Medicare Benefit Policy Manual
Chapter 3 - Duration of Covered Inpatient Services

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(Rev. 261; Issued: 10-04-19)

10 - Benefit Period (Spell of Illness)

(Rev. 261, Issued_10-04-19, Effective: 11-05-19, Implementation: 11-05-19)
A3-3035, HO-215

A "Benefit period" is a period of consecutive days during which medical benefits for covered services, with certain specified maximum limitations, are available to the beneficiary. Under Part A, 60 full days of hospitalization plus 30 coinsurance days represent the maximum benefit period. The *benefit* period is renewed when the beneficiary has not been *an inpatient of* a hospital or *of a* SNF *(see §20.B)* for 60 *consecutive* days. Refer to Pub.100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, "Deductible, Coinsurance Amounts, and Payment Limitations" for additional information on benefit periods.

20 - Inpatient Benefit Days

(Rev. 261, Issued_10-04-19, Effective: 11-05-19, Implementation: 11-05-19)
A3-3103, A3-3135, HO-216, SNF-242

A. Inpatient Hospital Benefit Days

A patient having hospital insurance coverage is entitled, subject to the inpatient deductible and coinsurance requirements, to have payment made on his/her behalf for up to 90 days of covered inpatient hospital services in each benefit period. Also, the patient has a lifetime reserve of 60 additional days (see Chapter 5, §10).

B. Posthospital Extended Care Days

A patient having hospital insurance coverage is entitled (subject to the coinsurance requirements described in detail in Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations") to have payment made on his/her behalf for up to 100 days of covered inpatient extended care services in each benefit period.

Refer to Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter *3, §10.4.4* for the definition of SNF inpatient for benefit period purposes.

20.1 - Counting Inpatient Days

(Rev. 1, 10-01-03)
A3-3103.1, A3-3104.3, A3-3135.1, HO-217.3, HO-216.1, SNF-242.1

The number of days of care charged to a beneficiary for inpatient hospital or skilled nursing facility (SNF) care services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in

counting days of care for Medicare reporting purposes even if the hospital or SNF uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a patient returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day. Charges for ancillary services on the day of discharge or death or the day on which a patient begins a leave of absence are covered.

20.1.1 - Late Discharge

(Rev. 1, 10-01-03)
A3-3103.2, A3-3135.2, HO-216.2, SNF-242.2

When a patient chooses to continue to occupy hospital or SNF accommodations beyond the checkout time for personal reasons, the hospital or SNF may charge the beneficiary for the continued stay. Such a stay beyond the checkout time, for the comfort or convenience of the patient, is not covered under the program, and the hospital's or SNF's agreement to participate in the program does not preclude charging the patient. However, the hospital must provide the beneficiary with an Advance Beneficiary Notice (ABN) before the noncovered services are provided. See Medicare Claims Processing Manual, chapter 30, for instructions about ABNs.

Where the patient's medical condition is the cause of the stay past the checkout time (e.g., the patient needs further services, is bedridden and awaiting transportation to their home or in the case of a hospital, transfer to a skilled nursing facility, or dies in the SNF or hospital), the stay beyond the discharge hour is covered under the program and the hospital or SNF may not charge the patient.

The imposition of a late checkout charge by a hospital or SNF does not affect the counting of days for:

- Ending a benefit period;
- The number of days of inpatient care available to the individual in a hospital or SNF; and
- The 3-day prior hospitalization requirement for coverage of post hospital extended care services and Part A home health services.

A late charge by a hospital does not affect counting of days for meeting the prior inpatient stay requirement for coverage of extended care services.

The Quality Improvement Organization is responsible for reviewing the appropriateness of early discharges.

20.1.2 - Leave of Absence

(Rev. 1, 10-01-03)
A3-3103.3, A3-3135.3, HO-216.3, SNF-242.3

The day on which the patient began a leave of absence is treated as a day of discharge, and is not counted as an inpatient day unless the patient returns to the facility by midnight of the same day. The day the patient returns to the hospital or SNF from a leave of absence is treated as a day of admission and is counted as an inpatient day if the patient is present at midnight of that day.

Refer to the Medicare Claims Processing Manual, Chapter 3, "Inpatient Hospital Services," or the Medicare Claims Processing Manual, Chapter 6, "SNF Inpatient Billing," as appropriate, for reporting inpatient leave of absence on the Medicare claim.

20.1.3 - Discharge or Death on First Day of Entitlement or Participation

(Rev. 1, 10-01-03)
A3-3103.4, A3-3135.4, HO-216.4, SNF-242.4

For SNF services, the cost of such services has been built into the SNF PPS base. This makes the PPS per diem somewhat higher than it would otherwise have been for all of the preceding SNF days that Part A does cover, even though the day of discharge itself is not a covered Part A day:

- A patient is admitted prior to the first day of entitlement and dies or is discharged from a participating hospital on the first day of entitlement; or

- A patient in a noncovered stay in a nonparticipating hospital dies or is discharged on the first day the hospital becomes a participating hospital. For a late discharge on such a day, the rules in §20.1.1 will be followed.

For SNF services, Medicare does not pay for accommodations on the day of discharge or death. Medicare pays for ancillary services (under Part A) when a patient dies or is discharged on the first day a facility becomes a participating facility and the other requirements for coverage of extended care services are met.

Although a day of utilization is not counted in these situations, a benefit period begins and any charges for covered services are applied against the inpatient hospital deductible.

30 - Inpatient Days Counting Toward Benefit Maximums

(Rev. 1, 10-01-03)
A3-3107, A3-3136, HO-216.5, SNF-244

A. 90-Day Benefit Limitation

Inpatient hospital (including psychiatric hospital) services count toward the maximum of 90 benefit days payable per benefit period only if:

- Payment for the services is made;

- Payment for the services would be made if a request for payment and claim were filed properly and timely, a physician certified that the services were necessary, if required, and the provider submitted all necessary evidence; or

- Payment cannot be made because the inpatient deductible or coinsurance is higher then the charges.

B. Lifetime Reserve Days

Part A benefits allow for 60 lifetime reserve days for use after a 90-day benefit period has exhausted. The 60 days are not renewable and may be used only once during a beneficiary's lifetime. Inpatient hospital services count toward the maximum of 60 lifetime reserve days under the same conditions as in subsection A except that days are not counted if:

- The individual elects not to have payment made (See the Medicare Benefit Policy Manual, Chapter 5, Lifetime Reserve Days, §30), or

- The coinsurance rate exceeds the daily charge. (See the Medicare Benefit Policy Manual, Chapter 5, Lifetime Reserve Days, §10.2).

C. Lifetime Inpatient Psychiatric Hospital Limitation

Inpatient psychiatric hospital services count toward the 190-day lifetime limitation on inpatient psychiatric hospital services only if the conditions in subsection A are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital (or distinct part).

D. Inpatient Post-hospital Extended Care Services Counting Toward Maximums

Post-hospital extended care services count toward the maximum number of benefit days payable per benefit period only if:

- Payment for the services is made, or

- Payment for the services would be made if a request for payment were properly filed, the physician certified that the services were medically necessary, and the provider submitted all necessary evidence.

When payment cannot be made because of the extended care coinsurance requirement, the day(s) used nevertheless count toward the beneficiary's maximum days of extended care.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R261BP	10/04/2019	Manual Updates for CR11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)	11/05/2019	11454
R1BP	10/01/2003	Initial Publication of Manual	NA	NA

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