



Medicare Part A Benefit Period/Spell of Illness

Everything You Need to Know

Joel VanEaton, EVP Post Acute Regulatory Affairs
and Education at Broad River Rehab

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.



SUCCESSFUL COMPLETION REQUIREMENTS

- In order to obtain nursing contact hours, you must participate in the entire program and complete the entire evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after 1 week





Learning Objectives

- Recognize the definition of the Medicare Part A Benefit Period.
- Understand how the benefit period aligns with the skilled definition of care
- Identify how to manage the benefit period
- Define when the benefit period ends
- Apply this knowledge to facility operations



Resources

- [CMS 100-2 Chapter 3](#)
- [CMS 100-2 Chapter 8](#)
- [CMS 100-1 Chapter 3](#)
- [CMS 100-4 Chapter 6](#)
- [CMS 100-1 Chapter 5](#)

Medicare Eligibility

Age-Based Eligibility

- **Age 65 or older:** You must be a U.S. citizen or a legal permanent resident who has lived in the U.S. for at least **5 consecutive years**.
- **Work history:** You or your spouse must have at least **10 years (40 quarters)** of Medicare-covered work to get premium-free Part A. If you do not have enough work credits, you can buy Part A by paying a monthly premium.
- **NOTE:** Regarding the 3-day hospital stay requirements, the hospital discharge must have occurred on or after the **first day of the month in which the individual attained age 65** or, effective July 1, 1973, became entitled to health insurance benefits under the disability or chronic renal disease provisions of the law.

Medicare Eligibility

Eligibility Under Age 65

You can qualify for Medicare before turning 65 if you meet one of these criteria:

- **Disability:** You receive Social Security Disability Insurance (SSDI) or a Railroad Retirement Board disability pension for **24 months** (automatic enrollment starts in the 25th month).
- **ALS (Lou Gehrig's disease):** You get automatic Medicare enrollment the exact month your SSDI benefits begin.
- **End-Stage Renal Disease (ESRD):** You have permanent kidney failure requiring regular dialysis or a kidney transplant, though you must actively apply through the Social Security Administration.

Benefit period Explained

- A benefit period is a period of time for measuring the use of hospital insurance benefits.
- It is a period of consecutive days during which covered services furnished to a patient, up to certain specified maximum amounts, may be paid for by the hospital insurance plan.
- **For example**, a patient is eligible for 90 days of hospital care in a benefit period and 100 days of extended care services during the same benefit period.

Benefit period Explained

- As long as a person continues to be entitled to hospital insurance, there is no limit on the number of benefit periods he/she may have.
- The term "benefit period" is synonymous with spell of illness. However, since the term "spell of illness" could connote a single illness or a particular "spell" of sickness, the term benefit period is used in communications with the public.

Starting a Benefit Period

- A benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished **inpatient hospital** or **extended care services** by a qualified provider in a month for which the patient is entitled to hospital insurance benefits.
- A provider qualified to start a benefit period is a hospital (including a psychiatric hospital) or SNF that meets all the requirements of the definition of such an institution.
- Note that all hospitals and SNFs that are Medicare-certified are automatically considered to meet the applicable basic definition in this context by reason of the Medicare certification itself.
- Moreover, even an institution (or portion of an institution) that is not certified for Medicare can serve to prolong an inpatient's benefit period if it meets either the basic "hospital" or "SNF" definition

Starting a Benefit Period

- Generally, the benefit period begins when covered inpatient services are initially furnished to an entitled individual.
- However, the noncovered services furnished by a nonparticipating provider can begin a spell of illness only if the provider is a qualified provider.
- A qualified provider is a hospital (including a psychiatric hospital) or a SNF which meets all requirements in the definition of such an institution even though it may not be participating.

Starting a Benefit Period

- If a person is in a nonqualified institution and is subsequently transferred to a qualified hospital (general or psychiatric), his/her benefit period begins on admission to the qualified hospital.
- Admission to a qualified SNF or to the SNF level of care in a swing-bed hospital begins a benefit period even if payment for the services cannot be made because the prior hospitalization or thirty-day transfer requirement has not been met.

Starting a Benefit Period

- It is also worth noting that the SNF benefit's "thirty-day" transfer requirement has a medical appropriateness exception (described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, section 20.2.2), under which the allowable interval between a beneficiary's discharge from a qualifying prior hospitalization and the initiation of SNF care can exceed the normal 30-day timeframe; moreover, in a situation where the allowable interval under this exception is 60 days or longer, the subsequent commencement of extended care services in the SNF would serve to trigger the start of a new benefit period.

Ending a Benefit Period

- The benefit period ends with the close of a period of 60 consecutive days during which the patient was **neither an inpatient of a hospital nor of a SNF**. To determine the 60 consecutive day period, begin counting with the day the individual was discharged.
- The onset of a new condition is not, in itself, relevant to the ending of a benefit period, which can occur only through a 60-day break in inpatient status, as described above.

Definition of Hospital or SNF for Ending a Benefit Period

- It is important to note that a benefit period cannot end while a beneficiary is an inpatient of an institution that meets the basic definition of a “hospital”, including a foreign hospital, even if the hospital does not meet all of the additional requirements that are necessary for starting a benefit period.
- Similarly, a benefit period cannot end while a beneficiary is an inpatient of an institution that meets the basic definition of a “SNF”.

Definition of Hospital or SNF for Ending a Benefit Period

- **Reminder:** All hospitals and SNFs that are Medicare-certified are automatically considered to meet the applicable basic definition in this context by reason of the Medicare certification itself.
- **Reminder:** Moreover, even an institution (or portion of an institution) that is not certified for Medicare can serve to prolong an inpatient's benefit period if it meets either the basic "hospital" or "SNF" definition.

Definition of Hospital or SNF for Ending a Benefit Period

- **Hospital Stay and End of Benefit Period**

- In order to end a benefit period, for at least 60 consecutive days, a beneficiary cannot have been (inpatient) in a hospital.
- That is, the beneficiary cannot have been (inpatient) in a facility that is primarily engaged in providing, by or under the supervision of a physician(s), to inpatients:
 - Diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for injured, disabled, or sick persons; or
 - Psychiatric services for the diagnosis and treatment of mentally ill persons.

Definition of Hospital or SNF for Ending a Benefit Period

- **SNF Stay and End of Benefit Period**

- A beneficiary cannot have been an **inpatient** of a SNF for at least 60 consecutive days; where SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- All Medicare-certified SNFs (including Medicare-certified distinct part SNFs) are automatically considered to meet this basic “SNF” definition by reason of the Medicare certification itself.

Definition of Hospital or SNF for Ending a Benefit Period

- **SNF Stay and End of Benefit Period**

- A nursing home that is not Medicare-certified (including the noncertified portion of an institution that also contains a Medicare-certified distinct part SNF), can meet the definition of a SNF for determining level of care.
- An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

Ending a Benefit Period

- **Example 1**

- Resident A was born 8/9/1936. On 7/28/2001, Resident A entered a participating general hospital. After he/she had been in the hospital for 2 weeks, Resident A was discharged on 8/11/2001. On his/her doctor's orders, Resident A entered a participating SNF on 8/15/2001, and remained an inpatient there until his/her discharge on 10/27/2001. He/she had no further inpatient stays in 2001.
- Resident A's benefit period began on 8/1/2001, the first day of the month he/she attained age 65 and was entitled to hospital insurance. The benefit period ended 12/25/2001, the end of the 60-day period beginning with the date of his/her last discharge.

Ending a Benefit Period

- **Example 2**

- Resident B, over age 65, entered a participating general hospital on 8/28/2000 for treatment of a heart condition. He/she was discharged on 9/11/2000. On 10/3/2000, Resident B entered a Medicaid-only nursing facility, and remained an inpatient of this facility until his/her discharge on 11/17/2000. On 12/26/2000, Resident B was again admitted to a participating hospital because of injuries suffered in an accident. He/she was discharged on 1/13/2001 and had no further inpatient stays in 2001.

Ending a Benefit Period

- **Example 2 (Cont.)**

- Resident B's benefit period began on 8/28/2000. His/her stay in the nursing facility began less than 60 days after his/her hospital stay and the benefit period was continued because he/she remained an inpatient there even though Medicare did not cover the stay. The subsequent hospital stay began less than 60 days after the nursing facility stay and continued the benefit period although the condition treated was unrelated to his/her prior stays. The benefit period ended on 3/14/2001, the end of the 60-day period beginning with the day of last discharge.

Ending a Benefit Period

- **Example 3**

- Resident C, over age 65 and entitled to hospital insurance benefits, was admitted to General Hospital on 8/1/2000 and discharged on 8/10/2000, having received nonemergency hospital services. General Hospital met all the requirements in the definition of a hospital except those concerning utilization review and health and safety. While General Hospital met the minimum requirements of an emergency hospital, Z's benefit period did not begin with his/her admission to this hospital because:
 - 1. The hospital did not meet all of the requirements in the definition of a hospital; and
 - 2. Although the hospital satisfied the minimum requirements for coverage of emergency services, Z did not receive emergency inpatient care there.

Ending a Benefit Period

- **Example 3 (Cont.)**

- Note: A stay in an emergency hospital does not begin a benefit period unless it actually involves the receipt of covered inpatient emergency services; by contrast, even a nonemergency stay in such a hospital can serve as a qualifying hospital stay for purposes of coverage under the posthospital extended care benefit. Resident C was admitted to Haven Convalescent Home on 8/20/2000 and remained an inpatient of the home until his/her discharge on 3/1/2001. He/she had no further inpatient stays in 2001. Haven Convalescent Home became a participating SNF on 1/1/2001.

Ending a Benefit Period

- **Example 3 (Cont.)**

- Resident C's benefit period began 1/1/2001, the day Haven Convalescent Home was determined to be a qualified SNF. The services he/she received from that date through discharge were extended care services even though they were not covered and, therefore, not charged against Resident C's Medicare SNF utilization. (The services were not covered posthospital extended care services because Z was not admitted to a participating SNF within 30 days after discharge from the hospital.) Z's benefit period ended 4/29/2001, the end of the 60-day period beginning with the date of his discharge from the convalescent home.

Definition of Inpatient for Ending a Benefit Period

- Generally, a beneficiary is an inpatient of a hospital if the beneficiary is receiving inpatient services in the hospital (i.e., not on an outpatient basis). The type of care actually received is not relevant.
- However, a different definition of inpatient applies in determining the end of a benefit period for a beneficiary in a SNF, under which such a beneficiary is considered an inpatient in this context only if the beneficiary's care in the SNF meets certain skilled level of care standards. Specifically, the beneficiary must need and receive a skilled level of care while in the SNF.

Definition of Inpatient for Ending a Benefit Period

- This means that in order to have been an “inpatient” for benefit period purposes while in a SNF, the beneficiary must have required and received skilled services on a daily basis which could, as a practical matter, only have been provided in a SNF on an inpatient basis. Requiring that the SNF care must in some way relate back to a condition that was present during the beneficiary’s qualifying hospital stay does not apply to benefit period determinations.

Definition of Inpatient for Ending a Benefit Period

- If these provisions were not met during the prior SNF stay, the beneficiary was not an inpatient of the SNF for purposes of prolonging the benefit period.
- Conversely, a beneficiary would remain an SNF “inpatient” in this context (thus prolonging his or her current benefit period) for as long as the beneficiary continues receiving a skilled level of care in the SNF--even if Part A payment has ended due to the beneficiary’s exhaustion of SNF benefits.

Special Considerations

- **Skilled Services defined**
 - Care in a SNF is **covered** if all of the following four factors are met:
 - The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel, are ordered by a physician and the services are (rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services);

Special Considerations

- **Skilled Services defined (Cont.)**

- Care in a SNF is **covered** if all of the following four factors are met:
 - The patient requires these skilled services on a daily basis
 - As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF
 - The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Special Considerations

- **Skilled Services defined (Cont.)**

- Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:
 - Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
 - Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.
 - NOTE: “General supervision” requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.
 - Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.

Special Considerations

- **Skilled Services defined (Cont.)**

- Skilled Nursing

- Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse.
- **Examples:** Intravenous or intramuscular injections and intravenous feeding; Application of dressings involving prescription medications and aseptic techniques; Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder

Special Considerations

- **Skilled Services defined (Cont.)**

- **Skilled Rehab**

- The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist.
- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;

Special Considerations

- **Skilled Services defined (Cont.)**

- **Skilled Rehab**

- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.
- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,
- The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Special Considerations

- **Skilled Services defined (Cont.)**

- **Daily Skilled Services**

- Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a “daily basis,” i.e., on essentially a 7-days-a-week basis.
- A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when they need and receive those services on at least 5 days a week. **(If therapy services are provided less than 5 days a week, the “daily” requirement would not be met.)**
- The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to “daily” skilled services.

Special Considerations

Medicare Secondary Payer (MSP) is the law and program rule that makes Medicare the **secondary** payer for a healthcare claim when another insurance plan or program has the legal responsibility to pay first ([Model Questions](#)).

How It Works: Primary Payer First: Healthcare providers must bill the primary insurance company first. The primary payer processes the claim according to its contract terms.

- **Medicare Steps In Second:** If the primary payer does not cover the full cost of the service, a secondary claim can then be submitted to Medicare to pay remaining-allowed amounts (up to Medicare limits).
- **Coordination of Benefits:** This process of determining which insurance pays first and second is known as

Special Considerations

- **Denial of Payment for New Admissions (DPNA)**

- SNFs under a denial of payment sanction are still considered Medicare-participating providers.
- Skilled services provided to a resident when a providers is under a DPNA are still effective when making benefit period decisions. If the patient is receiving a skilled level of care the benefit period cannot end.
- If the Medicare participating SNF assumes responsibility for the beneficiary's costs during the sanction period, i.e., not issuing proper notification, it will be considered the same as a program payment, and the days will count towards the 100-day benefit period.

Special Considerations

- **Denial of Payment for New Admissions (DPNA)**
 - **Exception:** If the SNF issues the appropriate beneficiary liability notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.
 - Days that a beneficiary spends in a SNF under a DPNA will be used to track breaks in the spell of illness.

Special Considerations

- **Benefit Exhaust Claims**

- **When to submit:** Required monthly when a resident exhausts their 100 Part A covered days but continues to receive a skilled level of care.
- **Why it matters:** It keeps the HIPAA Eligibility Transaction system (HETS) updated to track and extend the beneficiary's **benefit period**.
- **Transition rule:** When active skilled care ends after benefit exhaustion, submit a final benefit exhaust bill in the next billing cycle indicating care has ended.

Special Considerations

- **No-Pay Claims**

- **When to submit:** Required monthly for eligible Medicare residents who transition to a non-skilled (custodial) level of care while remaining in the facility.
- **Why it matters:** Prevents overlapping provider claim denials and maintains accurate tracking of **benefit periods.**
- **Exceptions:** No-pay claims are not required if the resident is formally discharged off Part A to a non-Medicare-certified section or bed of the facility.

Special Considerations

- Generally, the day of discharge, death, or a day on which a patient begins a leave of absence, **is not counted as a utilization day.** (See the Medicare Benefit Policy Manual, Chapter 3, “Duration of Covered Inpatient Services.”)
- This is true even where one of these events occurs on a patient’s first day of entitlement or the first day of a provider’s participation in the Medicare program. In addition, a **benefit period may begin with a stay in a hospital or SNF, on that day.**

Special Considerations

- The exception to the general rule of not charging a utilization day for the day of discharge, death, or day beginning a leave of absence is where the patient is admitted with the expectation that he will remain overnight but is discharged, dies, or is transferred to another, nonparticipating provider (or to a nonparticipating portion of the same provider) before the following midnight. In these instances, such a day counts as a utilization day.
- This exception includes the situation where the beneficiary was admitted (with the expectation that he would remain overnight) on either the first day of his entitlement or the provider's first day of participation, and on the same day he was discharged, died, or transferred to a nonparticipating provider.

Next Steps

- Understand how the benefit period guidelines affect your SNF population.
- Develop a consistent and accurate Benefit period tracking process.
- Don't assume that a resident has 100 days available when they are admitted. Always check HETS and ask the resident or family. Check with the prior SNF.
- Daily skilled services provision decisions are essential
- Don't forget limitations on liability issues
- Consistent communication is a must



QUESTIONS?

