caseworker, providers should contact the county office and ask that the information be added to ICES or find out the date the information was added to ICES. If the information has been added to ICES and claims continue to deny, send an inquiry for review to Written Correspondence, P.O. Box 7263, Indianapolis, IN 46207-7263.*

Pharmacy Claims

When a Traditional Medicaid member's spend-down met date is the same as the date of service, the pharmacy claim can be submitted on the *Drug Claim Form* with the *FI 008A* form attached. If the pharmacy claim is submitted electronically, a Claims Correction Form (CCF) will be generated requesting the *FI 008A* form. The corresponding prescription number(s) must be indicated on the *FI 008A* form with the amount of the deductible to be applied to each prescription number listed. Examples of a Drug Claim Form and the associated *FI 008A* are shown in Figures 1.1 and 1.2.

Compound Claims

When a Traditional Medicaid member's spend-down met date is the same as the date of service, the claim must be submitted on the *Compound Prescription Drug Claim Form* attached to a *FI 008A* form. If the compound claim is submitted electronically, a CCF will be generated requesting the *FI 008A* form. Claims may be submitted electronically after the date that spend-down is met and a *FI 008A* form is not required.

PLEASE PRINT CLEARLY

Indiana Family and Social Services Administration

DRUG CLAIM FORM

Provider Number 01	02	Telephone Number	Total Amount Billed 03

	PATIENT'S NAME: LAST, FIRST 04	RID NO. 05	PRESCRIBER'S I.D. NUMBER 06	EMERG 07	PREG 08	N.F.PAT. 09	BRAND 10	REFILL 11
0	**Doe, John**							
1	**Doe, John**							
2	**Doe, John**							
3	**Doe, John**							

	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18	3RD PTY PAID 19
0	**1234567**		**6/2/00**				**$100.00**	
1	**2345678**		**6/2/00**				**$90.00**	
2	**3456789**		**6/2/00**				**$50.00**	
3	**4567890**		**6/2/00**				**$59.00**	

Figure 1.1 – Example of Drug Claim Form

Note: The Drug Claim Form *example above does not include all the required fields.*

DPW Form 8A

Name of recipient **Doe, John**	Medicaid number (RID)
Spend-down effective date **6/2/00**	Deductible **$270.00**
Name of person completing notice	Date completed

Signature of County Director (or authorized designee)

Example A (Spend-down Documentation written by Provider)

Claim Number	*Prescription number*	*Dollar amount applied to Spend-down*
0	*Rx 1234567*	*$100.00*
1	*Rx 2345678*	*$90.00*
2	*Rx 3456789*	*$50.00*
3	*Rx 4567890*	*$30.00*

Figure 1.2 – Example of *FI 008A* Form

Third Party Liability

For physician, pharmacy, compound, and dental claim forms, if another insurance carrier pays a portion of the claim, EDS adds the spend-down deductible from the *8A* to the paid amount in the TPL field, when the claim is processed for adjudication. This new amount is the TPL payment plus the spend-down deductible amount, and is deducted from the allowed amount for the service. On a *UB-92* form, the deductible is entered in Box 50 of Line C of the claim form and the payment from other insurance is entered in Box 50 of Line B.

Adjustments

Providers must submit adjustment requests or refunds for claims paid incorrectly due to spend-down issues. The most common reasons for adjustments to claims that have spend-down involved include the following:

- *Spend-down deductible deducted from the wrong date of service* – The provider submits an adjustment form with a copy of the *FI 008A* form for the claim that was paid incorrectly. The adjustment form must state that the spend-down was deducted from the wrong *date of service*. The provider must also submit the *FI 008A* form indicating the correct spend-down date of service along with the corresponding claim that spend-down should have been deducted from.
- *Wrong Spend-down deductible amount deducted from the claim* – The provider submits an adjustment form with a copy of the *FI 008A* form for the claim that was paid incorrectly. The adjustment form must state that the spend-down amount must be corrected.
- *Spend-down taken from a previous claim with same* date(s) of service – When there are two claims with the same *date of service* and the spend-down is deducted from both claims, the provider submits an adjustment form to adjust the spend-down on the claim that paid last. The provider also submits a new *FI 008A* form indicating $0 for spend-down. The adjustment form must also state that the spend-down was deducted from a previous claim and must indicate the corresponding ICN number.
- *Spend-down not deducted from claim* – The provider submits an adjustment form with a copy of the *FI 008A* form for the claim that was paid incorrectly. The adjustment form must state that the spend-down was not deducted from the claim.

Helpful Hints

If the date of service is the same as the date spend-down is met, the IHCP does not pay the claim unless the *FI 008A* form is attached to the claim. Electronic claims are paid, denied, or suspended. If suspended, a CCF is generated for the *8A* form. Paper claims with attachments for spend-down members are paid, denied, or suspended as follows:

1. Denied if no spend-down met date is entered on the member's file. The denial code would be *0387* or *0388*, Spend-down not met for the month. Caseworkers are responsible for updating the member's file with the correct spend-down met date.
2. Suspended on the day the spend-down is met on the member's file. If the claim is suspended, the EDS Resolutions Unit does the following:

- Looks for the *FI 008A* form
- Verifies the member's name
- Verifies the date spend-down was met
- Verifies the date the spend-down form was completed
- Verifies the signature of the caseworker
- Verifies deductible
  - If there is no deductible, the allowed amount is paid for the service.
  - If there is a deductible, the deductible is applied in *TPL Field*.

After the deductible is applied, it is subtracted from the allowed amount paid on the claim. The suspended code would be *0385* or *0386*, *Spend-down date same as date of service*.

> *Claims billed on the* HCFA-1500 *form, pharmacy claim form, compound pharmacy claim form and dental claim form do NOT reflect the spend-down amount, since there is no field for this information. The spend-down amount information is taken from the* 8A *form, and deducted from the Medicaid allowed amount*
>
> *Claims billed on the* UB-92 *form reflect the spend-down amount in block* 54C *of the* UB-92 *claim form.*

Multiple Claims for the Same Date of Service

When multiple claims have the same date of service and the date of service equals the spend-down met date, a spend-down form is required for each individual claim. Each *FI 008A* spend-down form must reflect the exact amount to be deducted from the corresponding claim. This ensures that the correct spend-down amount will be deducted from each individual claim.

Billing the Member who has a Spend-down

The *IHCP Provider Manual* states, "If the date of service is prior to the date spend-down was met, the service is not reimbursable by the IHCP. In these situations, the provider may collect payment for the service from the member or bill the member if payment is not collected from the member on the date of service." If it is the provider's office policy to have a private-pay customer pay when the service is rendered or not receive the service, then the provider may use the same policy for IHCP members. The member remains liable to the provider for the incurred expenses used to meet spend-down, and the provider may take action to collect payment in the same manner that the provider would pursue collection from non-Medicaid customers.

Providers' office policies for delinquent payment of incurred expenses including spend-down must apply to both private-pay customers as well as IHCP members. The policy should reflect that the provider will not continue serving a member who has not made a payment on past-due bills for x months, has unpaid bills exceeding y dollars, and has refused to arrange or not complied with a plan to reimburse the expenses. Notification to the IHCP member of this policy must be made in the same manner that notification is made to private pay customers. Notification that the provider will no longer provide services to the IHCP member must be made in the same manner that notification is made to private pay customers.

Pharmacy and Transportation Providers

Billing the Patient for Delinquent Co-payments

IC 42 CRR 447.15 states that a provider may not refuse to provide services to a member who cannot afford the co-payment. However, the member remains liable to the provider for the co-payment, and the provider may take action to collect it. The provider may bill the

member for that amount and take action to collect the delinquent amount in the same manner that the provider collects delinquent amounts from private pay customers.

Providers may set office policies for delinquent payment of incurred expenses including co-payments. The policy must apply to both private-pay patients as well as IHCP members. The policy should reflect that the provider will not continue serving a member who has not made a payment on past-due bills for x months, has unpaid bills exceeding y dollars, and has refused to arrange or not complied with a plan to reimburse the expenses. Notification of the policy and the refusal to see the IHCP member must be done in the same manner that notification is made to private pay customers.

Hoosier Healthwise Program

PMPs may not initiate member transfer requests because of unpaid bills incurred prior to Hoosier Healthwise enrollment. PMPs should pursue charges outstanding prior to Hoosier Healthwise enrollment through the normal collection process. Likewise, pharmacists and transportation providers who have uncollected accounts from current IHCP members where the debt occurred prior to the member's enrollment in IHCP should pursue collection separately.

Questions about spend-down should be directed to the EDS Customer Assistance Unit at (317) 655-3250 in the Indianapolis local area or 1-800-577-1276.

CDT-3/2000 (including procedure codes, definitions (descriptions) and other data) is copyrighted by the American Dental Association.© 1999 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation System/Department of Defense Acquisition Regulation System (FARS/DFARS) Apply.

CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.