

Provider spenddown step-by-step

Description

Spenddown is like an insurance deductible and is used to determine a client's liability for the cost of medical care. Clients must incur medical expenses equal to their excess income (spenddown or liability) before medical benefits are covered. The spenddown liability is the client's financial obligation and can't be paid by the state. We compute the amount of the client's spenddown using a base period, consisting of three or six consecutive calendar months. Depending on when the client's incurred medical expenses meet the spenddown liability, the client may get medical benefits for all or part of the base period. Clients can also request retroactive eligibility for 1 – 3 months prior to the application month to cover their bills incurred before applying. When clients have met their spenddown, they will have medical coverage under the **Medically Needy Program (MNP)**. The agency reduces the provider's payment amount by the amount determined to be the client's financial obligation.

Process

If a client is on a spenddown, they will receive a letter describing their spenddown amount and their base period. If a provider is assisting a client to have bills applied to the client's spenddown, the provider can fax paid or unpaid bills incurred during the client's base period to the **Spenddown Fax Line at 1-888-338-7410**. Unpaid bills incurred outside of the base period should also be submitted and can be for any family member in the household. For urgent cases (immediate medication need, emergent medical condition, or needs immediate doctor appointment), providers can call the **Provider Spenddown Line at 1-877-501-2233 and leave a message to request a call back from the Spenddown Unit**.

Once the financial obligation of the spenddown is met, the client will receive a letter describing their eligibility. It will contain the amount of individual provider bills applied to the total, the base period, and any retroactive eligibility. It will also describe any bills unable to be used.

What will the client's eligibility look like in ProviderOne?

If the client has not yet met their financial obligation to gain medical benefits, the Benefit Service Package (BSP) will show **Pending Spenddown-No Medical** (providers can bill the client without Form 13-879) with ACES Coverage Group code S99. When the client satisfies their spenddown liability and is now eligible, their BSP will show **MNP (Medically Needy Program)** and could show retroactive dates. The provider must bill the agency once the client has medical coverage.

Pending Spenddown – no medical coverage:

Insurance Type Code ▲ ▼	Recipient Aid Category (RAC) ▲ ▼	Benefit Service Package ▲ ▼	Eligibility Start Date ▲ ▼	Eligibility End Date ▲ ▼	Review End Date ▲ ▼	ACES Coverage Group ▲ ▼
MC: Medicaid	1124	Pending Spenddown - No Medical	06/01/2023	12/31/2999	11/30/2023	S99

MNP – has medical coverage:

MC: Medicaid	1124	LCP-MNP	10/01/2022	12/31/2999	09/30/2023	S99
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When does a provider report the spenddown amount on a claim?

- If the claim “from” date of service is the same as the client’s eligibility start date; or
- The claim was used to satisfy the spenddown.

What amount do providers report on their claim?

- Call **1-877-501-2233** and leave a message requesting a call back to get the spenddown amount needed to report or get a copy of the client’s award letter.
- If no spenddown is reported on the claim, it will be denied.
- Spenddown must be reported accurately.
- The spenddown is subtracted from the agency’s allowed amount and the provider may be paid any difference.
- The client is only liable for the spenddown amount of the claim.

How does a provider report the spenddown amount on a claim?

Claim type	EDI claim transaction	DDE claim
Professional	Electronic batch 837P • HIPAA 5010, Loop 2300 • AMT Patient Amount Paid segment • Use Value Qualifier F5 in AMT01 • Enter the \$ amount in AMT02	Professional claim form • Claim Information section • Under Claim Data • Expand the “+ Additional Claim Data” section (click red +) • Enter \$ amount in Patient Paid Amount field
Institutional	Electronic batch 837I • HIPAA 5010 Value Codes, Loop 2300 • HI Value Information segment • Enter Value Code 66, enter \$\$ amount	Institutional claim form • Claim Information section • Expand the “+ Value Information” section (click red +) • Enter Value Code 66 (spenddown) • Enter \$ amount
Dental	Electronic batch 837D • HIPAA 5010, Loop 2300 • AMT Patient Amount Paid segment • Value Qualifier F5 • Enter \$ amount	Dental claim form • Claim Information section • Expand the “+ Additional Claim Data” section (click red +) • Enter \$ amount in Patient Paid Amount field



QMB-Medicare only clients

- Client would have QMB status through the spenddown period with Medicare as primary.
- Bill Medicare first, then bill Medicaid the crossover claim:
 - Medicaid may pay the crossover (depends on the Medicare payment);
 - Providers cannot bill the client for these balance amounts from crossover claims;
 - There is no spenddown amount to report on the crossover claim;
 - Balances not paid on the crossover claim cannot be applied to the spenddown liability.
- Services not paid for by Medicare are used to satisfy the spenddown liability.

Note for Nursing Homes: When billing for the patient participation on your Institutional claim, use Value Code 31 and enter the participation amount. If the patient also has a spenddown, enter the spenddown following the above Institutional Claim guidelines as a separate entry from a participation amount.