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Information for Medicare Fee-For-Service Health Care Professionals

MLN Matters Number: SE0663 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Notifying Medicare Patients about Lifetime Reserve Days (LRDs)

Note: This article was updated on October 10, 2012, to reflect current Web addresses. This article was also revised on January 31, 2008, to update the deductible and coinsurance rates to reflect the 2008 rates. In addition, some editorial changes were made to provide further clarification and references to A/B MACs were added.

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.

Provider Action Needed

This special edition article is for informational purposes only and reflects no change in Medicare policy. 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.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the Centers for Medicare & Medicaid Services (CMS) website.

Background

Under the Social Security Act (Section 1861; http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the Internet), 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 long term 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

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hospital or a critical access hospital nor an inpatient of a skilled nursing facility. The Social Security Act (Section 1812; http://www.ssa.gov/OP_Home/ssact/title18/1812.htm) further defines the scope of inpatient hospital benefits for Medicare beneficiaries and includes an additional provision regarding 60 nonrenewable lifetime reserve days (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). For the first 60 days of covered care during a spell of illness the beneficiary is not liable for paying a co-insurance.

For the 61st through the 90th 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.**

After the 90th day spent in the hospital during a spell of illness, beneficiaries may elect to use their 60 LRDs of coverage. Their **daily coinsurance amount is then equal to one-half (50 percent)** of the inpatient hospital deductible (42CFR409.83 (Inpatient hospital coinsurance); <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 Lifetime Reserve Days (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 II (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.)

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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.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c05.pdf>) for sample election format).

If a patient elects not to use LRDs, some of the hospital services may be covered by Medicare Part B. These 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:

1. 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 a portion of the outlier stay. (See *Section IIIB (Hospitals Reimbursed Under the Prospective Payment System)* below and the *Medicare Benefit Policy Manual* (Chapter 5, Section 10.2); <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c05.pdf> on the CMS website.)
2. **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), inpatient rehabilitation facility (IRF), and a normal stay under long term care hospital (LTCH) (i.e., not a short stay)]. (See *Section IIIB (Hospitals Reimbursed Under the Prospective Payment System)* below.)
3. **The beneficiary has no regular days available at the time of admission to a hospital** reimbursed under the prospective payment system and **the total charges**

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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 *Section IIIB- Hospitals Reimbursed Under the Prospective Payment System* below.)

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.

I. 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**.

II. 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 fiscal intermediary (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.

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EXAMPLE 1

Prior to July 1, Mr. Jones had used 90 days of inpatient hospital services in a benefit period. Beginning July 1, he was hospitalized for 10 additional days in that same benefit period. He was informed of his election right on July 1 at the time of admission, and he indicated that he wanted to use his LRDs for that stay. One month after being discharged from the hospital, Mr. Jones informed the hospital's billing office that he now wished to save his LRDs for a future stay. Mr. Jones agreed to pay the hospital for the services he received during the 10 days of hospitalization which were not payable under Part B, and the hospital agreed to the request. He was permitted to file a retroactive election not to use his LRDs, effective July 1.

EXAMPLE 2

On July 1, Mrs. Smith was discharged from a hospital after being hospitalized for 105 days. The hospital billed Medicare for 90 regular days plus 15 LRDs. On October 20 (more than 90 days following discharge), Mrs. Smith learned that a private insurer could pay for the last 15 days of the stay. She informed the hospital that she wished to file a retroactive election not to use LRDs for the last 15 days of the stay. The hospital agreed to the request, and Mrs. Smith filed an election form. The hospital refunded the Medicare payment and billed the private insurer instead.

III. Period Covered by Election

A. 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

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- 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); <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c05.pdf> on the CMS website.

B. Hospitals Reimbursed Under Prospective Payment System (PPS)

The rules described in Section IIIA above apply. In addition, for PPS discharges occurring on or after October 1, 1997, involving high cost outlier status, a beneficiary whose 90 days of benefits are exhausted before high cost outlier status is reached must elect to use LRDs for the hospital to be paid high cost outlier payments.

High cost outlier status is reached on the day that charges reach the high cost outlier status for the applicable DRG for inpatient PPS and LTCH PPS or case-mix group (CMG) in the case of IRF PPS. Use of LRDs must begin on the day following that day, to permit payment for high cost 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 a high cost outlier.

Additional Information

If you have any questions, please contact your intermediary or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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