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Notifying Medicare Patients about Lifetime Reserve Days (LRDs)

Key Words

SE0663, Lifetime, Reserve, LRD

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for inpatient hospital services furnished during a spell of illness

Note: MLN Matters article SE0663 was revised on January 31, 2008, to update the deductible and coinsurance rates to reflect the 2008 rates (page 2). In addition, some editorial changes were made to provide further clarification and references to A/B MACs were added.

Key Points

- MLN Matters article SE0663 is for informational purposes only and reflects no change in Medicare policy.

Benefit Period ("Spell of Illness")

- Under the Social Security Act (Section 1861), a Medicare beneficiary is entitled to an unlimited number of benefit periods, each of which includes 90 days of covered inpatient hospital services.
- A benefit period, or "spell of illness," begins on the first day the beneficiary is furnished inpatient hospital services, inpatient critical access hospital services or extended care services.
- The benefit period ends with the close of the first period of 60 consecutive days, thereafter on each of which he/she is neither an inpatient of a hospital or a critical access hospital nor an inpatient of a skilled nursing facility.
- The Social Security Act (Section 1812) further defines the scope of inpatient hospital benefits for Medicare beneficiaries and includes an additional provision regarding 60 nonrenewable LRDs, which a beneficiary may draw upon if hospitalized for more than 90 days in a benefit period.

- For inpatient hospital services furnished during a spell of illness, Medicare beneficiaries are responsible for an inpatient hospital deductible amount (which is deducted from the amount payable by the Medicare program to the hospital).

Deductibles and Coinsurance

- For the first 60 days of covered care during a spell of illness, the beneficiary is not liable for paying co-insurance.
- **After the 60th day** that beneficiaries receive inpatient hospital services (during a spell of illness), they are responsible for a coinsurance amount equal to one-fourth (25 percent) of the inpatient hospital deductible per day for the 61st- 90th day spent in the hospital.
- **After the 90th day** spent in the hospital during a spell of illness, beneficiaries may elect to use their 60 LRDs of coverage. Their coinsurance amount is then equal to one-half (50 percent) of the benefit period inpatient hospital deductible as a daily copayment for LRDs (42 Code of Federal Regulations 409.83 (inpatient hospital coinsurance) located at *http://www.gpoaccess.gov/cfr/retrieve.html* on the Internet).
- **In 2008**, the inpatient hospital deductible is $1,024.00 per benefit period or spell of illness. Therefore, beneficiaries pay the following daily coinsurance amounts for 2008:
  - $256.00 a day for days 61-90 in an ACH **in each period**; and
  - $512.00 a day for days 91-150 **for each LRD used.**

Election Not to Use LRDs

- An election not to use LRDs may be made by the beneficiary (or by someone who may act on his or her behalf) at the time of admission to a hospital or at any time thereafter, subject to the limitations on retroactive elections described below in the Section "*Election Made Retroactively*".
- Hospitals are required to notify patients who have already used or will use 90 days of benefits in a benefit period that they can elect not to use their LRDs for all or part of a stay.
- The hospital should give notice of the option to elect to not use LRDs when the beneficiary has five regular coinsurance days left and is expected to be hospitalized beyond that period.
- Where the hospital discovers the patient has fewer than five regular coinsurance days left, it should immediately notify the patient of this option (if notice was not provided earlier.)
- The hospital should:
  - Annotate its records at the time that it informed the patient of this option; and
  - Make available an appropriate election statement or form to be included in the patient's hospital record if the patient elects not to use LRDs. (See the *Medicare Benefit Policy Manual* (Chapter 5, Section 40.1; *http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf*) for the sample election format).
- If a patient elects not to use LRDs, covered Part B services are billed to the intermediary or A/B MAC on Form CMS-1450 or the electronic equivalent.

Note: A Medicare beneficiary who is eligible for medical assistance (Medicaid) under a state plan should be advised that such assistance would not be available if the beneficiary elects not to use the LRDs. However, this restriction on medical assistance payments does not apply to cases where the beneficiary is deemed to have elected not to use LRDs.

Beneficiary Deemed to Have Elected Not to Use LRDs

- A Medicare beneficiary will be deemed to have elected not to use LRDs in the following situations:
    - The average daily charge for covered services furnished during a lifetime reserve billing period is equal to or less than the coinsurance amount for LRDs; and
        - The hospital is reimbursed on a cost reimbursement basis; **or**
        - The hospital is reimbursed under a Prospective Payment System (PPS) and LRDs are needed to pay for all or part of the outlier days. (See the Section below, "Hospitals Reimbursed Under the Prospective Payment System" and the *Medicare Benefit Policy Manual* (Chapter 5, Section 10.2) located at *http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf* on the CMS website.)
    - For the nonoutlier portion of a stay in a hospital reimbursed under a PPS, if the beneficiary has one or more regular days (non-LRDs) remaining in the benefit period upon admission to the hospital [i.e., an Acute Care Hospital (ACH) PPS, inpatient rehabilitation facility (IRF) PPS, and a normal stay under long-term care hospital (LTCH) PPS)]. (See the Section below, "***Hospitals Reimbursed Under the Prospective Payment System***".)

      Note: The exception to this rule is the short stay outlier policy under LTCH PPS.
    - The beneficiary has no regular days available at the time of admission to a hospital reimbursed under the PPS and the total charges for which the beneficiary would be liable (if LRDs are not used) is equal to or less than the charges for which the beneficiary would be liable if LRDs were used (i.e., the sum of the coinsurance amounts for the LRDs that would be used plus the total charges for outlier days (if any) for which no LRDs would be available because LRDs are exhausted. (See the Section below "***Hospitals Reimbursed Under the Prospective Payment System***".)

      Exception: Even though a beneficiary would otherwise be deemed to have elected not to use LRDs, they will not be so deemed where:
        - Benefits are available from another third party payer to pay some or all of the charges, and
        - The third party requires (as a condition for payment) that LRDs be used.

      In such cases, LRDs will be used unless the beneficiary specifically elects not to use them.

Election Made Prospectively

- Ordinarily, an election not to use LRDs will apply prospectively.
- If the election is filed at the time of admission to a hospital, it may be made effective beginning with the first day of hospitalization, or any day thereafter.
- If the election is filed later, it may be made effective beginning with any day after the day it is filed.

Election Made Retroactively

- A beneficiary may retroactively elect not to use LRDs provided when:
  - The beneficiary (or some other source) offers to pay the hospital for any of the services not payable under Part B, and
  - The hospital agrees to accept the retroactive election.

  In this case, the hospital will contact the FI for procedures for correcting any claims already submitted.
- A retroactive election not to use the LRDs must be filed within 90 days following the beneficiary's discharge from the hospital unless:
  - Benefits are available from a third party payer to pay for the services, and
  - The hospital agrees to the retroactive election.

  In this case, the beneficiary may file an election not to use the LRDs later than 90 days following discharge.

  Note: There are examples of this rule on pages 4 and 5 of MLN Matters article SE0663.

Period Covered by Election

Hospitals Not Reimbursed Under Prospective Payment System (PPS)

- A beneficiary election not to use LRDs for a particular hospital stay:
  - May apply to the entire stay; or
  - May apply to a single period of consecutive days in the stay; but
  - Cannot apply to selected days in a stay.
- If an election not to use LRDs (whether made prospectively or retroactively) is made effective:
  - Beginning with the first day for which LRDs are available, it may be terminated at any time;

    (After termination of the election, all hospital days would be covered to the extent that LRDs are available. Thus, an individual who has private insurance that covers hospitalization beginning with the first day after 90 days of benefits have been exhausted, may terminate the election as of the first day not covered by the insurance plan.); or
  - Beginning with any day after the first day for which LRDs are available, it must remain in effect until the end of that stay unless the entire election is revoked in accordance with the *Medicare Benefit Policy Manual* (Pub. 100-02, Chapter 5, Section 40.2) located at *http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf* on the CMS website.

Hospitals Reimbursed Under Prospective Payment System (PPS)

- The rules described in the Section, **"Hospitals Not Reimbursed Under Prospective Payment System (PPS)"**, above apply. For PPS discharges on and after October 1, 1997, involving cost outlier status, a beneficiary whose 90 days of benefits are exhausted before cost outlier status is reached must elect to use LRDs for the hospital to be paid cost outlier payments.
- Cost outlier status is reached on the day that charges reach the cost outlier status for the applicable Diagnostic Related Group for inpatient PPS and LTCH PPS or CMS in the case of IRF PPS. Use of LRDs must begin on the day following that day, to permit payment for outlier charges.
- If the beneficiary elects not to use LRDs where benefits are exhausted, the hospital may charge the beneficiary for the charges that would have been paid as cost outlier.

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0663.pdf* on the CMS website.

The article is based on information contained in the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 5, Sections 30 - 30.4). This manual is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

The Social Security Act (Section 1861) may be found at *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet.

The Social Security Act (Section 1812) may be found at *http://www.ssa.gov/OP_Home/ssact/title18/1812.htm* on the Internet.