

YOU CAN LEAVE THE NURSING HOME! (May 2010 Update)

Spring and summer are times for myriad family celebrations prompted by graduations, weddings, and the holidays of Memorial Day and Independence Day, among other events. Residents of nursing homes often want to join in the family festivities but may be under the impression that they will lose Medicare coverage if they do so. This is not true.

The Medicare Benefit Policy Manual recognizes that although most beneficiaries are unable to leave their facility, an outside pass or short leave of absence for the purpose of attending a special religious service, holiday meal, family occasion, going on a car ride, or for a trial visit home, is not, by itself evidence that the individual no longer needs to be in a SNF for the receipt of required skilled care.^[1]

A facility should NOT notify patients that leaving the facility will lead to loss of Medicare coverage. Such a notification is "not appropriate," says the Manual.

If the resident returns to the facility by midnight, the facility can bill Medicare for the day's stay.^[2]

If the resident is gone overnight (i.e., past midnight) and returns to the facility the next day, the day the resident leaves is considered a leave of absence day. While the facility cannot bill Medicare for leave of absence days^[3], it is today unclear whether the facility can bill the beneficiary for those days.

As the Center for Medicare Advocacy has reported in prior years, Chapter 6 of the Medicare Claims Processing Manual says that the facility cannot bill a beneficiary during a leave of absence.^[4] However, a provision in Chapter 1 of the Medicare Claims Processing Manual, issued May 30, 2008, authorizes skilled nursing facilities to bill a beneficiary for bed-hold during a temporary "SNF Absence" if the SNF informs the resident in advance of the option to make bed-hold payments and of the amount of the charge and if the resident "affirmatively elect[s]" to make bed-hold payments prior to being charged.^[5] Whether these apparently contradictory provisions in the Medicare Claims Processing Manual can be reconciled remains to be seen.

^[1] Medicare Benefit Policy Manual, Pub. 100-02, Ch. 8, §30.7.3. (Page 35, Example, second paragraph) (<http://www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf>).

^[2] Medicare Benefit Policy Manual, Pub. 100-02, Ch. 3, §20.1.2. (Page 4) (<http://www.cms.hhs.gov/manuals/Downloads/bp102c03.pdf>).

^[3] Medicare Claims Processing Manual, Pub. 100-04, Ch. 6, §40.3.5.2. (Page 48) (<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>).

^[4] Medicare Claims Processing Manual, Pub. 100-04, Ch. 6, §40.3.5.2. (page 48) (<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>).

^[5] Medicare Claims Processing Manual, Pub. 100-04, Ch. 1, §30.1.1.1 (Page 51) (<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>). CMS cites, as authority for this payment option, the Nursing Home Reform Law, 42 U.S.C. §1395i-3(c)(1)(B)(iii), which requires that SNFs "inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under this subchapter or by the facility's basic per diem charge." CMS also cites 42 C.F.R. §483.10(b)(5)-(6).