Spend-Down Billing Tips

Policy: Medicaid Provider Manual (MPM) Chapter "Beneficiary Eligibility" Section 4-Medicaid Deductible Beneficiaries.

- Eligibility Criteria: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-35199--,00.html
- Eligibility verification tools: http://www.michigan.gov/documents/mdch/WebCo-PayTable_11-02-06_182172_7.pdf
- Co-payment descriptions: http://www.michigan.gov/documents/mdch/WebCo-PayTable_11-02-06_182172_7.pdf
- Verifying the patient spend-down amount/liability: https://healthplanbenefits.mihealth.org

Medicaid deductible means that the beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local MDHHS county case worker to qualify for Medicaid.

- **Process:** Beneficiary presents proof of ANY medical expense incurred to their local MDHHS county case worker. Items they can use e.g., care from hospitals, doctors, clinics, dentists, drugs, medical supplies and equipment, health insurance premiums, transportation to get medical care, personal assistance services, adult home help services, and other services from Community Mental Health.

- Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. In other words provider would not have to verify concrete amounts via EOB-this will speed up the process to get that eligibility started for the beneficiary.

Beneficiary should be advised to contact their respective local MDHHS county office caseworkers within 10 days of receipt of any charges they may use to satisfy their deductible. Next the MDHHS local county case worker is to review documentation and determine beneficiary liability and the first date of Medicaid eligibility.

- **FIRST DATE of eligibility**: Once calculated the caseworker sends letters to those providers whose service are entirely the beneficiary responsibility in whole or in part. Secondly the case worker sends same to beneficiary.

- Local MDHHS county caseworker will update system with applicable benefit plan=MA or MA-ESO, etc. Once the first date of eligibility has been established eligibility policy forbids recalculations. It is therefore imperative that expenses incurred be submitted on a timely basis and in the order incurred.

- Once the deductible amount is incurred, eligibility is established through the end of the month. And then it starts all over again-remember eligibility is established on a month by month basis.

Beneficiaries are responsible for payment of expenses that were incurred to meet the deductible amount. Payment for these services do not have to be made before Medicaid eligibility is approved.

- **Institutional Billers:** Use VALUE CODE 66 to report the spend-down amount on your claim. This amount will be deducted from the Medicaid "fee screen" or price of the claim. (Per uniform billing rules)

- **For Practitioner invoice types:** Reduce amount of providers' charges by the spend-down amounts in Form Locator 24F of the service line. (Per the chapter Billing & Reimbursement for Professionals Section 6-Special Billing (6.2 3rd Party Coverage))