# Guide to Patient Liability for Nursing Facility Services

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## Overview

Pursuant to federal law and regulation, patient liability is a ***monthly*** amount that persons receiving Medicaid-reimbursed Long-Term Services and Supports (LTSS) or hospice services in a Nursing Facility (NF) are required to contribute to the cost of their care if their incomes are at certain levels. For dual eligible members (i.e., eligible for Medicare and Medicaid) who are not Qualified Medicare Beneficiaries (QMBs), patient liability is also used to offset any Medicaid payment for Medicare services in a Skilled Nursing Facility (SNF) (i.e., Medicare deductibles and co-insurance). For QMBs, the Medicaid payment for Medicare deductibles and co-insurance cannot be reduced based on the member's patient liability obligation.

A person's patient liability obligation is determined by TennCare Member Services in accordance with federal post-eligibility provisions which take into account the person's income that is available to help pay for such care after a reasonable allowance for personal needs and other living expenses, allocation of income to a community spouse or dependents, and incurred medical expenses not subject to payment by a third party, as applicable.

NFs are obligated pursuant to TennCare Rules and their contracts with TennCare Managed Care Organizations (MCOs) to collect each Medicaid resident's patient liability. Medicaid payments made by the MCO to the facility for each month must be reduced by the *entire* amount of patient liability due for that month.

MCOs are responsible for reducing the Medicaid payments to a NF or to a hospice agency for hospice services in a NF by the applicable monthly amount of patient liability. Patient liability is thus applied in a manner similar to an insurance deductible, except on a monthly basis, as required under federal law. It is applied to the first payable NF claim received by the MCO, with any remaining balance applied to subsequent NF claims received and processed by the MCO (up to the cost of Medicaid services provided to the member during that month).

Patient liability is applied *only* to the cost of long-term care services or hospice room and board charges, including covered Level I NF bed hold days (bed hold days are not reimbursed for hospice or Level 2 NF). The amount of patient liability collected in a month should never exceed the total Medicaid payment obligation for LTSS and/or hospice services (including room and board) in a NF.

Except as provided below with respect to the month of enrollment into or disenrollment from CHOICES Group 1, MCOs are obligated to deduct the ***entire* monthly** patient liability amount from the payment for NF or hospice room and board claims, so long as that amount does not exceed Medicaid payments for long-term care services or hospice room and board provided during that month. This means that if a person is absent from the facility and there is a non-covered day, (because the person has exhausted his bed hold days or the facility does not meet minimum occupancy requirements to bill bed hold days), the facility must still collect the full monthly patient liability amount, and the total Medicaid payments made by the MCO for the month must still be reduced by the total monthly patient liability amount, so long as the total patient liability collections do not exceed total Medicaid payments for nursing facility services or hospice room and board for the month.

This does not preclude the facility from requiring a payment from the resident to hold the bed. However, the patient liability collected from the resident cannot be retained by the facility for that purpose, as the full monthly amount of patient liability must, pursuant to federal law, be deducted from Medicaid payments made by the MCO.

### I. Month of Enrollment into or Disenrollment from CHOICES Group 1

The total Medicaid payments made by an MCO for services (including hospice) in a NF during a month must be reduced by the total ***monthly*** patient liability amount, *except* for the month of enrollment into and disenrollment from CHOICES Group 1 or the month of election/withdrawal of election of hospice services in a NF and only in instances when, for some part of the month, the person was neither enrolled in CHOICES Group 1 nor receiving hospice services in a NF. ONLY in such instances is the monthly patient liability amount pro-rated based on the total number of days the person is enrolled in CHOICES Group 1 or receives hospice services in a NF during that month. This is primarily to allow the person sufficient income to pay community living expenses for the remainder of the month when neither NF nor hospice services in a NF are received. However, the same policy is applied regardless of the reason for disenrollment or withdrawal of election of hospice services in a NF, including when a resident is deceased.

When a Medicaid eligible member elects to receive hospice services in a NF, he is not enrolled into CHOICES Group 1 (or if enrolled in CHOICES at the time of hospice election, is disenrolled from CHOICES Group 1). However, such member (including a non-QMB dual eligible member) remains obligated to pay his patient liability obligation to offset the Medicaid payment for hospice services provided in the NF (including room and board which is paid by TennCare for dual eligible individuals receiving hospice benefits under the Medicare program).

If a person enrolled in CHOICES Group 1 at the beginning of the month disenrolls from CHOICES Group 1 during the month in order to elect hospice services in the NF, his patient liability obligations are unchanged. Likewise, if a person receiving hospice in a NF at the beginning of the month withdraws his hospice election during the month and enrolls into CHOICES Group 1 for receipt of NF services, the member remains responsible for the full month's patient liability unless for part of the month, the resident is neither enrolled in CHOICES Group 1 nor receives hospice services in a NF. However, a pro-rated share of the monthly patient liability amount is applicable to the Medicaid cost of NF services provided (based on dates of enrollment in CHOICES Group 1), with the remainder applicable to offset the cost of hospice room and board in the NF that is paid by the MCO to the hospice agency and by the hospice agency to the NF.

The NF will invoice the hospice agency for the room and board rate, which is 95 percent of the NF's per diem. On the invoice, the NF will show a credit for the patient liability amount that the NF is responsible for collecting. The payment that the hospice agency makes to the NF will therefore be reduced by the amount of the patient liability that the NF is obligated to collect. In turn, the amount billed by the hospice agency to the MCO for hospice room and board will reflect the member's patient liability obligation, and the amount reimbursed by the MCO to the

hospice agency for hospice room and board is net of the patient liability amount the NF is obligated to collect.

The TennCare Medicaid Management Information System (MMIS) is the system of record for CHOICES enrollment. Eligibility/enrollment files are sent from TennCare to MCOs on a daily basis. When a CHOICES member is discharged from the facility or elects hospice in the NF, it is critical that NFs complete and submit to the MCO in a timely manner the Discharge-Transfer-Hospice Form as is required by TennCare Rule 1200-13-01-.10(2)(b) and the NF's Provider Agreements with MCOs. This allows the MCO to notify TennCare when a member is no longer receiving NF services and to disenroll the member from CHOICES. From a claims processing perspective, MCOs will adjudicate claims and apply patient liability based on the eligibility information received from TennCare. Any necessary adjustments of patient liability amounts previously applied will be automatically made by the MCO once the updated eligibility/enrollment information is received.

**Example:** Resident A is enrolled into CHOICES Group 1 on April 16th. Resident A's monthly patient liability amount is $2,000. Resident A's monthly patient liability amount will be pro-rated based on the number of days he is in enrolled in CHOICES Group 1 during that month, i.e., $2,000 x 15 days divided by 30 days in the month or $1,000. The facility's Medicaid per diem rate is $150. The facility's charges of $2,250 for 15 days of NF services will be reduced by Resident A's pro-rated patient liability amount of $1,000. The balance of $1,250 will be paid by Resident A's MCO, subject to timely filing requirements.

Please note that when a resident is discharged to the hospital and will return to the facility (or to another NF), he is **not** disenrolled from CHOICES Group 1, and the monthly patient liability amount should **not** be pro-rated. The facility may be eligible to bill bed hold days (see TennCare Rule 1200-13-01-.03(9)). If not, the days the resident was hospitalized will be non-covered days, and may be billed accordingly. However, whether covered or non-covered, days absent from the facility do **not** reduce the amount of the resident's ***monthly*** patient liability obligation for Medicaid covered services.

**Example:** Resident B has been enrolled in CHOICES Group 1 for several months. Resident B's monthly patient liability amount is $2,000. On April 1st, Resident B is admitted to the hospital for fifteen (15) days, after which he returns to the NF for the remainder of the month (April 16th-30th). This is Resident B's first hospital admission (or therapeutic leave) for the year, such that none of his ten (10) bed hold days for the year has been utilized. Resident B's monthly patient liability amount will **not** be pro-rated because he has remained enrolled in CHOICES Group 1 for the entire month. At least eighty-five percent (85%) of all other beds in the NF were occupied at the time of Resident B's hospital admission; thus, the facility can bill for ten (10) of the fifteen (15) hospital days. The facility's Medicaid per diem rate is $150. The facility's total Medicaid charges will be $3,750 (15 days NF services + 10 bed hold days = 25 days x $150 per day). The facility is obligated to collect the full monthly patient liability amount since Resident B was enrolled in CHOICES Group 1 for the entire month. The Medicaid charges of $3,750 will be reduced by the $2,000 monthly patient liability amount. The balance of $1,750 will be paid by Resident B's MCO, subject to timely filing requirements.

If the full amount of a resident's monthly patient liability amount has been collected and the resident subsequently discharges from the facility and disenrolls from CHOICES Group 1, the facility must pro-rate the former resident's monthly patient liability amount based on the number of days he was enrolled in CHOICES Group 1 during that month, and promptly return any overpayment to the resident.

Appendix A includes additional examples of how patient liability amounts will be applied in the processing of NF claims, including instances where a member is enrolled in CHOICES Group 1 for only a portion of the month.

### II. Transition to CHOICES Group 2 or 3

When a resident transitions to CHOICES Group 2 or 3 and begins receiving HCBS, he is disenrolled from CHOICES Group 1. In such circumstances, as noted above, the monthly patient liability amount collected by the facility is pro-rated based on the number of days the person was enrolled in CHOICES Group 1 during that month. Upon discharge, collection of patient liability is the responsibility of the MCO, based on a community personal needs allowance that takes into account the income necessary to pay community living expenses.

**Example:** Resident C has been enrolled in CHOICES Group 1 for several months and is transitioning out of the facility and into CHOICES Group 2 for Home and Community Based Services (HCBS). Resident C's monthly patient liability amount in the NF is $2,000. Resident C is transitioned on April 16th. Resident C's monthly patient liability amount will be pro-rated based on the number of days he is in enrolled in CHOICES Group 1 during that month, i.e., $2,000 x 15 divided by 30 days in the month or $1,000. The facility's Medicaid per diem rate is $150. The facility's charges of $2,250 for 15 days of NF services will be reduced by Resident C's pro-rated patient liability amount of $1,000. The balance of $1,250 will be paid by Resident C's MCO, subject to timely filing requirements. Resident C's patient liability amount in the community will be re-calculated by TennCare Member Services based on the community personal needs allowance. Resident C's MCO will be responsible for patient liability collections once Resident C is transitioned to the community.

### III. Transfers between Medicaid NFs

When a resident transfers between Medicaid NFs during a month, the facility where the resident first resided is responsible for collection of the total monthly amount of patient liability up to the cost of Medicaid services provided by that facility during that month. The facility to which the resident transfers is responsible only for collection of any remaining patient liability amount up to the cost of Medicaid services provided by the second facility. Any Medicaid NF receiving a transfer from another Medicaid NF is responsible for obtaining as part of the transfer, information regarding the resident's monthly patient liability obligation and collections for the month, including whether any patient liability collections must be returned to the resident because they exceed the Medicaid payment obligation for services provided to the resident by the facility prior to the transfer.

Because claims are processed on a first-in/first-out basis, if a member transfers between NFs during a month, it will be important that the NF from which the resident is discharged promptly submits claims for dates of NF services provided. This will help to ensure that patient liability amounts are properly applied. If the first claims received and paid by the MCO are from the second facility (rather than the first), notification will be required by the NF to the MCO, with manual adjudication of the claims to ensure appropriate application of patient liability amounts.

**Example:** Resident D has been enrolled in CHOICES Group 1 for several months and is transferring to another NF closer to where his family resides. Resident D is transferred to the new facility on April 16th. Resident D's monthly patient liability amount is $2,000. The Medicaid per diem rate for the facility where Resident D resides is $150. Since the cost of Medicaid services provided by the facility where Resident D first resided during the month ($2,250 for 15 days of NF services) is at least as much as Resident D's monthly patient liability amount, this facility will be responsible for collecting the full monthly amount of Resident D's patient liability ($2,000). The facility to which Resident D transfers will not collect any patient liability for the remainder of the month, but will be responsible for patient liability collections for Medicaid services provided the following month.

If the full amount of a resident's monthly patient liability amount has been collected and the resident subsequently transfers to another facility, and the cost of Medicaid services provided by the first facility is less than the monthly amount of patient liability collected, the facility where the resident first resided must promptly return any overpayment to the resident for services provided in that facility. The facility to which the resident transfers will be responsible for patient liability collections for Medicaid services it provides during the remainder of the month, and for subsequent months.

**Example:** Resident E has been enrolled in CHOICES Group 1 for several months and is also transferring to another NF closer to where his family resides. Resident E is transferred to the new facility on April 16th. Resident E's monthly patient liability amount is $2,000. The Medicaid per diem rate for the facility where Resident E resides is $100. Since the cost of Medicaid services provided by the facility where Resident E first resided during the month ($1,500 for 15 days of NF services) is less than Resident E's monthly patient liability amount, this facility will be responsible for collecting patient liability for the full cost of NF services provided ($1,500). Resident E's MCO will make no additional payments for NF services provided by this facility. The facility to which Resident E transfers will be responsible for collecting the remainder of Resident E's patient liability ($500) to offset the cost of Medicaid NF services provided by that facility for the remainder of the month. The balance will be paid by Resident E's MCO, subject to timely filing requirements.

## IV. Patient Liability Collection for Residents Receiving Medicare SNF Services During the Month

In Tennessee (as in many states), the crossover claims reimbursement methodology for Medicare Skilled NF (SNF) services limits the Medicaid payment for Medicare deductibles and

co-insurance based on the Medicaid Level 2 per diem rate established for that facility. If the Medicare payment is higher than the allowable amount deemed by Medicaid (the Medicaid Level 2 per diem rate for NF services), the Medicaid crossover payment amount is zero. 42 CFR § 447.20-.21 prohibits the facility from collecting patient liability if it exceeds the allowed amount deemed by Medicaid and provides for sanctions in the event the facility does so. If Medicaid owes nothing on the SNF crossover claim, then patient liability cannot be collected by the facility for the claim.

**Example:** Resident F has been receiving Medicare SNF services following an acute hospitalization. He is a non-QMB dual eligible member. He is not enrolled in CHOICES Group 1. The Medicare per diem payment for the Medicare SNF service Resident F has been receiving is $300. The Level 2 Medicaid per diem rate for the facility providing the service is $200. Since the Medicare payment is higher than the Medicaid Level 2 rate, the crossover payment for the Medicare SNF service will be zero. Resident F's monthly patient liability amount cannot be used to offset the cost of Medicare SNF services.

Please note, however, that this does not impact Resident F's patient liability obligations for Medicaid NF services or Medicaid payments for hospice services in a NF that may also be provided during the month. If the total cost of Medicaid NF services or Medicaid payments for hospice services in a NF provided during the same month is at least as much as the resident's monthly patient liability amount (or the pro-rated share of the monthly patient liability amount for the month of CHOICES Group 1 enrollment or disenrollment and/or election of hospice services in a NF), then the entire applicable amount must be collected by the facility and will be used to offset the cost of Medicaid NF services or Medicaid payments for hospice services in a NF provided during the month. The facility is not entitled to keep any of this money for payment of the SNF deductible or co-insurance, and in fact, if it does so, is in violation of federal law, and is subject to sanctions as set forth in the law and its implementing regulation. To the extent that Medicaid payments made by the MCO do not fully account for the monthly patient liability amount and the facility is overpaid, as previously advised, the facility may also be in violation of the State and Federal False Claims Acts and subject to overpayment provisions as specified in Section 6402 of the Affordable Care Act.

**Example:** Resident G has been receiving Medicare SNF services following an acute hospitalization. He is a non-QMB dual eligible member. He is not yet enrolled in CHOICES Group 1. The Medicare per diem payment for the Medicare SNF service Resident G has been receiving is $300. The facility's Level 2 Medicaid per diem rate for NF services is $200. Since the Medicare payment is higher than the Medicaid Level 2 rate, the crossover payment for the Medicare SNF service will be zero. Resident G's monthly patient liability amount cannot be used to offset the cost of Medicare SNF services.

Following his Medicare SNF stay, Resident G is enrolled into CHOICES Group 1 for receipt of Medicaid NF services. His date of enrollment into CHOICES Group 1 is April 16th. Resident G's monthly payment liability obligation is $2,000. A pro-rated share of Resident G's monthly patient liability amount must be collected by the NF and used to offset the cost of Medicaid NF services provided, i.e., $2,000 x 15 days divided by 30 days in the month or $1,000. The

Medicaid charges of $3,000 (15 days x $200 per day) will be reduced by the pro-rated monthly patient liability amount of $1,000. The balance of $2,000 will be paid by Resident G's MCO, subject to timely filing requirements.

In the rare circumstance that the Medicaid Level 2 per diem rate exceeds the Medicare payment for SNF services provided to a non-QMB dual eligible member, a pro-rated portion of the monthly patient liability amount may be collected (based on the number of days of SNF services provided) to offset the Medicaid cost sharing payment for Medicare SNF services. **This amount is limited by the Medicaid payment obligation.**

**Example:** Resident H has been receiving Medicare SNF services following an acute hospitalization. He is a non-QMB dual eligible member. Resident H's monthly payment liability obligation is $2,000. The Medicare per diem payment for the Medicare SNF service Resident H has been receiving is $200. The facility's Level 2 Medicaid per diem rate NF services is $210. Since the Medicare payment is less than the Medicaid Level 2 rate, the Medicaid crossover payment for the Medicare SNF service will be the difference between the two amounts or $10 per day. A pro-rated portion of Resident H's monthly patient liability amount will be used to offset the cost of Medicare SNF services provided to Resident H up to the Medicaid payment obligation. Since the Medicaid payment obligation is $10 per day, $10 of Resident H's monthly patient liability amount will be used to offset the cost of each day of Medicare SNF services provided (unless Resident H is enrolled in CHOICES Group 1 on the date SNF services were received). This will be accounted for in the processing of the crossover claim by the TennCare Medicaid Management Information System (MMIS). The facility cannot collect any amount which exceeds the Medicaid payment obligation for purposes of Medicare cost sharing.

If the resident is subsequently enrolled into CHOICES Group 1 for receipt of Medicaid NF services for the remainder of the month, a pro-rated share of the resident's monthly patient liability amount will be collected by the NF and used to offset the cost of Medicaid NF services provided.

If Resident H enrolls into CHOICES Group 1 on April 16th, Resident H's monthly patient liability amount will be pro-rated based on the number of days he is in enrolled in CHOICES Group 1 during that month, i.e., $2,000 x 15 divided by 30 days in the month or $1,000. If Resident H qualifies to receive Medicaid Level 2 reimbursement at $210 per day, the facility's charges of $3,150 for 15 days of NF services will be reduced by Resident H's pro-rated patient liability amount of $1,000. The balance of $2,150 will be paid by Resident H's MCO, subject to timely filing requirements.

If instead, the resident was already enrolled in CHOICES Group 1 at the beginning of the month and then subsequently was hospitalized and received Medicare SNF services (while remaining enrolled in CHOICES Group 1), then the entire monthly patient liability amount, up to the cost of Medicaid NF services provided, must be collected and used to offset the cost of Medicaid NF services provided.

**Example:** Resident J has been enrolled in CHOICES Group 1 for several months. On April 1st, he is admitted to the hospital and subsequently returns to the facility for 10 days of Medicare SNF services, after which he resumes Medicaid NF services on April 16th, with Level 2 Medicaid reimbursement. He is a non-QMB dual eligible member. Resident J's monthly payment liability obligation is $2,000. The Medicare per diem payment for the Medicare SNF service Resident J has been receiving is $200. The Level 2 Medicaid per diem rate for the facility providing the service is $210. Since the Medicare payment is less than the Medicaid Level 2 rate, the Medicaid crossover payment for the Medicare SNF service will be the difference between the two amounts or $10 per day. Assuming the crossover claims are processed *prior to* June 28, 2013, a pro-rated portion of Resident J's monthly patient liability amount will be used to offset the cost of Medicare SNF services provided to Resident J up to the Medicaid payment obligation. Since the Medicaid payment obligation is $10 per day, $10 of Resident J's monthly patient liability amount will be used to offset the cost of each day of Medicare SNF services provided for a total of $100 (10 days x $10 per day).

Resident J's monthly patient liability amount will **not** be pro-rated based on the number of days he actually receives Medicaid NF services because he has remained enrolled in CHOICES Group 1 for the entire month. The Medicaid charges of $3,150 should be reduced by $1,900, i.e., Resident J's $2,000 monthly patient liability amount less the $100 that has already been accounted for in the crossover payment. The facility must notify the MCO provider representative and work with the MCO to ensure that such collections are appropriately accounted for in the application of patient liability for the Medicaid NF services, since the MCO will have no way of knowing about the SNF stay or patient liability collection for Medicaid crossover payments. The balance of $1,250 should be paid by Resident J's MCO, subject to timely filing requirements.

If instead the crossover claims were processed (or adjusted) *after* June 28, 2013, the new system logic will be applied, bypassing patient liability collections on Medicare SNF crossover claims since Resident J was enrolled in CHOICES Group 1 on the dates of service that the Medicare SNF benefit was received. This would allow all of the patient liability to be collected in the processing of the Medicaid NF claims by the resident's MCO and eliminate the need for a facility to notify the MCO when patient liability amounts have been deducted in the processing of crossover claims. As in the previous example, Resident J's monthly patient liability amount will **not** be pro-rated based on the number of days he actually receives Medicaid NF services because he has remained enrolled in CHOICES Group 1 for the entire month. The Medicaid charges of $3,150 should be reduced by $2,000—Resident J's full monthly patient liability amount since no patient liability would have been collected in the processing of crossover claims. The balance of $1,150 should be paid by Resident J's MCO, subject to timely filing requirements.

## V. Mid-Month Adjustments in Patient Liability

Even when a resident is enrolled in CHOICES Group 1 for an entire month, the resident's monthly patient liability amount may change—most often, because the resident's income has

changed, or because the resident has incurred medical expenses not subject to payment by a third party. (Reductions from a person's patient liability based on incurred medical expenses are often called "Item D" deductions.)

The adjustment in patient liability often occurs mid-month, i.e., at some point *after* the first of the month, resulting in two different patient liability amounts that are applicable for the month. In such circumstances, each of the monthly patient liability amounts must be pro-rated based on the number of days of the month that patient liability amount was applicable. The total of the two pro-rated amounts is the amount of patient liability that must be collected by the facility, and the amount by which an MCO must reduce its payments to the facility for Medicaid nursing facility services provided during the month.

**Example:** Resident K is enrolled in CHOICES Group 1 for the entire month. Resident K's patient liability amount effective April 1st is $1,500. However, Resident K submits incurred medical expenses not subject to payment by any third party which reduce Resident K's patient liability amount to $1,000 effective April 16th. Each of the two monthly patient liability amounts will be pro-rated based on the number of days of the month that patient liability amount was applicable (for April 1st through April 15th, $1,500 x 15 days divided by 30 days in the month or $750; and for April 16th through April 30th, $1,000 x 15 days divided by 30 days in the month or $500). The two pro-rated amounts are added together ($750 + $500) to calculate the total amount ($1,250) the facility must collect from the resident for the month. This is also the amount by which the MCO will reduce its payments to the facility for Medicaid nursing facility services provided during the month.

**APPENDIX A**

# Patient Liability Claim Examples

| Example | Member Eligibility (full or partial month) | Claim Billed (full or partial month) | Monthly Patient Liability | [1] | Claim Dates of Service | Patient Liability applied to claim | Allowed Amount | Calculation | Amount Paid to Provider |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Full month | Full month | $3,000 | 1/1 - 1/31/2013 | 1/1 - 1/31/2013 | $3,000 | $5,000 | Apply $3000 to Patient Liability from Total Claim Allowed Amount ($5,000 - $3,000 = $2,000). | $2,000 |
| 2.a | Full month | Partial Month | $3,000 | 1/1 - 1/31/2013 | 1st claim billed DOS (1/1 - 1/15/2013)<br>2nd claim billed DOS (1/16 - 1/31/2013) | $2,500<br>$500 | 1st- $2500<br>2nd- $2500 | * Apply full patient liability to first claim submitted for adjudication (apply $3,000 to Patient Liability from Total Claim Allowed Amount ($5,000 - $3,000 = $2,000).<br>* If first submitted claim's allowed amount is less than PL, store and apply remaining PL to second claim. | 1st- $0<br>2nd- $2,000 |
| 2.b | Full month | Partial Month | $3,000 | 1/1 - 1/31/2013 | 1st claim billed DOS (1/1 - 1/15/2013)<br>2nd claim billed DOS (1/16 - 1/20/2013) | $2,500<br>$400 | 1st- $2500<br>2nd- $400 | * Apply full patient liability to first claim submitted for adjudication (apply $3,000 to Patient Liability from Total Claim Allowed Amount ($5,000 - $3,000 = $2,000).<br>* If first submitted claim's allowed amount is less than PL, store and apply remaining PL to second claim.<br>* No 3rd claim received - (full PL owed regardless). | 1st- $0<br>2nd- $0 |
| 2.c | Full month | Partial Month | $3,000 | 1/1 - 1/31/2013 | 1st claim billed DOS (1/1 - 1/15/2013)<br>2nd claim billed DOS (1/16 - 1/20/2013) | $2,500<br>$500 | 1st- $2500<br>2nd- $833 | * Apply full patient liability to first claim submitted for adjudication (apply $3,000 to Patient Liability from Total Claim Allowed Amount ($5,000 - $3,000 = $2,000).<br>* If first submitted claim's allowed amount is less than PL, store and apply remaining PL to second claim.<br>* No 3rd claim received (full PL owed regardless). | 1st- $0<br>2nd- $333 |
| 3.a | Partial month | Partial Month | $3,000 | 4/1 - 4/20/2013 | 4/1 - 4/20/2013 | Pro Rate (20/30 * $3000 = $1,999.9998) rounds to $2,000.00 | $5,000 | * Pro rate PL to number of days member is elig in the month, and apply to claim. Do NOT develop a daily rate and then multiply by the number of days billed on the claim.<br>* Apply $2000 to Patient Liability from Total Claim Allowed Amount ($5,000 - $2,000 = $3,000). | $3,000 |
| 3.b | Partial month | Partial Month | $3,000 | 1/1 - 1/20/2013 | 1/1 - 1/20/2013 | Pro Rate (20/31 * $3000 = $1,935.4836) rounds to $1,935.48 | $5,000 | * Pro rate PL to number of days member is eligiblith in the month (this example has 31 days in the month).<br>* Apply $1,935.48 patient liability to claim submitted ($5,000 - $1,935.48 = $3,064.52). | $3,064.52 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 4.a | Partial month | Partial Month | $3,000 | 4/1 - 4/20/2013 | 1st claim billed DOS (4/1 - 4/15/2013)<br>2nd claim billed DOS (4/16 - 4/20/2013) | Pro Rate PL to (20/30 * $3,000 = $1,999.998) rounds to $2,000.00<br>1st- $2000<br>2nd- $0 | 1st- $2500<br>2nd- $833.00 | * 1st example - Apply $2,000 PL to claim ($5,000 - $2,000 = $3,000). | 1st- $500.00<br>2nd- $833.00 |